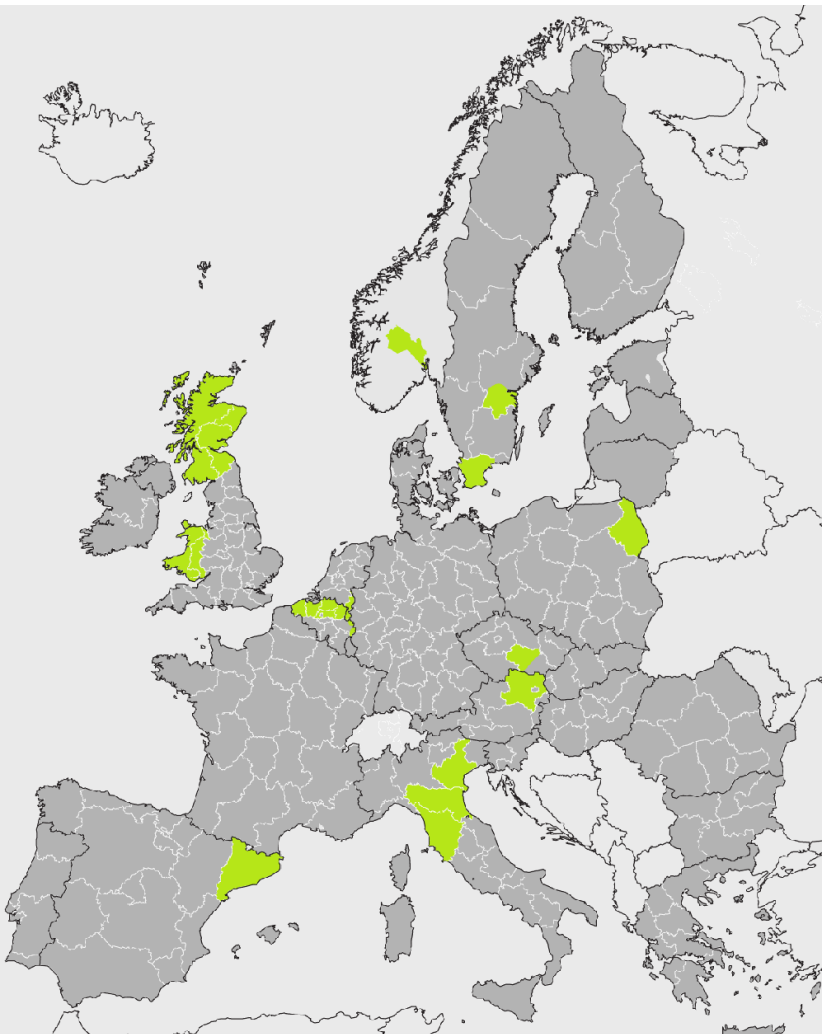
Integrated Care in Practice

A SHOWCASE OF BEST PRACTICES FROM EUREGHA'S MEMBERS

DECEMBER 2014



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European Regional and Local Health Authorities

BEST PRACTICES

INTEGRATED CARE IN CATALONIA

Name of Organisation : Generalitat de Catalunya
Region: Catalonia
Country: Spain
Total Region Population: 7.600.000

MAIN CHARACTERISTICS OF THE BEST PRACTICE

☐My region has a fully implemented integrated care model

☒**My region is in the progress of implementing an integrated care model**

☐ICT-tools as solutions for integrated care

☐Integrated funding mechanisms

☐Other key competencies

SUMMARY

In February 2014 the "Integrated Health and Social Care Plan" was launched by the Catalan Government. It is expected to develop integrated care between health and social sectors promoting a "person-centred model" with a great emphasis on community care. Apart from more collaborative work between health and social organisations, the plan will also develop territorial governance arrangements, integrated care pathways agreed by clinical and professional leaders, ICT-solutions to improve information sharing and communication tools between professionals and between the citizens and professionals. A new Shared Outcome Framework will also be elaborated and translated into the current commissioning of services process.

The government would like to prevent institutionalisation and potentially avoidable admissions, while promoting home care services and other alternatives to maintain people at home as long as possible.

GENERAL AND SPECIFIC OBJECTIVES

- ✓ To maintain people at home as long as possible
- ✓ To encourage home care and other community services
- ✓ To promote collaborative practice between professionals belonging to primary and secondary care and social services
- ✓ To develop a joint model of commissioning contracting integrated care services
- ✓ To construct a shared clinical and care record sharing information of common interest between health and social professionals
- ✓ To transform some long-term care beds into residential home beds

METHODOLOGY AND PROCESSES

- ✓ Governmental agreement creating an Integrated Care Plan accountable to the Department of Presidency of the Generalitat of Catalonia and involving both the Department of Health and the Department of Welfare

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

- ✓ In the health sector: central and territorial Commissioning body and different provider organisations working for the Catalan health service
- ✓ In the social sector: Councils and some County authorities
- ✓ Third Sector

FUNDING SOURCE(S) OF THE INITIATIVE

- ✓ Funding will be included in the commissioning process of both the Department of Health and the Department of Welfare. An increasing number of indicators related

OUTLINE THE KEY INNOVATIVE ELEMENTS OF YOUR BEST PRACTICE

- ✓ Real community care orientation encouraging home care services
- ✓ Person centred model introducing person sharing decision
- ✓ Construction of an integrated or shared clinical and care record. That is a very new initiative with no real experiences till now
- ✓ Vision of Integrated care based on functional approach instead of structural merging

IMPACT AND OUTCOMES

- ✓ We have achieved some good results based on the Chronic Care Program me initiative introduced 3 years ago resulting in decreasing potentially avoidable hospital admissions
- ✓ Implementation of the Integrated Care Plan started a few months ago

WHAT SUCCESS CRITERIA ARE USED TO DETERMINE THAT YOUR INITIATIVE IS WORKING WELL?

“A shared outcome framework” with a range of integrated care targets to be shared by both health and social care organizations working for people with complex needs.

