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Authors	Lutz Kubitschke	(empirica)
	Pilar Gangas Peiró	(IFIC)
Deliverable lead partner	empirica	
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Abstract

This report provides a summary of the achievements of the VIGOUR project and the underlying methodological approach. Moreover, short profiles of the specific care integration models developed by each of the 15 health organisations involved in the project are presented. Based on the experiences gained by the project partners, guidance is provided on how other care organisations that may want to better join up existing care delivery practices within their own health care eco-systems can make use of the methods and instrument developed by the VIGOUR partners. As the report addresses the wider audience, the use of specialist terminology has been avoided as far as possible.

Statement of originality

This Deliverable contains original unpublished work except where clearly indicated otherwise. Acknowledgement of previously published material and of the work of others has been made through appropriate citation, quotation or both. This document is intended to summarise the most important achievements of the VIGOUR project. In part, it is therefore based on content provided in other publicly available project deliverable. These are available for downloading on the VIGOUR project website. (www.vigour-integratedcare.eu).

Disclaimer

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Content

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1 Introduction

Integrated Care is a way of working collaboratively, between a range of health care, social care and support organisations, to help improve people's health and wellbeing. The organisations involved work together in a partnership, sometimes sharing budgets, staff and other resources where appropriate, to best meet people's needs and preferences. The VIGOUR project, co-funded by the European Union's Health Programme, supported 15 health care organisations in different regions across Europe to take the next step on their path towards better integrated care delivery. A common methodology was developed and applied for better joining-up existing health care delivery processes. This document summarises the main achievements of the VIGOUR project.

This starts with a brief overview of the activities conducted as part of the VIGOUR project, the outcomes achieved and the underlying methodological approach (Chapter 2). Next, context-related integrated care models developed by the 15 health organisations involved in the project are briefly presented (Chapter 3). Based on the experience gained by the project partners, the final Chapter 4 goes on with describing how other care organisation that wish to better join up existing care delivery practices can make use of the VIGOUR methodology and instrument for their own purposes.

This document is intended to summarise the most important achievements of the VIGOUR project. In part, it is therefore based on content provided in other documents available on the project website (www.vigour-integratedcare.eu), including the following project reports:

- Consolidated operational scaling-up plans (v2) of the VIGOUR care authorities (Deliverable 5.1)
- Scaling-up pilot report (Deliverable 6.1)
- Final evaluation report (Deliverable 3.1)
- VIGOUR guidance package

As a further source of information, several instruments developed by the VIGOUR consortium for internal use are annexed to the main document.

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2 The VIGOUR project in a nutshell

2.1 What integrated care is about

The debate about integrated care is anything else but new. The call for better joined-up service delivery, for example to older persons living with chronic conditions, traces back as far as into the 1950s.[1] Today, practitioners and researchers largely agree that integrated, patient-centred service delivery promises great benefits. Often referred to as "quadruple aim", integrated care aims at improving patient experience, outcomes of care, effectiveness of health systems and healthcare workforce experience. At least in theory, all this can be achieved through continuity and coordination of care services.

However, the practical implementation of integrated care seems to be far less widespread than one would expect given the benefits generally associated with it. Although examples of integrated care can be found in several countries, the reality for most patients is still care delivered through uncoordinated "islands of excellence".[2] There is much evidence to suggest that integrated care is unlikely to evolve as a natural response to emerging care needs in any system of care whether it is planned, or market driven. The reasons for this are complex and not easy to grasp. The absence of a unifying definition has for instance hampered the development of a common understanding of what integrated care is or should be about.[3] The World Health Organisation has for example concluded from a global review of integrated care schemes that, while it has been possible to identify general principles and core components, it cannot be stated that one model best supports all the integrated care efforts.[4]

Against this background, the VIGOUR project adopted a gradual concept of integrated care as graphically summarised by Figure 1 overleaf. In practice, different types of integration can help in better joining up hitherto disconnected care delivery processes around the needs of the patient. For example, systematically interlinking different services providers by the mere sharing of patient related information can help individual stakeholders make better decisions about the care to be provided, even if no common care pathway has been agreed (*linkage*). The latter typically requires a higher level of care coordination, e. g. in terms of multi-disciplinary protocols.

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[1] Burney, L. E. (1954). Community Organization - An Effective Tool. American Journal of Public Health, 44(1), 1–6. (p.6)

[2] Rigby, M., Koch, S., Keeling, D., Hill, P., Alonso, A., & Maeckelberghe, E. (2013). Developing a New Understanding of Enabling Health and Wellbeing in Europe - Harmonising Health and Social Care Delivery and Informatics Support to Ensure Holistic Care. Paper presented at the Standing Committee for the Social Sciences. London, UK. (p.42)

[3] A literature review conducted in 2009 uncovered for example some 175 overlapping definitions and concepts of integrated care, indicating the absence of consensus in its definition. See Armitage GD, Suter E, Oelke ND, Adair CE. Health systems integration: state of the evidence. Int J Integr Care. 2009;9(2).

[4] WHO Regional Office for Europe: Integrated care models: an overview. Health Services Delivery Programme, Division of Health Systems and Public Health, Working Document, 2016

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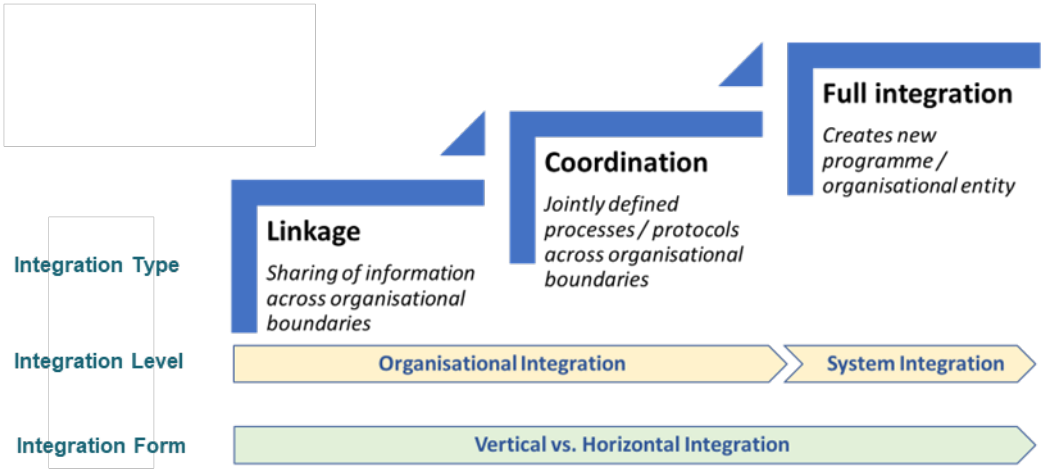
Figure 1 – Integrated care as a multi-staged concept



Source: VIGOUR adapted from McAdam 2008[5] ©

In general, care integration efforts that are directed towards the mere informational linkage of existing services or towards interdisciplinary care coordination tend to aim at making existing organisational boundaries more permeable (*organisational integration*).[6] In contrast, fully integrated care schemes tend to aim at eliminating such boundaries entirely, for example by setting up new organisational entities or units (*full integration*). Independently of this, integrated care can either take place within the health care system, for example between general practitioners and specialists treating the same patient (*vertical integration*), or it can take place across the boundaries of the health care system, for example when social service providers are involved in addition to health care providers (*horizontal integration*).

2.2 How VIGOUR helped to put integrated care into practice

Earlier experiences made with the implementation of integrated care schemes under everyday conditions suggest that any integrated care model development is strongly context-bound and nearly impossible to replicate.[7] There is a strong process element to the implementation of integrated care, e. g. when it comes to enabling stakeholders in different care settings or sectors to work together. On a case-by-case basis, such processes can ultimately take very different forms depending on the given implementation conditions. Also, the care authorities participating in the VIGOUR project did not start from the scratch. Most were able to build on previous efforts to better align

[5] MacAdam, M.. Frameworks of Integrated Care for the Elderly: A Systematic Review. CPRN, 2008.

[6] See ibidem.

[7] WHO Regional Office for Europe: Integrated care models: an overview. Health Services Delivery Programme, Division of Health Systems and Public Health, Working Document, 2016

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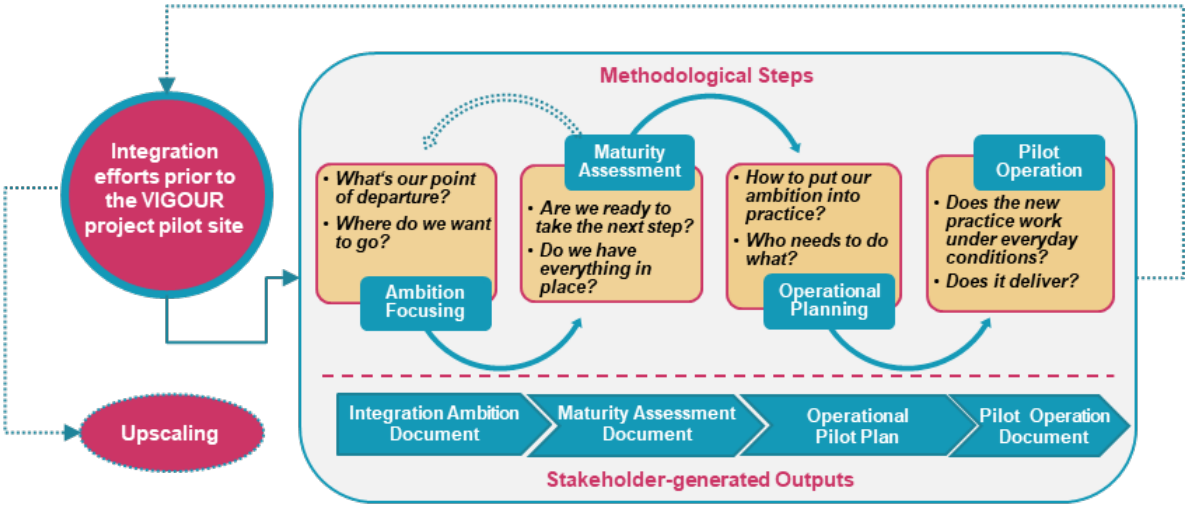
care delivery towards people with chronic or other conditions across the care chain, albeit in different ways and to different degrees.

Against this background, the VIGOUR project was not designed to transfer specifically selected models of integrated care that were successfully implemented elsewhere to the VIGOUR regions. Rather, the project was intended to support participating health authorities in initiating an incremental innovation process to take the next step on their own path towards integrated care. In this sense, the VIGOUR regions were picked up from where they were at the beginning of the project and supported in gradually improving the current level of health care interaction. To this end, each region went through a multi-staged process of defining and piloting better integrated care practices within existing health care eco-systems (Figure 2). A common methodology was developed to support the care authorities in this process, considering a range of patient needs, legacy processes, and digital support infrastructures.

Figure 2 – The VIGOUR innovation process



Source: VIGOUR ©

Considering prevailing implementation conditions and existing care practices, each care authority first consolidated its initial view on how to better integrate existing care processes (Ambition Focusing). This was followed by a systematic self-assessment of the envisaged integration approach with respect to its appropriateness and feasibility under given framework conditions (Maturity Assessment). Often, the results required a critical review of the originally envisaged care integration approach, e. g. when serious implementation barriers not previously considered were identified at this stage. Next, an operational implementation plan (Operational Planning) was developed as basis for piloting the hitherto developed care integration approach under everyday conditions, with a view to preparing further upscaling. Existing knowledge available from published sources of information was consolidated and fed into the innovation process in terms of thematic workshops. Also, mutual learning and knowledge exchange was facilitated by means of structured twinning activities.

2.3 Health care integration strategies pursued by the VIGOUR partners

As a result of the context-driven methodological approach adopted for the purposes of the VIGOUR project, different integration strategies were pursued by the participating care authorities. All in all, four strategic approaches towards better integrating existing care delivery practices can be discerned (Figure 3). Some of the VIGOUR regions focused on better coordinating care delivery to certain patient groups through multi-disciplinary care teams. Others put the emphasis on improving the coordination of remote patient management with help of digital care platforms. Another integration strategy concerned the linkage of health care services with social care services typically provided outside the health care system. Finally, some care authorities followed an integration strategy that aimed to link health care services with preventative wellbeing services available in the community, some of which are typically provided by voluntary organisations. In detail, however, the care integration approaches pursued by the VIGUR regions differ considerably from region to region. Brief profiles of the specific integration models developed in each region will be presented in the subsequent Chapter 3.

Figure 3 – Integration strategies supported by VIGOUR

Source: VIGOUR ©

In summary, in can be concluded that the VIGOUR regions have focused on different disease patterns and vulnerable patient groups that can be better cared for through integrated service provision. A common denominator for all regions was the need to improve care for patients with complex needs, including for example patients with diabetes mellitus (type I and type II), coronary artery disease, heart failure, depression, chronic obstructive pulmonary disease (COPD) or rheumatic diseases. Also, frail patients and female cancer survivors were addressed in some of the VIGOUR regions. In addition,

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the COVID-19 pandemic that emerged during the project has led some VIGOUR regions to expand their efforts to better integrate existing care processes to include patients with COVID-19 infection or specific COVID-19 risk groups.

Specific care interventions that were gradually integrated in the framework of VIGOUR, be it in terms of mere informational linkage of different services or a more comprehensive coordination of service delivery, also differ from region to region. This result may come as little surprise, as the VIGOUR regions have different starting points and levels of maturity in terms of care service integration efforts already pursued prior to the project. The further integration of existing care delivery processes in the framework of VIGOUR almost inevitably required different strategies, resources, and instruments to meet the locally prevailing framework conditions respectively.

In this context, the implementation of care pathways played an important role in almost all VIGOUR regions. Depending on the respective health care integration model pursued, the resulting care pathways took quite different forms. Some regions, for example, have defined new care pathways for individuals with specific diseases while others have developed collective care pathways for broader population groups. Still others have focused on expanding already existing pathways, for example, by incorporating additional care settings, stakeholders, patient profiles or transition points within the overall care cycle.

In many VIGOUR regions, the utilization of information and communication technologies (ICT) constitutes a major pillar for gradually integrating existing care delivery processes. Here, too, different types of digital health infrastructures and software tools were used for better integration of care processes cutting across different care organizations and/or sectors. In some cases, existing digital infrastructures and tools could be used, which may have been adapted or further developed. In other cases, new ICT applications had to be purchased or developed.

Not at least, capacity building represented an integral part of the overall activities pursued in all VIGOUR regions. Depending on the specific integration approach pursued in each region, these may concern the ability to use entirely new service delivery infrastructures (e. g. digital tools) and adopt related working models. Individual capacity-building measures targeted different professional groups from the health and social sectors, sometimes with a special focus on interdisciplinary education and training approaches. In addition, capacity-building measures were developed for patients.

Although the models of integrated care developed in the individual VIGOUR regions differ considerably from each other, some overarching topics can be derived from the VIGOUR project that should receive appropriate attention when introducing new models of integrated care. These are presented towards the end of this report (Chapter 4)

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3 Context-related integration models developed by the VIGOUR partners

As mentioned earlier, the methodological approach developed by the VIGOUR project takes account of the fact that integrated care is no "all-or-nothing" concept, and that its practical implementation within day-to-day practices is strongly context bound. It is thus clear that there is no "one-size-fits-all" solution.[8] To shed light on the specific care integration approaches developed by the VIGOUR partners, a short profile is presented for each pilot region in the following subsections.

3.1 Andalucía

Summary of the service integration ambition pursued in VIGOUR

The Andalusian Health Service (SAS) holds responsibility for health care provision throughout the entire region, whereby healthcare professionals rely on the use of a regional electronic health record and healthcare information system (Diraya). Social care is provided by a network of local services in the community, augmented by specialist services at the regional level. As the first point of contact for people with long-term care needs, typically, social service providers receive applications for service delivery under a statutory long term care scheme. The further application process is then administered by the Andalusian Agency for Social Services and Dependency (ASSDA) according to a legally defined procedure (Act 39/2006 on the promotion of the personal autonomy and care of persons in dependency situation). In this context, an eligibility assessment must be conducted by ASSDA relying, among other criteria, on a dedicated health assessment. The health assessment is carried out by healthcare professionals employed by the regional health service (SAS). In the VIGOUR project, the ambition was to better link health and social care services to streamline the legally required eligibility assessment procedure which involves health care professionals (SAS) and social care professionals (ASSDA).

[8] See for example WHO Regional Office for Europe: Integrated care models: an overview. Health Services Delivery Programme, Division of Health Systems and Public Health, Working Document, 2016

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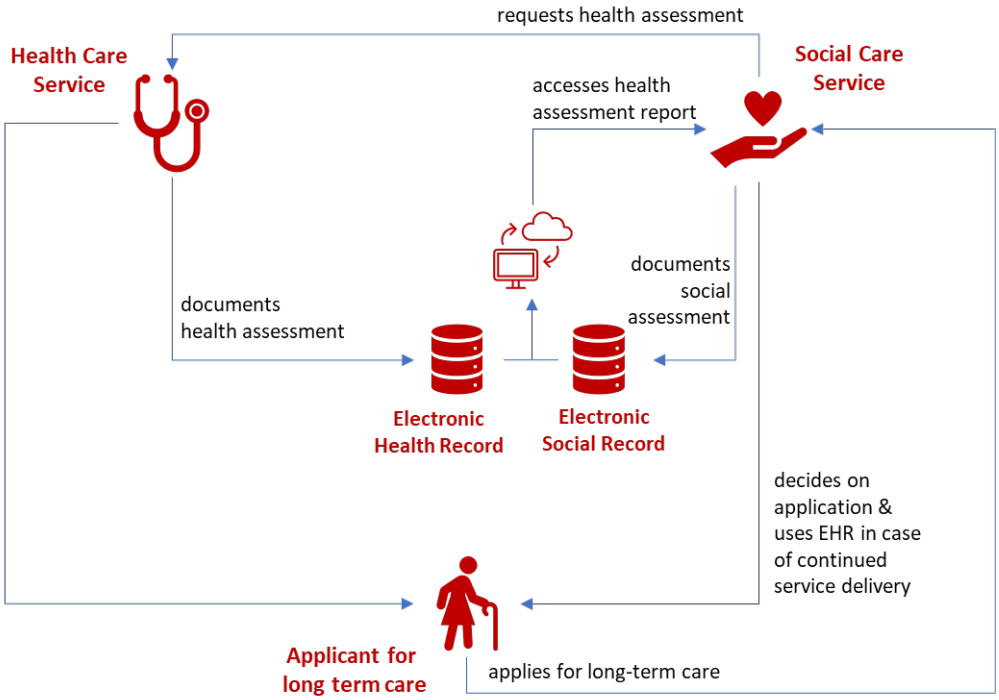
Summary of the service integration solution developed in VIGOUR

The linkage between the regional health care service (SAS) and the regional social care service (ASSDA) was improved by introducing a new, digitally supported eligibility assessment process, as graphically summarised by Figure 1. Before the VIGOUR project, the collaboration between the health care professionals and the social care professionals involved in the eligibility assessment procedure was carried out with help of a digital platform operated by the regional social care service (ASSDA) outside the electronic health record system (Diraya). The cooperation with the regional health service (SAS) took place exclusively in a paper-based procedure.

Figure 4 – Integrated Care Model in Andalucía



Source: VIGOUR ©

As part of the VIGOUR project, an electronic format for the legally required health assessment report was jointly developed by regional social care service (ASSDA) and health care service (SAS). An online-exchange procedure was jointly defined as well. Both components were technically implemented as part of the existing regional electronic health record and healthcare information system (Diraya). By means of the so called “report manager” utility, social care professionals at ASSDA can now access the newly designed electronic health assessment report directly in the electronic health record system and feed it into ASSDA’s internal IT system. To this end, ASSDA has developed a new platform for managing the application process for social services, which is again integrated into the overall IT system for social services (CoheSSiona).

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Conclusive outlook

On the health service side, health care professionals already had experience with the use of an existing electronic health record system (Diraya), which has been extensively used for quite some time. The solution developed in VIGOUR now allows medical staff to electronically generate the previously paper-based health report within the Diraya system they are familiar with. The regional social care service (ASSDA) which is, among other duties, responsible for managing the enrolment of care recipients to the statutory long term care scheme can access this health assessment report by linking to the health care IT infrastructure in the framework of a legally required health assessment. Within the VIGOUR project, 417 health assessment reports were generated by health care professionals throughout four selected primary healthcare districts according to the newly established process. A preliminary evaluation revealed a high level of user satisfaction and acceptance of among healthcare professionals, with a very positive feed-back on aspects concerning the integration of the new procedure into existing electronic health record system. Based on the technical linkage of the IT infrastructures of the health services and the social care service, the new health assessment procedure will be mainstreamed across the entire region of Andalucía. As in many countries, health care professionals and social care professionals in Andalucía have experienced a heavy work overload during the VIGOUR project duration due to the COVID-19 pandemic. Not at least against this background, the new health report developed in VIGOUR has proven to facilitate their daily work. The information is stored in the electronic health record and can be accessed as needed across existing infrastructural boundaries between the social care service and the health care service.

3.2 Campania

Summary of the service integration ambition pursued in VIGOUR

In Campania, the provision of coordinated health and social care services to people with complex support needs was already introduced in 2012 (Regional Law n.15 of 6 July 2012). Today, local health agencies hold responsibility for setting up territorial programs (Programma delle Attività Territoriali – PAT) to ensure that primary care and hospital care is delivered in a coordinated manner throughout their territory. So-called social territorial clusters (Ambito Sociale Territoriale) are inter-municipal governance units that hold responsibility for planning and overseeing social care services delivered by the municipalities. In

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collaboration with the local health agencies, they develop so called zone plans (Piani di Zona) setting out strategic objectives to be achieved by means of integrated service delivery. Moreover, the zone plans define the organisational set up for coordinated care delivery, the resources to be spent as well as related monitoring and evaluation methods. Integrated services are available to eligible patients, typically older people living in the community, after a formal needs assessment. However, the special care needs of children and adolescents with cerebral palsy have not been adequately covered by the existing integrated care model so far. As a result, the management of paediatric patients with cerebral palsy who suffer from gastrointestinal or nutrition related health problems is extremely variable throughout the regional territory. Such disorders are quite common in children and adolescents with cerebral palsy and can lead to significant subsequent problems for those affected. Apart from this, close cooperation between general paediatricians, hospitals and local referral centres is necessary for optimal care. The diagnosis and management of complex health problems such as nutritional and gastrointestinal conditions which are often associated with cerebral palsy require frequent hospitalisation. Today, patients are often inappropriately referred to centres outside the region. Therefore, multidisciplinary assessment and diagnostic testing during hospitalisation are often associated with considerable efforts and costs for the families, for example due to additional travel to specialist clinics and losses of working days. In addition, coordination between general paediatricians and hospital care is often difficult, e. g. due to long waiting lists and the lack of standardised clinical pathways. The primary objective pursued in the framework of the VIGOUR project therefore was to establish a care network around territorial hospitals for the diagnosis, clinical management and transition of children affected by cerebral palsy and associated nutritional and gastrointestinal health issues. In line with an existing national chronic disease plan, these activities aimed to improve the access to health services by children and adolescents with cerebral palsy and the quality of care available to them as well.

Summary of the service integration solution developed in VIGOUR

As graphically summarised in Figure 1, the model developed in Campania relies on the identification of a reference centre for children with cerebral palsy who suffer from nutritional or gastrointestinal complications. Training of general practitioners to a timely identification of eligible patients and their collaboration with the referral centre is crucial to adequately address GI and nutritional issues in children with CP. The general paediatricians who practice in the community screen their patients for nutritional and gastroenterological disorders. Such disorders are quite common in children and adolescents with cerebral palsy and can lead to significant subsequent health problems. Affected patients are referred to the reference centre according to a standardized diagnostic and therapeutic assistance pathway (PDTA).

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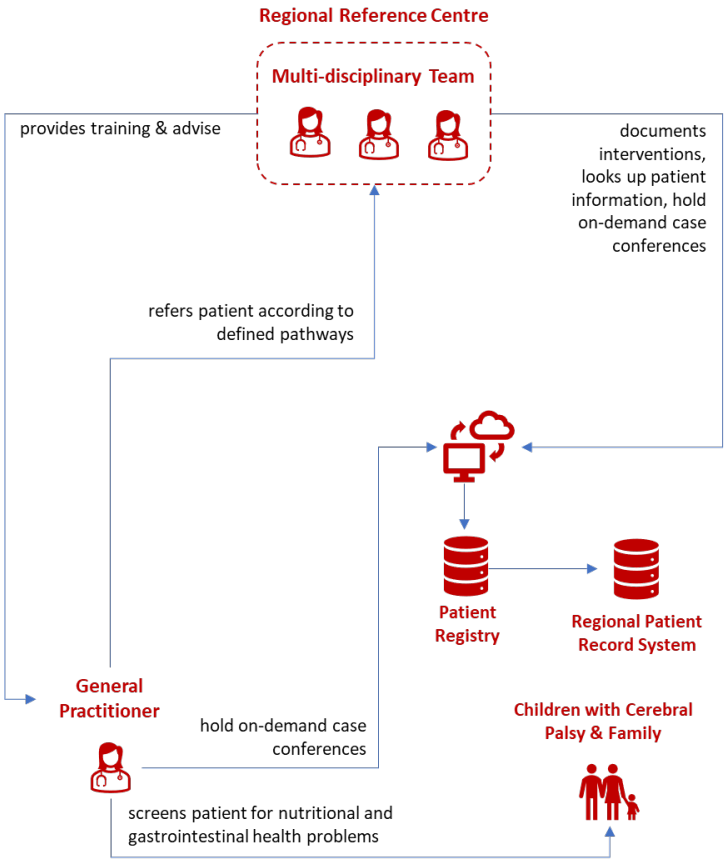
Figure 5 – Integrated Care Approach in Campania



Source: VIGOUR ©

Multi-disciplinary teams at the reference centre then perform diagnostic test and therapeutic measures according to defined clinical pathways. They hold remote case-based conferences involving different specialists to plan required healthcare interventions and define a personalised personalized care plan. The new pathways also include dedicated training measures to help patients and their families to acquire skills and confidence in managing the disease, the goal being to reduce the need for hospital care.

Conclusive outlook

A Regional Reference Centre was identified for the care of children and adolescents with cerebral palsy who suffer from gastrointestinal and nutritional comorbidities. Specific training measures for general paediatricians and healthcare providers were developed for the early detection of such gastrointestinal and nutritional health problems in paediatric patients with cerebral palsy. A regional registry of relevant patients was created which is expected to continuously grow in the future. Up to now, 72 patients have been enrolled. The technical infrastructure developed in VIGOUR will be further extended. Specific computer workstations are planned to be made available at different points of care for enabling teleconsultations. Moreover, it is planned to enable a direct export of person related information from the existing electronic record systems into the

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newly created repository of repository of patients with cerebral palsy suffering from gastrointestinal and nutritional comorbidities. Further, it is planned to develop a further pathway for the transition from paediatric care.

3.3 Crete

Summary of the service integration ambition pursued in VIGOUR

The main aim of the service integration efforts pursued in Crete was to develop tools for reducing vulnerability and improving quality of care in chronic diseases by linking primary health care with hospital and social care. This process focused on the expansion of existing and the development of new technologies, along with the update of guidance regarding the comprehensive patient monitoring and personalized care. Taking into consideration Crete's recent primary health care reform, an existing personal electronic health record system is intended to conclusively replace all paper-based medical record in both the public and the private sector over the coming years. Against this background, the VIGOUR activities in Crete focused on improving the exchange of patient related information among hospitals and social care services, and through the development of new tools for comprehensive patient monitoring and personalized care, in particular when to comes to patients with non-communicable diseases such as heart failure, coronary artery disease, diabetes mellitus, and depression

Summary of the service integration solution developed in VIGOUR

As graphically summarised by Figure 5, an internet service was developed to enable primary health care physicians to access patient related information stored by hospital physicians in an existing electronic health record system. Moreover, a mobile application was developed to enhance the flow of information about patients' chronic diseases and social care needs.

