

Austria: Sociomedical Centre Liebenau (2)

Astrid Segert, Susanna Ulinski, Thomas Czypionka

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

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

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

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

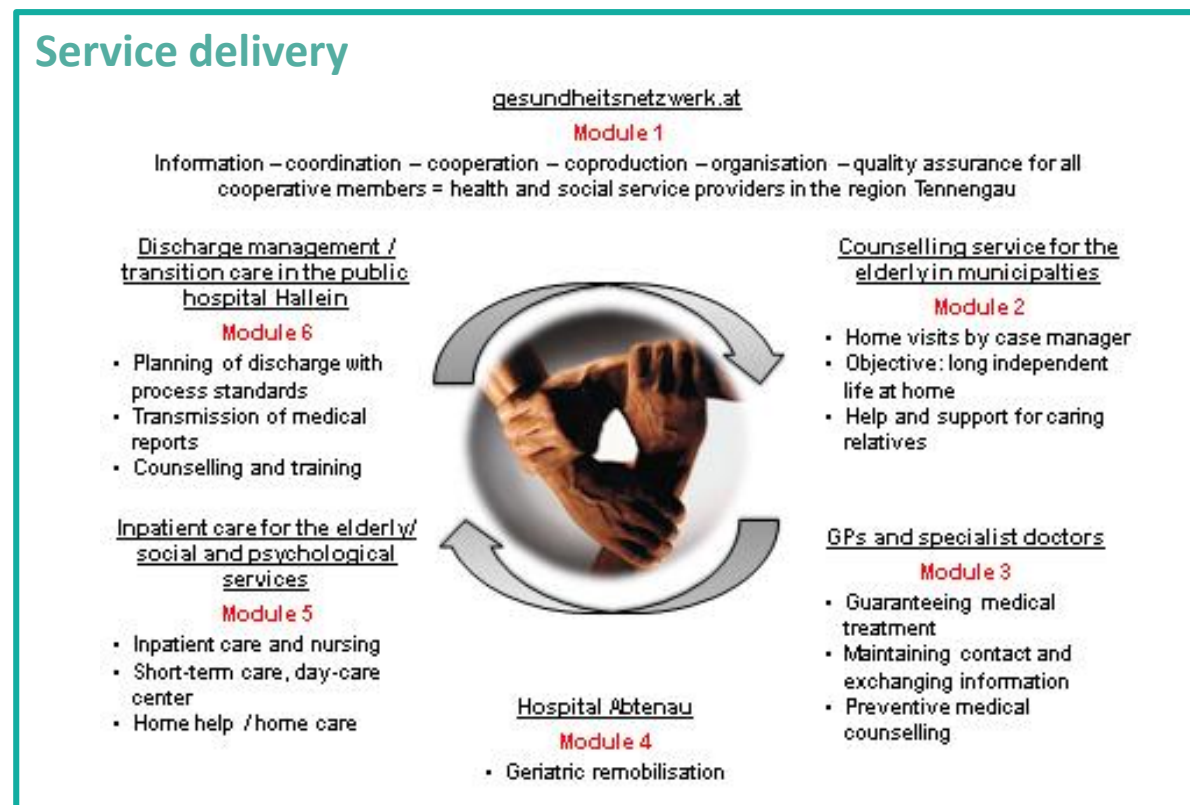
Austria: Health Network Tennengau (1)