ETHICAL ISSUES

A strong ethical position statement has been elaborated by the Catalan Ethical Committee supporting the complex care initiative developed in the earlier Chronic Care Programme.

TRANSFERABILITY TO OTHER REGIONS

There is an interest in scaling-up best practices to all territories during the implementation of the Integrated Health and Social Care Plan to transform the model of provision.

KEY LEARNING POINTS

- It is required **clinical, professional and managerial leadership commitment**
- To extend **collaborative practice** generated during the implementation of the Chronic Care Programme incorporating social Services in the new Integrated Care Plan
- Some **instrumental facilitators must be developed**: shared clinical and care record, shared outcome framework with transversal targets included in the commissioning process
- The construction of a "**person centred model**" should be the most important issue instead of structural merging

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EMILIA ROMAGNA: E-CARE NETWORK

Organisation Name: AUSL Bologna (CUP 2000 Spa)

Region: Emilia-Romagna Region

Total Region Population: 4.446.000

Country: Italy

Best Practice Target Population: Frail elderly over 75

MAIN CHARACTERISTICS OF THE GOOD PRACTICE

☐My region has a fully implemented integrated care model

☐My region is in the progress of implementing an integrated care model

☐ICT-tools as solutions for integrated care

☐Integrated funding mechanisms

☐Chronic Diseases and Diabetes

☒**Other key competencies: Integrated care model offered at provincial level**

SUMMARY

The eCare Network for frail elderly people was created in 2005 and consists of a technical and social network of citizens, associations, institutions and professionals. It provides a relational and support ecosystem to frail elderly people and is organised in an innovative management model which anticipates care needs in order to delay non self-sufficient conditions.

The e-Care service in Bologna was launched in 2005, counting a little over one hundred senior users. Since then, the service has evolved into a relational network, given both the number of assisted seniors, and the number of citizens, institutions and professionals involved. By the end of 2012, about 12 000 people were assisted by the e-Care service (80% women and 20% men). The growth is due, partly to the offer of provided services, which has continuously grown throughout the years, and partly to the inclusion of frail persons identified thanks to the "Frailty Database" established after 2011.

DESCRIPTION

The network performs a constant monitoring of frailty by means of a periodical personalised support and the promotion of lifestyles addressing the improvement of health conditions and adherence to medical treatments. Furthermore, it creates a close cooperation between volunteers, associations and institutional operators to facilitate a higher level of integration between services and good practices on the local authority.

The network is able to provide support to the frail elderly aiming at:

- ✓ favouring the long staying of the elderly in their homes
- ✓ preventing the increase of non-self-sufficiency conditions
- ✓ improving the quality of life by fighting social isolation
- ✓ reducing unnecessary hospital admissions

The service is addressed to seniors (over the age of 75), living alone or with their spouses, that are already known by local social services. They are not yet users of public services and their loneliness or depleted family and social networks are associated with frailty factors.

INNOVATION, IMPACT AND OUTCOMES

Including the third sector, such as associations and volunteering organisations, is one of the most distinctive and unique characteristics of the experience in Bologna. The eCare Network operates with the objective of a growing and always better involvement of all subjects, especially non-institutional ones, offering some form of support or service to seniors and frail people.

Currently, the associations belonging to the network and actively collaborating at the municipal or neighbourhood level are approximately 225. Moreover, over 90 social and recreational centres are involved, while approximately 30 are volunteering associations operating at the entire provincial level.

The portal Bologna Solidale (www.bolognasolidale.it) was developed as part of the e-Care Network, to provide an easy to use tool for social workers, seniors and their families to gather information on organisations and events and promote socialisation. Evidence on costs and quality of life is an undergoing activity, results will be made available shortly.

ETHICAL ISSUES

The service is fully compliant with rules on privacy and data security and regular agreements with the Local Health Authority of Bologna have been signed.

TRANSFERABILITY TO OTHER REGIONS

The ageing of the population is one of the highest priorities of action for any public organisation. The e-Care Network is a new and sustainable method which can optimize the use of healthcare resources, delaying the onset of non-self-sufficiency conditions. The support of a well-structured population based database and the involvement of different categories of social and healthcare professionals is an example of good practice appreciated and studied all over the country.

CHALLENGES WITH INTEGRATED CARE

The main challenges relate to making people from different organisations work together, and programming and optimising the use of social and healthcare resources.

KEY LEARNING POINTS

- Service as relational services
- Existing of a frailty database
- Importance of social empowerment
- Mapping resources (events, volunteers, relatives and friends)
- Promotion of healthy life stiles

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HEALTHCARE HOMES IN EMILIA-ROMAGNA: INNOVATION IN TERRITORIAL SERVICES SYSTEM

Organisation Name: Assessorato Politiche per la Salute Regione Emilia-Romagna

Region: Emilia-Romagna

Total Region Population: 4.446.000

Country: Italy

Best Practice Target Population: The total population of Emilia Romagna

MAIN CHARACTERISTICS OF THE GOOD PRACTICE

☐My region has a fully implemented integrated care model

☒**My region is in the progress of implementing an integrated care model**

☐ICT-tools as solutions for integrated care

☐Integrated funding mechanisms

☐Chronic Diseases and Diabetes

☒**Other key competencies: Integrated care model offered at provincial level**

SUMMARY

Emilia-Romagna chose to create the "Healthcare Homes" to answer to the need of relying - within the regional territory - on "trusted" reference points for both the access and the delivery of healthcare and social-health services. These access points allow to gather citizens' needs and plan and organise service delivery in the most suitable way. The main objective of the initiative is to assure appropriate and quality answers to chronic disease needs and to social and health frailty. To do so, the Healthcare Home has been designed as a system capable of taking care of people since the very first access. Regional guidelines have been drawn up accordingly (Resolution of the regional government 291/2010): the Homes can have various degrees of complexity depending on the density of the reference community population, their geographical location and the context needs (there are three types of Healthcare Homes: small, medium and large). The Homes are based on strong collaboration

among professionals from different services to guarantee full care and continuity of care. Strategies outlined in the resolution are being implementing in all Local Health Trusts of the Region. There are currently 61 fully functioning Healthcare Homes, which equals 61 key care access points capable of assessing people needs and guiding them towards appropriate services. Furthermore, these points provide primary healthcare and the taking care of patients with chronic diseases. The completion of the Healthcare Homes network is expected with the arrangement of 59 new houses and the related realignment of their clinical and organisational services.

