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Short Communication

Opportunities for authentic co-production in integrated care implementation

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ABSTRACT

This Short Communication proposes opportunities for authentic co-production in integrated care implementation. While there are targeted efforts to implement integrated care across healthcare systems, the extent to which these efforts have prioritized co-production is unknown. Opportunities for authentic integrated care implementation co-production are anchored to five core principles for implementation collaborations: 1) equity in relationship building, (2) reflexivity, (3) reciprocity and mutuality, (4) transformative and personalized, and (5) collaborative relationship structures or procedures.

Introduction

There are growing examples in the United States, United Kingdom, and globally to intentionally engage patients, providers, and healthcare leaders in shaping healthcare services, delivery, and evaluating impact (Stadnick et al., 2019). This engagement process has been referred to as co-production, co-creation, and "all things co" (Pérez Jolles et al., 2022). In the United States, examples include the National Institutes of Health Community Engagement Alliance (Community Engagement Alliance (CEAL) Against COVID-19 Disparities | Community Engagement Alliance [Internet]) and the Patient Centered Outcomes Research Institute's Engagement Award Program (Eugene Washington PCORI Engagement Award Program [Internet], 2014). In the United Kingdom, the National Institute of Heath and Care Research has identified co-production as a main initiative for ongoing research and practice efforts (Denegri et al., 2015). While the concept of co-production has been discussed in the context of healthcare and implementation research broadly (Pérez Jolles et al., 2022), there is a need to investigate co-production of specific, yet generalizable, healthcare implementation efforts, like those for integrated care. In recent decades, integrated care, defined as "an organising principle for care delivery that aims to improve patient care and experience through improved coordination" (Shaw et al., 2011) has received growing attention as holding promise in facilitating healthcare delivery improvements. Integrated care aims to address the historically siloed nature of healthcare that results in negative impacts on healthcare and health outcomes. Extensive efforts have targeted the implementation of integrated care models across a broad range of healthcare systems (Janamian et al., 2022; Baltaxe et al., 2022; Martin et al., 2022; Manley et al., 2023; Guise et al., 2019; Dugstad et al., 2019; Stevens et al., 2017; Martinez et al., 2023; Stadnick et al., 2022). However, the extent to which these integrated care implementation efforts have prioritized co-production remains unknown. Integrated care implementation efforts that neglect co-production may result in models of care that fail to address the needs, resources, and priorities of the people and context within which they are implemented.

Extending from our quest for action to advance integrated care implementation research (Stadnick et al., 2019), this Communication piece endeavours to provide examples from the literature targeting co-production of integrated care implementation efforts, and proffers avenues for future development. We use the term co-production, defining it as 'the interdependent work of users and professionals who are creating, designing, producing, delivering, assessing, and evaluating the relationships and actions that contribute to the health of individuals and populations" (Batalden, 2018). While many definitions exist for integrated care, we define integrated care as an organizational process of coordination across services or systems to achieve seamless care, tailored to patients' comprehensive needs (Stadnick et al., 2019). We define integrated care implementation as deliberate efforts to facilitate

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adoption of coordination across services or systems to achieve seamless and continuous care, tailored to patient needs, and based on a holistic view of the patient (Mur-Veeman et al., 2003).

Defining co-production

Broad definitions of co-production and co-creation refer to efforts motivated to produce a mutually beneficial outcome that is jointly developed by two or more actors (Dugstad et al., 2019). More narrow definitions include researchers and practitioners working together to create a shared knowledge model in delivering evidence-based practices (Giles and Graham, 2017); collaboration between patients and practitioners to create a responsive and feasible healthcare plan (Guise et al., 2019; Norton, 2021); and knowledge translation and improvement of clinical impact of research findings between researcher and healthcare professionals (Martin et al., 2022).

To uncover examples of co-production of integrated care implementation efforts, a scoping review methodology was utilized. In March 2025, a literature search was conducted in the PubMed database. A combination of free-text terms were entered to search the keywords, abstract, and title of publications. While the term "co-production" is frequently used to describe the process of engaging patients, providers, and healthcare leaders in the shaping of healthcare services, "co-creation" is another term often used interchangeably with co-production. As such, search terms included "co-production" or "co-creation" together with "integrated care," and "implementation." This search resulted in 109 publications, of which 19 were identified for further review. The other 90 publications were excluded due to lack of relevance to co-production in the integrated care setting, failure to consider implementation, or because they were not aligned with our definition of co-production. Included publications were empirical studies (n = 12), review articles (n = 6), personal views or editorials (n = 2), and case study or research methodology/protocol papers (n = 5) from hospitals, rehabilitation centers, nonprofit organizations, and journal editors focused on healthcare delivery and training.

