European Innovation Partnership on Active and Healthy Ageing

B3: Integrated Care Collaborative

Action Area 1: Organisational Models

Dr. Toni Dedeu
Ministry of Health of Catalonia
B3 Action Area 1
Organisational Models

- Objectives/activities

Support patients/users to actively participate and demand more responsive and integrated care programme for chronic diseases (Action Plan, 2012)
WP1-1 Map of partnership models for implementation of chronic and integrated care programmes

Task description
T1-1-1
Develop indicators (Structure, process and outcomes for integrated care)

Sub activity
SA1-1-1-1
Define and select key indicators for integrated care organisational models
**Task description**

**T1-1-1-2**
Design questionnaire on current models of chronic and integrated care programmes

**Sub activities**

**SA1-1-2-1**
Design questionnaire format for mapping dimension/theme (to be completed by regions and organisations within B3), in collaboration with other Action Areas to avoid duplication.

**SA1-1-2-2**
Disseminate Questionnaire
Task description

T1-1-3
Analysis of questionnaire

Sub activities
SA 1-1-3-1
Data collation form completed questionnaires/workshop/DELTA analysis

SA 1-1-3-2
Group Data – e.g. Geographically, thematically, system structure, etc.
Workshop organised by EUREGHA/CORAL/
Task description

T1-1-4
Identify different organisational models supporting integrated care delivery via good practice examples

Sub activities
SA 1-1-4-1
Gather good practices from across Europe via B3 members
**Task description**

**T1-2-1**
Develop the core evidence based knowledge in Integrated Care organisational models

**Sub activities**

**SA 1-2-1-1**
Desktop research of published evidence on organisational models of integrated care

**SA 1-2-1-2**
Cross data and analysis from published evidence on organisational models in the web repository
B3 Action Area 1 Deliverable 2015

Task description

T1-2-1

Develop **tools and practical tips** for organisational development

Sub activities

**SA 1-2-2-1**

Design a framework to support the development and implementation of integrated care organisational models

**SA 1-2-2-2**

Design a framework to support the development and implementation of integrated care
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>T1-1-1</td>
<td>Develop indicators (Structure, process and outcomes for integrated care)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TD</td>
<td>SA 1-1-1-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KL</td>
<td>SA 1-1-2-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KL</td>
<td>SA 1-1-2-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1-1-3</td>
<td>Analysis of questionnaire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LB</td>
<td>SA 1-1-3-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>SA 1-1-3-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1-1-4</td>
<td>Identify different organisational models supporting integrated care delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KL</td>
<td>SA 1-1-4-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KL</td>
<td>SA 1-2-1-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KL</td>
<td>SA 1-2-1-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1-2-1</td>
<td>Development the core evidence based knowledge in Integrated Care organisational models</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KL</td>
<td>SA 1-2-2-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KL</td>
<td>SA 1-2-2-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T1-2-2</td>
<td>Develop tools and practical tips for organisational development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LF</td>
<td>SA 1-2-2-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LF</td>
<td>SA 1-2-2-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
AA1 Co-ordination

• Area Co-ordinator  Toni Dedeu  TD
• Task Co-ordinator  Kai Leichsenring  KL
• Task Co-ordinator  Lotte Beck  LB
• Task Co-ordinator  Ingrid Jansson  IJ
• Task Co-ordinator  Lourdes Ferrer  LF
Time to get involved!

How can we better work together to develop a framework for Integrated Care models?

How could EIP and the B3 Action Group help?
Time to get involved!

Are you currently working on the projects where the outcomes of which can help to achieve the objectives of AA1?

Would you like to contribute and share the outcomes with AA1 Group?
European Innovation Partnership on Active and Healthy Ageing

B3: Integrated Care Collaborative

Action Area 2: Change Management

Cristina Bescos
Philips Healthcare, Germany
AA2: Change management

Map of **best practice methodologies** to support the implementation of chronic and integrated care

The transformation of the health and social care systems towards integrated care is a complex programme of change.

