

Work Package 2 Report

Norway



Work Package 2: Thick descriptions of

- Medically Assisted Rehabilitation (MAR) Bergen
- Learning networks for whole, coordinated and safe pathways (Learning networks)

WP leader:

Institute for Advanced Studies (IHS), Austria

WP co-leader:

August Pi i Sunyer Biomedical Research Institute (IDIBAPS), Spain

Authors:

Medically Assisted Rehabilitation (MAR) Bergen:

Rune Ervik¹, Tord Skogedal Lindén¹, Jan Erik Askildsen² and Sabine Ruths^{3,4}

Learning networks for whole, coordinated and safe pathways (Learning networks):

Rune Ervik¹, Tord Skogedal Lindén¹, Jan Erik Askildsen² and Sabine Ruths^{3,4}

¹ Uni Research Rokkan Centre, Bergen; ² University of Bergen, Department of Economics; ³ Uni Research Health, Bergen;

⁴ University of Bergen, Department of Global Public Health and Primary Care

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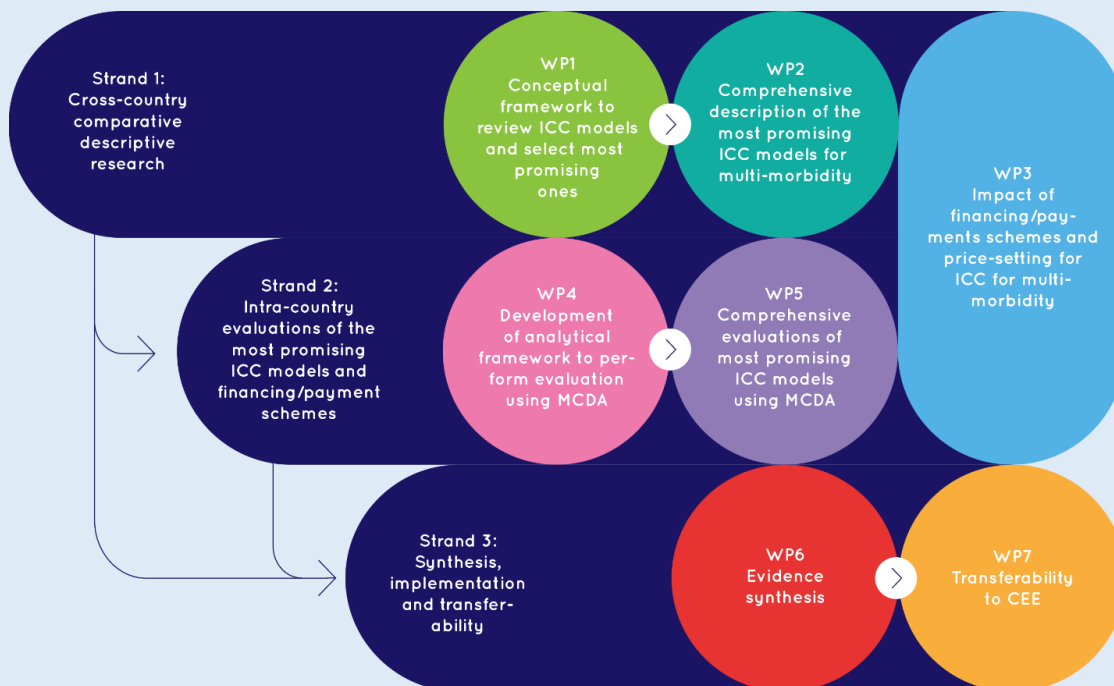
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The SELFIE project

SELFIE (Sustainable intEgrated chronic care modeLs for multi-morbidity: delivery, Financing, and performancE) is a Horizon2020 funded EU project that aims to contribute to the improvement of person-centred care for persons with multi-morbidity by proposing evidence-based, economically sustainable, integrated care programmes that stimulate cooperation across health and social care and are supported by appropriate financing and payment schemes. More specifically, SELFIE aims to:

- Develop a taxonomy of promising integrated care programmes for persons with multi-morbidity;
- Provide evidence-based advice on matching financing/payment schemes with adequate incentives to implement integrated care;
- Provide empirical evidence of the impact of promising integrated care on a wide range of outcomes using Multi-Criteria Decision Analysis;
- Develop implementation and change strategies tailored to different care settings and contexts in Europe, especially Central and Eastern Europe.

SELFIE strands of research and work package (WP) overview



The SELFIE consortium includes eight countries: the Netherlands (coordinator), Austria, Croatia, Germany, Hungary, Norway, Spain, and the UK.

Executive Summary

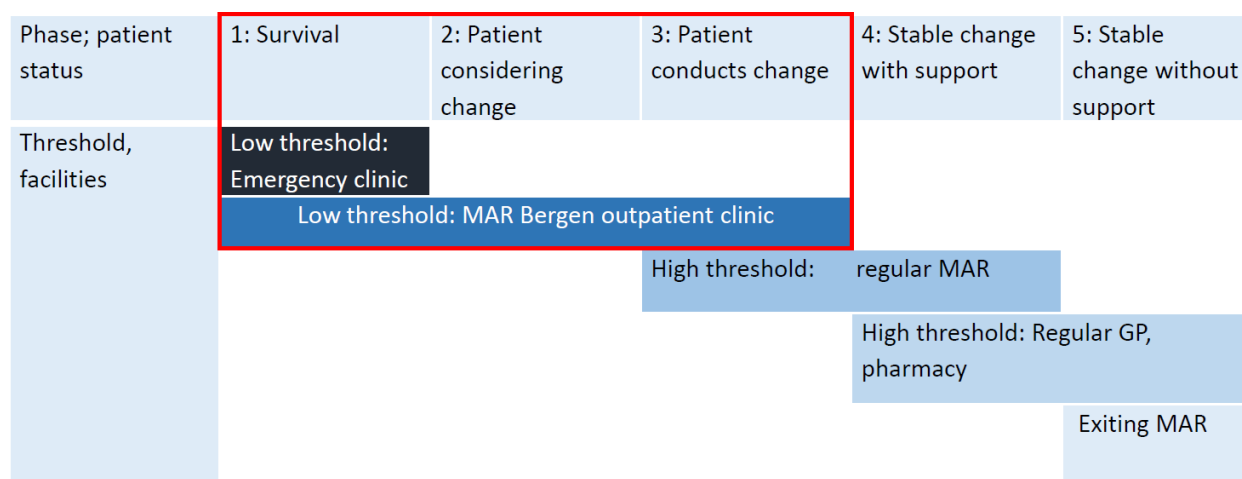
Medically Assisted Rehabilitation (MAR) Bergen

MAR Bergen is a treatment programme for opioid addiction at Haukeland University Hospital, Health Enterprise Bergen. In general terms, MAR is defined as an “interdisciplinary specialized treatment for opioid addiction, where requisition of addictive medicine in a fixed dose (substitution treatment) is a partial measure in an overall rehabilitation pathway”. At a national level, MAR treatment covers around 8,000 patients, with MAR Bergen covering around 1,000 of these.

Service delivery

The programme is being developed in collaboration between specialist healthcare services and municipal health and social care. The MAR Bergen model is of particular interest because of its emphasis on low-threshold access. The patients are in a phase where survival is the key objective, and the programme is aimed at patient support to promote change in opioid intakes. The patients typically have several diagnoses, both mental and physical, in addition to addiction, and often live in problematic conditions. The substitution treatment (i.e. requisition of addictive medicine in a fixed dose) is care-oriented, and considered as an ‘entrance ticket’ to further treatment. An overview of the process of service delivery in the MAR Bergen programme is given in the figure below.

Process of service delivery in the MAR Bergen programme



Leadership & governance

Treatment is organised in outpatient clinics at the specialist health service in collaboration with social services for the municipality as well as GPs. Special advisors are supposed to receive a supporting leadership in their role as frontline personnel meeting the patients. A major challenge is posed by the contrast between the care-oriented culture of the social services in the municipality and the disease-treatment oriented culture of the specialist health services.

Workforce

The programme has developed a new professional role of special advisor, usually a nurse or a social worker, who serves as the patient’s regular contact person with MAR. The MAR Bergen core team includes a physician, who is a specialist in addiction medicine, a psychologist and the special advisor. The programme faces challenges regarding time allocation, since there is a trade-off between

contact with individual patients and the expansion of and competence building within the programme.

Technologies & medical products

EMRs are developed for the programme, providing data that can be used for evaluation. The shared use of medical records by specialist and social services is, however, problematic.

Information & research

No systematic evaluation of MAR Bergen has been carried out so far aside from studies investigating specific medical interventions. However, from 2017 onwards individual data will be collected systematically, and a survey will be carried out. The Bergen Addiction Research group also aims to establish a Biobank.

Financing

The programme is financed through a combination of fixed block grants and fees, which depend on activity. Treatment activity can be underreported, resulting in lower income than budgeted given the patient population. Patients are also frequently unable to pay their own contribution to the scheme due to their financial circumstances.

Learning networks for whole, coordinated and safe pathways (Learning networks)

Learning networks are a national programme focusing on older persons enrolled in home nursing services or short-term stays in nursing home, e.g. after a hospital stay. Learning networks aim at facilitating person-centred approaches and improved patient pathways through multidisciplinary teams. They focus on functional ability rather than on disease and impairment, and new patterns of interaction represent a culture change.

Service delivery

Assessment of patient functioning based on validated tools, individual follow-up informed by the patient's own goals, and the involvement of the patient's GP are key elements of service delivery in the learning networks.

Process of service delivery in the learning network

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			

Leadership & governance

The programme is owned by KS (the Norwegian association of local and regional authorities) and has been implemented in 35 out of 428 municipalities so far. The programme includes user involvement, leadership, re-ablement, core competence, organization, measurements, management support and management involvement. There is a high level of political commitment both within municipalities and at the national level. Patient pathway is a keyword in the Norwegian Coordination Reform.

Workforce

As a minimum, the municipal multidisciplinary primary healthcare improvement teams are comprised of a GP and a nurse. Other primary care professionals (e.g. a physiotherapist, an occupational therapist) and a social worker are also involved if appropriate. A designated primary contact person (coordinator) is responsible for individual patient follow up.

Technologies & medical products

Some municipalities have introduced electronic white boards showing the status for all involved patients. This is a shared information system designed to raise awareness.

Information & research

No scientific evaluation has been conducted so far. The idea and practice of generic patient pathways is based on previous empirical research and the development of the so-called Orkdal model in Central Norway. Municipalities collect data on whether the service delivery items are conducted, data from assessment tools and data on patient experience.

Financing

The learning network is financed through the participating municipalities' general budgets. There are no direct financial incentives. In a longer-term perspective, potential savings for municipal assistance, institutional care or hospitalisation may be expected.

1. Methodological approach

This report is part of WP2 of the project SELFIE. The WP leader is the *Institute for Advanced Studies* (IHS) in Vienna, the WP co-leader is the *August Pi i Sunyer Biomedical Research Institute* (IDIBAPS) in Barcelona. The stated objective of WP2 is to comprehensively describe the 17 integrated chronic care (ICC) programmes selected in the course of WP1, covering the following features:

- **Barriers to and facilitators of implementation:** how were the most promising ICC models implemented and what were the barriers and facilitators during the implementation phase?
- **Patient centeredness:** how is the delivery of care designed around the patient?
- **Use of modern ICT:** which ICT (information and communications technology) applications are used in the most promising ICC models to support the care process and what are the requirements for implementing them successfully in the treatment of patients with multi-morbidity?
- **Use of self-management interventions:** which self-management interventions are used in the ICC models and how are they adapted to patients from different cultural and socio-demographic groups as well as to distinguish the conditions for their successful implementation?
- **Involvement of new professional roles:** are there new professional roles (e.g. physician assistants, nurse practitioners) involved in the ICC models and what are the barriers and facilitators in their successful introduction?
- **Existing evidence:** what is the existing evidence of the impact of the most promising ICC models?

The methodological approach chosen to achieve this objective is that of a “thick description”. For each of the eight countries participating in SELFIE, this report contains at least two¹ thick descriptions of the programmes selected in the respective country, resulting in a total of 17 thick descriptions.

The method of thick description is a well-established qualitative empirical approach. The basic idea was first introduced by the philosopher Gilbert Ryle (Ryle, 1949). In the 1970s, it was established as a qualitative method to investigate implicit social practices in their specific contexts by the anthropologist Clifford Geertz (Geertz, 1973). Geertz himself does not provide an explicit definition of this scientific approach. Studying thick descriptions by Geertz himself as well as other scholars, however, makes it possible to deduce the main aspects of the method. In the following quote, Geertz outlines the aims of the method:

- *“Setting down the meaning particular social actions have for the actors whose actions they are, and stating, as explicitly as we can manage, what the knowledge thus attained demonstrates about the society in which it is found and, beyond that, about social life as such. Our double task is to uncover the conceptual structures that inform our subjects’ acts, the ‘said’ of social discourse, and to construct a system of analysis in whose terms what is generic to those structures, what belongs to them because they are what they are, will stand out against the other determinants of human behavior. [...] provide a vocabulary in which what symbolic action has to say about [...] the role of culture in human life can be expressed.” (Geertz, 1973: 22)*

¹ Three in the case of the Netherlands.

In recent decades, Geertz' methodological and conceptual work has influenced empirical research in several disciplines (McCloskey, 1988). In sociology, it is widely used in a variety of research fields, including research of care practices (Maloney-Krichmar and Preece, 2005).

As shown in Figure 1.1, a thick description covers several levels of depth of analysis. The starting point is a formal description, which provides information on the surface of the studied phenomenon.

Figure 1.1. Levels of the programme description



Source: IHS (2015)

In the specific context of the SELFIE project, this formal description pertains to the general organisational structure of the programme and formal relations of the involved stakeholders. The formal description is valuable in itself, because it gives an overview of the domains and levels of integration, the individuals and organisations involved, the tools used and the processes employed. In particular, the formal description includes the following information:

- Name of the programme
- Contact details of the programme management
- Starting date of the programme
- Geographical scope of the programme
- Target group of the programme (type of individuals/scope/included combinations of morbidities)
- Number of persons treated in the programme (total and development over time)
- Aim of the programme
- Definition/understanding of “integrated care” (as far as described in documents)
- Definition/understanding of “multi-morbidity” (as far as described in documents)
- Definition/understanding of “person centredness” (as far as described in documents)
- Definition/understanding of “self-management” (as far as described in documents)
- Organisational form and ownership of the programme (including legal form)

- Involved partner organisations (payer(s), medical and social service providers), including subdivisions (e.g. departments of a hospital)
- Involved disciplines and professions

The formal description is mainly based on available literature, a variety of documents (e.g. official documents of the programme, grey literature) and expert information. A document analysis was performed on these materials, which comprise the first source of information and the basis for obtaining “hard facts” on the respective programme.

However, written documents are in general not suitable to give a deeper understanding of what actually constitutes the programme below its surface when put into practice. These substructures are, however, essential for the functioning of the programme. In addition to the formal description, the method of thick description therefore aims to gain insights on what lies beneath the surface of the studied phenomenon (see Figure 1.1).

For the purpose of gathering the necessary information, interviews were conducted with different stakeholders involved in the programme. These served as the second source of information. While the interviews were also used to complement the “hard facts” gathered in the course of the document analysis, their main aim was to obtain “soft facts” about the substructure of the programmes. Therefore, questions of “how” and “why” were at the centre of the interviews and the subsequent analysis of their contents. This comprehensive approach allows for a deeper understanding of what daily practice in the programme looks like and in which way multi-morbidity is addressed in the specific context of the programme.

A set of stakeholder types to be interviewed was defined in advance. This set consisted of the following stakeholder types:

- A. **Manager(s) of the programme**
- B. **Initiator(s) of the programme:** individuals or representatives of institutions that participated in initiating, conceptualising and planning the programme (e.g. representatives of sickness funds, physicians, etc...)
- C. **Representative(s) of sponsor/payer organisations:** individuals or representatives of institutions that fund the programme on a project basis or on a regular basis (e.g. representatives of sickness funds, representatives of municipalities, representatives of associations, etc...)
- D. **Medical and social staff**
 - D1: physician(s)
 - D2: non-physician medical staff (e.g. nurses), social staff, new professional groups (if applicable)
- E. **Informal caregivers** (e.g. relatives, neighbours, volunteers)
- F. **Clients or their representatives** (e.g. clients or persons in their close environment, representatives of self-help groups)
- G. **Other stakeholder(s):** individuals or representatives of institutions, who turn out to be of specific relevance for the respective programme and do not fit in the categories A.-F.

For each stakeholder type, the WP leader set a minimum number of persons to be interviewed. However, considering that the 17 selected programmes involve very different kinds of stakeholders, a specific sample of interviewees was developed for each individual programme. The partners

discussed these samples with the WP leader, in order to ensure a balanced sample structure in each programme.

For each of these stakeholder types, thematic focus areas were defined. Based on these focus areas, a set of interview protocols was prepared by the WP leader. The protocols accounted for the different backgrounds and relevant themes of the individual stakeholder types. This served the purpose of gaining insights into the programme from various perspectives. The included questions concerned, for example, the stakeholders' perceptions of delivery of care for persons with multiple chronic conditions, their roles and relationships in the programme, their specific problems and their personal views.

In general, all interview protocols were structured according to the following outline:

- A Brief introduction about SELFIE and the interviewer as well as clear information about the goal of the interview
- Signing and exchanging the anonymity agreement and the declaration of consent for recording
- First question: Regarding the person's qualification and position in the programme
- Next question: Regarding the main work of the interviewee and his/her specific role in the programme
- 1-2 main questions: Regarding the work in the programme (covering selected focus area of respective stakeholder type)
- (Direct and indirect follow-up questions)
- Last question: valuation of an important aspect of the programme

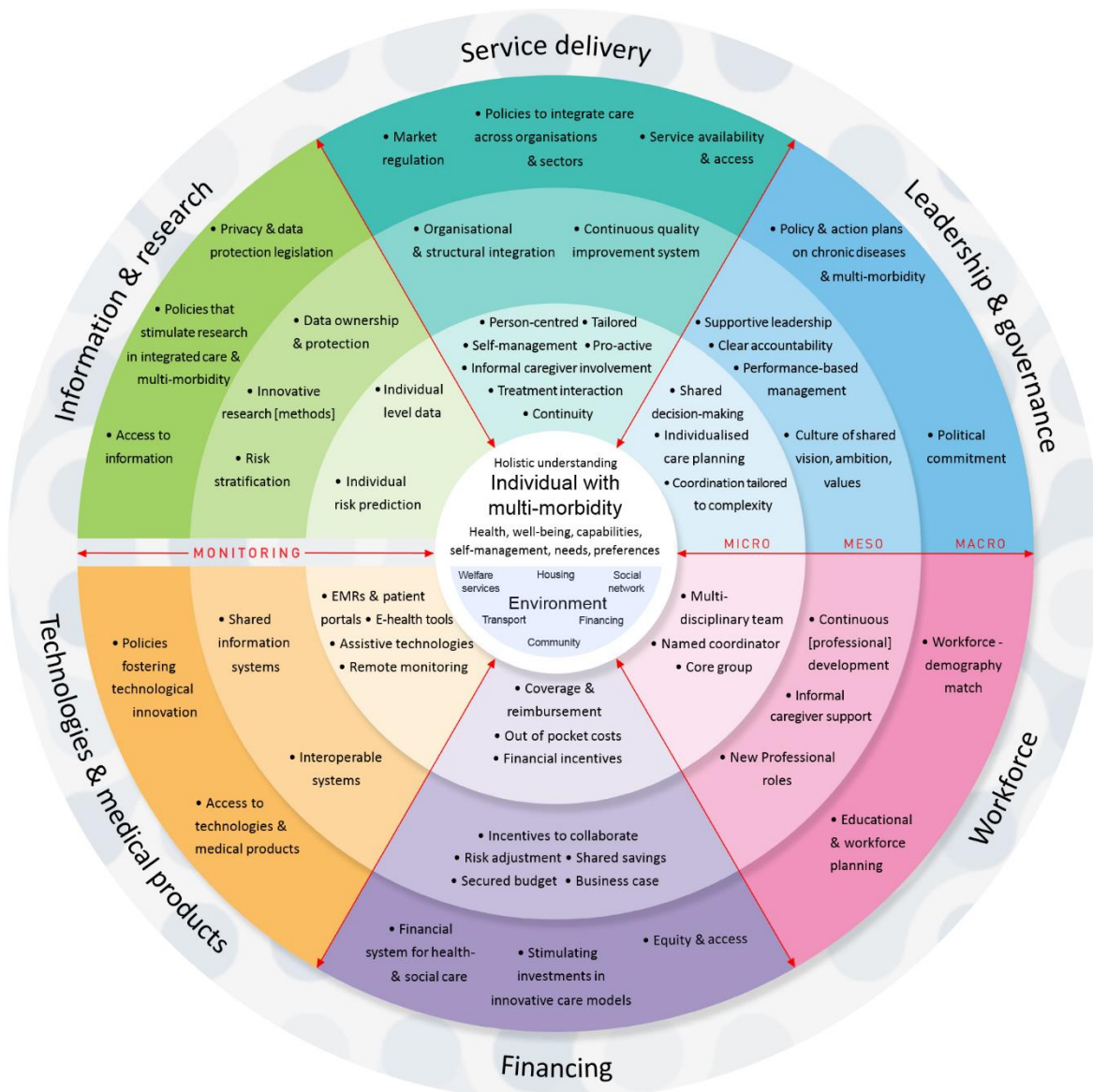
The interview protocols were adapted by the partners according to the specific context of each programme and interviewee, using prior knowledge obtained from the document analysis and from previous interviews. The interviews were carried out face-to-face and the interview duration was between 30 and 90 minutes. The interviews were recorded and transcribed. The resulting transcripts were analysed using the method of content analysis developed by Mayring (Mayring, 2001). This method involves the following steps of abductive interpretation²:

- Selecting units of analysis
- Paraphrasing these units of analysis
- Transforming the paraphrases to short forms
- Constructing categories, where possible

The thick descriptions are structured according to the elements of the conceptual framework developed in the course of WP1. The model is depicted in Figure 1.2.

² Timmermans and Tavory (2012) define abduction as a "creative inferential process aimed at producing new hypotheses and theories based on surprising research evidence."

Figure 1.2. Conceptual framework for the delivery of care for persons with multiple chronic conditions



Source: Leijten et al. (submitted manuscript, 2016)

Simultaneously, each thick description covers the eight tasks of WP2 set out in the SELFIE proposal, as well as one supplementary task (denoted by TS), which was agreed on by the project consortium at the kick-off meeting and actually belonging to WP3:

- **Task 1:** To develop the approach for the qualitative analysis of ICC programmes
- **Task 2:** To investigate how the most promising ICC programmes were implemented as well as to identify barriers and facilitators during the implementation phase
- **Task 3:** To analyse how the delivery of care is designed around the patient in the most promising ICC programmes
- **Task 4:** To analyse the relationship with long term care, social care and other partners beyond the healthcare system

- **Task 5:** To investigate which ICT applications are used in the most promising ICC programmes to support the care process as well as to explore the requirements for implementing them successfully in the treatment of patients with multi-morbidity
- **Task 6:** To analyse which self-management interventions are used in the most promising ICC programmes and how they were adapted to patients with multi-morbidity from different cultural and socio-demographic groups as well as to distinguish the conditions for their successful implementation
- **Task 7:** To explore new professional roles (e.g. physician assistants, nurse practitioners) involved in the ICC programmes as well as to identify barriers and facilitators in their successful introduction
- **Task 8:** To review existing evidence on the impact of the most promising ICC programmes
- **Task TS:** To explore the experiences of the stakeholders regarding financing and payment schemes

The WP leader provided the partners with continuous guidance in order to ensure that all partners are able to follow the methodological approach described above. This guidance mainly consisted in three parts. First, in the preparatory phase of WP2, methodological guidance materials were developed by the WP leader for all partners. These materials were presented to the partners in the course of the 2nd steering committee meeting in Vienna on January 25th and 26th 2016. Second, a special training course was held at IHS Vienna for researchers directly involved in the thick description on April 14th 2016. Third, all 17 thick descriptions were reviewed in order to ensure that they are harmonised to a certain degree. In this third part, the WP leader received support from the WP co-leader. The review process was divided as follows:

- **WP leader:** Germany, Netherlands, Norway and Spain
- **WP co-leader:** Austria, Croatia, Hungary and United Kingdom

However, it is part of the method that thick descriptions are not standardized but instead should be guided by what the prominent features of the individual studied phenomenon are. Therefore, the diversity in the thick descriptions reflects different topicalities, approaches, challenges and solutions.

As mentioned above, the method of thick description allows for a deep understanding of the implicit structures of the investigated programmes. This is of utmost importance also as a basis for further work packages of the SELFIE project. In the context of WP3, this deep knowledge can help to understand incentives of payment methods better and thus help to develop a comprehensive guide to financial and payment schemes that facilitate the provision of ICC to multi-morbid patients, as well as a guide to pricing of ICC programmes. In the context of WP4, this knowledge it can help to identify the relevant indicators to measure outcomes of ICC programmes. In the context of WP5, it can help to gain ideas regarding how to set up a suitable empirical evaluation of these programmes. Furthermore, it may help to better understand and explain the outcomes of the empirical evaluation.

Each report is structured in the following way: After the methods chapter, chapter 2 provides general information on the national health and social care system with a special focus on integrated chronic care for persons with multi-morbidity. This chapter covers the macro level of the conceptual framework and has the purpose of giving insight into the specific context the two selected programmes are embedded in. The programmes are subsequently described in detail in chapters 3 and 4, respectively. The descriptions present important findings obtained from the document

analyses as well as the interview analyses. After a short overview of basic information about the programme, the findings are structured according to the six segments of the conceptual framework: service delivery, leadership and governance, workforce, technologies and medical products, information and research/monitoring and financing. Furthermore, the implementation process is described in an additional section. The descriptions conclude with a discussion of the respective programme. The discussion summarises the distinctive features of the programme and puts the empirical findings in context of the conceptual framework.

The report includes several quotations from the interviews. These are intended to present the stakeholders' perspectives in their own words. They were selected in the process of "abduction" and are used as a source of, e.g., typical forms of care practices, cooperation forms and motivations for participating in the programme. All quotations are anonymised and translated into English. In the appendix, however, they can be found in the respective original language.

1.1. References

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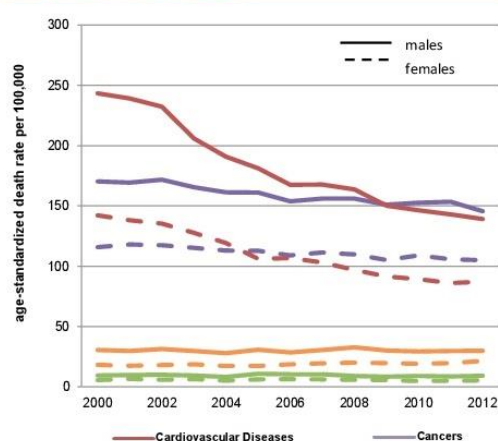
2. Macro level

2.1. Norway: Key facts, figures and geographical scopes of included programmes

Norway

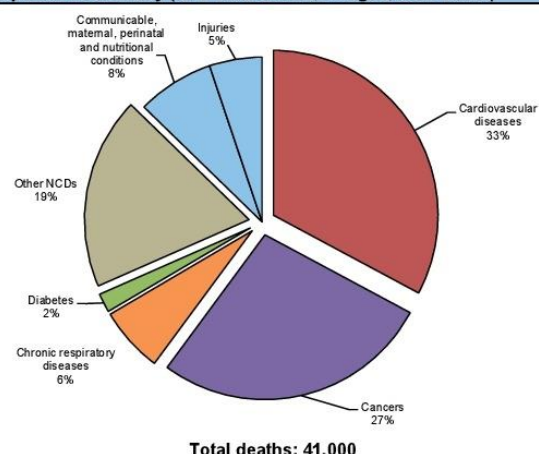
Total population: 4 994 000
Income Group: High

Age-standardized death rates



Percentage of population living in urban areas: 79.4%
Population proportion between ages 30 and 70 years: 51.3%

Proportional mortality (% of total deaths, all ages, both sexes)



Adult risk factors

	males	females	total
Current tobacco smoking (2011)	28%	26%	27%
Total alcohol per capita consumption, in litres of pure alcohol (2010)	10.8	4.7	7.7
Raised blood pressure (2008)	37.1%	29.0%	33.0%
Obesity (2008)	23.0%	20.1%	21.5%

National systems response to NCDs

Has an operational NCD unit/branch or department within the Ministry of Health, or equivalent	Yes
Has an operational multisectoral national policy, strategy or action plan that integrates several NCDs and shared risk factors	No
Has an operational policy, strategy or action plan to reduce the harmful use of alcohol	Yes
Has an operational policy, strategy or action plan to reduce physical inactivity and/or promote physical activity	Yes
Has an operational policy, strategy or action plan to reduce the burden of tobacco use	Yes
Has an operational policy, strategy or action plan to reduce unhealthy diet and/or promote healthy diets	Yes
Has evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach	Yes
Has an NCD surveillance and monitoring system in place to enable reporting against the nine global NCD targets	No
Has a national, population-based cancer registry	Yes

Source: World Health Organization - Noncommunicable Diseases (NCD) Country Profiles, 2014

http://apps.who.int/iris/bitstream/10665/128038/1/9789241507509_eng.pdf?ua=1

Norway	
Key facts and figures	
Population	5,236,826 (2016)
Population ≥ 67 yrs (%)	14.3% (2016)
Model of care	Beveridge
Life expectancy (yrs)	80.4 M & 84.1 W (2015)
Birth rate	1.73 per woman (2015)
Gross mortality rate	7.8 per 1000 inhabitants (2015)
Infant mortality	2.4/1000 live births (below 1 year, 2015)
Potential Years of Life Lost (PYLL)	2,118 (F) and 3,710 (M). (OECD source)
Healthcare expenditure % GDP	9.9% (2015)
Healthcare expenditure per capita €/year: Social expenditure per capita €/ year:	Health NOK 59,942 (ca € 6310 at € 9.5; not PPP-adjusted, 2015)
Coverage (% population) (paid by taxes)	100%
Public Payer	Health: Government and municipalities Social: Municipalities
Suppl. private insurance (% population)	Approximately 9% (double insured, source: Finance Norway)
Number of doctors per 10,000 population	44 per 10,000 inh (2014, OECD source)
Number of hospital beds per 10,000 population	38 per 10,000 inh (2014, OECD source)
Hospitalization rate per year	16,845 per 100,000 inh (discharges 2014, OECD source)



Legend:

(BLUE): MAR Bergen

(RED): Municipalities participating in the Learning network for whole, coordinated and safe pathways in municipalities

2.2. Service delivery

2.2.1. Description of the main policies and regulations shaping the health and social care system

In Norway, the Ministry of Health and Care Services has overarching responsibility for the population having access to good and equitable health and welfare services. The Ministry is responsible for the policy related to hospitals, healthcare and welfare in municipalities, prevention, mental health and substance abuse.