Astrid Segert, Susanna Ulinski, Thomas Czypionka

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

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

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

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:**

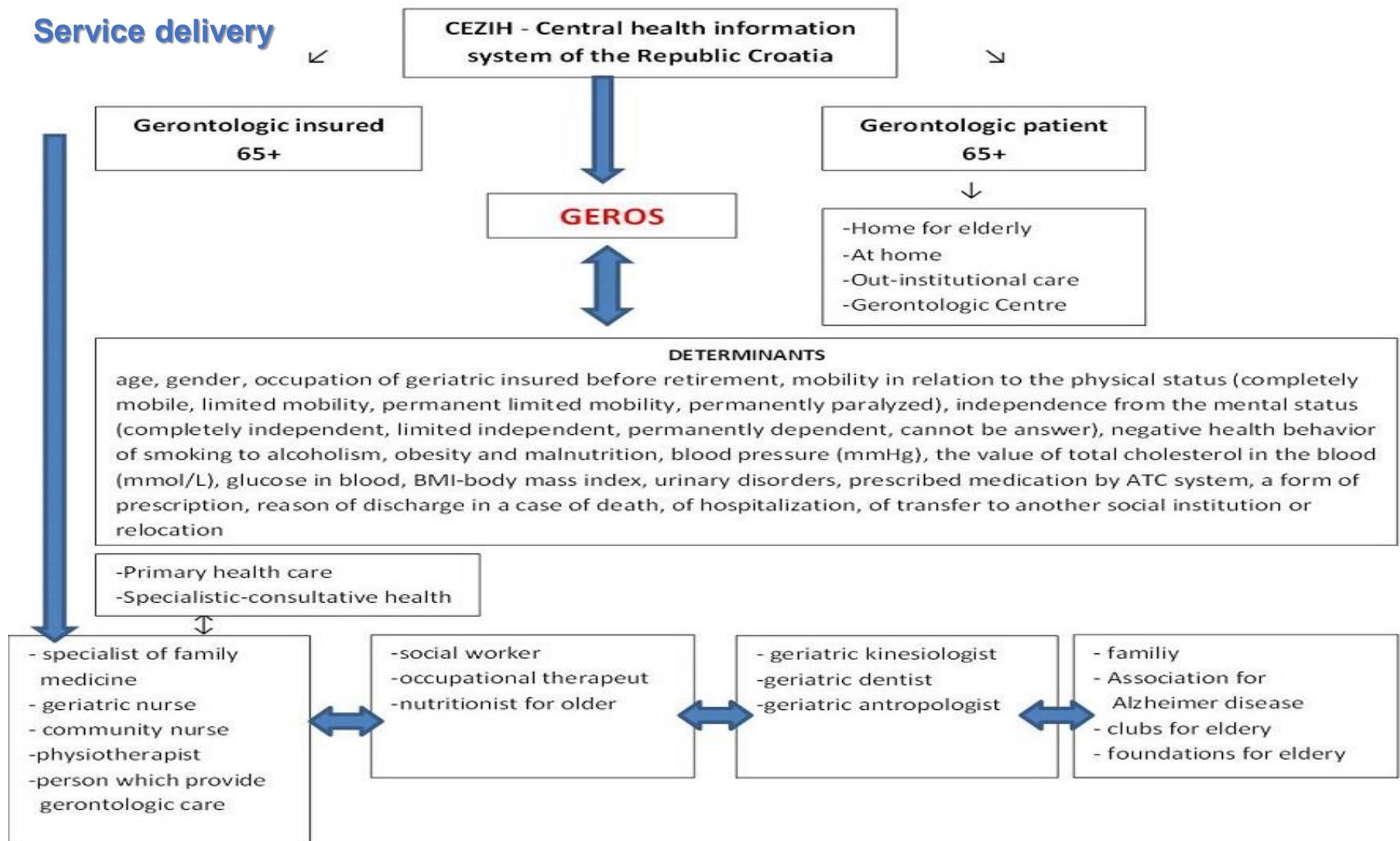
- Descriptive data analysis, comparison of trial and control group, pre- and post-measuring
- Mixed results: rate of re-hospitalisation is decreased, aims of decreasing length of stay and extramural cost only partially attained

Croatia: GeroS (1)

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

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



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
- **References and book:** Tomek-Roksandić at al.: *The importance of tracking health needs and functional abilities of psycho-geriatric patients*. Acta Med Austriaca. 2004;31(1):3; Tomek-Roksandić at al.: *The importance of medical gerontology training in the preservation of functional ability of geriatric patients*. Acta Med Austriaca. 2004;31(1):2; Tomek-Roksandić at al. *Functional ability of the elderly in institutional and non-institutional care in Croatia*. Coll Antropol. 2010;34(3):841-6.; Tomasović Mrčela et al. *When elders choose: Which factors could influence the decision-making among elderly in the selection of health tourism services?* Med Hypotheses. 2015;85(6):898-904.; Tomek-Roksandić at al.: *Four degree of geriatric health care with nursing documentation and representative of general/family medicine in the home for the elderly*. Zagreb, 2012.