Change Management is the discipline that takes responsibility for the people side of the change. Change management is the method, processes, tools and techniques for reducing and managing resistance to change when implementing organizational change to realize business results.

**Toolkit for Change Management:**

- Analysis of barriers & successful approaches to implementation of chronic care programmes & integrated care models

  Model business cases to support implementation & scale up

There are several methodologies and approaches in change management. In relation to integrated care, we would like to investigate which stakeholders are presenting the most resistance to care coordination models, which approach is being used to overcome these barriers and to which degree of detail the change management methodologies can foster the implementation of integrated care services in the European regions.
Change Management

Towards Integrated Care

Monitoring
- Indicators
- Evaluation methods to assess the progress/impact of the change

Culture / Vision
- Assessment of readiness for change

Strategy / organisation
- Definition / scope / goals and steps of the change

Guidance
- Leadership / sponsorship to lead the change

Capabilities
- Skills required by the change
- New Roles / old roles
- Education and training

Communications
- Stakeholders engagement
- Incentives
- Overcoming resistance to the change

Alignment
- Adequate policies / resources / financing for the change

Towards Integrated Care
Good Practices

- We would like to gather examples of good practices for change management methodologies, approaches and toolkits that have shown success, identify / develop key performance indicators (KPIs) and encourage replication in other regions / organisations.
- 8 out the 37 shared good practices are related to change management.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>ParkinsonNet</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Spain</td>
<td>Observatory of Innovative Practices for Complex Chronic Disease Management (OPIMEC)</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>Congestive Heart Failure Programme</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>Population Intervention Plans</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>Strategy to tackle the challenge of Chronicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>Hospital Clinic Integrated Care NEXES Project</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>Intermediate Care Improvement Community*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>Reshaping Care for Older People Programme*</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
Action Area 1 • Organisational Models

Action Area 2 • Change Management

Action Area 3 • Workforce Development

Action Area 4 • Risk Stratification

Action Area 5 • Care Pathways

Action Area 6 • Patient/User empowerment

Action Area 7 • ICT tools

Action Area 8 • Finance /Funding

Action Area 9 Dissemination
B3 Action Area 2 – Change Management – Incentivisation and Advocacy

Collection of good practices of change management
  Task 0

Collection of Indicators
  Task 2.1.1

Contribution of European Initiatives
  Task 2.1.3.1

Analysis of Good practices
  Task 2.1.3

Deep dive workshop
  Task 2.1.4

Map of best practices methodologies
  Task 2.1.5
AA2: Change management
Your contribution is asked...

• Highlight Change Management in the good practices
• Collection of:
  – Lessons learned
  – Indicators
  – Methodologies
• Deep dive workshop
• Map of best practices
EIP AHA

B3 Integrated Care
Area 3 Workforce Development

7 June 2013

Magdalene Rosenmöller, IESE Business School
## B3 Action Plan  
### Area 3 Workforce Development

<table>
<thead>
<tr>
<th>Workforce Development, Education and Training</th>
<th>New multidisciplinary teams for care of chronic patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fostering a culture of shared responsibility and joint working</td>
</tr>
<tr>
<td></td>
<td>Supporting improved collaboration</td>
</tr>
<tr>
<td></td>
<td>Improve knowledge amongst formal and informal carers</td>
</tr>
<tr>
<td></td>
<td>New management model for targeted health and quality of life outcomes</td>
</tr>
<tr>
<td></td>
<td>Identification of patient clusters, identification of targeted care plans and engagement of professionals</td>
</tr>
<tr>
<td></td>
<td>Develop understanding and agreement of what to measure and how to do it.</td>
</tr>
<tr>
<td></td>
<td>Multi-morbidity</td>
</tr>
</tbody>
</table>

**AIM is to obtain the following – Outcome Measures:**

- Shared understanding of the workforce development task at a European level
- Reusable materials being used to train key stakeholder groups
- Availability of sufficient and adequately trained staff
Objective Area 3 Workforce Development

Gather evidence / experience in order to get insights in:

• Identify need for, and design, **new roles** with associated competence development planning

• **Improve competences** (related to integrated care) in management and leadership, clinical roles, health and social care workforce (including third sector)

• Foster a **culture of shared responsibility** and **joint working**

• Provide **training, information and knowledge transfer** for patients / users

• Improve **knowledge of formal and informal carers**
• **Map of reusable learning resources** to support the delivery of awareness raising and education for all stakeholders, including the use of ICT education delivery methods and ICT decision support tools.