DESCRIPTION

GENERAL AND SPECIFIC OBJECTIVES

- ✓ to define 'trusted' and easy recognizable reference points for both the access and the offer of healthcare and social-health services
- ✓ to structure and organise the Healthcare Home as a *system* capable of taking care of citizens from the very first access by means of a global approach to people's needs
- ✓ to define care pathways based on specific clinical and assistance standards
- ✓ to develop a proactive management of chronic diseases, also by means of nursing service specifically devoted to manage such pathologies
- ✓ to entrust the case-manager with the duty of guaranteeing effectiveness and efficiency of the abovementioned pathways

METHODOLOGY AND PROCESSES

In order to achieve the Healthcare Home general and specific objectives, the Emilia-Romagna Region put in place a number of actions also aimed at supporting their step-by-step implementation:

- ✓ to appoint a strategic regional Group for the project assessment
- ✓ to plan and conduct audit meetings at local level in 10 Healthcare Homes – carried out by regional professionals – aimed at deepening quality aspects by means of structured interviews to highlight existing best practices and facilitate their dissemination across the region
- ✓ starting from 2010, annual monitoring activity to assess the functioning Homes' of Health evolution in the territory

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

- ✓ Within the local healthcare system: general directors of local health trusts and professionals of primary healthcare
- ✓ In the Healthcare Homes: general practitioners, paediatricians, healthcare assistants, consultants
- ✓ In the regional social context: municipal welfare officers
- ✓ Citizens' representative association: joint consultative committees

FUNDING SOURCE(S) OF THE INITIATIVE

Health services provided by the Healthcare Homes are Essential Levels of Assistance (the so-called LEA) and are funded by the Regional Healthcare Fund.

HOW DO YOU PLAN TO SUSTAIN THE INITIATIVE?

Next steps to be taken:

- ✓ to complete the Healthcare Homes network by arranging 59 new Houses
- ✓ to redefine clinical and organizational services to be provided through the Healthcare Homes
- ✓ to support both professional and organisational change by means of targeted training

INNOVATION, IMPACT AND OUTCOMES

A specific questionnaire has been drawn up and administered at regional level in order to observe the Healthcare Homes' specific functions. The regional questionnaire results highlight:

- ✓ **information, taking in charge and access to services**: traditional information points as well as access points to healthcare services are available in all Healthcare Homes (59 HHs); Unified Booking Centres[1] have been found in 51 HHs; Offices for Relations with the Public[2] have been seen in 22 HHs
- ✓ **needs assessment, guidance to services:** in 27 HHs (44%) triage nurse function is available; in 30 HHs an integrated home care service access point, involving professionals, is available; while in 21 HHs social help desks are found
- ✓ **care continuity:** outpatient service for small urgent cases in 55 HH (91%). As regards the latter: in 18 HHs patients are assisted by the general practitioners (GPs), in 31 from both GPs and healthcare assistants, in 6 from the so-called Practitioner of the Care Continuity. A care continuity structure (the former "out of hours service doctors") is active in 32 HHs. Tele diagnosis and tele consultation services (radiology and cardiology) are available in 16 HHs.
- ✓ **taking care of patients with chronic diseases:** care pathways fitting the local context are seen in 71% of HHs, mainly with regards to diabetes, chronic cardiac impairment, Chronic Obstructive Pulmonary Disease and post-acute myocardial infarction (post-AMI)
- ✓ **integrated outpatient space for chronic disease management:** available in 47 HHs (78%). Moreover, in 45 Houses nursing and outpatient services are seen, these imply self-care/education treatment to patients with chronic diseases (i.e. diabetes, chronic cardiac impairment). It is interesting to note that 6 HHs also provide obstetric outpatient services target to the management of physiological pregnancy

What success criteria are used to determine that your initiative is working well?

Strategies outlined at a regional level are being put into effect in all the Local Health Trusts within plans for local programming shared with local authorities; moreover care paths suitable for the local context have also been activated; there are currently 377 general practitioners working in the HHs, out of these 229 are still working in a second outpatient service in order to guarantee a widespread service presence on the territory.

ETHICAL ISSUES

The increasing gap between the health needs and the available resources, the greater incidence of chronic pathologies, the citizens' claims of the right to actively participate in the care processes, all

[1] Italian acronym for "Unified Booking Centres" is *CUP*

[2] Italian acronym for "Offices for Relations with the Public" is *URP*

encouraged the Emilia-Romagna Region to invest more resources in primary healthcare and to promote coordination among general practice physicians, paediatricians, healthcare professionals and professionals in hospital in order to improve healthcare system reactivity.

TRANSFERABILITY TO OTHER REGIONS

The project has a high degree of transferability to other regions, since the easier access to healthcare and social-health services and the active offering of medical attention in a single location of territorial healthcare and social-health services are consistent with citizens' demands, needs and expectations, also in the wider European context.

CHALLENGES WITH INTEGRATED CARE

- ✓ A cultural change is needed, as well as investments to guide professionals and decision-makers' drive and motivation
- ✓ Synergies among healthcare systems, social systems and all community resources should be enhanced

It is of utmost importance to develop the Healthcare Home system grounding it on the patient centred primary care concept, organising Healthcare Homes' services crosswise, according to specific target population (by age range: adolescence, childhood), capable of interacting on that particular patient.