Discussion and reflection

Challenges to co-production

Multi-level challenges and opportunities exist to advance co-production efforts for integrated care implementation. While a recent rapid evidence review found that "references made to barriers to integrated care exceeded those of enablers by more than a third," (Thomson and Chatterjee, 2024 p. 15) co-production was found to be a main enabler of integrated care. Challenges at the patient or community-level include awareness of opportunities to engage in co-production, skills to effectively advocate for co-production, and biopsychosocial factors that may impede or impact one's ability to engage in co-production (Bee et al., 2015; Brooks et al., 2018; Neil et al., 2013; Holland-Hart et al., 2018; Beckett et al., 2018). Attitudes at the level of patient or community might also serve to limit co-production efforts for integrated care implementation including minimal interest or willingness to engage in co-production and a preference to defer to the expertise of healthcare professionals (Bee et al., 2015; Brooks et al., 2018; Holland-Hart et al., 2018). At the provider-level, challenges may include time constraints, competing demands, compensation structures that emphasize service delivery (Bee et al., 2015; Brooks et al., 2018; Holland-Hart et al., 2018; Beckett et al., 2018) over co-production initiatives (Bee et al., 2015; Holland-Hart et al., 2018), or poor climate for co-production (Brooks et al., 2018). Like patient or community-level challenges, negative provider attitudes about co-production might also serve as a limiting factor (Bee et al., 2015; Brooks et al., 2018; Beckett et al., 2018). At the system-level, challenges may include infrastructure constraints, competing demands or priorities, limited buy-in about the value of co-production (Brooks et al., 2018), absent oversight evaluation (Beckett et al., 2018), failure to embed service user involvement at a "higher level on the 'ladder of co-production'," (Conquer et al., 2024 p. 11) and accountability to facilitate successful co-production. Furthermore, misalignment across these multiple levels, including "varying opposing positions and conflictual interests," (Martens et al., 2023 p. 2) can serve as a barrier to co-production in integrated care implementation. While multi-level frameworks and guides exist to support co-production efforts in integrated care implementation, significant opportunity exists for their application (Gencturk et al., 2024; Martens et al., 2023; Carrandi et al., 2024; Hafiz et al., 2024).

Opportunities for co-production of integrated care implementation

Pérez Jolles et al. (2022) proposed a perspective centered on five core principles needed for implementation collaborations in service of authentic co-creation. These principles are (1) equity in relationship building, (2) reflexivity, (3) reciprocity and mutuality, (4) transformative and personalized, and (5) relationship structures or procedures are developed collectively to facilitate implementation collaboration. We now offer examples of how these principles could be applied in co-production efforts for integrated care implementation and to address the multi-level challenges described.

1) **Equity in relationship building**. The equity principle emphasizes an equal valuing of the knowledge and experience of all relevant partners (Pérez Jolles et al., 2022; Dufour et al., 2023). Regarding integrated care implementation efforts, relevant partners might include patients and their families, healthcare providers, healthcare leaders and staff, payers, implementation facilitators, and/or quality assurance/improvement representatives. The equity principle calls for valuing the knowledge and experiences of all partners and ensuring equitable access to information and resources, and decision-making power (Pérez Jolles et al., 2022; Carrandi et al., 2024). Equity in integrated care implementation necessitates a consideration for the varying needs and strengths of relevant partners, including language/cultural differences (e.g. convening meetings and making resources available in preferred languages), areas of expertise (e.g. community resources, evidence-based medicine, healthcare administration), (Berryman et al., 2024) and privilege and/or access to resources (e.g. transportation to attend meetings, high-speed internet to access online documents).
2) **Reflexivity**. The reflexivity principle encourages all co-production partners to be cognizant of their positions, backgrounds, worldviews, and/or assumptions that they bring to the process (Pérez Jolles et al., 2022). A critical awareness for how these differing values influence group dynamics and processes is essential to reflexivity (Dawson et al., 2022; Berryman et al., 2024). Regarding integrated care implementation efforts, reflexivity might require protecting time and space for relevant parties to reflect upon their positions, and how these positions might influence group dynamics and processes. Power imbalances and assumptions should be scrutinized, as well as group processes for sharing and making decisions. Recently, the editors in chief and the editorial board of a research journal focusing on integrated care published an editorial detailing a process that can serve as an example of reflexivity. The editorial noted that, despite the increasing centrality of co-production at multiple levels of an integrated care system, "there has been relatively little recognition of this within the research and practice innovations that underpin" published articles (Miller et al., 2024 p.1). With this realization of how the journal was failing to use its position of power to advance co-production in integrated care implementation, it endeavoured to pursue change further detailed in the Relationships Facilitated section below.
3) **Reciprocity and mutuality**. The reciprocity and mutuality principle emphasizes the relationships between co-production partners and the genuine exchange of support for the benefit of all partners (Pérez