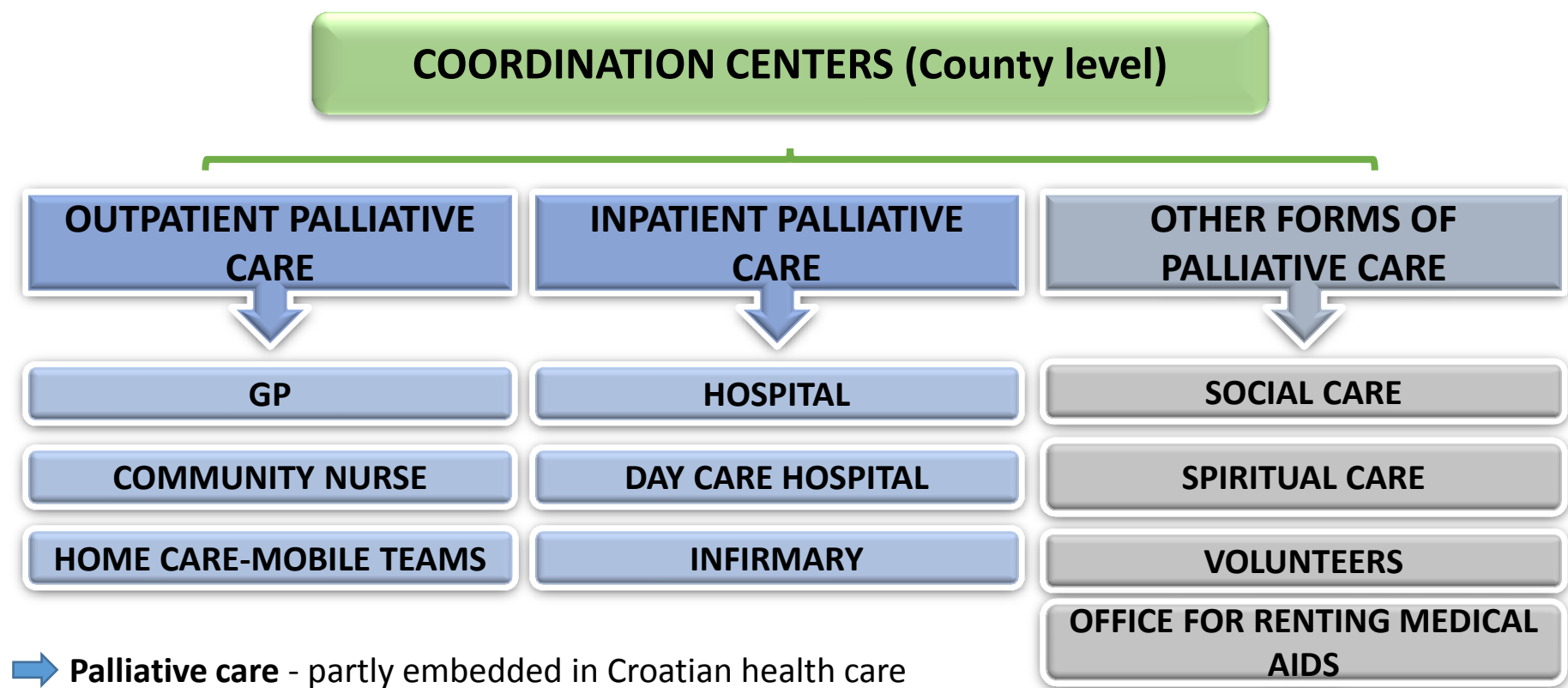
Croatia: PALLIATIVE CARE SYSTEM (2)

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



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



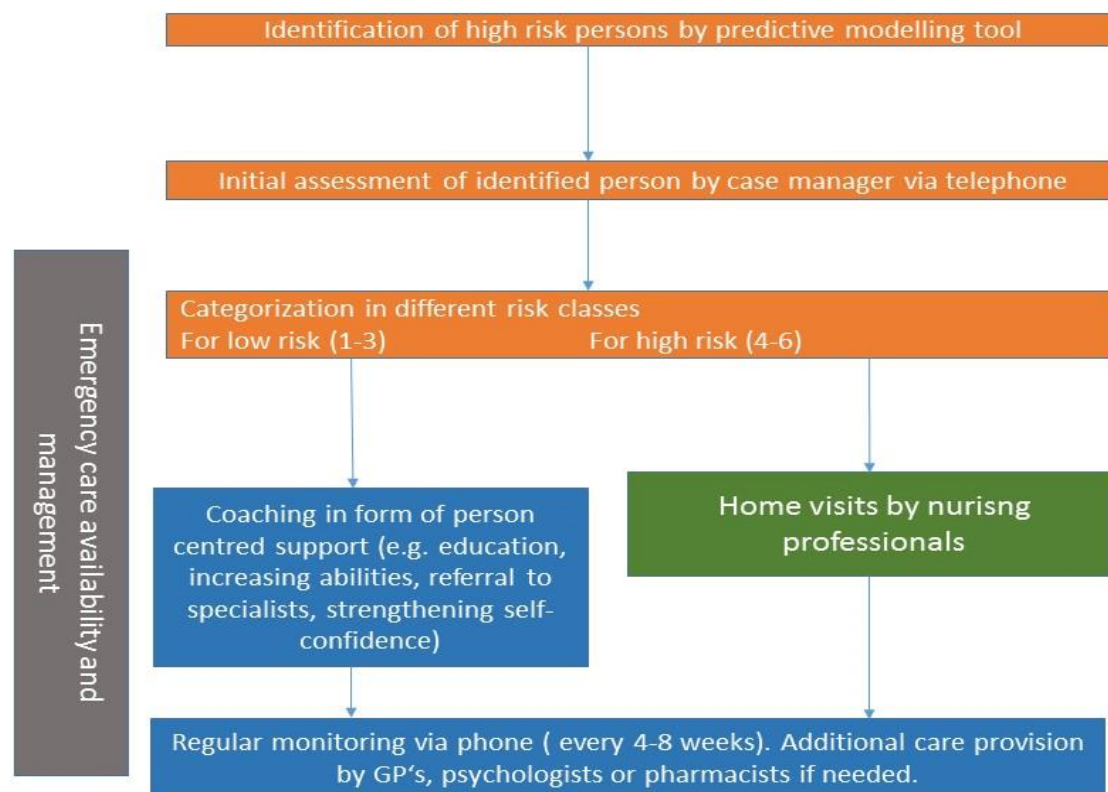
Germany: CASAPLUS (1)

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



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.