KEY LEARNING POINTS

- It is fundamental to rely on team work that values the competences of the involved professionals
- The integrated work allows to achieve a stable trust and confidence relationship with citizens
- Thanks to the integrated approach clinical activity in care paths is enhanced allowing to better manage the most complex cases

FURTHER INFORMATION

http://www.saluter.it/ssr/aree/cure-primarie/cure-primarie

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HOSPICE/PALLIATIVE CARE (RPP PAL) IN LOWER AUSTRIA

Organisation Name: Lower Austrian Health and Social Fund (NÖGUS)

Region: Lower Austria

Total Region Population: 1.618.592

Country: Austria

Best Practice Target Population: People with incurable diseases and their relatives

MAIN CHARACTERISTICS OF THE GOOD PRACTICE

☒**My region has a fully implemented integrated care model**

☐My region is in the progress of implementing an integrated care model

☐ICT-tools as solutions for integrated care

☐Integrated funding mechanisms

☐Chronic Diseases and Diabetes

☐Other key competencies

SUMMARY

The first ideas to hospice/palliative care were launched in 1998 with the aim to build fixed hospice departments in nursing homes and mobile hospice teams. The overall target is to help patients stay in their home environment as long as possible without unnecessary hospitalisation and to support their relatives by home care. The initiative also aims to improve the economic benefit through development of an integrated palliative supply all over the country. This should be reached through prevention of inpatient treatment and reduction of unnecessary diagnostics. Therefore a discharge of existing structures of general supply should be achieved.

GENERAL AND SPECIFIC OBJECTIVES

The general objective is to develop hospice and palliative care structures in Lower Austria. Before starting the project many single initiatives, feasibility analysis and single concepts were developed to ensure that people in Lower Austria have a region wide access to hospice facilities. The specific aim of the teams is to help patients stay in their home environment as long as possible and support the relatives who are usually over-challenged with the care at home. In building up palliative care teams, patients don't need to go to the hospital and can stay in their home environment.

METHODOLOGY AND PROCESSES

In 2002/2003 pilot projects in 4 hospitals in Lower Austria were established to gather experiences in inpatient treatments. In 2005 the government decided to implement this pilot project all over Lower Austria in addition to the beds in the hospitals' mobile palliative teams.

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

The initiative involves the Lower Austrian Health and Social Fund, the hospitals in Lower Austria, GPs, mobile services (home care, home nursing etc.), emergency ambulances and nursing homes.

FUNDING SOURCE(S) OF THE INITIATIVE

The funding comes from the Lower Austrian Health and Social Fund.

HOW DO YOU PLAN TO SUSTAIN THE INITIATIVE?

The initiative has been transferred into the national healthcare system.

INNOVATION, IMPACT AND OUTCOMES

The aim is the preservation and improvement of the quality of living for mortally ill patients through a holistic approach through physical, psychological and social support. Patients should stay in their home environment as long as possible and should get the care they need at home. Treatments and care are made through a multi professional team of physicians, nursing staff, social workers etc. Through establishment of mobile palliative teams, patients can stay at home and do not need to go to the hospital. This contributes to a discharge of the hospital structures (also financially) and helps patients to stay their last days at home.

TRANSFERABILITY TO OTHER REGIONS

The initiative has not been transferred to regions beyond Austria but it has been transferred and included into the national healthcare system. However, the model could be transferred to other regions as well.

KEY LEARNING POINTS

- build up fixed hospice departments in nursing homes and mobile hospice teams
- help patients to stay in their home environment
- support their relatives
- improve the economic benefits (prevention of inpatient treatment, reduction of unnecessary diagnostics, etc.)

FURTHER INFORMATION

www.noegus.at

REGION SKÅNE: LEDNINGSKRAFT AND BETTER LIFE FOR THE MOST SICK ELDERLY (BLMSE)

Organisation Name: Region Skåne and Skåne Association of Local Authorities

Region: Region Skåne

Total Region Population: 1.274.069

Country: Sweden

Best Practice Target Population: The most sick elderly, defined as "people above 65 years with substantial impairments due to age, injury or disease" and "in substantial need of social and/or healthcare services".

MAIN CHARACTERISTICS OF THE GOOD PRACTICE

☐My region has a fully implemented integrated care model

☒**My region is in the progress of implementing an integrated care model**

☒**ICT-tools as solutions for integrated care**

☐Integrated funding mechanisms

☐Chronic Diseases and Diabetes

☐Other key competencies

SUMMARY

Ledningskraft is part of Better Life for the Most Sick Elderly (BLMSE) which is an initiative for integrated care that strives to enhance the quality of life of the most sick elderly. BLMSE has been nationally funded through an agreement between the Swedish Association of Local Authorities and Regions (SALAR) and the national government. It is to a large extent financed by means of economic incentives and performance-based bonus schemes. The model strives to achieve a patient-centred health and social care focusing on these five improvement areas:

- ✓ Coordinated health and social care
- ✓ Good pharmacological treatment
- ✓ Good palliative care
- ✓ Preventative care
- ✓ Good dementia care

DESCRIPTION

Ledningskraft is a management programme that aims to integrate the care between primary healthcare, hospitals and social care. It works with Leadership Teams from all organisations to co-ordinate and improve their respective care of the elderly. To their help the Leadership Teams have Improvement Leaders, which have the role to drive, inspire and facilitate change.

The whole model has the goal to implement a way of working which continuously strives for improvements and better co-ordination. The change is not about implementing a fixed process but rather to give incentives for health and social care units to move in the direction of more satisfied patients and caregivers and a better use of resources.

Ledningskraft is part of Better Life for the Most Sick Elderly (BLMSE). Two of the basic requirements for taking part in the BLMSE initiative is: **(1) A Regional Action Plan** based on a political decision for improvements and for the development of an agreed joint political structure between the region and the municipalities for management and co-operation. **(2) Local Action Plans** that the Leadership Teams within every municipality develop in collaboration with their Improvement Leader.

Region Skåne is the only region in Sweden where all the municipalities are directly involved in Ledningskraft. There are subsequently 33 different action plans and 33 Leadership Teams in Skåne. These teams are striving to coordinate and improve care of the elderly by using the local- and regional action plans as guidelines and the Improvement Leaders as facilitators.

