KEY FINDINGS:
• One of the few bottom-up pioneer models in Austria
• Focus on the combination of health and social problems of low-income groups
• Collaboration of different health care professionals and social care as central aspect
• Sustainability of model depends on future financing structures

Service delivery
• All activities based on a “social health and medicine approach”, focus on inequality with respect to health and social status
• Targets persons with physical and mental disorders and/or social problems, disadvantaged groups
• Multidisciplinary team with physicians, social workers and social pedagogues
• Continuous holistic assessment of the patient with emphasis on social aspects
• Services offered:
  • Medical care (e.g. primary medical care, psychotherapy, addiction treatment, health promotion)
  • Social care (e.g. various counselling services, community work)
• Target group appropriate communication and working together in close proximity on an everyday basis
• Cross-sector cooperation in SMZ incorporates social projects to realise low-threshold access to integrated care
• Regular joint case conferences

Leadership & governance
• Organised as a collaboration of a group practice with the Association for Practical Social Medicine
• Association runs several projects for social work/care and health promotion
• Flat hierarchy in cooperation of physicians, assistants and social workers

Technology & medical products
• Specifically developed electronic data gathering and processing system
• Patient-used ICT applications viewed critically due to considerations of equitable access
• Positive attitude towards EMRs due to possibility to monitor patients’ medication use and avoid prescription medication addiction

Workforce
• Personnel with multiple qualifications in all positions
• Participation of entire staff in hiring decisions
New roles assumed by old professions:
• Responsible participation of all staff in joint case analyses
• Assumption of wound management duties by assistants

Financing
• Annual funding from regional health insurance fund + project-based funding from various sources + voluntary work
• Financing is a central problem due to missing financing framework for group practices in Austria
• Current negotiations on future financing

Information & research (EVIDENCE)
• No comprehensive evaluation carried out so far – interest in evaluation but no resources available
• SMZ physicians engage in research activities in the field of social medicine
Austria: Health Network Tennengau (1)
Astrid Segert, Susanna Ulinski, Thomas Czypionka

**Leadership & governance**
- Organised as not-for-profit cooperative comprising social and health service providers and voluntary organisations
- Climate of equitable cooperation between small and large network members
- High communication effort required to uphold contacts between involved partners

**Technologies & medical products**
- Secure data network for patient data established between hospital and approx. 100 regional GPs – is well-accepted
- No specific ICT applications to be used by patients – focus on personal relationships

**Financing**
- Annual funding from Salzburg health fund + project-based funding from various sources + voluntary work
- Financing problems are omnipresent, e.g. limited compensation of partners, no resources for public relations, lack of funding at start of pilot projects

**Service delivery**

**Leadership & governance**
- Organised as not-for-profit cooperative comprising social and health service providers and voluntary organisations
- Climate of equitable cooperation between small and large network members
- High communication effort required to uphold contacts between involved partners

**Workforce**
New professional roles:
- **Senior citizen counsellor**: background as nurse, assesses needs, provides information and coordinates social/nursing care
- **Discharge manager**: background as nurse, works in hospital, performs Discharge Risk Screening and organises discharge
- Planned: Mobile specialised nurse
- **HNT Manager**: manages communication and cooperation between involved stakeholders

**Information & research (EVIDENCE)**
Evaluation of counselling services:
- Descriptive analysis of questionnaire data
- Positive response: Patients use variety of offered services and feel to be better informed after counselling

Evaluation of discharge management:
- Descriptive data analysis, comparison of trial and control group, pre- and post-measuring
- Mixed results: rate of re-hospitalisation is decreased, aims of decreasing length of stay and extramural cost only partially attained

**Key Findings**:
- Shared decision-making, culture of communication and trust perceived as important features
- Appreciation of non-hierarchical structure, but wish for further professionalisation of network
- Sustainability of financing is questionable, problem of structural financial barriers in Austria
- New professional roles: senior citizen counsellor, discharge manager

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**Secure data network** established between hospital and approx. 100 regional GPs is well-accepted. No specific ICT applications are used by patients; focus is on personal relationships.

**New professional roles** include:
- **Senior citizen counsellor**: Background as nurse, assesses needs, provides information and coordinates social/nursing care.
- **Discharge manager**: Background as nurse, works in hospital, performs Discharge Risk Screening and organises discharge.
- **HNT Manager**: Manages communication and cooperation between involved stakeholders.

**Evaluation** of counselling services shows:
- Positive response: Patients use variety of offered services and feel better informed after counselling.