• **Toolkit for Workforce re-design, development, education and training:**
  – Workforce and training needs analysis
  – Workforce development plans
  – System design to support best practice
  – Design and implementation of ICT decision support tools
  – Tools / practical tips
Area 3 Workforce Milestones

M3-1 **Improved access to education and training programmes** to support improved functioning of multi-disciplinary teams:

– Identification of new roles
– knowledge, skills and competences
– communication skills
– behavioural and attitudes changes
– culture of shared responsibility and team work
– co-operation with universities (teaching curricula)

• M3-2 Enhanced **availability of education and training programmes** for informal carers /volunteers/citizens to support their skills, motivation and willingness to use ICT and other innovative tools and solutions, drawing on the repository for curricula and training materials.
## B3 Work Plan Area 3 Workforce

<table>
<thead>
<tr>
<th>Work Package Description</th>
<th>Task Description</th>
<th>Sub-activities</th>
<th>Timescale for delivery</th>
<th>Task Co-ordinators and collaborators</th>
<th>Organisation / Region</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>WP3-1</td>
<td>T3-1-1</td>
<td>SA3-1-1-1</td>
<td>mar-13</td>
<td>Task Co-ordinator:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Design questionnaire to identify workforce and training needs and available resources</td>
<td>Design questionnaire to gather information on identified competencies, workforce development strategies and existing education / training resources in collaboration with other Action Areas to avoid duplication (to be completed by regions and organisations within B3).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SA3-1-1-2</td>
<td>may-13</td>
<td>Alejandro Lopez</td>
<td>Andalusian School of Public Health</td>
<td><a href="mailto:alejandro.lopez.easp@juntadeandalucia.es">alejandro.lopez.easp@juntadeandalucia.es</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disseminate questionnaire.</td>
<td></td>
<td>Nessa Barry</td>
<td>NHS 24</td>
<td><a href="mailto:nessa.barry@nhs.net">nessa.barry@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SA3-1-2-1</td>
<td>ago-13</td>
<td>Task Co-ordinator:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Analysis of questionnaire</td>
<td>Data collation from completed questionnaires</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SA3-1-2-2</td>
<td>ago-13</td>
<td>Collaborators:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group data – e.g. identification new roles and competences, approaches to workforce development; available learning resources; unmet training needs, etc.</td>
<td></td>
<td>Carles Blay</td>
<td>Departament de Salut Generalitat de Catalunya</td>
<td><a href="mailto:cblay@gencat.cat">cblay@gencat.cat</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SA3-1-3-1</td>
<td>mar-13</td>
<td>Task Co-ordinator:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Create repository of best practice examples</td>
<td>Identify best practice examples / case studies which include: effective workforce development strategies; comprehensive training / education strategies and programmes; learning resources / materials, including online resources (including those for staff, patients and informal carers); use of online decision support tools to improve competency.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SA3-1-3-2</td>
<td>sep-13</td>
<td>Collaborators:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop web-based repository of best practice examples</td>
<td>Develop web-based repository of best practice examples, as cited above. Training strategies, course outlines, training materials and tools, decision support tools, etc</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Map of reusable learning resources and repository to: support the delivery of awareness raising and education for all stakeholders, including the use of ICT education delivery methods and ICT decision support tools.
<table>
<thead>
<tr>
<th>Work Package Description</th>
<th>Task Description</th>
<th>Sub-activities</th>
<th>Timescale for delivery</th>
<th>Task Co-ordinators and collaborators</th>
<th>Organisation / Region</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>WP 3-2</td>
<td>T3-2-1</td>
<td>SA3-2-1-1</td>
<td>mar-13 may-13</td>
<td>Task Co-ordinator:</td>
<td>Andalusian School of Public Health</td>
<td><a href="mailto:diana.gosalvez@gmail.com">diana.gosalvez@gmail.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Collaborators:</td>
<td>Regione Piemonte - ARESS</td>
<td><a href="mailto:valeria.romano@aress.piemonte.it">valeria.romano@aress.piemonte.it</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Anna Sachinopoulou</td>
<td>CHT OULU</td>
<td><a href="mailto:anna.sachinopoulou@oulu.fi">anna.sachinopoulou@oulu.fi</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Giorgio Vezzani</td>
<td>ASSRERIT (SIT)</td>
<td><a href="mailto:giorgio.vezzani@asmn.re.it">giorgio.vezzani@asmn.re.it</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dr Pantelis Angelidis</td>
<td>Municipality of Palaio Faliro</td>
<td><a href="mailto:pantelis@vidavo.eu">pantelis@vidavo.eu</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Benigno Rosón Calvo</td>
<td>SERGAS</td>
<td><a href="mailto:benigno.rozon.calvo@sergas.es">benigno.rozon.calvo@sergas.es</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Julio García Comesaña</td>
<td>SERGAS</td>
<td><a href="mailto:julio.garcia.comesa@sergas.es">julio.garcia.comesa@sergas.es</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tasos Rentoumis</td>
<td>Municipality of Palaio Faliro</td>
<td><a href="mailto:a.i.rentoumis@gmail.com">a.i.rentoumis@gmail.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Benigno Rosón Calvo</td>
<td>SERGAS</td>
<td><a href="mailto:benigno.rozon.calvo@sergas.es">benigno.rozon.calvo@sergas.es</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dr Pantelis Angelidis</td>
<td>Municipality of Palaio Faliro</td>
<td><a href="mailto:pantelis@vidavo.eu">pantelis@vidavo.eu</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tasos Rentoumis</td>
<td>Municipality of Palaio Faliro</td>
<td><a href="mailto:a.i.rentoumis@gmail.com">a.i.rentoumis@gmail.com</a></td>
</tr>
</tbody>
</table>

