Exploring new models for implementing sustainable integrated health access for people in vulnerable positions: Research protocol for a mixed methods multiple case study

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Abstract

Background: Health care is a strongly universal right across European welfare states, however, social inequalities in health persist. Literature argues that healthcare organisation is an important but overlooked determinant of social inequalities in health, as health systems buffer or amplify structural and individual health determinants. The People-centred Coordination (PCC) model offers integrated health access to people with severe mental illness, through core groups of professionals from across health and social services.

Objective: This study focuses on the vulnerable people with severe mental health problems and aims to analyse how the model can give people with severe mental illness more integrated access to health and social care. This can form a stepping-stone for the upscaling of the PCC model

Methods: We conduct a five-year multiple case study of three municipalities in Denmark, where PPC is being implemented. In a one-year pilot study, we expect to gather quantitative registry data from the municipalities and the Central Denmark Region to explore the characteristics of people included in PCC. We will also collect qualitative data, including 21 hours of observations, 36 interviews with users, professionals and managers, and 3 focus groups across the three municipalities. In a subsequent, four-year qualitative study, we aim to conduct 120 hours of observations, 120 interviews and 24 focus groups. In parallel with the qualitative study, we will facilitate a co-creation process to develop tools for sustaining integrated health access.

Results: As of January 2024, we have completed the individual interviews with users of PCC and professionals and the focus groups. Individual interviews of managers will be conducted during the 1st quarter of 2024. The quantitative data is being collected.

Conclusions: Inequality is one of the greatest challenges European societies face. Understanding new and innovative approaches to integrated care may provide valuable solutions to the challenges posed. Especially understanding and designing health and social care systems that meet the needs and abilities of those users requiring them most, is vitally important to tackle inequality.

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Research Protocol

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Keywords: healthcare organisation, social inequality in health, vulnerable people, integrated health access

Introduction

Health care is a strongly universal right across European welfare states: citizens have access to health care based on need rather than income. However, social inequalities in health persist. In Denmark, the risk of dying before the age of 65 is almost four times higher for people who left school after nine years compared to those who continued with their education [1]. Social inequalities in health can be defined as systematic, avoidable, and unfair differences in health outcomes between social groups in a population [2].

The social inequalities in health are especially high among people in vulnerable situations, who experiences many avoidable health and social care problems and a high risk of early death [3,4]. People in vulnerable situations are individuals who lack personal, material, and social resources to tackle the challenges of getting the right health and social care when in need [5]. They are a highly heterogeneous group and include people experiencing homelessness, people with disabilities, people with limited social support, and those with complex health conditions. Their life situations are highly complex and potentially volatile, and people in vulnerable situations have typically very frequent contact with a wide range of different health and social care services [5-7]. Paradoxically, however, the chance to reach and obtain appropriate care in situations of perceived need, remains poor [3,8].

Many countries struggle with increasing fragmentation of health and social care services, including the Nordic countries [9]. Studies document the continued negative consequences of fragmentation for people in vulnerable situations, and it becomes evident that fragmented services affect this group particularly strongly [10].

Providing better access to health and social care for people in vulnerable situations, should involve easy and flexible opportunities to reach and obtain an appropriate range of services [11]. Approaches to strengthen access to care have typically fallen into two camps, focusing on either an individual level (e.g., empowerment, health literacy, social capital, trust and expectations) or an organisational level to make services more accessible (e.g., changes to service information, opening hours, location of services, outreach services and appointment procedures) [6,9]. However, the reach of the second type of approach is often limited [12,13]. As Smithman et al. [5] conclude, health care organisations must adapt their accessibility to vulnerable populations' abilities, which requires innovations, tailored to reach and meet people in vulnerable situation's specific needs (similarly Hardin et al.,[(12]; Richard et al. [6]). This calls for a new approach of integrated access that combines the individual level and organisational level approaches and adopts an intersectoral perspective across the health and social care system.