**Evaluation** of discharge management indicates:
- Mixed results: Rate of re-hospitalisation is decreased, but aims of decreasing length of stay and extramural cost are only partially attained.
Croatia: GeroS (1)
Romana Tandara Hacek, Renata Gerenkovic, Darija Ercevic, Mirjana Hucic

KEY FINDINGS:
- System for monitoring and evaluation of health needs and functional ability of geriatric patients inseparably linked to the national health information system CEZIH (Central Health Information System of the Republic Croatia)
- Warning alarms in system - requests for action; prevention of duplication of services; new professional roles with prefix “geronto”
- Follow-up of negative health behavior ↔ reimbursement ↔ self-management
- “Four degree of geriatric health care”: Proactive care vs. long term care
- Step by step upgrading of Modules to full functionality - Financing?
- Supporting of out-institutional care for elderly

Service delivery

Leadership & governance
MoH Referral Centre for Protection of Health of Elderly:
- Support service for all stakeholders
- Four degree of geriatric health care
- Long term care and social care

Workforce
- New professional roles with prefix geronto, education through geronto-WSs
- Lack of educators
- Lack of health professionals and other staff

Financing
- Still as Pilot project
- Waiting for new Croatian Government decision on financing
- Close cooperation of Ministry of Health and Ministry of Social Policy and Youth is needed

Technology & medical products
- In function: already implemented electronic data in CEZIH (Record sheet 1 and 4, NRS 2002) and DOGMA (Primary care level, Homes for elderly level)
- Should be upgraded to all levels in health care in several stages
- Connection with social care system in the future

Information & research (EVIDENCE)
- Monitoring system is not yet sustainable
**Croatia: PALLIATIVE CARE SYSTEM (2)**

*Mirjana Huic, Romana Tandara Hacek, Darija Ercevic, Renata Grenkovic*

### KEY FINDINGS:
- Integration of health and social care, new role of mobile teams, inclusion of informal caregivers
- Coordination Centers should ensure coordination and cooperation between different sectors
- Implementation on national level, sustainable systematic data collection and monitoring, quality indicators and national Registry of palliative patients are necessary

### SERVICE DELIVERY

**COORDINATION CENTERS (County level)**

<table>
<thead>
<tr>
<th>OUTPATIENT PALLIATIVE CARE</th>
<th>INPATIENT PALLIATIVE CARE</th>
<th>OTHER FORMS OF PALLIATIVE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>HOSPITAL</td>
<td>SOCIAL CARE</td>
</tr>
<tr>
<td>COMMUNITY NURSE</td>
<td>DAY CARE HOSPITAL</td>
<td>SPIRITUAL CARE</td>
</tr>
<tr>
<td>HOME CARE-MOBILE TEAMS</td>
<td>INFIRMARY</td>
<td>VOLUNTEERS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OFFICE FOR RENTING MEDICAL AIDS</td>
</tr>
</tbody>
</table>

**Palliative care** - partly embedded in Croatian health care

### LEADERSHIP & GOVERNANCE

- Partner organisations: Ministry of Health, Ministry of Social Policy and Youth, Croatian Health Insurance Fund, other on county levels
- Coordination Centers for Palliative care → Coordination of palliative care on county levels, ensuring vertical, horizontal and intersectoral collaboration

### WORKFORCE

- Multidisciplinary palliative care teams: Physicians (GPs, specialists), nurses, community care nurses, psychologists, social workers, volunteers, family, university staff, priests, mobile teams
- Additional education (upgrading the existing professions): CEPAMET, Medical School University of Zagreb

### TECHNOLOGY & MEDICAL PRODUCTS

- ICT applications: Electronic health records (EHR), internet, cellular phones, telemedicine in future
- Important for sustainable linkage of palliative care network
- No unified IT system on national level, only under own organisation: e.g. Istrian County, KBC Rijeka

### FINANCING

- The palliative care is and will be financed at national level through national mandatory health insurance
- Funds for special programs used for financing 10 pilot projects: Mobile palliative teams
- Additional funding provided by certain counties (e.g. upgraded services)

### INFORMATION & RESEARCH (EVIDENCE)

- National Guideline for working with palliative patients in emergency centres was published in 2015
- Registry of palliative patients is planned; Quality indicators are needed
- Monitoring system is not yet sustainable → The MoH Committee for Palliative Care is responsible for further activities and new Strategic plan after 2017
Germany: CASAPLUS (1)
Verena Struckmann, Anne Spranger, Ewout van Ginneken

KEY FINDINGS:
• A nurse is trained to act as ‘case manager’ and plays a key role in provision and care integration.
• Collaboration with health- and social care providers could be expanded.
• Longer contract durations between MeCo and participating sickness funds seem crucial for favourable results.
• Difficult to interpret some evaluation results, need to be more transparent and comprehensive.

Service delivery
- Identification of high risk persons by predictive modelling tool
- Initial assessment of identified person by case manager via telephone
- Categorization in different risk classes
  - For low risk (1-3)
  - For high risk (4-6)
- Coaching in form of person-centred support (e.g. education, increasing abilities, referral to specialists, strengthening self-confidence)
- Home visits by nursing professionals
- Regular monitoring via phone (every 4-8 weeks). Additional care provision by GPs, psychologists or pharmacists if needed.

Leadership & governance
• Medical Contact AG (MeCo) is voluntarily contracted by sickness funds to coordinate all the participating providers.
• 17 participating sickness funds (mostly company related funds).
• Cooperation with 177 local outpatient nursing services to conduct home visits.

Workforce
• **Case manager** main care provider: specially trained, background as nurse (traditionally at hospitals), work according to current clinical practice guidelines, shared decision making.
• **Core team with nurse practitioner.** Additionally, other professionals participating are: GP’s, psychologist, pharmacist, care manager of participating sickness fund.
• Continuous training paid by MeCo for case managers and nursing professionals.