**Toolkit for Workforce redesign, development, education and training to include:**
- workforce and training needs analysis;
- workforce development plans;
- design and implementation of ICT decision support tools.

**Task Description:** Identify tools for workforce and training needs analysis; and workforce development plans.

**Sub-activities:**
- Desktop research of published evidence on workforce change and future capacity needs in relation to integrated care.
- Cross data and analysis from published evidence and check with results of WP3.1.

**Timescale for delivery:**
- **SA3-2-1-1:**
  - Start: mar-13, End: may-13
  - **SA3-2-1-2:**
  - Start: jun-13, End: oct-13
  - **SA3-2-2-1:**
  - Start: dic-13, End: dic-15
  - **SA3-2-2-2:**
  - Start: dic-13, End: dic-15

**Task Co-ordinator:**

**Collaborators:**
- Diana Gosalvez
- Valeria Romano
- Anna Sachinopoulou
- Giorgio Vezzani
- Tasos Rentoumis
- Benigno Rosón Calvo
- Julio García Comesaña
- Dr Pantelis Angelidis
- Dr Pantelis Angelidis

**Equipment:**
- Design and develop Toolkit for workforce development
- Design and develop Toolkit for workforce development
- Design and develop Toolkit for workforce development
- Design and develop Toolkit for workforce development
- Design and develop Toolkit for workforce development
- Design and develop Toolkit for workforce development
- Design and develop Toolkit for workforce development
- Design and develop Toolkit for workforce development

**Email address:**
- diana.gosalvez@gmail.com
- valeria.romano@aress.piemonte.it
- anna.sachinopoulou@oulu.fi
- giorgio.vezzani@asmn.re.it
- a.i.rentoumis@gmail.com
- benigno.rozon.calvo@sergas.es
- julio.garcia.comesa@sergas.es
- pantelis@vidavo.eu
- pantelis@vidavo.eu
- pantelis@vidavo.eu
- pantelis@vidavo.eu
- pantelis@vidavo.eu
- pantelis@vidavo.eu
Members of Area 3 Workforce

Adolfo Munoz
Alejandro Lopez
Anna Sachinopoulou
Benigno Rosón Calvo
Carles Blay
Diana Gosalvez
Dr Pantelis Angelidis
Edwin Mermans
Florian Meissner
Francesca Venato
Giorgio Vezzani

Irene Monsonis
Johanna Schmidt
Julio Garcia Comesaña
Magda Rosenmoller
Nessa Barry
Tasos Rentoumis
Valeria Romano
We need you!!! - How you can contribute...