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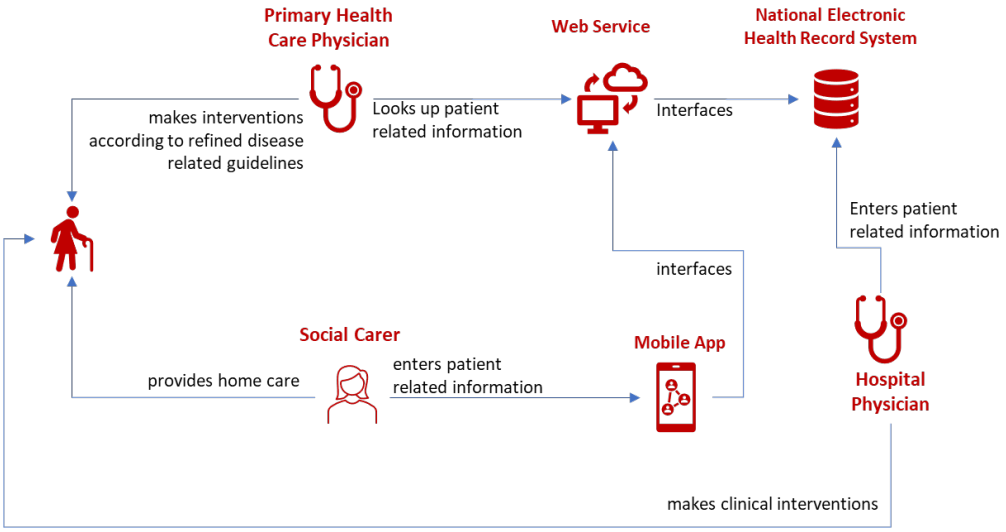
Figure 6 – Integrated Care Approach in Crete



Source: VIGOUR ©

Both applications are aimed to support the decision-making process and improve clinical outcomes and patients' quality of care. In addition to this, existing primary health care guidelines were revised with a view to supporting the multidisciplinary management of patients with multimorbidity, including diabetes mellitus, hypertension, coronary artery disease, heart failure and depression.

Conclusive outlook

During the VIGOUR project, a patient portal launched in primary health care has been expanded to include relevant information from the hospital electronic record system, such as discharge history, referrals, hospitalization history, laboratory test results, diagnostics and guidance given at discharge. In this context, the electronic communication between the system available in primary health care with the one that is in operation at the hospital setting was enhanced by developing certain IT mechanisms and pathways in the current web-services through a new web application entitled SYZEYXIS. This enables primary health care physicians to access essential patient information for proper decision-making. All participating primary health care professionals reported that SYZEYXIS was one of the most valuable and useful tools they have encountered, as it provided them with access to the patient's essential information. The greater reported advantage of the new web application was the fact that the whole process of updating the patient's electronic medical records was completed automatically from the hospital electronic medical record system.

Beyond better informational linkage between primary health care and hospital care, efforts were made towards the optimization of home care services through the development of a digital mobile application to enhance integration and assist chronically ill people in their autonomy and self-care management capacity. Although this could be achieved at a basic level within the duration of the VIGOUR project, primary health care

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professionals reported that there is still a need for further collaborations, exploitation of results and capacity-building to increase the provision of quality services and the effectiveness and efficiency of care that could be provided by the solution piloted within VIGOUR.

Overall, VIGOUR facilitated the development and implementation of novel approaches in primary health care in Crete and provided the opportunity to develop a strong stakeholder engagement network for further support. The activities and tools introduced by VIGOUR seem to have a substantial impact on strengthening and improving the capacity of the primary health care workforce and clinical decision-making. The exploitation of this outcome in other settings in Greece is another challenge. A proposal is currently being prepared and submitted for the Ministry of Health to include the revised guidelines developed in VIGOUR to the training hub for health practitioners that is going to begin its operations mid-September this year. Additionally, the revised guidelines are to be submitted to the Central Health Council for approval and further dissemination across the country to share the evidence in the rest of primary health care settings in Greece. They will be included in the training curriculum of the General Practice / Family Medicine Residence program in Crete, and the results will be evaluated. Also, joint training measures addressing primary care and social care practitioners started during VIGOUR will be continued. Apart from this, the VIGOUR innovations will be included as educational standards of the under- and post-graduate medical programme and the residency programme of the School of Medicine at the University of Crete. The revised guidelines are already included in the training curriculum of the general practitioners in Crete.

3.4 Emilia-Romagna

Summary of the service integration ambition pursued in VIGOUR

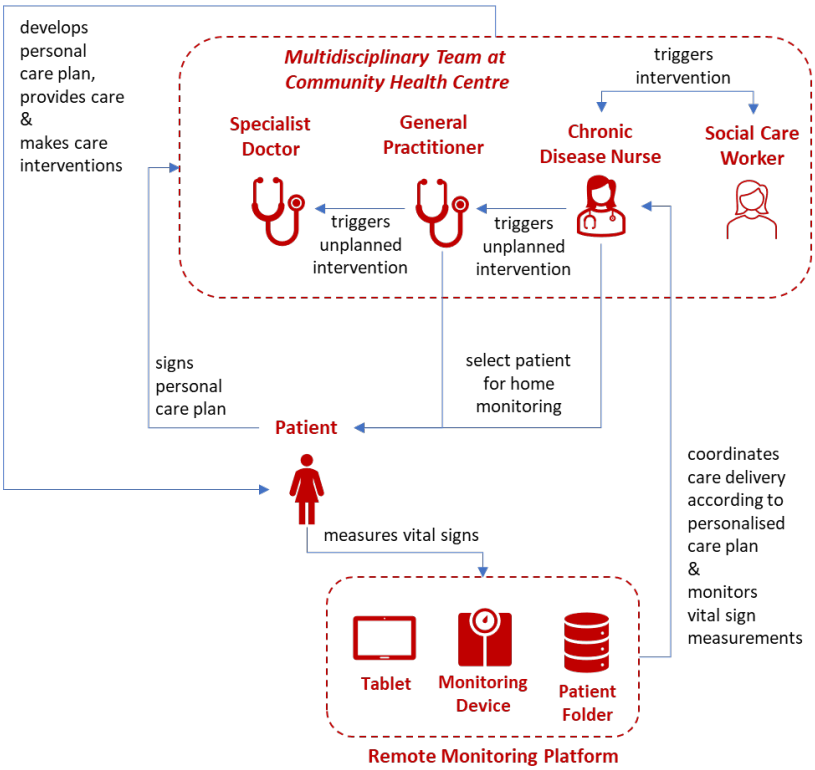
The health care integration efforts pursued in the framework of the VIGOUR project built upon an earlier telemedicine project that had revealed digital platform for the remote monitoring of patients with complex care needs, in particular patients suffering from diabetes mellitus (Type II), heart failure and chronic obstructive pulmonary disease. The objective pursued in the framework of the VIGOUR project was to develop a functional and organisational model for exploiting the capabilities generally provided by this digital tool

for the multi-disciplinary management of the patients, especially of those with complex needs.

Summary of the service integration solution developed in VIGOUR

As summarised by Figure 6, the patient management model developed in VIGOUR relies on multi-disciplinary care teams at 16 community health centres located throughout the region. Patients who have been selected and enrolled by these teams are equipped with medical devices such as tablets, electronic weight scales, blood pressure monitors, pulse oximeters, activity trackers. These devices enable the patient to submit relevant vital data from their home to the local health care centre with help of a mobile telecommunications connection. At the same time the patient receives health and social care according to a jointly agreed personalised care plan.

Figure 7 – Integrated Care Approach in Emilia Romana



Source: VIGOUR ©

A chronic are nurse, as a case manager, coordinates care delivery to the patient and regularly checks the vital sign values submitted by the patient to the community health centre. In case the chronic care nurse identifies a need for an unplanned medical intervention, she informs the general practitioner who regularly treats the patient. If required a specialist doctor ca be involved by the chronic care nurse or the general practitioner as well.

Conclusive outlook

During the VIGOUR project, the organisational model sketched above was at first piloted with two community health care centres under the auspice of the local health care authority of Parma. Particular attention was paid to the training of health professionals directly involved in the pilot activities and to the identification of potential barriers to the application of the new model under everyday conditions. After an initial pilot phase, the pilot activities were extended to 14 further community health centres belonging to the local health authorities of Piacenza, Reggio-Emilia, Modena, Bologna and Romagna. All in all, 150 chronic patients were enrolled to the new model. As a next step, the model will be extended to further community health centres in the region. During the initial VIGOUR pilot phase, some health care staff showed a certain level of resistance to adapt existing care practices to the new model. However, the resistance of health professionals has decreased more and more as the number of patients enrolled in the new model under the VIGOUR project has increased. Overall, the VIGOUR scaling-up pilot has demonstrated that the incorporation of a telemonitoring scheme into a multi-disciplinary care model represents a way to better join-up care delivery around the needs of chronic patients, and that such an approach can also contribute to their empowerment. In the context of the COVID 19 pandemic, the new care model has also shown advantages in enabling the provision of coordinated care even under conditions where direct physical contact had to be reduced as much as possible. A strong commitment at the management level of the local health authority can also be seen as an important factor for the success of the pilot activities. As a next step, the long-term impacts of the new model will be assessed, e. g. in relation to clinical and organisational aspects. For the future, it is considered to enable a systematic involvement of voluntary organizations into the digitally supported care loop managed by the community care centres. Moreover, it is considered to extend the new care coordination even further to hospitals located in the region, both technologically and service process wise, to streamline current referral processes.

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3.5 Lazio

Summary of the service integration ambition pursued in VIGOUR

In region of Lazio, the efforts pursued within the VIGOUR project for better join-up existing health care delivery processes built on an existing digital care platform that had been developed by the local health care authority of Viterbo. The ambition was to exploit the capabilities generally provided by this digital infrastructure for improving the management of patients affected by chronic diseases in terms of multidisciplinary, patient centred chronic care approach called "Smart Digital Clinic" (SDC). The overarching goal was to enable better joined-up care delivery to chronically ill patients by giving different health care providers (specialist doctors, nurses) who treat the same patient access a shared patient folder. This way the multi-disciplinary treatment was to be optimised, e. g. by avoiding overlapping diagnostics (e.g. repetition of the same lab tests in the same period prescribed by different specialist) and therapies prescription (e.g. drugs, in the light of polypharmacy and related risks). Furthermore, the aim was to harness telecare devices for delivering more person-centred care.

Summary of the service integration solution developed in VIGOUR

As visually summarised by Figure 7, specialist doctors at the health care centre treat chronic patient enrolled to the "Smart Digital Clinic" according to jointly agreed care protocols. In this context, they utilise a joint electronic patient where they document own care interventions and look-up any interventions made by other specialist doctors, when it comes to patients with complex care needs. At the same time, the patients measure selected vital signs such as blood pressure or weight on a regular basis and submit their measurements with help of a mobile telecommunications connection to the Smart Digital Clinic.

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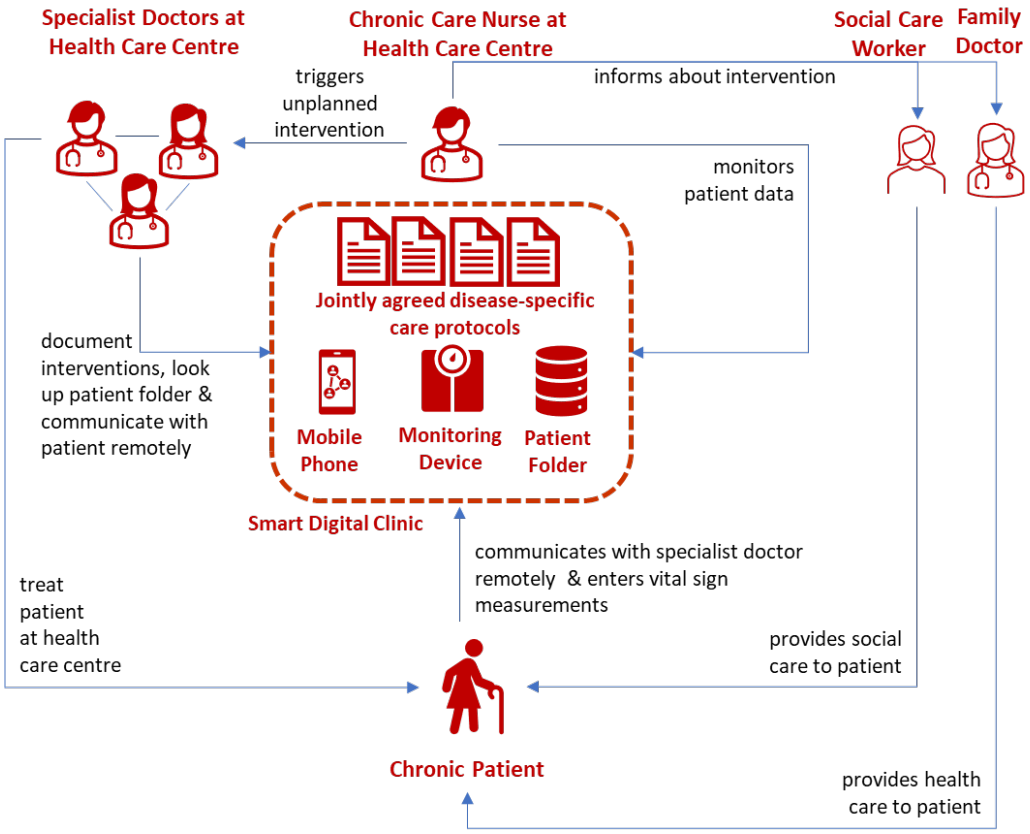
Figure 8 – Integrated Care Approach in Lazio



Source: VIGOUR ©

A chronic care nurse monitors the patient's' measurements and alerts the specialist doctors involved in the treatment of a particular patient should a potential need for an unplanned intervention arises. At the same time, the chronic care nurse informs the family doctor or a social care worker if deemed necessary.

Conclusive outlook

As part of the VIGOUR project, the existing Smart Digital Clinic concept was expanded from three to eight chronic conditions that can now be managed according to the multi-disciplinary approach (diabetes, COPD, heart failure, anticoagulation therapy, rheumatic diseases, geriatrics, neurology, pain therapy). To this end, additional multidisciplinary care protocols were collaboratively developed by different health care professions concerned. This way multi-disciplinary collaboration between health care specialists in new medical fields was enhanced. Furthermore, the platform was enriched by routinely provided indicators for the monitoring of the Smart Digital Clinic's performance based on available data. Technology development work became necessary for optimising existing platform functionalities (shared patient folder) and adding new ones (remote patient monitoring by means of a mobile APP). Beyond this, a training programme was developed and implemented to support health care staff and patients in utilising the "Smart Care Clinic". To comply with existing regulatory requirements, a new treatment and care model contract was developed which must be concluded with each individual

patient who wishes to receive care via the “Smart Care Clinic”. In response to the COVID-19 pandemic regional telemedicine guidelines and a regional plan for strengthening primary care were developed and implemented, and both ultimately enforced the activities pursued as part of the VIGOUR project. Within the duration of the VIGOUR project, the number of chronic patients enrolled to the “Smart Care Clinic” increased for the three conditions previously addressed from 11,622 to 15.032. For the newly added chronic conditions another 1,213 patients were enrolled during VIGOUR. Overall, 594 patients were equipped with a self-monitoring App. On average, 678 electronic communication messages were issued per month by patients or care providers via the “Smart Care Clinic”. By means of an internationally validated questionnaire (Patient Assessment of Chronic Illness Care - PACIC) the patients reported a high level of planned, proactive, patient-centred care. The level of service integration achieved around the Smart Digital Clinic concept in the framework of VIGOUR will be maintained in regular service provision in the pilot area.

Clearly, the emergence of the Covid-19 pandemic during the project absorbed substantial staff capacities, and this has ultimately slowed down the further upscaling process which will however be continued beyond the VIGOUR project. At the same time, the pandemic had also highlighted the need for a better coordination of health care beyond those chronic conditions originally targeted by the “Smart Digital Clinic” concept, which e. g. led to the development of a generic patient folder to support care delivery to other patient groups. As a result, the collaborative management of COVID-19 related services and remote services delivery to at-risk populations could be swiftly integrated into the Smart Digital Clinic concept. Various options are currently considered for systematically involving further stake holders in the Smart Digital Clinic concept such as family physicians and voluntary organisations. During the VIGOUR pilot a step towards closer collaboration with social care providers was made in terms of exchanging information on unmet patient needs, e.g., if health care professionals identify a potential need for social care. Based on experiences gained so far, further steps towards integrating health and social care delivery are envisaged to be taken in the future. Beyond the evaluation activities that were conducted within the boundaries of the VIGOUR upscaling pilot, longer term impacts of the level of service integration achieved during the project will in future be monitored with help of specific performance indicators developed for this purpose.

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3.6 Liguria

Summary of the service integration ambition pursued in VIGOUR

Throughout the region of Liguria, health care services are delivered under the auspice of five local health authorities (ASL) which are again coordinated by a central regional health authority (A.Li.Sa). Each local health authority in turn oversees several social health districts. Continuity of care is typically organised at district-level, by means of different services including hospice and palliative care, nursing home care, community home care and other geriatric services. On a case-by-case basis, relevant services tend to be delivered according to a personalised care plan tailored by multi-disciplinary evaluation team and according to related care pathways codified at the regional governance level. Against this background, the project activities pursued in Liguria were originally aimed at achieving more flexible service coordination at the local level in response to short-term changes in care needs which are not necessarily covered by the care pathways defined at the regional governance level. For example, unpredictable situations sometimes require flexible coordination between available home care services and palliative care. The COVID-19 pandemic that emerged during the initial phase of the VIGOUR project even enforced the need for flexible problem-solving in the context of long-term care. In particular, the needs for ensuring the continuity of care across of home care and palliative care services became apparent during the pandemic, while at the same time effectively managing COVID-19 related health risks of the care recipient. Especially at the beginning of the pandemic, there was a lack of personal protective equipment and an urgent need to limit the risk of spreading COVID-19 among caregivers and patients. The focus was therefore put on achieving flexible service coordination for long term care recipients at the point of care, which means in the local community, while at the same time effectively managing COVID-19 related health risks of the care recipients.

Summary of the service integration solution developed in VIGOUR

As graphically summarised by Figure 8, the integrated care approach pursued in Liguria builds upon a multi-disciplinary assessment of people in need of long-term care. In the local community, different health and social care services are then delivered according to a personalised care plan developed in response to the outcomes of the needs assessment. Based on the personal care plan, service delivery at the community-level

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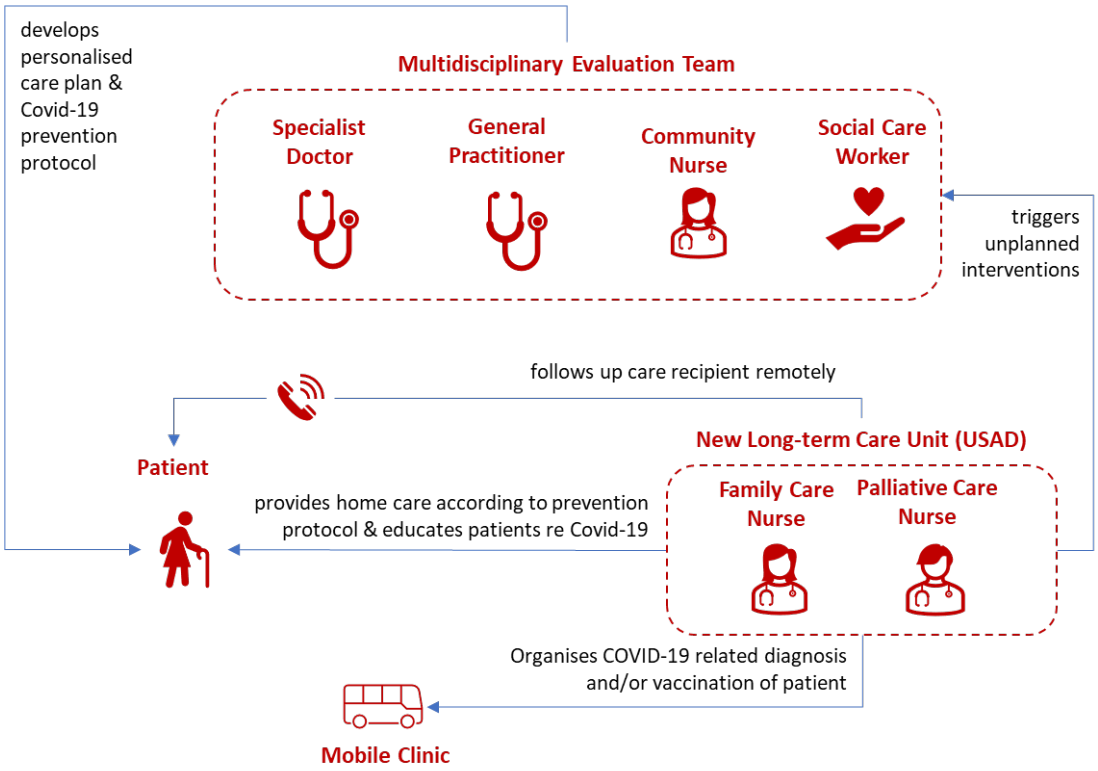
tends to rely on pre-defined care pathways. To enable more flexible problem-cantered coordination of care at the level of the local community, a new organisational unit was created, the so-called *Special Homecare and Home Palliative Care Unit* (UASD) operating in the local community. The unit comprises two nurses, a family and community nurse and a palliative care nurse. In collaboration with the multidisciplinary evaluation team, both nurses jointly manage long-term care recipients who are affected by COVID-19 in different ways.

Figure 9 – Integrated Care Approach in Liguria



Source: VIGOUR ©

To this end, a new COVID-19 related intervention protocol developed. It concerns symptomatic home care recipients affected by COVID-19 who do not require hospital care as well as patients discharged from the hospital after an infection. Also, the unit manages long-term care recipients showing COVID-19 symptoms but who have not yet been diagnosed. Moreover, the unit provides COVID-19 related education and organises vaccination of the care recipient. Since mid-2021, the specialist home care and palliative care unit has been able to rely on a mobile clinic, a specially equipped bus that travels to rural communities and also serves as a local hub for vaccinations. Where required, home care delivery is followed up by regular telephone calls.

Conclusive outlook

In Liguria, a new model of managing COVID-19 related risks of long-term care recipients was developed by means of the VIGOUR methodology. The model was successfully

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piloted in two social and health care districts. For the implementation of the pilot, cross-disciplinary collaboration among different service provider organisations and supervisory authorities turned out as crucial. Also, carefully designed training measures for care staff concerned contributed to the success of the pilot. As a result, the newly created Special Homecare and Home Palliative Care Unit (UASD) was able to ensure the continuity of care under the specific circumstances of the pandemic, while effectively managing COVID-19 related risks of the care recipients. In its role as a local intermediary between different health and care services available in the community, the newly created unit has helped to maintain multi-disciplinary care for vulnerable people in times of pandemic. The new model will be continued after the end of the VIGOUR project duration in the pilot area. The monitoring process that has been put in place during the VIGOUR project will be continued as well. This will allow for constant improvement of the new model and related quality assurance. It is expected that beyond the current Covid-19 pandemic, the new model will help to better manage further waves of infections such as seasonal flu.

3.7 Lodz

Summary of the service integration ambition pursued in VIGOUR

The health care integration efforts pursued in Lodz as part of the VIGOUR project focused on better interlinking the provision of hospital care and home care to frail people. Even if frail patients have been well-diagnosed and treated during a stay at the geriatric hospital ward, they often are requested to carefully follow further therapeutic recommendations upon returning into the own home. Typically, such recommendations concern the patients' daily routines, and not infrequently they tend to require the involvement of family carers and/or home care professionals. The Polish health care system in its current form does however not provide for structural coordination of care delivery in the transition from hospital treatment to continuous home care. Rather than waiting for respective structural reforms of the health care system, the activities pursed as part of the VIGOUR project therefore aimed at developing an easy-to-use tool that can be applied under the given framework conditions to better link hospital care and home care for frail patients.

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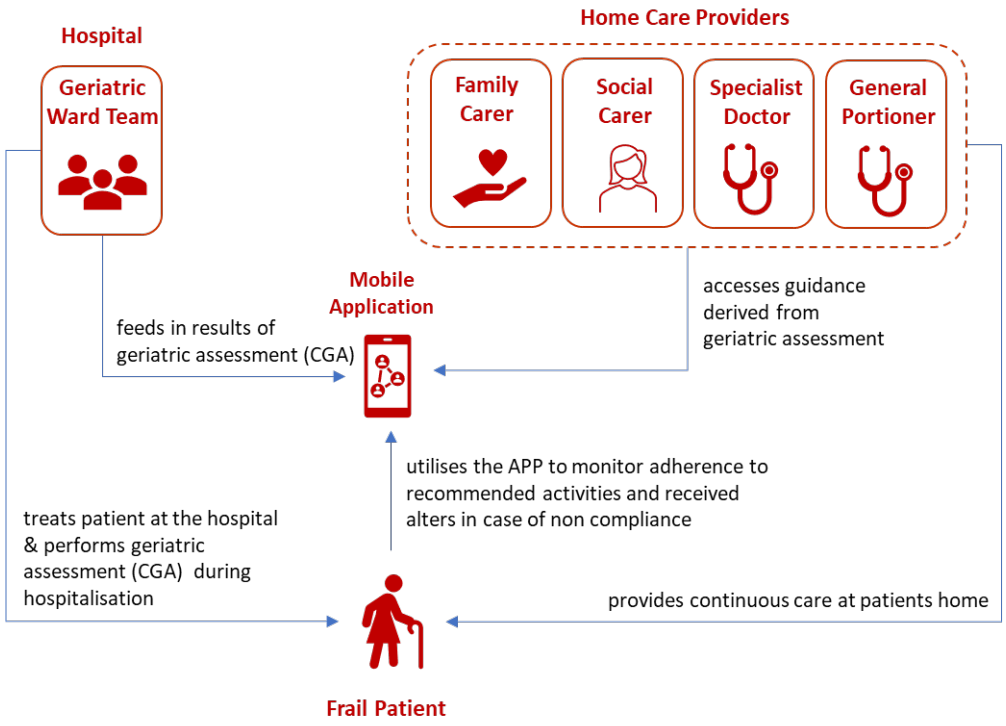
Summary of the service integration solution developed in VIGOUR

Lacking compliance with geriatric recommendations by frail patients after hospital treatment often contributes to a further deterioration of their health situation, which also tends to put additional strain on the medical and the social care systems. In response to this situation, a digitally supported process was developed that enables a better connection of hospital care with subsequent home care potentially provided by different parties within the silo structures of the current health and social care systems. This is graphically summarised by Figure 9. During the hospitalisation of a frail patient a multidisciplinary team comprising of a geriatrician, a doctor, a nurse, a physiotherapist, a psychologist and a dietitian performs several validated tests with the frail patient at the geriatric hospital ward. Each test contributes to the so-called Comprehensive Geriatric Assessment (CGA) which is required to be conducted according to national legislation. The assessment concerns the nutritional status of the patient as well the patient's functional and physical fitness. The mental condition and the risk of pressure ulcers are assessed as well. The outcomes of all tests are documented and communicated to the patient in form of a discharge report. The patient interprets the assessment results with help of a mobile application.

Figure 10 – Integrated Care Approach in Lodz



Source: VIGOUR ©

At the same time, he is supported by the mobile application in getting acquainted with health and lifestyle related recommendations resulting from the Comprehensive Geriatric Assessment (CGA). Compliance with recommended

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activities can be monitored with help of the mobile application as well. Upon the patient's consent, data can be shared with general practitioners, specialist doctors or social carers who may be involved in ambulatory care provision to the frail patient following a discharge from the hospital. This way, the mobile application supports better joined-up care delivery to frail patients after a hospital discharge.

Conclusive outlook

According to national regulation geriatric hospital wards must carry out a multi-disciplinary assessment of their patients, the so-called Comprehensive Geriatric Assessment (CGA). This regulation represented the starting point for developing digitally supported process in the framework of the VIGOUR project. According to the project's methodology, the process was co-developed with different stakeholder groups. The medical team of the geriatric ward at the University Hospital in Lodz was consulted patients and care providers from the patient's home environment. Based on these consultations' guidelines were developed for being communicated with help of a mobile application. The resulting mobile APP transfers patient-related specialist knowledge into easy-to-understand guidance supporting the patient after a discharge from the hospital. At the same time, upon the patient's consent, this information can be shared with other parties providing ambulatory care to the patient after his/her hospital discharge. The mobile App was successfully piloted in the metropolitan area of Lodz. Feedback collated from the pilot user suggests an improved sense of safety, whereas the demonstration of clinical effects requires further piloting. It is currently under consideration to expand the functionalities currently provided by the mobile App. Beyond this, options for including the APP in the Internet Patient Account (IKP) platform operated by the national ministry of health are currently discussed.

3.8 Northern Ireland

Summary of the service integration ambition pursued in VIGOUR

In Northern Ireland the health system is integrated in terms of health and social care delivered through health and social care trusts. However, co-ordination at a broader level between general practice and the community and voluntary sector is more fragmented. Typically,

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collaboration is dependent on local relationships and not delivered in any systemic way. Against this background, the integrated care approach pursued in the framework of the VIGOUR project builds upon a growing movement that, under the heading of "social prescribing", aims to link statutory health care services with non-medical support typically delivered by the community and voluntary sector. Over the last years, a very diverse range of social prescribing schemes has started to emerge in local communities throughout Northern Ireland. Such schemes are primarily but not exclusively aimed at people with long term conditions. Some schemes also support people with low-level mental health issues and those who may be socially isolated. In essence, social prescribing schemes enable health care professionals such as general practitioners to refer patients to supportive service offerings locally available from outside the statutory health and social care system. Often, a so-called "link worker" takes the role of a case manager supporting the patient in finding the way from the doctor to appropriate support services available in the local community and to make use of these services in the longer term. The ambition pursued in VIGOUR was to promote a more systematic use of high-quality social prescribing.