This is precisely the aim of the novel Client Centered Coordination Platform (3CP) model that has been implemented in three municipalities of the Central Regional Psychiatry in Denmark. This model is inspired by Flexible Assertive Community Treatment (FACT) but emerged from the bottom-up and has a distinct intersectoral focus. The 3CP model combines an individual, needs-based approach with an intersectoral, integrated service organisation. The 3CP requires specialised competence and organisational coordination which is costly, and 3CP is therefore targeted and limited to people who, in addition to severe mental illness, often have a limited level of social functioning, reflecting for example unstable housing, substance abuse and financial problems [14]. The 3CP model includes an individually tailored core group of professionals from the regional specialist mental health services and the community-based services provided by municipalities. This multidisciplinary and cross sectoral integration distinguishes 3CP from other, existing integrated care/case management models. The cross-sectoral implementation of 3CP in the Central Denmark Region, however, proved to be complex. In the current study, we therefore investigate a cross-sectoral implementation of the 3CP model between the three municipalities and the specialist mental health services in the region.

There is not yet scientific evidence for the effectiveness of FACT in Denmark (which inspired the 3CP model). However, studies conducted elsewhere show positive results. Some main findings of FACT suggest increased remissions [15,16[, fewer hospital admissions and inpatient bed use [17], better psychosocial functioning and more use of outpatient [18,19,20] care, increased compliance with treatment, decrease in unmet needs and improved quality of life [21], better working environments for professionals and an increase in quality of care [22]. Many studies, however, often pertain to implementation, evaluation, or clinical issues and we need more knowledge on: how vulnerable people with severe mental illness experience the integrated access to care under this novel model; what specific organisational practices best support and sustain the integrated access to health and social care; and the distribution of health and social care costs in primary and secondary care. To answer these questions, this study adopts a theoretical perspective from the sociology of organisations.

Objectives

The overall aim of this study is to analyse how 3CP can give people with severe mental illness more integrated access to health and social care. This can form a stepping-stone for the upscaling of the 3CP model to FACT.

More specifically, our aims are:

1. To map out the characteristics of the people with severe mental illnesses participating in 3CP

and their use of services.

2. To explore how vulnerable people with severe mental illnesses perceive and engage in ongoing processes of integrated health and social care access as well as treatment under the 3CP model;
3. To analyse the organisational mechanisms of implementing and sustaining innovative practices for integrated health and social care access and ongoing treatment under the 3CP model;
4. To support people with severe mental illness, professionals, managers, and policy makers in sustaining practices for integrated care pathways and ongoing treatment.

Methods

The investigation of complex and multilevel processes and systems requires a range of data. We conduct a five-year multiple case study in Silkeborg, Skive and Viborg municipalities in Denmark, where 3CP is implemented. This allows for comparisons across different local contexts and underlying organisational structures. The study includes three parts: 1) a one-year explorative study of how 3CP can give vulnerable people more integrated access to care; 2) a four-year qualitative study of how to sustain user engagement in and organisational practices of integrated health access and ongoing treatment under 3CP; and, in parallel, 3) a four-year co-creation process to develop tools for sustaining integrated health access, through bridge-building committees (see Figure 1).