Norwegian policy initiatives in the extended area of health and welfare services have been salient for the last two decades, including the *Hospital Reform in 2002*, a major reform of the welfare administration (NAV) from 2006 and onwards, and the introduction of the national policy reform termed *The Coordination Reform* (St.meld. nr. 47 (2008-2009)), which has gradually been implemented in the period 2012 to 2016. See: <https://www.regjeringen.no/no/dokumenter/stmeld-nr-47-2008-2009-/id567201/>. The three primary objectives of the Coordination Reform are (i) A more cohesive and coordinated approach to health and care services; (ii) A greater proportion of health and care services are to be provided in the local communities; (iii) Greater focus on preventative measures and improving public health. Through this reform, the municipalities were given increased responsibility for community-based treatment, care and rehabilitation, according to a principle that care should be provided at the “lowest effective level”. National plans have been launched for the municipality sector (Meld. St. 26 (2014-2015)) and the hospital sector (Meld. St. 11 (2015–2016)). See: <https://www.regjeringen.no/no/dokumenter/meld.-st.-26-2014-2015/id2409890/> and <https://www.regjeringen.no/no/dokumenter/meld.-st.-11-20152016/id2462047/>.

2.2.2. Description of clear and well-designed national/regional policies/plans and programmes supporting integrated care for chronic patients with multi-morbid condition/complex care needs

The Coordination Reform and subsequent policy documents have stressed the need to develop health and care services that are more integrated and closer to the patient. Particular attention towards patients with multiple and chronic illnesses is strongly signalled. The policy tools were designed and presented in Meld.St. 16 (2010-2011), *The National Health Plan* (2011-2015), pointing at needs of adequate staffing capacity and multidisciplinary competence in primary care, as well as planned patient trajectories and cooperation with hospitals. Financial, legal, organisational and technical measures should promote the overall goal of comprehensive and flexible patient care. It was envisaged that the specialist and municipal health increasingly interact with each other and that municipalities should take a greater share of responsibility for health services. See: <https://www.regjeringen.no/en/dokumenter/meld.-st.-16-2010-2011/id639794/>. The most important actions have been:

- Review and adaptation of statutes and regulations
- Requirements regarding cooperation between municipalities and specialist health services for the design of policies and cooperation
- Financial incentives in the form of payment for pending ready for discharge patients, and co-financing of stays in hospital (latter now abolished)
- Requirements and grants for the creation of a local emergency care beds in the municipality

The Health&Care21 (HelseOmsorg21) strategy process was launched by the Ministry of Health and Care Services in 2013, aiming at evidence-based health and care services characterised by high quality, patient safety and efficiency. A subsequent Action Plan for follow-up of the strategy was launched in 2016. See: <https://www.regjeringen.no/no/dokumenter/HelseOmsorg21/id764389/> and https://www.regjeringen.no/contentassets/3dca75ce1b2c4e5da7f98775f3fd63ed/handlingsplan_ho_21.pdf.

2.2.3. Description of specific policies for integration of social and healthcare programmes for management of patients with multi-morbidity with current or potential social needs?

To date, no reform has aimed at improving the coordination and interaction between sectors, in spite of the obvious need for improved interaction (and in spite of the label, *Co-ordination*, of the above-mentioned reform). There have been policy initiatives however, such as the 1999-2008 national *Escalation Plan for Mental Health* which led to a significant allocation of resources to integrated care for people with mental health disorders. More recently, the *Norwegian Directorate of Health* has launched integrated pathways for patients with suspected cancer. The relative lack of attention to cross-sectorial integration may be explained by the relative institutional strength lent to the hierarchic, sector-based capacities that the Norwegian system of ministerial governance is built on.

2.3. Leadership & Governance

2.3.1. Briefly describe how governance of the health and social care system is structured at national/regional level and who the main actors are

As mentioned, the Ministry of Health and Care Services has overarching responsibility for both types of services. The Norwegian Directorate of Health is an executive agency of health and care policy, and professional authority under the Ministry, acting across services, sectors and administrative levels. The *Norwegian Board of Health Supervision* (<https://www.helsetilsynet.no/Norwegian-Board-of-Health-Supervision/>) is a national public institution organized under the Ministry, with responsibility for supervision of child welfare services, social services, and health and care services.

The Norwegian healthcare system is organised in primary and secondary healthcare sectors. The municipalities are responsible for primary healthcare provided through e.g. general practitioners (GPs), home care services, nursing homes, health centres for children, and emergency out-of-hours clinics; the municipalities decide which patients to be granted different types of services. The municipality has the right to demand that a GP devote up to 20% of their time to public health or municipal healthcare services. The municipalities are responsible for home care and institutionalised care, and they decide which patients to be granted different types of services. The municipality has the responsibility to take care of patients discharged from hospital, and to find adequate further care. If they are not ready to offer this care, the hospitals may charge the patient's home municipality for the prolonged stay in the hospital.

The secondary healthcare (hospitals and outpatient clinics) is organised through four regional health authorities (RHAs), which have the responsibility for providing treatment to all inhabitants of their

region. Furthermore, they also provide most of specialist treatment, organised in health enterprises (HE) owned by the RHAs. Some treatment is also provided by private specialists on a long term contract with a RHA, or by private hospitals on a short term contract with a RHA, covering specific diagnoses. The hospitals are organised as state-owned enterprises, exempt from regional and local political control. This situation differs from that of primary healthcare services (municipal sector), where local political considerations on the organisational and expenditure level are quite central.

2.3.2. Briefly describe how governance of the integrated care initiatives/programmes at national/regional level is structured and who the main actors are

The Norwegian Directorate of Health (<https://helsedirektoratet.no/english>) is in charge of following-up national integrated care initiatives.

2.4. Workforce

2.4.1. How is the workforce prepared for and involved in the transitions and scale-up of integrated care?

Nearly 100% of the population is enrolled in the regular GP list patient system, with an average size of 1200 persons on a list for a GP working full time. Most GPs are working in group practices with 2-4 colleagues; only a few GPs work in primary healthcare centres with nurses and other health professionals. GPs' roles include gate-keeping vis-a-vis secondary healthcare and the social security system (sickness and disability pension). The Coordination Reform has led to quicker discharge from hospital but the municipalities have not been able to increase their staffing capacity at the same pace. Preparation of the workforce for providing integrated care is mainly organised through specific post-graduate courses. For example, a "competence area" for elderly care medicine in the municipalities was established in 2010; however, interest and involvement in this training is limited.

2.4.2. Describe the occurrence of new professional roles and occupations involved in integrated care.

The Practice Consultant Scheme (PKO) is a network of GPs, part-time engaged in hospitals, working for facilitating and improving transitional care and communication between hospital departments and GPs / private specialists. Many municipalities have employed nurses specialised in chronic care (e.g. COPD, heart failure, or cancer). The Norwegian Directorate of Health is about to launch establishment of primary healthcare teams. These teams will be mainly dedicated to manage complex care for patients with chronic conditions / multi-morbidity living at home. Nurses specialised in chronic care will be working together with GPs at their clinics and also conduct home visits.

From 2016 all municipalities are obliged to provide community emergency beds (around-the-clock) care for selected cases, as an alternative to hospital admission. There are mainly older patients (but also younger ones) with chronic conditions and multi-morbidity living at home and who need acute medical care if the condition deteriorates.

2.5. Financing

2.5.1. Brief description of the funding system for the health and social care sector in general and integrated care specifically

Most GPs are since 2001 part of a patient list system. More than 90% of GPs are self-employed. GPs are financed by fees for services and a fixed payment per patient on the list. A minority of the GPs are employed on fixed term contracts by municipalities. In this case the municipalities receive all payments depending on the list and patient contacts. Less than 2% of GPs works privately, outside the list patient system.

The RHAs are financed by the government by combinations of block grant and activity based finance based on a DRG system, now 50% activity based within somatic care. For mental care, there is a pure block grant. The HEs are usually financed by the RHA through capitation based formulas, since also the RHs have a geographically defined catchment area. The RHAs may make use of private hospitals for treatment in specifically defined areas. Then the contracts are usually signed on the basis of a market tendering (auction), and payment based on DRG-weights of the diagnoses involved. The patients have, with some restrictions, the right to a free choice of hospital when referred to secondary healthcare. This also includes possible private suppliers on contract with a RHA.

Municipalities are given monetary incentives to establish adequate treatment (municipal emergency beds) for patients that do not necessarily have to receive hospital treatment.

The municipal health and social care services, comprising home nursing, nursing homes, health centres and social assistance measures, are financed through a combination of local taxes, risk-adjusted block grants from the government, and user fees. Some municipalities also have a property tax, though at a rather low level. Local taxes are now at the same rate for all municipalities in Norway, whereas block grants depend on population and its characteristics.

Through the Coordination Reform, municipalities are supposed to have contracts with the Health Enterprises for coordinating transfer of patients. The does not follow monetary resources as such based on these contracts. However, municipalities are responsible for receiving patients ready for discharge. If they are unable to receive a patient, they have to pay a fee of, currently (2016), NOK 4 505. During the period 2012-2014 there was also a municipal co-payment, through which the municipalities paid 20% of the DRG price (up to a ceiling of 4 DRG) for patients receiving somatic treatment. To finance this, a compensating share of hospitals' expected DRG base income was transferred to municipalities.

2.5.2. Are financial policies aligned with large scale implementation of integrated care?

As seen above, different public units share responsibility of patients. Finance systems are only to some degree coordinated, thus there is always the possibility of financially motivated activities that reduce efficiency and optimal delivery of care.

The discharge fee implemented as part of the Coordination Reform seems to be associated with a reduction in length of stay in hospitals. On the other hand, the 20% co-finance from municipalities to

hospitals, which was abolished 2015, did not have any effect on activity at the hospitals within relevant treatment.

2.5.3. How is sustainability of funding for integrated care ensured?

The Coordination Reform included as detailed above incentive mechanisms for integration of care. The mechanisms have been evaluated, and new policies implemented will generally be exposed to further evaluation. There is in general a large degree of consensus when it comes to procedures for reforms in the public sector, thus avoiding sudden and unexpected changes of organization and finance.

2.6. Technologies & medical products

2.6.1. Describe national/regional policies to promote the use of ICT to support integrated care?

Every GP, hospital, privately practicing specialist and pharmacy has an electronic patient record (EPR) system. Even though there is no national standard to define functionality and inter-provider exchange, communication between these actors on referrals, discharge, prescriptions and various tests (e.g. blood tests or radiography) often works well. However, communication with EPRs in other parts of the healthcare system such as home nursing service, nursing homes, child health clinics and school health service, as well as with social services is not yet established. Under the auspices of the Norwegian Directorate of Health, a *Core Journal* has been established recently for all citizens (voluntary); this is an electronic tool comprising selected and important health data that are accessible for the citizen and health personnel.

2.6.2. Describe national/regional policies stimulating e-health applications and assistive devices?

Established in January 2016, the *Norwegian Directorate of eHealth* (NDE) is a sub-ordinate institution of our Ministry of Health and Care Services. The Directorate will implement the national policy on eHealth, establish the requisite standards, and administrate the use of eHealth methodology nationwide. Responsibilities comprise (i) National steering and coordination of eHealth through close cooperation with regional health authorities, local authorities, technical organisations, and other interested parties. (ii) Develop and administrate digital solutions that will improve and simplify our health and care sector.

2.7. Information & research

2.7.1. Describe legislative framework on data privacy with respect to integrated care? Does it follow the current EU directive? Is it constraining implementation of integrated care?

The Personal Data Protection Act (Personvernloven) is in place, requiring medical care providers to keep patient records up to date and to treat all information confidentially. Individual patient data cannot be exchanged between care providers without explicit patient consent.

2.7.2. Describe specific national/regional research programmes for integrated care and/or multi-morbidity

The Ministry of Health and Care Services has commissioned the *Research Council of Norway* to carry out a research-based evaluation of the Coordination Reform. The Research Council has conducted a research programme tailored at integrated care (EVASAM) from 2012 to 2015. The evaluations of financial mechanisms are referred to above.

2.7.3. Describe if and how they are embedded in larger (European-wide) innovation & research platforms for integrated care?

Norwegian teams have been involved in prior EU-research on multi-morbidity and / or integrated care research (e.g. MUNROS).

3. Programme 1: Medically Assisted Rehabilitation (MAR) Bergen

3.1. Basic information

WP 2 of SELFIE rests on a two-step strategy where the document analysis is meant to acquire “hard facts” about the selected ICC-programmes whereas the interviews should provide “soft facts”. Examples of “hard facts” are basic information about the programme, implementation process and design of delivery of care (task-related information). “Soft facts” for instance include information about establishment of the programme, how it works, relationships between actors, and challenges.³ The two data sources should supplement each other, and there is no definite distinction between information from these two sources. However, in the case of MAR the interviews are of particular importance because relatively few documents exist and can be analysed. Given the programme’s recent origin this is to be expected and also means that we will use interviews to gather “hard facts” to a somewhat larger extent than foreseen by the SELFIE-framework. However, as shown by Smith, Wallace, O’Dowd and Fortin (2016), there is in general limited research on programmes for multi-morbidity, and in particular there is limited documentation on effectiveness of such programmes.

What is Medically Assisted Rehabilitation (MAR) [*Legemiddel Assistert Rehabilitering, LAR*]? MAR treatment is defined as specialized health services, according to the MAR regulation. It states that: “MAR is interdisciplinary specialized treatment for opioid addiction, where requisition of addictive medicine in a fixed dose (substitution treatment) is a partial measure in an overall rehabilitation pathway” (Helse- og omsorgsdepartementet, 2009, §3, authors translation into English).⁴

In analysing the MAR Bergen programme, the following key documents have been included, cf. table 3.1.1 below:

³ In our work with the two programmes we have interviewed a total of 25 persons. We would like to extend our strong gratitude to each one of them for providing us with unique and valuable knowledge on the workings of the programme from many different angles and backgrounds of experience. As will be revealed throughout this text their help has been essential for providing a thick description of the two cases included as promising programmes for Norway.

⁴ Throughout this report numerous texts are translated from Norwegian into English by the authors of this report. If not stated otherwise this is the case for all interviews and sources originally given in Norwegian language. To improve readability we have sometimes deviated partly from a verbatim translation.

Table 3.1.1. Classification of included documents for the MAR Bergen programme

Type of document	Document name, Norwegian	English translation	Referred in text as*:
Programme description	Faglig grunnlag for M31	Scientific basis for M31**	(Ohldieck, 2015b)
Programme description	LAR – modellen i Bergen	The MAR-model in Bergen	(Ohldieck, 2015a)
Programme description	LAR Bergen	MAR Bergen	(Ohldieck, 2016)
Contractual documents related to the programme	Protokoll frå styremøte i Helse Vest RHF, 22.12.2009,	Protocol from Board meeting Health Enterprise West Region, 22.12.2009	(Helse Vest, 2009)
Contractual documents related to the programme	Verksemdsovertaking LAR	Transfer of MAR programme	(Helse Bergen, 2010)
Contractual documents related to the programme	Oppdragsdokument 2013 til Helse Vest RHF	Mission/task document 2013 to The Western Regional Health Enterprise	(Helse- og omsorgsdepartementet, 2013)
Contractual documents related to the programme	Prop. 1 S (Statsbudsjettet)	Proposition 1 S to the Parliament (State budget)	(Prop. 1 S, 2014-2015)
Annual reports/Activity reports			
Evaluation reports			
Scientific article about the programme/related programmes		Open drug scenes and overdose mortality.	(Waal <i>et al.</i> , 2011)
Other documents	LAR Forskriften	MAR Regulations	(Helse- og omsorgsdepartementet, 2009)
Other documents	Nasjonal retningslinje for legemiddelassistert rehabilitering ved opioidavhengighet	National guideline for MAR in opioid addiction	(Helsedirektoratet, 2010a)
Other documents***	Heroinbyen Bergen	Heroin town Bergen	(Ohldieck, 2014)
Other documents***	Lukket park åpner muligheter	Closed Park creates opportunities	(Ohldieck and Waal, 2015)

* For complete references, cf. references list at the end of this report

** The name M31 refers to Møllendalsveien 31, the visiting address of a polyclinic established in November 2014. The polyclinic is the lowest threshold and entering point into MAR treatment of the Bergen MAR model.

*** Newspaper chronicles

Additional sources on context and background include: (Clausen, 2014; (Lie and Nesvåg, 2006; (Skeie, 2012; (Waal Helge *et al.*, 2015).

Table 3.1.2. provides basic information on the MAR Bergen programme.

Table 3.1.2. Basic information about MAR Bergen

Information category	Description
Programme name:	MAR Bergen (Medically Assisted Rehabilitation Bergen)
Contact details, programme management	Christian Ohldieck, christian.ohldieck@helse-bergen.no
Starting date of the programme	M31 and the specialized outpatient clinics started on 1 November 2014. (At the national level, general opioid maintenance programmes were established in 1998.)
Geographical scope	Municipality of Bergen (second largest city in Norway, around 275 000 inhabitants in 2014).
Target group of the programme	Patients with opioid addiction who have entered an extensive opioid maintenance treatment programme in Bergen. All patients have an F11.2 diagnosis, meaning that they satisfy the ICD-10 criteria for opioid addiction. They have multiple physical and mental comorbidities, substantial social needs; they have almost no income or wealth, they are unemployed and many are without residence. *
Number of patients treated in the programme	By the end of 2015 the total number of patients included in the MAR Bergen programme was about 1000. Approximately 500 patients are attending the specialized outpatient clinics several times per week; another 300 patients in Bergen receive ambulant follow up at the outpatient clinics. In addition, 210 patients in surrounding municipalities are followed up ambulant.
Aim of the programme	To provide low-threshold integrated care to a patient group with high disease burden. They are hard to reach with standard care, and therefore often receive poor quality of care. The main goal is to improve quality-adjusted life expectancy. *
Organizational form and ownership	MAR Bergen is organised as part of the Bergen hospital enterprise (<i>Helse Bergen</i>), Department of addiction medicine (AFR). It is owned and financed by the Norwegian Government.
Involved partner organizations	Haukeland University Hospital in Bergen. Community social services and primary healthcare (general practitioner).
Involved disciplines and professions	Medical doctors (specialists in drug addiction, general practice, internal medicine, psychiatry), nurses, social workers and psychologists.

* See below for further description

Adding to the description of the **target group** above it should be stressed that a majority of the patients have experienced severe traumas during childhood or adolescence. There is a high prevalence of co-existing drug addictions, with an average of 2-4 drug addictions. The mental disease burden is high, with a high prevalence of severe personality disorders, anxiety, depression, ADHD and

psychotic disorders. Many patients have somatic diseases, often untreated. Infectious disease such as Hepatitis C is particularly common. Pulmonary and cardiovascular diseases emerge at younger ages than in the general population (Helsedirektoratet, 2010a: p.19, p.46).

The following comparison with “average” patients reveals explicitly why a different design of care delivery is needed for the group of particularly vulnerable users:

Table 3.1.3. Contrasting cases and the need for a well-designed delivery of care

Norwegian average patients	Particularly troubled patients with addiction
Have their own housing	Have no own housing
Have normally good functional level	Have very poor or critically poor functional level
Have managed economy and are able to pay health user charges/ fees	Have no control over personal economy and are unable to pay any health user charges/fees
Have control over time and places, keep appointments	Have no control over time and places, do not keep appointments
Have family and a drug free network	Have neither contact with family, nor a drug free network
Are not traumatized	Are traumatized
Are „old“ at age over 75 years	Are „old“ at age 50 years
Average expected life expectancy is 83 years	Average expected life expectancy is 60 years
Have well defined diseases	Have complex conditions and multi-morbidity; somatic, mental, as well as drug- and addiction-related conditions
Contact regular GP when ill	Do not contact regular GP when ill
Do not experience stigmatization or being denied access to the health system	Many have experienced stigmatization and being denied access to the health system
Their conditions do not require GP with competence in drug and addiction medicine in order to treat simultaneously occurring physical and mental illnesses	Their conditions do require GP with competence in drug and addiction medicine in order to treat simultaneously occurring physical and mental illnesses

Source: The content of the table is adopted and translated into English from (Ohldieck, 2016)

Before entering the MAR treatment programme, these patients have lived a large part of their lives on open drug scenes, in a drug culture characterized by crime, violence, prostitution and extensive drug abuse. They have not been part of ordinary society for many years or not at all.

The overall **aim of the programme** is to improve quality-adjusted life expectancy. This is accomplished by having specialists in relevant professions working in an integrated manner. For instance, psychologists may focus on mental health problems while social workers facilitate adequate housing to optimize patient outcomes. Rehabilitation and integration/reintegration into society are key treatment goals of the programme.

Quality of care: (1) To provide a delivery platform for existing evidence-based services with currently poor coverage for this patient group, e.g. standard treatment for hepatitis C. (2) To provide a package of integrated services rather than multiple single interventions in different clinics. As part of the opioid maintenance therapy, patients meet at the outpatient clinics on a daily basis, and this facilitates linkage of a range of services to the programme. The daily substitution drug provision

offers a unique position for good adherence and better follow-up of other types of care. All professions are located in the same building as patients receive their opioid medication.

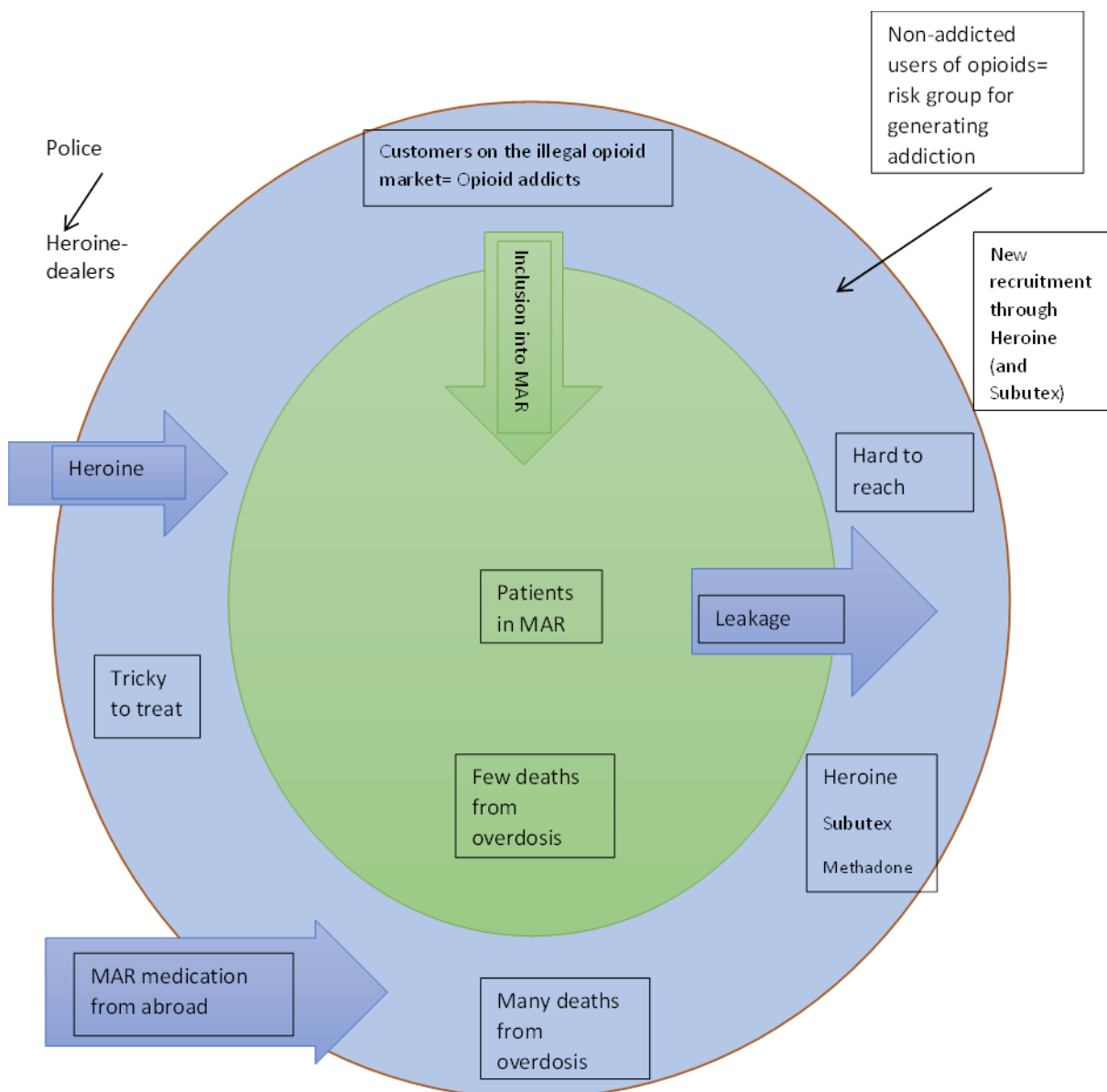
One important objective of LAR-Bergen is to reduce societal costs by lowering total number of hospital admissions and imprisonments, among others.

3.2. Service delivery

3.2.1. Design of delivery of care

In order to include hard-to-reach patients the delivery of care design of MAR Bergen/M31 has no barriers in terms of a need for pre-arranged appointments; patients are free to meet at any time and evaluation of treatment needs will start immediately. The following figure illustrates the focus on including also those being both hard to reach and tricky to treat (cf. outer circle of the figure below). This is a central part of the MAR Bergen programme, and one dimension where it is distinctly different from traditional MAR treatment programmes with their focus on patients with documented abstinence as requirement for inclusion into MAR (cf. the inner circle of the figure):

Figure 3.2.1.1. MAR Bergen: Including hard to reach and tricky to treat patients



Source: Figure adopted from Ohldieck (2016).

Within a few days the patient may enter MAR treatment, without any demand to be abstinent, but conditioned that criteria for the diagnosis of opioid addiction are met (Ohldieck, 2015a).⁵ In contrast to ordinary MAR treatment, the MAR Bergen model, does not request regular urine tests to be provided by the patient. However, the patient must meet for daily supervised intake of MAR medication seven times a week. Medication for addiction treatment includes the use of Suboxone and Methadone (op.cit.).

⁵ Criteria for opioid addiction follows the ICD-10 system of the WHO (cf. Helsedirektoratet 2010a, p. 39-41). The dependence syndrome is described as follows: "A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances" (WHO, 2016a).