Summary of the service integration solution developed in VIGOUR

The solution developed within the VIGOUR project considers the fact that multiple different models of social prescribing are already in existence, but without any underlying strategy and with no co-ordination across the models. Multiple stakeholders with an interest in social prescribing were identified. But there was no meaningful way of engaging with them in a co-ordinated manner. As graphically summarised by Figure 10, a organisational infrastructure was therefore set up. This model enables multiple stakeholders to systematically co-develop the concept of social prescribing as a means of quality ensured linkage between the health care system and community-based support offerings. A strategic body, the so-called Social Prescribing Strategic Development Board, was set up to bring together senior leaders and managers from across a wide range of sectors and government agencies to agree key principles of social prescribing, with a view to driving forward the scale up and spread in a co-ordinated way.

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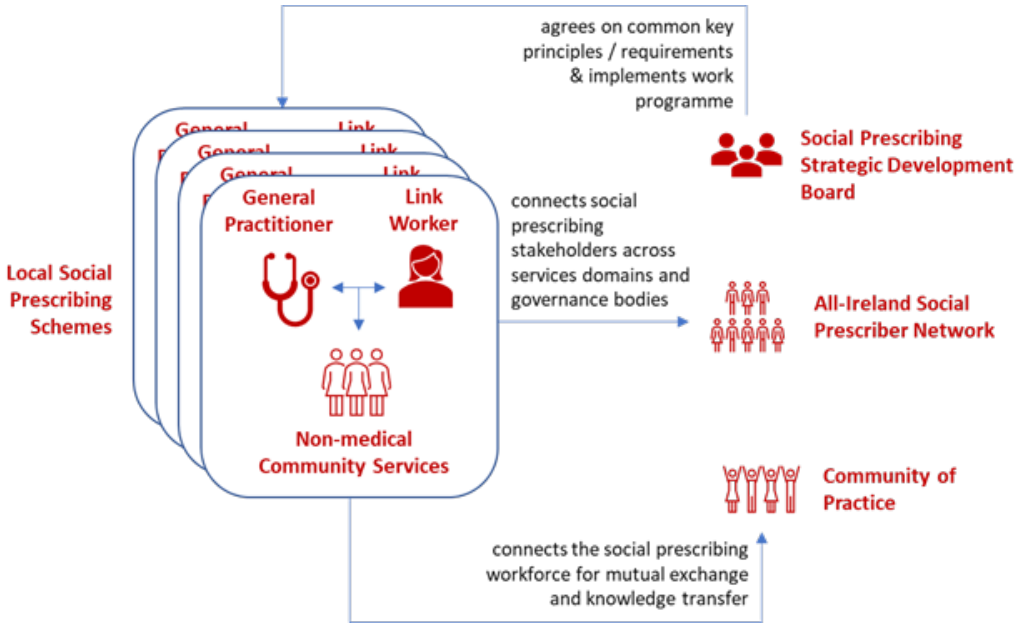
Figure 11 – Integrated Care Approach in Northern Ireland



Source: VIGOUR ©

The social prescribing workforce has been connected by setting up a community of practice with help of a digital platform. This helps to build more consistency of the social prescribing approach across locally implemented schemes from a more hands-on perspective. Moreover, the community of practice enables to share lessons learned and challenges identified under day-to-day conditions and to inform how local scale up plans are developed. Apart from this, social prescribing stakeholders from a diverse range of sectors and backgrounds were connected by systematically liaising with a country wide network, the so called All-Ireland Social Prescribing Network.

Conclusive outlook

A collaborative leadership and governance approach was adopted for the purposes of the VIGOUR project. Right from the beginning, a broad range of stakeholders were involved in the project to discuss and agree how the concept of social prescribing could be scaled up and spread in a meaningful manner. To this end, representatives from the health and social care domains were brought together with stakeholders from the voluntary and community sector. Also, representatives from local councils were involved at an early stage. Taking the time to build relationships, supporting networks to develop and to focus on what stakeholders see as important rather than just setting up working groups in a top-down manner has again led to much more support than just expecting stakeholders to get involved to deliver projects priorities. People tend to be much more willing to learn from other areas of good practice and to adopt models from elsewhere when they are not imposed, and when the adoption of good practice is seen as an evolving process with room for discussion and for models to be adapted for local circumstances. All in all, it has been a slow process to bring stakeholders together from

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across government departments and across sectors and to start to work collaboratively, but the process has finally yielded an agreed plan to further scale up activities in a co-ordinated way across a diverse range of organisations and government departments. To further support this process, the new collaboration infrastructure set up during the VIGOUR project will be maintained. Based on a jointly agreed definition of social prescribing and agreed principles of social prescribing, which both did not exist before VIGOUR, ongoing work focuses on co-developing a minimum outcomes framework and agree on core competencies for social prescribing link workers. Based on these components, social prescribing will be anchored within relevant strategies as a tool for improving population health and addressing health inequalities. There have been some early signs that pooled budgets and aligned use of resources across a range of organisations and sectors may be possible in the near future based on the work achieved in the VIGOUR project. It is recognised among the stakeholders that the social prescribing intervention has benefits across many sectors and that match funding or pooled budgets is a reasonable approach.

3.9 Piemonte

Summary of the service integration ambition pursued in VIGOUR

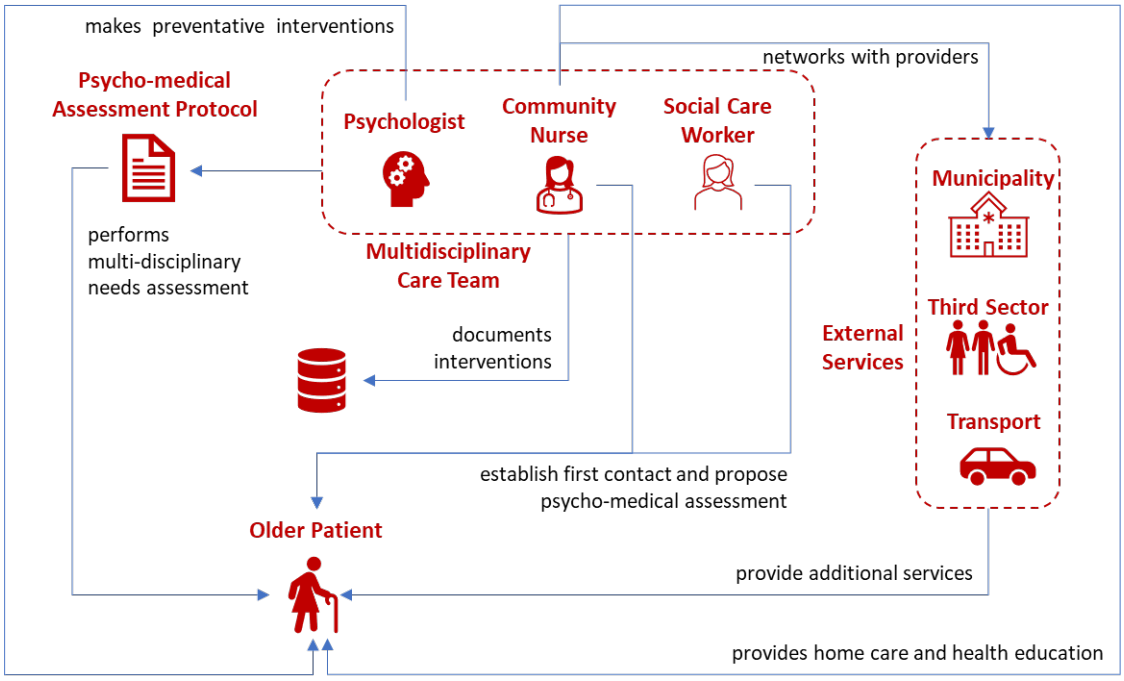
The healthcare authority of the region of Piemonte holds responsibility for ensuring region-wide provision of chronic care in accordance with requirements imposed by the national ministry of health. A chronic care plan developed by the regional health authority sets out an organisational model for the delivery close-to-home services through multidisciplinary teams, including health care professionals and social care professionals. Throughout the region, local health units have recently implemented a new organisational model for health and social care service delivery relying on a network of community care centres (Case della Salute) established throughout the region. Specific pathways have been established for the major chronic diseases to diagnose and care for those affected, complemented by a disease prevention plan. The community care centres and the local health units hold responsibility for providing basic primary care and health promotion services through multidisciplinary teams located in the same building. An analysis of care needs revealed that loneliness represents a health risk for a considerable share of older people living in the region. Considering the association between dementia and loneliness the ambition was to coordinate dementia prevention through the multidisciplinary teams at the

community care centers. Against this background, the aim was to integrate psychological expertise into the multidisciplinary teams at the community care centres, which previously consisted mainly of medical doctors, family nurses and social workers.

Summary of the service integration solution developed in VIGOUR

As graphically summarised by Figure 11, the multi-disciplinary approach developed in part of the Vercelli province of Piemonte builds on a multidimensional assessment protocol developed in the framework of the VIGOUR project. The protocol represents a basis for decision making on how to integrate psychological dementia prevention measures within the overall service portfolio for long-term care recipients at risk of facing health related impacts due to loneliness. Typically, such risks concern older patients who suffer from one or more chronic condition and who live alone in their own homes. The assessment protocol is applied by a multi-disciplinary team comprising of a family and community nurse, a social care worker and a psychologist during a home visit or during a clinical visit at the community health centre.

Figure 12– Integrated Care Approach in Piemonte



Source: VIGOUR ©

The various care professionals involved in the overall process document the services provided to the patient and relevant patient related information in a common data base. The data base is also used to share calendars of the professionals involved and related contact data. If required, personal transport is organised by the team at the local health care centre on a case-by-case basis. Based on the outcomes of the multi-dimensional assessment protocol, psychological interventions for dementia prevention are proposed and incorporated into the patient's overall service portfolio coordinated by the

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community care centre team. In this context, the family nurse has a central role in case management by organising the assessment of the patient's needs and arranging personal transport if required. Beyond providing home care and health education to the patient, the family nurse also networks with other relevant services provided by organisations outside the community care centre. These may for example concern as social services available from the municipality or support service available from third sector organisations, let them be provided by volunteers or professional staff.

Conclusive outlook

The model described above was piloted in the area of the local health unit of Vercelli covering 88 municipalities located in the province of Vercelli and several municipalities located in the provinces of Biella and Novara. In total, the local health unit is responsible for the care of 167,308 inhabitants. The activities pursued in the context of the VIGOUR project have boosted new professional relations along the vertical structure of the regional health care system. With a view to meeting the needs of the target population identified for the VIGOUR project, different services of the local health unit for the first time systematically co-developed common goals and instruments. This aspect in itself has already contributed to the creation of more solid network structure. Team building activities conducted around the VIGOUR pilot, including both care professionals and decision makers at the strategic service management level, have further contributed to this. Care professionals from different domains participated in the co-development of a consolidated view on the needs of the target population and to the creation of the multi-dimensional needs assessment instrument. Also related intervention planning was conducted in a multi-disciplinary manner. This work was complemented with a systematic review of voluntary organisations operating in the area. The newly established collaboration structure is now formally recognized in the local health units' strategic planning. The occurrence of the COVID-19 pandemic has put a considerable strain on all services involved in the new cooperation model and has absorbed significant capacities. Moreover, respecting the "chain of command" internal to the local health unit when engaging with diverse stakeholders has extended the time required for implementing the first phase of the VIGOUR pilot, especially when it comes to the design of multidimensional needs assessment instrument and related operational aspects. Against this background, the pilot activities could start only with some delay so that the pilot is still ongoing. Impacts will therefore be further monitored until October 2022. Nevertheless, some conclusions can be drawn already now. To begin with, it has become clear during the first phase of the VIGOUR project that building relationships among professionals and facilitating co-planning and co-working is not an easy task. It is not sufficient to just create the opportunity for co-working and joined-up service delivery because it cannot be taken for granted that professionals will always welcome more collaborative ways of working. Good leadership is the key to spreading a network culture and shared goals, ambitions and values. To promote change in existing working practices, it is fundamental that decision makers in the local health units develop a clear vision and strategy about the expected change, and that these are clearly

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communicated to the professionals working at different levels in the overall care chain. In this context, the identification of a common vocabulary has turned out as fundamental for effectively communicating such a strategy across different service domains and levels. In this regard, a glossary shared among all professionals involved turned out as a useful means for reducing the risk of misunderstanding and conflicts among them. Apart from this, a brief training of professionals on the general concept of integrated care and hands-on experiences gained so far turned out as helpful in facilitating attitudinal and behavioural change at the part of care professionals. When it comes to the technological infrastructure available to support the new service model developed in the VIGOUR project, it was clear right from the beginning that no dedicated digital solution could be developed or procured within the boundaries of the current project. However, the experience gained so far suggest that the newly developed model can effectively be supported by means rather low-cost mainstream applications such as Microsoft Excel. As a next step, it is planned to include the new model piloted within the VIGOUR project as “good practice” in the statutory Local Prevention Plan of Vercelli’s local health unit. Moreover, it is planned to progressively integrate further external organisations and stakeholders such as general practitioners and local volunteering organizations into the model. Based on the experiences gained so far, it is envisaged to co-develop further preventive and health promotion interventions with the different services and organisations that are involved in the collaborative mechanism set up during the VIGOUR project.

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3.10 Styria

Summary of the service integration ambition pursued in VIGOUR

The importance of an optimal diet for geriatric patients to avoid consequential health damage has been known among experts for some time. Especially malnutrition constitutes a major challenge in this regard and the number of geriatric patients identified as malnourished increases with rising age. In Styria, the activities within the VIGOUR project therefore aimed at a better integration of nutritional competence into inpatient long-term care for older people. The styrian hospital trust KAGes is the body responsible for management of the three nursing homes. The hospital trust employs nurses, cooks and special allied health professions (MTDs) such as dieticians or physiotherapists on a case-by-case basis and according to medical referral. Basic medical care for the residents of the nursing homes is provided by general practitioners who practise under the national health insurance contract in the local area around the care homes. Typically, basic medical care is provided by three to five physicians from the vicinity of the respective nursing home. So they are not directly employed by the hospital trust. When it comes to the provision of specialist health care to the nursing home residents, the nearby located hospitals play an important role. The in-house teams at the nursing homes work with an existing electronic information and communication system operated across all facilities of the hospital trust, the so called openMEDOCS system, thereby also providing linkage to patient data management across all hospitals and nursing homes of the KAGes hospital trust. General practitioners use a national electronic health record, the so-called ELGA system, to retrieve and document patient-related information. This system is embedded within the internal information and communication platform of the hospital trust (MEDOCS). This allows the local general practitioners to also share patient information with the in-house teams at the nursing homes. Technology wise, linkage to the in-house kitchens and information exchange with the cooks is provided by an electronic meal-supply system operated by the hospital trust, the so-called VESTA system. Against this general background, the aim was to harness the available infrastructure for a closer collaboration of the different care specialities by means of newly developed nutritional pathways and related capacity building of care staff.

Summary of the service integration solution developed in VIGOUR

The solution developed in the framework of the VIGOUR project is graphically summarised by Figure 12. The new approach centres around an interprofessional

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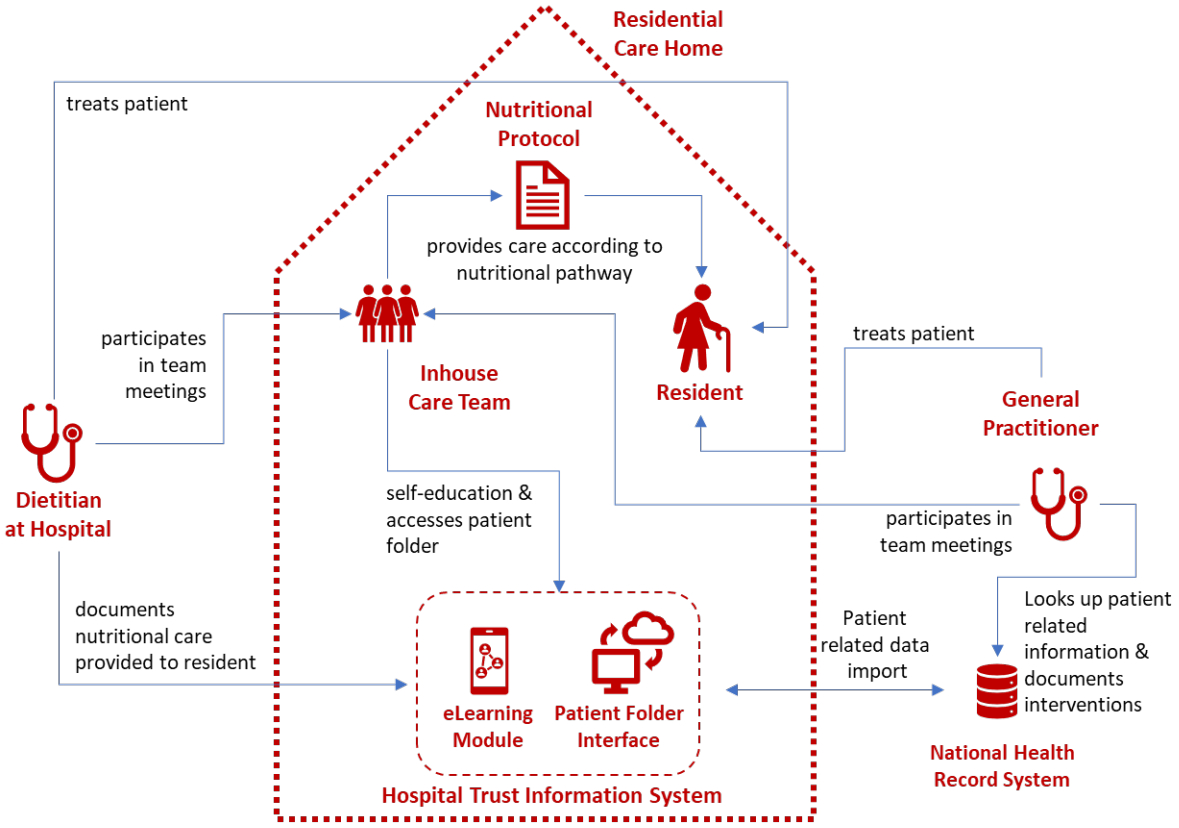
nutritional pathway co-developed by the different stakeholders in the framework of the VIGOUR project which is intended to serve as fundamental algorithm of action for the inter-professional care team.

Figure 13 – Integrated Care Approach in Styria



Source: VIGOUR ©

Moreover, a new online learning tool was developed to enable continuous capacity building at the part of the multidisciplinary care staff at the nursing home. The tool has been integrated into the hospital trust's internal training platform. The new model promotes informed communication and collaboration between the different professionals involved in the care process to enable integrated, interprofessional nutrition care in inpatient long-term care and an improved interface management. An important aspect of this model is to align existing capacities in such a way that more efficient care is possible and daily work is simplified.

Conclusive outlook

The new model was developed and piloted in three Styrian nursing homes. In methodological regard, the new model was developed by adopting a design thinking approach. In this context, a series of inter-professional team-meetings were held involving the inhouse care team at the nursing home, involving for example nurses, dieticians, cooks, and general practitioners. One key outcome of the pilot activities that

is worth to be noted concerns the fact that the daily routines in the three nursing homes involved already differed considerably before the VIGOUR project, although they are all operated by a single hospital trust in the same region. As a result, the implementation activities in relation to the new model sketched above differed on micro-level and required adaptation to the respective "in-house context" prevailing in each nursing home. From a bird's eye view, however, the strong leadership by the Styrian Hospital Association KAGes with its clearly established decision-making hierarchy and clearly distributed roles and competences has proven to be an important factor for the successful implementation of the project. However, the human resources required for implementing the VIGOUR pilot turned out to be higher than initially expected, and this situation was aggravated by the occurrence of the COVID-19 pandemic during the VIGOUR project's live cycle. Therefore, the most synergetic use of interdisciplinary meetings was necessary at all pilot sites. For example, individual meetings had to be used for the simultaneous exchange of project information and for training purposes. Based upon the existing technological infrastructure, especially the openMEDOCS platform, inter-professional communication with external stakeholders could be fostered up to a certain extent. Changing existing working routines across all service delivery levels has itself proven to be a tough process, even if they are generally considered inadequate by the professionals concerned. As a reaction to this, incentives were developed at one of the nursing homes involved in the VIGOUR pilot for health and social professionals for more often relying on the available digital infrastructure. In future, this approach can serve as "good practice" for deploying the new model to further nursing homes. Best practices, experiences and processes arisen during the VIGOUR implementation phase will be kept and sustainably transformed into everyday routine. The model developed and piloted in the framework of VIGOUR has already won a national award competition. The so called INTEGRI award is an Austrian national prize awarded every two years to organisations and people who make a valuable contribution to the development of integrated care. The jury explained its choice by the high importance of optimal nutrition for geriatric patients to avoid subsequent health damage. According to the jury, the integrated care model developed in the framework of the VIGOUR project highlights the often-neglected importance of indicator-based integrated care processes and makes a major contribution to geriatric health. Furthermore, the project's emphasis on communication and optimal nutrition, which cannot be taken for granted, was highlighted.

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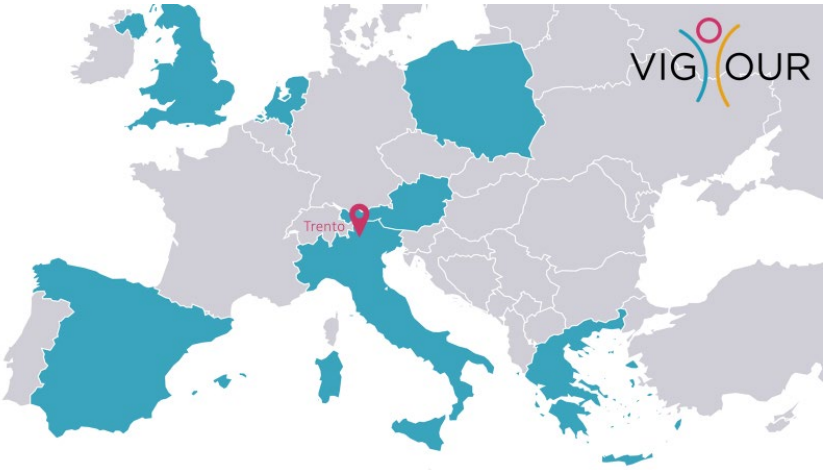
3.11 Trento

Summary of the service integration ambition pursued in VIGOUR



In 2016, the provincial government of Trento launched a regional competence centre for the development of digital health, Trentino Salute 4.0, through a formal legal act. The competence centre plays a strategic role in boosting digitalisation of health care in the region. The Autonomous Province of Trento (PAT) and the Provincial Healthcare Trust (APSS) are represented as decision-making bodies, whilst the Bruno Kessler Foundation (FBK) is a reference centre for technology and research. Among other activities, Trentino Salute 4.0 supports the development of an electronic health record system, the so-called Trentino Citizens Clinical Record (TreC+). Moreover, the competence centre supports patient-oriented health care delivery by developing and providing standardised, user-friendly eHealth applications such as mobile applications for medical referrals, prescriptions and advanced telemedicine services. Such digital tools are interconnected with the electronic health record system. Together they constitute the so called TreC+ ecosystem as a basic digital health care infrastructure operated throughout the region. The system is used by more than 265.000 citizen throughout the region (about 50% of the overall population) via a public internet portal as a “one-stop-shop” to the regional health care system. About 90.000 citizen access the portal by means of a mobile device (as of 31/07/2022). Against this background, the ambition was to harness the available technological infrastructure for supporting a multi-disciplinary care model addressing patients who suffer from diabetes or heart failure. More specifically, the aim was to set up a chronic care platform as part of the TreC+ ecosystem to enable communication between patients and health care staff, but also for supporting telemedicine and a novel organisational asset based on multi-professional monitoring and management of the patients with the support of new technologies.

Summary of the service integration solution developed in VIGOUR

The health care integration approach pursued in the VIGOUR project centres around the integration of two platform components, TreC Cardiology and TreC Diabetis, into the existing digital health care infrastructure in terms of a chronic care portal (TreC+), as graphically summarised by Figure 14. As can be seen from the diagram, a specialist doctor assesses the patient and, if deemed medically appropriate, prescribes a

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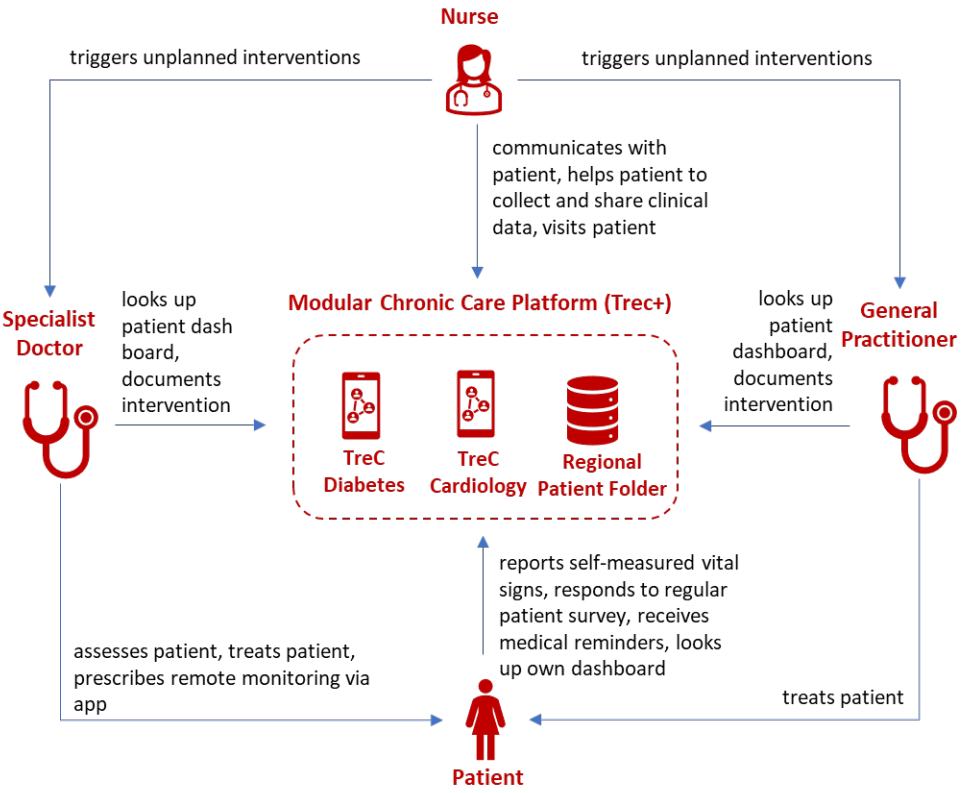
telemedicine system. According to a personalised care plan the patient measures selected pieces of information and reports the accomplishment of selected tasks on a regular basis. A nurse communicates with the patient on a regular basis and provides support if required. The nurse also monitors the patient's measurement data and contacts a doctor in case an unplanned intervention becomes necessary. The specialist doctor and the general practitioner who treat the patient look up patient related information stored in the patient's health folder. They also document their own interventions.

Figure 14 –Integrated Care Approach in Trento



Source: VIGOUR ©

The TreC Diabetes platform component includes two main features, namely a mobile app interface used by the patient and a web dashboard used by health care staff. Through the mobile app, the patient reports on his health status with the support of an automated system, a so-called chatbot (virtual coach), according to selected questions. Moreover, the app includes a personal diary with medical reminders and self-reported patient data. A diabetologist can prescribe the app in the framework of a personalised care plan as part of the standard treatment. During the first weeks after the prescription, the patient's adherence to the treatment is monitored via a virtual coaching feature included in the TreC Diabetes app. At the health care service's side, health professionals can view the patient's data with help of a medical dashboard on a regular basis and modify the treatment with a view to increasing the patient's adherence. When needed, they can prescribe a tele visit and other medical examination to be performed before the

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visit. Results can be uploaded onto the tele visit system which enables a more complete picture during the visit. Basically, the same model developed for patients with diabetes was expanded to patients with heart failure with help of the TreC Cardiology platform component. Here, a specific questionnaire based on validated items is administered via chatbot to regularly monitor symptoms reported by the patient that relate to heart failure.

Conclusive outlook

The Trentino Citizens Clinical Record (TreC) has been developed as a modular system whose extensible architecture allows sub-systems to be integrated for the provision of specific services. The TreC Diabetes component and TreC Cardiology component piloted in VIGOUR will be sustained as part of the overall TreC infrastructure. The digitally enabled chronic care model sketched above was piloted with a confined number of patients. As a next step, it is planned to increase the number of enrolled patients step by step and expand the use of the platforms as part of the routine clinical practice. During the VIGOUR project, different working groups such as a privacy group, a technology group and a change management group were set up as a means of achieving consensus-oriented decision-making by involving health professionals and decision makers at the service management level. Joint development labs have turned out as a useful means of multi-disciplinarity, inter-professional co-creation which also involved patients, information technology experts and front-line care staff. Apart from this, proper training of those professionals using the technological components as part of the chronic care model has turned out as essential. Beyond knowledge about the specific functionalities provided by the new applications, this also concerned general IT skills and knowledge about general principles of digitally enabled health service delivery. Also, measures to promote team culture among the different professions involved needs to receive appropriate attention.