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.

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.

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.

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.

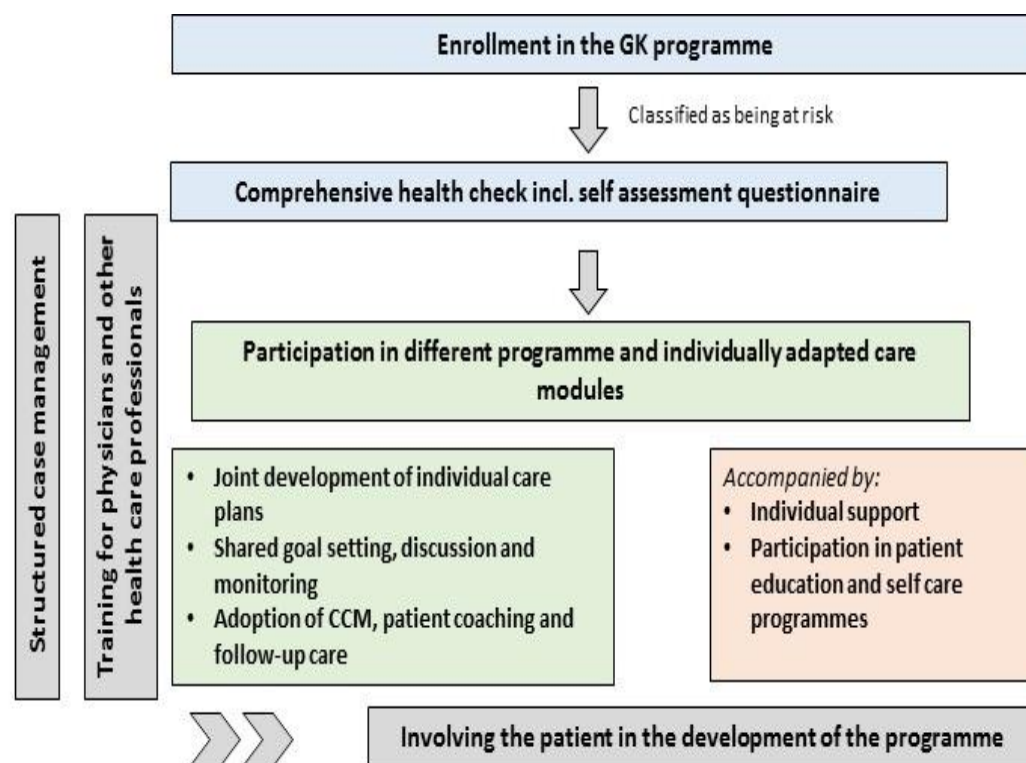
Germany: Gesundes Kinzigtal (2)

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.

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.

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.

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 Zemlényi, Kata Csetneki, Zoltán Kaló

KEY FINDINGS:

- Local initiative in Somogy county, self-sustainable without macro-level financial support
- Aims to improve clinical outcomes via timely access to quality assured, un-fragmented healthcare
- New / changed professional roles and a custom IT development to support individual patient path monitoring and management

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.

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).

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)

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

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.

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.

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 cardiology diagnostics to select their optimal therapy regimen. (...) Cardiology 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]