What is actually happening within the programme? Firstly, in each of the six out-patient clinics (cf. table. 3.2.1.1 and figure 3.2.1.2 below) there is a team consisting of a leader, a social educator, social worker, or nurses serving as special advisors, and in addition doctors and psychologists. Each patient will be designated to a specific person in the team that will serve as patient responsible advisor. Thus each special advisor will have a portfolio of patients; but there is teamwork around each patient and team meetings where each patient is discussed and follow up decisions made. The involvement of different health and social professional groups aims at providing a holistic assessment of the multi-morbid patient. An overall slogan for working within the out-patient clinics is according to the initiator of the programme:

- *“as many as possible, as long as possible. As many as possible, because we actively want to include as many as possible of the patient group within the MAR programme, because we know that just this will have a positive effect for them, and in addition we contribute towards breaking the heroin market. And as long as possible, because according to the MAR regulation and in every way we would like the patient to reach as far as possible in the rehabilitation course” (IP01_1, l. 291-295).*

The initiator also stresses as a core principle in therapy of having continuous, stable and good relations between therapists and patients. This is considered as decisive for effective treatment and was emphasised by several of our informants, e.g. initiator, other stakeholder, non-doctor medical staff (IP01_1; IP02_1; IP08; IP09). Closely related to this was the importance of building trust and confidence between the therapist and the patient. In the words of a non-doctor medical staff:

- *“..this is a user group, if we are to generalize a bit, they are very different these patients, but if I am to generalize, they are a group that are used of being met with distrust, they experience very little confidence around, they walk about in the shopping centres and shops and the security guards are following you all over, the bus driver is watching you, people are crossing the street to avoid you, and the family that you have failed, failed, failed and burnt many bridges. So to meet a system that tells you: I believe in you, I believe, I know it is difficult for you, because you are used to not keeping promises, you are usually experiencing that things doesn't work out as planned, but to meet a system that says, I believe in you whatever and I give you my confidence, time and time again „without compromising with what is responsible of course, and I don't give up on you, this is where I want us to be” (IP08_1, l. 336-346).*

We will return to the issue of confidence and trust, when we discuss self-management below; first, additional information on how the programme works in practice is spelled out. As noted above a team of professionals representing different competences and traditions of therapy and care meets the patient to cover his/her needs. If the patient is dropping in at the low threshold M31 clinic (cf. fig 3.2.1.2) a doctor's assessment is firstly required to diagnose that opioid addiction is present. Moreover the doctor will screen the patient and assess his/her overall health condition.⁶ If addiction is documented treatment with MAR medicine will start within two to three days. This speedy expedition low threshold approach is a significant characteristic of MAR Bergen. In this first phase strict observation is important, as there are risks involved (overdose), for instance in establishing the

⁶ The name M31 alludes to *Møllendalsveien 31*, the visiting address of an outpatient clinic established in November 2014. The professional basis for M31 is given in a short, four page note (Ohldieck 2015a).

right doses of medicine and the needed titration to avoid risks of exits, non-compliance and concomitant use of illegal substances if the patient experiences that doses are too low to cope with the addiction problem or side effects of other medications, according to the initiator (IP01_1).

Based on the diagnosed somatic diseases, mental conditions and social problems, the team will assess how their specific knowledge and therapeutic approaches may be put together to offering health and social services to the patient. As a way of understanding how the team works with the individual patient two of the interviewed non-medical health professionals refer to Maslow's needs hierarchy (IP03_1, IP08_1). This illustrates nicely how they fit into different levels of that hierarchy with their specific competences and approaches. Interviewee IP03_1 (non-doctor medical staff) argues that starting from a situation with complex problems, there is a need of sorting out which problems can be handled or not, and prioritising which problems are most important. Thus, if the patient has an acute medical condition, e.g. vitamin deficiencies, under- or malnourishment then this is the most important condition to treat. In such a situation, where malnourishment had led to cognitive impairment, it is no point in starting with mental therapy. Referring to Maslow the non-doctor medical staff says:

- *"My way of thinking has been that you must attend to the basics first, before you move on. For many the opioid addiction or the search for heroin will be the one thing that overshadow everything else, it takes control over all other needs, so if you got that right, then you need to secure housing, and attend to economic problems and then you can start to dig into [mental problems]"* (IP03_1, l. 140-144).

The same thinking is reflected in this brief quote from another non-doctor medical staff:

- *"..and perhaps the focus on quitting with substance abuse is a bit overwhelming, maybe we should see to it that the person is fed, maybe we should start with that, how to get the person properly nourished, yes, that is good old Maslow, we often start a bit too high on that ladder* (IP08_1, l. 330-333).

The above quotes stress the importance of making an initial complete assessment of patients' problems and resources, to work out a customised treatment plan. In this work different professions contribute with their specific outlook that together aims at providing a holistic assessment of the patient. The special advisor in the team has responsibility for daily contact with the patients. Their professional background may be registered nurse (regular or specialised) or psychiatric nurse, social worker or social educator. These professionals are well trained and clinically oriented, and they have good relations with their patients, according to IP07_1 (doctor). The special advisors thus represent the frontline within the out-patient clinics. The advisors have about 20 patients in their portfolio (IP08_1) (Non-doctor medical staff).⁷ They have the responsibility of following up within the specialist health service area as well as participation and coordination in the so-called responsibility group (*ansvarsgruppe*) (IP01_1) (initiator). These comments should not be understood as contradicting the overall aim of the MAR Bergen case in providing integrated care. MAR Bergen rests on the idea that simultaneous treatment of drug addiction, somatic diseases, mental conditions and social problems is the best way to help these patients. Although there is limited research on this topic, indications

⁷ For special advisors with follow up responsibility outside the outpatient clinics (e.g. MAR patients receiving their medication at the pharmacy) they will have 40 patients according to the initiator (IP01_1, information provided in personal electronic communication, 19.09.2016).

exist for this approach being more effective than step wise approaches, e.g. treating first the drug addiction and then the patient's mental problems (Helse- og omsorgsdepartementet, 2009: p.46; (Helsedirektoratet, 2010a).

According to the guidelines of the Norwegian Directorate of Health, this (voluntary) responsibility group is cross-disciplinary and cross-sectoral, where the most central support instances are represented (Helsedirektoratet, 2010b). The starting point for the work of the group is the individual plan (*individuell plan*) of the patient.⁸ The responsibility group shall secure that the work is

systematized and coordinated in such a way that it secures that different rehabilitation efforts are pulling in the same direction. Representatives from social services, as well as the doctor and MAR special advisor participate naturally in the responsibility group. In addition the group may include representatives from mental healthcare, care and supervision of convicted, support organizations and addiction care institutions may participate. According to the guidelines, in many cases it may be natural that a friend or relative of the patient participates. The patient may also wish other persons to be part of the group.

In addition to work with the responsibility group, the special advisors work with referral to various treatments, counselling and importantly work with MAR medication, in terms of regime for drug collection, medicine doses, when the patient is on holidays. Thus there is much patient administration work, but also systematic rehabilitation work within the responsibility group, support work for housing in cooperation with municipal social services, coordination and having individual meetings with the patients (IP01_1). The initiator stresses the special advisor's role in MAR medication handling:

- "All the functions that I now have described, they do today as well, they have all these functions, but in addition they also have the medicine management out there, supervise the intake of the MAR medicine themselves, instead of someone else doing it, as it was before... now we are doing this direct on site, so to speak, so we have that closeness.. ordering and clarifying medication and of course they are now face to face meeting them, direct one to one follow up, so it's quite intense, with a poorly functioning group of patients over years so to speak" (IP01_1, l. 492-495, l.498, l.500-503).

One of the non-doctor medical staff describes how clients with multi-morbidity are unable to make use of health services due to their drug addiction and poor health condition, and how special advisors for instance take "their" patients to their GP and dentist, thus insuring that they receive the care they need. This comes in addition to the psychology and medical services that are now offered within the outpatient clinics when patients collect their medication. The informant considers this to

⁸ According to the Norwegian Directorate of Health; "Patients in need of continuous and coordinated services from social and health services have according to the current legislation a right to an individual plan. Every person with opioid addiction receiving MAR will in practice have such a right. The patient is to be carefully informed about the content of individual plan and to be encouraged to accept the offer of having an individual plan. Social, municipal and special health care services have an independent duty to inform and eventually effectuate the work with individual plan. The MAR-regulation stresses the specialist health care services particular duty to ensure that a committed cooperation with necessary instances is established and shall initiate work with forming an individual plan" (Helsedirektoratet, 2010c). Individual plan is to be a tool and a method for cooperation between the service receiver and the service apparatus and between the different service providers. Furthermore: "The individual plan is the user's plan. This implies that the goals and wishes of the service receiver shall be the starting point of this process. The user has the right to and should be encouraged to participate actively in describing the need of services, wishes and goals that is important for the person – today and in the future» (Helsedirektoratet, 2016).

be a major change compared to when the municipality was responsible for these patients and only offered distribution of medication. For instance, through blood sample collection that is now carried out in the outpatient clinics serious illnesses have been identified (IP09_1). This illustrates how the care process is designed around the person with multi-morbidity.

Psychologists are more in the background because they are not present at the clinics every day. At the weekly team meetings the doctor, psychologist and special advisor meet and discuss patient cases that the special advisor report to them. Thus, problems that the special advisors are unable to handle themselves are then handled by the doctor or the psychologist. One doctor describes the role of the doctor more closely:

- “Often the special advisors are in dialogue with the patient, and if there are special concerns that need assessment from a doctor, then they [the special advisors] make an appointment with the patient, that the doctor will be present once or twice a week. So then we have a sort of a fixed appointment with the doctor. So then we have a conversation and an assessment. It may be assessments of medicine, changes of doses, or change of medication or it may be somatic problems they would like to discuss. It is not like we have capacity to perform polyclinic appointments with every patients, e.g. that a list is made with appointments and the doctor meets and runs through it, it’s not like that, and often acute incidents happens. Thus, a patient that we consider to be intoxicated (ruspåvirket) and in danger of an overdose, then we need to prioritize this person, and assess the dose of medicine, or there may be [other] acute incidences, a sudden infection to be treated, a mental outburst” (IP07_1, l. 157-167).*

The doctor also describes the relationship between doctor and patient, and how this has changed with the establishment of MAR out-patient clinics:


- “Here you come to something new. Before [e.g. when the municipality was running the MAR centres] there was no doctor present at the out-patient clinics. So we do not have a long period of experience with this. So it varies. Some patients are not used to meet with doctor at the clinics. They are used to collect their medicine and leave. Now we have established these out-patient clinics, two years ago this November [2016]. So I think that the patients, there is a big change for the patients also, it’s new for the patients as well. But now I feel; now I have been a bit away from the out-patient clinics for a while, but I feel that the doctors working there, there is now better contact between patients and the doctors. Before, when we established these out-patient clinics, I recall that I had to go around and sit in the living room together with the patients, in order to show them that there is doctor present, that you may come to and speak with, if something is wrong. So there we were, and they didn’t really understand that they could attend the doctor. Now they know that it is possible and they do ask to see the doctor and we have got very good Doctor Trainees in addiction medicine (LIS lege). They are very concerned with finding out what’s the patient needs, is it a liver problem, is it an infection, is it COPD? So I do believe that the doctor/patient relation has improved. Both the doctors and the patients understand how they are to work together”.. (IP07_1, l. 231-245).*
- “Previously, it was at a distance, the patient- doctor relationship, then it was usually so that.., MAR is very much about control, so it is the doctor who decides what kind of medicine the patient should have.. if there are traces of illegal substances in urine samples, then we will*

effectuate sanctions, and in relation to the distribution and picking up of medicine. So previously, it was a not so nice relation between the patients and .. because they felt they were punished by the doctors. But, I do think it was worse when there was distance, but now in a way, the doctors are present there [at the Out-patient clinics], and so there is much more of a direct dialogue with the patients, it is easier for the patient to understand that we do these things to help them, not to punish them. I think it is a better relation, and they do understand why we do the things we do, we are controlling, we take urine samples, we restrict, and yes, we in a way do different measures in order to provide them with a responsible treatment” (IP07_1, l. 249-260).

Thus, the inclusion of doctor as part of the treatment teams at site seems to be an important pre-condition for providing better and more regular access to medical expertise for the patient. Overcoming distance and increasing possibilities for face to face interaction also enhances the quality of the doctor-patient relationship.

The following table illustrates how a successful patient within MAR is supposed to pass through different phases of the programme with increasing mastery of drug use and addiction.

Table 3.2.1.1. Phases and patient status in MAR treatment, as basis for allocation of resources

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Haukeland universitetssjukehus

Phases, patient status, as basis for allocations of resources				
Phase 1 Survival	Phase 2 Considering change	Phase 3 Change	Phase 4 Stable change with support	Phase 5 Stable change without support
Survival, the patient do not consider changes towards better control with drug use and addiction	The patient consider changes to obtain a better coping of drug use and addiction	The patient conducts change, showing increasing mastery of drug use and addiction with support from the help team/apparatus	The patient reveals a stable mastering of drug use and addiction with support from the help team/apparatus	The patient reveals a stable mastering of drug use and addiction with a controlled wind up of support

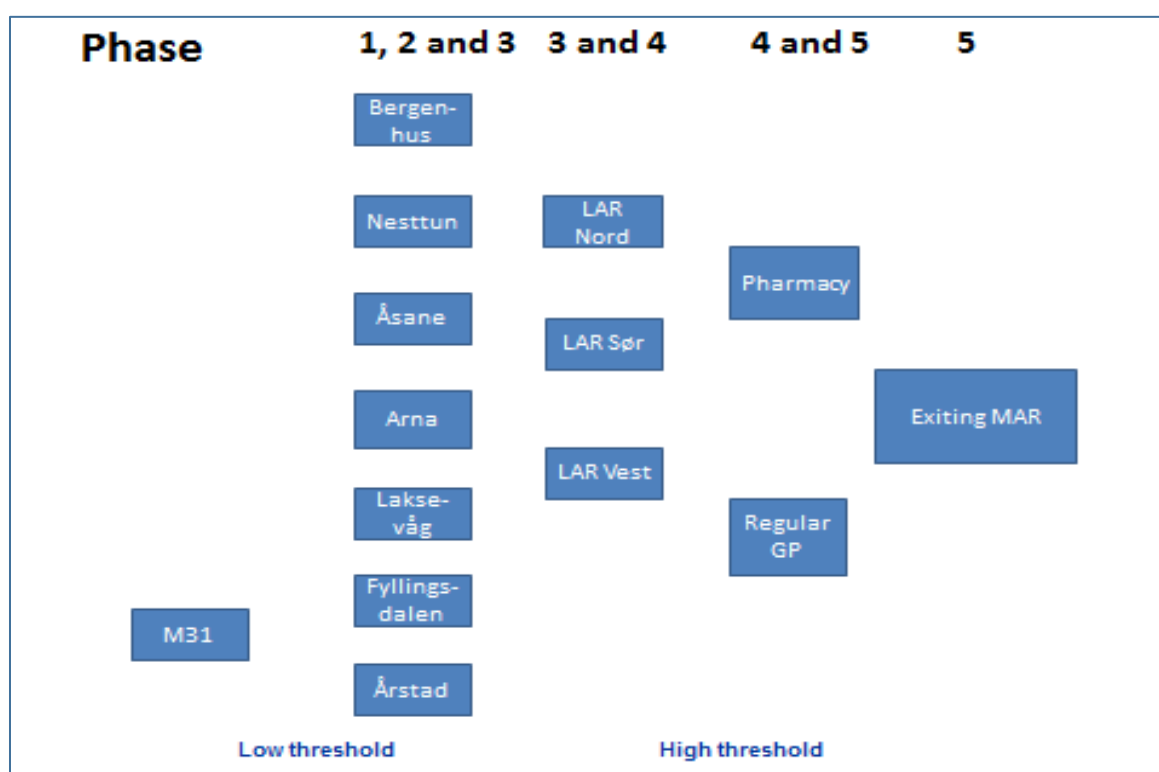
Source: Table content adopted from Ohldieck (2016).

The Bergen municipality refers to the above phases and categorisation of patients developed by the AFR, as a good starting point for targeting of services provided by the MO centres (*Mottaks- og Oppfølgingscentre*), Norwegian Work and Welfare Administration (*NAV for short in Norwegian*), and

voluntary organizations (Bergen kommune, 2014).^{9 10} The above mentioned division into phases is particular for MAR Bergen within the Norwegian context of MAR treatment. Moreover, the NAV social services have grouped/categorized all MAR patients receiving services from NAV in order to establish service provision for activity and leisure time based support. These initiatives should be organized in close dialog with the Health Bergen Enterprise and the establishment of outpatient clinics for MAR users (op.cit). Thus, these ambitions point towards an integrated care model for this group of multi –morbid patients combining closely medical and social services and at the same time seeking to address the individual patient’s specific needs.

The above mentioned phases are reflected in the way the MAR Bergen programme is organized in outpatient clinics and other facilities in adherence with an overall labour of division and emphasis on low threshold and high threshold activities. Figure 3.2.1.2 shows this in more detail:

Figure 3.2.1.2. Overview of MAR Bergen: Phases, Thresholds and Facilities



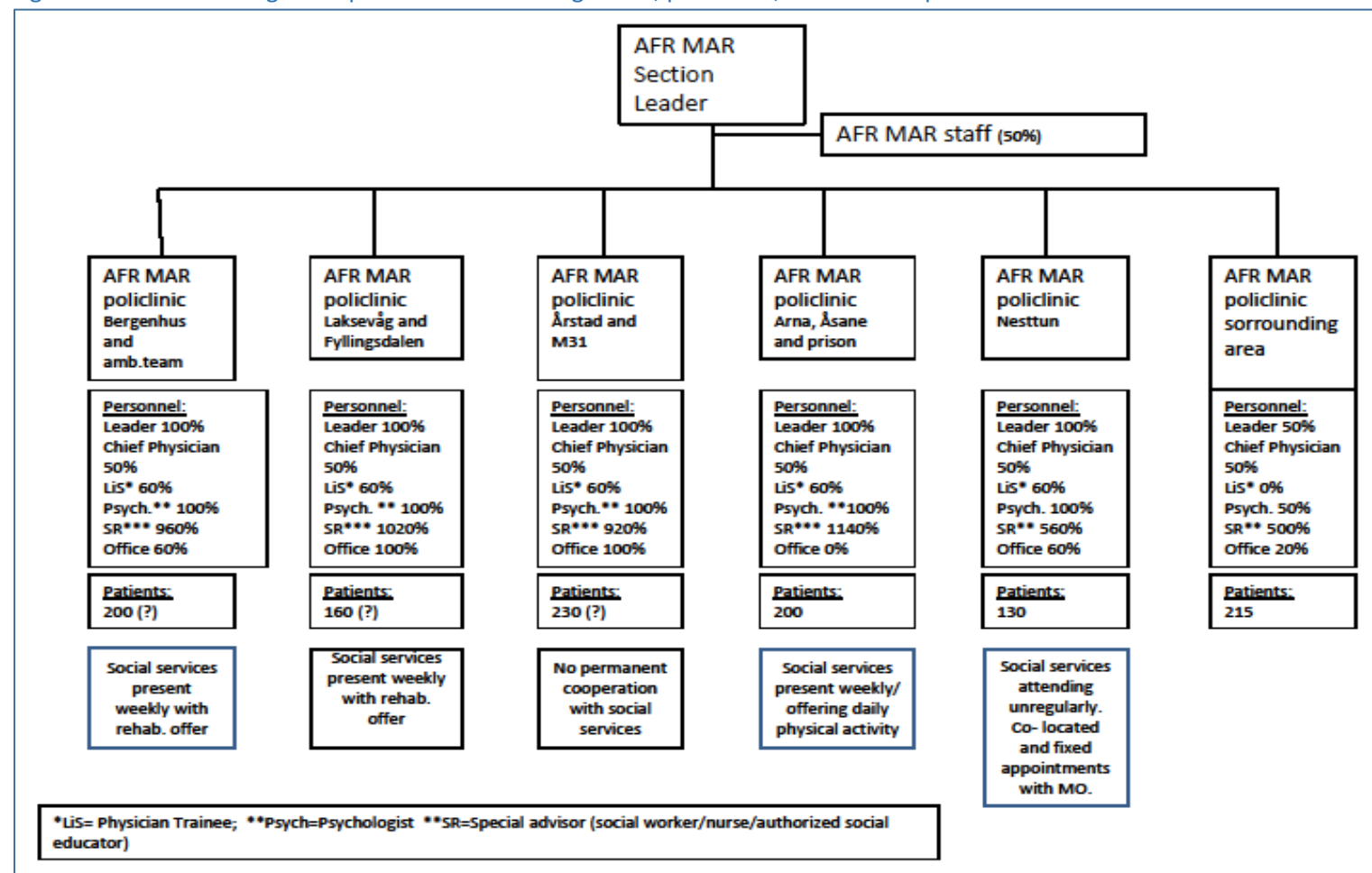
Source: Table content adopted from Ohldieck (2016).

The names in the boxes of the three first columns refer to geographical sites of the outpatient clinics (*poliklinikker*) of different areas within the Bergen municipality. The following figure (3.2.1.3) specifies in more detail the management structure, personnel, service provision and number of patients at the outpatient clinics (cf. two first columns of figure 3.2.1.2)

⁹ AFR, Avdeling for Rusmedisin, refers to the Department of Addiction Medicine at the Bergen Health Enterprise

¹⁰ The MO centers are municipal resource sites, containing rehabilitation services, work training and activity services.

Figure 3.2.1.3. MAR Bergen outpatient clinics: Management, personnel, services and patients



Source: Table content adopted from Ohldieck (2016) and translated from Norwegian into English by authors of this report.

Legend: amb.team= ambulant team. "Office": refers to office staff, mercantile personnel. Percentage points refer to percentage of a yearly full time position employment of different professional categories (e.g. LiS 60%, refers to a 60% of full time position employment, whereas SR 960%, implies that close to 10 full time work years are employed).

3.2.2. Self-management interventions

The MAR regulations (Helsedirektoratet 2010c) state how medicine should be distributed. Safe treatment of the patient and access for others than the patient is among the criteria deciding how this is done. Patients with high level of mastery of their addiction and use of medicine enjoy more freedom in terms of control (e.g. whether drug consumption is supervised and frequency of urine tests) and how many doses the patient can collect at a time. According to Waal et al. (2015: 41), for Norway in general, distribution of medications varies from one to seven days a week, the average being approximately four days a week. Over time, the number of urine tests has decreased (Waal et al. 2015: 43).

According to the MAR regulations (Helsedirektoratet 2010c, p. 32), MAR patients experience loss of control when joining a medically assisted rehabilitation programme, even “a high level of incapacitation”; “this is especially so during the initial phase of MAR treatment, a period seen as decisive for establishing good habits” (op.cit, p.32). Self-management within MAR has some special challenges compared to other healthcare programmes, especially the trade-off between control and trust for a group of patients that are addicted to drugs.

As noted by one of the non-doctor medical staffs the situation is rather paradoxical:

- *“if you look at the criteria set up for opioid addiction, the opioid addiction preclude your ability to make good health choices or make sensible decisions, it takes control over everything, thus in this way, the criteria for entrance (into the MAR programme), is really that you don’t have control over your life, you have no self-determination right actually” (IP03_1, l. 217-221).*

An informant explains that MAR patients are interested in their rights, health, side effects of medicine and the collection of medicine. According to this informant, some MAR patients have a feeling of powerlessness, and the interviewee finds the level of control exaggerated.

Because of the paradoxical starting point where additional lack of control is induced by a programme that has independence and normalization as ultimate goals, one way of balancing this asymmetry is to strongly emphasize user-involvement (*brukermedvirkning*) and information (Helsedirektoratet 2010, p. 32).

For this group of patients, the balance between the need for control and providing the patient with freedom is central in treatment and rehabilitation throughout the patient pathways. As indicated by Table 3.2.2.1 above, in an ideal patient pathway increasing degrees of self-management and individual autonomy is expected as the patient passes through different phases. For instance, in working with management of the addiction problem, patients are asked what they need and what goals they would like to reach, how can the therapists involved in MAR possibly assist? The patients are involved in decision-making regarding choice of medication; although they don’t make the final decision, their opinions are always taken into consideration. The doctor has conversations with the patient concerning adjustment of doses according to one of the non-doctor medical staff (IP09_01). A key feature in working with self-management within MAR is the provision of trust and responsibility given to the patient. This may be done either by first providing the patient with a fixed period with for instance a less strict control regime for medicine distribution and then evaluate if the outcome is satisfactorily and in

line with responsible and safe treatment. Or it may be the other way around if the patient would like a better (more liberal) medicine distribution than for instance six times a week, the patient first has to take regular urine tests, combined with clinical observation and then after a fixed period, relaxation of the distribution are considered and granted if tests and observations are as expected. Moreover, as part of the team meetings, the patient's view is communicated by the special advisors responsible for the patient in question and decisions are reported back to the patient from the team meeting. Usually agreements are reached within the team according to a non-doctor medical staff (IP08_1).

An important tool within drug treatment is motivational interviews which aim at making patients responsible for their own development/progress and goal setting. This is done very systematically and one also works very consciously with physical education and to fill everyday life with meaningful activities according to the initiator (IP10_1).

Motivational work and work with behavioural change were considered by initiator, other stakeholder and non-doctor medical staffs, to be important means for increasing self-management and autonomy of the patient (IP01_1; IP02_1; IP03_1; IP08_1). An example and reflection on the importance of behavioural work are provided in the following quote from our interview with a non-doctor medical staff:

- “..to work with behaviour, that is a basic form of rehabilitation. Here we make quite clear to the patient what we are doing when we work with this. I never correct behaviour without telling why I do it and the background for it. That is something you need to have competence on in order to work with this patient group, because they have to understand why we think as we do. Then it's their own choice, it's their call if they go outside and hit someone on the street, not that this is ok, I don't mean that, but he is responsible for his own choices. And then it's our task to contribute and make arrangements so that he has the chance to make some good choices. But it should not be a good choice for me, it should be a good choice for the patient, if not it has no purpose, he isn't going to choose for my sake, that's not helpful. If that's the case they will not make it, if they do things for the sake of the therapist. And then obviously there are some patients that experience that we treat them contrary to their own wishes. This relates to the professional responsibility we have and the responsibility towards third parties, all this according to our guidelines. So then we can't provide the patient with a week's consumption of medicine, just because he think it's not ok or he doesn't bother to meet at the outpatient clinic, or because we have put forward some demands on mastery of drug use towards him” (IP09_1. 286-302).*

Thus, the involvement and provision of responsibility and trust toward the patient are essential parts of the programme: “Without the patient's own strong commitment towards his/her own healing process, the treatment will fare poorly” (Ohldieck, 2015a). Motivational work and the method of motivational interviewing are important tools when trying to build capacity for self-management and increasing degrees of autonomy, according to the manager of the programme:

- “The most knowledge based, evidence based method within addiction treatment is motivational interview and in motivational interviewing a main goal and tool, is to work with the patient's own motivation, goals, and expectations in a way, and responsabilization of the patient, related*

to the very way you work with motivational interviewing, that is responsabilization of the patient ...and also the addiction treatment field has a strong focus on training, music and life quality and to get some content into daily life... and this is what the patients want, if you ask people in the 'experience panel'¹¹ for example, what is important for them, then it isn't necessarily to treat just this or that symptom, but in fact to get help with having a valuable everyday life. So it's on the patients' own term, linked to thinking responsabilization" (IP10_1, l. 333-347).

Whereas some social activities are provided at the outpatient clinics, within the new division of labour between MAR Bergen and Bergen municipality, activities including daily life activities, physical training (swimming, ball sport etc.), hiking, cycling, and music are now mostly part of the MO centres. In addition voluntary organizations are also involved, including work training. All such activities demand to a different degree the motivation and engagement of the patient to take responsibility for meeting regularly and participating. At the same time participating in these activities is considered decisive for increasing independence and normalization of their life situation.

As noted by one informant it is important to be occupied with meaningful activities throughout the day in order not to have too much time in situations where one could be exposed to risks of previous drug habits. A problem noted, is that these activities are only available during ordinary working days and closed during weekends, making the weekends a challenging and potentially troubling time for these patients as part of their recovery.

From the interviews we learn how different actors within the healthcare sector gradually try to give patients more responsibility for keeping track of appointments and making the patients themselves make contact with other people or institutions to set up appointments. This is a way of training patients in managing their own life.

Housing is a well-known challenge that is also addressed in our interviews. Many former drug addicts have economic problems and end up in shelters provide by the municipality. As many of the residents have a similar background the way back to using drugs may be short according to an informant. Housing thus has clear consequences for self-management ability. As stated in the MAR regulations (2009: 77), continuous attention in a sober environment is important. The importance of housing for a successful MAR treatment is stressed by non-doctor medical staff as well (IP03_1; IP09_1):

- *"Housing, yes that is, those who don't have housing, they don't make it, the sickest of our patients are homeless, or they live in poor housing arrangements, such as shelters (hospits), insecure places, and I think that housing is alpha and omega for further rehabilitation. We may send them, and we have many examples of that, patients that have been on long-term treatment stays, ... when they came back we saw that they had gained weight, we saw a totally different person coming back, and then they are placed in shelters, then after two months they*

¹¹ An experience panel is consisting of patients and/or their relatives with own experiences within for instance mental health and functions as a forum for discussing and coming up with solutions and ways of dealing with problems that professional in the field discovers in their work. In addition the participants of the panel may contribute in teaching based on their experience competency (IP10_1).

hit the ground again, because they have no housing, and end up in the same (negative) networks” (IP09_1, l. 520-530).

Thus in order to make self-management strategies to work, it is decisive that supporting environments, e.g. housing and networks not related to drugs and addiction, create a contexts that enables the patient to grow these capacities for self-determination and autonomy.

Summing up, what is a particularly important aspect of self-management strategies for this group of patients with multi-morbidity then, is an initial situation of lack of control over one’s own life when entering the MAR programme, and so much work is really about building capacity for autonomy and control, of making a sense of the self of the person in question. Perhaps empowerment work is a better concept than self-management particularly for the initial phases of the MAR programme. User participation (*brukermedvirkning*) is the term used in the MAR guidelines:

- *“User participation in a broad sense - empowerment - could be defined as a process where the patient obtains control over important aspects of his life. User participation in medical treatment and social rehabilitation means that the patient actively participates or takes control over his own rehabilitation and through this increases his own authority. For the therapist, user involvement presupposes an attitude towards the patient, where attentiveness and respect towards the choices of the patient are central. For the patient user participation is a possibility for escaping a victimizing role and become an acting, responsible person” (Helsedirektoratet, 2010a, p. 32).*

Relatives are considered important resources in the treatment of drug addiction, but many patients either have bad relationships to family members or have relatives with similar challenges. One non-doctor medical staff explains that within MAR Bergen there are plans to try to involve relatives more in the treatment than they have been able to do so far (IP09_1). In some situations, professional confidentiality can be a barrier for the involvement of relatives and informal caregivers.