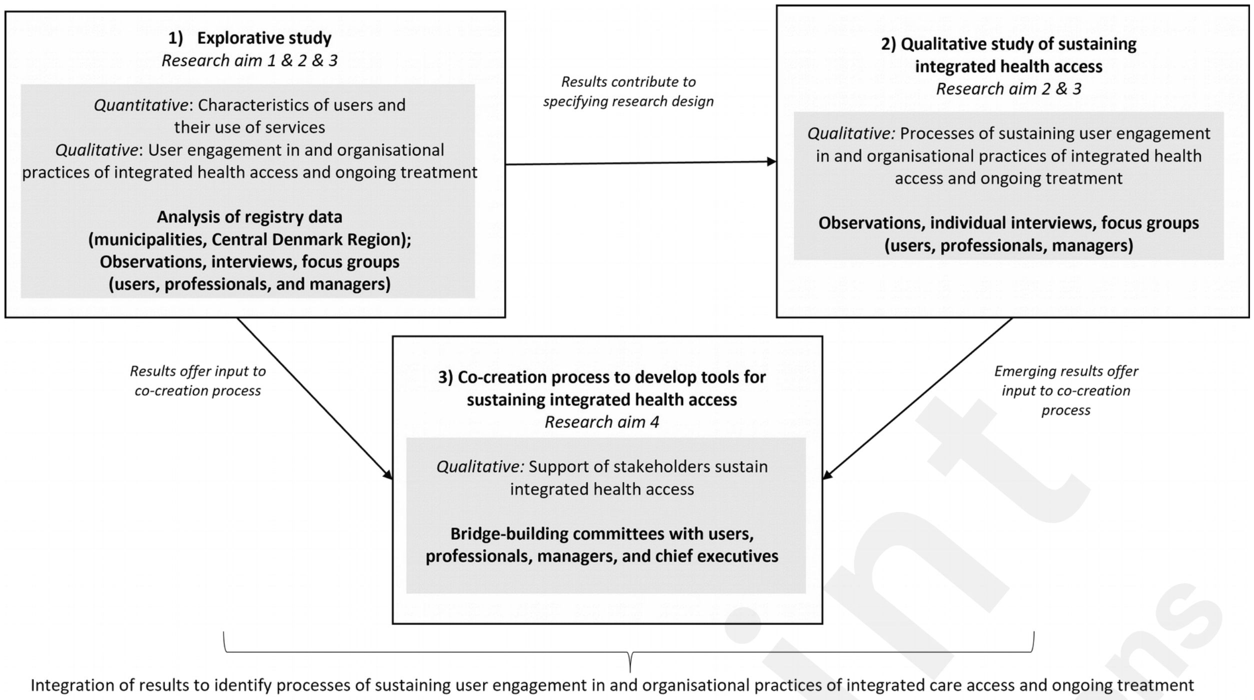

Figure 1.Overview of study

Theoretical foundation

In many countries, mental health services are provided in a broad and complex structure between the health care and social care system. This co-exists with the competing organisational and individual interests and pressures from e.g., regulators, decision makers, professionals, and the public. Navigating these structures may be challenging for people in vulnerable situations and there is therefore a need for organisations to meet the specific needs of individuals. The present study uses the theory of *inhabited institutionalism* [23,24] as this allows examining both organisational structures and social interactions. The focus is on-the-ground activities of people doing things together against the background of how rules, norms and culture operate in society [23,24]. This is because, these rules, norms, and cultures of health and social care organisations (institutions) shape and are shaped by the interactions of users, professionals, and managers. This approach is therefore ideally suited to understand the interplay between the institutions underpinning health and social care organisations, and the processes of service delivery, and how this interplay shapes the unequal pathways of services for people [23,24].

Ethical aspects

This research will be carried out in accordance with the Helsinki Declaration. An ethical approval was waived by The Central Denmark Region Committees on Health Research Ethics (No.1-10-72-124-22) Participants gave signed informed consent for study activities.

The study involves people with severe mental illness, health and social care professionals and managers. Health and social care professionals will assist in selecting people with severe mental illness to ensure that those involved have the sufficient personal resources to participate. As the professionals possess a high degree of integrity towards the 3CP users and have gained their trust, professionals are highly suitable to select those who are able to participate in this research. The life course of the people with severe mental illness, who are included in 3CP core groups, varies (e.g., from maintaining a stable daily life to having relapses). Therefore, the inclusion of participants will occur in a continuous dialogue between researchers, health and social care professionals and managers. Data collection, handling, and analyses will further be done in accordance with national and EU regulations, and participants will remain entirely anonymous. Participants in the study are also volunteers, receive information to make an informed decision about participation, and can withdraw at any time. Finally, a supervision team will be established as in-depth ethnographic encounters with people in vulnerable positions can pose distinct ethical challenges, that require self-reflection about researcher position, biases and relationship building [25,26]. This team of researchers, professionals and users will discuss these issues as part of regular meetings.

Research setting

The 3CP model in this study distinguishes itself from FACT approach in the following ways: there is less coordination across health and social care services; this occurs in an core group rather than a team with a shared caseload and a joint management; meetings take place once a week instead of daily; and there are fewer professional groups involved and less flexibility in terms of scaling up or scaling down treatment.

The implemented model builds on a collaboration between mental health services in the Central Denmark Region, the municipalities of Skive, Silkeborg and Viborg, and the Certification Centre for ACT and Flexible (F)ACT in the Netherlands. The research team consists of the Danish Center for Social Science Research (VIVE), Aarhus University, and managers from the municipalities and the Central Denmark Region. This co-production provides a unique platform for understanding the mechanisms and structures that are needed to be successful in implementing and sustaining models of integrated care access. It further safeguards the users of health and social care services, as the professionals act as advocates for this group.