Financing
• Usual reimbursement schemes between sickness funds and the MeCo.
• Profit-sharing of yearly average hospital cost savings between the MeCo and the sickness funds.
• Initially pay-for-performance model, but did not yield expected results.
• Capped payment amount per insured.

Information & research (EVIDENCE)
• Focus of the evaluation: **triple aim**.
• Internal evaluation of competency, care and economic goals.
• Client satisfaction survey – positive results (e.g., ADL, QoL, satisfaction with care).
• Cost-effectiveness evaluation positive - reduced hospitalisation costs, medicine costs and medical products.

Technology & medical products
• **EHR data** used by case managers for care coordination, but not shared.
• Online platform for regular communication between case managers and nursing professionals.
Germany: Gesundes Kinzigtal (2)
Verena Struckmann, Sabine Fuchs, Ewout van Ginneken

KEY FINDINGS:
• Population-based approach that organizes care across all health service sectors and indications.
• Designed around the “Triple Aim”.
• Shared-savings approach.
• Consistent savings and improved health outcomes.
• Since 2016, no longer a pilot programme after receiving long-term contract.

Service delivery

Leadership & governance
• A management organisation (Optimedis) acts as a regional integrator. Ownership is shared.
• Collaboration with sickness funds, GPs, nursing homes, community groups, ‘World of Health’, physiotherapists, hospitals, pharmacies.
• Networking among providers is a priority.

Financing
• GK is accountable for the whole (i.e. trans-sector) health care service budget.
• Shared savings contract: Savings are shared between the management organization, funds and physician network.
• Provider receive payments for their time invested in participation, additional patient care and follow up.

Workforce
• GPs are the main care provider, act as gatekeepers and are trained in shared decision making.
• A new professional role is currently being planned that will act as coordinator and will collaborate closely with the GPs.
• ‘Healthy Kinzigtal Academy’ a training and education institute, mainly for health professionals.

Technology & medical products
• EHR for information exchange, transparency and care quality improvement.
• Cockpit records contain benchmark information to compare prescribing behaviour of the participating physicians.

Information & research (EVIDENCE)
• Comprehensive, scientific internal and external evaluations.
• Experiences of care: biannual patient survey - high levels of overall satisfaction.
• Health outcomes: better health outcomes compared to usual care. Reduction of hospital admissions, reduction of morbidity and lower mortality rate.
• Costs: Favourable development, savings achieved, especially due to a reduction in hospital admissions.
Hungary: OnkoNetwork (1)

János G. Pitter, Marcell Csanádi, Antal Zemplényi, Kata Csetneki, Zoltán Kaló

**Leadership & governance**
- Strong leadership, fully committed to clear goals (timely diagnosis and therapy initiation).
- Accountability, escalating levels of quality assurance referrals (technical clarifications -> top management interventions).

**Workforce**
- New professional roles for non-physicians and for physicians
  "The new roles were composed by scratch, without precedent cases to learn from. There was a need for administrators who overview the full care process, with a supportive role but also with some power; and it became evident early that communication between non-physicians and physicians is not ideal in this context, so we need a supervisor physician role also." [IP12_1]
- Department physicians: less administrative burden, enforced teamwork

**Technology & medical products**
- A tailored IT software for individual patient path monitoring and management
- Interoperability with the medical IT systems is a challenge: non-automated functions are replaced by human resources (manual searches / data transfers across IT systems)

**Financing**
- No specific coverage or reimbursement for OnkoNetwork services from any external source. The low operational costs are financed from the Hospital’s budget.
- No specific financial incentives for the participating professionals. Instead, the staff is motivated by immaterial values of the project.

**Service delivery**
- A patient enters the Centre with a suspect diagnosis of a new solid tumour -> diagnosis in 30 days and therapy initiation in +14 days.
- Personalized diagnostics and stabilization of comorbidities in the 30-day window.
- Prioritization of all enrolled patients.

**Holistic assessment**
- Aims to improve the severe coordination deficits within the healthcare in Hungary.
- Individual preferences of patients on their treatment options are acknowledged.
- Social, physical and mental needs and the related individual preferences / capabilities are out of the scope.

**Information & research (EVIDENCE)**
- Relatively short lifetime of the project (started in Nov 2015) – no outcome analyses.
- Patient-level clinical data at the Centre (evaluation may need text mining)
- Patient-level economic data at the National Healthcare Payer
- Limited data on patient experience, except for timely and equal access to care which is in the forefront of OnkoNetwork.