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3.12 Trieste

Summary of the service integration ambition pursued in VIGOUR

For several years already, the regional health authority of Trieste and Gorizia in the region of Friuli Venezia Giulia has been pursuing various measures for delivering health and social care in an integrated manner, not at least due to a high share of older people living in the area. All in all, 30% of the population living in the territory is older than 65 years. Today, the so-called personal health budget (Budget di Salute) represents a key means for delivering primary health care in conjunction with other support services addressing the needs of frail or chronically ill people. It provides a funding mechanism for the delivery of personalized care cutting across a range of different services, often involving the third sector and specialized support services. In general, these services target people with complex care needs who require multi-disciplinary support to promote their access to healthcare, employment, social relationships, or independent living more generally. However, this instrument is not used in a consistent manner in all health districts in the region for the provision of integrated support services. When it comes to the day-to-day provision of integrated care services, the service landscape today therefore looks quite different in local health districts across the region. The Trieste Health District, for example, has a long history and a consolidated strategic background in the development of integrated care. Here, efforts to deinstitutionalise health care began as early as 1980 with the so-called Basaglia reform in mental health care. However, there is currently a gap in the integrated care of vulnerable patients between the occurrence of an emergency event and the agreement of a joint plan for their long-term care by different services available in the community. As a result, there are often temporary hospital admissions that would not be necessary in every case from a purely medical perspective. The ambition therefore was to close the current gap in the provision of integrated home care to vulnerable patients immediately after an emergency.

Summary of the service integration solution developed in VIGOUR

The solution developed in the VIGOUR project centres around the systematic involvement of local third sector organisations in the delivery of home care to vulnerable patients during the first days after an emergency has occurred. This is graphically summarised by Figure 15. In line with an established model of continuity of care, the

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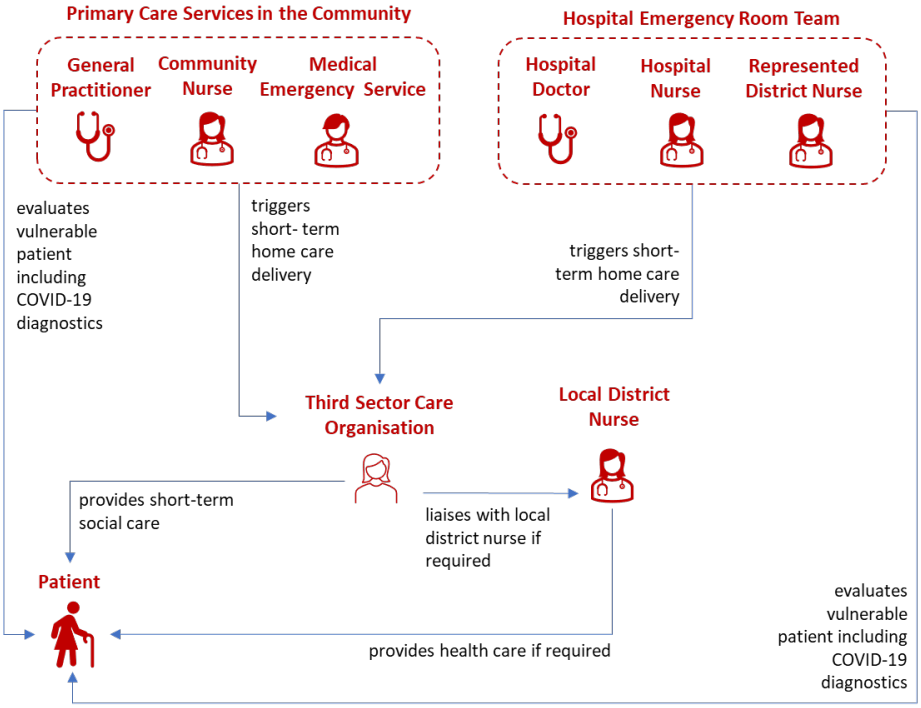
hospital ensures that not only a hospital doctor and a hospital nurse are always available in the emergency department, but also at least one community nurse from one of the health districts in the region.

Figure 15 – Integrated Care Approach in Trieste



Source: VIGOUR ©

Should the assessment reveal that the patient does not require a treatment at the hospital, but at the same time is unable to stay in his or her own home without any support, short term social care by a third sector organisation is triggered through a fast-track intervention within three hours. Based on the same assessment protocol, the new VIGOUR pathway for short-term home care can also be triggered directly by local primary health care providers to avoid going to a hospital emergency room. The third sector organisation provides social car for a maximum of seven days, until a long-term care plan is agreed. During that period, the social care worker also leases with local health care providers in the patient's local community should any unexpected health care intervention become necessary. The new service is financed in the framework of the personal health budget. Due to the occurrence of the COVID-19 pandemic within the VIGOUR project duration, the initially developed multidimensional assessment protocol was also extended to COVID-19 diagnostics.

Conclusive Outlook

The model sketched above was successfully piloted in all territorial areas managed by the local health authority of the cities of Trieste and Gorizia. This area encompasses six local health districts. During the VIGOUR pilot activities, details of the model had to be adapted to the local circumstances prevailing in each of the local health districts on a

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case-by-case basis, especially when it comes to the involvement of different social cooperatives at the local level. During the VIGOUR pilot, 104 older patients have been referred after an emergency to the integrated short-term care pathway developed in the project, which means hospitalisation could be avoided for these patients. On average, each patient received 2 hours of home care per day under the new scheme. As a result, the average care costs per day and patient amounted to 46.94 euros. If the patients had to be temporarily hospitalised, as was usual before VIGOUR, the costs per day and patient would have amounted to 184.- euros. In the light of these results the regional health authority has decided to continue the provision of the services model developed in the VIGOUR project. In this context, the local health authority (ASUGI) will formalise its further collaboration with the social cooperatives in the area within the framework of the personal health budget. To this end, the new service model will be defined as a new service beyond the VIGOUR project. This will also include the definition of a dedicated budget for the next planning period. To foster the effectiveness of the service model in all health districts the local health authority will launch a training program comprising two workshops per district. The workshops will impart a set of competences required to foster integrated care and continuity of care within emergency services. The training program will also include local visits throughout the region to enable knowledge transfer among health care professionals involved within and beyond the boundaries of individual health care districts. In the longer run, opportunities for harnessing digital solutions within the new service model will be examined, especially mobile applications, with a view to facilitating more efficient communication between the different parties involved in the new integrated service model.

3.13 Twente

Summary of the service integration ambition pursued in VIGOUR

Type 2 Diabetes Mellitus (T2DM) is a major chronic disorder with a significant impact on quality and costs of care. It is estimated that the prevalence of diabetes, of which more than 90% have T2DM, will rise to 1.3 million people in the Netherlands in 2025. This prospect emphasises the urge to shift our current approach from care to prevention, self-management and cure of T2DM. A healthy lifestyle can significantly result in health gains for T2DM patients. A main challenge in lifestyle management for T2DM is that patients often have insufficient knowledge about proper self-management and are insufficiently motivated for lifestyle change. It is therefore assumed that interventions with more motivational strategies and

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personalization are needed for T2DM patients treated in primary or secondary care. However, with the rising capacity issues and limited financial resources available this cannot be achieved via face-to-face programs. eHealth is hypothesized to be of potential to support lifestyle self-management in patients with T2DM. Studies have shown that digital care such as smartphone apps, daily informational and motivational text messages and blended web-based care can support lifestyle changes. The emergence of sensors that provide patients with biofeedback, such as tracking of physical activity (e.g. Fitbit) or glucose monitoring further stimulates self-management of patients, while at the same time these biosensors make it possible to make coaching more tailored to the personal circumstances of a patient and enables better scalability of lifestyle interventions when offered as stand-alone or as blended care.

However, the current health system structures are not well geared towards putting preventative measures such as digitally supported lifestyle counselling into practice. Both in primary and secondary care, lifestyle counselling (using digital health monitoring and coaching) is currently available to a limited extend, while the number of digital and blended lifestyle interventions is growing for T2DM patients. An important challenge therefore is how to organize the provision and referral system for (digital supported) lifestyle interventions for people with T2DM in the Twente region. Against this background, the efforts pursued in the context of VIGOUR were aimed at this challenge, by setting up a regional stakeholder network for harnessing technology supported lifestyle interventions. Different existing initiative were to be brought together such as “Vital Twente”, a network of stakeholders from the regional healthcare system including care organisations, insurance companies, educational institutes, and patient representatives. Moreover, the so called “TOPFIT Citizen Lab” was to be involved. Here, citizens, care professionals and companies work with scientists to develop and use technological innovations for the health and social care domains. Within this overall organizational fabric, the VIGOUR activities were aligned with two regional programs, namely “Twente Beter” (a better Twente) and “Zorg voor Morgen” (care for tomorrow) which facilitated joined-up strategy building across governmental departments in Twente, with a view to facilitating the exploitation of eHealth solutions for the support of chronically ill people within the structures of the existing health care system.

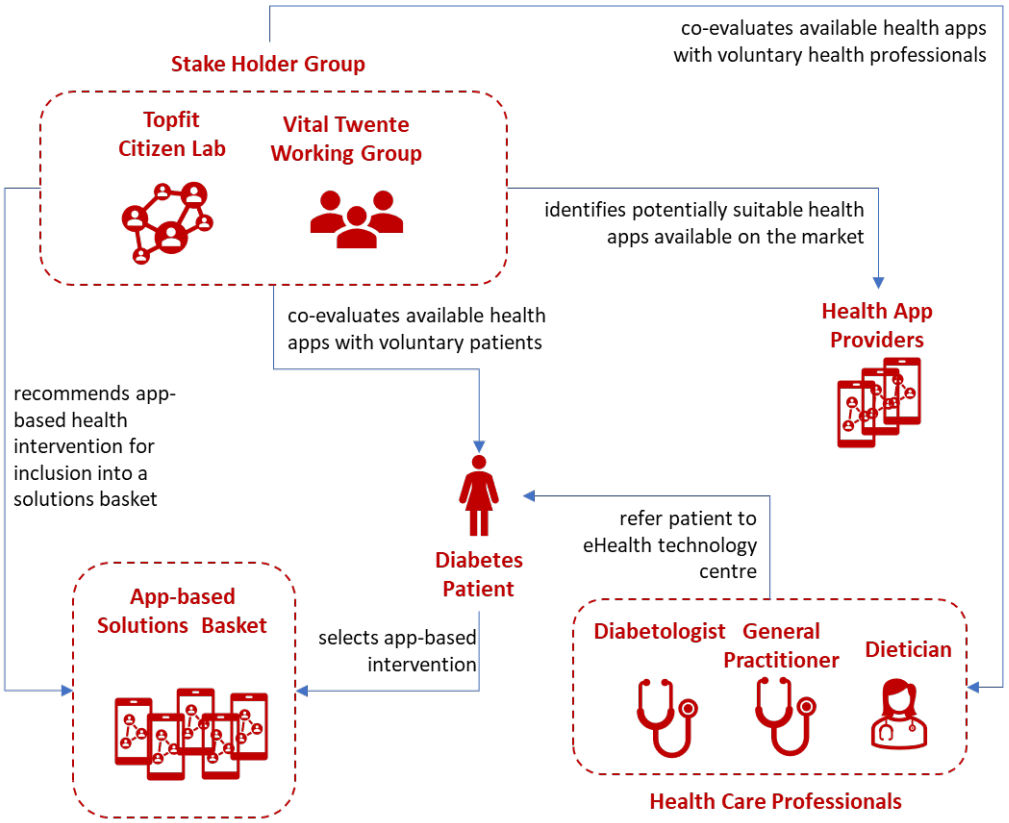
Summary of the service integration solution developed in VIGOUR

The solution developed within the VIGOUR project centres around the collaboration of two regional initiative, namely a network of stakeholders from the regional health and long-term care eco-system and a regional citizen lab. As graphically summarised by Figure 16, both initiatives collaborate in the framework of the VIGOUR solution in two different regards. A working group with representatives of the Vital Twente organisations set up an implementation plan to provide and regionally organise a new healthcare pathway for technology-supported lifestyle coaching for people with T2DM. The project entailed a step-wise approach from composing a regionally available eHealth basket, including eHealth technologies that are stand-alone to integrated blended care approaches, to piloting it in practice. They collaborate with voluntary patients and health

professionals when it comes to assessing potentially available apps with respect to their suitability for life system management. With the stakeholders, it was discussed how the pathway should be (financially and operationally) organized regionally, for example organization of the eHealth basket from a centre where patients are counselled in deciding about the best eHealth option for their situation/needs, and regional referral guidelines.

The project aimed to 1) contribute to better quality of care through personalisation and integration of lifestyle management into diabetes care, but also on the access and scalability of healthcare via a new regional pathway for the provision and referral of technology-supported diabetes care and 2) to strengthen local and regional collaboration between different types of professionals and policy makers around person-centred and technology supported diabetes lifestyle management in the Twente region.

Figure 16 – Integrated Care Approach in Twente



Source: VIGOUR ©

Conclusive outlook

A permanent working group was set up involving a diverse range of stakeholders from the regional health eco system, including patients, general practitioners, nurses, specialist doctors, insurance companies, lifestyle counsellors and paramedics. The current health system structures are not conductive to implement preventative, digitally supported care models on a wider scale. Therefore, a stepwise approach was adopted

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for involving all stakeholders in designing a new digital care pathways suitable for operating as a "regional window" to preventative care for people with diabetes. During the stakeholder group's work, it became increasingly apparent, that the sustainability of any digitally supported solution for lifestyle management model was strongly dependent on the acceptance of the available tools and related work models by the patients themselves, and professionals' expectations about patients' adoption of digital care. An approach relying on the prescription of a digital tool by the health professionals – in a top-down manner if you so want - would bear a high risk of failure due to non-adherence by the patients and low adoption by professionals. It was therefore decided to focus the further activities on carefully assessing solutions available on the market from multi-stakeholder perspective, i. e. from the perspectives of the professionals to become involved in preventative lifestyle management and from the perspective of the patients. By means of this approach a range of tools were identified and assessed, the outcome being a basket of currently four mobile applications from which patients can select. As a next step it is planned to further pilot an integrated pathway where preventive, primary and secondary care providers can refer patients to self-managed and blended care of diabetes. When it comes to strategic policy development, the network that was set up during the VIGOUR project and the results obtained contributed to the further development of a regional strategy and vision to facilitate the use of emerging technologies by people with chronic conditions in the Twente region ("Twente Beter" and "Zorg voor morgen").

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3.14 Valencia

Summary of the service integration ambition pursued in VIGOUR

Scientific research has shown that physical activity reduces vulnerability to non-communicable diseases and frailty. Moreover, it has been shown that physical activity represents an important aspect when it comes to strengthening physical and mental health in old age more generally. Against this background, the activities pursued in the context of the VIGOUR project built on an existing health prevention scheme that had been developed by the University of Valencia and the gynaecological department of the university hospital in the framework of the European Union's previous Health Programme. This health prevention scheme was specifically directed toward female patients, because women exhibit specificities regarding the occurrence, progression, and outcomes of several non-communicable diseases. Examples include osteoporosis, dementia, breast cancer, depression and cardiovascular disease, which women often suffer from, with important specifics often overlooked in treatment. In addition, women experience menopause, which can cause symptoms affecting quality of life, and which can increase susceptibility to certain diseases, such as postmenopausal osteoporosis. Against this general background, the existing prevention scheme centred around physical exercise programme for female patients who have been discharged from hospital. Within the VIGOUR project, the ambition was to extend the scheme beyond current patient groups such as female cancer survivors and women suffering from pelvic floor disorders or osteoporosis. Beyond these groups, the program was to be extended to diabetes patients and older people at risk of loneliness, independent of their sex. Apart from this, VIGOUR aimed to further develop the existing programme by integrating further stakeholders from the local community into the overall scheme, let them be volunteers or care professionals, with a view to increasing the variety physical and social activities available to the patients.

Summary of the service integration solution developed in VIGOUR

As can be seen from Figure 16, the local primary care centre takes a central role within the solution developed in VIGOUR. It hosts and professionally supports a range of activity groups, ranging from physical exercises supervised by a physiotherapist up to walking groups managed by a so called "expert patient" on a voluntary basis. Depending on the

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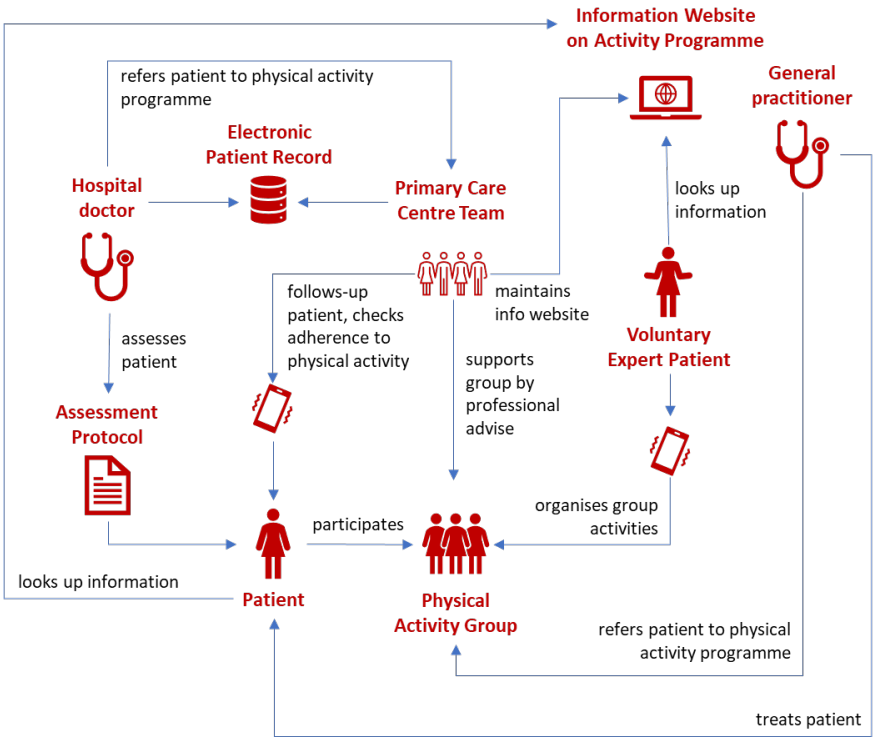
local circumstances in the retraction area of a given primary care centre the type and number of individual activity groups offered may vary on a case-by-case basis. In all cases, however, a specialist doctor at the hospital refers patients to the physical activity program in his or her local community upon an assessment in accordance with an agreed protocol.

Figure 17 – Integrated Care approach in Valencia



Source: VIGOUR ©

Both, the specialist doctor at the hospital and the team at the primary care centre can look up relevant patient information stored in an electronic health record system. General practitioners operating in the community can also refer patients to the activity programme hosted by the local primary care centre. The primary care centre provides up to date information about the programme by means of a publicly accessible information website. Both, the hospital doctor and the team at the primary care centre team increasingly use telephone-based telehealth to facilitate visit appointments and to follow up the patient in order to improve adherence to the activity programme.

Conclusive Outlook

The model described above was piloted by five community health centres in the wider area of Valencia. To this end, the physical activity programme that existed prior to the VIGOUR project was enhanced by a newly defined role, the so called “expert patient”. This new role is now formally recognised by the health authorities. Within VIGOUR, the expert patients have facilitated the further broadening of activities offered under the

overall scheme and a higher degree of self-management of the individual activity groups. Activities offered now range from Nordic walking, over tai chi workshops up to physical activity with midwifes. Not at least, the involvement of expert patients has facilitated the social interaction between the patients participating in the programme. Also, further patient groups are now included in the overall scheme. However, depending on local conditions, the services offered by individual primary care centres differ from one another. The stakeholders involved, especially the health centres, currently finance the model through their general budgets. For the future, a specific funding stream is being sought which would help in offering a common "minimum selection" of activity groups across all community health centres involved. As a next step it is planned to expand the model to further primary care centres. Based on the experiences made so far, it is also under consideration to integrate further stake holders into the overall scheme such as the social services provided under the auspice of the municipalities.

3.15 Veneto

Summary of the service integration ambition pursued in VIGOUR

The Regional Council of the Province of Veneto has recently adopted several resolutions on health care, which constitute the strategic framework for the activities carried out within the VIGOUR project. Among other aspects, the delivery of palliative care services has been extended to non-oncology patients, and this has also highlighted the need for a better integration of home-based primary care services and territorial palliative care services delivered in the region. In this context, a better integration of clinical care with long term care and welfare services holds the potential to ensure the provision of high-quality home care during all phases of the patient's disease pathway, including end-of-life. Against this background, the ambition was harness available technology for facilitating the sharing of information among care professionals of different service providers involved. Beyond this, the aim was to improve continuity of care through the standardization of procedures within various care contexts.

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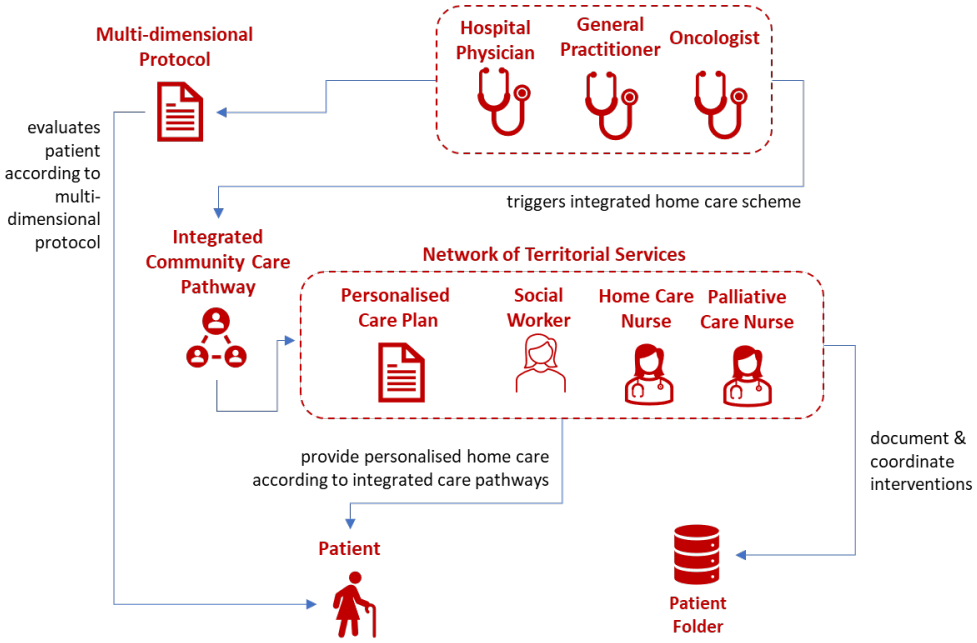
Summary of the service integration solution developed in VIGOUR

The solution developed within the VIGOUR project focuses on multi-disciplinary provision of home care to patients with a single or multiple non-communicable chronic diseases, including cancer patients, as graphically summarised by Figure 13. On discharge from the hospital or upon request by a general practitioner or by the oncology health service, patients are enrolled to regional services scheme for the provision of health care, social care and palliative care. Following an assessment according to a newly developed multi-dimensional protocol, a health professional triggers the enrolment of the patient into the integrated home care scheme. A personal care plan is established setting out the portfolio of services to be delivered by the patient.

Figure 18 – Integrated Care Approach in Veneto



Source: VIGOUR ©

An electronic patient folder is used to document patient related information which can be accessed by all services included into the patient's service portfolio.

Conclusive Outlook

The model of multidisciplinary home care and palliative care outlined above was piloted by the Eastern Veneto Territorial Network (Azienda Ulss4), which comprises five district offices, each responsible for service delivery in a specific area. In each of these areas, quite different service delivery structures had developed over a long period of time. Setting up a stable working group representing a diverse range of stakeholder from the territory such as general practitioners, social workers, healthcare professionals in palliative care, primary care professionals and third sector representatives represented a challenge. A massive turnover of health workers at all levels due to the COVID19 pandemic has added to the challenge. At the same time, however, this situation has

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made clear to all stakeholders the need for fundamentally new forms of cooperation and mutual support. Against this background, a series of meetings were organised to gather the different points of view of the various stakeholders using the focus group technique with a view to help designing an organisational model that would better meet the needs of everybody. The level of integration achieved with the VIGOUR project in the immediate pilot area will successively be extended to further areas. To assess the long-term impact of the level of integration achieved between the various care settings and to maintain a high level of interest among the various stakeholders, periodic meetings are planned to be held in future for the discussion of specific clinical-assistance cases deemed of particular interest or complexity. Also, a resolution of the regional council adopted in 2022 imposes new requirements on the role of the family and community nurse which will need to be incorporated into the new model.

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4 How to apply the VIGOUR methodology for own purposes

The deployment of integrated care practices represents a multi-dimensional challenge. It should be considered as a continuous process of change and adaptation that can take different forms. VIGOUR lessons derive from the experience of implementing integrated care pilots in 15 different public health provider organizations. In view of the diverse framework conditions within which integrated care service delivery occurs in different countries and regions, the service integration strategy pursued needs to be flexible both in terms of service process and in terms of supportive technology. A non-contextual, purely normative care integration approach would be risky. Adopting integrated care models that have proven successful elsewhere in a purely top-down manner can, for example, pose major budgetary problems for service providers and introduce risks in terms of system delivery and potential loss of service continuity.[9] To avoid these risks, the VIGOUR methodology supports gradual, controlled migration from existing work practices and technologies (Figure 2) towards newly integrated care practices. This involves four core work steps as follows:

1. *Ambition focusing*: The first step puts the focus on making sure that all stakeholders share the same vision when it comes to migrating from current practices towards a better joined up care delivery model.
2. *Maturity assessment*:
   Once a joint vision for better integrating current practices has been agreed among all local stakeholders, the next step focuses on assessing the appropriateness and feasibility of this vision under day-to-day conditions.
3. *Operational implementation planning*: This work step aims at translating the outcomes of the previous work into an operational plan setting out how and when exactly the different steps of the envisaged integration are to be put into practice.
4. *Pilot operation*: Before a wider roll-out of the new care delivery approach, it should be tested under every-day-conditions with a limited number of participants and/or in a confined geographic area.

In the following subsections, further guidance is presented on how each work step should be put into practice.

[9] Kubitschke, L., Müller, S., Meyer, I., Stellato, K., Di Lenarda, A. (2016): Digital Technologies as a Catalyst for Change towards Integrated Care Delivery. Hype or Reality? In: International Journal of Reliable and Quality E-Healthcare (IJRQEH) 5(2), pp. 31-49

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4.1 Ambition focusing

What this step generally is about

What's our point of departure?

Where do we want to go?

The transformation of existing health care practices requires a joint effort by all stakeholders concerned. This effort should be guided by a joint vision to make sure that all stakeholders share the same understanding of the envisaged transformation process and what the goal of this process should ultimately be. In essence, the joint vision should include not only to express an initial idea on which existing care delivery processes should be better integrated, but also on how this might best be achieved, and any benefits envisaged to flow from better joined-up care delivery processes to the different stakeholders involved. It should not be assumed that a common understanding of this will emerge almost automatically. Of particular importance is a thorough understanding of the factors that have shaped and may continue to shape those care delivery processes that are to be better joined up in future. Based on such an understanding, initial priorities for effective integration measures can be drawn up by care planners and practitioners for review before being proposed to relevant decision-makers. The need to prioritise on a case-by-case basis is clear. Health and social care systems across European regions are very diverse in organizational, financial, and legal terms. The integrated care configuration that would best suit a particular local situation differs in consequence.

What this step should include in particular

Alongside clinical, technical, and organisational issues, a set of factors continuing to shape the system is constituted by the respective interests of various stakeholders involved. Many groups have different stakes in the methods, process, organisation and financing of care delivery in each health care system. Differences of perspective - and possibly of economic interest - between stakeholder groups are particularly likely in cases where joined up care delivery crosses traditional organisational process or system boundaries. If the perspective of one or more groups setting integration priorities may not fully align with the perspective of other stakeholders, the latter would then not share the necessary sense of urgency to change and potentially not carry out necessary actions in the expected time. This will particularly apply where one or more stakeholders benefit from maintaining the status quo. A response can be to attempt to compensate them for losses faced in change.