INNOVATION, IMPACT AND OUTCOMES

The type of integration pursued by the BLMSE approach is mainly to facilitate the establishment of new kinds of relations, the engagement and interaction of leaders (which in many cases barely ever met before Ledningskraft came into place), as well as the joint planning of activities.

As service responsibilities and budgets remain separate, and as coordination and collaboration occur in a more or less structured way, depending on local circumstances, full integration has however not been achieved.

The percentage of inappropriate medications prescribed to the 75 years and older is one of the indicators followed within BLMSE and one which has steadily declined in Skåne as a whole (but with important local differences) since the starting point in October 2011. Such an improvement would probably not have happened without the increased contacts and communication between the different actors involved in the BLMSE initiative such as primary care, hospitals, municipal health and social care, as well as private providers at all levels. The same goes for process outcomes, which show an increase in adherence to routines, protocols and guidelines. A clear example of such a positive impact is the assessments for Behavioural and Psychological Symptoms of Dementia (BPSD) that have been carried out and registered.

Two of the criteria considered important in order to measure the level of coordinated care – the amount of "unnecessary" (based on 13 diagnostic groups generally believed to be better handled in an early stage by primary or municipal care) hospital admissions and the amount of readmissions within 30 days – has however not shown any consistent improvements.

Lastly**,** another kind of impact can be sensed from the responses to these initiatives. A large number of staff members and political and healthcare leaders of different levels, from both healthcare and social care, as well as public and private institutions, are involved in one way or the other in this new "movement", and overall there is a general perception that these issues are of utmost importance and that there is a need to move in the direction of more coordination and integration of services, although no survey has been carried out to measure that type of perceptions.

ETHICAL ISSUES

Integrated care requires an efficient flow of information between caregivers, which in several situations puts questions of integrity to the surface, especially when patients (e.g. with dementia) cannot give informed consent to this sharing of information about them. There was also until recently a legal un-clarity about this, but there are now (since October 2014) better possibilities to act for the best of the patient, even without this explicit consent. For more information on this, see here.

TRANSFERABILITY TO OTHER REGIONS

Starting at the local leadership level by arranging forums for discussions and decision-making across the organisations has received very positive feedback in the BLMSE case in Skåne. The approach adopted could constitute a lesson that could be of interest to other regions and organisations. Promoting better ways of doing things through performance-based bonuses has probably facilitated this process to a great extent and constitutes an interesting experience.

To follow-up and study what will happen once the economic incentive and, eventually, other kinds of support cease, can also be of interest to others. It remains to be seen whether the approach adopted in this case brings about changes that could lead to sustained co-operation and continuous improvement or whether key people back-off from their commitments once the direct economic compensation has gone. The economic incentive has to be evaluated in order to identify to what extent this measure could be considered as an effective way to foster integrated care.

CHALLENGES WITH INTEGRATED CARE

Collaboration of organisations that have historically been separated and still maintain their separate budgets can be rather complicated, despite the obvious and undisputed need for cooperation for the sake of the patient!

KEY LEARNING POINTS

- Ledningskraft is a forum for dialogue with the aim of strengthening the power of the participants to achieve results by helping them see new perspectives and strengthen co-operation.
- Ledningskraft focuses on implementation and results. The focus is not on finding the "right" solution but to acknowledge that different solutions can be pursued to achieve the goal.

- Local ownership is at the core of Ledningskraft. The local Leadership Teams are working in parallel with the overall implementation of Better Life for the Most Sick Elderly (BLMSE) at the national level to improve the health for the most sick elderly.

FURTHER INFORMATION

http://skl.se/tjanster/englishpages/activities/betterlife.1273.html

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REGION SKÅNE: HÄLSOSTADEN ÄNGELHOLM

Organisation Name: Hälsostaden

Region: Skåne

Total Target Population: 1.200.000

Country: Sweden

Best Practice Target Population: Ängelholm Municipality, 150 000 people

MAIN CHARACTERISTICS OF THE GOOD PRACTICE

☐My region has a fully implemented integrated care model

☒**My region is in the progress of implementing an integrated care model**

☒**ICT-tools as solutions for integrated care**

☒ **Integrated funding mechanisms**

☒**Chronic Diseases and Diabetes**

☐Other key competencies

SUMMARY

Hälsostaden is a fairly small healthcare organisation with around 600 employees but with big plans to do great deeds for Swedish healthcare. We are challenging established healthcare structures, by implementing new solutions bringing primary care, hospital-based specialist care and municipal services together. The pilot project, set to three years started in October 2013, but several initiatives are already implemented. The county council Region Skåne is the mandator and is collaborating with Ängelholm's municipally. There are good prospects of expanding this integrated care model and eventually make Hälsostaden permanent. A changing demography with an aging population requires new solutions and prevailing systems is not the future. Healthcare should be organised with the patient in focus, to avoid letting people fall between the cracks created in the gap between different healthcare providers. The healthcare system needs to become more efficient with better patient flow. Hälsostaden creates care and nursing without barriers.

Hälsostaden has envisioned three general objectives for the project.

- ✓ To improve accessibility
- ✓ Provide healthcare and nursing at the appropriate level and at the right place

- ✓ Integrated care to improve patient flow between hospital-based specialist care, primary care and municipal elderly care.

DESCRIPTION

The key components of Hälsostaden's integrated care that has been implemented during the first year in operation are described briefly in this section as well as how to develop them.

The mobile emergency team started in June 2014 and they make home visits to patients who most likely would have been sent to the emergency room at the hospital otherwise. It has been successful not only from a financial perspective of reducing pressure on the emergency room and unnecessary hospitalisation, but also for the well-being of the patients, who often are multi sick elderly people. The mobile emergency team spares the patients the unpleasantness of going to the hospital. At the moment they are operating part time (50 %). In January 2015 Hälsostaden will further develop the concept by expanding the geographic area and their service hours as well as including not only emergency visits, but also planned check-ups to patients with chronic diseases. This mobile community health team will become a cornerstone Hälsostaden, since it widens the concept of bringing the care home to the patient.