Objective: improve workforce development related to Integrated Care in Europe

Volunteers for taking on a Task Coordinator role

Examples of your own related practices in this field:

• Needs Assessment for new Workforce role
• Strategies for Workforce Development
• Training tools and materials
  – Use of IT in integrated care / Clinical guidelines / homecare, ...
• Inclusion of informal carers – training / incentives, etc.
Thank you very much for our interest!

Looking forward to a great Collaboration!

magda@iese.edu
Benchmarking Integrated Care for better Management of Chronic and Age-related Conditions in Europe

- Gaining in-depth knowledge of integrated care approaches to chronic conditions
- Identifying success-promoting and hindering factors of integrated care.
- Generate knowledge in the key aspects of integrated care: process and human resources management, patient involvement, financing models and regulatory issues and information technology
- Producing a toolkit containing operational and managerial implications.
- Policy recommendations for fostering integrated care at regional/ national/ European levels

Project INTEGRATE will look into best practices of integrated care that have a proven impact in terms of positive patient care experiences; care outcomes and cost-effectiveness. The key aim is to define what constitutes good quality integrated care provision.
Budget: 3.676.649 €
EC Funding: 2.898.468 €
Call: FP7-HEALTH (Collaborative Project)
Duration: 2012-09-01 to 2016-08-31
Coordinator: IESE Business School
Collaboration with MiHEALTH / Fira de Barcelona

• Scientific Committee
• Track on Organisation – Innovation in Management
  – Session 3.3 – Integrated Care
InnPACT
Healthcare Innovation Impact Study

JAUME RIBERA / MAGDA ROSENMÖLLER / PABLO BORRÁS
European Innovation Partnership on Active and Healthy Ageing

B3: Integrated Care Collaborative

Action Area 4: Risk Stratification

Esteban de Manuel Keenoy

Basque Country
B3 Action Area 4
Risk Stratification

- Objective
  - Contribute to the implementation of risk stratification for optimised delivery of Integrated Care
Workplan of Risk Stratification Action Area

Kick Off Meeting

WP 4-1. Mapping of stratification experiences
WP4-1.1 Mapping practices
WP4-1.2 Analyze information
WP4-1.3 Describe models
WP4-1.4 Develop European baseline

WP 4-2. Toolkit Risk stratification
WP4-2.1 case studies
WP4-2.2 Packs for risk stratification
WP4-2.3 Education material

Report on risk stratification baseline

Toolkit Risk Stratification

Deliverables
WP4-1 Mapping practices on current models of risk stratification

Task description:
Map of existing patient stratification solutions which:
• identify in which Regions risk-based stratification has been used;
• document the approaches developed and challenges achieved as a result;
• extrapolate the results of above to develop a European baseline, with associated potential benefits resulting from adoption of risk stratification-based change at a delivery organization, regional and European level;
• identify best-in-class patient stratification tools (with focus on disease severity/activity, co-morbidities, frailty and technological skills of users).

Tasks:
WP4-1.1 Mapping practices and design information gathering tool on current models of risk stratification (questionnaire)
WP4-1.2 Analyze collected information
WP4-1.3 Describe models of risk stratification examples
WP4-1.4 Develop European baseline of the use of risk stratification
Actions

WP4-1.1 Mapping practices and design information gathering tool on current models of risk stratification (March-June 2013)

• Agree on a common information gathering method: Methodology for Desktop Search
• Postpone the Questionnaire to next year; Desktop Search tool will be used instead to gather the information.
• Consider and agree on how to:
  • Do the search of the different key information sources
  • Storage of collected information
• Geographical area assignments and division of participants into teams
WP4-1.1 Mapping practices and design information gathering tool on current models of risk stratification (March-June 2013)

Information Sources *
- Contact stratification experts. OPIMEC online survey?
- First commitments and delta questionnaire
- 66 new commitments*
- Delta questionnaires
- B3 Good Practices
- Hospitals
- Websites search
- European and other Projects

Storage of Information
- New Marketplace
- Temporary solution provided by OPIMEC until the Marketplace is available(???)

