

Why an implementation rubric?

An implementation rubric can be used by health authorities and organizations to strengthen consistency in the operationalization of integrated care for older persons living with complex health and social care requirements and their care partners. The rubric is a knowledge translation tool designed to facilitate moving evidence into practice. The rubric describes varying levels in the operationalization of integrated care specific to this population. As organizations will differ in terms of readiness, resources and opportunities for implementing integrated care, this formative self-assessment tool can help to determine current levels of integration, and identify target goals and priority areas for program development.

The rubric was developed based on the following process: (1) identifying key concepts in contemporary frameworks of integrated care relevant to older persons and care partners living with complex health conditions; (2) identifying exemplars of the operationalization of key concepts in practice; (3) grouping and labelling operational criteria for each design element; (4) applying criteria across weighted categories (informed by evaluation results associated with best evidence models). This process is in keeping with the key stages for constructing rubrics proposed by Stevens and Levi (2005).

How might this rubric be used?

The rubric enables formative assessment of the achievement of integration (implementation of design elements) based on assessment criteria corresponding with distinct levels of integration (basic, mid, high). The vertical (side) axis of the rubric lists the design elements (i.e. assessment criteria), while the horizontal (top) axis identifies weightings (i.e. low, mid, high) associated with different approaches to operationalizing a particular element in practice. The centre rows define the different levels of implementation. The rubric generates both individual (per design element) and overall (across elements) implementation scores.

The structured feedback from the rubric can be used to inform operational strategies including: setting specific implementation objectives; clarifying implementation criteria; designing implementation tasks; and tracking implementation progress. The rubric is intended to inform a continuous learning process regarding the design, implementation and measurement of integrated care for older persons living with complex health and social care requirements and their care partners. Organizations and broader health authorities can use the rubric to develop their ability to direct local learning, implementation and evaluation processes

Implementation Rubric for Integrated Older Adult Care

Design Elements	Basic-level Implementation	Mid-level Implementation	High-level Implementation	Score (assessed level)
Multi-disciplinary teams	Representation from multiple traditional health sectors. Fixed team membership .	Representation from multiple traditional health sectors. Flexible team membership (may involve representation across organizations).	Extended non-traditional health and social sector professions. Flexible support network (involves representation across multiple organizations/supports)	
Collaboration	Multi-disciplinary approach to team-based care (representation of knowledge and practice from different disciplines).	Inter-disciplinary approach to team-based care (synthesizing knowledge and practice across different disciplines).	Trans-disciplinary approach to team-based care (blurring of professional knowledge and practice).	
Cross-sector partnership	Joined-up health services (across traditional organizations operating at same layer of support).	Joined-up health services (across traditional organizations operating at same and different layers of support).	Joined-up health and social services (across traditional and non-traditional organizations operating at same and different layers of support).	
Comprehensive assessment & care planning	Focus of assessment & care planning is on illness-related issues.	Focus of assessment & care planning is on illness-related issues, <i>and</i> functioning and QoL issues.	Focus of assessment & care planning is on illness-related issues, functioning , QoL issues <i>and</i> social and prevention issues.	
Integrated care at-the-point-of-care	Coordinated delivery of multi-disciplinary supports (provided by different healthcare organizations) at the point-of-care.	Coordinated delivery of multi-disciplinary supports and intentional knowledge exchange (provided by different health care organizations) at the point-of-care.	<i>Co-delivery</i> of multi-disciplinary supports and concurrent knowledge exchange (involving representation from different health care organizations) at the point-of-care.	
Shared responsibility for continuity of care	Individual practitioners assume responsibility for delivering discipline/organization-specific interventions.	Individual practitioners assume responsibility for co-ordinating discipline/organization-specific interventions with other members of the team (both within and across organizations).	Individual practitioners assume shared responsibility for all interventions performed by the team (regardless of discipline/organization affiliation).	
Integrated specialized geriatric expertise	Geriatric expertise available via consultation.	Geriatric expertise is embedded into an integrated care team (either a stand alone SGS team or an SGS provider embedded as a member of an integrated team with representation across multiple organizations).	SGS team joined-up with one or more interprofessional health and/or social care services (forming an integrated support network).	
Integrated community & home-based interventions	Community & home-based version of traditional hospital-based care.	Community and home-based version of hospital-based care (representation from multiple health and social care disciplines/organizations in the design process).	Innovative community and home-based care interventions (representation from multiple health and social care disciplines/organizations <i>and</i> older persons and care partners in the design process).	
Older person-centred care	Primary focus on illness-related care goals. Older persons are invited to attend care conversations.	Focus is on illness-related issues <i>and</i> functioning and QoL issues. Older persons & care partners are invited to contribute to care conversations.	Focus is on illness-related issues, functioning , QoL issues <i>and</i> social and prevention issues. Older persons & care partners are invited to play an active role in guiding care conversations.	
Engaged older persons & family/friend caregivers	Older persons & care partners are invited to attend conversations regarding the development of care goals.	Older persons & care partners are invited to play an active role in developing care goals and making suggestions regarding care interventions.	Older persons & care partners are invited to play an active role in designing and implementing care interventions.	
Self-management support	Illness-related information is provided to older persons and care partners to inform them about symptoms and potential treatment interventions.	Illness-related information is provided to older persons and care partners to inform them about symptoms and potential treatment interventions. Information is also provided regarding extended service and support options, along with tips for managing related day-to-day health concerns.	Self-management Interventions are designed (with input from older persons and care partners) to actively support older persons and care partners to self-manage everyday health concerns These interventions are monitored with the intention of tracking ongoing progress.	
Integrated technologies (e-health)	Intentional design/ implementation of e-technology to enable a comprehensive health and care profile of older persons (e.g. EMR with contributions from practitioners across multiple health-related organizations).	Intentional design/ implementation of e-technology to enable to enable a comprehensive and accessible health and care profile of older persons (e.g. EMR with contributions from practitioners across multiple health-related organizations. EMR can be accessed by practitioners across multiple organizations).	Intentional design/ implementation of e-technology to enable to enable a comprehensive and universally accessible health and care profile of older persons (e.g. EMR with contributions from practitioners across multiple health and social care organizations. EMR can be accessed by practitioners across multiple organizations, and older persons and care partners).	
Integrated technologies (m-health)	Intentional implementation of m-technology to enhance the care of older persons (e.g. health-related smart phone applications).	Intentional, consistent and systematic implementation of m-technology to enhance the care of older persons (e.g. health-related smart phone applications).	Intentional, consistent and systematic implementation of m-technology to enhance the care of older persons <i>and</i> linked services to extend the reach/breadth of support (e.g. health practitioners whose job it is to communicate directly with patients based on symptom reporting via m-technology devices).	
Multi-tiered evaluation	Intentional evaluation of integrated care process and outcomes using relevant macro, meso and micro-level indicators	Intentional evaluation of integrated care process and outcomes using relevant macro, meso and micro-level indicators. Intentional and embedded, systematic continuous learning process is applied to inform ongoing program development.	Intentional evaluation of integrated care process and outcomes using relevant macro, meso and micro-level indicators. Intentional and embedded, systematic continuous learning process is applied to inform ongoing program development. Efforts are made to connect data collection/analysis across organizations/sectors.	
Score (# of design elements/level)				