**Key finding**: Local initiative in Somogy county, self-sustainable without macro-level financial support

**Key finding**: Aims to improve clinical outcomes via timely access to quality assured, un-fragmented healthcare

**Key finding**: New / changed professional roles and a custom IT development to support individual patient path monitoring and management

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**Cancer and comorbidities – need for integrated care**

“It frequently occurs that patients with recent coronary stent implantation arrive to colonoscopy because of occult blood in their faeces, and a colon tumour is found. From the cardiologist’s perspective, triple anticoagulant therapy is obligatory for 6 months after coronary stent implantation and it can’t be discontinued. On the other hand, the treatment of colon tumour should not wait for 6 months albeit the surgical removal is contraindicated by the triple anticoagulant therapy. Another example was when multiple gastric ulcers with an in situ carcinoma were found in a patient after a recent coronary stent implantation. How to solve the conflict between obligatory 6-month triple anticoagulant therapy, and complete gastrectomy recommended by the oncology team? If the triple anticoagulant therapy is prematurely discontinued, the coronary stent may get blocked. But if we wait for six months, the in situ carcinoma may shift to invasive carcinoma with worsened prognosis.” [IP02_1]

“Several chemotherapy agents are cardio-toxic. Patients with cardiology disease in their anamnesis undergo additional cardiological diagnostics to select their optimal therapy regimen. (…) Cardiologic examinations before chemotherapy were required even before OnkoNetwork. However, OnkoNetwork makes the diagnostics and their results easily accessible and transparent, assuring that everybody is complying with these rules.” [IP10_1]
Hungary: Palliative Care Consult Service (PCCS) (2)

Antal Zemplényi, János G. Pitter, Marcell Csanádi, Kata Csetneki, Zoltán Kaló

**KEY FINDINGS:**
- First initiation in Hungary to provide palliative care for in-patients in acute hospital
- Strong collaboration with home hospice-palliative care to assure the subsequent patient pathway
- Innovative model in Hungarian context for its patient centred approach
- Implementation in an academic environment was beneficial in terms of educational aspects of palliative care (knowledge transfer for future physicians and health professionals)
- Programme supported by EU fund; a dedicated financing method is required

### Service delivery

<table>
<thead>
<tr>
<th>Requesting consultation</th>
<th>Including: State of the disease</th>
<th>Treatment plan</th>
<th>Organizing further care</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic request submitted by physicians</td>
<td>Physical and mental status</td>
<td>Patient’s goals and preferences dominate over aggressive treatment aims</td>
<td>Shared decision-making with patients and family members</td>
<td>Patients with relatively good conditions followed by outpatient palliative clinic</td>
</tr>
<tr>
<td>Reasons: pain relief, symptom management, psychosocial support at the ward or organizing transfer to other provider</td>
<td>Pain, other symptoms, performance status</td>
<td>Focus on the quality of life</td>
<td>Assessment of the patient’s environment at home, social and financial capabilities</td>
<td>Physicians of PCCS visit patients upon the request of the home care coordinator</td>
</tr>
<tr>
<td>Introductory assessment</td>
<td>Social, spiritual and cultural aspects</td>
<td>Patients may refuse demanding therapies in advanced stage</td>
<td>Involving informal caregivers</td>
<td></td>
</tr>
</tbody>
</table>

### Leadership & governance

- PCCS programme serves a bridge between the clinical departments, home-based hospice-palliative care, institutional hospice care and home-based social care
- Strong commitment by the management of the Medical Centre
- No formalized agreements yet regarding the cooperation with partners

### Technology & medical products

- Improvement of the electronic referral system to support consultation request and to keep record of the electronic documentation

### Workforce

- Multidisciplinary team: palliative coordinator, physician, psychologist (dietetics, physiotherapist available), specific qualification requirements for the coordinator and physician
- Cooperation among providers facilitated by the overlap in human resources (members of the team work for more providers in parallel)
- PCCS team involved in under- and postgraduate medical education to support knowledge transfer for future physicians
- Risk regarding staff retention: burnout, low income, no priority in health politics

### Financing

- No direct reimbursement is provided for the operation of palliative consult services
- EU grant (for a specific time period) was a great incentive in the initial phase
- Internal financing methodology is used within the Medical Centre
- Long-term sustainability requires dedicated reimbursement

### Information & research (EVIDENCE)

- Regular analyses of PCCS’s activity (number of consultations; reasons for referral; time-data on entering and leaving the palliative care process; leading symptoms at enrolment
- No evaluation was performed on the effects and outcomes
- Current measurements: assessment of pain and performance status, internal satisfaction surveys of clinical department
The Netherlands: U-PROFIT (1)
Fenna Leijten, Melinde Boland, Maaike Hoedemakers, Apostolos Tsiachristas, Antoinette de Bont, Roland Bal, Maureen Rutten-van Mölken

SUMMARY:
- Proactive frail elderly programme in primary care, close collaboration with social care
- Started as an RCT, continued implementation via internal funding and additional grants
- Screening and nurse-led care

KEY FINDINGS:
- New professional role ‘elderly care nurse’, practice vs. community nurse
- Financing using existing modules not sustainable or sufficient, who is responsible for prevention?
- Difficulty in interpreting research has hampered discussions with health insurer.

Leadership & governance
- Main role for primary care centres, collaboration with home-care organisations (financed in part via social care), nursing homes, municipality.
- GP and elderly care nurse responsible.
- Issues surrounding where district nurse is stationed (primary care centre vs. home-care org) and access to EMR data.

Workforce
- Elderly care nurse main care provider: specially trained, background as practice nurse (primary care centre) or district nurse (traditionally at home-care organisations).
- Core team with GP and district nurse (when elderly care nurse is practice nurse).
  Additionally, other professionals in primary care centre (e.g., physical therapists, pharmacists), elderly care physician (nursing home), social district teams (municipality).