It is important that the different stakeholders involved in this consensus building process share a “common language” on what they are generally striving for and – not less important – what their individual point of departure is when attempting to better align care delivery processes in concrete care settings. The taxonomy of different “types”, “levels” and “forms” of integration presented earlier in Figure 1 can for instance be used

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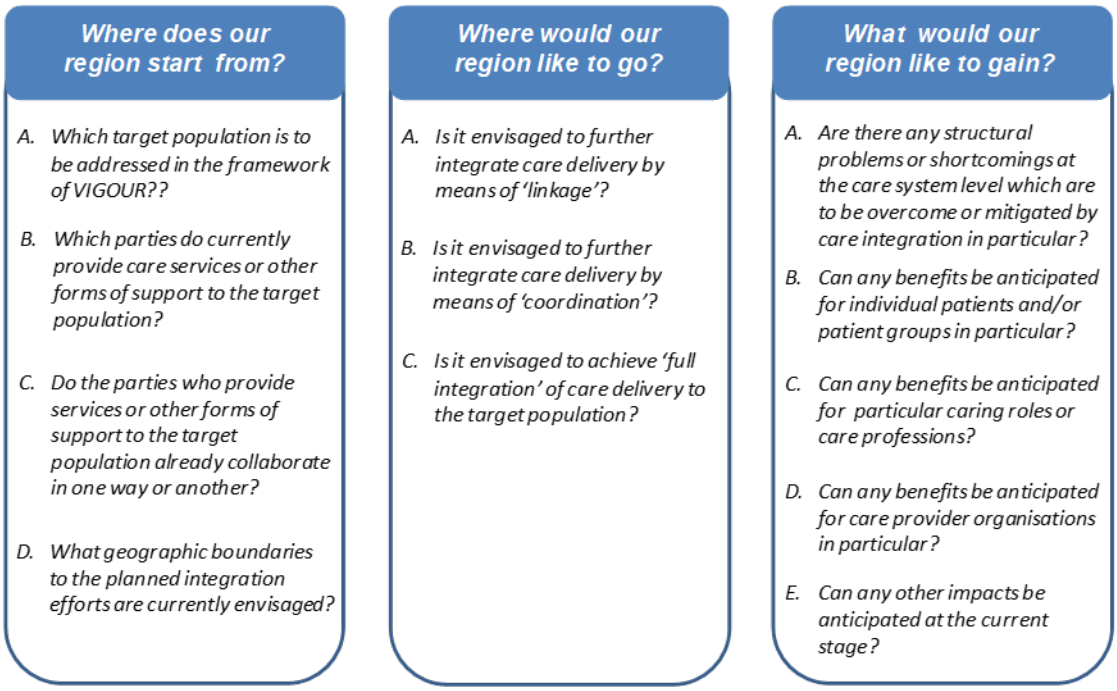
to facilitate a "common language". This taxonomy has proven useful in VIGOUR as it provides a general vocabulary for different health systems and care settings at a conceptual level. Also, digital technologies have frequently been ascribed the role of catalyst for change towards better joined-up care delivery. However, by simply adding ICT to current care practices one will most likely not end up with better care.[10] Rather, a multi-pronged innovation approach should be adopted, one that simultaneously pays attention to the different stakeholders involved, to the working models and workflows of service providers affected and to the technologies to be deployed.

Figure 19 - Key questions to guide the joint development of an initial ambition statement by the stakeholders to be involved



Source: VIGOUR

Against this background, a set of key questions has proved useful in the VIGOUR project to guide different stakeholders in jointly reflecting on what they are striving for. As summarised by Figure 5, the first set of questions aims primarily at elaborating a common view among all stakeholders on what exactly are the main "pain points" that should be addressed by better integrating existing care delivery processes, and which existing care delivery practices need to be changed in this context ("Where does our region start?"). The second set of guiding questions aims at arriving at a shared view on how progress might best be achievable under given framework conditioners ("Where would our region like to go?"). Here it has turned out as beneficial in VIGOUR to encourage the stakeholders participating in the joint reflection process to think about

[10] Kubitschke, L., Müller, S., Meyer, I., Stellato, K., Di Lenarda, A. (2016): Digital Technologies as a Catalyst for Change towards Integrated Care Delivery. Hype or Reality? In: International Journal of Reliable and Quality E-Healthcare (IJRQEH) 5(2), pp. 31-49.

these questions with different time horizons in mind, e. g. from a short-term and a long-term perspective. The final set of guiding questions aims to help arriving at a common view among the stakeholders concerned on what tangible benefits should be finally achievable by means of the envisaged care integration approach ("What would our region like to gain?"). The views on the goals that should be achieved and/or whether priority should be given to certain goals - and to expected benefits potentially related to these goals - may well vary across different stakeholders involved.

All stakeholders should finally agree on a common position on the guiding questions, which they can credibly represent to third parties inside and outside their own organisation or unit, if necessary. Although this initial vision may undergo further detailing and/or revisions throughout the further joint planning process, it should be set out in writing to serve as a reference document to all stakeholders involved. For the purposes of the VIGOUR project, the participating care authorities were for example provided with a template (Annex I) to document the outcomes of the stakeholder discussions in a common format along the guiding questions presented in Figure 5.

4.2 Maturity assessment

What this step generally is about

Are we ready to take the next step?
Do we have everything in place ?

This preparatory work step focuses on a critical appraisal of the initially stated integration ambition as elaborated in the previous work step. Aspects that might make it difficult or perhaps even impossible to put the currently stated ambition into practice should receive particular attention in this context. Depending on existing framework conditions, a range of quite different factors may potentially impede the successful implementation of the jointly developed ambition. Equally, diverse supportive capacities may potentially be available for putting the currently envisaged care integration approach into practice, albeit these may not yet have been considered in a systematic way. Therefore, the stakeholders involved should "take a step back" and critically reflect on whether the practical implementation of the initially envisaged integration approach seems indeed appropriate and feasible under existing framework conditions.

What this step should include in particular

It is worth noticing that the maturity assessment approach developed for the purposes of VIGOUR does not aim at assessing the level of integration achieved in relation to the health system in general. Also, it does not aim at enabling a comparison of different levels of integration different regions or countries may have reached, for example, according to a defined set of indicators or quantitative scores. Rather, the various stakeholders are to be supported in the joint implementation of planned integration

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measures. To this end, VIGOUR developed a two-staged assessment approach as graphically summarised by Figure 19 overleaf. Both steps should be conducted by means of focus groups involving all stakeholders concerned.

Figure 20 – Summary of the VIGOUR maturity assessment approach

Source: VIGOUR ©

In the first step, the envisaged care integration approach should be jointly assessed by means of a so-called SWOT analysis. A SWOT analysis is an analytical method suitable for evaluating strengths, weaknesses, opportunities, and threats potentially associated with the envisaged care integration approach. This method considers so-called "internal" and "external" factors that can influence the planned implementation under day-to-day conditions. As summarized in Table 1 overleaf, strengths and weaknesses are regarded internal factors while opportunities and threats are regarded as external factors.

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Table 1 – Overview of key elements of a SWOT analysis

1 INTERNAL FACTORS fall within the scope and control of the envisaged integrated care pilot scheme	1a	STRENGTHS are understood as characteristics of the envisaged integration approach that give it an advantage over other options potentially under consideration. Certain STRENGTHS can sometimes be used to address certain WEAKNESSES.
	1b	WEAKNESSES are understood as characteristics of the envisaged integration approach that place it at a disadvantage relative to other options potentially under consideration.
2 EXTERNAL FACTORS are conditions that are outside the direct control of the envisaged integrated care pilot scheme	2a	OPPORTUNITIES are understood as factors that may facilitate the implementation of the envisaged integration approach.
	2b	THREATS are understood as factors that may stand in the way of the practical implementation of the intended integration approach.

In the second step, the results of the SWOT analysis should then be assessed in a systematic manner with respect to possible implications for the implementation of the envisaged care integration approach under day-to-day conditions. Throughout the two works steps the initial Ambition Statement should be assessed in relation to four core dimensions:[11]

1. the target population to be addressed by the envisaged integration approach.
2. the service intervention to be integrated,
3. the information system design to be utilized to support integrated service delivery,
4. and the funding and political support of the envisaged service integration.

[11] For the purposes of VIGOUR, these assessment dimensions were derived from a broader assessment framework developed by the SCIROCCO project. See L. Grooten et.al. (2018) "A scaling-up strategy supporting the expansion of integrated care: a study protocol", Journal of Integrated Care. Available at: https://doi.org/10.1108/JICA-04-2018-0029

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As graphically summarised by Figure 19 above, for each assessment dimension two analytical steps should be performed as follows:

a. **STEP I: Perform a SWOT analysis of the Initial Ambition Statement**

   For each assessment dimension strengths and weaknesses of the envisaged care integration approach should be identified (internal factors). Moreover, conditions that are outside the direct control of the envisaged pilot scheme should be identified which potentially facilitate or hinder the implementation of the current integration ambition under day-to-day conditions (external factors).

b) **STEP II: Assess practically implications of SWOT results for the planned pilot scheme**

   The results of the SWOT analysis should be assessed in relation to possible implications for operationally implementing a fully up-and-running pilot scheme to test the envisaged integration approach under day-to-day conditions. Here, different aspects deserve attention:

   - Can any issues be identified that may make it difficult or even impossible to put the integration ambition into practice under day-to-day conditions?
   - Should such "roadblocks" indeed be identifiable at the current stage, are there any options available for successfully addressing them?
   - Equally to barriers, can any capacities be identified potentially supporting the implementation of the integration ambition under day-to-day conditions?
   - If so, are there any options available for practically exploiting them under day-to-day condition?
   - All in all, when could a pilot scheme be considered as a success within existing framework conditions?
   - Are there any specific indicators that could be used to monitor the success of the envisaged integration efforts within existing framework conditions in qualitative and/or quantitative terms?

For the purposes of the VIGOUR project, a common reporting template was developed to document the outcomes of this assessment process. The template also provided some further explanations on each of the assessment dimensions and on how they should be assessed in the context of a SWOT analysis. For illustrative purposes, it is presented in Annex II.

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4.3 Operational pilot planning

What this step generally is about

How to put our ambition into practice?

Who needs to do what?

The results of the maturity assessment should be used to critically appraise the initially stated integration priorities and the level of integration envisaged to be ultimately realised. In this context, a care authority can also rely on the solid understanding gained in the initial ambition focussing exercise of where it is coming from, and of the factors which have shaped developments so far and are expected to continue to shape the system. Taking all these aspects into account, a concrete plan should be established on how to put the envisaged integration approach into practice. Depending on the respective framework conditions, this can concern a variety of planning dimensions in individual cases, such as target populations, organisational issues, care pathways, ICT infrastructures/tools, resources to be allocated and the like.

What this step should include in particular

A plan of change to integrated care, to be successful, should address the needs and wishes of all key stakeholder groups, obtain their buy-in, and instil in those who need to become active an appropriate sense of urgency. Consensus on urgency is particularly important to ensure that integration priority targets are met, and success is maintained in the long run. Once consensus has been achieved among all stakeholders concerned, they should agree an operational plan setting out in writing how the planned integration approach is to be piloted under day-to-day conditions. In this context, different core planning dimensions should deserve attention, as graphically summarised by Figure 20 overleaf. Each of these dimensions may again require careful planning of several operational sub-tasks which may need to be accomplished if a given integrated care pilot scheme is indeed to work within daily routine.

In the VIGOUR project, as mentioned earlier, the care integration approaches envisaged at the individual pilot sites differed considerably. The detailed tasks that needed to be planned under each core planning dimension varied accordingly. The planning dimensions identified in Figure 20 should thus be considered as a list of generic “headings” under which specific sub-tasks need to be identified on a case-by-case basis. For each individual task, it should be stated which party must do what and by when for the task to be completed successfully.

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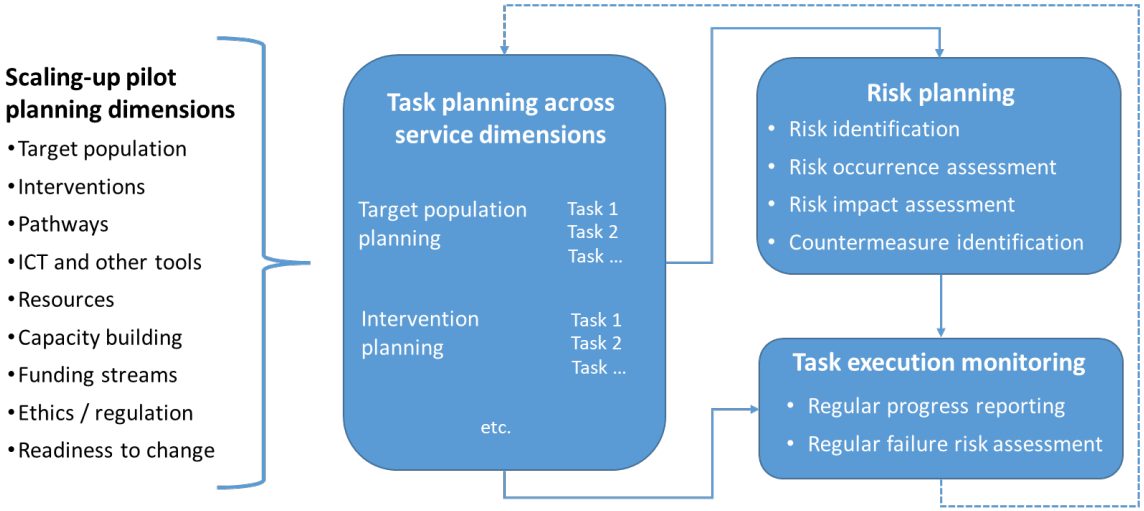
Figure 21 – Core elements integrated care pilot planning



Source: VIGOUR

In a next step, dedicated risk factors should be identified at this planning stage already which may potentially delay or even prevent the successful completion of the identified tasks. Counteracting measures potentially available under given circumstances should be anticipated respectively. The operational pilot plan should also enable a continuous monitoring of progress in the execution of the individual task identified. This is to enable swiftly putting remedial action in place, should any deviations from the planned task execution occur at some stage. Also, relevant lessons learned, and actions not foreseen at the planning stage should be documented. In the VIGOUR project, a common template was used for operational pilot planning purposes which is n is provided in Annex III for illustrative purposes.

4.4 Pilot operation

What this step generally is about

Does the new practice work under everyday conditions?

Does it deliver?

Based on a carefully prepared operational implementation plan, the envisaged care integration approach should be piloted by involving a confined number of individuals and/or within a confined geographical area. Ultimately, the pilot phase should enable an assessment of whether the envisaged care integration approach works under everyday conditions as originally anticipated, and whether it delivers the expected outcomes. To this end, the pilot activities and its outcomes should be systematically documented with a view to informing subsequent decision making on wider upscaling.

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What this step should include in particular

A literature review conducted in the framework of the VIGOUR project revealed several factors that have tended to facilitate the successful implementation of integrated care schemes in the past. These match with the different dimensions of the operational pilot planning approach developed for the purposes of VIGOUR (Annex III), as graphically summarised by Figure 21 overleaf. Some general conclusions can be drawn in this regard[12]:

- When it comes to introducing a new care delivery model, a basic distinction can be made between an incremental innovation approach, in which existing services are gradually changed according to a new service delivery model, and a disruptive innovation approach, in which existing services are replaced by the new model at once. In the VIGOUR regions, incremental innovation approaches have turned out as the preferred change model.
- In doing so, the successful innovators typically strive for a balance between flexible decision making and formalised implementation structures. Different stakeholders affected by the envisaged care integration approach tend to be involved in collaborative governance models, and leadership is frequently distributed throughout different levels of the care eco-system.
- Context-specific measures for facilitating a multidisciplinary team culture with mutual recognition of each other's roles typically deserve attention as well. Moreover, the development of new roles and competencies for integrated care is often stimulated by dedicated capacity building measures.
- With respect to financing, secured long-term funding and innovative payments are often applied to overcome fragmented financing of health and social care.
- Apart from this, integrated care implementers often rely on digital solutions to support collaboration and communication and, where appropriate, on specific telehealth solutions involving the patient.
- When it comes to effective risk management, feedback loops and a continuous monitoring of the implementation process deserve appropriate attention.

The pilot activities carried out should therefore be documented from these points of view, in order to ultimately provide an instructive source of information for the subsequent decision on how the new model might best be rolled out further after successful piloting in a confined setting.

[12] For the following see also W. Looman et al.: Drivers of successful implementation of integrated care for multi-morbidity: mechanisms identified in 17 case studies from 8 European countries - Social Science and Medicine. 25 January 2021 (https://www.sciencedirect.com/science/article/pii/S0277953621000605), the SELFIE project website (https://www.selfie2020.eu/selfie-project/) and the SCIROCCO project website(https://www.scirocco-project.eu/=

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Figure 22 – VIGOUR documentation framework for pilot implementation

Operational pilot plan dimensions	Success factors derived from the literature		Description of contextualised task implementation activities	
			During pilot phase	After pilot phase
Target population Intervention Pathways Readiness to change	Service delivery (A)	Incremental grows model vs. disruptive innovation approach		
	Service delivery (A)	Balance between flexibility and formal structures of integration		
	Leadership (A)	Collaborative governance by stakeholders		
	Leadership (B)	Distributed leadership throughout different levels of the system		
Resources	Workforce (A)	Team culture		
Capacity building	Workforce (A)	New roles and competencies		
Funding streams	Financing	Funding typology / Innovative payments		
ICT & tools	ICT	Collaboration support / communication support		
Risk planning Execution monitoring & evaluation	Information	Feedback loops / continuous monitoring		

Source: VIGOUR ©

The care authorities that participated in the VIGOUR project used a common template for documenting the operational implementation of the integrated care pilot activities. For illustrative purposes this is provided in Annex IV.

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5 General lessons learned from the VIGOUR project

Each of the 15 VIGOUR regions has gained its own experience with the practical application of the care integration methodology described in this document. In summary, however, several general topics can be derived that should receive appropriate attention when introducing new models of integrated care with help of the VIGOUR methodology.

Flexible service integration strategies:

Diverging framework conditions within which existing care services were to be better joined-up in the framework of VIGOUR required the development of flexible service integration strategies. Pursuing a “one-size-fits all” care integration approach across different care authorities would very likely have failed to deliver the desired outcomes. Against this background, the VIGOUR methodology was designed to be applicable under varying framework conditions. Depending on the type and level of service integration already in place, it can for example be used in a “fast” or “slow” track when it comes to some or all of its sequential methodological work steps (see Figure 2). In this sense the VIGOUR methodology should be seen as a generic approach which, on a case-by-case basis, requires careful contextualisation and adaptation to prevailing framework conditions.

Gradual service innovation approach

The VIGOUR methodology supports the gradual, controlled transition from existing working practices and technologies to better joined-up care processes. Such a gradual approach to care service integration appears all the more necessary when integration efforts involve several existing services provided by different care organisations or managed under different regulatory and administrative systems, such as health care services and social care services. Full horizontal integration of such services (c.f. Figure 1) typically requires far-reaching reforms of existing health and social systems, which in turn require comparatively lengthy political decision-making processes. The VIGOUR methodology, on the other hand, offers a possibility to start with gradual integration steps that are already possible under the given system conditions and without having to wait for a comprehensive system reform.

Stakeholder engagement and consensus

The care authorities participating in the VIGOUR project were supported by means of a multi-staged process in defining and implementing better joined-up care delivery models. The resources and time required for gathering the necessary knowledge and evidence to systematically define integrated care delivery processes that involve a diverse range of stakeholders can easily be underestimated. Furthermore, the effort required to reach consensus among all stakeholders on how best to implement commonly defined care processes in everyday practice should not be underestimated as well. Ultimately, however, it is worth spending sufficient time and resources on

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consensus building. Only through a joint effort of all stakeholders concerned can the operational complexity and the associated implementation dynamics of integrated care models be successfully managed.

Piloting of new care delivery practices

Before testing new care practices with a limited number of users, all stakeholders involved should agree on how such a test phase should be documented. Different stakeholders may have different information needs when it comes to deciding on the expansion of the new care model after a successful pilot phase. In general, the case for wider mainstreaming of a care integration approach should be as robust as possible. However, a key challenge concerns the fact that there is a limit to how much one can prove things during the early implementation stage. Therefore, a pragmatic approach towards getting started needs to be adopted. The full impacts of changes, for example in relation to economic effects, can usually be expected to materialize only in the longer term, i.e. only sometime after a 'proof of concept' was successfully achieved in the framework of a local pilot implementation.

Context sensitive pilot evaluation

The diversity of possible care integration models and procedures that emerged in the framework of the VIGOUR project does not make it seem sensible to apply a uniform evaluation model. A general evaluation framework was therefore developed by the project. It was used by the individual pilot sites to develop their own, locally adapted pilot evaluation plans. In this context, it seems advisable to consider different phases of the implementation of a pilot project. In the first phase, the focus of the evaluation may be primarily on questions around the adoption and acceptance of the new procedures by relevant stakeholders, and on the practical feasibility of the new care model as such. In subsequent phases, the focus may change towards performance and sustainability related aspects.

New caring roles and responsibilities

As mentioned earlier, diverging framework conditions within which existing care services were to be better joined-up in the framework of VIGOUR required the development of flexible service integration strategies. Nevertheless, new roles and responsibilities favouring multidisciplinary work need to be acknowledged and formalised to grant the future sustainability of the integration of care achieved. Especially in the case of service integration measures that overlap the health and social sectors, a clear distribution of responsibilities and competences at leadership and management level helps to avoid a lack of coordination and shared visions in the regional health and social care system.

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Technological innovation

Digital technologies should be considered as enablers of change, as they hold great potentials for making information exchange processes and interpersonal communication more efficient. Although we have noted that technology in itself is usually not a limiting factor for the wider implementation of integrated care, there remains a continuing need for further technological innovation. Issues of relevance here vary from case to case, for example, when it comes to “ease of use” of existing digital solutions or lacking interoperability of new solutions with legacy infrastructures.

Technology related competencies

A critical analysis of digital literacy in advance may help to prevent failure of integrating new digital solutions into the overall care cycle. Sometimes, digital tools are not taken up as expected due to missing skills and lacking interest in new technology. Health and social care professionals, family carers and patients may need specific training in the use of digital tools. In this context, any uncertainties or fears on the part of envisaged users, which may ultimately lead to mental rejection, should be taken seriously right from the beginning.

Annex I

Evidence-based Guidance to Scale-up Integrated Care in Europe

Task 4.1

Initial Ambition Statement Template

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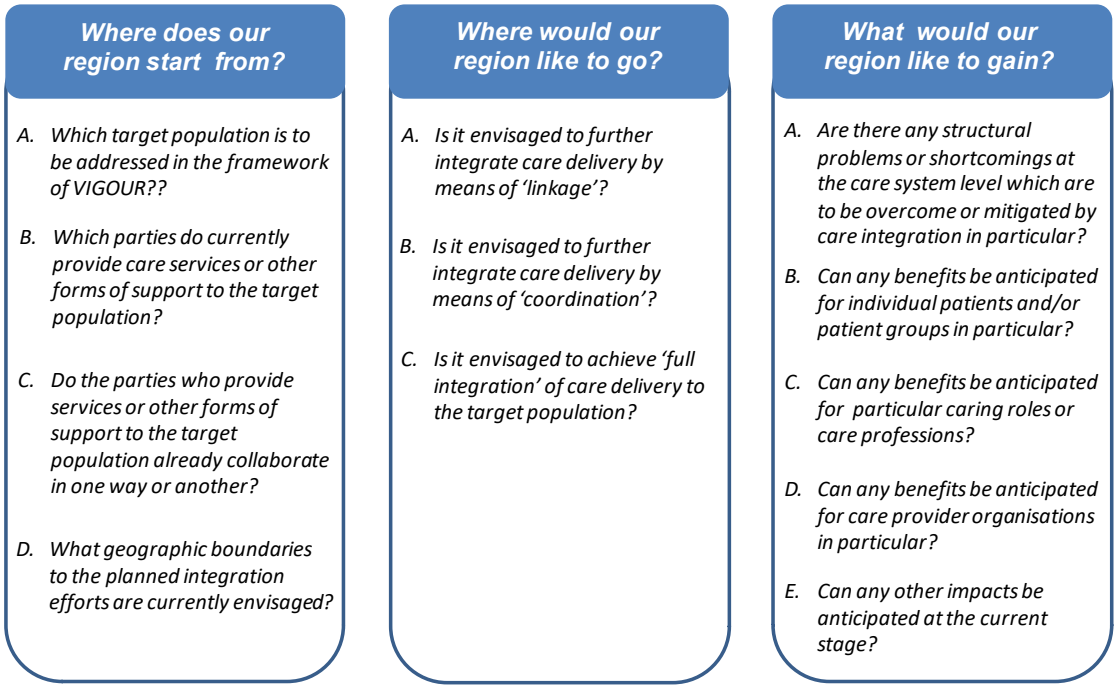
6 Introduction

The VIGOUR project intends to up-scale pilots for integrated care in 15 participating regions. During the proposal submission phase, each region briefly sketched the efforts which have been pursued to date to achieve more joined-up care delivery processes. Taking these initial descriptions as a point of departure, the current template is intended to help in consolidating the service integration work which is to be further pursued in the framework of the VIGOUR project. To this end, several service integration aspects are addressed throughout the remainder of this document. They are summarised by the schema below (Figure 1).

Figure 1 – Key questions to guide the joint development of an initial ambition statement by the stakeholders in the pilot region



As can be seen from Figure 1, at the current stage of the project a number of guiding questions have been formulated at a rather generic level. In this way, we hope to enable capturing the widest possible variety of maturity levels of integration considerations currently prevailing across the different pilot regions. In addition, we have tried to avoid the use of domain-specific terminology wherever possible. This way, we hope to encourage local stakeholders from different care domains such as health care, social care and/or family care to express their initial views on the envisaged service integration in a "common language".

Please try to describe the current service integration considerations in your region as precisely as possible with help of the current template, thereby reflecting on the following aspects:

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- What is it that could be 'integrated' in our region (the "what")?
- At what scale could it be 'integrated' in our region (the "how much")?
- How could it be 'integrated' in our region (the "how")?

Please note that, in accordance with the overall project's workplan, this initial 'ambition statement' will undergo further detailing and/or revisions throughout the project's life cycle in an iterative manner.

7 Where does our region start from?

7.1 Which target population is to be addressed in the framework of VIGOUR?

According to the input received during the proposal preparation stage, the target populations to be addressed in the framework of VIGOUR vary across the participating regions. Some regions have for instance put the focus on a further integration of service delivery to specific disease groups, while others have emphasised the need for further joining up service delivery across primary, secondary and tertiary care more generally. This subsection is intended to gain a better understanding of the target population(s) which is (are) currently envisaged to be addressed in your region.

As mentioned earlier, we have deliberately refrained from prescribing a specific terminology or a common set of descriptive dimensions to be used by all regions in the same way at the current stage of the project, e.g., clinical ones, socio-demographic ones or others. Please note that, as far as required, the next step in the project plan will offer an opportunity to further concretise and/or differentiate any initial considerations in this regard.

Using your own terminology, please try to describe as precisely as possible at the current stage which target population(s) is (are) expected to be addressed in your region. If possible, please support your description with available evidence, e.g. epidemiological and/or other data, you deem relevant at the current stage.

Please insert your text here

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7.2 Which parties do currently provide services or other forms of support to the target population?

Integrated care delivery typically requires the coordination of the efforts of different agencies and services such as clinical, public health and other services. In addition to formal services, be they health care services or social care services, individuals or groups who are not part of the formal care system tend to carry a considerable share of the caring burden in almost all countries today. These may include family carers, volunteer groups or third sector organisations.

Please try to describe as precisely as possible at the current stage each party providing formal services or other forms of support to the target population in your region. Here again, we have deliberately refrained from prescribing a particular terminology or specific descriptive dimensions.

Using your own terminology, please be as comprehensive as possible at the current stage. If ever possible describe the type(s) of service(s) or support provided by each party to the target population (the "what") and the scale at which these are currently provided to the target population (the "how much"). If possible, please also describe how each type of service/support is typically managed, funded and regulated today (the "how"). If possible, please also support your description with available evidence you deem relevant at the current stage.

Please insert your text here.

7.3 Do the parties who provide services or other forms of support to the target population already interact or collaborate in one way or another?

All participating regions have already pursued efforts to achieve better joined up care delivery, albeit in different regards and to varying extent. This subsection aims to better understand in what way and to what extent the different parities that provide services and/or other forms of support to the target population in your region do already collaborate or otherwise interact with each other.

Here again, we have deliberately refrained from prescribing a particular terminology or specific descriptive dimensions to be commonly used at this stage. Using your own terminology, please try to describe as precisely as possible in what way the different parties concerned do typically interact or collaborate (the "what"), and at which scale they interact/collaborate (the "how much"). If possible, please also describe whether they typically utilise any particular tools or technical infrastructures for their interaction/collaboration, be these ICT-based ones or others (the "how").

Please insert your text here.

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7.4 What geographic boundaries to the planned integration efforts are currently envisaged?

Please describe as precisely as possible at the current stage of the project which geographic area is envisaged to be covered by the service integration to be achieved in the framework of the VIGOUR project. It may for instance be intended to cover the whole region or just particular sub-areas or locations within a given region.

Please insert your text here.

8 Where does our region want to go?

8.1 Is it envisaged to further integrate care delivery by means of 'linkage'?

For our purposes, the term 'linkage' refers to integration efforts directed towards better guiding the patient through the care system according to his/her needs without requiring any special arrangements. Implementing a smooth referral process may serve as an example here. Service integration in terms of 'linkage' is thus not directed towards creating new organisational structures or caring roles.