Danish health and social care setting

In Denmark, the responsibility for health and social care is shared between the national, regional, and municipal administrative levels. Each of the administrative levels has considerable autonomy in relation to the management, structure, and composition of services. Therefore, the contexts for the implementation and sustainment of the 3CP model can vary to some extent. The three included municipalities vary somewhat in size but possess a comparable population composition. At the same time, there are differences in the internal organisational structure and collaborative culture that may impact on the implementation and sustainment of 3CP. For example, in each of the three municipalities different departments are responsible for introducing 3CP and the extent of collaboration with the regional mental health services varies (see Table 1). Great political and administrative autonomy is another reason, why municipalities may implement and sustain 3CP differently.

	COMPOSITION OF CORE GROUP	ORGANISATIONAL SETTING
Skive	Region 3 Nurses, 1 middle manager Municipality 9 Outreach support workers, 1 social worker	*Municipality* Centre for Mental Health and Substance Abuse
Silkeborg	Region 5 Nurses, 2 doctors, 2 secretaries, 2 middle managers Municipality 4 Outreach support workers, 3 substance abuse counsellors, 2 secretaries, 3 middle managers, 1 development officer	*Region/municipality* Integrated Mental Health Centre
Viborg	Region 8 Nurses, 1 middle manager Municipality 4 Outreach support workers, 1 middle manager	*Municipality* Centre for Substance Abuse, Centre for Welfare Services

Table 1. Local context of 3CP core groups in Silkeborg, Skive, and Viborg

3CP model in Skive, Silkeborg and Viborg

In Skive, Silkeborg and Viborg municipalities, the 3CP core groups are organized differently, reflecting variations in resources (personnel and economic), values and existing collaborations with the region (see Table 1). In Skive and Viborg, the core group consists of housing support professionals from the municipality and a municipal manager (only in Skive), and specialist mental health professionals from the region. In contrast, in Silkeborg, professionals from the municipal centre for substance abuse play a prominent role together with professionals from the specialist teams for ADHD and substance abuse in the region (see Table 1).

However, the tasks of the three 3CP core groups are similar: following disease and symptom development, providing guidance and practical help in everyday life, working with rehabilitation, and supporting the person's recovery. Those users included in 3CP teams experience severe mental illness and have chaotic life circumstances (e.g., abuse, homelessness). The 3CP core groups thus provide long-term follow-up services for people living in their local community. The core groups offer services at two levels of treatment intensity:

1. Regular individual follow-up in the core group
2. Intensive treatment and follow-up, where the user has contact with several group members, and where the core group discusses the user every week and plans what services are delivered by whom.

The core groups have shared caseloads and meet once a week to discuss those users who receive intensive treatment and follow-up support. Most users manage with regular individual follow-up, but if there is a risk of e.g., psychotic relapse, alcohol or drug relapse, or increased need for hospitalization, the core group intensifies its effort. The core group can provide this intensified effort in both the short and the longer term and during crises. When the crisis is over, professionals go back to normal individual follow-up.

Data collection (Part 1 & 2)

All participants are chosen based on being part of a 3CP core group in one of the three municipalities. The users are together with the professionals from the core groups selected for individual interviews. This will be a dialogue between the researchers, health and social care professionals and managers in the interdisciplinary core groups, to understand the users' capabilities to participate. Secondly, the health and social care professionals, who are involved with the users, will also be invited to participate in individual interviews and/or focus group discussions. This will help provide an understanding of the 3CP users' care pathways from their own perspective and from the perspective of the professionals surrounding them. The first two parts of the study involve various data collection methods, which are described below.

1) Explorative study

In the one-year exploratory study, the collection of quantitative and qualitative data occurs in parallel (convergent mixed methods) to maximise synergies in the analysis of the data (see Figure 1) [27]. This will offer a powerful platform for methodological triangulation [27, 28]. Data consist of registry data and ethnographic material (e.g., observations, focus groups, and interviews) (see Table 2). The explorative study focuses on mapping out the characteristics of people with severe mental illness included in 3CP core groups. On this basis, the study explores the experience and engagement of these people, and the health and social care professionals around them (e.g., nurses, social workers, substance abuse counsellors). The study seeks to gain new knowledge about how people with severe mental illness navigate multiple encounters with health and social service providers, and their opportunities to reach and obtain appropriate access to services. It further focuses on the organisational practices across different local contexts that underpin processes of integrated access to care.