A **primary care emergency centre** open in evenings and weekends staffed by 20 different healthcare centres started in April 2014. It has improved the accessibility for the residents in all the surrounding municipalities. The next step is to optimize the accessibility in the outpatient clinics in terms of doctor's appointments, phone hours and replying to emails.

The department for short-term stays was originally a municipal department that merged with the hospital of Ängelholm in 1 January 2014. The fact that the department is located at the hospital improves patient flow by having the municipal rehabilitation as an integrated part, and the transition is smoother for the patient. The ratio of care-givers and nurses per patient is not as high as in the specialist departments. In the event of deterioration, the patient can be transferred into an appropriate specialist department at the hospital without passing through the emergency room.

In October 2014 the new **discharge planning and rehabilitation department** was inaugurated with 12 beds to begin with. Often, the medical treatment of the patient is considered complete, but they are still in a need of rehabilitation and mobilisation. They are often waiting for a placement in municipal nursing homes. By gathering all those patients in one department we can provide care at the right level and hence have a lower staffing ratio here as well. The goal is to improve the patient flow out of the hospital and decrease the rate of returning patients. The discharge planning process between municipalities, hospitals and primary healthcare will be streamlined, by using new technical equipment for video conferences.

Hälsostaden will facilitate communication between primary care, municipalities and hospitals, by introducing a **shared electronic medical record**. By the end of 2014, the national system NPO (National Patient Overview) will be available for all participating organisations within the integrated care model.

The benefits of having the different parts of the integrated care model gathered at the hospital has made moving the primary care centre to the hospital a natural step in the progress, as a first step a primary care emergency care service at day time will be connected to the emergency room. During 2015 the whole primary care centre will be moved into the hospital facilities. Next year the possibilities to integrate more of the rehabilitation operations in the concept will be evaluated. Hälsostaden is also

cooperating with the universities in the region to develop a new specialist program for municipal home care, since this will get more and more advanced.

INNOVATION, IMPACT AND OUTCOMES

Hälsostaden is a small organisation with a mandate from the county council and municipality, meaning that decision procedures are somewhat streamlined and projects can be implemented faster. Several evaluations have been conducted to try to establish the outcomes of Hälsostaden.

Regarding the mobile emergency team, the first evaluation was made after 49 days and showed in the target group 65 years and older that hospitalisation decreased with 70%. The feedback from the patients has been very positive. The Centre for Ageing and Supportive Environments (CASE) at Lund University will evaluate the Hälsostaden project and investigate if the quality of the healthcare in Ängelholm has been improved thanks to the integrated care model. This will be made from thee different perspectives; patient, personnel and organization. The main focuses will be the reorganisation affecting the accessibility and the process of redirecting some of the healthcare from the hospitals to home care and primary care.

ETHICAL ISSUES

The fact that a larger portion of the care is located at home will better the living standards for the target group, but at the same time it means more responsibility for relatives and friends. Twisting the focus from hospitals to home-care also requires other of the municipal nurses and caregivers. As it is today there is a competence gap among the municipal nurses that has to be addressed, since their mission is expanded. It can also be an ethical issue not having the resources to provide the same standard of home care to elderly living further away from the hospital, due to transportation time. By using modern ICT solutions there's a big responsibility on Hälsostaden as a care-giver to make sure that everything is working properly.

TRANSFERABILITY TO OTHER REGIONS

The plan is to include additional municipalities to the integrated care model and the dialogue is quite far along with Båstad's municipality. Other municipalities have also shown interest in working with Hälsostaden, for example by using the mobile emergency team. The next step is to develop a strategy for exporting Hälsostaden's concept to other hospitals within Region Skåne. This will be implemented in spring 2015. Hälsostaden is also continuously being inspired by other regions, and about six organisations visits Hälsostaden per month. The visiting organisations are mostly county councils and municipalities in Sweden. Close cooperation is established with the City of Helsingör, Denmark just across the inlet Öresund, and the same goes for the county council of Region Själland, Denmark. Contact with organisations in Norway is also getting established.

CHALLENGES WITH INTEGRATED CARE

There are legal challenges as hospital/primary care and some parts of the municipal care are regulated by different legal frameworks in Sweden which make fusion of organisations very complex. As hospital, primary care and municipal services merge and challenge the established healthcare systems, there is also a culture clash. This requires change management to turn this into an opportunity that enriches

the integrated care model, not only within the organisation, but also regarding how to manoeuvre external scepticism.

For any integrated care model, ICT solutions are key to improving patient and information flow. Systemic barriers that have to be torn down are everything from having the same electronic medical record to the intranets used. Implementing an integrated care model requires new ways of doing things, but when integrating new parts and personnel to the project it's important to uphold efficient and well-functioning routines to the extent that it is possible. Therefore the pros and cons should always be weighed and detailed risk-analysis is necessary before making a decision on which level of integration that is appropriate.

KEY LEARNING POINTS

To expand Hälsostaden and make it a permanent organization, new organisational solutions are needed, due to the complexity of the project. We have to create a new juridical entity by changing the mode of operation to a committee comprised my municipality and country council.

FURTHER INFORMATION

http://www.skane.se/sv/Webbplatser/Angelholm-samlingsnod/Angelholms-sjukhus/Sjukhuset/Projekt-Halsostaden-Angelholm/

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HEALTH AND SOCIAL CARE INTEGRATION IN SCOTLAND

Organisation Name: NHS24/Digital Health Institute (DHI)

Region: Scotland

Total Region Population: 5 300 000

Country: United Kingdom

Best Practice Target Population: The total population of Scotland

MAIN CHARACTERISTICS OF THE GOOD PRACTICE

☐My region has a fully implemented integrated care model

☒ **My region is in the progress of implementing an integrated care model**

☐ICT-tools as solutions for integrated care

☒ **Integrated funding mechanisms**

☐Chronic Diseases and Diabetes

☐Other key competencies

SUMMARY

On the 25th February 2014 an Act on 'Public Bodies' (Joint Working) was passed by the Scottish Parliament and received Royal Assent on 1st April 2014. The Act provides the legal framework to support improvements in the quality and consistency of health and social care services by integrating health and social care in Scotland. Integration will ensure that health and social care provision across Scotland is joined-up and seamless, especially for people with long term conditions and disabilities, many of whom are older people.