3.3. Leadership and governance

It is the responsibility of the RHAs to assure that persons with a permanent address or staying within the health region are to be offered necessary specialist health services within and outside institutions. As part of this service offer is the provision of interdisciplinary specialized addiction treatment (*tverrfaglig spesialisert rusbehandling, TSB*). The units responsible for treatment of MAR patients are to assure that the services are responsible and of good quality (Helsedirektoratet, 2010b, p. 29). When the Department of addiction medicine at the Bergen Health Enterprise was given responsibility for MAR in 2011, one important reason was the improved possibilities this provided for coordinating services; drug abuse support and rehabilitation as well as somatic and psychiatric treatment (Helse Bergen, 2010: 10). In addition, it was seen as instrumental in securing increased responsibility and quality in distribution of medicine (Waal Helge *et al.*, 2015, p.23). According to SERAF there exist six different models of MAR as part of the Health Enterprises. MAR Bergen is placed in the category “Specialized MAR units within departments of addiction medicine” (op.cit, p.22).

The basic model for MAR treatment is based on a tripartite cooperation and partnership between the social services in the municipality, the GPs and the specialist health services. Hearing statements on a previous evaluation (2004) concluded that this model is good and should be continued (Helsedirektoratet, 2010b, p. 29). The MAR Bergen model fits into this general model, but it is important to note that the specialist health services in the form of outpatient clinics has been constructed as to function on par with other primary care services in the municipality. Hence in terms of partnerships, of key importance was the one with the municipality, with their overall responsibility for medical, social and rehabilitation services. Voluntary organizations providing addiction care was also taking part in this extended partnership. Moreover, within the MAR Bergen programme, the role of the GPs has been diminished, as the specialist healthcare services increasingly have assumed responsibility for the MAR X patients previously covered by their GPs.¹² As an indication of this, the share of MAR patients in Bergen with prescription of MAR medication from their GP was only 4%, whereas national average was 59% in 2015 (Waal *et al.*, 2016, p. 37).

A major challenge according to our informants was to secure good cooperation and understanding between the specialist health services (within the outpatient clinics) and the social services in the municipality. The challenge is described by other stakeholder as follows:

- *«There is no doubt that the specialist health service meets the patient more often than earlier, and that is good, but it also has a drawback, because I do not think that one is good enough at involving the municipality (...) Earlier it was the municipality that met them [the patients] at the place of distribution and yes, it was probably easier then, that they [the municipality] made contact with NAV, right, they called Avdeling for Rusmedisin [The Department of Addiction Medicine], in the past, to ask whether “he should be allowed to take along medication, should he not be allowed to take along medication, he wants increased dosage”, right, then they had to...*

¹² Since the doctor interviewed was part of the MAR Bergen team, we do not have access to any regular GPs assessment of these changes. However, according to one informant some patients would like the GPs to have been more strongly involved concerning medication, as they were assumed to know the individual patient better than the MAR doctors.

You have got rid of that part and that can be good, but it can also be a drawback, I think, because now there are the other... you must not forget to involve the others, then, because the municipality is responsible for housing, for follow-up services, for measures, for activity, for economy, right" (IP02_01, l. 280-281, l. 292-298).

There seems then to be a strong need to focus on this patient group outside the MAR programme, and within the surrounding somatic care. According to the representative of the payer organization:

- *"What comes into sight is that these patients live shorter lives, systematically, this indicates that we focus too little on the somatic need, for this group of patients, now I am a bit uncertain as to whether research has been conducted on MAR drug patients from this perspective, but at least research has been conducted on psychiatric patients and life, systematically shorter life, it could probably indicate that the somatic perspective on the patient is too weak, so we intend to see things more closely, also drug-psychiatric disorders that we find within the somatic" (IP04_1, l. 140-146).*

Moreover, within MAR plans for expanding somatic medical services to their patients are to be implemented in the near future (cf. section 3.8.3)

MAR Bergen has different strategies for making use of experiences from the users of their services. MAR Bergen has employed four persons with previous experience with drug problems ("erfaringskonsulenter") to support their services. A further idea is to set up a panel of people with experiences as patients or relatives to discuss new ideas and initiatives and make use of their experiences and advice. These people may also take part in working groups and educational activities according to the manager of the programme (IP10_1).

3.4. Workforce

From one non-doctor medical staff we learned that there has been a very good process of competence building and knowledge exchange between special advisors formerly employed by the primary and secondary care now working together within secondary care (IP09_1). Although the position as special advisors also was present before the introduction of the MAR Bergen programme, the role of special advisor has assumed some new tasks. Previously they worked with systematic rehabilitation work within the responsibility groups; they referred patients to detoxication clinics, to various treatments, to housing, e.g. coordination work and individual conversations with patients. Moreover, in the new role an additional important task they now perform is the handling of medication, e.g. supervise the ordering, preparing and intake of MAR medication. Also they now have much closer one to one contact with the patient (IP01_1). As gleaned from the interviews, there has not been identified any professional rivalries over these new tasks added to the role of special advisors.

Examples of competence building that are mentioned by the interviewees comprise educating therapists in suicide screening techniques and working therapeutically with traumas.

MAR patients have somatic and mental health problems in addition to their drug problems. The key to being able to address all these issues is a team model uniting competence on all these issues. This is why the outpatient clinics have employed special advisors, doctors and psychologists. However, as there are so many patients, and since many patients are sceptical towards psychologists; after all they often use drugs to avoid their traumas, the special advisors get an important role in this system. In a way, the doctors and psychologists work indirectly through the special advisors by supervising and advising them. The professional role as doctors and psychologists is not yet fully developed according to the manager of the programme, who considers it very interesting to see how this develops further (IP10_1).

A stronger focus on psychiatric illnesses and mental care within the programme is very much in line with findings of the latest status report on MAR stating that many mental illnesses are not treated as they ought to (Macdonald, 2016).

One interviewee describes the transition of responsibility from the municipality to the health enterprise as a change of culture from focusing on care to specialist healthcare. This culture change is a continuous process that depends on gaining new competences. The manager of the programme informs that former employees with the municipality for instance had to learn to enter everything into a medical journal (IP10_1). According to this informant the special advisors who used to work for the municipality have some important characteristics that other employees do not have to the same degree. They show more patience and accept more verbal acting-out from patients (IP10_1). This informant considers doctors and psychologists within MAR to have parts of this “extra care” as well, and at least more than in other parts of the health system. The informant, however, is more uncertain as to whether they have adopted this from their colleagues after the health enterprise assumed responsibility or whether this has always been like this within the field of medical assisted rehabilitation. The importance of using pre-existing expertise and competence from those with background from municipal social services to secure comprehensive treatment of patients was underlined in interviews with non-doctor medical staff involved in interdisciplinary specialist treatment (TSB), stressing particularly their relational competence:

- *“This is a very demanding patient group, many of them are terrible toilsome to deal with and very pathological, and those (employees) coming from the municipality, they have worked closely with these (patients), they meet them daily for years, and in this I think, there is a vast relational competence, both in terms of competence in nursing, but also competence in social work as entry on subject matters, that I consider to be quite unique. I don’t believe so many people would have the capability to work for so many years, so close to the users... Since they work so close with them they also have a great knowledge of the environment and the drug culture. ..They have real knowledge of each individual patient that I consider to be very valuable” (IP03_1, l. 351-361).*

According to another informant such relational competence and the need to have stable and continuous relationships between the therapist and the patient was imperative for successful treatment (IP01_1).

The Ministry of Health and Care Services adopted in June 2012 to create an own specialty for doctors in Addiction Medicine. Several university hospitals provide now training for junior doctors employed in positions as doctor trainee (*LIS lege*) in addiction medicine. These doctors were practicing at the

outpatient clinics under the supervision of specialists in psychiatry with long experience from work at the division of addiction medicine at Haukeland university hospital in Bergen.

3.5. Technological & medical products

One informant explains how different medical records systems in public and private institutions challenge the interaction between such providers and slow down processes. Common medical records or shared information systems would support the continuity and coordination of care (IP10_1). Traditionally health workers from psychiatric and somatic healthcare have not had access to each other's medical records, confidentiality of data being one important reason, but currently the trend in Norway is to create common medical records across different healthcare levels (IP10_1). Problems with not having a common medical record system, excessive time used for registering activity (especially for those coming from the municipal sector, with little tradition and experience with systems of reporting), and the consequences lack of registration activity had for financing (cf. also 3.7) was mentioned by several informants (IP01_1; IP02_1; IP04_1; IP08_1). Some of these problems were described by one of the non-doctor medical staff:

- *“entering into a journal and registering, earlier we hardly entered into a journal ... So now, it is a huge difference now, where we really take the legislation serious and enter into a journal as we are supposed to, by all means, and that we have to register and get income, to get more positions so we actually have to work more and register more and get revenues, so the economic reasoning in this is much stronger, so, and that is probably what they find most challenging, yes, the documentation part and... is very time consuming as we have many patients” (IP08_1, l. 219-220, l.224-229).*

Because of problems with different medical records, within MAR Bergen a particular MAR treatment scheme has been developed and implemented into the DIPS medical record system.¹³ The scheme provides an overview of the patient's treatment within MAR and contains for instance information on responsible persons for treatment, status for treatment (medication, urine tests, etc), drug use, the patient's resources, and summary of treatment over the last three months and the treatment plan for the coming three months (Helse Bergen. Haukeland Universitetssjukehus, 2016).

In communication with patients, there are no specific ICT products developed, but the use of mobile phones and sms messages to keep patients informed and reminded about appointments are mentioned by informants (therapists as well as patients) as very helpful. This is particularly important for this group of patients since they often struggle with being quite aware of time and place, planning ahead and keeping appointments.

¹³ DIPS (*programvaren Distribuert Informasjons- og Pasientdatasystem i Sykehus* (DIPS) is short for a software called: Distributed Information- and Patient Data System in Hospitals. The enterprise is the largest provider of E-health solutions to the Norwegian health service.

3.6. Information and research/monitoring

There are few evaluation reports available for the MAR model in Bergen. Waal et al. (2015) discuss MAR in Norway in general. The authors emphasize that the different organization of and modes of treatment in MAR in Norway increases the need for evaluation (2015: 5-6); according to Waal et al. (2015: 6), there is currently a stronger focus on the importance of reporting. Their report to a large extent provides data on the level of Regional health authorities.

There are some issues relevant for the evaluation of the MAR-programme in documents from the municipality of Bergen. In a document on the status of the action plan on open drug scenes in September 2015, it is for instance claimed that there has been too little focus on rehabilitation, activity provision and work the last few years. If low threshold measures are given disproportionate emphasis, it is argued, this may result in patients making limited progress and achieving less health improvement (Bergen kommune, 2015). This concern was confirmed in some of our interviews (IP03_1; IP09_1). One other stakeholder explains:

- “It is good that we have a movement towards providing treatment for more patients, but at the same time I am thinking that we shouldn’t organize the services neither at the level of specialist care nor at the municipal level, in such a way that you are, so to say cementing misery. I am thinking that even though you can’t discharge these patients because they are smoking hash or use amphetamine or consume pills, it is still something with the treatment approach and philosophy, that there ought to be a kind of a simple educating effect, in the sense that, if no one put any demands on us, we just continue to do things in the same way. But if we set up some stricter limits for them, than they have today, then I think it will be easier to have some movement in the user group. Some will always be in the low threshold group, but still they are to be informed and oriented about the possibilities, and also they are to be worked with in a way so that they can see options for change. So in this respect I feel we aren’t just there yet” (IP02_1, l. 132-144).*

Thus, the focus and importance of survival of patients may initially have eschewed emphasis somewhat away from the rehabilitation element in MAR.

Another critical point that came up from interviews with municipal stakeholder and non-doctor medical staff, connected to the above mentioned importance of moving patients through different phases, was the need of differentiating between patients belonging to different phases of drug mastery (IP02_1; IP09_1). It was seen as a contra-productive in this respect that patients with wholly different levels of mastery and self-management for instance had to meet at the same localities (MAR outpatient clinics) to get their medication. This represented a potential risk situation for those at higher levels of drug mastery in terms of being exposed to illegal selling of substances. A similar risk situation was apparent when MO centres and MAR centres were almost co-localised. This quote from one of the non-doctor medical staff exemplifies:

- *“Just the other day, speaking to a patient that has get rid of his addiction problem and really copes well with his situation saying: ‘it’s so difficult to attend at the MAR centre, because I meet so many (patients) that would like to return all the drugs that they owe me’ (IP09_1, l. 530-533).*

Moreover, the need for differentiation was also discussed in relation to medication. Here a key point was to extend the range of choice of medicine in order to find medicine that was individually adapted according to one informant (cf. also section 3.4 on this). The issue of housing as described above (cf. 3.2.2) could also be seen as a problem of missing differentiation, where patients belonging to different phases of drug mastery were placed in the same poor housing conditions. For all these aspects of differentiation and the need to tailor services and medicine to the individual multi-morbid patient, there is a cost element involved (cf. also 3.7 on financing). E.g. the idea put forward by one of our informants of perhaps having several smaller units for medicine distribution in order to differentiate between patients is an example. The informant in this case referred to the economy of scale, e.g. that it was less costly to organize distribution of MAR medicine through larger units. Thus depending on the time perspective applied for costs and benefits, ways of improving the quality of services involving cost increases, may be restricted by budgetary limits and overall priority settings.

One informant has a positive attitude to the new system and the integrated care approach. The outpatient clinics, however, offer few social activities. And this informant thinks that MAR Bergen maybe has become too big in some respects. The MAR-centres use very much time for activity-based costing, for urine sample tests, for medication, and everything is registered every day. Employees with MAR end up using tremendously much time on things they did not spend time on earlier. In addition this informant mentioned that many patients feel that the relationship to their GP is weakened as the specialist service makes most decisions regarding medicine and other issues. These patients would like their GP to be stronger involved. The informant does not report much change for voluntary work for MAR patients after the specialist health service assumed responsibility for MAR. One positive thing is that the specialist service now turns to volunteers and makes use of them. Different categories of informants express similar views.

When asked whether all patients profit from the new system with integrated care, one non-doctor medical staff says that the patients with the heaviest drug problems miss the social activities and meal servings that the municipality offers in connection with the distribution of medication in their MAR centres. This is now moved to the MO centres (IP09_1). From different interviewees we learned that in or around the polyclinics a drug market emerged. To reduce this problem the outpatient clinics have taken measures to reduce the time patients stay at the outpatient clinics and thus reduced social gathering even more.

An issue raised by several interviewees is the restrictive attitude towards the use of other medications next to Suboxone or Methadone. In the opinion of these informants, MAR Bergen should prescribe tranquilizers to patients to a larger degree, thus also reducing the problem that many patients buy such medication illegally. This would also be a way of trusting patients.

In the view of one none-doctor medical staff MAR patients receive much better treatment after the responsibility was transferred from first line (municipal) to second line (Health Enterprise) because the

relation between patients, special advisors, doctors, and psychologists is much closer (IP09_1). However, the same informant thinks there are too few social activities offered by the municipality (IP09_1).

MAR Bergen is in fact of a moving target. Given that a key word characterising MAR Bergen has been change, first and foremost in terms of expansion of the number of patients covered by the programme, and as part of that lowering the threshold for entry markedly, evaluation is difficult. Because the workings of the programme are still struggling to find its final form, any definite conclusions are hard to find. Another problem is how to define the target, e.g. how should we define the MAR Bergen programme, when patients are part of treatment and rehabilitation going on not only as part of MAR itself but participate in activities and services provided by the municipality, NAV and voluntary organizations?

One general challenge within healthcare is that it is possible to document what is done but much more difficult to document what one achieves. As the manager of the programme asks; “what are good outcome goals?” (IP10_1, l.501-502).

One possibility for evaluating the effects of MAR discussed in this interview was to see whether there were movements of patients from one phase to another (cf. table3.2.2.1), and where a positive outcome would be a net movement of patients from the initial phase towards phases characterized by increasing mastery of opioid addiction and thus towards rehabilitation. However, this informant did not know in fact if this was done.

A more unsystematic ongoing evaluation was also mentioned by the manager:

- *“It’s not that systematic, there is evaluation, in meetings with the first line services, there is quite a lot of meeting activity going on at a more general level with the municipality, a kind of continuing evaluation, trying to identify what are current problems and are we to do about it” (IP10-1, l. 544-547).*

In sum perhaps the most positive effect of the programme so far relates to the main goal of improving the patients’ quality adjusted life years (Ohldieck 2015b). In this respect increasing the coverage of MAR medical treatment for the target group of opioid addiction, seems to be a necessary condition as it is seen to contribute positively towards increasing the survival rate for this group of patients with multi-morbidity.¹⁴ The programme has been successful in reaching out to this patient group, and there are indications that overdose deaths have been reduced quite dramatically, that could be associated with the working of the programme. As noted above one informant was wondering whether the MAR Bergen programme has become too big. In the latest status report for MAR at the national level, it is argued that in terms of coverage and expansion the programme at national level is close to having reached its limits. According to authors of the SERAF Status report: “It is soon time to turn the attention more towards quality than quantity” (Macdonald, 2016).

¹⁴ The most recent SERAF status report states that MAR has an overdose preventive effect: “In Norway over the last ten years there has been c. 250 drug related deaths per year. The over 7000 people within MAR makes up at least 50% of those opioid addicted in Norway that is the target group for MAR treatment, but only 5-10% of overdose deaths occur in this group. The risk of lethal overdoses is therefore dramatically reduced under MAR treatment”.

3.7. Financing

As described in the introduction, the financing system for MAR will follow the general system of financing health enterprises (HE), where MAR is part of the Bergen Health Enterprise, which is owned by the regional health authorities (in our case RHA West). The RHA are financed by the central government through a combination of block grants and activity based financing (*innsatsstyrt finansiering*) through a Diagnosis Related Groups (DRG) system. The activity based financing makes up 50%, but only within somatic care. For mental care financing is based wholly on block grants. In its turn the Bergen HE is financed by the RHA West on a capitation based formula.

The Department of Addiction Medicine (*Avdeling for Rusmedisin*) AFR as part of the Bergen Health Enterprise is thus following this system of financing. With the transfer of ownership of undertakings in 2014, this implied a large expansion of the AFR from 14-15 NOK millions in 2009 when the department was established, to around 260 NOK millions in 2015 (IP04_1). A challenge regarding financing of the outpatient clinics as part of MAR was how to integrate the rehabilitation part with the distribution of medicine as part of the outpatient clinics activity and how this activity should generate income (through the DRG system). The key question according to the representative of the payer organization, being what kind of activity should count as income generating activity in terms of releasing outpatient clinic rate payments (*poliklinikkstakst*):

- “... how to get the outpatient clinic rate payments, not only to get the payment in itself, but to integrate the distribution (of MAR medication) activity with the rehabilitation part. Some of us, at a certain point of time, were of the opinion that we perhaps could charge outpatient clinic rate payments for every consultation where medicine was distributed. We at the management side felt that this was to stretch the payment system a bit too far.. Because you cannot.. if you have distribution of medicine six times a week, you cannot get six payments of rates, because we doubt it that every time (during this week) there is also rehabilitation activity going on, e.g. that there is a sort of medical kind of treatment/follow up, so then we said that only for every fourth or fifth consultation with distribution of medicine, you may have a rehabilitation element, this we said from the management side and also that the budget had to be adjusted to this level, and that the practice of registration must adjust to this as well” (IP04_1, l. 82-91).

The above quote nicely illustrates the challenge of getting incentives right in a system of activity based financing that should be directed towards providing effective treatment of the patient, rather than just providing an income stream for, in this case, the outpatient clinics. The interviewee goes on to argue that there are problems with registering the activity performed in order to generate incomes at the level indicated by the budget. The problem is not the activity level itself but lack of registration of activity. This was related to the need for training employees in registration practice, and also to build loyalty to registration system. So far the system had stabilized on a lower level of registration, then what was originally planned. This suggested that there might be the case that the requirement for when a rehabilitation element was to be counted, was set to high by the professionals doing the registration activity at the outpatient clinics. Accordingly, this raised interesting questions on what the professionals at the outpatient clinics, understood as being treatment and the content of their services and that

qualified for reimbursement through the registration system. This problematic also came up during additional interviews with municipal stakeholder and one of the non-doctor medical staff (IP02_1; IP08_1) and is closely related to questions dealt with in sections on workforce, management and ICT. Whereas getting the financing system and incentives as correct as possible, the representative of the paying organization underlined the following:

- *“... financing keys and models they are very powerful if they are put together wrongly, but it isn’t so that such models can solve all our challenges. This is because what we are doing is such a complex activity, we can’t manage to construct a perfect incentive system, .. so therefore we have to discuss overall goals, speak about values and content, we have to speak about the patient, and we have to put forward what is most important” (IP04_1, l. 211-217).*

In practice this implies that if a new treatment that is developed where costs are high and the financing system is lagging behind, rendering the treatment very unprofitable, this treatment may still be considered very important, and then its import to support this activity:

- *“..so then we have to say: ““Come on people, this is very unprofitable, but it is very important , so go on””, then we have to transfer resources at the enterprise level .. So if MAR is important for us, let’s say there are thousand patients that are expected to enter into MAR ..and we think this is the volume we are to reach, then we have to search in every corners, to find resources to put into the department of addiction medicine (AFR), so that’s what we have been doing since 2009, to move the block grant into the AFR and then demand the activity... so now the AFR has changed its focus from inpatient to outpatient clinics in order to handle the (growing) group of patients. This is connected to a philosophy that says it is good to treat these patients in their local area, at adapted cost level, inpatient costs are high, does the change bring out effects, that is the question. If not, we have to do something else” (IP04_1, l. 233-247).*

To sum up so far, the present financing system of AFR with responsibility for MAR starts with a general block financing as a part of priority setting within the health enterprise and results in a specific budget for the AFR. This is then combined with an activity based system relying on registration of treatment activity through the system of outpatient clinic rate payments. As noted previously, the DRG system is applied for somatic diseases. However, probably from 2017 the Government will introduce the DRG system also for mental disorders and addiction diagnosis.

Arguments about the costs of reporting, time used on reporting rather than directly on patients was mentioned by non-doctor medical staff (IP08_1).

There are no direct economic incentives within the programme for the patients to participate, e.g. the patient is not paid a premium to participate. However, this does not mean that incentives are absent. The whole idea of providing a low threshold access to treatment could as seen from the side of the patient as providing strong incentives to participate, when compared to ongoing illegal substance abuse. Incentives, in the form of reducing costs and insecurity (e.g. criminal or other activity to secure financing for drug use, risks of violence), as well as travelling costs, should act strongly towards participation by

lowering such transaction costs. Although, for the patient, these cost savings have to be weighed against the costs incurred by the control regime of MAR.

For outpatient clinics, there is an out of pocket payment (*egenandel*) required for consultations, with an annual ceiling. In principle there is no exception for MAR patients.¹⁵ Given the precarious financial situation of this group this may serve as a potential barrier against participation, even though the ceiling is at a moderate measured against a typical income. However, MAR Bergen does not charge its patients for any own pocket payment/out of pocket payment.¹⁶ Even though the conversations made during consultations with supervised intake of MAR medication, in many instances will provide income (through the outpatient clinic rate payments), and thus could release out of pocket payment, this is not done. The consideration is that it would be unreasonable towards patient in a situation of supervised intake of medicine, to charge him/her with out of pocket payment. In this respect the general system of financing is not adapted to the MAR Bergen outpatient clinics, and so MAR Bergen has decided to adjust differently from what is done elsewhere.¹⁷ An additional reason for not charging patients was the fact that these people often are so sick and functionally weak so that they will not have any money to pay with. The exclusion function of out of pocket payments, is not in line with the low threshold approach of MAR Bergen. The implication for financing is clear, as it implies that services towards patients are under-financed. This accordingly leads to less developed services for this group of patients, then what would be the case if the health authorities developed systems of financing better tuned towards this particular patient group.

Another problem that came up during the interviews regarding financing and incentives was the possibility for patients to choose medicine. For the payer, e.g. the HE Bergen, there was an economic interest in keeping MAR medicine costs within acceptable limits, and in having the opportunity to obtain discounts when buying large quantities of medicine and using a market tendering system. One of our informants argued that this practice could be detrimental to the health and functioning of the patient because when only one or a few types of medicine are available and offered to the patient, often changing from one year to another, they were not necessarily offered the best medicine to enhance their level of functioning and wellbeing. The problem being that patients were not listened to in regard of something that means very much to them, i.e. how the medicine is shaping the daily life and how people feel. The interviewee lamented that a society using so much money on enabling a better offer of medicine and providing a better life for people did not take the patients interest better into account. It was wrong in this informant's view that for a patient group consisting of many thousands, to decide that for all these people there is only this type of medicines that fit.

The above view was also voiced by stakeholders representing user organizations: "MAR doesn't utilize an adequate spectre of medication" (Waal *et al.*, 2016, p. 75).

¹⁵ The regulation reads under payments for MAR patients: „There is no exception for out of pocket payments for MAR patients Outpatient clinics may charge MAR patients with own pocket payments in line with other patients when they meet for consultation, treatment and control"(HELFO, 2011).

¹⁶ Information in this paragraph is provided by the initiator of the programme, IP01_1 in personal electronic communication, 19.09.2016.

¹⁷ Here it should be noted that one of the interest organizations proLAR in a hearing statement argues that it is problematic that different Health Enterprises have different practices for charging the out of pocket payments (proLAR, 2014).

The gist of the above concerns the importance of considerations of financing trying to balance the need for cost efficiency and keeping within budgets on the one side and the importance of providing medicine that is individually efficient and improves the life quality of the multi morbid patient, on the other side. This is really a specific instance of the priority story on MAR (cf. quote from IP04_1 above), e.g. how much resources should be allocated to the individual patient, here in terms of spending on individually adapted medicine? Start-up costs may be high, but in a longer time perspective, these investments may be rewarded, in terms of swifter recovery and better prospects for participation in society, work and education.

The issue of choice is also a topic that appeared in financing regarding the individual patient right to choice of treatment. This could potentially create some challenges within a framework of pathways for patients with multi-morbidity within MAR. The basic issue was within a context of free choice of provider of services, involving several actors from private enterprises to voluntary organizations and public institutions, how to secure that the involvement of these actors in a patient pathway that secured a surplus value for society as a whole, according to the representative of the payer organization, (IP04_1). The free choice of provider could be beneficial for the patient, offering him a service that he was genuinely motivated to be a part of. The challenge for the payer was to secure that what was payed for provided benefit for the money. With the free choice of provider financing responsibility still rested fully with the Health Enterprise, but with less real control over the content of the patient pathway (IP04_1).

3.8 Implementation process

The main goal for MAR Bergen is to offer Medically Assisted Rehabilitation (MAR) as a low-threshold service to “hard to reach” opioid addicts. This group has not been able to make use of the ordinary, established system for MAR (Ohldieck 2015a: 1). Furthermore, as the opioid addicts meet at the MAR policlinics on a regular basis it is possible to reach this group with other medical services as well (Ohldieck 2016). (cf. also basic information 3.2. above)

In an annual assignment document from the Ministry of Health and Care to all regional health authorities (*Regionale helseforetak*) in 2013, a goal was launched of “establishing low-threshold MAR for those most in need within the group of opioid addiction with multiple illnesses in cooperation with the municipality” (Helse- og omsorgsdepartementet, 2013: 13). In 2012 the city council of Bergen with a broad majority support adopted an “action plan against open drug scenes” (Bergen kommune, 2012). The action plan consists of cooperation between the municipality of Bergen, the local police and Health Bergen.¹⁸ The scientific basis for the action plan is research conducted by SERAF revealing that low threshold availability of MAR without waiting time is decisive for dealing with open drug scenes (Waal *et*

¹⁸ The role of the police is twofold: secure closing of the physical space of the open drug scene by means of repression, obstruct the development of destructive gatherings of drug users, but first and foremost channel drug addicts into help and treatment. Thus the police and the social services need to cooperate on solving problems (Ohldieck and Waal, 2015).

al., 2011).¹⁹ This is especially important for covering those opioid addicted who are “hard to reach”, i.e. ordinary ways of helping through established ways and means are less successful (Ohldieck, 2015b). Thus, both national and local policy initiatives seem to have worked in concertation in benefit of the implementation process. In addition to research supporting the implementation of the MAR Bergen model, other stakeholders such as the “Foreningen for en mer human narkotikapolitikk” have argued for several years for including methadone treatment in a low level threshold setting.

Key barriers for the most vulnerable substance users making use of the traditional system of MAR include the requirement of meeting with social assistance service officers and the regular general practitioner (regular GP) several times in order to work out a referral to be enrolled in MAR treatment. Another reason is the Norwegian Directorate of Health’s guidelines recommending documented drug abstinence before entering MAR (Helsedirektoratet, 2010a: 53-54 and cf. pp.70-72 on urine samples). Finally, a barrier may be that because the regular MAR treatment demands urine samples to be provided, those on heroin addiction resist seeking treatment (Ohldieck, 2015b).