The quantitative study will present the demographic and socio-economic profile of the people included in 3CP core groups, such as level of education, patterns of disease, labour market participation and occurrence of homelessness. The study is based on registry data from the participating municipalities, the Central Denmark Region, and the national registries (for example, information on diagnosis, contacts with the health and social care services and receipt of transfer payments) (see Table 2). Data is collected in collaboration with the municipalities and the region, and data will cover a period of 5 years (2018-2022) and include 51 individuals included in 3CP core groups between 2020-2022. The characteristics of the individuals will be reported as simple yearly means. The qualitative data will include a total of 7 hours of observations of core group meetings/interactions between users and health and social care professionals, 12 interviews with users and professionals and 1 focus group in each municipality (see Table 2).

	Explorative study (1 year)		**Qualitative study** (4 years)
Silkeborg, Skive, Viborg municipalities	IN EACH MUNICIPALITY *Observations:* 3 core group meetings 2 Professional/user interactions *Individual interviews:* -5 users of 3CP -5 professionals -2 managers *Focus groups:* -3-4 professionals IN ALL 21 hours observations 36 Interviews 3 Focus groups	IN EACH MUNICIPALITY *Registry data:* Silkeborg municipality: 19 users of 3CP Skive municipality: 16 users of 3CP Viborg municipality: 16 users of 3CP IN ALL 51 users of 3CP	IN EACH MUNICIPALITY PER YEAR *Observations:* 3 core group meetings 4 Professional/user interactions *Individual interviews:* -2 users of 3CP -4 professionals -2 managers -2 chief executives *Focus groups:* -3 professionals -3 managers/chief executives IN ALL 120 hours observation 120 Interviews 24 Focus groups

Table 2. Overview of planned data collection

2) Qualitative study of sustaining integrated health access

This four-year qualitative study aims to understand how to sustain user engagement in and organisational practices of integrated health access and ongoing treatment under 3CP in the longer term. Like in the exploratory study, we will focus on both: how vulnerable people with severe mental illnesses perceive and engage in ongoing processes of integrated health and social care access as well as treatment; and how organisational practices by professionals, managers and chief executives can sustain these innovative practices. In each municipality we expect to gather the following material each year, over a period of four years: 10 hours of observations of core group meetings/interactions between users and health and social care professionals, 10 interviews with users, professionals, managers and chief executives, and 2 focus groups with professionals and managers/chief executives respectively. The interviews and focus groups will also be informed by the data collected in the explorative study (see Figure 1).

Co-creation process to develop tools for sustaining integrated care access (Part 3)

To support the sustainment of integrated access to health and social care, this third part of the study consists of a co-creation process with local stakeholders. We will initiate and conduct bridge-building committees involving users of 3CP and the relevant professionals, managers, and politicians. Initially, a planning team with representatives from all three municipalities and the region will meet to discuss implementation. This is part of the co-creation process and will occur once a year and involve users, professionals, and managers. Subsequently, the planning team will meet once a year to share experiences of the bridgebuilding committee meetings (see Table 3).

In each municipality, we aim to organise five bridgebuilding committee meetings of two hours each (over a period of four years). Each meeting will include 10 participants from across the municipality and the region; two users (who are able to participate), four professionals, two managers, and two politicians (see Table 2).

The first meeting is a kick-off meeting, where the participants will assist in tailoring the structure and function of the meetings as part of a co-creation process. Next, there is a pilot-meeting, before moving on to the regular committee meetings (see Table 3). The final meeting focuses on sustainment to secure the long-term involvement of users, the adaptation of the 3CP model, and the continuous flexibility in care pathways. At all the committee meetings, the researchers involved in this study will develop questions and topics to facilitate discussion.

		Committee meetings Silkeborg	**Committee meetings Skive**	**Committee meetings Viborg**
Year 1	1	Planning team meeting		
	2	#1 Co-creation workshop (Kick-off)	#1 Co-creation workshop (Kick-off)	#1 Co-creation workshop (Kick-off)
	3			
	4	#2 Pilot	#2 Pilot	#2 Pilot
Year 2	1	Planning team meeting		
	2	#3	#3	#3
	3			
	4			
Year 3	1	Planning team meeting		
	2	#4	#4	#4
	3			
	4			
Year 4	1	Planning team meeting		
	2	#5 Sustainment workshop	#5 Sustainment workshop	#5 Sustainment workshop
	3			
	4			