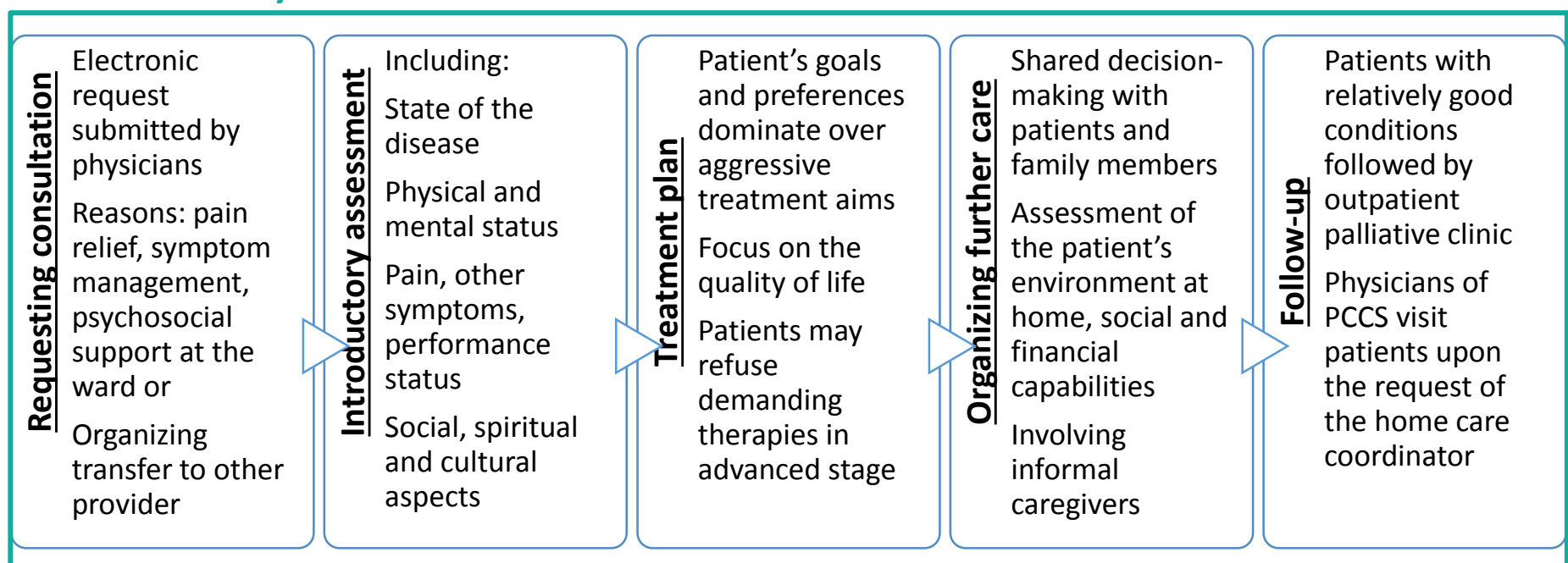
Hungary: Palliative Care Consult Service (PCCS) (2)

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



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

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**

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

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, Maaïke Hoedemakers, Apostolos Tsiachristas, Antoinette de Bont, Roland Bal, Maureen Rutten-van Mölken

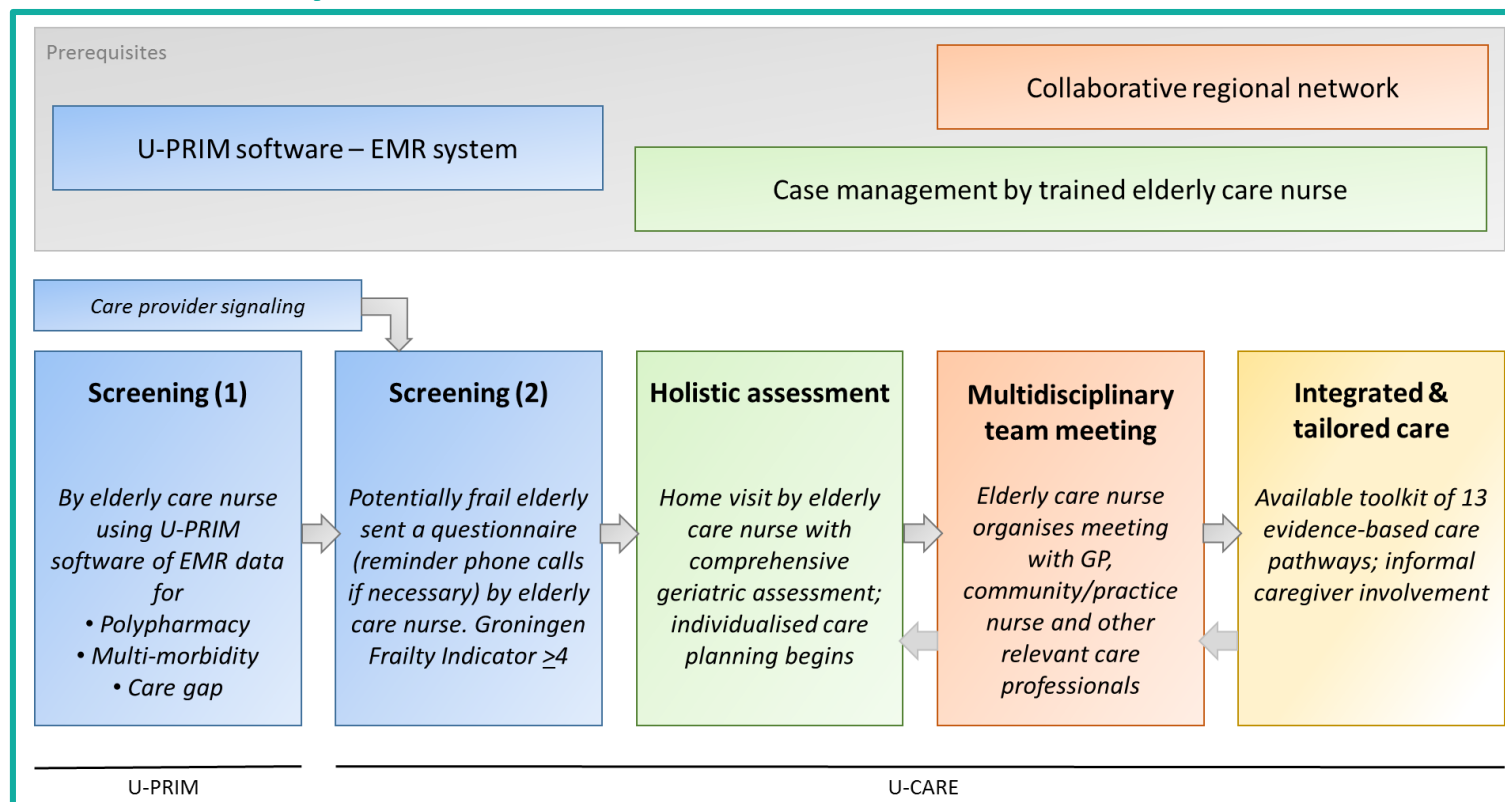
SUMMARY:

- 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.

Service delivery



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.

Technology & medical products

- **EMR data** used to **screen** frailty
- Issues surrounding access to EMR by non-primary care centre professionals

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.

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).

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)

The Netherlands: CCFE (2)

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

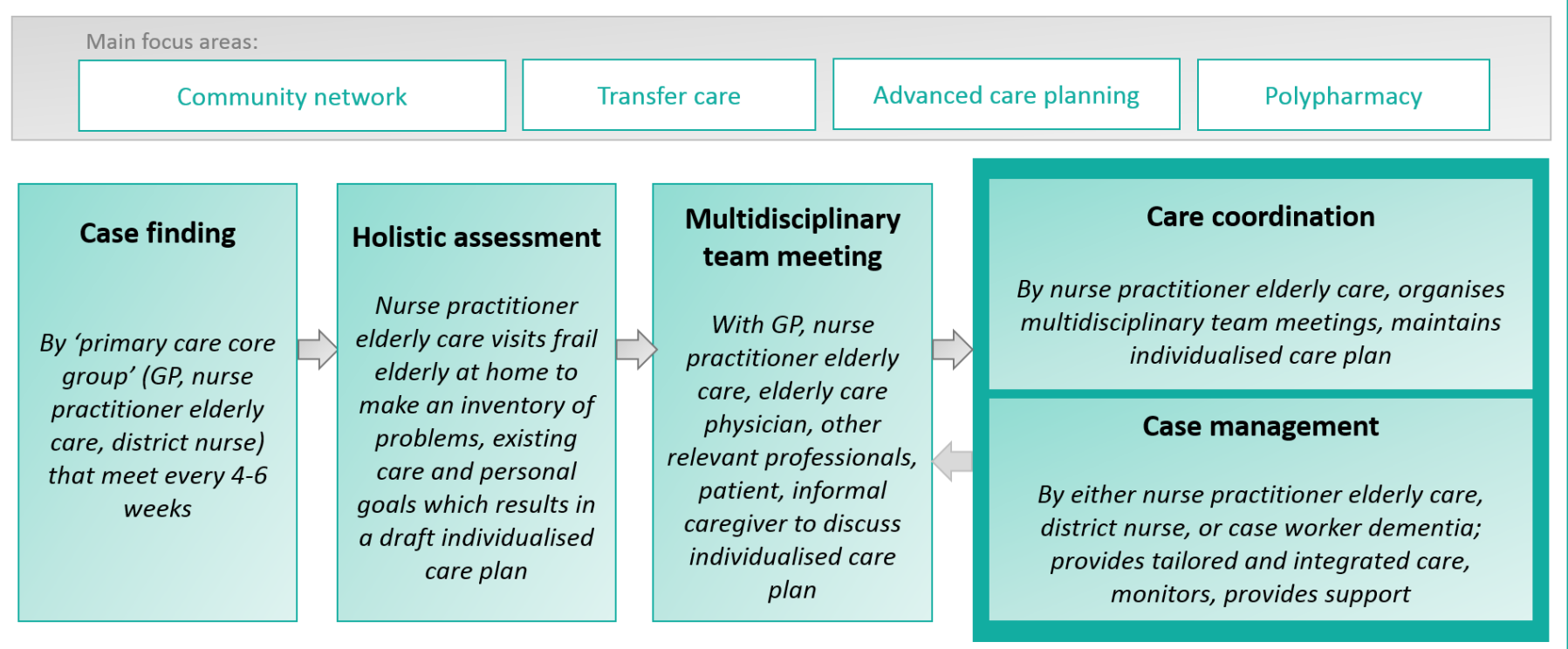
Summary

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?