Please indicate whether your region is seeking any integration efforts that could be described as 'linkage'. If so, please try to describe as precisely as possible at the current stage which parties could be linked and in what way they could be linked in the framework of VIGOUR (the "what"). If possible, please also describe the scale at which linkage could be achieved in your view (the "how much"). If possible, please also describe whether any existing or new tools could be utilised to achieve successful linkage of the different parties concerned, be it ICT-based ones or others (the "how").

Please insert your text here

8.2 Is it envisaged to further integrate care delivery by mans of 'coordination'?

For our purposes, the term 'coordination' refers to service integration efforts requiring that explicit structures and/or roles are put in place to coordinate service delivery to the target population(s). In this sense, coordination of service delivery may cut across one or more care domains such as health care, social care and informal/voluntary care. The implementation of joint case management structures may serve as an example here.

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While coordination is a more structured form of integration than linkage, it still operates through separate structures of current systems, e.g., when it comes to regulating, governing and/or funding the different services concerned.

Please indicate whether your region is seeking any integration efforts that could be described as 'coordination'. If so, please try to describe as precisely as possible at the current stage which parties could become involved in coordinated care delivery and in what way these could coordinate their activities (the "what"). If possible, please also describe the scale at which coordination could be achieved in your region (the "how much"). If possible, please also describe whether any existing or new tools could be utilised by the different parties to successfully coordinate their activities, be it ICT-based ones or others (the "how").

Please insert your text here

8.3 Is it envisaged to achieve 'full integration' of care delivery to the target population

For our purposes, the term 'full integration' refers to integration efforts directed towards creating entirely new programs or entities where resources from multiple systems are pooled.

Please indicate whether your region is seeking any integration efforts that could be described as 'full integration'. If so, please try to describe as precisely as possible at the current stage which hitherto separated entities could pool resources (staff, financial, other) and in what way these could deliver integrated services to the target population by pooling resources (the "what"). If possible, please also describe the scale at which joined-up service delivery could be achieved by means of full integration in your region (the "how much"). If possible, please also describe whether any existing or new tools could be utilised for the purpose of fully integrated service delivery to the target population, be it ICT-based ones or others (the "how").

Please insert your text here

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9 What would our region like to gain?

9.1 Are there any structural problems or shortcomings at the level of the care system which are to be overcome or mitigated by care integration in particular?

Depending on the local context, the 'value case' for integrated care delivery may vary across the participating regions. It has for instance been shown that joined up service delivery can provide an opportunity for addressing structural problems that may be particularly pressing at the level of the care system in each region, e.g., reducing the number of emergency admissions to mention just one example here.

Please indicate whether there are any structural problems or shortcomings in your region which are hoped to be mitigated in the framework of VIGOUR. If so, please try to describe as precisely as possible at the current stage which problems/shortcomings are expected to be mitigated and in what way service integration could make a positive contribution in this regard (the "what"). If possible, please also describe the scale of the problem/short coming to be mitigated (the "how much").

Please insert your text here.

9.2 Can any benefits be anticipated for individual patients and/or patient groups in particular?

Please indicate whether any benefits can be anticipated for individual patients and/or patient groups. If so, please try to describe as precisely as possible at the current stage which patient categories/groups may benefit from the service integration efforts to be pursued in the framework of VIGOUR, and in what way these are expected to benefit (the "what"). If possible, please also describe the scale at which patients are likely to benefit (the "how much").

Please insert your text here

9.3 Can any benefits be anticipated for particular caring roles or professions?

Please indicate whether any benefits can be anticipated for different caring roles or care professions. If so, please try to describe as precisely as possible at the current stage which caring roles/professions may benefit from the service integration efforts to be pursued in the framework of VIGOUR, and in what way these are expected to benefit (the

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"what"). If possible, please also describe the scale at which particular caring roles or professions are likely to benefit (the "how much").

Please insert your text here

9.4 Can any benefits be anticipated for care provider organisations in particular?

Please indicate whether any benefits can be anticipated for care provider organisations. If so, please try to describe as precisely as possible at the current stage which provider organisations may benefit from the service integration efforts to be pursued in the framework of VIGOUR, and in what way these are expected to benefit (the "what"). If possible, please also describe the scale at which particular care provider organisations are likely to benefit (the "how much").

Please insert your text here

9.5 Can any other impacts be anticipated at the current stage?

Please indicate whether any other impacts can be anticipated at the current stage of the VIGOUR project. If so, please try to describe as precisely as possible in what way these impacts may ultimately materialise (the "what") and the scale at which they may materialise (the "how much")

Please insert your text here

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Annex II

Evidence-based Guidance to Scale-up Integrated Care in Europe

Task 4.2

Maturity Assessment Template

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1 Purpose of this document

VIGOUR has the aim to support the participating health care authorities in developing context-related models of integrate care delivers. During a preparatory phase, the so called 'Baseline Phase' described in the workplan, three subsequent work steps are to be concluded by each pilot region. These are graphically summarized by Figure 1. The overarching aim is to thoroughly prepare the implementation of local scaling-up pilots to be launched at a later stage in the overall project. The current document aims at supporting the VIGOUR regions in evaluating their local capacities and barriers for driving change management to implement their respective integrated care models, as outlined in their Initial Ambition Statement (Step I).

Figure 23 - The three tasks of the VIGOUR Baseline Phase

As can be seen from the above schema, the first two steps can be summarized as follows:

- The first step includes formulating a high-level vision for the further integration of current care practices. The outcomes of this process were already documented with help of a common 'Ambition Statement' template.
- The second step focuses on a critical appraisal of the initially stated ambition. Here, each region is requested to critically reflect on the strengths and weaknesses of the envisaged care integration approach described in its initial 'Ambition Statement'. When doing so, aspects that might make it difficult or perhaps even impossible to put the currently stated ambition into practice during the project should receive particular attention. Depending on the given framework conditions, a range of quite different factors may potentially impede the successful implementation of the initially stated ambition by means of a fully up- and running pilot scheme. Equally, diverse supportive capacities may be potentially available for putting the currently envisaged care integration approach

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into practice within the boundaries of the project, albeit these may not have been considered in a systematic way until now.

In this sense, this document is intended to serve as a tool to be utilized by each VIGOUR region for conducting a critical appraisal of its initial 'Ambition Statement' in a systematic manner. In methodological regard, the tool relies on self-assessment techniques known from the so-called SWOT (**S**TRENGTHS, **W**EAKNESSES, **O**PPORTUNITIES, **T**HREATS) analysis.[13] These should be applied along several assessment dimensions. These assessment dimensions were derived from existing models for assessing a region's level of maturity for implementing integrated care.[14] In the subsequent Chapter 2 it is described in more detail how this methodological approach should be applied in practical terms.

As a tangible output, this exercise is intended to help identifying:

a) potentials for further optimizing the envisaged approach towards care integration as it has been documented in the initial 'Ambition Statement' so far;

b) local circumstances that may make it difficult or even impossible to practically implement the initially stated ambition during the course of the VIGOUR project in terms of a fully operational pilot scheme;

c) options potentially available for addressing any identified "road blockers" for the implementation of a fully up-and-running pilot scheme;

d) meaningful criteria that could be applied for assessing whether or not the implementation of the envisaged care integration approach can be regarded as successful under the particular framework conditions prevailing in a given VIGOUR region.

In summary, the current work step is intended to yield a solid foundation for the subsequent development of a detailed operational implementation plan for a local pilot scheme.

It is worth being noted here that the methodological approach presented throughout this document does not aim at assessing a given region's maturity for integrated care in general terms, e.g. for comparing different regions according to a set of common indicators or quantitative scores. Rather, it is intended to help a given VIGOUR region in assessing - as far as this is possible at the current stage - whether there might be any aspects deserving particular attention when setting up its specific pilot scheme, as envisaged according to its initial 'Ambition Statement'.

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[13] A review of existing maturity assessment approaches and tools including the SCIROCCO model and others revealed, that none of these were suitable for the purposes of VIGOUR.

[14] These dimensions have been derived from the analysis of existing assessment approaches.

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2 How to perform the assessment

A two-staged methodological approach is proposed to be adopted for the purposes of the current task. It relies on established methods, in particular SWOT analysis and focus group sessions. The results of the SWOT analysis are then to be assessed in a systematic manner with respect to possible implication for development of a fully operational pilot scheme. Both analytical steps are to be conducted by means of a focus groups. This methodological approach and how it is to be practically applied is described in more detail in the following subsections.

What is a SWOT analysis about?

A SWOT analysis is an analytical method which is to be used in the context of VIGOUR for evaluating strengths, weaknesses, opportunities, and threats of the envisaged care integration approach. This method considers so-called "internal" and "external" factors that can influence the planned implementation under day-to-day conditions in terms of a fully up-and-running pilot scheme. As summarized in Table 1, strengths and weaknesses are regarded as internal factors while opportunities and threats are regarded as external factors.

Table 2 – Summary of key elements of SWOT analysis

1	INTERNAL FACTORS fall within the scope and control of the envisaged pilot scheme	1a	STRENGTHS are understood as characteristics of the envisaged integration approach that give it an advantage over other options potentially under consideration. Certain STRENGTHS can sometimes be used to address certain WEAKNESSES.
		1b	WEAKNESSES are understood as characteristics of the envisaged integration approach that place it at a disadvantage relative to other options potentially under consideration.
2	EXTERNAL FACTORS are conditions that are outside the direct control of the envisaged pilot scheme	2a	OPPORTUNITIES are understood as factors that may facilitate the implementation of the envisaged integration approach.
		2b	THREATS are understood as factors that may stand in the way of the practical implementation of the intended integration approach.

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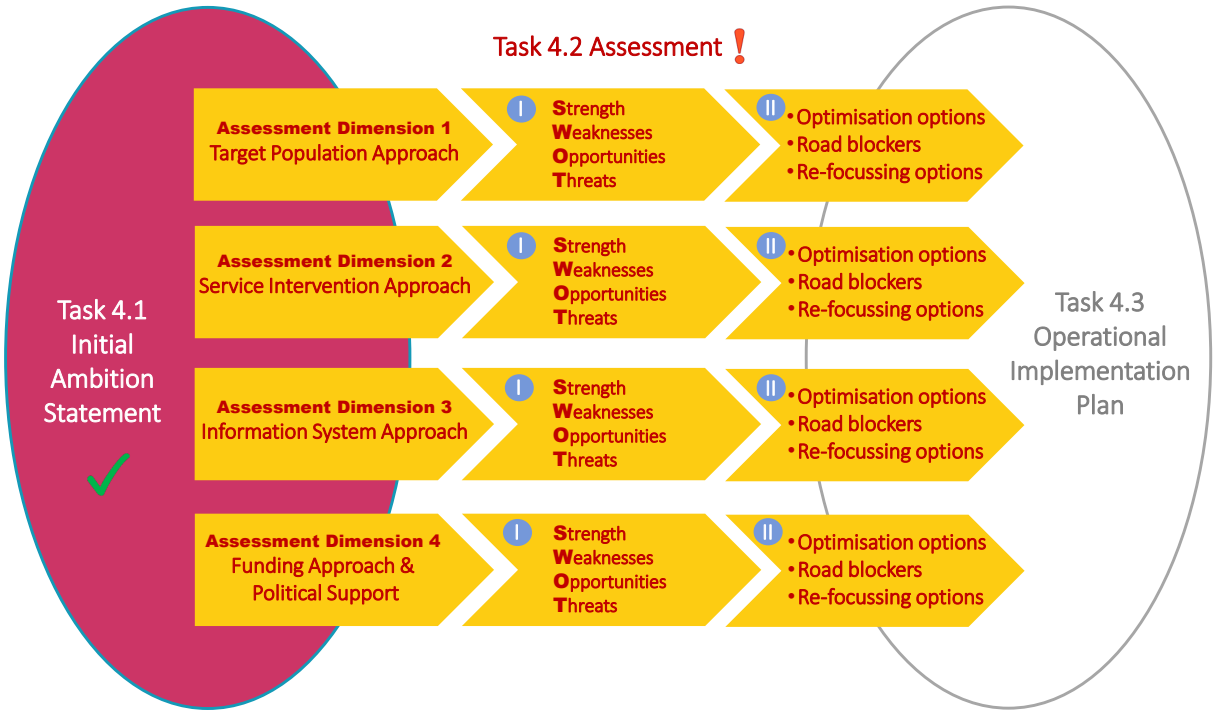
What should be analyzed?

As already mentioned, the initial 'Ambition Statement' as it currently stands should undergo a critical appraisal as graphically summarized by Figure 2.

Figure 24 – Summary of the overall assessment approach



As can be seen from the schema, the Initial Ambition Statement should be assessed in relation to four core dimensions[15]:

1. the target population to be addressed by the envisaged integration approach;
2. the service intervention to be integrated;
3. the information system design to be utilized to support integrated service delivery;
4. and the funding and political support of the envisaged service integration.

Each of these assessment dimensions is explained in some more detail in the following subsections. Generally speaking, for each dimension two analytical steps should be performed:

a) **STEP I: Perform a SWOT analysis of the Initial Ambition Statement**
The current care integration ambition should be assessed in relation to both, internal and external factors. For each assessment dimension, please identify potential strengths and weaknesses of the envisaged care integration approach (internal factors). Moreover, conditions that are outside the direct control of the envisaged pilot scheme should be identified which potentially facilitate or hinder

[15] For the purposes of VIGOUR, these dimensions were derived from the SCIROCCO maturity assessment model. See for example Grooten, L, et al. An Instrument to Measure Maturity of Integrated Care: A First Validation Study. International Journal of Integrated Care, 2018; 18(1): 10, 1–20. DOI: https://doi.org/10.5334/ijic.3063

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the implementation of the current integration ambition under day-to-day conditions (external factors).

b) **STEP II: Assess practically implications of SWOT results for the planned pilot scheme**

This analytical step focuses on assessing results of the SWOT analysis in relation to possible implications for operationally implementing a fully up-and-running pilot scheme at later stage of the overall project. Here, different key questions should deserve attention:

- Can any issues be identified that may make it difficult or even impossible to put the integration ambition into practice under day-to-day conditions?
- Should such "road blockers" indeed be identifiable at the current stage, are there any options available for successfully addressing them within the boundaries of the VIGOUR project?
- Equally to barriers, can any capacities be identified potentially supporting the implementation of the integration ambition under day-to-day conditions?
- If so, are there any options available for practically using these within the boundaries of the VIGOUR project?
- All in all, when could the VIGOUR pilot scheme be considered as a success within the given framework conditions? Are there any specific indicators that could be used to assess the success of the envisaged integration efforts under such conditions?

What practical issues deserve attention?

A number of practical issues deserve attention when assessing the initial 'Ambition Statement' with help of the hitherto described methodological approach. From a methodological point of view, a key challenge is to cope with diversity across the participating regions, e.g. in relation to prevailing framework conditions within which current care delivery processes are to be better joined up. Also, the design of the overall VIGOUR project puts certain boundaries to the practical application of the proposed methodological approach, e.g. time wise and resource wise. The method proposed to be adopted for the purposes VIGOUR therefore enables a certain degree of flexibility when it comes to its application in different local contexts. This is described in the following subsections.

Who should do the assessment?

Typically, different stakeholders have a role to play when it comes to joining-up different care processes around the needs of the care service users, including the patients themselves. Ideally, all stake holder groups which can be envisaged to become involved in the pilot scheme should be involved in critically assessing the initial 'Ambition Statement' as it currently stands. When it comes to care provider organizations that may

have a role to play in the envisaged pilot scheme, these should ideally be represented at the decision-making level and the service delivery level. However, for various practical reasons, it may happen that full coverage of all actors and organizational levels by the composition of the assessment group is not always possible, at least not at the current stage. As a rule, the widest possible range of stakeholders and decision levels should be involved in the assessment process. When documenting outcomes, type and number of participants should be indicated. The documentation format presented in the subsequent chapter caters for this requirement.

In what setting should the assessment be done?

The SWOT analysis (Step I) as well as the assessment of its results in relation to possible implications for the implementation of a fully operational pilot scheme (Step II) require a self-critical reflection process. Such a process can best be facilitated by an interactive and discursive research format, rather than e.g. by a survey. Both steps of the two-staged assessment method (Figure 2) should therefore be conducted in a focus group setting. There are no strict rules how to conduct a focus group. For the purposes of VIGOUR, a focus group session should be organized as a structured workshop. Experiences from earlier research and the literature suggest a number of aspects deserving attention:

- **How many people should take part in a focus group session?**
  Usually, having more than 20 people in a focus group will seriously hamper effectiveness. Within larger workshops, you can also choose to incorporate smaller sub-groups.
- **How many people should run a focus group session?**
  Conducting a focus group session requites a small team. At a minimum, the team should consist of a moderator and a note taker. Generally speaking, the role of the moderator is to share knowledge, lead the content of the discussion and to undergo passive, individual learning. The moderator should take a neutral position vis-à-vis to the other group members. The role of the note taker is to make notes and observations throughout the focus group session. The moderator should try to build trust amongst the group and secure their buy-in. At the same time the moderator should try to keep participants focused and attentive. The reporting sheets to be utilized for documenting the assessment of the initial 'Ambition Statement' should be completed on the basis of the notes taken.
- **How should a focus group be structured?**
  In comparable research settings it has turned out as useful to start preparing a focus group by writing up brief topic guide that can be used by the moderator. For the purposes of VIGOUR such a topic guide may best be structured along the line of the "research questions" emerging from the two staged method described earlier. It seems thus useful to split the focus group session in two parts, one for addressing the questions emerging from the SWOT analysis (Step I) and another one for addressing the questions emerging from the subsequent assessment

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implications of the SWOT outcomes for the pilot implementation (Step II). This may be illustrated as follows:

Assessment Dimension 1: The target population approach

Part I (SWOT):

- What are the strengths of the target population approach described in the Initial Ambition statement, if any?
- What are the weaknesses of the target population approach described in the Initial Ambition statement, if any?
- What factors outside the control of the envisaged pilot scheme may facilitate the practical implementation of the approach described in the Initial Ambition Statement, if any?
- What factors outside the control of the envisaged pilot scheme may hinder the practical implementation of the approach described in the Initial Ambition Statement, if any?

Part II (Implications Assessment):

- Can any issues be identified that may make it difficult or even impossible to put the envisaged target population approach into practice under day-to-day conditions?
- Should such “road blockers” indeed be identifiable at the current stage, are there any options available for successfully addressing them within the boundaries of the VIGOUR project?
- Equally to barriers, can any capacities be identified potentially supporting the implementation of the envisaged target population under day-to-day conditions?
- If so, are there any options available for practically using these within the boundaries of the VIGOUR project?
- All in all, when could the VIGOUR pilot scheme be considered as a success when it comes to the envisaged target population approach? Are there any specific indicators that could be used to assess the success of the envisaged target population approach under given framework conditions?

These topics would then be addressed in relation to the other three assessment dimensions as well. Before asking questions to the group the assessment dimension under discussion should be briefly introduced by the moderator.

- **How should a focus group session be started and ended?**
  The beginning of a focus group tends to be critical in putting all participants at ease and encouraging discussion. Before asking any questions, the group should be welcomed, and any housekeeping notes covered. It is also important that participant understand the confidentiality policy. Depending on the composition

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of the group, it may also be useful to begin with an 'icebreaker' tailored to the participant group. The icebreaker does not need to be related to the topic matter at all, but just needs to stimulate conversation and give everyone a chance to speak. The introduction part of the session is also critical in establishing the moderator as the leader of the group and it gives them the authority to manage the group. In terms of timing, it has turned out as useful to allow approximately 10 minutes for this introduction. When ending a focus group session, the important things that have been learned should be briefly summarized, and the next steps in utilizing the inputs of the group within the VIGOUR project.

- **How long should a focus group session last?**
  Typically, a focus group session tends to last between one to two hours. Extension beyond three hours should be avoided. A session of more than three hours of intense discussion is very likely to put a strain even on a well-trained professional. Ideally one short break should be foreseen.

- **How many focus group session should be organized?**
  The number of focus group sessions required for the purposes of VIGOUR depends on the number of individuals to be involved in a particular region. In case more than 20 people are to be involved, it is strongly recommended to split-up the group. Another factor determining the number of sessions that may be required concerns the scope and length of the discussion emerging in relation to a given assessment dimension. The group should have the opportunity to discuss the initial 'Ambition Statement' in relation to each of the four assessment dimensions at sufficient lengths. Should it turn out that not all dimensions can be sufficiently discussed within one single session one or more additional sessions should be organized. All in all, you should strive to reach an appropriate saturation level as far as the thoughts and ideas to be captured are concerned.

- **How should the outcomes of a focus group session be utilized for the purposes of VIGOUR?**
  As already mentioned, the focus group discussion should be documented in terms of notes. Based on a synthesis of the notes the reporting sheets presented in the subsequent chapters. It is strongly recommended to not utilize the focus group session for jointly completing the reporting sheets directly.

- **Are there any ethical aspects deserving attention?**
  There are key ethical principles that underpin all elements of running a focus group. This means that a focus group session should be designed to ensure integrity and quality. The following principles need to be respected:

    - Focus group participation is voluntary. When conducting a focus group session participants must understand that they are under no obligation to participate and that there will be no consequences for refusing or withdrawing, at any time. Recorded consent (preferably written) should be secured from all participants before undertaking any research. The team

conducting the focus group, e.g., the session moderator, should explain the purpose and objective of the research openly, honestly and clearly.

- Participant confidentiality. The team conducting the focus group need to agree to keep any identifiers or personal information confidential. It should be explained to the participant how their confidentiality will be protected and where their data is being stored. No information should be publicly reported unless you have obtained written consent from the participant to do so. Harm to the participants must be avoided.

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3 Assessment dimensions and reporting sheets

This chapter introduces each of the four assessment dimensions to be addressed by means of focus groups. Moreover, two reporting sheets to be utilize internal to the VIGOUR project are provided for each dimension.

3.1 Assessment Dimension 1 - Current target population approach

Care integration efforts can typically be driven by two different health perspectives, the "individual health perspective" and the "population health perspective".

Individual health perspective

Joined-up delivery of care has shown to benefit those individuals who are not thriving under existing systems of care, in order to help them manage their health and care needs in a better way, and to avoid emergency calls and hospital admissions and reduce hospital stays. In this sense, care integration efforts can be regarded as a practical response to meeting today's demands.

Population health perspective:

Population health goes beyond this and uses methods to understand where future health risk (and so, demand) will come from. It offers ways to act ahead of time, to predict and anticipate, so that citizens can maintain their health for longer and be less dependent on care services as they age. When adopting a health policy perspective in particular, a better integration of care delivery processes may by be seen as a means of

- Understanding and anticipating demand; meeting needs better and addressing health and social inequalities.
- Improving the resilience of care systems by using existing data on public health, health risks, and service utilization.
- Taking steps to divert citizens into person-centered care pathways based on user preferences.
- Predicting future demand and taking steps to reduce health risks though technology-enabled public health interventions.

When adopting a population health perspective in particular, a systemic application of a population risk approach to the services envisaged to be integrated in the framework of VIGOUR can certainly be regarded as a strength. Independent whether an individual health perspective of a population health perspective is adopted for the purposes of VIGOUR, systematic consideration of health equity can certainly be regarded as strength as well, e. g. when it comes to socio-economic and minority groups but also in relation to gender. It has e.g. been highlighted that there is not enough attention on how diabetes specifically affects women when compared to men, independent of their socio-economic status.

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Table 3 - Reporting sheet

Assessment Dimension: Target population approach	
No. of focus group sessions conducted:	*Please insert here*
No. of participants involved:	*Please insert here*
Stakeholder groups represented:	*Please insert here*
SWOT	
Identified Strengths	Please insert here
Identified Weaknesses	Please insert here
Identified Opportunities	Please insert here
Identified Threats	Please insert here
Implications for pilot scheme implementation	
Road Blockers to the envisaged target population approach	Please insert here
Options for addressing these for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Supporting capacities to be used for a target population	Please insert here
Options for making use of supportive capacities for the purposes of optimizing a pilot scheme under day-to-day conditions	Please insert here
Options for optimizing other aspects of the envisaged target population approach for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Identified criteria for the successful implementation of the target population approach in the framework of a pilot scheme	Please insert here

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3.2 Assessment Dimension 2 - Current service intervention approach

Integrated care includes many levels of integration, such as integration between primary and secondary care, of all stakeholders involved in the care process, or across many organisations. It may be developed simply for healthcare needs (vertical integration) or it may include social workers, the voluntary sector, and informal care (horizontal integration). The broader the ambition, the more numerous and diverse the stakeholders who have to be engaged. Similarly, integration may include all levels of the system or may be limited to clinical information sharing. The long-term goal should be fully integrated care services which provide a complete set of seamless interactions for the citizen, leading to better care and improved outcomes, aiming for:

- Integration supported at all levels within the healthcare system – at the macro (policy, structure), meso (organizational, professional) and micro (clinical) levels.
- Integration between the healthcare system and other care services (including social, voluntary, informal, family services).
- Seamless transition for the patient between and within care service

Concrete questions may help triggering a discussion during a SWOT session when it comes to the assessment of the service intervention approach adopted. Who can take the leadership for the new pilot? Do you have trained stuff to deliver the new pilot as a part of the overall service? Are you able to deliver a structured process management pathway for the pilot (sub-tasks, check availability of staff, milestones, and timing)? The questions listed here are only meant to be indicative examples. Depending on the breath of the integration ambition to be pursued in the framework of the VIGOUR project and the specific service intervention(s) to be integrated, you may want to develop a more tailored set of triggering questions in advance.

A theme that deserves sufficient attention in any case concerns capacity building to support the envisaged integration of interventional services. Capacity building is the process by which individual and organisations obtain, improve and retain the skills and knowledge needed to do their jobs competently. As the systems of care are transformed, new roles may need to be created and new skills developed. These may range from technological expertise and project management to successful change management. Ideally, the systems of care should become 'learning systems' that are constantly striving to improve quality, cost and access. They should develop their capacity so as to become more adaptable and resilient. As demands continue to change, skills, talent and experience should be retained. Depending on the service integration approach pursued in an individual case, a suitable capacity building approach may include diverse measures such as:

- Increasing skills; continuous improvement.
- Building a skill base that can bridge the gap and ensure that the capacity needs are understood and addressed by digital solutions where appropriate

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- Providing tools, processes and platforms to allow organizations to assess themselves and build their own capacity to deliver successful change.
- Creating an environment where service improvements are continuously evaluated and delivered for the benefit of the entire care system.
- Human resources and capacities to be involved is an important aspect to be addressed, please consider identifying specific strengths and weaknesses in this regard as well.

Table 3 - Reporting sheet

Assessment Dimension: Current service intervention approach	
No. of focus group sessions conducted:	*Please insert here*
No. of participants involved:	*Please insert here*
Stakeholder groups represented:	*Please insert here*
SWOT	
Identified Strengths	Please insert here
Identified Weaknesses	Please insert here
Identified Opportunities	Please insert here
Identified Threats	Please insert here
Implications for pilot scheme implementation	
Road Blockers to the envisaged service intervention approach	Please insert here
Options for addressing these for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Supporting capacities to be used for the integration of the service integration(s)	Please insert here
Options for making use of supportive capacities for the purposes of optimizing a pilot scheme under day-to-day conditions	Please insert here
Options for optimizing other aspects of the envisaged service intervention approach for the purposes of	Please insert here

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running a pilot scheme under day-to-day conditions	
Identified criteria for the successful implementation of the service interventions approach in the framework of a pilot scheme	Please insert here

3.3 Assessment Dimension 3 - Current information system design approach

Integrated care requires, as a foundational capability, sharing of health information and possibly care plans across diverse care teams that lead progressively to systems for enabling continuous collaboration, measuring and managing outcomes, and enabling citizens to take a more active role in their care. This means building on existing eHealth services, connecting them in new ways to support integration, and augmenting them with new capabilities, such as enhanced security and mobility. Depending on the integration ambition to be pursued within the boundaries of the VIGOUR project, diverse aspects may deserve attention in a given local context such as:

- Essential components to enable information-sharing, based on secure and trusted services.
- 'Digital first' policy (where possible, move phone and face-to-face services to digital services to reduce dependence on staff and promote self-service).
- Availability of fundamental building blocks to enable eHealth services ('ICT infrastructure').
- Data protection and security designed into patient records, registries, online services etc.
- Enabling of new channels for healthcare delivery and new services based on advanced communication and data processing technologies.
- Address the risk of the digital health divide.

Again, it may be helpful to develop a set of contextualized questions in advance to trigger a lively discussion during a SWOT session. Some generic examples are provided in the following for indicative purposes. Do you have a data sharing plan for the pilot available, based on secure and trusted services? Do you have fundamental building blocks to enable eHealth and e-services (e.g. infrastructures)? Do you have fundamental blocks available to support the new pilot to exchange medical data from different systems across care settings (at least the settings addressed in the pilot)?