Table 3. Overview of bridge-building committees

Collecting data with people in vulnerable positions

Ethnographic methods are characterised by flexibility and studies that are less fixed in terms of their specific form and extent of empirical material [29,30]. This is a highly suitable approach, as the users in our study all are vulnerable as well as heterogenous; they possess very different resources for participating in research. Their experiences with health and social care services may also change over time [30]. Likewise, the interactions between service users and service providers are ‘in the making’ as our study progresses [29]. Even the organisational practices of 3CP are intended to be ‘flexible’, so that they can be adjusted to the needs of the user. We thus expect to combine various methods of data collection and do so in a flexible manner; this includes qualitative semi-structured interviews, observations, photovoice [28,31] and informal conversations. Interviews will allow us to gain knowledge about the experiences of being part of a 3CP core group, as well as views of the organisation of the services under the 3CP model. In relation to users, we will combine this with photo-voice to help us inquire into their underlying understandings of health and social care services. This method particularly provides a way of engaging people with intellectual disabilities, as their thoughts may be illustrated in a picture rather than expressed in wording [28,31]. We will provide the 3CP users with a disposable camera, where they can take pictures that they find relevant to their involvement in treatment. These pictures will be used in the interviews, to facilitate the discussion around their experiences with accessing health and social care services under the 3CP model. Observations and informal conversations will further give us more in-depth knowledge about their concrete experiences navigating the system as users and professionals respectively.

Results

As of January 2024, we have completed the individual interviews with users of 3CP and professionals and the focus groups (see Table 2). We will, during February or March 2024, proceed with the individual interviews of managers in each of the three municipalities.

We are further in the process of collecting the quantitative data (See table 2)

Discussion

Fragmented health and social care services affect people in vulnerable positions particularly strongly [4] and therefore organisations must adapt their accessibility to the needs and abilities of vulnerable populations. This study aims to analyse, if and how the 3CP model can give people in vulnerable positions a more integrated access to care, drawing on an in-depth analysis of the interplay between individual needs and care seeking practices and organisational practices and underlying structures and mechanisms.

We anticipate that our study will contribute to existing knowledge in three respects. Firstly, it will provide in-depth knowledge about pathways of health and social care seeking and the related barriers and facilitators, particularly under the 3CP model. Secondly, this knowledge can contribute to better understanding and addressing unequal access to health and social care. The causes of inequality in health are often assigned to ‘social determinants’ (education, income, gender) although these are correlations rather than causations; being a poor, low educated man does not determine one’s health or access to health, even if more low educated men have poor health. The relationships between social factors and health are not simple and instead this requires a more careful exploration of the “causes of the causes” [32]. That is: What are the specific links between social factors on the one hand and health on the other? Thirdly, the study will contribute to existing knowledge on the relations between individual care practices and organisations’ practices of service delivery; in short, how organisations can facilitate and hamper access, especially across different sectors. This will contribute to addressing the lack of knowledge about the interplay between human interactions on the one hand and organisational structures on the other [33].

One limitation of our study is the uncertainty in collecting data with a highly group of vulnerable people. We therefore need to be flexible and adapt our strategies as we are in the field. Further, using the 3CP teams provides us with valuable knowledge on integrated health access, however this is one context to be explored. Other models or settings might provide other insights.

Dissemination of results

To disseminate the results, we will reach out to stakeholders by presenting results on a regular basis at relevant workshops, conferences and in (professional) journals. We will also give presentations at practitioner conferences on mental health care and substance abuse counsellors, such as those organised by the umbrella organisation of Danish Regions. The research team will publish the results of the study in at least three articles in international, peer reviewed journals.

Implications

The results of this study will strengthen the integrated health access for vulnerable people. More specifically, the study will:

1. Identify strategies to help *people in vulnerable positions* with severe mental health problems to improve their experience of access across different sectors of the health and social care system.
2. Develop a catalogue of strategies for good practice for *professionals* and *decision-makers* in municipalities, hospitals, and general practice to strengthen integrated access to care for people in vulnerable positions who suffer from severe mental health problems.
3. Offer a steppingstone for upscaling the 3CP model across other regions/municipalities and to other vulnerable groups, based on detailed knowledge about the specific contexts and mechanisms fostering integrated access to care.