A key question was how to rig a health service for functionally weak patients with multi-morbidity, characterized by: “.. nearly without exception they have both somatic and mental illnesses and addiction related illnesses and even maybe degrees of cognitive deficiency. They are more or less homeless, at least a major part of them and they are in a poor economic and social situation” [IP01_1, lines, l. 212-215]. A central design of the programme in this respect in order to include this group into active treatment was to provide MAR pharmaceuticals/medicine at the outpatient clinics and at the same time offer other forms of therapy. In this way patients who otherwise do not attend to appointments at outpatient clinics, now had a strong incentive to meet in order to get their substitution medication. This creates opportunities for exploiting this in a therapeutic sense, by coordinating necessary health – and social services for these patients located at the outpatient clinics (IP01_1).

3.8.1. Historical information

According to the Bergen Health Enterprise, this initiative was to be undertaken by a section in the AFR department, with its own leader, also taking part in the leader group of AFR. Importantly it was emphasized that MAR Bergen was to secure a continuation with interdisciplinary examination and diagnosing. The interdisciplinary team would include medical, psychologist, social work, and nursing competence. The team would be headed by a doctor or specialist in psychology. It is further underlined as a particular benefit to have MAR Bergen localized together with other assessment teams, so that when proper, other non-MAR treatment of relevance, may replace MAR-treatment. Finally, and important in the context of ICC, the Bergen Health Enterprise underscores the following:

- *“MAR patients with serious psychiatric illnesses, previous severe drug addiction, and also most frequently with one or more serious somatic diseases, need to be offered coordinated and integrated treatment. Usually the regular GP and the social worker within the municipal*

¹⁹ SERAF Senter for rus- og avhengighetsforskning (Norwegian Centre for Addiction Research) is a national addiction research centre and a competence centre for interdisciplinary specialized addiction treatment and medically assisted rehabilitation.

structure will be the most important elements in a continuous line of service. In addition this patient group need regular follow up from specialist health services. The DPS [(Distrikt Pyskiatriske Sentre) District Psychiatric Centres] structure will be the first entrance point within mental health, while the addiction treatment policlinics will be central for TSB (interdisciplinary specialized treatment). Somatic wards sections must also be part of a coherent health service for MAR” (Helse Bergen 2010: 2, our translation).

The background of the M31 shows that there was political commitment to support the programme. Nationally, the annual letter of assignment from the Ministry of Health and Care Services in 2013 stated that *Helse Vest RHF* (the Western Norway Regional Health Enterprise) and municipalities together should establish “low-threshold Medically Assisted Rehabilitation for those opioid addicts with complex conditions in need of comprehensive services (HOD 2013: 13). Locally, Bergen municipality, Bergen police, and *Helse Bergen* (Bergen Hospital Enterprise) developed an action plan against open drug scenes. According to Ohldieck (2015a), this action plan rested on research by the Norwegian Centre for Addiction Research, stating that services that are easily accessible are crucial to reach this particular target group (Waal et al. 2011). According to Ohldieck (2015b: 2), The White Paper on the Coordination Reform emphasizes how drug addicts are one of the groups who would benefit from stronger coordination. Thus at national political level the Coordination Reform (*Samhandlingsreformen*) implemented gradually as from 2012, signifies a strong national political commitment behind the ideas of the MAR Bergen programme, being very much in the spirit of the central policy ideas of the reform. In a feature article from 2015, Ohldieck and Waal argues that tackling drug addictions problems effectively depends on a common understanding among different actors that drug addiction is a health problem which needs to be treated accordingly, and not as a criminal act. Still, Ohldieck and Waal (2015) call for a national strategy aiming at handling open drug scenes.

According to (Ohldieck, 2015a) an important barrier in the process of implementation was that financing arrangements were not adapted to coinciding steering signals from two key documents. The first was the White Paper on the Coordination reform (*Samhandlingsreformen*) as a national policy document (St. meld. nr. 47, 2008-2009).²⁰ The second document was the MAR Regulations (*LAR- forskriften*) (Helse- og omsorgsdepartementet, 2009) as a legal document. The White Paper identified the following key challenges:

1. Patients’ need for coordinated services are not met sufficiently
2. In the services there is too little initiative aimed at limiting and preventing disease
3. Population development and the changing range of illnesses among the population

Ohldieck refers to the former Minister of Health and Care Services, Bjarne Håkon Hansen, stating the following in the preface of the report to the *Storting* on the Coordination reform:

“Insufficient coordination is the main reason that our ill elderly as well as people with chronic diseases, substance abuse problems and mental health disorders too easily lose out in Norway’s current healthcare system” (Norwegian Ministry of Health and Care Services, 2008-2009:1).

²⁰ For English summary cf. Norwegian Ministry of Health and Care Services, (2008-2009).

Moreover, the report stresses that:

- *“Many patients and users of health and care services have a need of coordinated services, implying that the services are provided from different locations of service provisions and also during a shorter or longer time periods. Today, there is few systems directed towards the totality of services that are to meet the patients need for coordinated services (...) Poorly coordinated services also means insufficient and low efficiency of resource utilization” (St. meld. nr. 47, 2008-2009: 13, Authors translation into English).*

The MAR Bergen programme is seen to be tailored to the diagnosis as described in the above quotes. The concept of ‘patient pathways’ [*‘pasientforløp’* in Norwegian, (cf. table 3.4.1 below for an illustration of this within MAR treatment)] was introduced as a way of developing coherent services for patients with chronic diseases (Ohldieck 2015b: 3). The patient pathway thinking had as its goal to direct all systems and services towards helping the individual to master their own life or restore own functioning/self-mastery to the greatest extent possible. The existing structure of the health services was insufficiently adapted to chronic diseases (St. meld. nr. 47, 2008-2009: 14). The Coordination Reform provided the municipalities with the main responsibility for developing these services (e.g. services for those with chronic diseases) and that funds for making this transformation should be allocated to the level where responsibility was placed. However, this creates a financial barrier for the MAR programme according to Ohldieck (op.cit), since MAR treatment is defined as specialized health services, according to the MAR regulation. It states that: “MAR is interdisciplinary specialized treatment for opioid addiction, where requisition of addictive medicine in a fixed dose (Substitution treatment) is a partial measure in an overall rehabilitation pathway” (Helse- og omsorgsdepartementet, 2009, §3, Authors’ translation into English). Although providing an ICC model for treatment at local municipal level (as called for in the Coordination reform) that otherwise would be the responsibility of the municipality and receiving the strengthened funding of municipal services advocated in the reform proposal, the MAR’s present placement within specialist health services, leads to a lack of funding:

- *“The problem has been that the central government has not delivered on its promise to strengthen the financing of such services (e.g. MAR programme, our insertion). The money for developing such services is allocated to the municipalities.... The problems with uncoordinated steering documents, in this context the Coordination reform and the MAR regulation, confronts leaders at a low level within the health services. In this position you have to expose lack of coherence and swim against the tide, in order to secure adequate financing of necessary health services for the particular group of vulnerable people that our politicians otherwise speak warmly of helping. This in spite of realizing central political goals, such as those of present health minister Bent Høye’s of making ‘a patient’s health service’. The reality reveals itself as rather paradoxical” (Ohldieck 2015b: 7, our somewhat free translation into English).*

Interviews confirmed the above description based on documents but added some more details. According to interview with the initiator of the programme the main motivation for starting the programme came as a result of a changed MAR regulation in 2010 with basic implication for how to work with the group of opioid addicted:

- *“to put it simply, where previously the criteria for participating in MAR was that the patient had a good mastery and control over his/her addiction and that without such mastering you may be discharged from the programme, e.g. in cases where the treatment plan was not followed up within reasonable limits. This was now changed so that patients should not be discharged from the programme; because research had revealed that those patients did not fare well, e.g. in terms of overdoses. So this was one part of it, and the other was that the new MAR regulation lowered the admission criteria, e.g. the new ones as from 2010, the absolute criteria is though still present, and luckily so I must say, that opioid addiction must be present according to diagnostic criteria, so that is still present, but as from 2010 that is the only absolute criteria. Where previously there also were additional criteria, e.g. that you had followed a different kind of treatment and care in advance, and that you had to be above 25 years of age, these criteria and others they disappeared. So now it is more loosely formulated in the regulation, so that; yes, you ought to be particularly careful if of young age, and so on and usually it (MAR) should not be the first option/choice and .. but after a full consideration it might also.. Discretion, it opens up for a much wider discretion that I do support very much. But in sum, this made it, and again somewhat simply formulated, there was more patients entering and fewer that left” (IP01_1, l. 80-96).*

A key motivation for the MAR Bergen, was the fact that previous ways of working did not function well, with a heroin market unfolding more or less freely and hence coining Bergen as “heroin city”, and a high incidence of overdose deaths:

- *“and part of the reason for this situation was the old regulations where patients were discharged from the MAR programme, into the illegal heroin market again, so we actively upheld a market for heroin and thus also new recruitment. Thus based on research made by Helge Waal on European cities [and their drug scenes] that the action plan against open drug scenes in Bergen are based on, of course a coordinated effort, as the action plan is, but also to directly interfere with the market, this was all part of what happened in these European cities. And that was also what we based our own thinking on, when we made efforts to include to the greatest extent all patients into the programme [the IP here refer to the circles of figure 3.4.1. above].. that informs about our strategy to include most patients with a opioid addiction into our programme, just in order to take the bottom out as much as possible of the illegal opioid market and especially heroin, that leads to overdoses, and without forestalling any event, but we do see some signs, a positive development over the last months, the police reports that there is a so-called dry up of heroin in Bergen. (IP01_1, l. 100-114).²¹*

In terms of challenges and barriers the initiator points to the sudden growth of patients from 535 in 2011 to 1030 in 2016 and at the same time building the new structure and organization of the programme. In addition media attention on drug problems have been high both towards open drug

²¹ Available statistics seems to confirm a dramatic reduction of overdose casualties. According to the Bergen Police Office, whereas the number of casualties was 38 in 2014, this was reduced to 19 in 2015, thus representing a 50% reduction (NRK Hordaland, 2016). However these are preliminary figures and the official statistics from the Norwegian Institute of Public Health (Folkehelseinstituttet) will be available in November 2016.

scenes and also more specifically on MAR, the form of treatment and problems of leakage. Also, changes in financing represented a challenge and were decisive in shaping the present organization with MAR outpatient clinics. Here it was the Ministry of health and care that in the autumn of 2013 in connection with the preparation of the State budget for 2014 made a proposal to the *Storting* (the Norwegian parliament), advocating that also financing distribution, that is costs for distributing the medicine, that was to be transferred to the specialist health services. Thus, whereas in the Bergen area the municipality of Bergen and the surrounding municipalities had responsibility for these costs, now this was transferred to the specialist health services and the division for addiction medicine at Bergen health enterprise, representing a sudden bill of 40 million NOK to be covered. According to the interviewee this necessitated a dialogue characterized as very good, with the managers of the regional health authorities, internally in Bergen health enterprise, in order to cover these costs. However, this also implied that some outpatient facilities for other patient groups had to be closed according to the initiator of the programme (P01_1, l. 134-147).

Moreover, the initiator points out that at the time of takeover in the beginning of 2014, the Bergen municipality had already established so-called city area MAR centres where patients got supervised intake of MAR medicine and a social assistance follow up, emphasising milieu efforts, as part of the municipal service offers. These centres were opened some years earlier because there was no capacity, already at that time, for the pharmacies in the Bergen area to take in MAR patients. Still, the number of patients moved upwards fast and steady and even though work on assessing patient rights, start up and offering of places for distribution, and work within responsibility teams all tried to keep pace, a capacity problem was evident so that in some cases this resulted in breaking the time limit (*fristbrudd*) towards the patient. In this build up period the interviewee stresses the importance of the good cooperation with different stakeholders, e.g. the unit for social services, and the unit for addiction and mental health, from the Bergen municipality, as decisive for the positive outcome of the process. The transfer of financing responsibility from the municipality to the specialist health service implied that either specialist health services and Bergen health enterprise had to finance these municipal MAR centres themselves or they had to take over and run the centres themselves. Decisive for choosing the second solution seems, in addition to the capacity problems described above, to be the existence of a category of MAR patients designated as MAR- X patients. These were MAR patients where the follow up responsibility for treatment rests with the regular GP and where the specialist health services according to the regulations are obliged to supervise closely. Again, because of capacity problems according to the initiator, this supervision was not followed up adequately:

- *“...and what we have seen when we have increased our contact with them [e.g. the MAR-X patients].. is that there is a substantial degree of irresponsible treatment, in terms of control and the leakage problematics, a lot of these problems stems from this category, this we know from the police who reports to us, we do see that this is totally irresponsible, and so we needed to tighten control. There were around 350 to 400 so-called MAR-X patients, that we did not have the capacity to follow up and we knew that this was a substantial source of leakage. Many patients did not get the follow up that they needed, but I would like to stress that many regular GPs do a splendid job, but some of the regular GPs, do not possess the knowledge needed and also the problematics of the patients are that of co-morbidity and complexity, and therefore it is*

wholly unrealistic to expect that the regular GPs are able to handle this, that is at least my assessment of it. So the thought I had back then, when this rushed on, and considering all these factors, and the leakage problematics, it was on the front page of BT [Bergens Tidende, the major newspaper of the region] with methadone overdose deaths, all that, and we knew that these MAR-X patients were out sailing on their own, then I got the idea of a transfer of ownership of undertakings and build competence of the employees within the municipality that were working on the MAR centres, so that they could work as therapists in the specialist health service at the same time. In this way they did not only continue, not only, because they did a good job, but how should I put it, when we anyway had to pay for these services, we could kill two birds with one stone, so that we got therapists as well for these 350 patients [MAR-X]. Thus since 1st of November 2014, the time of the transfer of ownership of undertakings, we have built competence, they were very competent on a wide field before, I don't need to say anything else than that, but the specialist healthcare competence has been built successively in this group, so that we now have therapists for patients, and this has made us able to receive a major part of the MAR-X population" (P01_1, l.177-201).

3.8.2. Present information

Information for this section is provided throughout the previous sections (3.1.-3.8).

3.8.3. Future implementation/development

A major weakness/challenge for present MAR Bergen programme in a national context is dealing with the patients' somatic illnesses. Distribution of death causes reveals that somatic diseases dominate, with liver diseases as the most frequent and related to chronic hepatitis C, coronary diseases, cancer and serious bacterial infections (Waal *et al.*, 2016) p. 16).²² The SERAF report argues that: "In an ageing MAR population, the occurrence of chronic somatic diseases will be expected to grow. This requires increasing focus on diagnosing and treatment of these somatic diseases, and this ought to be a main focus within MAR in the years to come" (op. cit, p.16).

MAR Bergen is currently planning to implement systematic diagnostics and efficient treatment of hepatitis C at the outpatient clinics. This is seen as an effective way in treatment of this disease, by utilizing the fact that patients meet regularly at the outpatient clinics to get their medication (IP01_1). Often if these patients are referred to treatment for hepatitis C at the Haukeland university hospital in

²² According to the WHO (2016b) "Hepatitis C is a liver disease caused by the hepatitis C virus: the virus can cause both acute and chronic hepatitis infection, ranging in severity from a mild illness lasting a few weeks to a serious, lifelong illness. The hepatitis C virus is a blood borne virus and the most common modes of infection are through unsafe injection practices, inadequate sterilization of medical equipment, and the transfusion of unscreened blood and blood products. A significant number of those who are chronically infected will develop liver cirrhosis or liver cancer. Approximately 700 000 people die each year from hepatitis C-related liver diseases. Antiviral medicines can cure approximately 90% of persons with hepatitis C infection, thereby reducing the risk of death from liver cancer and cirrhosis, but access to diagnosis and treatment is low" (WHO, 2016b).

Bergen, they will not meet and so go on untreated with detrimental health consequences. Therefore the goal is to offer treatment at the outpatient clinics according to the doctor interviewed (IP07_1).

There is a major research effort on MAR patients within what is called BAR (Bergen Addiction Research Group), at the Health Bergen HE building biological research bank with biological material sampled from person with an addiction illness, including MAR patients [startup date 01.01 2017, (REK (REgionale Komiteer for medisinsk- og helsefaglig forskning), 2016)]. One driver of this research effort is to provide and implement new methods of working with these patients based on research. Among the projects is one on Hepatitis C, as well as others concerning typical somatic problems of this patient group, according to the manager of the programme (IP10_1).

Currently MAR Bergen is developing what they refer to as “level 2 psychological treatment” to be offered in one of the outpatient clinics. This will include making more specific diagnoses and provide treatment for anxiety and traumas. The manager of the programme argues that such a system requires quite much organization and introduction of a culture for doing such work (IP10_1).

Another measure to be implemented, is a concerted effort between MAR Bergen, the municipality and the local police, towards the vulnerable and functionally weak group with triple diagnoses (mental, somatic and addiction), these are often “revolving door patients” (*gjengangere*), going in and out of hospitals numerous times. A group is to be established to work and follow up very tightly around 30 - 40 patients within this category of patients. Much resources is spent on them already and the aim is to provide even more help to them, to secure an even better communication and cooperation towards the individual patient, according to the manager, (IP10_1).

At the other end the above interviewee stresses preventative work and the need to have strategies for early detection of young people with addiction problems. Here the idea is to establish a sort of ambulant team, serving somatic departments and primary care services, e.g. the child welfare service.

3.9. Discussion

3.9.1. General discussion

The recent national policy reform, i.e. the Coordination Reform and subsequent policy documents have stressed the need to develop health and care services that are more integrated and closer to the patient. Particular attention towards patients with multiple and chronic illnesses is strongly signalled. Both promising ICC programmes in Norway are developed to attend to the specific needs of patient groups with multi-morbidity by means of an integrated care approach.

MAR Bergen provides health- and care services towards a particularly weak and vulnerable group of patients suffering from opioid addiction and additional heavy burdens of somatic and mental illnesses. Whereas MAR treatment is of national scope covering around 8000 patients, MAR Bergen covers around 1000 of these. Features distinguishing the MAR Bergen programme from other MAR programmes in Norway is first and foremost its focus on providing a low threshold entry to treatment for those hard to reach, enabling a swift start-up of substitution treatment. Secondly, to assure access and maintenance

of patients in treatment, a decentralised system of MAR outpatient clinics have been established, providing services close to the patient's area of living. This is very important as patients have (more or less) direct access to specialist health services offering a treatment team around the patient outside hospital settings. Thirdly, MAR Bergen has developed its own unique patient pathway, based on different phases of treatment; each phase reflecting the patient's own capability in terms of addiction mastery, and also securing continuity of care. Finally, as part of this rehabilitation course there is extensive cooperation with the municipality, offering complementary social services, to attend fully to the patient's needs. The integration of medical, care and social services is also a key for a holistic approach to the patient.

For the purpose of this study we have conducted 11 face to face interviews. They were conducted in the period May-September 2016. The interviews were allocated among the stakeholders as follows: one interview with following groups: Initiator of the programme, representative of sponsor/payer organization, other stakeholder, informal caregiver, doctor and manager of the programme. Three interviews were conducted with non-physician medical staff and finally two patients were interviewed.

3.9.2. Discussion of the programme in the context of the conceptual framework

Moving from the general discussion of the programme, we now turn to a consideration of the different domains identified by the SELFIE framework as essential for securing integrated chronic care for multi morbidity (Struckmann *et al.*, 2016).

Service delivery

Service delivery in the MAR programme is built on the ideas of patient centred strategy and holistic assessment of the patient. A team based model including therapists and professionals in somatic, psychological and social care secures interdisciplinary specialist work with the patient. At the meso level this is reflected in the organization of decentralized outpatient MAR clinics, with a low threshold for entry, in order to cover this group of hard to reach patients. A strong partnership with municipal services providing social care and additional rehabilitation services to the patient, adds to comprehensiveness in service delivery. One important aspect of service delivery at the micro-level is the use of self-management strategies. A particularly important aspect of self-management strategies for this group of patients with multi-morbidity is an initial lack of control over one's own life when entering the MAR programme. Consequently, much work is about building capacity of autonomy and control, of making sense of the self of the person in question. At the micro-level motivational and behavioural work are central methods in helping to build and develop self-management and own capacity of the patient in MAR. Critical points in service delivery were related to the balance between medical treatment, basically securing survival, and stabilization and rehabilitation elements consisting of social - and other services oriented towards change and advancement along the patient pathway. Some concerns were raised by our informants whether this balance was tilted too much towards the goal of survival, whereas rehabilitation was being marginalized to some extent. Clearly securing the integration of these equally

important goals will be decisive in providing services that are in line with the goals of the conceptual framework in respect of person centred, pro-active and tailored services to be offered at the micro level.

Leadership & governance

Due to the extraordinary challenges of this patient group in terms of behaviours and capabilities, substantial hardships are put on the workforce; especially the special advisors in charge of day to day contact with the patients within their portfolio. Therefore, the segment of supportive leadership as part of the ICC model is very pertinent for the MAR Bergen programme. A major task of the outpatient clinic leaders is to provide this kind of support to their employees. The organization into responsibility group (*ansvarsgruppe*) is also important in relieving the special advisors, and fostering a culture of shared decision making. Importantly the responsibility group includes the patient and secures the patient's own involvement and voice in developing care goals and treatment plans.

The MAR Bergen programme is characterized by leadership with long experience from work within MAR and with a strong commitment to a vulnerable and marginalized patient group. This also characterizes leadership within the municipality that constitutes the key partnership of MAR Bergen. These factors are important in providing foundations for a culture of shared visions, ambitions and values, identified as an important segment at the meso level in the framework.

To realise a culture of shared visions there still may be some way to go. Our informants refer to different cultures: a care oriented culture within the municipal sector and a specialist health services culture. Whereas the first one emphasizes the importance of supporting the patient in managing daily life and social relations, the other one is focusing on treatment of illnesses. With the takeover from the municipality to the health enterprise, previous employees of the primary care services within the municipality now came to be working together within the second-line specialist health services. A successful MAR programme is dependent on integrating both perspectives on treatment to provide individually tailored services. Leadership and governance work is ongoing both to strengthen cooperation and at the same time clarify labour of division and identifying accountability within the partnership between MAR Bergen and the municipality of Bergen.

Workforce

Service delivery is strongly related to a highly skilled and attentive workforce. In MAR Bergen a team model of interdisciplinary specialist treatment is developed around the patient to address multi-morbidity, as these patients often suffer from both somatic and mental illnesses in addition to their addiction problem. Therefore, the team consists of doctors, nurses, psychologists and social workers to be able to attend to the diverse treatment and rehabilitation needs of the patients. The strength of the workforce seems to be the relational competence social workers bring with them, based on long-standing knowledge of the individual patient's life history, and developed skills in handling problematic

behaviours of the patients. Moreover, and in line with the ICC framework, each patient has a designated coordinator, i.e. the special advisor.

Competence building is central in developing the programme; for example, new positions have been established for doctor trainees in addiction medicine, thus being able to providing specialist treatment at the outpatient clinics. In addition to working directly towards the patients, new professional roles have been developed; both doctors and psychologist work indirectly via the special advisor, in terms of providing professional advice and support that strengthens the competence of the special advisors and builds confidence towards the special advisors' own professional role (cf. also leadership, above).

An important step towards a more person oriented service delivery has been to bring the doctors much closer to their patients. This is an important change in their professional role as previously, the MAR doctors were at a distance from their patients. With time spent at the outpatient clinics, the doctors and patient now experience more direct personal contact and communication.

The way MAR Bergen is developing its workforce is in accordance with central elements of the ICC framework, especially the organization of a core team around the patient with a designated coordinator and the continuous education and development of competencies across the fields of somatic -, mental - and addiction related illnesses that these patients are suffering from.

A critical point for the effectiveness of the treatment concerns the time allocated to each patient. The MAR Bergen programme has been characterized by substantial expansion and simultaneous building of competencies; consequently, the time spent on each patient has been reduced. Thus, a potential problem arises if this time resource allocation is less than optimal in a therapeutic perspective, jeopardizing the patient's advancement through the different phases of the patient pathway.

Technological and medical products

One aspect regarding different cultures brings us to another component of the ICC framework concerning the various familiarities with registration of activity and the use of medical records. Whereas such work is daily routine for therapists within the specialist health services, this was new to those with background from the municipal social services. An additional challenge was the lack of a shared information system, since somatic and mental diseases had their own different medical records, and therapists not having access to both systems. Thus, the leadership of MAR Bergen developed a new MAR treatment scheme for this patient group, with comprehensive information on status and future treatment plans. Plans are ongoing to make the MAR Bergen treatment scheme a template for a national MAR record system.

Problems with registration of activity and time use have been identified as troublesome as they may divert attention and time away from treating patients. As previously discussed regarding financing, registration of activity has direct bearing on incomes of the outpatient clinics; failure to register treatment activity that release outpatient clinic rate payments will reduce budget and hence means less resources to be spent on work with patients.

No specific ICT products have been developed for use by patients; in terms of communication, the use of text messages via mobile phones are important technical devices in securing that patients meet for appointments etc. with therapists. (See also discussion on financing above for the issue of medical products).

Information and research

With the increasing coverage of the risk group of opioid addicts, the MAR Bergen programme will generate and collect important individual patient level data that may be used for future research. The major research effort on MAR patients within what is called BAR (Bergen Addiction Research Group), at the Health Bergen HE is establishing a biological research bank with biological material sampled from persons with an addiction illness, including MAR patients. Targeting evidence-based individual risk prediction, provision and implementation of new diagnostic and therapeutic approaches for these patients, several projects are planned regarding Hepatitis C as well as others typical somatic problems in this patient group.

Financing

The financing mechanism for the programme is a semi-secured budget consisting of a fixed block grant and importantly a variable grant depending on the registered treatment activity at the outpatient clinics. Particularly in the area of medication, there are incentives for collaboration and collective action in acquiring medications to obtain cost savings. This results from a market tendering system wherein the MAR clinics operate as a large buyer, being able to obtain rebates.

At the micro level, there are no direct financial incentives for participation by the patient. However, given the particular circumstances of these patients, the basic logic of the MAR programme is that the substitution medicine offered, represents a benefit that outweigh the alternative high costs and risks involved in acquiring opioids at the illegal market.

The deliberate choice of MAR Bergen of not charging patients with out of pocket payments for consultations has important consequences; firstly and in line with the low threshold approach of MAR Bergen, a potential financial barrier against participation is avoided and serves the goal of increasing coverage of the target population. Secondly, this decision weakens the financial resources, with negative consequences for the quality of service provision.

Critical points with respect to a secured budget were also the variable grant part dependent on treatment activity at the outpatient clinics. The problem identified here was that of registering treatment activity to reflect the actual activity level. So far the registered activity had been lower than actual treatment activity, implying lower incomes/grants than budgeted.

A key element in financing according to the framework is coverage. In this respect the low threshold approach has been successful in reaching the target group, and coverage of patients in MAR has increased substantially since start-up of the programme.

In terms of incentives, a potential conflict has been identified between payer and patients, because the payer at meso level has to secure that purchase of medications is cost effective (i.e. substitution medicines as well as other medications). To the extent that this reduces the free choice of medicines and the possibility to provide individually tailored medication for the patient, there is then a problem of prioritization. This is not a specific problem of MAR but arises in other parts of the health system as well (e.g. treatment for cancer patients including access to expensive new medicines) reflecting dilemmas of prioritizing within a financial context of limited resources.