Jolles et al., 2022; Heaton et al., 2015). The principle of reciprocity and mutuality concerns the deliberate actions to build and sustain relationships, and to help others. There is a willingness and investment to meet the needs of others (Farr et al., 2021). Regarding integrated care implementation efforts, reciprocity and mutuality might be demonstrated when co-production partners collaborate on the creation of products, resources, or solutions that are beneficial to partners. In doing so, co-production partners may experience deepened connections with other partners, and perceive the relationship as mutually beneficial. Integrated care implementation efforts might experience pressures to enhance decision-making efficiencies. Co-production partners of integrated care implementation should remain mindful of these pressures to enhance decision-making efficiencies, as doing so can subvert efforts to prioritize reciprocity and mutuality.

4) **Transformative and personalized**. In addition to achieving the goals of a co-production effort, the transformative and personalized principle concerns the individual fulfilment one may experience by engaging in a co-production effort (Pérez Jolles et al., 2022; Heaton et al., 2015). When a co-production effort is transformative and personalized, partners may demonstrate greater buy-in with the endeavour, remain active in the process, and experience enrichment from engaging in a process that is aligned with their values. Regarding integrated care implementation, transformative and personalized co-production can be enhanced by exploring each partner's motivation for collaborating on the co-production process (Pérez Jolles et al., 2022). Family members might express motivation to join an integrated care implementation co-production to advocate for the needs of their loved ones who experience chronic illness, while internal medicine physicians might express motivation to join an integrated care implementation co-production to communicate the challenges they experience when aiming to engage in shared decision making with patients. When values-aligned behaviours are reinforced and encouraged in a co-production process, the result may be an individually and transformative and personalized experience (Ranjan and Read, 2014).
5) **Relationships facilitated**. The relationship facilitated principle concerns the systems, practices, and/or procedures that are developed in a co-production process to support collaboration (Pérez Jolles et al., 2022). Explicit agreements about member roles and responsibilities are created collaboratively to promote successful relationships and participation of all members (Cassidy et al., 2024; Carrandi et al., 2024). Regarding integrated care implementation, relationships facilitated by co-production can be achieved through the development of team charters wherein member roles and responsibilities are outlined (Shuffler et al., 2018). A memorandum of understanding or agreement may be used to formalize expectations regarding member roles and responsibilities throughout the co-production process. As detailed above, the editors in chief and the editorial board of a research journal focusing on integrated care published an editorial detailing a launch of three requirements to promote co-production in the publication of research targeting integrated care: 1) that all submissions to the journal must detail how people with lived experience were involved in the development and delivery of the activities underpinning the submission, 2) the journal must recruit people with lived experience on the editorial board, and 3) the journal must recruit a pool of reviewers with lived experience who can contribute to this core aspect of the journal's processes (Miller et al., 2024).

Conclusion

Co-producing successful integrated care implementation requires attention to multi-level challenges and opportunities. This Communication piece offers concrete recommendations for integrated care implementation organized by co-production core principles for implementation collaboration.

CRediT authorship contribution statement

Sklar Marisa: Writing – review & editing, Writing – original draft, Conceptualization. **Conradi Lilliana:** Writing – review & editing, Writing – original draft. **Brubaker Anna:** Writing – review & editing, Writing – original draft. **Stadnick Nicole:** Writing – review & editing, Writing – original draft, Conceptualization. **Sadler Euan:** Writing – review & editing.

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Competing interests

The authors do not have any competing interests to declare.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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