Service delivery



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).

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.

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.

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.

The Netherlands: BSiN (3)

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

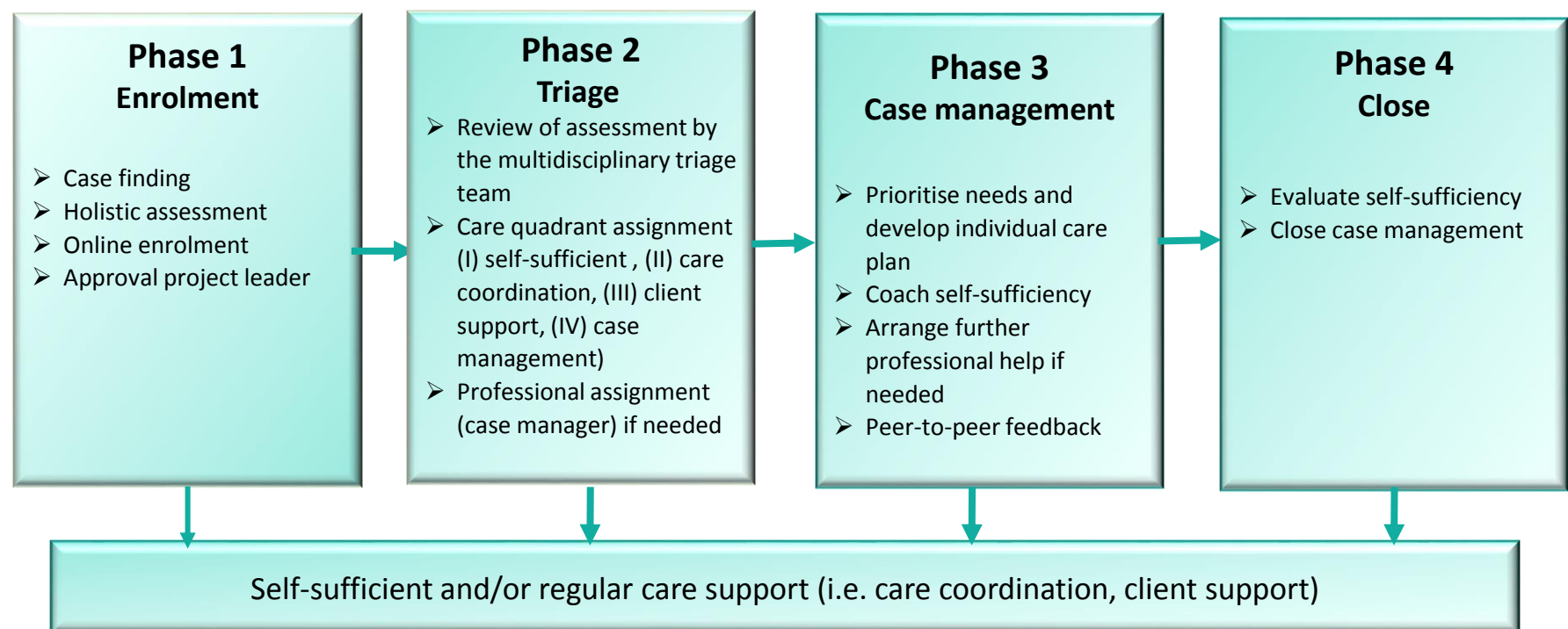
Summary

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

Phase; patient status	1: Survival	2: Patient considering change	3: Patient conducts change	4: Stable change with support	5: Stable change without support
Threshold, facilities	Low threshold: Emergency clinic	Low threshold: MAR Bergen outpatient clinic		High threshold: regular MAR	High threshold: Regular GP, pharmacy
					Exiting MAR

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).

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.

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.

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.
- Challenges regarding time resource allocation to individual patients vs. expanding and competence building within the programme.

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).

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

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

SFS = Patient Specific Functioning Scale; COPM = Canadian Occupational Performance Measure

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.

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.

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.