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Table 4 - Reporting sheet

Assessment Dimension: Current information system approach	
No. of focus group sessions conducted:	*Please insert here*
No. of participants involved:	*Please insert here*
Stakeholder groups represented:	*Please insert here*
SWOT	
Identified Strengths	Please insert here
Identified Weaknesses	Please insert here
Identified Opportunities	Please insert here
Identified Threats	Please insert here
Implications for pilot scheme implementation	
Road Blockers to the envisaged information system approach	Please insert here
Options for addressing these for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Supporting capacities to be used for the implementation of the information system approach	Please insert here
Options for making use of supportive capacities for the purposes of optimizing a pilot scheme under day-to-day conditions	Please insert here
Options for optimizing other aspects of the envisaged information systems approach for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Identified criteria for the successful implementation of the information system approach in the framework of a pilot scheme	Please insert here

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3.4 Assessment Dimension 4 - Current funding approach and political support

The broad set of changes typically required to deliver integrated care at a regional or national level presents a significant challenge. Frequently, multi-year programmes are required to be set up with efficient change management, funding and communications, and the power to influence and (sometimes) mandate new working practices. This means alignment of purpose across diverse organisations and professions, and the willingness to collaborate and put the interest of the overall care system above individual incentives. It also means managing the introduction of technology enabled care services in a way that makes them easy to use, reliable, secure, and acceptable to care professionals and citizens alike. Here again, diverse aspects may deserve attention in a given implementation context such as:

- Enabling properly funded programmes, including a strong programme, project management and change management; establishing ICT or eHealth competence centers to support roll-out; distributed leadership, to reduce dependency on a single heroic leader; excellent communication of goals, progress and successes.
- Managing successful digital innovation within a properly funded, multi-year transformation program.
- Considering the need to address the risk of health and social inequalities.
- Establishing organizations with the mandate to select, develop and deliver digital services

Funding has frequently turned to be a key issue. Changing systems of care so that they can offer better integration requires initial investment and funding; a degree of operational funding during transition to the new models of care; and on-going financial support until the new services are fully operational and the older ones are de-commissioned. Ensuring that initial and on-going costs can be financed is an essential activity that uses the full range of mechanisms from regional/national budgets to 'stimulus' funds, European Union investment funds, public-private partnerships (PPP) and risk-sharing mechanisms).

Again, it may be helpful to develop a set of contextualized questions in advance to trigger a lively discussion during a SWOT session. Some generic examples are provided in the following for indicative purposes. Which domains are included for political support of the current pilot? Do you need any changes of the law (medical acts, information governance, data sharing)? Are you supposed to create new organisations to encourage boundary working? Do you need to change reimbursement to support behavioural change and process change? Is there funding available to support the pilot?

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Table 5 - Reporting sheet

Assessment Dimension: Current information system approach	
No. of focus group sessions conducted:	*Please insert here*
No. of participants involved:	*Please insert here*
Stakeholder groups represented:	*Please insert here*
SWOT	
Identified Strengths	Please insert here
Identified Weaknesses	Please insert here
Identified Opportunities	Please insert here
Identified Threats	Please insert here
Implications for pilot scheme implementation	
Road Blockers to the envisaged information system approach	Please insert here
Options for addressing these for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Supporting capacities to be used for the implementation of the information system approach	Please insert here
Options for making use of supportive capacities for the purposes of optimizing a pilot scheme under day-to-day conditions	Please insert here
Options for optimizing other aspects of the envisaged information systems approach for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Identified criteria for the successful implementation of the information system approach in the framework of a pilot scheme	Please insert here

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Annex III

VIGOUR
Evidence-based Guidance to Scale-up Integrated Care in Europe

Task 4.3
Initial Operational Scaling-Up Plan
Guidance Document

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TABLE OF CONTENTS

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1. Background

The overall aim of the VIGOUR project is to support regional care authorities in implementing a local pilot scheme for integrated care in different European regions. This document concerns the final output to be generated towards the end of the first project phase (Pilot Baseline Phase), namely a first version of an operational plan for practically implementing the envisaged pilot scheme under day-to-day conditions (Pilot Plan). The remainder of this document provides guidance on how to generate such a pilot implementation plan. The initial pilot plan that is now to be elaborated by each pilot site team should consider all lessons learned throughout the previous work steps.

2. Overview of the scaling-up pilot planning template and how it should be applied

The template of the initial pilot implementation plan is structured to allow preparing and managing the local upscaling pilots in a circular manner. This is graphically summarised by Figure 2. To this end, the outputs of the previous work steps (Initial Ambition Statement, SWOT report) were taken as a starting point. From this work, several core dimensions (scaling-up pilot planning dimensions) could be identified which deserve attention when practically implementing the overall pilot scheme under day-to-day conditions. These core planning dimensions are "labelled" in a generic manner. Each of these core dimensions may again require careful planning of several operational tasks which may need to be accomplished if a given pilot scheme is to work within daily routine.

However, the pilot schemes envisaged at the individual pilot sites differ quite a lot across the core planning dimensions identified from the previous work steps. It is therefore difficult to provide a definite list of tasks that need to be planned in any case under each core planning dimension. Taking the dimension labelled "target population" as an example (Figure 2), it may be the case that the population group(s) targeted by a given pilot scheme may be difficult to reach, so that particular measures may need to be planned for successfully enrolling users in the pilot service. In another pilot scheme, this may be a straightforward task requiring much less complex planning.

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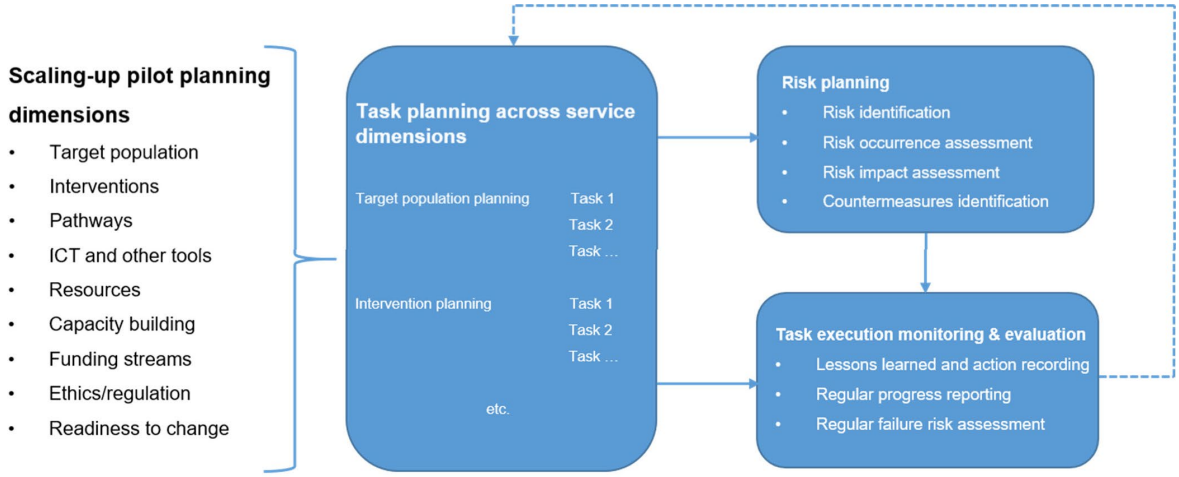
Figure 2 - Core elements of VIGOUR up-scaling pilot planning



Source: VIGOUR ©

Therefore, the core planning dimensions identified in Figure 2 should be considered as a list of generic "headings" under which specific tasks should be identified by each individual pilot site which may require practical implementation planning. When doing so, please try to be as comprehensive as possible at the current stage. With regard to each of the identified tasks, please consider who has to do what by when in order for the task to be completed successfully.

In a next step, the pilot planning template focuses on identifying risk factors potentially delaying or even preventing the successful completion of the identified tasks, and of counteracting measures potentially available under given circumstances (risk planning). Also, relevant lessons learned and actions not foreseen at the planning stage can be noted down and may be of help for the project success.

Finally, the pilot planning template focuses on monitoring of progress in the execution of the task identified earlier. This is to enable putting remedial action in place, should any deviations from the planned task execution occur at some stage (task execution monitoring and evaluation).

Beyond this, the current pilot planning template includes a section intended to help in developing initial considerations for the further upscaling of care integration approach to be piloted beyond the immediate duration of the VIGOUR project.

2.1. Pilot scheme summary

In the pilot scheme summary, the main features of your regional pilot project should be outlined briefly, as well as the aims and expected objectives of the pilot scheme.

2.2. Task planning across pilot planning domains

It is clear from the work conducted so far within VIGOUR that the great diversity of integration approaches and implementation circumstances prevailing across the VIGOUR regions require the elaboration of customised pilot plans. The following subsections provide further guidance on how customised task planning should be achieved with help of the current template:

a) Please start with describing each planning dimension of your scaling-up pilot as detailed as possible

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at the current stage. To support this work step, a set of illustrative indicators is provided in relation to each dimension in the following subsections. The individual indicators have been derived from the previous work conducted within the VIGOUR project, in particular initial ambition statements (Task 4.1) as well as from the evaluation framework (Task 3.1).
Please feel free to select or add descriptive indicators which you deem most appropriate to describe a given pilot planning dimension in your region.

b) In a second step, please identify all tasks in relation to a given planning dimensions which need to be completed in order to successfully prepare, launch and conduct the VIGOUR scaling-up pilot in your region. It is advisable to keep in mind the formulation of "SMART" measures (Specific, Measurable, Attainable, Realistic, Time-bound). To support this work, some exemplary tasks are provided for each planning dimension in a tabular format. Here again, these are intended to serve illustrative purpose only.
Please feel free to select and extend the task list as you deem appropriate in your pilot context.

c) As a third step, risk management and monitoring measures should be taken. This document provides a comprehensive step-based approach to keep an overview of the project progress, to identify and address risks, to record lessons learned and unplanned actions and to capture and evaluate progress during implementation. In the follow-up section, further scaling-up methods to ensure sustainability can be specified.

2.2.1. Pilot planning dimension #1: Target population

The Initial Ambition Statement document you have completed during the first stage of the VIGOUR project includes an outline of the population group(s) to be addressed within the upscaling pilot in your region. The current planning document aims at identifying concrete tasks required to be completed for practically involving individuals into the pilot. This starts with describing as precisely as possible the target population along a set of indicators suitable to serve as a starting point for specifying unambiguous inclusion/exclusion criteria for your pilot scheme. It emerges from the Initial Ambition Statements that the target populations identified so far vary a lot across the VIGOUR regions, and that suitable inclusion/exclusion criteria are strongly context dependent. It is therefore neither meaningful nor possible to define a common set of criteria that are equally applicable across all regions. Figure 3 below provides a collection of possible indicators derived from the available Ambition Statements. Together, they are reflecting the different target populations mentioned so far. With a view to deriving meaningful excursion/inclusion criteria for your pilot scheme, you may pick individual indicators or use additional ones as deemed meaningful in your region.

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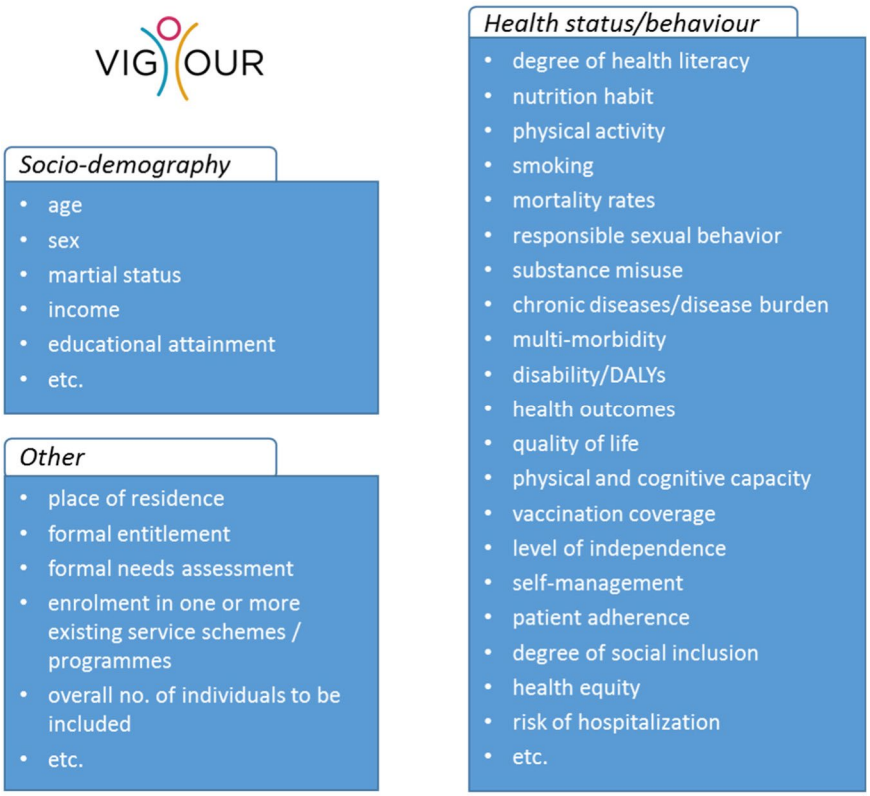
Figure 3 – Possible indicators for defining the pilot population



Source: VIGOUR ©

Some of these indicators may immediately be applicable as inclusion/exclusion criteria. Others may however require careful transposition into criteria that can be unambiguously applied in practice, e.g., with reference to existing guidelines, standards or measurement scales. In certain cases, it may also be required to agree upon exclusion/inclusion criteria among different stakeholders that have a role to play in successfully piloting the envisaged care integration approach within a given regional setting. Under certain circumstances, it may also be necessary to agree upon a specific enrolment process for the purposes of the VIGOUR pilot in your region.

For all activities to be implemented successfully, careful planning is required. Such a planning should include a clear description of the task(s) to be achieved together with clearly assigned responsibilities, timelines and required resources. Table 1 overleaf provides an indicative example of how such a task planning should be conducted in a tabular format.

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Table 1 –Example of documenting planned tasks in tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Clear definition of the project target group → inclusion and exclusion criteria with the help of indicators	01/01/20	15/01/20	Name of project team member	Stakeholder name	Target group identified
2	Analysis of setting of the target group (meso- & macro-level) and alignment with target group (micro-level)	15/01/20	31/01/20	Name of project team member	Stakeholder name	Setting of target group identified
3	Develop strategies for contacting and inclusion of target group in pilot project (plan: how to contact etc.)	31/01/20	15/02/20	Name of project team member	Stakeholder name	Strategies for target group inclusion developed (plan)
4	Approach and inform the target group about pilot-project (eventually provision of information material)	15/02/20	28/02/20	Name of project team member	Stakeholder name	Target group informed and included in project
...n	...?.	...?	...?	...?	...?	...?

2.2.2. Pilot planning dimension #2: Interventions

This section focuses on planning which intervention(s) is (are) to be delivered in a better joined up manner as part of the VIGOUR scaling-up pilot in your region. Diverse aspects may deserve attention when planning the interventions to be better integrated in one way or another, e.g., whether the VIGOUR scaling-up pilot is expected to concern any interventions that do already exist, so transferring an existing intervention to another context, or whether it is planned to develop new interventions. Which settings and core services do they address? Do they comprise different settings of care and core services? Do they contain any horizontal integration of interventions (multi-professional interventions for example) or on longitudinal level? If the pilot scheme refers to already existing interventions, that should be transferred to another context, transferability constitutes an important issue. Further information on assessing transferability of interventions can be found in the publication of Schloemer and Schröder-Bäck (2018). For illustrative purposes, Figure 4 indicates several other aspects that may be relevant in the context of the scaling-up pilot in your region.

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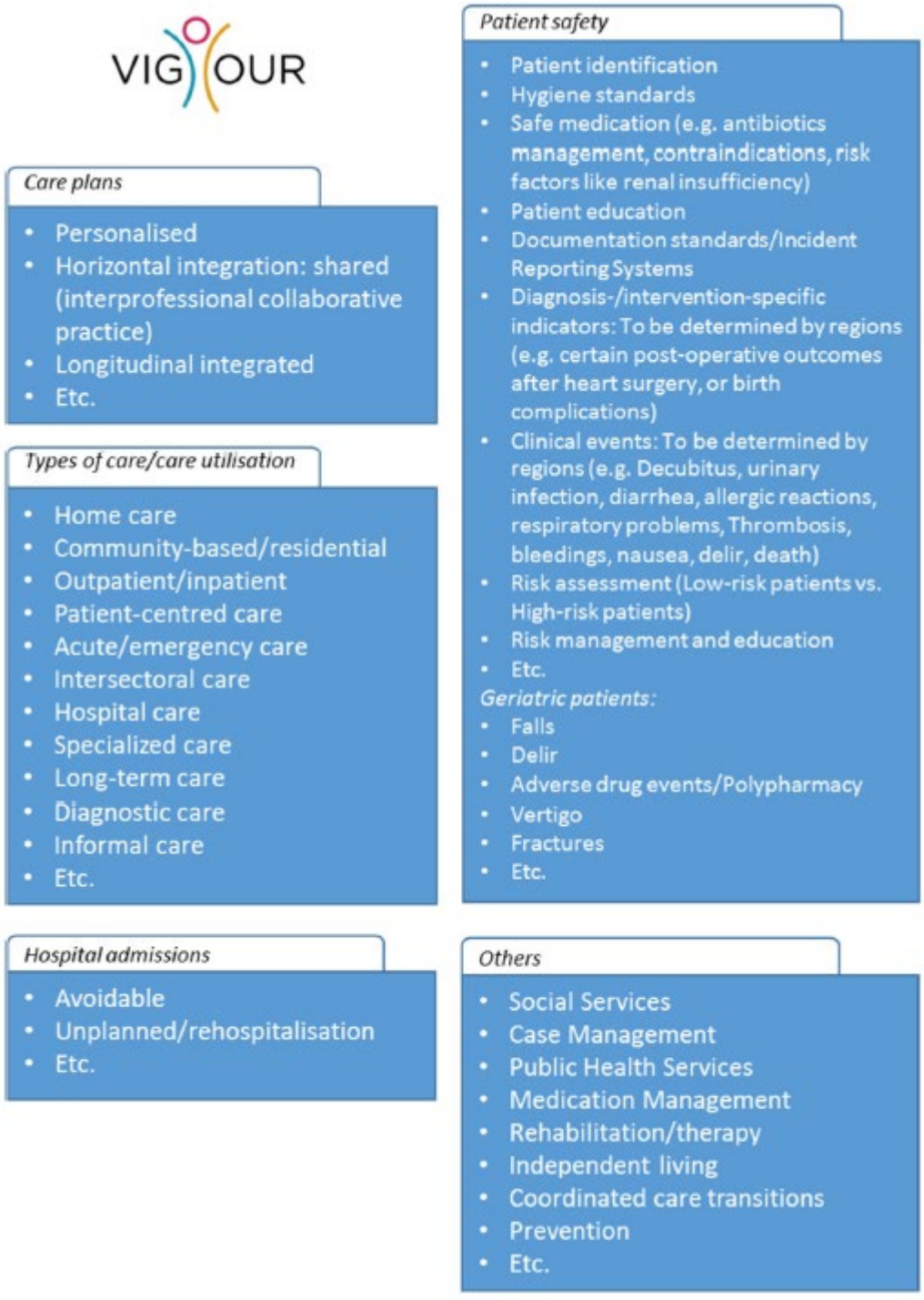
Figure 4 - Possible aspects of interventions
(not exhaustive)



Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (the current list is not exhaustive) for the implementation and pilot testing of a safe medication approach in a clinical setting (department of internal medicine) to increase patient safety as an overall goal.

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Table 2 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Implementation of a departmental contact point for informal carers (family, relatives, ...)	01/01/20	31/01/20	Internal Medicine administration	Project team	Contact Point established
2	Development of information documents about safe medication for patients and informal carers	15/01/20	31/01/20	Clinicians	Internal Medicine administration, project team	Information documents developed
3	Process implementation: Information talk about safe medication with patient and informal carers before discharge and offer of contact point in case of questions/problems	01/02/20	30/05/20	Departmental workforce (physicians, nurse, ...)	Internal medicine administration	Milestone: 50 patients better informed about safe medication & improved handling with drugs
4	Evaluation of pilot phase	01/06/20	15/06/20	Internal Medicine administration	Departmental workforce, Project team	Evaluation report

2.2.3. Pilot planning dimension #3: Pathways

This section focuses on planning any care pathways, which may need to be developed and/or adapted for the purposes of the VIGOUR scaling-up pilot in your region. Again, diverse aspects may deserve attention in this regard. For instance, are there any guiding pathways or other structured care plans available? Are there any other national protocols or guidance documents that help you to put change into practice?

Figure 5 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

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Figure 5 - Possible aspects of pathways

Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for the implementation and pilot testing of a new discharge management process in a hospital setting.

Table 3 Examples of documenting planned tasks in a tabular format (not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Development of a coordination structure for discharge management	01/01/20	31/01/20	Project team, hospital workforce	Hospital administration	Coordination structure for discharge management developed
2	Process management: development of a clear discharge management process & process description	01/02/20	28/02/20	Project team, hospital workforce	Hospital administration	Process for discharge management developed
3	Information, education and training of workforce on behalf of the discharge management process	01/03/20	30/04/20	Project team, hospital workforce	Hospital administration	Workforce is educated in discharge management
4	Development and provision of documentation files	01/03/20	30/04/20	Project team	Hospital administration	Documentation files for discharge management developed

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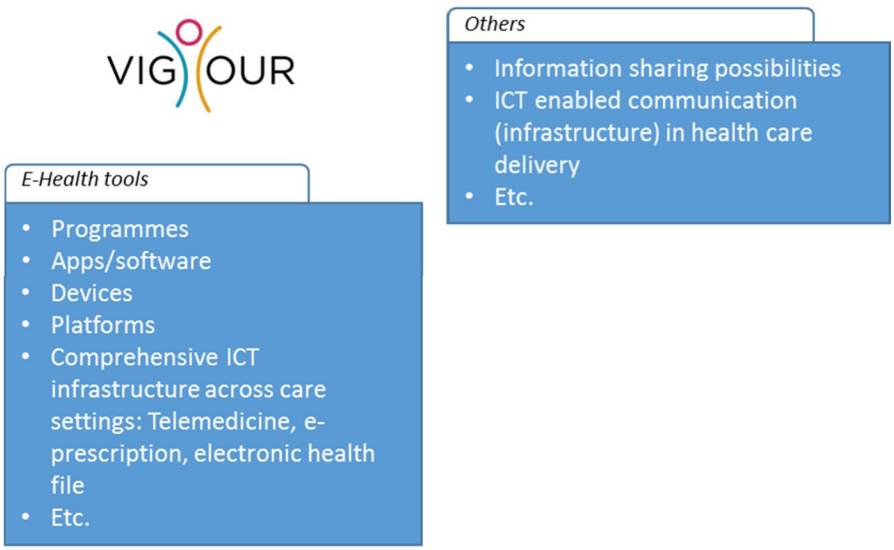
5	Application of new discharge management process in pilot phase	01/05/20	31/08/20	Project team, hospital workforce	Hospital administration	Pilot project completed
6	Evaluation of new discharge management process	01/09/20	30/09/20	Project team, hospital workforce	Hospital administration	Evaluation report

2.2.4. Pilot planning dimension #4: ICT and other tools

This subsection focuses on any ICT and other tools expected to be utilised for the purposes of care integration in the framework of the VIGOUR scaling-up pilots. Amongst other aspects, the question how to communicate data and information effectively among the stakeholders involved may deserve particular attention when planning your VIGOUR scaling-up pilot in your region. Potentially, a wide range of aspects may be relevant in your specific region. The question which ICT and other tools are already in use or available and which professions have access to the information may deserve attention, for instance. Are there any telecare, tele-rehabilitation solutions or apps which are supposed to be utilized? If any new ICT tools are to be developed or purchased, how can this realistically be achieved within VIGOUR process wise, time wise and resource wise? Which resources do you need for utilising any existing and/or newly developed tools in the framework of the VIGOUR pilots? Figure 6 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

Figure 6 – Possible aspects of ICT and other tools



Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for the implementation and pilot testing of an e-prescription platform in a PHC setting.

Table 4 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Development of e-prescription platform	01/01/20	01/03/20	(IT-company)	Project team, PHC workforce	e-prescription platform established
2	Implementation of e-prescription platform in pilot PHC settings	02/03/20	30/04/20	(IT-company)	Project team, PHC workforce	e-prescription platform implemented in settings
3	Patient information and participation on voluntary basis (informed consent, data regulation!)	01/04/20	30/04/20	PHC workforce	Project team	Participating patients are informed
4	Test-run of e-prescription platform in settings	01/05/20	31/07/20	PHC workforce	Project team	Usage of e-prescription in daily routine
5	Evaluation of e-prescription platform	01/08/20	31/08/20	PHC workforce	Project team	Evaluation report

2.2.5. Pilot planning dimension # 6: Resources

This subsection focuses on planning any technical resources and human resources expected to be utilised in the framework of the VIGOUR scaling-up pilot in your region, including all care settings and core services to become involved in one or another way. Again, several issues may require attention from a planning perspective. For instance, do care professionals already work in inter- or multidisciplinary teams with agreed roles and responsibilities? If not, will it be required to establish such teams and if so who will need to be involved? Are there any decision- making tools for professionals and service users? Figure 7 provides illustrative examples of further aspects potentially worth to be considered for the purposes of planning the scaling-up pilot in your region.

Figure 7 - Possible aspects of resources (not exhaustive)

Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for allocating higher organisational or financial resources for integrated care research.

Table 5 Examples of documenting planned tasks in a tabular format (not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Provision of financial resources for integrated care research	01/01/20	31/03/20	Financial department	Project team	Financial resources provided
2	Composition of an integrated care research team	01/04/20	30/04/20	Project team	Project organisations	Research team put together
3	Allocation of financial resources to newly established integrated care research	01/04/20	31/12/20	Financial department	Project team	Financial resources allocated
4	Implementation of integrated care research and research projects according to funding purposes	01/04/20	31/12/20	Project team		Integrated care research performed

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2.2.6. Pilot planning dimension # 7: Capacity building

This subsection focuses on planning any capacity building measures potentially required for successfully implementing the VIGOUR scaling-up pilot in your region. Diverse questions may deserve attention here again. For instance, is there a need to engage the staff in a process of

joint learning and continuous quality improvement? If so, how can this be achieved? Is there a need to increase or train special skills for a continuous improvement of work? If available, can you rely on any tools or platforms to assess and build your own capacity? Is there an evaluation of service improvements or cooperation on capacity building? It may also be worth considering opportunities to increase individual resilience. Which care settings and core services are to be involved in capacity building? Figure 8 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

Figure 8 - Possible aspects of capacity building (not exhaustive)

Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for the implementation and pilot testing of a shared-decision making approach in the cardiology department of a regional hospital.

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Table 6 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Education and training of the cardiology workforce in shared-decision making with a one-day seminar	10/01/20	10/01/20	(seminar administration)	Project team	Capability in shared-decision making acquired (Certificate)
2	Team meeting in small groups to plan implementation of shared-decision making in clinical routine	15/01/20	15/01/20	Team leader cardiology	Cardiology workforce	Shared-decision making approach determined
3	Pilot application of shared-decision making in clinical routine (interdisciplinary case conferences, inclusion of patients → options discussions, decision meetings,...)	15/01/20	31/03/20	Team cardiology	Patients eventually	Milestone: Successful care of 50 cases with the help of shared-decision making
4	Evaluating discussion and regular refresher courses	01/04/20	01/04/20	Team cardiology and seminar administration	Cardiology workforce	Benefits of shared-decision making outlined, reinforcement of capability

2.2.7. Pilot planning dimension # 8: Funding streams

This subsection focuses on planning any funding streams, which may need to be secured to successfully implement the VIGOUR pilot in your region, thereby considering different settings of care or core services expected to become involved. Questions deserving attention in your region may for instance include whether or not any existing funding streams may be available to support the move towards integrated care in the framework of VIGOUR. Is it only available for the pilot project or on a regular basis? At which level (regional/national/European) is funding available and from which sources? Figure 9 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up

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pilot in your region.

Figure 9 - Possible aspects of funding streams

Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for a health research department for submitting more project proposals in integrated care funding schemes.

Table 7 Examples of documenting planned tasks in a tabular format (not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Systematic search for open funding calls for integrated care projects	01/01/20	15/01/20	Project team	Research management in organisation	Funding calls detected
2	Check funding eligibility of projects and the organisation	15/01/20	15/01/20	Project team	Research management in organisation	Funding eligibility clarified
3	Write project proposal according to requirements in collaboration with project partners	15/01/20	15/02/20	Project team	Research management in organisation	Project proposal
4	Submit project proposal	15/02/20	15/02/20	Project team	Research management in organisation	Project proposal submitted

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2.2.8. Pilot planning dimension # 9: Planning Ethics/regulation

This subsection focuses on planning any aspect of the VIGOUR scaling-up pilot in your region when it comes to ethical aspects and/or potentially existing regulation. Again, a diverse range of issues may potentially have relevance for the pilot scheme envisaged to be implemented in your region. For instance, which ethical regulations do exist locally, regionally, nationally and Europe-wide with relevance to the integration approach expected to be piloted in your region? Do you need the approval of an ethics commission and/or an informed consent? Are there any special considerations for your target population (e.g. children, people with dementia, people with a custodianship)? Please consider different care settings and core services expected to become involved in your regional pilot scheme. Figure 10 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling- up pilot in your region.