Teams and Areas
- Team Leaders
- Geographical area assignments
- Participants assignment to teams
- 5/6 people per team

* The Commission has offered resources to help scan commitments, questionnaires...
We will work in teams of 5/6 people, led by people that attended the first teleconference of AA4 group. The goal is to make a systematic review of the key sources of literature related to Risk Stratification, following the rules of the Desktop Search Methodology. Suggested teams are listed below.
Time to engage!

Would you like to contribute to develop AA4 Group. We need to recruit enthusiastic participants!!

- Join our group in Yammer!
- Sign for one of the search teams
- Next week teleconference
European Innovation Partnership on Active and Healthy Ageing

B3: Integrated Care Collaborative

Action Area 5: Care Pathways

Jean Bousquet
Region Languedoc Roussillon
Goals

- To meet the work plan of Area 5 defined by the B3 action plan
- With deadlines
  - September 2013
  - December 2013

Specific goals

1. Focus on existing tools which can be shared to the EIP on AHA
2. Develop tools which can be delivered by September 2013
3. In line with Commitments for Action proposed to the EIP on AHA
Area 5 – Action Plan B3

Members

• A Alonso, G Iacarino, J Redon (task co-ordinators)
• Members of commitments for action

Proposal

1. Focus on chronic respiratory diseases as tools are available (WHO Collaborating Center for Asthma and Rhinitis): AIWAYS-ICPs
2. WHO essential package for NCDs
3. Initiate ICPs for cardiovascular diseases (July 2013)
**AIRWAYS-ICPs: members**

**Action Plan B3, European Innovation Partnership on Active and Healthy Ageing**

- Région Languedoc Roussillon: J Bousquet, P Demoly, J Mercier, A Bedbrook, R Chiron, D Caimi, D Costa, O Benezet, M David, R Bourret, T Camuzat
- FILHA (Finnish Lung Health Association): T Haahtela, T Vasankari
- GARD (Global Alliance against Chronic Respiratory Diseases) Turkey: A Yorgancioglu
- NAH (National Allergy Health Programme, Norway): KC Lodrup-Carlsen, KH Carlsen
- PNDR (Portuguese National Respiratory Programme): E Melo Gomes, A Arrobas, C Barbara, J Correiro da Sousa, C Gomes, M Morais-Almeida, J Rosado-Pinto, DC Robalo Cordeiro
- Polasthma: B Samolinski, A Bialozewski, P Kuna
- Area 5 of Action Plan B3: G Crooks, A Alonso, G Iacarino, J Redon, M Esteban de Kenoy, D Henderson

**WHO Collaborating Center for Asthma and Rhinitis (Montpellier)**
**Patient’s organizations**

EFA (European Federation of Allergy and Airways Diseases patient’s association): S Palkonen

Association Asthme et Allergy: C Rolland

**Scientific Societies**

- EAACI (European Academy of Allergy and Clinical Immunology): N Papadopoulos, P Demoly
- ERS (European Respiratory Society)
- ERS (European Rhinology Society): P Hellings, WJ Fokkens
- EuroAsian Respiratory Society: A Chuchallin, A Bazengai, T Soroonboev
- IPCRG (International Primary Care Respiratory Group): N Chavannes, D Price, M Roman, D Ryan, J de Sousa
- Slaai (Societad Latinoamericana de Allergia, Asthma and Immunologia): S Garcia-Diaz
- SFA (Société française d’Allergologie): P Demoly, B Wallaert