Technology & medical products
- EMR data used to screen frailty
- Issues surrounding access to EMR by non-primary care centre professionals

Information & research (EVIDENCE)
- Two PhD theses about RCT of the U-PROFIT approach, compared screening U-PRIM and nurse-led U-CARE (1) to only U-PRIM screening (2), and to usual care (3).
- Effect evaluation ‘mixed’, no differences in groups (1) and (2), but better than (3) on primary outcomes (e.g., ADL, QoL, satisfaction with care).
- Cost-effectiveness evaluation positive - prob 75% cost-effectiveness at 20,000€ WTP for (1) vs. (3)

Financing
- Mix of: project-based funding, health-insurer’s elderly care modules, and internal investments.
- Financing is a main issue because 1) existing elderly care financing meant for 75+ which results in insufficient funds for larger group and general prevention focus, 2) professional roles, prevention tasks financed through district nurse not primary care centres.
Summary
The care programme Care Chain Frail Elderly (CCFE) targets frail older persons living at home with complex care needs that require multidisciplinary care and case management. Simultaneously, a new way of financing care for frail elderly is being developed and implemented, in the form of a bundled payment.

Key findings/discussion points
- Case finding instead of screening;
- Is there an added value in having the patient and informal caregiver present at the multidisciplinary team meeting?;
- Should the nurse practitioner or the district nurse be the core professional in the CCFE?;
- Sufficient financing is necessary to stimulate the GP to implement the care programme;
- Role of insurer’s evaluation for continuation?

Leadership & governance
- Three different care groups are collaborating to develop the CCFE and are working to arrange bundled payment;
- Care groups work on behalf of the GPs that implement the approach in daily practice;
- The health insurer is an important stakeholder in the development and continuation of the care programme;
- The community network is central in the care process (collaboration health- and social care).

Workforce
- Separation of care coordination and case management tasks are assigned to the nurse practitioner or district nurse;
- Elderly care physician acting in primary care to support and ‘educate’ the GP;
- Focus on unburdening the informal caregiver, rather than transferring care to the informal caregiver.

Financing
- The initial financing of the CCFE, via the regularly financed Elderly Care Module, was not sufficient;
- In collaboration with the insurer a bundled payment is being developed (pilot-DTC for frail elderly), implemented and evaluated;
- Role of predominant insurer has a large influence on the progress of implementation of pilot-DTC.

Technology & medical products
- ICT-structure (Care2U) connecting all chain partners at various access-levels;
- Focus on structuring care and communicating with one-another, rather than mere sharing information.

Information & research
- Mainly process indicators to measure the progress of implementation;
- Ongoing evaluation by insurer.

Service delivery
Main focus areas:
- Community network
- Transfer care
- Advanced care planning
- Polypharmacy

Case finding
By ‘primary care care group’ (GP, nurse practitioner elderly care, district nurse) that meet every 4-6 weeks

Holistic assessment
Nurse practitioner elderly care visits frail elderly at home to make an inventory of problems, existing care and personal goals which results in a draft individualised care plan

Multidisciplinary team meeting
With GP, nurse practitioner elderly care, elderly care physician, other relevant professionals, patient, informal caregiver to discuss individualised care plan

Care coordination
By nurse practitioner elderly care, organises multidisciplinary team meetings, maintains individualised care plan

Case management
By either nurse practitioner elderly care, district nurse, or case worker dementia; provides tailored and integrated care, monitors, provides support
The Netherlands: BSIN (3)

Melinde Boland, Fenna Leijten, Maaike Hoedemakers, Apostolos Tsiachristas, Antoinette de Bont, Roland Bal, Maureen Rutten-van Mölken

Summary
Better Together in Amsterdam Noth (BSiN) aims to develop and apply a well-aligned approach in caring for people with complex needs in multiple life domains (finances, daily activities, housing, relationships at home, mental health, physical health, addiction, activities of daily living, social network, social participation, and justice issues), by professionals across different sectors. The goal is to improve the quality of care and services, and in turn to a healthier, more self-sufficient, population with reduced care costs (i.e., triple aim).

KEY FINDINGS:
• Collaboration between different sectors
• Multiple problems vs. multi-morbidity
• Long start-up period
• Low recruitment rates
• Four quadrants?

Service delivery

Leadership & governance
• BSIN is developed and delivered by providers from the alliance of the 12 organisations of that together form the KMA. The KMA includes primary health care, secondary health care, mental health services, welfare, social care, and youth care.
• The health insurer, municipality of Amsterdam and research organisation TNO are important stakeholders in the development (and financial support) of BSIN.

Workforce
• Professionals from different KMA organisations and different sectors are acting as case managers next to their day-to-day work.
• A case manager has an integrated and holistic view of the problems of the person, and coordinates and supports care provided for by multiple sectors, organisations, and providers.
• Case management training is provided

Financing
Financing for 2016, by the municipality (75%) and health insurer (25%) via a direct and indirect payment mechanism:
• Direct: a fixed negotiated additional budget from the municipality and health insurer for triage (n=150) and case management (n=60);
• Indirect: the providers of the KMA contribute proportionally by sharing a part of their regular budget for health care, social care and welfare. Long-term contracts are being prepared for the period 2017-2020.