Conclusions

Inequality is one of the greatest challenges European societies face and there are many opportunities for future research within this field. However, understanding new and innovative approaches to integrated care may provide valuable solutions to the challenges posed. Especially understanding and designing health and social care systems that meet the needs and abilities of those users requiring them most, is vitally important to tackle inequality.

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None

Conflict of interests

The authors declare that they have no competing interests.

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Multimedia Appendix 1: [Interviewguide]

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Abbreviations

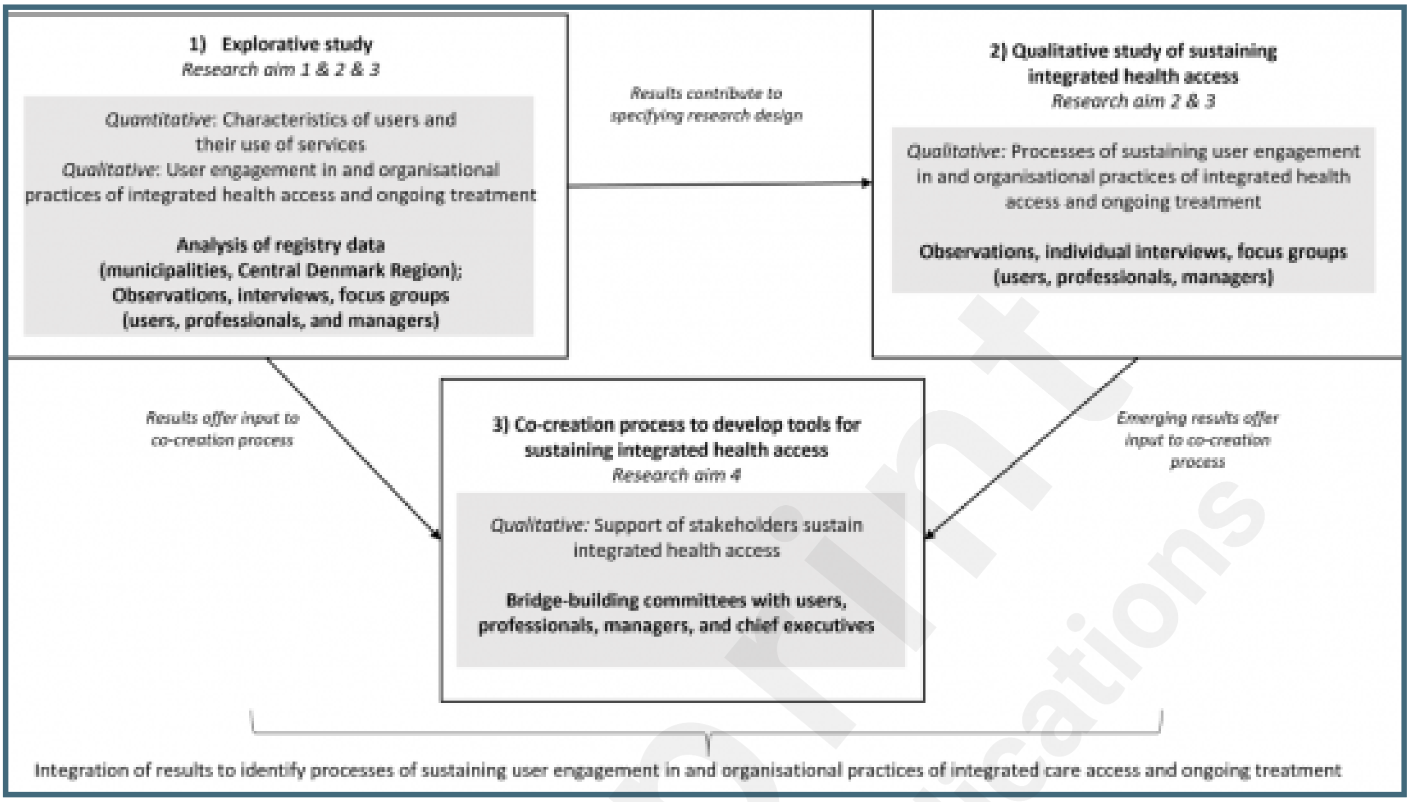
FACT: Flexible Assertive Community Treatment

3CP: Client Centered Coordination Platform

Supplementary Files

Figures

Overview of study.



Multimedia Appendixes

Interviewguide.
URL: http://asset.jmir.pub/assets/9d739a241492bcaada40d8d1498d7785.docx