**MedALL (Mechanisms of the Development of Allergy, FP7):** JM Anto
## WP5-1: Map of best practices

### T5-1-1: Design of questionnaire

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SA5-1-1-1a: Design questionnaire</td>
<td>A first draft is available. It will be sent to members May 20</td>
</tr>
<tr>
<td>SA5-1-1-1b: Questionnaire for CRD</td>
<td>A first draft is available and sent to members June 1 (including members of the WHO Collaborating Centre of Asthma and rhinitis)</td>
</tr>
<tr>
<td>SA5-1-1-2a: collate data</td>
<td>Questions: who will send the questionnaire and when?</td>
</tr>
<tr>
<td>SA5-1-1-2b: collate data for CRD</td>
<td>The WHO CC (MACVIA-LR) will start June 1</td>
</tr>
</tbody>
</table>

### T5-1-2: Collate map of best practices in the EU regions (SA5-1-2-1)

- We can use what has been sent for the Dublin meeting and expand with new best practices.
- Moreover, “good practices” have been sent for reference sites and they can also be used although they are not similar.
- For CRDs,
  - A map of best practices in primary care will be available 09-2013 by IPCRG (SA5-1-2-1b)
  - Finnish plans on asthma, COPD, allergy
  - Portuguese national plan in respiratory medicine
  - Most usual guidelines and ICPs
## WP5-2: Toolkit for ICPs

### T5-2-1: ICP redesign

<table>
<thead>
<tr>
<th>CRDs</th>
<th>A first draft will be circulated at the end of June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other NCDs</td>
<td></td>
</tr>
</tbody>
</table>

### SA5-2-1-1: identify barriers to multi-morbidity guidelines

- **CRDs**
  - A Delphi questionnaire to prioritize questions has been initiated and stage 1 is ongoing. Questions:
    - Asthma in the elderly
    - COPD in the elderly
    - Rhinitis in the elderly
    - Asthma/COPD and comorbidities
    - Impact of paediatrics (risk factors, prevention, early diagnosis and control) on CRDs in the elderly
  - The prioritized questions should be available 09-2013

- **CVDs**
  - To be initiated July 15-2013

- **Multimorbid NCDs**
  - To be initiated October 15-2013
<table>
<thead>
<tr>
<th>CRDs</th>
<th>A paper has been written</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>It has been approved by</td>
</tr>
<tr>
<td></td>
<td>all commitments for</td>
</tr>
<tr>
<td></td>
<td>action of the EIP on</td>
</tr>
<tr>
<td></td>
<td>CRDs</td>
</tr>
<tr>
<td></td>
<td>It has been approved by</td>
</tr>
<tr>
<td></td>
<td>the co-coordinators of</td>
</tr>
<tr>
<td></td>
<td>Area 5</td>
</tr>
<tr>
<td></td>
<td>It has been circulated</td>
</tr>
<tr>
<td></td>
<td>to action B3 members</td>
</tr>
<tr>
<td></td>
<td>June 2</td>
</tr>
<tr>
<td></td>
<td>It will be finalized</td>
</tr>
<tr>
<td></td>
<td>July 15</td>
</tr>
<tr>
<td></td>
<td>It has been provisionally accepted for publication</td>
</tr>
</tbody>
</table>

| CVDs                        | An approach similar to CRDs will be initiated July 15 |

| Multimorbid NCDs            | Starting October 2013 |

<p>| Multimorbid NCDs in low resource settings | WHO has developed a package of Essential NCD (PEN) interventions for primary health care in low resource settings |
|                                          | The WHO CC (MACVIA-LR) will deploy the PEN for use in low resource settings of the EU as the minimal set of interventions for NCDs |
|                                          | Available 09-2013 |</p>
<table>
<thead>
<tr>
<th><strong>SA5-2-2-2:</strong> Develop a repository of protocols and workflows</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCDs in low income settings</td>
</tr>
<tr>
<td>WHO PEN tools are available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SA5-2-2-3:</strong> Plan how care pathways can be translated in the EU</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRDs</td>
</tr>
<tr>
<td>Guidelines for rhinitis and asthma co-morbidities are already translated in many EU languages. ICPs will then be translated</td>
</tr>
<tr>
<td>NCDs in low income settings</td>
</tr>
<tr>
<td>WHO PEN is available in several languages</td>
</tr>
<tr>
<td>NCDs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SA5-2-2-4:</strong> Deploy ICPs for individual NCDs using existing programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCDs</td>
</tr>
<tr>
<td>Initiated by the WHO CC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SA5-2-2-5:</strong> Design and implement an evaluation framework to measure care pathway implementation</th>
</tr>
</thead>
</table>
European Innovation Partnership on Active and Healthy Ageing