Technology & medical products
ICT portal includes documents and tools to support enrollment (by professionals from one of the KMA organisations), triage and case management, e.g. online:
• Enrollment form, including holistic assessment by the self-sufficiency matrix (SSM)
• Multi-disciplinary team discussion by triage team
• Registration of individual care plan
• Registration of appointments

Information & research (EVIDENCE)
The preliminary 6 months results showed improved self-sufficiency.
Norway (1): Medically assisted rehabilitation (MAR) Bergen

Sabine Ruths, Tord Skogedal Linden, Rune Ervik, Kamrul Islam, Jan Erik Askildsen

KEY FINDINGS:
- New professional role ‘special advisor’.
- Mismatch between actual and registered treatment activity causes lower incomes.
- Collaboration health- and social care in specialist service and municipality.
- No scientific evaluation; substantial reduction of deaths from opioid overdoses has been observed.

Service delivery

<table>
<thead>
<tr>
<th>Phase; patient status</th>
<th>1: Survival</th>
<th>2: Patient considering change</th>
<th>3: Patient conducts change</th>
<th>4: Stable change with support</th>
<th>5: Stable change without support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threshold, facilities</td>
<td>Low threshold: Emergency clinic</td>
<td>Low threshold: MAR Bergen outpatient clinic</td>
<td>High threshold: regular MAR</td>
<td>High threshold: Regular GP, pharmacy</td>
<td>Exiting MAR</td>
</tr>
</tbody>
</table>

Leadership & governance
- Organised within outpatient clinics at the specialist health service, collaboration with social services (municipality) and GPs.
- Patient group with opioid addiction is hard to reach, tricky to treat. Substitution treatment is ‘entrance ticket’.
- Supporting leadership for special advisors.
- Care oriented- (municipality) vs. disease treatment oriented culture (spec. service).

Workforce
- Special advisor (designated coordinator) main care provider: background as social worker, nurse or authorised social educator.
- Core team with doctor (specialist in addiction medicine, trainee in add. med.), psychologist and special advisor. Long experience and strong commitment. Cooperation with municipal social service (rehabilitation, physical activity).
- New professionals roles: doctor and psychologist work indirectly via special advisor who is in daily contact with patient.

Technology & medical products
- Electronic Medical Record: MAR Bergen treatment scheme was developed for this programme. Data can be used for evaluation.
- Issues surrounding shared use of medical records by specialist- and social services.

Information & research (EVIDENCE)
- No scientific research on MAR Bergen, so far.
- From 2017 individual patient data will be collected systematically and may be used for research.
- The Bergen Addiction Research Group aims at establishing a Biobank (e.g. blood samples for Hepatitis C).

Financing
- Semi-secured budget: fixed block grant and variable grant depending on the registered treatment activity at the outpatient clinics.
- Registered treatment activity is lower than actual activity, implying lower incomes/grants than budgeted.
Norway (2): Learning networks for whole, coordinated and safe pathways in the municipalities (Learning networks)

Sabine Ruths, Rune Ervik, Tord Skogedal Linden, Kamrul Islam, Jan Erik Askildsen

KEY FINDINGS:
• New focus on functional ability rather than disease and impairment represents a culture change.
• Secured budget for the Learning network, no direct financial incentives for participant municipalities.
• Collaboration health- and social care.
• No scientific evaluation so far. One report (Deloitte 2016).

Service delivery

<table>
<thead>
<tr>
<th>Week 1: Patients that have been hospitalised</th>
<th>Week 1: All patients, including those discharged from hospital</th>
<th>Week 2: All patients</th>
<th>Week 5: All patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipality and hospital plan discharging together by phone/ video/meeting</td>
<td>Assessment of patient functioning by PSFS or COPM</td>
<td>Follow up by GP/ nursing home doctor</td>
<td>New assessment of patient functioning by PSFS or COPM</td>
</tr>
<tr>
<td>Preparation of discharge together with patient/family</td>
<td>Follow up directed by what matters to the patient</td>
<td>Assessment of patient’s experience with follow up by interview or questionnaire</td>
<td></td>
</tr>
<tr>
<td>Necessary assistive equipment is ordered for the patient to manage his/her own situation best possible</td>
<td></td>
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<tr>
<td>Case summary (medical report) surveyed before meeting with patient</td>
<td></td>
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<tr>
<td>The patient is familiar with the primary contact person responsible for follow up</td>
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</tbody>
</table>

Leadership & governance
• User involvement, leadership, re-ablement, core competence, organization, measurements, management support, management involvement.
• Owner: KS (Norwegian association of local and regional authorities).
• High level of political commitment within municipalities and at the national level.
• Patient pathway is a key word in the Norwegian Coordination Reform

Technology & medical products
• Some municipalities have introduced electronic white boards showing the status for all involved patients. This is a shared-information system raising consciousness.