4. Programme 2: Learning networks for whole, coordinated and safe pathways in the municipalities (Learning networks)

4.1. Basic description

The Learning network has the following goals:

- To develop whole patient pathways in the municipalities
- To make use of and develop relevant tools and methods for use in the municipalities and their work with whole patient pathways (as part of this cooperation agreements between hospitals and municipalities)
- Strengthen the users experience of mastery
- Strengthen the role of the user in improvement of patient pathways
- Strengthen improvement competence among leaders and staff
- Reduce “unnecessary” hospital stays for chronically ill and older patients

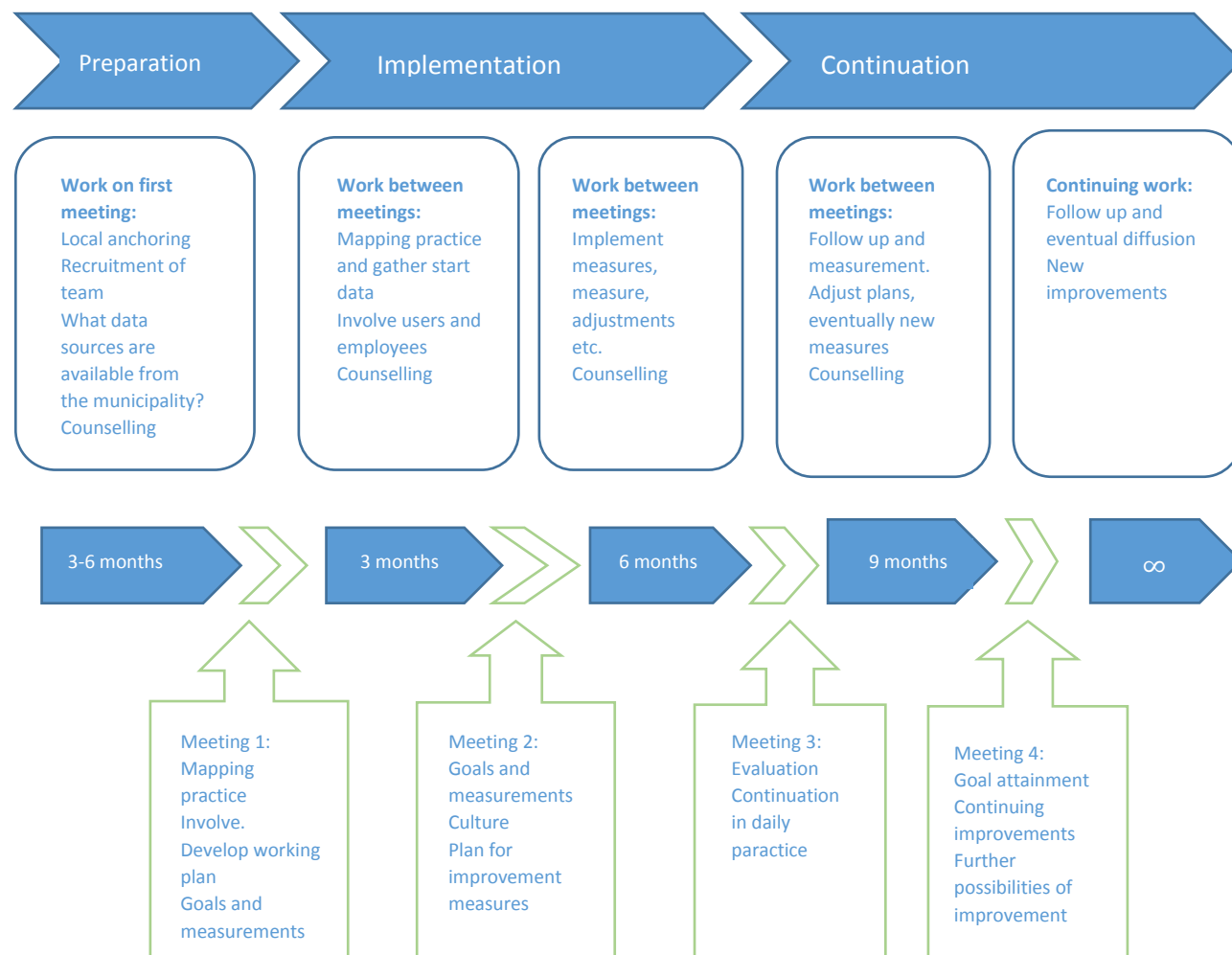
(KS and Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015b)

The “Learning network for good patient pathways for elderly and chronically ill” programme comprises up to date 35 municipalities in 13 counties (cf. map in section 2.1).²³ The participating municipalities are divided into two subnetworks; one is referred to as “Læringsnettverk Gardermoen” (“Learning network Gardermoen”), the other as “Læringsnettverk Sør” (“Learning network South”). Our study includes municipalities from both subnetworks. The learning process takes place through regular gatherings/meetings of the involved municipalities. The periods between gatherings are used actively for implementation and data collection in the respective municipalities. This process of active counselling is considered to be of great significance for the success of the development work. (The Learning networks will last for 18 months; in addition there is a 3 month period for preparations). The following figure presents an overview of different phases and content of the Learning network.

²³ The other Learning network is the «Learning network for good user/patient pathways within addiction and mental health”

Figure 4.1.1. Overview of Phases and Content of the Learning network

Learning network for good patient pathways in the municipalities



Source: (Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015a), authors' translation from Norwegian into English, and figure redrawn from original.

Table 4.1.1. Classification of included documents for the Learning networks

Type of document	Document name, Norwegian	English translation	Referred in text as
Programme description	Virksomhetsplan Kvalitetsutvikling	Activity plan, quality development	(Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2014b)
	Virksomhetsplan Seksjon for kvalitetsutvikling	Activity plan, Department of quality development	(Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2014a)
	Prosjektdirektiv for satsingen nasjonalt læringsnettverk	Project directive for the national Learning network effort	(KS, 2014)
	Kunnskapssenteret: webside:	http://www.kunnskapssenteret.no/	(Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015a)
Contractual documents related to the programme	Tilskudd til KS over statsbudsjettet 2015	Financial contribution to KS, state budget 2015	(Helse- og omsorgsdepartementet, 2015)
Annual reports/Activity reports	Notat styringsgruppemøte 3. juni 2014	Note, steering group meeting 3. June 2014	(KS and Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2014)
	Referat fra styringsgruppemøte i læringsnettverk for gode pasientforløp	Minutes, steering group meeting, Learning network for good patient pathways	(Helse- og omsorgsdepartementet, 2014)
	Notat til styringsgruppemøte 25. Februar 2015	Note, steering group meeting 25. February 2016	(KS and Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015b)
	Læringsnettverk for gode pasientforløp for eldre og kronisk syke. Oppsummering av status 25. februar 2015	Learning network for good patient pathways for elderly and chronically ill. Summary of status, 25. February 2015	(KS and Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015a)
Other documents	Invitasjon til samarbeid om utvikling av fastlegens rolle i pasientforløp	Invitation to cooperation on the development of the regular GP's role in patient pathways	(KS and Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2014)

Additional sources on background and context include: (Røstad *et al.*, 2015; (Røstad *et al.*, 2013)

The pathway approach is very much in line with the ideas of current political reforms. A key step for securing proper treatment at the right place and the right time, e.g. the overarching goal of the Coordination reform, was “patient pathways”. According to the Coordination reform White Paper:

- *The services lack cohesion, so the patient’s opportunity to participate is mostly limited to individual services. More involvement from patients and their organisations should be encouraged in efforts to implement structures and systems for more cohesive patient pathways. Good, cohesive patient pathways should increasingly become a common frame of reference for all stakeholders within the health and care services. The pathway approach will help to orient all systems and services toward assisting the individual with coping with life or restoring functioning (Norwegian Ministry of Health and Care Services, 2008-2009: 5).*

Furthermore, the Coordination Reform recommends maintaining and strengthening patient participation. Moreover the reform calls for involvement of patients and their organisations in efforts towards more cohesive patient pathways, also in terms of influencing how this involvement is to be accomplished. Finally, the reform paper recommends more systematic efforts in analysing and describing good patient pathways, which can promote measures for improved coordination (op.cit, p. 6).

The Learning networks address the above challenges with its focus on developing whole and coordinated patient pathways for elderly.

Table 4.1.2. Basic information about Learning networks

Information category	Description
Programme name:	Learning networks for whole, coordinated and safe pathways in the municipalities
Contact details, programme management	Sigrid Askum: Sigrid.Askum@ks.no
Starting date of the programme	1.10.2013
Geographical scope	Norway. 35 municipalities in 13 counties (cf. map on p.5), organized in 2 networks during 2013-2015. The model will be further developed and extended in 2016-2019 to comprise municipalities in all parts of the country as well as Health Enterprises
Target group of the programme	Inhabitants who are new users of home nursing services or short-term stay in nursing homes (eventually after discharge from hospital). Mostly frail older people with multi-morbidity.
Number of patients treated in the programme	Unknown, but at least 1000
Aim of the programme	<p>The main purpose is to develop coordinated and safe patient-pathways, and health-promoting health services</p> <p>Primary drivers:</p> <ul style="list-style-type: none"> • Change of mind set from: What's the matter? To: What matters to you? • Develop supportive infra-structure <p>Secondary drivers: user involvement, leadership and QI, re-ablement, elements in existing coordinated care models (HPH), municipal coordinator, core competence, organization, e-communication, measurements</p>
Organizational form and ownership	<p>Steering committee: KS (Norwegian association of local and regional authorities), Ministry of Health and Care Services, user organisations</p> <p>Reference group: hospital enterprises, user organisations, trade unions for health workers</p> <p>Expert group: professionals with experience from similar processes in Norway, Sweden and Denmark</p>
Involved partner organizations	See above. All health, social and community care providers
Involved disciplines and professions	Multidisciplinary primary healthcare team in the municipalities: home care nurses, healthcare workers, general practitioners (GP), other disciplines (physiotherapist, occupational therapist etc)

4.2. Service delivery

4.2.1. Design of delivery of care

Building on the above mentioned need for cultural change and a stronger focus on **designing the delivery of care around the patient**, a key tool for the organization of care delivery is the What matters to you scheme. The scheme is a tool for functional ability assessment (Patient Specific Functional Scale-PSFS) and is visualized below:

Figure 4.2.1.1. What matters to you scheme

What matters to you- scheme											
This scheme contains activities and goals that are important for you. In the first conversation we write up 3-5 of these and give a score based on where you think you are placed for each one of them. These points are important goals that we are going to work on together as equal cooperating partners. In the second conversation we talk through and score the progression that has been made. This may be repeated for as long as it is seen as useful											
Important activities and goals for you										Score	
										1. Conversation	2. Conversation
Where am I now?										1. Average	2. Average
1	2	3	4	5	6	7	8	9	10		
Can not perform the activity					Can perform the activity without difficulties					Experienced usefulness (2. Average – 1. Average)	
A score difference from first to second conversation of two points is considered to be a significant improvement, both practically and clinically											

Source: KS and Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015a) (translation from Norwegian into English by the authors, and figure redrawn from original.

The above scheme is used in two conversations with the user/patient. The first one aims at getting an overview and coming to terms with which functional abilities are important for the patients in order to master the specific activity of daily living or goals stated. The other conversation is conducted after 4 weeks when care measures are planned and applied, so that it is possible to measure whether the interventions lead in the right direction, e.g. towards increasing ability to perform activities without difficulties. Our study confirms that patients were active in the formulation of goals. One interviewee

stressed that a common understanding and agreement between patient and health worker is necessary to succeed. Patients particularly appreciate that the workers take their time and follow up properly.

To see how the scheme may work to change the focus of care, the following story reported by one of the municipal multidisciplinary improvement teams constructed as part of the programme is telling:

- *“An elderly lady that had ticked the request for home help entry of the traditional application scheme to the municipality was offered a conversation with the “what matters to you?” scheme. In this conversation she said that the most important for her was “to have social company with other people”. She had marked the entry for home help, because in the traditional scheme, this was the only way to get regular contact with other people. On the first measurement (What matter to you? scheme) she scored 0, for the activity considered to be most important for her; she had no contact with others. Based on this decisive information the municipal office for distribution of services (tildelingskontoret) was able to offer daily based activities together with other elderly instead off home help. In the second conversation of the “what matters to you scheme?” scheme she scored 10*

After this experience the municipality, in addition to its ordinary regular categories of the application scheme, has added the “What matters to you?” question as an open field of entrance within the scheme” (KS and Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015b), authors’ translation from Norwegian).

The Learning network seeks to promote coordinated and safe pathways. PSFS and individual patient care pathway checklists constitute the two key elements of the Learning network. The overall aim of these checklists is to ensure that the patient experiences good patient pathways (KS and Kunnskapssenteret 2015b: 5). The checklist is presented below in table 4.2.1.1:

Table 4.2.1.1. Check list for patient pathway

Checking list patient pathway, filled out by primary contact, to be documented in patient journal:

			Patient/Serial number	Evaluation						
			Date of discharge	Completed		Not relevant	PSFS ²⁴	COPM ²⁵	COPM satisfaction	Commentaries
			Readmission date	Yes	No					
For patients that have been hospitalized	1	Week 1	Municipality and hospital/ municipal institution have planned discharging together by phone/ video/ meeting							
	2	Week 1	Preparation of discharge is done together with Patient/relatives							
	3	Week 1	Necessary assistive equipment is ordered/on site for the patient in order to manage his/her own situation best possible							
	4	Week 1	Case summary (or similar medical report) has been surveyed before meeting with patient							
	5	Week 1	The patient is familiar with the person who is primary contact and responsible for follow up							
	6	Week 1	Assessment of patient function is made in accordance with checking list and measurement instruments such as PSFS or COPM							
	7	Week 1	Follow up directed by what matters to the patient							
	8	Week 2	Follow up by regular GP/ nursing home doctor has been completed							
	9	Week 5	New assessment of patient functioning has been made in accordance with checking list/measurement instruments such as PSFS or COPM							
	10	Week 5	The patient's experience with follow up/coordination is assessed/surveyed by interview or questionnaire							

Source: Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten (2015),(Sjekkliste for pasientforløpet, PWP, Vibe)

²⁴ Patient Specific Functioning Scale (PSFS)

²⁵ Canadian Occupational Performance Measure (COPM)

According to the initiator of the programme, a main reason why patient pathways are so well received by different stakeholders lies in its combination of focusing on the individual patients without losing sight of the whole system. A strong focus on the system and standardization may result in the individual being given insufficient attention. Within the pathway approach, however, the individual is at the centre of attention without being system-less; this appeals to many stakeholders according to the initiator of the programme (IP10_2).

The checklist is a tool with four specific aims (presentation by Vibe available at www.pasientforlop.no) (Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015b): (i) provide feedback on whether municipalities follow up as agreed; (ii) measure compliance of the patient pathway; (iii) (indirectly) measure how resources are used; and (iv) adapt for reflections on readmissions. The checklists include important questions and critical situations, and municipalities may adjust their checklist to local relations. Our interviews in different municipalities confirm that such adjustments are made. One primary care nurse is quoted by Røstad et al. (2013: 6) saying: “They [checklists] help us remember to ask all the questions that need to be asked to ensure a proper follow-up”. Our interviewees make similar comments, and add that the use of checklists ensures that all patients get the same treatment and are offered the same services, independently of staff (IP01_2, IP03_2, IP05_2). This is explained by one non-doctor medical staff:

- *“Yes, or, I feel that now things are not forgotten, you have a checklist in a way, a checklist in order not to forget anything, that all are attended to the same way, all have the same scope of ..., to receive help, and there is quite much on the screen there and for those with comprehensive needs, then you are well attended to, quite much is uncovered”(IP01_2, l. 330-334).*

Although several interviewees say that they do not work differently with patients with multi-morbidity, this effect of checklist may be particularly important for patients with multi-morbidity and make them feel that they are well taken care of. The checklist may also uncover incremental changes that otherwise might have been overlooked and they increase user involvement according to a non-doctor medical staff (IP01_2).

Another stakeholder explains how employees working according to the methods set by the Learning networks were offered a nine-hour course (IP03_2). Another non-doctor medical staff refers to “*temadager*” organized by the municipality as a training measure (IP05_2), and some of our informants have participated in the Learning network gatherings and gained knowledge this way, e.g a non-doctor medical staff (IP14_2). A doctor describes how the patient pathway approach resulted in much more systematic training and the development of a system that secures that new employees are trained in-house in using checklists. Although this training is not only relevant for patient pathways it was the patient pathway approach which led to the new training. This clearly improved quality and is of particular importance in a field with quite much turnover according to this doctor (IP13_2).

Documents and interviews give us rather scant information on the role of informal caregivers. One non-doctor medical staff finds that patient pathways help staff getting relatives involved, which can be important for the patient, but stresses that relatives do not take part in the PSFS-test (IP04_2). Our interviews do not indicate that the pathway approach demands informal caregivers to act differently in

any way. One interviewed doctor says that informal caregivers are obvious collaborators; however, the municipality has not developed a special arrangement within the patient-pathway to involve this group (IP13_2).

4.2.2. Self-management interventions

The Learning network has a strong focus on user perspectives (Kunnskapssenteret 2014 b). The aim of user involvement and health-promoting health services has resulted in the wish to change the focus in health services from “What’s the matter?” to “What matters for you?” (KS and Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015b). While health services traditionally have emphasized diseases and treatment for these, the Learning network approach is more concerned with patients’ resources and health promoting reasoning (Kunnskapssenteret 2014 b: 1). This represents a “change from being problem-oriented to become goal-oriented” (KS and Kunnskapssenteret 2015b: 2). The Learning networks rely on PSFS (Patient-specific functioning scale) to identify what is most important to the patient, cf. figure 4.4.1 and section 4.2.1 on design and delivery of care. The patient identifies 3-5 activities of daily living and to what extent she or he is able to carry out these activities on a scale from 0 – 10. 0 means being unable to carry out the activity, 10 means that the patient can carry out the activity without difficulties. The patient is asked to fill out this scale before start-up of service provision and then again after four weeks to assess whether her or his objectives have been achieved. In addition, non-doctor medical staffs evaluate patient satisfaction with follow-up through interviews or surveys. The mapping by means of the “What matters for you – scheme?” represents an intervention as does the follow-up assessment. The PSFS scale forms the basis of the individual initiatives and training carried out by the patient after being instructed by the municipal healthcare workers. Empowerment is an important key word here as the activities of daily living are identified by the patient and not the professionals. One non-doctor healthcare staff claims that;

- *“the text “What matters for you” has come into focus and been brought up much more with good patient pathways so I think user involvement has got through much more now than earlier, we maybe thought we had this before, but now we are much better at asking the user first...” (IP14_2, l. 39-43).*

One interviewee explains that the PSFS schemes help patients develop a greater consciousness around their situation and that they should aspire to take care of oneself without (much) assistance from the municipality. This approach may help changing the way patients think. In this respect the self-management embodied in the “What matters to you?” scale contributes to more patient satisfaction and sometimes the ending of public assistance. Interestingly, the interviewee also thinks that staff becomes more conscious with regard to conducting tasks for the patient, that the patient could carry out herself/himself, may result in unnecessary helplessness (IP01-2). This interviewee has experienced that patients often have less need for help than suggested by the hospital that the patient has been discharged from.

One challenge and obstacle with regard to self-management is that some patients with cognitive impairment are unable to set goals and assess their own condition (IP01-2).

4.3. Leadership & governance

The Learning network collaborates with user organizations (Kunnskapssenteret 2014 b) and the Centre for Quality in Medical Practices (SKIL) (KS and Kunnskapssenteret 2015b). There is, however, limited information about such collaboration available in written sources. The manager of the programme describes how they try to get SKIL to help them in getting GPs more involved (IP12_2).

From the manager of the programme we also learned that there is a division of work between The Knowledge Centre for the Health Services and KS in that the former concentrates largely on quality enhancement whereas the latter focuses on getting the municipalities to get going with their improvement efforts (IP12_2).

Several interviewees (e.g. non-doctor medical staffs) emphasize how important it is that managers are dedicated to this way of working as it is quite time consuming (IP01-2, IP04_2). The representative of the paying organization stresses the importance of strong support from the management in order to get the most out of the Learning networks (IP02_2):

- *“And then I can say that this is also about, this can also be connected to aims of leadership, because actually analyzing services, that is systematics in work procedures, is largely about leadership too, (...) one of the aims of the Learning networks this time is stronger management support in the participating municipalities to show that this is important to achieve effect from the networks” (IP02_2, l.183-185, 192-195).*

4.4. Workforce

According to Røstad et al. (2015: 5), introducing integrated care pathways meant that primary care nurses, traditionally focused on assisting patients, now had to systematically observe, assess and document health and functional issues by using checklists. Another stakeholder describes how the Learning networks have led to a kind of culture change where nurses and community nurses now have learned to focus more on rehabilitation (IP03-2). One interviewee representing non-doctor medical staff makes a similar comment; saying that nurses and community nurses are used to work hard with specific tasks and not to allocate time for conversations and mapping work (IP04_2).

The manager of the programme describes the focus on “What matters to you?” as a change from treatment for illness to healthcare. Nurses and GPs are trained in searching for symptoms and diagnoses and then think compensating services, an approach with clear limitations;

- *“regarding multi-morbidity we deal with chronic diseases, these cannot be set in order, right, one has to find a way of living with them, and then one can question how far one gets by asking “what is the matter with you?”. Getting the health service to ask the new question [...] that is the*

big, big challenge. People do not disagree, we are simply not trained for it, and we do not have a culture that goes in for this way of developing services, [...] as individuals and health workers we want to be good at our profession, and be experts and maybe we take the expert perspective too far” (IP10-2, l. 229-239).

One non-doctor medical staff says that GPs have become more involved as they also use the checklists (IP01-2).

An important constituent of the care design promoted by the Learning network is the formation of local municipal multidisciplinary primary healthcare improvement teams, consisting of general practitioners (GP), home care nurses, healthcare workers, other disciplines (physiotherapist, occupational therapist etc). The improvement teams comprise 5-6 participants; it is recommended by KS that the municipalities let an existing leader lead the team, and to include a representative for regular GPs/municipal GPs and representative for users of services (KS, 2014).²⁶ One interviewed non-doctor medical staff describes these improvement teams as a new way of working that results in interdisciplinary rather than multidisciplinary cooperation where they draw on each other’s competence to the best for the patient (IP14_2). However, the fact that many of the involved persons are part-time employed shift workers is a challenge for communication and continuity (IP04_2):

- *«Yes, the challenge with patient pathways in general is that very many work shifts. So to have continuity, that is a challenge... Obviously, for each patient some extra responsibility rests on the primary contact to sort of direct the pathway, and if this is a person working 70 or 60 per cent and evening duty and weekends and everything, then some days may... parts of the checklist can be accomplished by anyone, but to have the main responsibility, that is the challenge with shift work. And time, that is in the community care, they run so fast and far that one can hardly believe it, I am really impressed by its efficiency. It is so efficient that it is hard for them to sit down and have a good conversation, both as a work method and to have sufficient time for it” (IP04_2, l. 442-454).*

One GP (doctor) explains that he does not really work differently with people in patient pathways. Still, the patient pathway is very structured, and for instance demands that the GP provides an appointment/home visit within two weeks. This has clear positive health effects. He considers allocating more time for the patient as the main benefit of patient pathways as the development of routines results in more attention; “The GP is forced to use time, and GPs must be forced to do that, because there are so many competing tasks. If one has to do something then one actually does this” (IP06_2, l. 305-306). People enrolled in patient pathways belong to a group of patients that earlier often received less attention from their GP because they are not very demanding and seldom see their GP. A further benefit according to this GP is awareness of polypharmacy. Another interviewed doctor also describes how management of polypharmacy is part of their checklists and that this increases safety (IP13_2).

²⁶ The government recommends more use of primary health care teams in their white paper on future primary and health care services (Meld. St. 26, 2014-2015: 50). This is also emphasized by the representative of the payer organization (IP02_2). Such teams may be extra effective towards people with chronic diseases (Meld. St. 26, 2014-2015: 122-123, 131-132).

From the interviews with non- doctor medical staff we learned that PSFS scales did not represent a completely new approach as COPM, the more comprehensive scheme upon which PSFS is based, was already used by some occupational therapists and physical therapists (IP04_2). Employees familiar with COPM could thus teach other colleagues how to use PSFS; some health professionals actually continued using COPM rather than PSFS as they consider the former to be user controlled. Checklists for patients with multi-morbidity were also in use before and independently of the Learning network.

A doctor comments that municipal healthcare workers gain self-confidence towards GPs in terms of what they can expect GPs to do, and that one important consequence of patient pathways is an improved dialogue between GPs and the primary health service (IP13_2).

Another interviewed doctor agrees that the Learning networks may contribute to better dialogue. This doctor, however, considers it problematic that GPs are not always informed about new measures taken by for instance specialist nurses. Sometimes he experiences a reluctance to involve GPs and that for instance specialist nurses become protective of their patients while involving GPs would increase the position and status of the measure and would be in the best interest of the patient (IP11_2):

- *«A small tendency, actually maybe pronounced, I think, in a large municipality, is that you have good, strong occupational groups in addition to the GPs in the municipality that develop services without informing about these, or they only inform the public, not sufficiently maintaining lines of communication with their own municipal medical service, where... (...) I witness that there is actual resistance to showing the service and connect it with the medical service, in an inconceivable manner, this is something which has struck us GPs (...), we have experienced a distinctive feature that I think is actually somewhat universal and somewhat underestimated. (...) Yes, it is a bit paradoxical, but I think, I think the nurses with specialized education in the municipality become very proud of their arrangements and quickly start thinking of the patients as their patients and become protective of this, you do not realize that connecting it with other groups actually strengthens position and status and that it is very positive for the groups themselves” (IP11_2, l. 241-245, 247-251).*

This doctor emailed us after the interview to add some further points. As a GP he was critical towards the healthcare workers when it comes to achieving interaction with GPs. Without accepting his view on who is to blame for the lack of interaction it is easy to see the relevance of the issue he addresses; if initiatives such as the Learning networks shall succeed they must be mutual initiatives where healthcare workers make a common cause with GPs. A GP that gets the impression that she or he is just a guest in a new initiative and not a core actor is not likely to commit oneself. This is very much in line with what other interviewees and the report by Deloitte (2016) says about ownership, but it adds important information to the challenge of involving GPs; their absence might rest less on reluctance than ownership.

4.5. Technologies & medical products

The Knowledge Centre for the Health Services has produced ten short videos on motivational conversations, which are less comprehensive than motivational interviewing. The idea is that healthcare workers may go further than the short questions in the checklists allow for, through motivational conversations. The videos last no longer than five minutes, and may thus be suitable for instance in connection with “changing of the guard” for healthcare workers with partly overlapping working hours; the videos are meant for educating healthcare workers, according to the paying organization (IP10-2).

Several municipalities have started using electronic white boards. One non-doctor medical staff says this screen was important in getting the work according to patient pathway procedures really going (IP04-2). This is a large touch screen in a meeting room where the healthcare workers meet to discuss the situation and progress for each patient. A non-doctor medical staff informs that several times each week they go through the list of patients on the whiteboard to make sure that all get the attention they need, with the aim that a patient name can be removed from the white board after four weeks (IP01-2).

In the words of one non-doctor medical staff, the touch screen has an important function in reminding them of all possible services that may be important for the patients. By displaying different options available, staff thus has to make a deliberate choice when not providing a service. Prior to the introduction of electronic white boards the challenge was that staff did not necessarily take a stand on such services at all:

- *“As they [referring to employees and teams in the municipality working e.g. particularly with dementia or COPD] are listed on the screen and you see them this is a pretty important tool. Also for these, not only the regular GP, but for the whole interaction in the municipality as well. We used to depend on one staff member to remember nurses with expertise on dementia, and this does not always happen. There were no procedures for that” (IP04_2, l. 260 - 264).*

The electronic white board is emphasized by other interviewees as well. Although they had similar non-digital tools the new electronic white boards make it more visual, and the screen together with the ordinary work and checklists for each patient secures a kind of dual control according to another non-doctor medical staff (IP05_2). Tablets are sometimes mentioned in interviews, allowing for documentation on site and giving workers access to health records with important information when meeting patients in their homes; but this seems to part of a more general development and not directly connected to pathways (e.g. IP05_2).

ICT applications thus have an obvious function in promoting continuity, comprehensiveness and coordination of care for patients with multi-morbidity. This is also supported by the interviewee emphasizing the importance of flexible tools as the patient approach challenges the existing patient systems in terms of documenting tasks and orienting oneself in the system. Being constantly pressed for time presupposes easy-to-use systems, and there is still potential for improvement according to this non-doctor medical staff (IP04-2).

The interviews also provide information on technology which is not developed as part of the Learning networks but is used much within the patient pathway approach. E-message (E-melding), a system that helps GPs and municipal health workers to communicate efficiently, is one example. One aim of patient pathways is closer collaboration between different parts of the healthcare system, and e- messages are helpful in this regard. One interviewed physician considers communication by e- messages to be even more effective if the GP and healthcare worker has met personally a few times first:

- *“(…) E-messages, and that implies that there is intensive messaging between home based services, especially, case officers and regular GPs where the partner sends approximately as many messages, the regular GP has sent some more messages than the municipality and my experience is that when one has met each other, then the quality of the messages increases, it takes some degree of general agreement, so this is a bit difficult to achieve without physical meetings, but it does not take many meetings and my experience is that community nurses and regular GPs are very similar, because all are busy and interested in getting their job done, they are looking for something which is efficient and flexible and limited enough and that can be included in the schedule” (IP11_2, l. 131-139).*

Physicians in this municipality thus let health and social workers make an appointment with the GP just as a patient would do through the ordinary appointment system (IP11_2). Unfortunately, the physician explains, health and social workers are not sufficiently informed about this, and this opportunity is not exploited as much as it should.

4.6. Information & research/monitoring

According to KS (The Norwegian Association of Local and Regional Authorities) (2014), the Learning networks will develop common measures for patients’ functioning and experiences of use, readmissions and utilization of resources, based on checklists for their pathways. KS (2014: 4) identifies important conditions for successful implementation of work within the Learning network, for instance participation being entrenched at management level and user involvement.

The steering committee of the Learning network considers the networks to be successful (KS and Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2015b), although they also identify several weaknesses, for instance limited participation by regional health authorities. The steering committee has initiated a rather comprehensive evaluation of the Learning network and its goal attainment from the perspective of the participating users and municipalities (KS and Kunnskapssenteret 2015b). The Learning network collaborates with researchers at the University of Oslo.

The most comprehensive evaluation existing so far is a memo that was authored by Deloitte for KS in May 2016 based on a conference to promote knowledge exchange (Deloitte, 2016). The memo summarizes experiences and presents Deloitte’s recommendations. As this, to our knowledge, currently is the most extensive collection of experiences, we present this memo more closely. For our purpose,

the comments regarding the content and processes are more relevant than those pertaining to the network model in itself.

This memo starts by emphasizing the importance of active participation; at the level of municipalities interdisciplinary teams, professionals and managers must be involved, but also hospitals and regular GPs. Furthermore, the work associated with the Learning networks must be well entrenched in the municipalities (Deloitte 2016: 1).

The memo collects experiences in two main categories; general preconditions for Learning networks to succeed and municipal experiences with Learning networks.