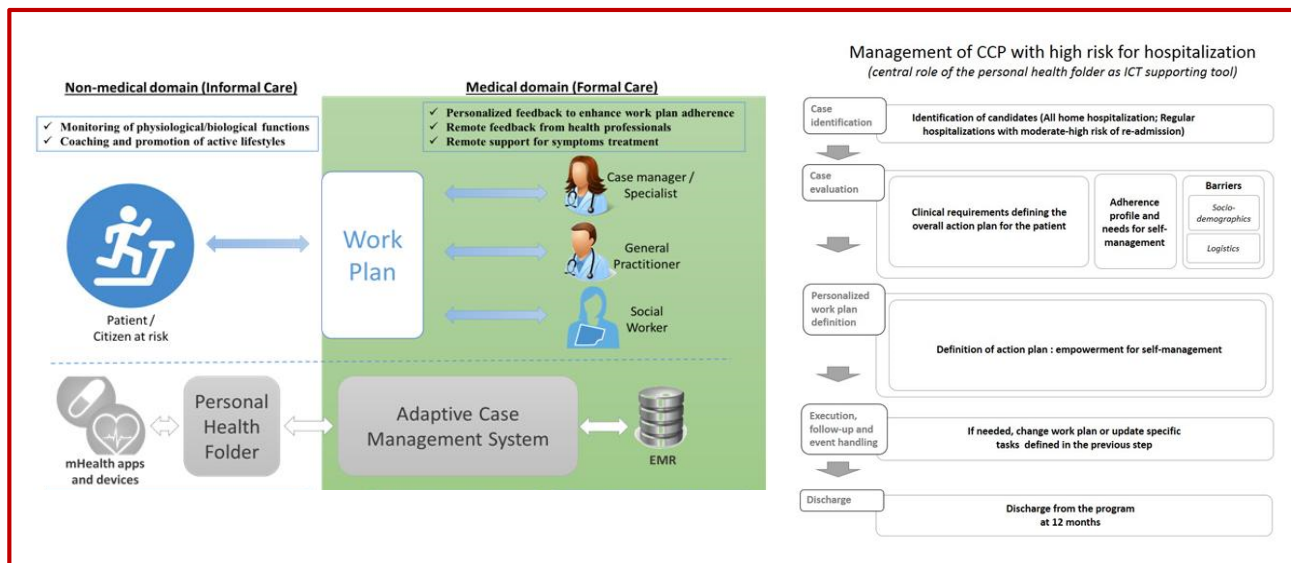
Spain: Area Integral de Salut, Barcelona Esquerra (Ais-Be)

Claudia Vallve, Joan Carles Contel, Isaac Cano, Josep Roca

KEY FINDINGS:

- New roles: Advanced Practice Nurse, Case Management Nurse, Liaison Nurse and Home care physician.
- 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

Integrated Healthcare Committee Barcelona Esquerra (CAISBE)	<ul style="list-style-type: none"> • Representation of the first management level of all suppliers involved. • 1-2 meetings a year • Monitoring the Strategic Plan and the main lines of work.
Standing Committee (SC)	<ul style="list-style-type: none"> • Integrated Health Area "Barcelona Esquerra" (AIS-BE) Manager, Barcelona Health Consortium (CatSalut), Primary Care Manager of the Catalan Health Institute, CAPSE Manager, representative of each Hospital (Clínic, Plató, Sagrat Cor), Head of the Technical Office. • Fortnightly meetings. • Supervising execution of the plans and of the development of the work lines.
Technical Office (TO)	<ul style="list-style-type: none"> • Staff of the Standing Committee comprising 3 professionals and support for professionals from the institutions • Co-ordination and methodological support for the different Committees
Operational Committees (OC)	<ul style="list-style-type: none"> • Consisting basically of medical and nursing personnel of the institutions. • With a Co-ordinator for each Committee who reports to the TI and the SC. • Methodological support for the TO. • Proposals for improvements to organisation and processes, organising the role of each Hospital in relation with the Primary Care Teams both for the basic pathology and for tertiary care.

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.

Information & research (EVIDENCE)

- Expanded population use of GMA risk-stratification tool.
- Results of Hernandez C. Int J Integr Care. 2015 15:e006.

Workforce

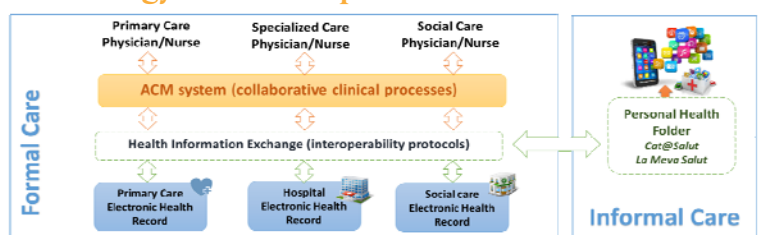
Advanced practice nurse: highly skilled nurse with deeper knowledge of a given pathology or of the different equipment's that are mobilized during home care. Can act proactively in the care of patient. Professional profile: experience in the surgical field ; post-graduate training.

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 team work, 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 if utmost importance.

Technology & medical products



Spain: Badalona Serveis Assistencials (BSA)

Claudia Vallve, Jordi Piera, Joan Carles Contel, Isaac Cano, Josep Roca

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.

Service delivery

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)

Medical attention at home

- Team composed by a physician, and a CMN 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.

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 proceedings 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.



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.

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.

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.

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.

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.

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

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

Workforce

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

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

1. Complex care hub

2. Enhanced primary care

- 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

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