Workforce
• Municipal multi-disciplinary primary health care improvement teams with GP and nurse. Additionally, other professionals in primary care (e.g. physiotherapist, occupational therapist) and social worker.
• Designated primary contact person (coordinator) responsible for follow up.
• Focus on functional ability rather than disease and impairment, and new patterns of interaction and represent a culture change.
• Nurses use validated assessment tools (PSFS and COPM). Individual follow-up is informed by the patient’s own goals.

Information & research (EVIDENCE)
• No scientific evaluation so far.
• The idea and practice of generic patient pathways is based on previous empirical research and development of the so-called Orkdal model (A Grimsmo).
• Municipalities collect data on whether the service delivery items are conducted, data from PSFS and COPM, and of patient experience assessment.

Financing
• The learning network is financed through participating municipalities’ general budgets. There are no direct financial incentives.
• In a longer perspective, potential savings for municipal assistance, institutional care or hospitalisation.
Spain: Area Integral de Salut, Barcelona Esquerra (Ais-Be)
Claudia Vallve, Joan Carles Contel, Isaac Cano, Josep Roca

**KEY FINDINGS:**
- The technological integration between EMRs is central for the deployment of an ACT supported program.
- Regulatory and technological issues are crucial to integrate Informal (patient gateways) and Formal care.
- Proposed bundled payment in order to reduce costs and enhance quality of care.

**Service delivery**

**Leadership & governance**

**Financing**
- Based on the conclusions of the NEXES project (www.nexeshealth.eu).
- Proposed bundled payment as a way to incentivize collaboration among providers in order to move to less intensive and expansive care that would result in better health outcomes.
- Technological innovation is considered part of the bundled payment and not a specific reimbursable charge.

**Technology & medical products**

**Information & research (EVIDENCE)**
- Expanded population use of GMA risk-stratification tool.

**Workforce**

**Advanced practice nurse:** highly skilled nurse with deeper knowledge of a given pathology or of the different equipment’s that are mobilized during home care. Can act proactively in the care of patient. **Professional profile:** experience in the surgical field; post-grade training.

**Case management nurse:** role in coordination of the different specialists. Is the main reference person for the patient. **Professional profile:** expert nurse with strong relational competences, especially in relation to teamwork, proactivity and autonomy.

**Liaison nurse:** manages the relationship between primary care and hospital care. Located at the primary care centres. Follows up patients from primary care that are admitted in the hospital. On discharge from the hospital, the liaison nurse is informed in order to activate all the services needed to guarantee the continuity of care of this patient.

**Homecare attention physician:** the medical tasks performed by this professional may not vary from the ones carried out in conventional settings, but the physician must be confident and have tolerance for risk. Team work with the advanced practice nurse is of utmost importance.
Spain: Badalona Serveis Assistencials (BSA)
Claudia Vallve, Jordi Piera, Joan Carles Contel, Isaac Cano, Josep Roca

**Leadership & governance**
- The president of the BSA Board is the mayor of the city.
- Care provision done by Clinical, Social and Nursing areas covering the different type of care from primary care to specialist care, as well as social care services.
- Resistance from professionals creates a division in two different areas in which the population receives different kind of attention.

**Medical attention at home**
- Team composed by a physician, and a CMN is in charge.
- Assessment of the patient needs.
- Visits and monitoring at the patient’s home.
- When decompensated, the patient has priority at the hospital.
- Caregiver receives health education by the doctor and nurse.
- Social needs are catered by the social worker.

**Screening**
By primary care doctor, internist doctor at the hospital or specialists:
- Age > 65 years old
- Complexity > 2 chronic cond.
- Poly-pharmacy > 5 drugs
- Re-incidence > 3 readmissions

**Nursing Homes**
- Integral evaluation of all the patients institutionalized.
- Multidisciplinary care in coordination with diverse specialists.
- Pharmacologic control of all the drugs taken by each patient.
- Periodic visits to all the residences to avoid the use of emergency services and hospitalization.

**Integral Hospital at Home**
- Assessment of the clinical conditions from a global point of view.
- Individualized care plan in which visits can take place every 12 hours, daily or every two days.
- Most medical procedures conducted at home.
- Weekly meetings of all professionals involved to revise the therapeutic planning.
- Caregiver receives sanitary education from the nurses, in relation to healthcare and prevention.

**Palliative Attention Program**
- Multidisciplinary team attending the patient at home or at the nursing home.
- Telephone number 24-7 attended by the doctor on call.
- Support given is varied, and can go from telephone support to the activation of urgent services (visit to the patient at home or sending an ambulance to take the patient to the hospital for emergency care).
- Reassurance given to the patient.

**Workforce**
- **Domiciliary Attention Physician**: work together with other professionals (nurses, family workers the patient and caregiver). They build a close relationship with patients and caregivers.
- **Case Management Nurse**: highly experienced. Coordinates the different teams treating the patients. They also empower patients fostering their functionality, comfort and independence. Also responsible of the follow up of patients and family during all the process of care, independently of other resources and services.

**Financing**
- The Catalan health system is a NHS-based system (Beveridge model), financed by the Catalan Government.
- The payment is based on activities performed, especially in the case of hospitals, and health objectives and population assigned, in the case of Primary Care.
- Social care services are responsibility of the Department of Social Welfare and Family.
- Issue with financing from different budgets.