Regarding how to make Learning networks succeed, the single most important identified factor is that there is one person in the municipality with overall responsibility and time set aside for this work (Deloitte 2016: 2). That participation is entrenched at management level and in the organization is also of great importance. Thus, Deloitte recommends that KS secures top level commitment in future work (2016: 2). Representatives of municipalities that participated at the conference agree that management support is important, and some would like to see stronger management involvement for instance by participating in network gatherings. Moreover, the municipalities have experienced that interdisciplinary cooperation may be very helpful. A third important general factor for making Learning networks succeed is thus to make sure interdisciplinary cooperation between physiotherapists, occupational therapists, nurses, GPs, case officers and managers work (Deloitte 2016: 3). Hospitals should also be included in the Learning networks.

Regarding municipal experiences with Learning networks, Deloitte first summarizes experiences with network gatherings and corresponding programmes. As our analysis is not so concerned with the network model in itself, we leave this issue out.

Secondly, Deloitte summarizes success criteria and barriers. According to the memo, municipalities describe the Learning networks as a success criterion as such. Communication and dissemination are considered crucial in reaching different stakeholders. Enthusiasts dedicated to patient pathways, cooperation and exchange of experiences between municipalities are important factors to be successful. Similarity and geographical proximity that allows cooperation and sharing of experiences have been important in some municipalities (Deloitte 2016: 5). The Knowledge Centre for the Health Services is a further success criterion as its expertise and support secures legitimacy (Deloitte 2016: 6). Important barriers are concurrent, competing initiatives (daily life rehabilitation or welfare technology), time, resources, economy, absence of hospitals, limited training in change leadership and ICT-systems that are not compatible, change fatigue and insufficient patience for culture change to materialize (Deloitte 2016: 5, 7).

Thirdly, experiences with Learning networks tools such as patient care pathway checklists are summarized. Deloitte refers to individual adjustment of such tools as particularly important. Difficulties with getting existing and new ICT applications to communicate and that employees need time to understand and integrate checklists in their work are among the most important barriers (Deloitte 2016: 7-8).

Fourthly, Deloitte presents results. The memo focusses on culture change, and how municipalities consider the Learning networks to be very useful, although there is limited evidence from evaluations and measurement; “**Patient Trajectory for Home dwelling elders – PaTH** (*“Helhetlig pasientforløp i hjemmet”*, HPH) [in Norwegian also known as the Orkdal model, developed by A Grimsmo] is a way of working. It is thus difficult to measure in itself, and one is left to develop indicators relevant for the results the working method is expected to produce... There is a strong positivity towards measurement. Many municipalities are eager to get better measurement of indicators and would like more help to signify the benefits of working this way. Work on how and what can be measured, as well as how this could be rendered visible ought therefore to be given more attention in forthcoming Learning networks” (Deloitte 2016: 8, our translation). There is hardly any real measurement of change; the positive changes are more general views and impressions. Still, participating municipalities consider increased security for patients, stronger focus on patients’ preferences, better services, stronger professionalism, enhancement of competence, more interdisciplinary cooperation and interaction within services, e.g. with GPs and hospitals, as important positive results (Deloitte 2016: 8). One of Deloitte’s final recommendations is for KS to assist municipalities in measuring change (Deloitte 2016: 9).

We have also gained access to a two-page note summarizing observations from two meetings organized by KS in the spring 2016 (Steinsbekk, 2016). Among the observations and opinions voiced by this researcher was the need to consider that focus concerning patient pathways was kept firmly on activities within the particular municipalities. The researcher noticed that much focus of the meetings was on coordination between municipalities and hospitals and patient pathways in terms of registering admittance and discharging to and from hospitals, and less on coordination and teamwork within the municipalities. This note also refers to future studies that will provide more evaluation of different aspects of the Learning network.

Interviews confirm many of the factors described by Deloitte (2016), also the present lack of evaluation studies of the Learning networks, yet the representative of the payer organization emphasizes the clear impression of an efficient and important programme (IP02_2). The same interviewee explains that the networks now will focus on identifying barriers and facilitators, e.g. management support, involvement of GPs and interaction with the specialist healthcare. Interviewed non-doctor medical staff and representative of payer organization emphasize the importance of dedication and that participation is entrenched at management level (e.g. IP01_2, IP02_2, IP04_2). Another interviewee (other stakeholder) says they work more systematically, that patients receive equal services independently of diagnose and staff, and that staff perceive more patients are discharged and take care of themselves (IP03_2). This and other interviewees (other stakeholder and non-doctor medical staff) explain how new patients more easily change their way of thinking than patients that have been in the system for a long time (IP03_2, IP05_2). A non-doctor medical staff refers to ongoing evaluation work where they look at how patients manage when they are given extra focus after being discharged from hospital and met with a patient pathway approach. Although this work is not finished yet, the clear impression is that this has positive consequences in terms of economy, user satisfaction and quality of life (IP04_2):

- *«As the years go by and the Coordination reform means more and more for our work we experience that people are insecure in the transitions [e.g. between hospital and home nursing*

care or short term stay in nursing home], that is patients and relatives, so having an interdisciplinary team that takes their time, then... We see that this is invaluable. We receive very good feedback on this. Quite simply. We take the heat off this period, we put things straight quickly. We do not experience that it takes 14 days before they get a wheeled walker, (...). We sit down with them, spend time. And this used to be a challenge, earlier it was very evident that one did not get started, one did not get past the first, insecure days and then one dragged this along for weeks and months. One is not able to create trust in the system, so to speak" (IP04_2, l. 183-192).

The same interviewee emphasizes how getting one primary contact person increases patient satisfaction (IP04_2). One interviewed doctor finds that patient pathways simplify many tasks, and that work now has a higher quality, although one does not really save much time (IP13_2):

- *«If there is a tool developed that you can start using quite directly this means that you are relieved of some tasks, and still one has to (...), one has to take responsibility for doing things and make sure that they are carried out and so on. Things still have to be done, but you save some time using a tool developed by others" (IP13_2, l. 82-92).*

One non-doctor medical staff suggests that it might be an advantage to wait for six rather than four weeks between the first and second PSFS conversation as some changes need more time (IP05_2). Other interviews confirm further important points in the report by Deloitte (2016), including the importance of municipal adjustment of check lists and dedicated enthusiasts, according to a non-doctor medical staff (IP14_2), or geographical proximity in the meaning of being able to build on already existing relations, according to the initiator of the programme and the manager of the programme (IP10_2, IP12_2).

One interesting reason why patient pathways are well received in the municipalities, as mentioned by the initiator of the programme, is that the Learning networks offer help to improve already existing services rather than introducing new tasks through a project which is difficult to transfer to the ordinary running of health services. Services must be carried out differently in the meaning of more systematic tasks, but this does not demand a reorganization of the service (IP10_2).

Although there are a few comprehensive evaluation reports, interviews provide information about more continuous evaluation in the form of meetings, for instance in work groups discussing how to adjust checklists, and this has resulted in improvements; according to one doctor (IP13_2). The initiator of the programme also informs that the Knowledge Centre for the Health Services receives much feedback from the municipalities suggesting that the Learning networks improve municipal health services (IP10_2).

In summary, our impression from documents and interviews is that systematic data collection and a comprehensive monitoring system are yet to be established. Interviewed professional in different positions, however, express positive views upon such evaluation and monitoring, and this will probably be helpful when introducing measures for quality assurance in the future.

4.7. Financing

The Learning networks are financed by the Ministry of Health and Care and KS (The Norwegian Association of Local and Regional Authorities) while the Knowledge Centre for the Health Services carry out most of the work. The networks have received quite modest economic support, especially the first years, according to the representative of the paying organization (IP02_2).

The municipalities, professionals and patients with multi-morbidity involved are not paid extra to participate, and it is the quality enhancement rather than economic profit which motivates participants. However, representative of the paying organization, as well as the initiator and manager of the programme argue that from the perspective of preventive action, municipalities may save costs and defer institutional care (IP02_2, IP10_2, IP12_2). Moreover, in the view of one non-doctor medical staff, the focus on functional ability rather than disease-based care makes it easier to terminate public assistance, and this may also reduce costs for the municipality (IP01_2). There is, however, no documentation of this so far, according to the manager (e.g. IP12_2).

The municipalities have extra costs associated with the networks gatherings, e.g. because they need to find temporary help in the care services while they are present at gatherings. In the view of the interviewed manager of the programme participants from the municipalities barely speak about this (IP12_2). Municipalities may, however, apply for compensation for travel costs. And doctors may be given “*praksiskompensasjon*” (IP12_2). This means that lost earnings are compensated based on an agreement between KS and the Norwegian Medical Association.

4.8. Implementation process

4.8.1. Historical information

Røsstad et al. have studied the development of integrated care pathways (2013) and their implementation process (2015). Røsstad et al. (2013, 2015) study what can be considered a precursor to the Learning network, and their studies were conducted 2009-2010 and 2011-2013 respectively. These articles thus provide information about integrated care pathways in general and not *the Learning network for whole, coordinated and safe pathways in the municipalities*, starting in 2013, in particular.

Røsstad et al. (2013) identify cultural differences between primary and specialist care as one important challenge in the development of integrated care pathways. One particular challenge was the different focus; on disease and diagnose in specialist care, on patients’ functional abilities in primary care (2013: 4). This resulted in different views on care pathways (2013: 5). However, a common care pathway for most diagnoses was developed. Røsstad et al. (2013) call for more research on outcomes of care pathways for patients.

Røsstad et al. (2015) find that reaching a shared understanding between involved professionals was difficult. It was challenging to teach primary care nurses to use the care pathways correctly, and “training in using and understanding the elements of the checklists” (2015: 6) seems to have been

important for subsequent degree of success. Røstad et al. (2015: 1) identified “involvement of the executive municipal management, strong managerial focus on creating engagement and commitment among all professional groups, practical facilitation of work processes, and a stable organization without major competing priorities” as further crucial issues to secure effective implementation.

The change of thinking towards common pathways for patients with chronic co-morbid conditions and promotion builds on research and previous development work on patient centred care pathways in hospitals, municipalities and patient organizations in Central Norway (Røstad et.al. 2013; 2015). Importantly the authors noted that: “in the literature care pathways based on a single medical condition are also found to be unsuitable for this patient group. This is because disease-based care pathways are founded in studies that largely exclude patients with co-morbid conditions” (op.cit, p. 7). Moreover, the authors identified important cultural differences between specialist care and primary care for patients with home care needs, which needed to be overcome in order to build a common care pathway. The table below sums up their findings of cultural differences:

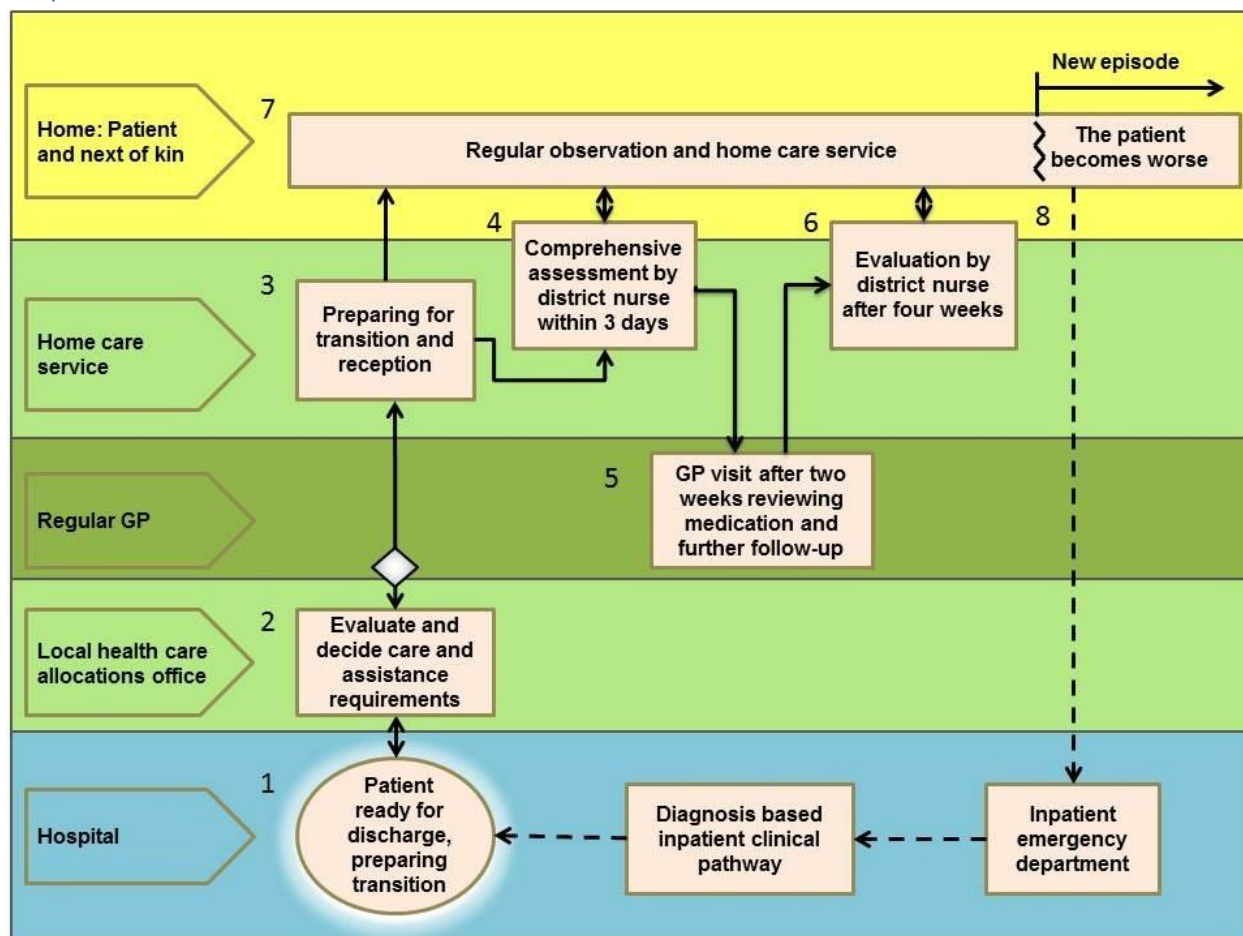
Table 4.3.1. Cultural differences found between specialist care and primary care for patients with home care needs

Activity	Specialist care	Primary care
Planning	Short perspective – major changes in a short time	Long perspective – small changes over time
Assessment	Diagnosis with advanced technology	Functional ability, patient preferences and degree of self-management
Diseases	Attention to one disease at a time	Simultaneous attention to all of the diseases patients have: a majority of patients have multiple diseases
Clinical guidelines	Strong adherence to clinical guidelines	Clinical guidelines for multi-morbidity hardly exist
Patient role	Passive; health personnel decide what has to be done	At home the patient decides; focus is on resuming daily activities
Decision making	Often in teams, many involved, and in a confirmed hierarchical structure	Often by health personnel alone or by few; more autonomous

Source: Røstad et.al 2013, Table 4, p. 7.

The development process within the participating health professional groups and administration (hospital nurses, district nurses in home care services, health and social administration of primary care; hospital/regional health administration, occupational therapists, GPs) and Patient organizations moved in favour of a generic pathway (**Patient Trajectory for Home dwelling elders – PaTH** (“*Helhetlig pasientforløp i hjemmet*”, HPH), in Norwegian, also known as the Orkdal model (which is also called for Grimsmo model, after the project manager of the development project) (KS and Kunnskapssenteret, Nasjonalt kunnskapssenter for helsetjenesten, 2015b). The patient pathway is described in the following figure and adhering legend:

Figure 4.8.1. Generic care pathway (PaTH), for transition from hospital and follow-up of home care recipients



Source: Røstad et.al. 2013, Figure 1, p. 6, Figure heading and text below figure refers to Røstad et.al. 2015, p. 2.

“The boxes represent procedures and checklists and the arrows the flow of information between involved parties. It starts with the patient being reported ready for discharge and information is exchanged (1, 2 and 3). Within three days a home care nurse performs a thorough and structured assessment (4). The patient has a consultation with the GP 14 days after discharge (5), and a nurse or nursing assistant performs an extended assessment during the first four weeks (6). A daily care plan is continuously updated (7), and if the patient’s condition gets worse, the home care service has a routine for what to observe, whom to contact and which information to pass on (8). The checklists included practical issues (e.g. whether assistive devices had been ordered and when they would be installed), health issues (e.g. review of medication), social conditions (e.g. if the present accommodation was appropriate for the patients’ level of functioning) and physical and cognitive functioning (e.g. ability to climb stairs, reduced memory). Some checklists were to be used by nurses only (3 and 4), while others were also to be used by nursing assistants (6 and 8). All of the issues on the lists were not necessarily

relevant for all patients and the nurses and nursing assistants had to use their professional insight to decide what to assess and how to follow-up”.

The above mentioned research and development process in terms of patient pathways served as inspiration for the programme development of the Learning network (KS and Kunnskapssenteret, Nasjonalt kunnskapssenter for helsetjenesten, 2015b, IP10_2). Grimsmo also contributed actively by counselling and giving advice at the Learning network meetings (cf. Fig. 4.3.1.). Several stakeholders were involved in the development and implementation process, including the Knowledge Centre for the Health Services, KS, the Norwegian Directorate of Health, important trade organizations and the Norwegian Medical Association. One interviewee explains how important it was that such central stakeholders participated in a study trip to learn more about the Grimsmo model, and how this resulted in a shared understanding that going for patient pathways would be a good strategy (IP10_2). The Learning network started up a corps of instructors based on the KS regions in cooperation with the Knowledge centre. Important in terms of **financial barriers**, was that capacity was limited because of allocated resources for the effort (op.cit). Whereas the Learning network originally was planned for 3-5 Learning networks with approximately 100 participating municipalities, this was eventually reduced to 2 networks and 49 municipalities (KS and Kunnskapssenteret, Nasjonalt kunnskapssenter for helsetjenesten, 2014). This has probably led to a stronger emphasis on building and extending local networks, departing from those municipalities and hospitals that naturally work together on a daily basis and have reciprocal obligations made through cooperation agreements. These will have the possibility of receiving advice and instructions from KS regional offices. Another possibility is to let persons from the initial improvement teams of the participating municipalities contribute with their experiences towards newly entered local teams, with building of networks and sharing of experiences on an extended time basis, and connected to natural and vigorous structures (KS and Kunnskapssenteret, Nasjonalt kunnskapssenter for helsetjenesten, 2015b). According to the interviewed manager of the programme one important reason for focusing on elderly patients with multi-morbidity was research documenting that this group of patients received insufficient attention and that the potential for preventive action was large (IP12_2).

4.8.2. Present information

The Ministry of Health and Care, the Norwegian Directorate of Health, the Knowledge Centre for the Health Services²⁷, and KS are key **stakeholders** and cooperate on **implementing** the national Learning networks for developing good patient pathways for persons with chronic illnesses/elderly patients. In terms of services the Learning networks aims at including municipal health and care services, but also specialist health services are invited to participate (KS, 2014: 3). The **main goal** of the programme is to develop whole patient pathways in the municipalities. Additional goals include: development of and application of methods and tools (including cooperation agreements) for use in municipality work on

²⁷ The centre was established in 2014 and since 1.1.2016 it was incorporated in the Norwegian Institute of Public Health. The centre contributes to quality improvement in the health services by summarising research, promoting the use of research results, measuring the quality of health services, and working to improve patient safety (Kunnskapssenteret. Nasjonalt kunnskapssenter for helsetjenesten, 2016).

whole patient pathways; reducing “unnecessary” hospitalization (and readmissions) for chronically ill and elderly patients; strengthen the users’ experience of coping; strengthen the users’ role in improving user/patient pathways; strengthen competence on improvement of leaders and coworkers (op.cit). In terms of **preparation** and **organization** of the national Learning networks, the networks are rooted in the wider Quality Agreement (*Kvalitetsavtalen*) between the government and the KS, and are one of several important areas of cooperation the ministries and the KS are working together. The origin of the Learning network in an already established Quality Agreement and involving key stakeholders within health and care policy thus mustered strong **political commitment** for the initiative. Moreover, as noted above, by addressing a central policy tool of the coordination reform, e.g. good and safe patient pathways, there was also national government support and involvement for the Learning network. The Learning network still enjoys a high level of political support. This is confirmed in the recent white paper on future primary and healthcare services²⁸; the Government states that they will continue the Learning network for whole, coordinated and safe pathways for elderly and chronically ill (Meld. St. 26, 2014-2015: p.82), in line with the view of the representative of the payer organization (IP02_2). The manager of the programme is for instance very pleased with how the current Minister of Health promotes the “what matters to you” approach of the Learning network (IP12_2). However, in addition to the above facilitators, a successful implementation of the programme rests fundamentally on local level (e.g. municipal health and care) commitment, including **political support** from municipal local governments.

As seen from figure 4.1.1, there is in principle no ending of the learnings network as continuing improvement are seen as a permanently ongoing process and the idea is also to diffuse the processes and content to a wider group of municipalities.

Cultural change is seen as one of two central measures in order to develop good patient pathways in the municipalities: The essence of this cultural change is to move the attention away from asking: “What is the matter with you?” towards asking: “What matters to you?” It represents a change from a focus on diagnoses of illness towards the whole person, their goals and activities.

The change from problem orientation to goal orientation implies to emphasize functional ability and the patient’s preferences, to assess feasibility and the treatment burden for the patient and their relatives, within primary care to departure from what is common to patients with chronic illness, e.g. independent of particular diagnoses.

4.8.3. Future implementation/development

Covered in 4.1.-4.7 of the report.

²⁸ An English summary of the Report to the Storting (white paper) is available (Norwegian Ministry of Health and Care Services, 2014-2015).

4.9. Discussion

4.9.1 General discussion

KS has initiated and conducted two Learning networks for developing good patient pathways in the municipalities for persons with chronic illnesses/elderly patients. Our study covers both Learning networks by including three municipalities across these networks.

The Learning networks introduce a new approach of whole patient pathways in the municipalities. The patient pathways represent a more systematic way of working with existing tasks and encourage stronger interaction between involved professions than existing procedures. The “What matters to you?” approach moves the focus of patients and health workers from diagnoses and disease-based care to functional ability and patient goals and preferences. The programme has not been developed exclusively to improve care for patients with multi-morbidity, but the person centred care provided within the programme is expected to be particularly beneficial for this group of patients.

For the purpose of this study we have conducted 14 interviews in June-July 2016. Interviewees include the initiator of the programme, a representative of the paying organization, a manager of the programme, two patients, one informal caregiver, three physicians and four non-medical professionals, and one other stakeholder. We recruited the patients through municipalities in a two-step process. A representative of the municipality first asked whether the patient accepted that we were given their contact information. We then invited these patients to participate. Our first priority was to conduct interviews face to face, and all interviews with patients and the informal caregiver were conducted this way. However, it proved difficult to set up interviews in a way that could fit the schedule of all informants. This was further complicated by the fact that our informants do not necessarily live in geographical proximity, implying substantial travelling distances and time. Six interviews were thus conducted as telephone (4) or video (2) interviews. One interviewee supplemented the interview with some further comments per email and one interviewee provided us with additional written information afterwards.

One general impression from the interviews is that not all interviewees necessarily are well informed about the concept of the Learning network or consider themselves to participate actively in the network. Still, in describing their work and experiences they reveal that they often work very much according to the procedures and principles of the patient pathway approach. This could illustrate several things. First, much of what is done within the patient pathway approach is, as initiators and organizers openly acknowledge, not completely new, although it represents a more systematic way of working. Secondly, it may suggest that procedures and principles of the patient pathway approach have become so strongly integrated in the everyday life that one is no longer aware of changes. We cannot say what interpretation is most correct, but if the latter interpretation is the case then it is a strong indication of success.

4.9.2. Discussion of the programme in the context of the conceptual framework

The following elements of the six segments in the Selfie-framework are important for the Learning networks for whole, coordinated and safe pathways in the municipalities.

Service delivery

The idea of person-centred care is at the very core of the service delivery of the Learning networks. The most prominent expression of this is the use of the “What matters to you?” scheme (PSFS scheme). This is used to assess patients’ functional ability at two different stages; initially when enrolled in home nursing care or short term stay in nursing (eventually after discharge from hospital), and then again after approximately four weeks. Activities and goals are set by the patient, not the care worker. The PSFS scheme is obviously a very important self-management intervention at the micro level as well. A second key tool is the checklist, which is adjusted to local relations in the municipalities, and that secures that all patients receive the same services. This promotes coordinated services for patients with multi-morbidity and improves procedures for instance for managing polypharmacy. At the meso level, the pathway approach results in more effective interdisciplinary interaction and a stronger focus on quality assurance. In particular, GPs play a more important role within the pathway approach.

Leadership and governance

So far the Learning networks have been evaluated to a limited degree. A report by Deloitte (2016), however, identifies management support, management involvement, and that the municipality’s participation is entrenched both at the management level and in the organization more generally as important for the success of Learning networks. Several of our interviewees emphasize the importance of management support as well. As there are few financial incentives for participation, the Learning networks depend on being able to persuade municipalities that the pathway approach is favourable for them. Interviewees describe the level of political commitment as very good, providing good pacing for the Learning networks.

Workforce

One important aspect of workforce at the micro level is the local municipal multi-disciplinary primary healthcare improvement teams. Their composition of different competence increases the level of interdisciplinary interaction. The new patterns of interaction and the new focus for some professional groups on functional ability rather than disease and impairment represent a culture change for the workforce within the pathway approach. Particularly, the relationship and collaboration between GPs and other municipal healthcare workers is improved, something one would expect that would be beneficial for the patient. While some professions were familiar with the PSFS-thinking this represents a completely new approach to other professions, thus being described above as a culture change. Training

in using the new approach differs between the municipalities covered in our study, but it is interesting to see that at least in one municipality it has resulted in more systematic training in general within the healthcare sector.

Technologies and medical products

Participation in the Learning networks for whole, coordinated and safe pathways in the municipalities does not involve any programme specific new technologies or medical products. Neither do Learning networks aim at technological innovation at the macro level. Some municipalities have, however, as a consequence of the pathway approach, introduced electronic white boards showing the status for all involved patients. Being exposed to this white board everyday has proved to have a strong consciousness-raising function, helping nurses and other healthcare workers secure that all patients receive the same attention and services. This may be considered a shared-information system at the meso level. In this respect it is fair to say that ICT applications promote continuity, comprehensiveness and coordination of care for persons with multi-morbidity.

Information and research/monitoring

The Learning networks have currently not developed a strong system for evaluating and monitoring ongoing activities. However, we notice a great interest among our interviewees in measuring potential impact. We may expect that this will be given priority in the time to come. As such, our study does not reveal resistance towards such research. To the contrary, actors in the Learning networks are positive towards the current research and evaluation initiatives. This goes both for actors at the local (municipal) and central level.

Financing

As far as we have been able to clarify in our analysis of documents and interviews, participation in the Learning networks does not give access to new financial resources of significance, although some expenses associated with participation may be covered. Quality enhancement is thus a much more important incentive to participate than financial resources. Still, in a longer perspective the municipalities and society at large may save costs for institutional care or hospitalisation. Also, the move from problem orientation to goal orientation sometimes results in termination of public assistance, which obviously reduces costs for the municipality.