The Act requires the integration authorities to prepare a strategic commissioning plan, establishing the arrangements for delivery of integrated functions and how these arrangements will achieve the national health and wellbeing outcomes. Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

OBJECTIVES

The main purpose of the integration planning and delivery principles is to improve the wellbeing of service-users and to ensure that those services are provided in a way which:

- ✓ improves the quality and consistency of services for patients, carers, service users and their families
- ✓ provides seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and
- ✓ ensures resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.

The Act requires that Health Boards and Local Authorities jointly prepare, consult and submit to Scottish Ministers an Integration Scheme by April 2015. This Integration Scheme sets out the key agreements that need to be reached in developing their integrated arrangements. It includes information such as:

- ✓ The model of integration chosen
- ✓ The scope of functions and services that are to be delegated
- ✓ The clinical and care governance arrangements
- ✓ Financial management
- ✓ Operational arrangements and a number of other key agreements

To support Health Boards and Local Authorities to develop these agreements, the Scottish Government, supported by the Legal Working Group, has produced a model integration scheme. This should be used by the teams who are preparing integration schemes locally. It provides a comprehensive picture of what is required within the Integration Scheme Regulations and the relevant section of the Act and an agreed legal format for collating the information.

METHODOLOGY AND PROCESSES

Work has now commenced on the Regulations relating to the Act and the underpinning statutory guidance. The Regulations and Guidance will support the arrangements for integrating health and social care, in order to improve outcomes for patients, service users, carers and their families. This will enable Health Boards and Local Authorities to work together effectively to deliver quality, sustainable care services.

During the development and implementation stages a collaborative work with stakeholders will continue. When a final set of regulations is produced, the Scottish Government will fully consult with our stakeholders before they are introduced to Parliament. There is a specific integration implementation timetable for the period 2014 – 2016.

The Public Bodies Act 2014 allows Health Boards and Local Authorities to integrate health and social care services in two ways. It is up to Health Boards and Local Authorities to agree which approach/model is best for local needs.

Model 1: The Health Board and Local Authority delegate the responsibility for planning and resourcing service provision for adult health and social care services to an Integration Joint Board.

Model 2: The Health Board or the Local Authority takes the lead responsibility for planning, resourcing and delivering integrated adult health and social care services.

INNOVATION, IMPACT AND OUTCOMES

Innovation

- ✓ Role for policy making and legislation in integrating health and social care
- ✓ Planning for care groups, rather than historic structures, to improve outcomes
- ✓ Tackling cost shunting to facilitate person centred integration
- ✓ Integrating health and social care budgets
- ✓ Strengthening the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services

Outcomes

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care. By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

- ✓ Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer
- ✓ Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- ✓ Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected
- ✓ Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- ✓ Outcome 5. Health and social care services contribute to reducing health inequalities
- ✓ Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
- ✓ Outcome 7. People who use health and social care services are safe from harm
- ✓ Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- ✓ Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.

TRANSFERABILITY TO OTHER REGIONS

The shape of European society is changing. People are living longer, healthier lives and as the needs of the society change, in the same way must the nature and form of the public services. The integrated

care model of Scotland sets a collaborative approach under a specific legal framework providing a roadmap with many transferable elements to other regions.

CHALLENGES WITH INTEGRATED CARE

- ✓ Multiple stakeholders
- ✓ Make the best use of the available facilities, people and other resources
- ✓ Cross- sectorial cultures

KEY LEARNING POINTS

- Strong and determined political will
- Planned and led locally in a way which is engaged with the community
- Strategic planning to support people, particularly those with multiple complex needs

FURTHER INFORMATION

http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf

Int J Integr Care 2014; Annual Conf Suppl; Alison Taylor

http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration

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USING ACG ® SYSTEM (ADJUSTED CLINICAL GROUPS) A CASE-MIX TOOL TO IMPROVE CARE INTEGRATION IN VENETO REGION

Organisation Name: Area Sanita' e Sociale della Regione Veneto

Region: Veneto

Total Region Population: 5.000.000

Country: Italy

Best Practice Target Population: Population with multi-morbidity at high risk for adverse health outcome

MAIN CHARACTERISTICS OF THE GOOD PRACTICE:

☐My region has a fully implemented integrated care model

☒**My region is in the progress of implementing an integrated care model**

☒**ICT-tools as solutions for integrated care**

☐Integrated funding mechanisms

☒**Chronic Diseases and Diabetes**

☐Other key competencies

SUMMARY

Since 2012, Veneto Region has started a collaboration with Johns Hopkins University for the use of the ACG® System within the regional healthcare organisation. The ACG system represents a tool to stratify the case-mix of the population aimed at identifying the most frail part of the population with a high burden of multi-morbidity and disability. It also aims at reaching this part of the population with an integrated approach, using case management as a health management tool, and at increasing the cost-efficiency in the use of healthcare resources. The system collects diagnostic, pharmacy and cost data from all possible sources (claims or electronic medical records), and grouping patients in groups that are similar in terms of prognostic perspective. The first year of piloting has been very successful. The system has been very useful in describing multi-morbidity patterns in the population, in profiling the providers' performance and in better explaining the variability of healthcare costs.

During the second year, ACG has been used not only retrospectively to analyse the equity and sustainability of the healthcare system but also prospectively to improve the health management of patients with chronic conditions using the disease management approach and, for patients with multi-

morbidity, using the case management approach. We are now entering the third year of the use of the ACG System, expanding the stratification and screening activity to the entire Veneto population.