**Technology & medical products**
- Implementation and use of shared EHRs (HC3)
- Development of Telecare, electronic prescription and advanced care plans.
- Technological and co-payment barriers for Telecare.

**Information & research (EVIDENCE)**
- Evaluation process underway.
- Preliminary results of the analysis reveal that there has been a reduction on the average length of stay, average amount of bed-days, as well as emergency visits.
- The clinical pathways developed have facilitated an improvement in the process outcomes, including compliance and adherence to the guidelines.
- Physicians are more interested in the quality of the attention or, even, the satisfaction of the patients.

**Key findings:**
- Integration between health assistance and social care services.
- Two new roles: Case Management nurse and Domiciliary Attention Physician.
- The Case Management Nurse stands at the centre of the program and coordinates among all its components.
- The program is financed from different budgets arising issues.
- The geographical area is divided between two different kinds of attention due to professional resistance.
UK: Salford (1)
Jonathan Stokes, Sudeh Cheraghi-Sohi, Søren Rud Kristensen, Matthew Sutton

Service delivery

1. MDGs (Multidisciplinary Groups)
2. Community Assets
3. Centre of contact (/ health coaching)

- Those with multimorbidity (particularly elderly and frail) may be those who struggle the most to self-manage, despite being those who potentially have most to gain from it
- Professionals in the Salford programme appear to agree that organisational and structural integration is important aspect of delivering efficiency savings, and so sustainability
- The protection of market regulation at the macro level, can sometimes act as a barrier to integration (particularly organisational integration)

Leadership & governance

- Time pressures have made MDT attendance and shared decision-making difficult
- Continued issues coordinating with those not directly involved in integrated care programme
- Supportive leadership, historical relationships & direction of wider national policy seen as key enablers

Technology & medical products

- Seen as particularly important, but have been difficult to implement due to macro context

Workforce

- MDT team management not sufficient for integration to occur
- Co-location seen as particularly beneficial for relationship building

Financing

- Other work pressures beyond those additionally incentivised remain
- Non-financial incentives beneficial for ensuring participation
- Moving towards single provider of services model v national choice and competition agenda

Information & research (EVIDENCE)

- Value of healthcare data used for risk prediction questioned (by definition, already known to healthcare services)
- Some evidence of evaluation fatigue, but CLASSIC study allows us to ease this workload

KEY FINDINGS common across two UK sites:

- Financial pressures on health and social care more broadly in the NHS were seen as unsustainable
- Use of a risk tool for risk-stratification was seen as selecting the wrong patient target group
- Rather than multiple conditions (multimorbidity), social needs of the patients and their mental health was seen as the primary definer of complexity
- Having multiple providers of IT systems proved difficult to implement effective shared records
- History of positive working relationships between providers was seen as a key enabler of integration
- Cost-saving and utilisation outcomes were seen as likely to take years to come to fruition (and only with the help of organisational integration), whereas evaluations and pump-prime funding were short-term
- The independent nature of primary care practices was seen as particularly difficult to integrate/contract for effective primary care delivery (however primary care was seen as key to change of care delivery models)
- There remained issues with integrating with anyone not directly involved with the programme
- Co-location of services was seen as particularly beneficial to inter-professional relationships
UK: South Somerset (2)
Jonathan Stokes, Sudeh Cheraghi-Sohi, Søren Rud Kristensen, Matthew Sutton

**Service delivery**

<table>
<thead>
<tr>
<th>1. Complex care hub</th>
<th>2. Enhanced primary care</th>
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- Self-management is a major focus of the programme through health coaching (in both delivery models), but realisation that changing complex patient’s ability to self-manage is difficult, and there is also the danger of creating a dependency on additional services.
- Shared decision-making and life goal setting is seen as an important first step to self-management, but the approach is not for everyone (some patients prefer a traditional paternal relationship).
- Room for informal caregiver involvement, but some safeguarding issues have arisen.

**Leadership & governance**

- Supportive leadership and historical relationships seen as key enablers.
- Issues with connecting with those outside of immediate boundary of the integrated care programme.

**Technology & medical products**

- Single shared record exceptionally difficult in macro environment, but seen as essential.
- Patient interaction with technology has so far been poor (teething problems + elderly and IT-illiterate unlikely to use).
- Use of telehealth developing and seen as positive for keeping patients at home, but requires active participation, so ability of neediest complex patients is questionable.

**Workforce**

- Co-location seen as particularly beneficial for relationship and trust building.
- New less professionalised roles seen as positive for addressing patients needs and professionals to work to top of their license.
- Some patients see interaction with new roles as ‘downgrading’ of their importance though.

**Financing**

- Pump-priming funding was seen as necessary, but amounts were not given as requested.
- National competitive tendering and governance policies v formation of IACO.
- Independent GP practices difficult to contract and to integrate into hospital’s vision.

**Information & research (EVIDENCE)**

- Data-driven risk tool seen as potentially useful starting point for identifying patients, but not entirely adequate. GP knowledge seen as ultimate deciding factor.
- Moving away from highest risk patients to attempt to prevent escalation in the first instance.

**KEY FINDINGS common across two UK sites:**

- Financial pressures on health and social care more broadly in the NHS were seen as unsustainable.
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