5. References

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6. Appendix

6.1. Information on interview partners, programme 1

Table 6.1.1 provides an overview of interviewees according to the different stakeholder groups to which they belong:

Table 6.1.1. Overview of interviews with MAR Bergen stakeholders

Interview number	partner	Stakeholder	Interview date
IP01_1		Initiator of the programme	10.05.2016
IP02_1		Other stakeholder	11.05.2016
IP03_1		Non-doctor medical staff 1	12.05.2016
IP04_1		Representative of sponsor/payer organization	23.05.2016
IP05_1		Patient 1	24.05.2016
IP06_1		Informal caregiver	26.05.2016
IP07_1		Doctor	26.05.2016
IP08_1		Non-doctor medical staff 2	30.05.2016
IP09_1		Non-doctor medical staff 3	02.06.2016
IP10_1		Manager of the programme	21.06.2016
IP11_1		Patient 2	08.09.2016

6.2. Information on interview partners, programme 2

Table 6.2.1 provides an overview of interviewees according to the different stakeholder groups to which they belong:

Table 6.2.1. Overview of interviews with Learning network stakeholders

Interview number	partner	Stakeholder	Interview date
IP01_2		Non-doctor medical staff 1	21.06.2016
IP02_2		Representative of the sponsor/paying organization	24.06.2016
IP03_2		Other stakeholders	27.06.2016
IP04_2		Non-doctor medical staff 2	27.06.2016
IP05_2		Non-doctor medical staff 3	27.06.2016
IP06_2		Doctor 1	27.06.2016
IP07_2		Patient 1	27.06.2016
IP08_2		Informal caregiver	27.06.2016
IP09_2		Patient 2	28.06.2016
IP10_2		Initiator of the programme	28.06.2016
IP11_2		Doctor 2	29.06.2016
IP12_2		Manager of the programme	29.06.2016
IP13_2		Doctor 3	01.07.2016
IP14_2		Non-doctor medical staff 4	06.07.2016

6.3. Quotations included in the original language for programme 1

- «...det er nesten mer regel enn unntak at de har både somatisk psykiatrisk og ruslidelser og kanskje også til og med grader av kognitiv svikt og de er mer eller mindre bostedsløse, nær sagt sant, eller en stor andel i hvert fall og sosial nød og økonomisk dårlig stilt og hele pakken.» [IP01_1, lines (l.) 212-215]
- «flest mulig lengst mulig, men flest mulig fordi at vi aktivt ønsker å ha inn flest mulig i målgruppen i LAR, for vi vet at bare det har en rekke positive effekter for de og vi bidrar til å knekke heroinmarkedet samtidig og lengst mulig, for det at i henhold til LAR-forskrifter og på alle måter så ønsker vi å få de så langt som mulig i en rehabiliteringsprosess.» (IP01_1, l. 291-295).
- «...dette er en brukergruppe, hvis vi skal generalisere litt da, de er jo veldig ulike disse pasientene, men hvis jeg skal generalisere de, så er det jo en gruppe som er vant til å bli mistrodd, sant, de opplever veldig lite tillit rundt om, de går ut på... de går på sentrene og på butikken og vekterne følger etter de uansett, sant, altså det er helt, ja, bussjåføren følger med, de opplever at folk går over på andre siden av gaten, når de kommer, sant, og dette er jo det generelle, familien selvfølgelig, de har sviktet og sviktet og sviktet og sviktet og brent veldig mange broer, så det å møte et system som sier jeg har tro på deg, jeg tror, jeg vet det er vanskelig for deg, for du er vant til å bryte, du er vant til at ting ikke går sånn som de skulle gått, men det å møte systemet, jeg tror på deg, sant, jeg tror på deg uansett og jeg gir deg den tilliten gang på gang, uten at det går utover det forsvarlige selvfølgelig, men jeg gir meg ikke, det er der jeg har lyst at vi skal være..» (IP08_1, l. 336-346).
- «Men min tanke har på en måte vært at du må, hva skal jeg si, du må få på plass de grunnleggende før du går videre, på sett og vis, altså du... for mange så vil opiatavhengigheten eller søking på heroin egentlig være det som overskygger alt, altså det overstyrer alle andre behov, så hvis du får den på plass, så må du få bolig på plass, også må du få økonomi på plass og så kan du begynne å plukke i...» (IP03_1, l. 140-144).
- “Og så kanskje det er fokuset på rusfrihet sant... er ofte litt stort, kanskje vi skal sørge for at de skal få mat i seg, kanskje vi skal begynne med det, hvordan få bæring, hvordan... ja, det er litt sånn gode gamle Maslow, vi begynner ofte litt høyt i den stigen der...” (IP08_1, l. 330-333).
- «Og alle de funksjonene som jeg nå har beskrevet, gjør de i dag også, de har alle disse funksjonene, men i tillegg har de da selve medikamenthåndteringen der ute, overvåke inntakene av LAR-legemiddel selv, istedenfor at det er noen andre som gjør det, altså nå gjør vi det selv ‘on site’, så å si ... så vi har den tettheten og ... bestilling, klargjøring,... og selvfølgelig er jo de nå ansikt til ansikt møter med de, så nå er det jo direkte en til en oppfølging, ganske intenst, med en ganske dårlig fungerende gruppe pasienter i år etter år nær sagt...» (IP01_1, l. 492-495, l.498, l.500-503).
- «Ofte er det sånn at spesialrådgiverne, de er i dialog med pasienten, og hvis det er veldig spesielle ting som lege skal vurdere, så avtaler de med pasienten at for eksempel én gang i uken så er lege der eller to dager i uken. Da avtaler de, så vi har på en måte en time med legen. Så tar vi en samtale og vurdering. Det kan være medikamentelle vurderinger, doseendringer, medikamentbytte, ja.. eller kan være somatiske ting de vil ta opp med oss, det er ikke sånn at vi har kapasitet til å ha polikliniske timer for alle pasienter slik at de skal opp og så kommer de på en måte en dag og kjører gjennom listen, det er ikke sånn og ofte så blir det litt sånn akutte ting som oppstår. Altså en pasient som vi

føler er ruspåvirket, kan være i fare for overdose, da må vi prioritere det. I forhold til hvilken dose pasientene skal ha eller det kan oppstå akutte ting, det skjer hele tiden, de kan få infeksjon plutselig og så må du vurdere, psykotiske utbrudd (IP07_1, l. 157-167).

- « Altså her kommer du til noe nytt. Før var det i det ikke noe lege til stede på poliklinikkene. Så vi har ikke så lang erfaring med det. Det er sånn i varierende grad. Noen pasienter er ikke vant til å møte lege på poliklinikker. De er vant til å komme og hente medisin og gå. Nå har vi opprettet disse poliklinikkene, det blir ca. Det blir to år i november, da. Så jeg tror at pasientene, det er veldig sånn omstilling for pasientene også. Litt nytt for pasientene også. Men nå føler jeg at, nå har jeg vært litt vekke fra poliklinikkene, men føler at de legene som jobbet der, det er blitt bedre kontakt mellom pasientene og leger. Før var det sånn at når vi opprettet disse poliklinikkene så husker jeg at jeg møtte gå rundt og sitte i stuen sammen med pasientene for å vise at det er en lege her som dere kan komme og snakke med, hvis det er noe. Vi var på en måte litt sånn, de skjønnte ikke at man kunne gå til legen. Nå tror jeg det har blitt sånn at de har skjønnt, og de benytter legene på en måte og vi har fått veldig flinke LIS leger og de er veldig opptatt av å finne ut hva pasientene trenger og de skal på en måte ta tak i.. er det leverproblemer, er det infeksjon, er det kols. Så jeg tror at pasient/lege-relasjonen har blitt bedre. Både legene og pasientene forstår hvordan de skal jobbe sammen» (IP07_1, l. 231-245).
- «Men tidligere var det litt på avstand, lege/pasient-relasjonen, så var det oftest slik at.. LAR er veldig mye kontroll, så er det legen som bestemmer hvilken medisin pasientene skal ha.. er det noen rusmidler i urinen ... så sanksjonerer vi, og i forhold til hente-ordning. Så det var tidligere så var det litt sånn ikke så grei relasjon mellom pasientene og.. fordi at de følte litt sånn at det at de har blitt straffet av legene. Men altså, jeg tror at det var verre når man var på avstand, men nå er det på en måte, legene er tilstede der, og så er det blitt en direkte dialog med pasientene, det er lettere for pasientene å forstå at vi gjøre dette for å hjelpe de, ikke for å straffe de. Jeg tror det er en bedre relasjon, og de skjønner hvorfor vi gjør det vi gjør, vi kontrollerer og tar urinprøver, vi strammer og vi ja.. vi på en måte gjør ulike tiltak for å gi dem en forsvarlig behandling» (IP07_1, l. 249-260).
- «hvis du ser på de opiatavhengighetskriteriene, så er jo på en måte en av kriteriene at opiatavhengigheten overskygger for eksempel evne til å ta gode helsevalg eller gode beslutninger, altså du overstyrer alt annet, sånn at på den måten, så kan du si at inngangskriteriet her er jo egentlig at du har ikke kontroll over livet ditt, du har ikke selvbestemmelses rett, egentlig» (IP03_1, l. 217-221),
- « å jobbe med adferd som er en helt sånn basic rehabilitering og vi er ganske tydelig med pasienten på hva vi gjør når vi gjør det, jeg korrigerer aldri adferd uten om å si hvorfor jeg gjør det og bakgrunnen for det, for det er jo noe av det som man er nødt til å ha en kompetanse om, for å jobbe med vår pasientgruppe er at det må jo forstå hvorfor vi tenker som vi gjør, også er det jo deres valg, det er klart at det er helt opp til pasienten om han vil gå å slå ned en utenfor gaten, ikke det at det hadde vært greit, det er ikke det jeg mener, men han er ansvarlig for sine valg, og så skal vi bidra og legge til rette for at han skal ha muligheten til å gjøre noen gode valg, men det skal ikke være et godt valg for meg, det skal være et godt valg for pasienten, eller så har det ingen hensikt, han skal ikke velge for min del, det hjelper ikke, det er ikke noe de blir stående i og det er ikke noe de klarer å gjennomføre, hvis de gjør ting for behandleren sin del, også er det klart at det er nok noen pasienter

som opplever at vi behandler de på tvers av deres ønsker, og der er jo igjen det med den faglige forsvarligheten og ansvaret for tredje part som vi og veldig, veldig tydelig har, i retningslinjen vår, sant, vi kan ikke gi med pasienten en ukes forbruk av metadon fordi at han ikke tenker at det er greit å komme i poliklinikken, for det gidder han ikke eller det orker han ikke, eller han blir møtt med noen utfordringer om rusmestring», (IP09_1, l. 286-302).

- «den mest kunnskapsbaserte, evidensbaserte behandlingsmetoden innenfor rus, det er det vi kaller for motiverende intervju og motiverende intervju er egentlig hovedmålsetning og verktøy, det er å jobbe med pasientenes egne motivasjon og målsetning og forventning, på en måte, og ansvarliggjøring av pasienten selv, i forhold til hva ønsker du, på et vis, sant, ja. Så det er noe med selve måten å jobbe motiverende intervju på, er ansvarliggjøring av pasienten, ja, så jeg synes rusfeltet nesten gjør dette mer systematisk enn hva jeg er vant til, psykisk helsevern, så det var litt morsomt, ja, og i tillegg så har jo rusfeltet veldig mye fokus på sånn type, holdt på å si trening og musikk og livskvalitet og få innhold i hverdagen. Og det har jo psykisk helse akkurat oppdaget nå, også har de tatt patent på det holdt jeg på å si, mens man har holdt på med det i rus i tretti år, det er litt artig å se da. Og det er jo det pasientene ønsker, sant, hvis du spør folk i erfaringspanelet for eksempel, sant, hva er det egentlig som var viktig, så var det ikke nødvendigvis å behandle akkurat det og det symptomet, det var faktisk å få hjelp til å få en verdifull hverdag, så det er mer på pasientens premisser da, linket til å tenke ansvarliggjøring, hos pasientene (IP10_1, l. 333-347).
- «Bolig, det er, ja, de som ikke har bolig, de klarer seg ikke, altså, de dårligste av våre pasienter er bostedsløse eller bor i veldig dårlig botiltak, type hospits, ja, utrygge og, jeg tenker det er, bolig er alfa omega for videre rehabilitering, vi kan sende de og det har vi jo sett mange eksempler på, pasienter som har vært i langtidsbehandling, før når vi var i kommunen sant, var i langtidsbehandling og kom tilbake, de hadde lagt på seg, de hadde, altså virkelig så ser man en helt annen person som kom tilbake, også kommer de på hospits, så går det to måneder så er det helt, altså behandlingen i seg selv har ikke vært bortkastet, for det at pasienten har kjent på det å kunne ha et annet liv uten rus, men nederlaget og igjen, en ny rekke med masse tap sant, masse brutte illusjoner om tanker om rusfrihet som blir brutt for det at de går på en ny smell for de har ingen bolig, de kommer i akkurat det samme nettverket der» (IP09_1, l. 520-530).
- «det er jo sikkert at spesialisthelsetjenesten ser pasienten mer enn man gjorde før, og det er bra, men det har og et minus, for jeg tror ikke man er flink nok til å koble på kommunen, før var det kommunen som møtte de på utdelingsstedet og som ja, lettere er at da kanskje, at kontaktet NAV, sant, de ringte til avdeling for rusmedisiner, Bergensklubben i sin tid, til å spørre om "skal han få med seg medisin, skal han få ikke med seg medisin, han vil ha økt dose" sant, da måtte de... det leddet er du kvitt og det kan være bra, men det kan og være et minus, tenker jeg, fordi at nå er det de andre... du må ikke glemme å koble på de andre da, for kommunen er ansvarlig for bosetting, for oppfølging, for tiltak, for aktivitet, for økonomi, sant «(IP02_01, l. 280-281, l. 292-298).
- «Det som viser seg, det er vel at disse pasienten har forkortet levetid, systematisk, det indikerer at vi er for lite opptatt av det somatiske behovet, for denne pasientgruppen, nå er jeg litt usikker på om det har blitt forsket på LAR ruspasienten med det som perspektiv, men det har i alle fall blitt forsket på psykiatriske pasienter og livslengde, systematisk kortere levetid, det kan mest sannsynlig indikere

det at det somatiske perspektiv på pasienten er for svakt, så vi akter jo å se ting tettere, også på ruspsykiatrilaterte lidelser som vi finner i somatikken» (IP04_1, l. 140-146).

- «det her er jo en krevende pasientgruppe, mange av de er jo forferdelig slitsomme å ha med å gjøre og veldig patologiske og de fra, altså de som kom fra kommunen, de har jo jobbet tett på de, de ser de daglig i årevis og jeg tenker i det, så ligger det en enorm sånn relasjonell kompetanse, altså både sånn sykepleierfaglig men også mer sånn sosialfaglig inngang på en del ting, som jeg tenker egentlig er ganske unik, altså jeg tror ikke det er så mange som hadde orket å stå mange, mange år i den der jobben, så tett på, på en måte, og så har de en mer sånn... siden de har en veldig mye tettere inngang på de, sånn, så har de også en veldig stor kunnskap om, altså, miljøet og litt mer den, hva skal jeg si, ruskulturen er en egen kultur på mange måter, det er en litt sånn subkultur på flere plan, sant, så der har de dradd inn mye, også har de reell kjennskap til hver enkel pasient som jeg tenker er god» (IP03_1, l. 351-361).
- “journalføring og taksting, vi journalførte jo ikke før nesten ... Så nå, det er en kjempe forskjell nå, der vi virkelig tar lovgivningen på alvor og journalfører sånn som vi skal, for all del, og at vi må takste og få inntekter for å, skal vi få flere stillinger så må vi faktisk jobbe mer og takste mer og få inntekt, så den økonomitankegangen oppi det er mye sterkere, så, og det er nok det de synes kanskje er det tøffeste, ja, den dokumentasjonsbiten og... tar veldig mye tid, vi har jo mange pasienter innom» (IP08_1, l. 219-220, l. 224-229).
- «det er bra at vi har bevegelse i den retningen man har beveget seg og gitt flere behandling, men samtidig så tenker jeg at enn må ikke organisere verken tjenestene på spesialisttjenestenivå eller på kommunalt nivå på en slik måte at man, holdt jeg på å si, sementerer elendighet, sant, jeg tenker at selv om, ja, man ikke kan skrive de ut av behandling på grunn av at du røyker hasj eller du bruker amfetamin eller du spiser piller, så er det noe med at likevel behandlingstilnærming og filosofi, sant, altså litt sånn enkel oppdragende effekt, altså hvis noen ikke stiller krav til oss, fortsetter vi bare å gjøre som vi har gjort, men hvis man, ja, faktisk gir de litt, kanskje litt mer strengere rammer enn det man har praksis per i dag, så tror jeg også at du kan lettere få bevegelse i brukergruppen, noen vil være på lavterskel alltid, men de skal likevel bli informert å orientert om mulighetene og også bli jobbet med på en måte som gjør at de kan se muligheten for endring da. Så der tenker jeg at... man er ikke helt der i dag» (IP02_1, l. 132-144).
- «... akkurat en pasient vi snakket med seinest hin dagen som er blitt rusfri og klarer seg egentlig bra rusfri som sier det at “det er så vanskelig å komme i poliklinikken, for det er så mange som gi meg tilbake alt det stoffet de skylder meg” (IP09, l. 530-533).
- «det er jo ikke så systematisk, det blir jo evaluering da, i møte med førstelinjen, vi har... det er ganske mye møtevirkosomhet på et mer sånn overordnet nivå da, sant, med kommunen, som på en måte er en slags kontinuerlig evaluering sant, hvor trykker skoen og hva skal vi gjøre med det?» (IP10_1, l. 544-547).
- «... og få poliklinikk takst, ikke bare for å få taksten da, men med å integrere utdelingsaktiviteten med rehabiliteringsdelen, så var det vel enkelte hos oss som mente på et tidspunkt at kanskje kunne vi ta poliklinikk takst på alle utdelingene, det mente vi fra ledelsen at var å trekke takstsystemet vel langt, for du kan ikke... hvis du har utdeling seks ganger i uken til en person, så kan du ikke kjøre seks poliklinikk takster, for vi betviler at du da driver med rehabiliteringsaktivitet hver gang, altså en

medisinsk, type oppfølging da, som er poliklinikk, så da gikk vi inn på, vi sa at, du maks hver fjerde eller femte utdeling, kan ha et rehabiliterende element, sa vi fra ledelsen og at budsjettet måtte legges på det nivået og at registreringspraksisen måtte innlegges seg i forhold til det» (IP04_1, l. 82-92).

- «finansieringsnøkler og modeller, de er veldig kraftfulle hvis de er skrudd sammen på feil måte,..., men det er heller ikke sånn at finansieringsmodellen greier å løse alle utfordringene våre, fordi at virksomheten vi holder på med er så kompleks, vi klarer ikke å lage et perfekt insentivsystem,..., derfor må vi snakke om overordnede målsetninger, snakke om verdier, vi må snakke om pasienten og vi må løfte opp hva som er viktigst» (IP04_1, l. 211-217).
- «da må vi si ««kom an folkens, dette er veldig ulønnsomt, men det er veldig viktig, kjør på»» så må vi flytte økonomi på sykehusnivå, .., så hvis LAR er viktig for oss, la oss si det er tusen stykker som skal inn i LAR, .. og vi mener at det er volumene vi skal nå, så må vi lete i alle krokene for å få finne nok økonomi å putte inn i avdeling for rusmedisin, så det har vi holdt på med fra 2009, det å flytte rammebevilgningen inn i avdeling for rusmedisin og så etterspør aktiviteten,.. så nå har jo rusmedisin dreiet en del fra inneliggende til poliklinikk for å greie å håndtere pasientgruppene sine, knyttet opp til en filosofi om at det er bra å behandle de i nærområde, også på et tilpasset kostnadsnivå, de inneliggende, døgnplasser, det er kostbart, gir det effekten, det blir spørsmålet, gir det effekten, hvis det ikke gir effekten, da må vi finne på noe annet» (IP04_1, l. 233-247).
- «..., veldig forenklet fortalt, at der man tidligere, for å få bli i LAR, så måtte man ha god rusmestring, og man kunne bli skrevet ut av LAR hvis man ikke fulgte behandlingsopplegget som man ønsket det, innenfor en viss rimelighet eller hva vi skal kalle det. Det ble endret, man skulle ikke skrive pasienter ut av LAR, fordi at vi hadde forskning om at det gikk dårlig med de, overdose og i det hele tatt. Så det var det ene og det andre var at de på en måte senket inntakskriteriene for å komme inn i LAR, gjennom LAR-forskriftene 2010, det absolutte kriteriet er fortsatt til stede og heldigvis for det nært sagt, at det skal foreligge opioidavhengighet etter diagnostiske kriterier for det, så det foreligger, men det er også fra 2010 det eneste absolutte kriteriet, der det før var også sånne tilleggskriterier om at du skulle prøvd... måtte ha prøvd behandling av annen type i forkant og du måtte være over 25 år, altså sånne der kriterier og forskjellig, de forsvant, så nå er det løsere formulert i den forskriften om at, ja, du skal hensynta særlig om, altså, hvis ung alder vær særlig forsiktig også videre og det skal som regel ikke være førstevalg og... men etter en helhetsvurdering kan det også, altså, skjønnet, det er åpent for et helt annet bruk av skjønn, som jeg også støtter veldig da. Men i sum, så gjorde jo dette, altså litt forenklet formulert igjen, så var det flere som kom inn og færre som gikk ut» (IP01_1, l. 80-96).
- «... deler av årsaken til det er jo de gamle retningslinjene der man skrev pasienter ut av LAR, til det illegale heroinmarkedet igjen, så vi vedlikeholdt aktivt et marked for... og dermed nyrekruttering. Sånn at med Helgevolds sin forskning fra disse europeiske byene, sant, som handlingsplanen i Bergen mot åpne russcener baserer seg på, så kom det jo også en kunnskap om forskningsbasert, om hva en målrettet innsats, selvfølgelig koordinert innsats sånn som handlingsplanen er, også i Bergen, men også dette med å gripe inn i opioidmarkedet rett og slett, sant, det var jo en vesentlig del av det som skjedde i disse europeiske byene. Og det var jo det vi også basert vår tenkning på da, når vi da satset videre med å skulle inkludere flest mulig i LAR og jeg har også oversendt nå, i hvert

fall til xxx, de der sirklene våre som sier noe om strategien vår for å inkludere flest mulig opioidavhengige, for nettopp å ta bunnen så mye som mulig ut av det illegale opioidmarkedet og særlig heroinn da, som fører til overdoser og sånn, og det uten å foregripe noe, men vi ser jo noen tegn til at vi... at noen positiv utvikling da, der man de senere månedene... politiet rapporterer om at der såkalt herointørke i Bergen» (IP01_1, l. 100-114).

- «...og det vi har sett, når vi nå har fått økende kontakt med de, det skal jeg si litt mer om, det er jo at det har vært mye uansvarlig behandling, både på kontroll og lekkasjeprosjektet har mye vært der, det vet vi jo gjerne fra politiet, sant, som melder til oss, vi ser at dette er jo helt uansvarlig, så må vi stramme inn og, ja, men i så fall så var det 350 til 400 såkalte LAR-X pasienter som vi ikke har kapasitet til å håndtere og vi visste at dette var en lekkasjekilde, stor. Det var mange pasienter som ikke fikk god nok oppfølging, mange, jeg vil understreke at mange fastleger gjør en strålende jobb, men en del fastleger kan ikke nok om dette og i mange tilfeller, så blir også, hva skal jeg si, problematikken til pasientene så sammensatt og komplisert at det er helt urealistisk å forvente av fastleger å skulle egentlig håndtere det ansvaret, det er min vurdering i hvert fall. Sånn at tanken jeg hadde den gang da, var jo at når dette smalt inn og jeg hadde disse faktorene opp og det var lekkasjeprosjektet, sant, det var på forsiden av BT med metadonoverdose dødsfall og det var liksom alt... stod litt sånn, og vi visste at disse LAR-X pasientene var ute å seilte, så var det jo... jeg fikk tanken da, om å virksomhetsoverdra og bygge kompetanse hos de ansatte fra kommunen som jobbet på sentrene til at de kunne bli behandlere i spesialisthelsetjenesten samtidig, sånn at de ikke bare fortsatte, altså ikke bare, for de gjorde en god jobb, men, hva skal jeg si, når vi først måtte betale for den tjenesten, så slo vi to fluer i et smekk, sånn at vi dermed fikk behandlere til disse 350 pasientene, sånn at siden 2014, siden første november 2014, da er det tidspunktet for verknadsoverdragelsen vår, så har vi jo da tatt inn og bygget denne kompetansen, altså, de var veldig kompetente på veldig mye fra før, jeg trenger ikke å si noe annet enn det, men den spesialisthelsetjenestekompetansen har blitt bygget suksessivt i den gruppen, sånn at de når er behandlere for pasienter som igjen da har gjort at vi har kunne ta inn en stor del av denne såkalte LAR-X populasjonen» (IP01_1, l. 177-201).

6.4. Quotations included in the original language for programme 2

- «Ja, det som er utfordringen ved pasientforløpet generelt, det er at veldig mange som jobber turnus. Så det å få kontinuiteten, det er en utfordring. .. For klart, for hver pasient så ligger det jo et litt ekstra ansvar hos den som er primærkontakt for å på en måte dra forløpet, og hvis det er en person som jobber 70% eller 60% og jobber kveld og helg og alt det der, så kan det være noen dager.. deler av sjekklisten kan hvem som helst utføre, men det å ha hovedansvaret, det er utfordringen med turnusarbeidet. Og tid, det er i hjemmetjenesten, de løper så fort og så langt at man skal ikke tro det nesten, jeg er helt imponert over hvor effektivt det er. Det er så effektivt at det er vanskelig for de å sette seg ned og ha en god samtale, både som arbeidsmetode og i forhold til å ha tid til det» (IP04_2, l. 442-454).
- «Teksten «hva er viktig for deg» har jo blitt mye mer i fokus og trukket mye mer fram, med gode pasient forløp, så jeg synes at brukervedvirkning har kommet mye tydeligere fram nå enn den var

før, vi trodde kanskje vi hadde den før, men nå er vi mye flinkere til å spør brukeren først da...
«(IP14_2, l. 39-43).

- “Ja, eller, jeg føler at nå blir ikke ting glemt da, du har på en måte en sjekkliste, en huskeliste for å ikke glemme noen ting, altså at alle på en måte blir ivaretatt på samme måte, alle har et like stort spekter av... for å få hjelp da, og det er jo ganske mye på den tavlen der og for de som på en måte har store behov, så blir du ganske godt ivaretatt da, det er ganske mye som blir avdekt « (IP01_2, l. 330-334).
- «... i multimorbiditet så snakker vi om kroniske sykdommer, det lar seg ikke fikse, ikke sant, man må finne ut av hvordan kan man leve med det, og da er spørsmålet om en kommer til det bare ved å stille spørsmålet ”hva er i veien med deg?” og det å få helsetjenesten til å stille dette nye spørsmålet som jo har en helseminister som nå, på en fantastisk måte, formidler ut betydning av spørsmålet hva er viktig for deg, fordi svaret ikke ligger i den naturvitenskapelige rammen, ikke sant, det er den store, store utfordringen og folk er ikke uenig i det, vi er bare ikke trent til det og vi er heller ikke en kultur som dyrker den måten å utvikle tjenester på, dypst sett så handler det vel kanskje også om at vi som individer, altså helsearbeidere, ønsker jo også å være flinke i faget vårt, og være eksperter og kanskje trekker vi det ekspertperspektivet for langt, ikke sant, vi er eksperter på faget vårt» (IP10_2, l. 229-239).
- “Og så kan jeg også si at dette også handler om, kan også kobles opp mot målsetningene om ledelse, fordi at det å faktisk, går inn og ser på tjenestene, altså systematikk i hvordan du jobber, handler i stor grad om ledelse også, ett av målsetningene med læringsnettverkene denne runde er enda sterkere ledelsesforankring i de kommunene som deltar, for å vise at det er viktig for å få effekt av nettverksarbeidet» (IP02_2, l.183-185, 192-194).
- «det som er en liten tendens, faktisk kanskje markant, synes jeg, i en stor kommune, det er at du har gode, sterke faggrupper utenom legene i kommunen som konstruerer tilbud og ikke forteller om de, eller forteller om de bare til publikum, ikke holder forbindelseslinjene med sin egen kommunale legetjeneste tydelig nok, der... (...jeg ser jo at det er jo faktisk motstand mot å vise tjenesten og koble den sammen med legetjenesten, på et helt ubegripelig vis, det er noe som har slått oss leger vi har møtt et særtrekk som jeg tror faktisk er litt universelt og litt underkjent. ..Ja, det er litt paradoksalt, men jeg tror, jeg tror de spesialutdannede sykepleiergruppene i kommunen blir veldig stolte av oppleggene sine og har veldig fort for å tenke at dette er mine pasienter og så hegner de om det, du ser ikke at det å koble det sammen med andre grupper faktisk styrker posisjon og status og at det er faktisk veldig positivt for gruppene selv» (IP11_2, l. 241-245, 247-251).
- «I og med at de er på skjermen og lyser mot oss, så er det ganske viktig verktøy. Også ovenfor de, ikke bare fastlegen, men for hele generelle samhandlingen i kommunen også. Før var vi avhengig av at et av hodene som satt rundt bordet tenkte på demenssykepleiere, og det er ikke alltid det skjer. Det var ikke noen rutiner på det” (IP04_2, l.260-264).
- «E-meldinger, og det betyr at det er en høygradig meldingsflyt mellom hjemmebaserte tjenester, spesielt, saksbehandlere og fastleger og der sender partneren omtrent like mange meldinger, fastlegen har sendt litt flere meldinger enn kommunen og min erfaring er at når man har møtt hverandre, da øker kvaliteten på meldingene, det må være en viss grad av samstemming på en eller annen måte, så den er litt vanskelig å få til uten fysiske møter, men de trenger ikke være mange og

der opplever jeg at hjemmesykepleierne og legene er veldig like, for alle har det travelt og vil ha jobben sin gjort, de er ute etter noe som er effektivt og fleksibelt og lite nok og som går inn i timeplanen...» (IP11_2, l. 131-139).

- «Og vi merker jo det at etter hvert som årene går nå og samhandlingsreformen kommer mer og mer innover oss, så er folk utrolig utrygge i disse overgangene, altså pasienter og pårørende, så det å ha et tverrfaglig team som går inn og tar seg tid, da. Det ser vi at er helt uvurderlig. Det får vi en veldig god respons på. Rett og slett. Vi tar ned temperaturen, vi ordner ting raskt. Vi opplever ikke at det går 14 dager før de har en rullator eller, (...). Sette oss ned med de, bruke tid. Og det har vært en utfordring før, altså når de startet her var det veldig tydelig å se at man kom liksom ikke ordentlig i gang, man kom ikke forbi de første, utrygge dagene og da dro man det med seg mange uker og måneder fremover. Man klarer ikke å skape en tillit på en måte, til systemet» (IP04_2, l. 183-192).
- «...hvis det er et verktøy som er laget, du kan ta i bruk nokså direkte, så betyr jo det at det er en del oppgaver du slipper å måtte gjøre selv, og fortsatt må man jo (...) må man jo ta ansvar for å gjøre tingene og man må sørge for at de blir gjennomført og så videre, det er ikke det at ting gjør seg selv, men du sparer litt grann ting når du kan bruke et verktøy som er laget av andre» (IP13_2, l. 82-92).