OBJECTIVES

- ✓ identifying the most frail part of the population with a high burden of multi-morbidity and disability
- ✓ reaching this population with an integrated approach using the case management as a health management tool
- ✓ increasing the cost-efficiency in the use of healthcare resources

METHODOLOGY AND PROCESSES

- ✓ Multidimensional evaluation by healthcare- (GP, nurses) and social care (social workers) providers, followed by a proactive multi-professional intervention led by a case manager nurse

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

- ✓ Municipalities, providers of nursing services, third sector
- ✓ Johns Hopkins University, Baltimore (US)

FUNDING SOURCE(S) OF THE INITIATIVE

Regional funds coming from general taxation that will guarantee the continued implementation of this best practice.

INNOVATION, IMPACT AND OUTCOMES

This approach tries to lead the most frail patients through the labyrinth of health and social care delivery, overcoming the usual "silos" approach (hospital care, ER, outpatient clinics, primary care, home care, and nursing services) that leaves the patient and its family without a clear driver in the continuum of the care process. It has been demonstrated (Walters et al) that this approach, empowered by the screening and predictive tools provided by ACG, improves patients' experiences and reduces the healthcare costs, mainly improving communications and team work among providers and preventing inappropriate hospital readmissions. The experiences in the past two years of ACG implementation in Veneto have demonstrated a successful outcome of this approach in patients at high risk of hospitalization (> 60%) where re-admissions have been reduced and patients have been assisted in home care settings, as indicated in their preferences.

ETHICAL ISSUES

The multidimensional evaluation will include a consent request to the intervention and the recording of the patient or family-members preferences.

TRANSFERABILITY TO OTHER REGIONS

The ACG system is actively used in other Regions of EU Member States such as Sweden, United Kingdom, Spain and Germany but also in countries outside Europe such as Israel. The use of this integrated tool will facilitate comparisons and experience sharing with other health and social care providers.

CHALLENGES WITH INTEGRATED CARE

The real integration of this care system will better succeed when the care planning will include not only the list of services needed and provided but will be supported by an integrated planning of the total budget available (services and monetary benefits). So far, social and healthcare budgets have been kept separated and the integration has always been very difficult because of this original sin.

KEY LEARNING POINTS

- Information integration as a backbone of care integration
- Improving the care experience and quality is often associated with cost containment

FURTHER INFORMATION

Http://acg.regione.veneto.it

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REGION VÄSTRA GÖTALAND: INTERACTING CARE

Organisation Name: NU Hospital Group

Region: Västra Götaland

Country: Sweden

Total Population: 1.623.406

Best Practice Target Population: Fyrbodal, 272 315

MAIN CHARACTERISTICS OF THE GOOD PRACTICE

☐My region has a fully implemented integrated care model

☒**My region is in the progress of implementing an integrated care model**

☐ICT-tools as solutions for integrated care

☐Integrated funding mechanisms

☐Chronic Diseases and Diabetes

☐Other key competencies

SUMMARY

Interacting Care is implemented in Fyrbodal, a geographical area of 10 local authorities in Region Västra Götaland. The common interaction model includes four different mission types. The form chosen depends on when, where and which health needs that arise and which resources that are available at the moment. An important part of the interaction is that the collaborative partners can ask each other for help and have a close dialogue with each other.

Interacting care was started to create a faster, safer and more secure healthcare in Fyrbodal. The interaction model means that the partners promote the overall health resources in the most efficient manner and offer the right care in the right place as close to the patient's home as possible. All residents should be aware that they have access to a fast, safe and secure care regardless of where they live.

GENERAL AND SPECIFIC OBJECTIVES

The vision of Interacting Care is to provide quality healthcare, to coordinate health and the healthcare resources available in the patient area. The aim is to provide the right care at the right place and to use the health resources for the patient's best.

METHODOLOGY AND PROCESSES

The initiative works through the meso and macro levels in local healthcare. A steering committee has been established with participants from the involved local health organisations and a working group has also been established, which develops collaborative healthcare. Further, a coaching network of nurses from the different organisations has been created who work near the patients.

INVOLVEMENT OF OTHER ORGANISATIONS/ACTORS

Cooperation is established between local healthcare homes, primary care, national medical counselling, SOS-alarm, ambulances and the hospital unit "MÄVA medical eldercare". Two courses have also been started at University West for nurses who work in collaborative healthcare.

FUNDING SOURCE(S) OF THE INITIATIVE

Interacting Care is financed by the local healthcare offices in Fyrbodal.

HOW DO YOU PLAN TO SUSTAIN THE INITIATIVE?

Local healthcare is a must because healthcare has become increasingly specialised and linked to major hospitals and not everyone is in need of specialised care. The overall political goal in Fyrbodal is to collaborate even further in healthcare. The next step of Interacting Care is to involve patients' feedback to improve the work.

OUTLINE THE KEY INNOVATIVE ELEMENTS OF YOUR GOOD PRACTICE

The innovative aspect is firstly that Interacting Care is implemented across (local) care boundaries. This requires that all actors involved do a little extra work outside their own threshold for achieving good health.

WHAT SUCCESS CRITERIA ARE USED TO DETERMINE THAT YOUR INITIATIVE IS WORKING WELL?

The majority of patients who receive care in home collaborative do not need to seek emergency at hospitals.

ETHICAL ISSUES

All residents should feel that they have access to a fast, safe and secure care regardless of where they live.

TRANSFERABILITY TO OTHER REGIONS

Interacting Care focuses on the interaction of healthcare providers with the concerns of the patients in mind. Local authorities in Sweden most likely have the most to gain from being inspired by the model, however all care providers will benefit in the long run from increased interaction and integration.

CHALLENGES WITH INTEGRATED CARE

Interacting Care is currently in the distribution stage, and 7 of 15 local authorities in the Fyrbodal area have initiated cooperation. The challenge is to get all of these organisations to actually see the patient focus instead of focusing on budgetary issues.

KEY LEARNING POINTS

- Working with values
- Involve co-workers who work near the patient
- Education is the glue for co-workers from different organisations

FURTHER INFORMATION

www.samverkandesjukvard.se

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