Figure 10 - Possible aspects of ethics/regulation

Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for complying with ethical regulations (if required/applicable) in your organisation for projects.

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Table 8 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Gather information about necessity of an ethical approval for project (→ ethics committee or other institutional information point)	01/01/20	15/01/20	Project team	Ethics committee	Information if ethical approval is required gained
2	If necessary: Make application for ethical approval with all documents required	15/01/20	31/01/20	Project team	Ethics committee	Ethical approval application completed
3	Submit application for ethical approval	01/02/20	01/02/20	Project team	Ethics committee	Submission completed
(4)	(Revise application if necessary according to statements of ethics committee)	(01/02/20)	(28/02/20)	(Project team)	(Ethics committee)	(Revision completed)
4	Start project upon reception of ethical approval	01/03/20	31/12/20	Project team members	Ethics committee	Ethical approval gained

2.2.9. Pilot planning dimension # 10: Readiness to change

This subsection focuses on planning any tasks that concern the readiness to change of the different stakeholders, which are expected to become involved in the VIGOUR scaling-up pilot in your region. For instance, is there any political consensus or social support to foster change management in the framework of VIGOUR and/or beyond? Is there any strategic plan, vision or a care of urgency to scale-up integrated care in the framework of VIGOUR? How is the climate towards changes in your team/organisation? Please consider different settings of care and core services that are expected to become involved in the framework of VIGOUR.

Figure 11 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

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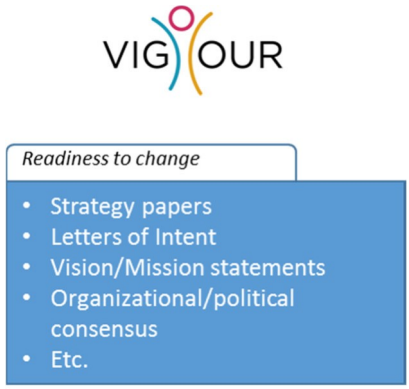
Figure 11 - Possible aspects of readiness to change



Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for a kick-off initiative for a long-term system change approach in order to enable a full inclusion of integrated care in policy and healthcare systems of a project setting.

Table 9 Examples of documenting planned tasks in a tabular format (not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Expression of commitment of health policy, health professions and health insurance organisations in project region for collaboration	01/01/20	31/01/20	Project team	Key stakeholders (policy, health care, ...)	Commitment expressed, open for collaboration
2	Coordination meeting of key stakeholders	15/02/20	15/02/20	Project team	Key stakeholders	Meeting held
3	Signing of Letter of Intent to acknowledge integrated care as	15/02/20	15/02/20	Project team	Key stakeholders	LOI signed

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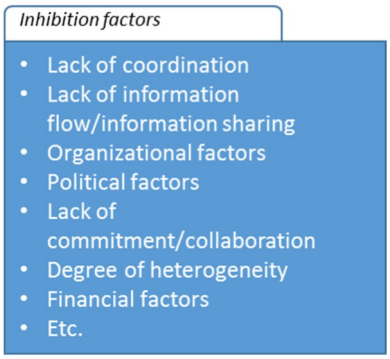
	strategic priority within project region					
4	Set the course for fostering systemic collaboration in integrated care (next possible steps could be: inform relevant institutions, develop guidelines and frameworks, coordination meetings, ...)	15/02/20	31/12/20	Project team	Key stakeholders	System change introduced

2.2.10. Pilot planning dimension # 11: Inhibition factors

This subsection focuses on planning any measures addressing factors that may inhibit the successful preparation, launching and/or operation of the VIGOUR scaling-up pilot in your region. For instance, is there a need for any particular measures/activities to address any organisational or financial factors that may inhibit the VIGOUR pilot scheme? Will any specific measures be required to address any legal or ethics related inhibitors that may exist in relation to the planned VIGOUR pilot scheme? How do you deal with inhibition factors within the pilot team?

Figure 12 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

Figure 12 - Possible inhibition factors



Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for the planning and implementation of any desired integrated care project by focusing on inhibiting organizational factors. By clarifying the project aim and developing a clear management structure and proceeding stepwise (model-like), potential organizational barriers may be inhibited.

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Table 10 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Formation of a steering group to build a structured process on how to implement an integrated care project	01/01/20	15/01/20	Project team	Organisation concerned	Steering group built
2	Development of an organigram and management structure	15/01/20	31/01/20	Project team	Organisation concerned	Organigram and management structure developed
3	Project plan: Definition of aim, tasks and regulatory framework (who is responsible for what and does what)	01/02/20	15/02/20	Project team	Organisation concerned	Project plan developed
4	Step-based approach towards project goal (focus on small tasks and milestones)	15/02/20	30/06/20	Project team	Organisation concerned	Project results/Milestones

2.3. Risk Management and Monitoring

Following completion of the task planning described in the previous sections, a dedicated effort should be made towards monitoring and risk assessment measures. The following chapter provides a spectrum of tools to meet the requirements for adequate project monitoring and risk assessment. The structure of this section is built as follows:

1) Gantt-chart: The Gantt-chart helps to keep the overview of upcoming tasks with regards to the timeframe. It supports the VIGOUR project regions in easily checking where they stand and what the next activities will be. Please note that the gantt chart below is intended to serve illustrative purposes only.
Please feel free to use your own designed gantt chart or other charts, which you deem most appropriate to illustrate and monitor the timeframe of project activities in your region.

2) Risk plan: In case of any deviation, it is highly recommended to timely come up with appropriate measures in order to avoid damage and secure project progress. Such a risk planning should be as comprehensive as possible. By additionally rating the occurrence probability and the degree

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of impact, the extent of certain risks is visible and prioritization of measures is possible.

3) Lessons learned and actions recording: In any project, lessons learned will emerge. They constitute highly valuable experiences, sometimes resulting from risks, problems or issues that came up during the project implementation. Lessons learned should be noted down as they may lead to future success, improvements or new opportunities. The action items comprise high prioritized, unexpected work mainly linked to uprising issues or risk management and often form during meetings and discussions. The project success also depends on the identification and completion of these unplanned action tasks; therefore, they should be recorded as well (adapted from Carewell project, 2014).

4) Project status report: This tool enables indicating the status quo of the project and any problems associated. Internal reporting and monitoring activities facilitate a successful control of project progression. Monitoring should be conducted on a regular basis; however, the frequency highly depends on the project context. At least biannual monitoring processes should be carried out, thus minimizing the risk of severe problems that evolve beyond control.

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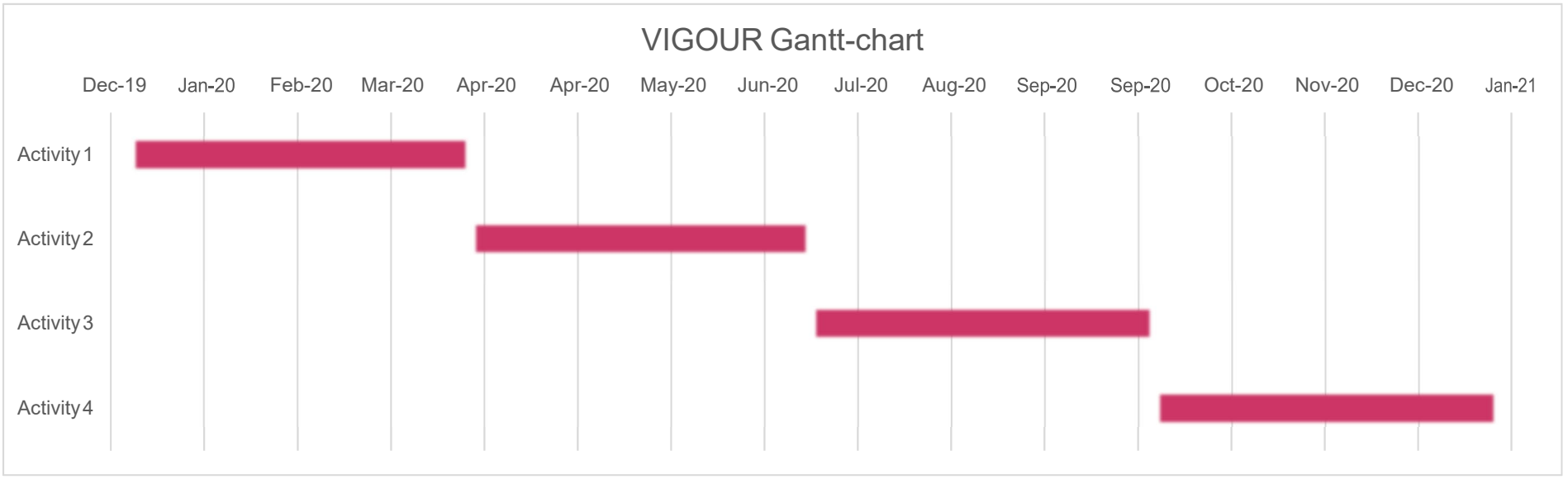
2.3.1. Gantt-chart

Figure 13 Gantt-chart - example



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2.3.2. Risk and contingency plan

Table 11 Risk and contingency plan - example

Domain	Risks	Probability of occurence	Impact degree	Remarks to risk assessment	Countermeasures
Domain	Fill in possible risks 1. 2. 3.	Choose between: - Very likely - Likely - unlikely	Choose between: - Severe - Moderately severe - mild	Fill in any information with regards to risk assessment (e.g. methods), if applicable and available	Fill in Countermeasures 1. 2. 3.
Target population	1. High drop-out rate during intervention	Likely	Severe		1. Keeping close contact with participants and keeping open the possibility for follow-up recruitment/enrolment
Interventions	1. Intervention does not address target populations' needs 2. Intervention proves to be ineffective	Unlikely Unlikely	Severe Severe		1. Implementation of quality management with regular effectiveness control loops 2. Intervention modification
...					

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2.3.3. Lessons learned and action recording

Table 12 Lessons learned recording - example

Serial number	Detail of problem or issue	Type of lesson	Description of lesson learned	Action taken	Date lesson learned raised
1	(e.g. timescale, cost, quality, staff)	**Start** (suggestion for improvement) **Stop** (stop continuation in future) **Continue** (something went well and should be continued)	Detailed description of lesson learned	Action taken to address problem or issue	When was lesson learned raised?
1	Timescale	Stop	Keeping shorter deadlines for feedback	All participants of the project meeting have now 5 working days (instead of 10) to give feedback on the draft of minutes in order to stay on time schedule.	March 3rd, 2021

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Table 13 Action recording - example

Serial number	Initiated by	Action date	Priority	Description of Action	Deadline	Progress/notes
1	Who started action?	When initiated?	High, medium, low	Detailed description of action to be taken	By when should action be done?	Any further information necessary
1	…	April 17th, 2021	High	Organization of originally unplanned staff meeting in order to clarify questions and details for Task …	April 30th, 2021	All participants are informed and invited, staff meeting will take place on April 27th, 2021

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2.3.4. Project status report

Table 14 Project status report - example

Name and Date:	Max Mustermann	31.03.2020
Project name:	Integrated Care in …	
Start date:	01.01.2020	
End date:	31.12.2021	
Project progress in %:	12,5% (1st Quarter 2020)	

Overall project status:

Here you can give a short overview about the current project status and report where you stand and what the next steps are. Please also bear in mind to inform about achieved tasks and milestones and any modifications done during the reporting period.

Legend for status assessment:

Green = Project activity, task, milestone or indicator is on schedule, no problems occur

Yellow = There are problems or delays, but effective countermeasures are already implemented

Red = Severe deviations occur and project milestones, indicators or goals are endangered

Activity/Task/Milestone/Indicator	Target deadline	Current deadline	Status			Remarks
Please insert the activity, task, milestone or indicator to be monitored here	Insert targeted date for completion	Actual date with achieved completion				After crossing applicable status in the column left, insert any informative remarks here
A1	31.01.2020	15.02.2020		x		Minor delay but no further problems
M1	15.02.2020	15.02.2020	x			Milestone 1 achieved in time
Ind. 1	28.02.2020	15.03.2020			x	Target population recruiting delayed: contingency plan!
…						

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2.4. Follow-Up

Upon the completion of the VIGOUR scaling-up pilot in your region, results and effects should not only be made visible, but the impact of results should be disseminated beyond project duration and context. Documentation, dissemination and scaling-up serve the purpose to communicate project outcomes to the target group and to a broad audience as well as to increase awareness about the project context in general. Results and ideas stemming from the VIGOUR scaling-up pilot may be taken up and transferred to different settings and broader contexts. The following subsections provide input and guidance on how to design the overall follow-up phase of the VIGOUR scaling up pilot in your region.

2.4.1. Dissemination and documentation of results and project sustainability

Indicate how the dissemination and documentation of results as well as communication to the target population are organized and how you plan to ensure the project sustainability. In this context, the following aspects should be covered:

- Dissemination and communication objectives
- Dissemination and communication measures
- Documentation measures
- Dissemination, communication and documentation schedule (see example below)
- Dissemination evaluation aspects (if applicable)

The dissemination, communication and documentation schedule can be prepared with a table as the example below illustrates:

Table 15 Dissemination schedule - example

Measure	Expected target audience	Suspected deadline
Project report	General audience	Month 24 (Project end)
Flyer	Scientists, Health Professionals	Month 10
...		

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2.4.2. Potential for Transferability/Scaling-Up

Scaling-up means to expand or replicate innovative pilot or small-scale projects to reach more people and/or broaden the effectiveness of an intervention (World Health Organization, 2016). Once the VIGOUR pilot is finished, its potential for transferability or scaling-up should be put into concrete consideration. Again, the PIET-T model (Schloemer & Schröder-Bäck, 2018) or the following approach explained by particular phases, introduced by the Ministry of Health in New South Wales, Australia (World Health Organization, 2016) may be of help in this matter:

1) Assess scalability
2) Develop a scaling-up plan
3) Prepare for scaling-up
4) Scale-up the intervention

Especially during the assessment phase, potential promoting and hindering factors for further scaling-up the VIGOUR pilot scheme should be analysed. Also, the following questions should be considered: Could the VIGOUR pilots scheme address further target groups? Could it address further topics? Is further support (organisational, political, and financial) required? Is the outcome/result of the VIGOUR pilot useful, effective and feasible enough to be further scaled-up? Is the context/environment where it should be further scaled-up stable? Are willingness/acceptability, motivation and required expertise of involved partners available? If answers to these questions point in the direction of further scaling-up, a detailed plan needs to be set up.

In general, the plan gives insight about the following aspects: What are we going to do exactly? What are the goals? Who are the relevant stakeholders? How are we going to do it? Especially the factors of the pilot intervention that need to be modified for the further scaling-up need to be elaborated cautiously. Other aspects may be transferred as supplied before during the VIGOUR scaling-up pilot implementation. If further information in this regard is required, the World Health Organization provided a detailed guidance document (2016).

References

Carewell. (2014). Internal Deliverable: Lessons Learned, Issues, Actions and Risks (LIAR) Pilot Management Tool.

Schloemer T, Schröder-Bäck P. (2018). Criteria for evaluating transferability of health interventions: a systematic review and thematic synthesis. Implement Sci. 2018;13(1):88. Published 2018 Jun 26. doi:10.1186/s13012-018-0751-8

World Health Organization.(2016). Scaling up projects and initiatives for better health: from concepts to practice. Copenhagen: WHO Regional Office for Europe. http://www.euro.who.int/data/assets/pdf_file/0004/318982/Scaling-up-reports-projects-concepts-practice.pdf?ua=1 (access 20.11.2019).

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Annex IV

VIGOUR
Evidence-based Guidance to Scale-up Integrated Care in Europe

Task 6.1 “Local scaling-up pilots”

REPORTING STRUCTURE

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Content

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1 Introduction

The present document responds to the objective "to scale up good practice in integrated care under day-to-day conditions prevailing in VIGOUR regions", providing a template of the common reporting structure that will be applied by each VIGOUR care authority in order to document their pilot activities.

The template has been created based on both the dimensions (implementation tasks) identified in the Operational Pilot Plan and a comprehensive review of the currently available knowledge base on existing change management models (SELFIE), in order to collect all the necessary information about what have been already done with regard to the pilot's implementation and how should it be done, taking into account the specific context of the pilot.

Operational Pilot Plan Task dimensions

SELFIE project dimensions

Implementation Tasks	Implementation approach		Implementation activities	
			during pilot	after pilot ?
• Target population • Interventions • Pathways • Readiness to change	Service delivery (A)	Incremental growth model vs disruptive innovation approach		
	Service delivery (B)	Balance between flexibility and formal structures of integration		
	Leadership & governance (A)	Collaborative governance by engaging stakeholder		
	Leadership & governance (B)	Distribution leadership throughout all levels of the system		
	Health and social care system	Alignment work		
• Resources • Capacity building	Workforce (A)	Team culture		
	Workforce (B)	New roles and competencies		
• Funding streams	Financing	Funding typology / Innovative payments		
• ICT & tools	ICT (technology & medical devices)	Collaboration support / Communication support		
• Risk planning • Execution monitoring & evaluation	Information & research	Feedback loops / Continuous monitoring system		

In particular, to define a common framework, ProMIS studied, looked into and took into consideration different European project results and deliverables such as a recent publication[16] produced in the framework of the EU-funded Horizon2020 project "Sustainable Integrated Care Models for Multi-Morbidity Delivery, Financing and Performance – SELFIE"[17]. The Project has deepened several European Projects and related deliverables. As well as the framework of the INTEGRATE Project, which provided

[16] Drivers of successful implementation of integrated care for multi-morbidity: mechanisms identified in 17 case studies from 8 European countries - Social Science and Medicine. 25 January 2021. https://www.sciencedirect.com/science/article/pii/S0277953621000605

[17] SELFIE Project website: https://www.selfie2020.eu/selfie-project/

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practical guidance to managers and planners. Moreover, in the context of the SCIROCCO[18] Project, the designed tool to assess whether the health care system is mature enough to provide integrated care has turned particularly useful to identify the implementation strategies for integrated care[19].

The publication coming from the SELFIE Project provides a deeper understanding of the mechanisms underlying implementation strategies for integrated care, and for this purpose 17 integrated care programmes, addressing multi-morbidity from eight European countries, were selected and studied. Data was extracted from 'thick descriptions' of the 17 programmes and analysed both inductively and deductively using an implementation theory. This analysis finally revealed ten empirically derived mechanisms for successful implementation of integrated care:

1. With regards to *service delivery*, successful implementers (a) commonly adopted an incremental growth model rather than a disruptive innovation approach.
2. Also - when it comes to *service delivery* - they found (b) a balance between flexibility and formal structures of integration, as follows.
3. For *leadership & governance*, they (a) applied collaborative governance by engaging all stakeholders.
4. When it comes to *leadership & governance*, they (b) also distributed leadership throughout all levels of the system.
5. For the *workforce*, successful integrated care implemented were able to build a multidisciplinary team culture with mutual recognition of each other's roles.
6. Moreover – with respect to the *workforce* - they (b) stimulated the development of new roles and competencies for integrated care.
7. With respect to *financing*, secured long-term funding and innovative payments were applied as means to overcome fragmented financing of health and social care.
8. Successful implementers emphasised the implementation of ICT that was specifically developed to support collaboration and communication rather than administrative procedures (*technology & medical devices*),
9. They also created feedback loops and a continuous monitoring system (*information & research*).
10. As an overarching mechanism, successful implementers engaged in alignment work across the different components and levels of the *health and social care system*.

[18] SCIROCCO Project website: https://www.scirocco-project.eu/

[19] Grooten, L., Borgermans, L., & Vrijhoef, H. (2018). An instrument to measure maturity of integrated care: a first validation study. IJIC, 18.

These evidence-based mechanisms for implementation are applicable in different local, regional, and national contexts as a guide in managing/innovating the organisational model of integrated care, enhancing the cultural heritage of different contexts.

In order to learn about other care authorities, the reporting structure (template) has the objective of helping VIGOUR care authorities to document final scaling-up activities and achievements. The outcome will be an easy-to-use synthesis of evidence-based mechanisms for implementation of each local activity, identifying also common features and existing differences among all scaling-up pilot regions.

2 Summary of the integrated care practice(s) piloted in VIGOUR

Please summarise how current care practices will be integrated in the VIGOUR pilots. Please bear in mind that your summary is intended to be understood by external readers who may not yet have familiarised themselves with any interim outputs generated in the framework of the VIGOUR project. To this end, please briefly summarise the situation before VIGOUR and then describe how integration is taking place as part of your pilot. In total, your description should not exceed one page.

Please insert your text here.

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3 Description of implementation activities

This Chapter focuses on describing in more detail how integrated care practices are practically implemented in your pilot. In relation to each of the generic integration mechanisms identified by the SELFIE project (see introduction), please summarise the specific approach adopted for the purpose of your pilot. Moreover, please describe tangible activities carried out for putting this approach into practice during the pilot duration. Please also describe any activities planned to be carried out after the pilot duration, as far as they concern the further implementation of your specific integration approach.

3.1 Service delivery A (incremental vs. disruptive approach)

This section focuses on the approach taken by the Pilot region in terms of services provided. In particular, it is required to specify if you have adopted a gradual approach to change, building on what was already existing (incremental growth model) or a disruptive innovation approach which implied the radical creation of new products or new environments.

Example: stakeholders adopted a stepwise approach to change by building upon what was already there (e.g., existing collaborative networks) and gradually expanded and broadened the scope of the integrated care programmes.

Key words: market regulation; policies to integrate care across organisations and sectors; service availability & access; organisational and structural integration; continuous quality improvement system; person-centred; tailored; self-management; pro-active; informal care givers involvement; treatment interaction; continuity

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Incremental growth model vs disruptive innovation approach?** (Please describe the approach adopted) .....

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

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3.2 Service delivery B (flexible vs. formal structures)

This section aims to identify the approach adopted on delivery service in terms of balance between flexibility and formal structures of integration. A person-centred approach is flexible by definition in terms of service delivery (meaning that systems in place a priori expect the unexpected and are ready and able to truly personalize care), so a balance between flexibility and formal structures of integration means that a service is delivered taking into account both of the need of the person that is not static and the establishing of formalized structures and responsibilities. This happens through an integration across health- and social care sectors.

Example: division of tasks in multidisciplinary teams, the use of protocols for specific groups of patients or protocols around common themes and the use of standardised procedures or tools etc.

Key words: market regulation; policies to integrate care across organisations and sectors; service availability & access; organisational and structural integration; continuous quality improvement system; person-centred; tailored; self-management; pro-active; informal care givers involvement; treatment interaction; continuity

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Balance between flexibility and formal structures of integration** (Please describe the approach adopted) .....

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

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3.3 Leadership & governance A (collaborative governance)

This process of engaging different stakeholders, building trust and solid relationships is known as collaborative governance.[20]

The specific context of each region shapes the way leadership and governance is exercised, but common ingredients of good practice in leadership and governance can be identified. In this section we ask to describe if and how the pilot provides a collaborative governance by engaging stakeholders.

Example: promoting communication and consensus-oriented decision-making and continuously invest in building good relationships between professionals and the management, between professionals, and with payers, politicians, patient representatives and the community

Key words: political commitment; supportive leadership; clear accountability; performance-based management; culture of shared vision, ambitions, values; shared decision-making; individualised care planning; coordination tailored to complexity; trust; common vocabulary

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Collaborative governance by engaging stakeholder** (Please specify the kind of collaboration established) ...

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

[20] Ansell & Gash, 2008

3.4 Leadership & governance B (leadership distribution)

Whereas in the previous mechanism on collaborative governance the focus was on the ways in which actors were brought together in forming a network (engagement of stakeholders etc), it is also of importance underlining how these networks/relationships are organized and led.

Supportive leadership throughout all levels of integrated care that promotes open discussion is seen as an important success factor for inter-professional collaboration. Furthermore, a good leadership should carefully avoid opportunistic behaviour, but instead creates a culture of continuous improvement and sharing of responsibilities.

The aim of this section is to identify if the pilot has benefit from any kind of distribution of the leadership throughout all levels of the system and which are the actions adopted for this purpose.

Example: setting up of specific management boards overseeing the integrated care initiative

Key words: political commitment; supportive leadership; clear accountability; performance-based management; culture of shared vision, ambitions, values; shared decision-making; individualised care planning; coordination tailored to complexity; trust; common vocabulary.

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Distribution leadership throughout all levels of the system** (Please specify the way leadership has been distributed)

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

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3.5 Health and social care system

Good governance is only possible with a good work alignment across the different components and levels of the health and social care system.

This section aims to identify what approach was taken by the pilot to align health care, public health, and social services aspects to better address the goals and needs of the people and communities involved.

Example: optimising multidisciplinary residential care towards supporting self-management, self-sufficiency of patients at home[21] / foster communication between multidisciplinary professionals involved / build an enabling environment to co-create integrated care initiatives

Key words: housing; welfare services; community; holistic understanding; communication; enabling environment; social determinants.

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Work alignment** (Please describe the approach adopted) .....

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

[21] https://www.sciencedirect.com/topics/social-sciences/autonomy

3.6 Workforce A (team culture)

This section aims to collect information about the actions undertaken by the pilot to build a multidisciplinary team culture with mutual recognition of each other's roles.

Example: New ways of working in teams and collaborations / meetings with professionals and managers from different disciplines and organisations / exchange of information and joint contributions of different professionals / co-creation of integrated services with respectful acknowledgement of each other's competencies

Key words: team culture; multi-disciplinarity; inter-professional relationship; co-creation

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Resources • Capacity building (NOT TO BE FILLED)	**Team culture** (Please describe the approach adopted)

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

3.7 Workforce B (new roles and competencies)

A well performing workforce is one that is responsive to the needs and expectations of people, is fair and efficient to achieve the best outcomes possible given available resources and circumstances (WHO).

This section is meant to identify the development of new roles and competencies for integrated care implemented by the pilot region.

Example: recruitment of new professionals to engage in the teamwork; creation of new roles (trained); task-shifting to counterbalance the shortage of health care; development of new competencies specifically related to the changing role of patients

Key words: new professionals' roles; new competencies; task-shifting.

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Resources • Capacity building (NOT TO BE FILLED)	**New roles and competencies**

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

3.8 Financing

Health financing can be a key policy instrument to improve health and reduce health inequalities.

Apart from financing, it is generally acknowledged that we need innovative payment models that incentivise integration instead of fragmentation (Leijten et al., 2018; Struckmann et al., 2017).

In this section we ask to describe the funding typology applied and if innovative payment methods have been provided.

Example: payment incentives used to motivate professionals to participate in the integrated care programmes / stipulation of long-term contracts / payment models in which budgets are pooled, shared-savings/loss agreements are included.

Key words: stimulating investments in innovative care models; incentives to collaborate; risks adjustments; secured budget; equity & access; out of pocket costs; coverage and reimbursements

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Funding streams (NOT TO BE FILLED)	**Funding typology / Innovative payments** (Please specify the type of funding/innovative payments if applicable) **.....**

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

3.9 ICT (technology & medical devices)

Information and communications technology (ICT) can be a facilitator of integrated and coordinated care.[22] ICT innovation should line up with cultural and organisational change with the aim to generate a fit between technology and working practices.

This section aims at identifying the pilot's approach in the use of technologies and medical devices and the implementation of ICT to support collaboration and communication rather than administrative procedures.

Example: implementation of EHRs (Electronic Health Records) to enhanced communication and information flows; use of open-source algorithm that predicts individual patient risks; use of telemedicine

Key words: E-health tools; remote monitoring; EMRs and patient's portal; assistive technologies; remote monitoring; shared information systems; interoperability; policies fostering technological innovations.

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• ICT & tools (NOT TO BE FILLED)	**Collaboration support / Communication support** (Please specify the support provided by ICT tools) ……

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities) ……	(Please describe if future activities are planned) …..

[22] N. Goodwin, A. Dixon, G. Anderson, W. Wodchis "Providing integrated care for older people with complex needs: Lessons from seven international case studies", The King's Fund, London (2014)

3.10 Information & research

Feedback and monitoring of the activities implemented, and their results are crucial strategies for the implementation of the integrated care programmes and might guarantee the inclusion of all the stakeholders involved. Feedback from the patient as from the professionals, managers and other stakeholders involved are very important to identify problems and needs, make evidence-based decisions on health policy, and allocate scarce resources optimally.

This section aims to collect information on how the pilot has conducted feedback loops and continuous monitoring of the information, processes and outcomes reached.

Example: outcomes of quality indicators related to integrated care systematically collected; provision of continuous monitoring of working processes and outcomes at different levels of the organisations and of different stakeholders involved in the integrated care programmes; provision of access to data / information.

Key words: process monitoring; innovative research methods; access to information

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Risk planning • Execution monitoring & evaluation (NOT TO BE FILLED)	**Feedback loops / Continuous monitoring system** (Please specify the approach adopted) ……

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities) ……	(Please describe if future activities are planned) …..

End of Document

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