B3: Integrated Care Collaborative

Action Area 6: Patient/user empowerment, health education and health promotion

Francesca Avolio
Regional Healthcare Agency of Puglia-Italy
B3 Action Area 6
Patient/user empowerment, health education and health promotion

- Objectives/activities

Support patients/users to actively participate and demand more responsive and integrated care programme for chronic diseases *(Action Plan, 2012)*
WP6-1 Mapping of coaching, education or approaches to support patient/user empowerment and improve patient adherence and compliance

Task description:
1. Design a template to collate Case Studies on approaches used to support health education processes and patient/users empowerment to improve patients self management, adherence and compliance and to collate “definitions” used for those processes and initiatives.

Sub activities:
1. Design a template to collate Case Studies (CS) for mapping activities carried out and definitions adopted by Organisations/Institutions/Regions for each of the following:
   a. empowerment (coaching) of patients (organizational model: structural analysis),
   b. health education processes (procedures and tools, process analysis);
   c. evaluation of patients to guarantee an equal level of delivery (equity processes) according to a mix of clinical indicators and social indicators: complexity of patient, intensity of care required personalised approach, level of integrated approach needed;
   d. Integrated approach (welfare system structure) and involvement of communities
B3 Action Area 6 Deliverable-WP 2013

Sub activities:
2. Testing template completing it by two different delivery organisations (one region, one association, etc.) and defining a dissemination plan (agree on the tool to use to send the case study template around and collect feedback)
3. Disseminate the CS template, together with the two completed examples to all EIP on AHA members

Task description
2: Analysis of Case Studies

Sub activities:
1. Data collation from completed Case Studies on:
   a. empowerment
   b. education processes
   c. evaluation of patients
   d. integrated approach and involvement of communities
Sub activities:
2. Group data: geographically, thematically, healthcare/welfare systems structure.

Task description
3: Develop indicators to monitor coaching, education and/or approaches that support patients empowerment, self management changes (adherence, compliance, and others), impact of health education on the population

Sub activities:
1. Define common indicators to evaluate the changes per pathology (clinical outcome, clinical process: adherence, compliance, follow up, )
2. Define and select indicators to monitor self management ability
3. Define and select indicators to monitor education processes (health literacy)
4. Define indicators to monitor integration processes and community involvement
5. Define common indicators to evaluate patient satisfaction
B3 Action Area 6 Deliverable 2015

Toolkit for Patient/user empowerment, health education and health promotion

It covers: tools / practical tips for roll out and scale up of patient empowerment initiatives;
- support for patient / user access to clinical / care records, and full participation in decision making relevant to their own health / care management;
- patient / user advocacy in the form of training and facilitating patient / user representatives to participate in policy development / decision making bodies;
- approaches to assessment and promotion of patients’ ability to understand and adhere to self management plans, tailoring advice and support to the level of independence and health intelligence.
Time to get involved!

How can we better work together to support and promote health education and patient empowerment to foster the scale up of integrated care in Europe?

How could EIP and the B3 Action Group help?
Time to get involved!

Are you currently working on the projects where the outcomes of which can help to achieve the objectives of AA6?

Would you like to contribute and share the outcomes with AA6 Group?
European Innovation Partnership on Active and Healthy Ageing

**B3: Integrated Care Collaborative**

**Action Area 7: ICT and Teleservices**

Dr Andrea Pavlickova
Programme Manager, Epossi
B3 Action Area 7 ICT and Teleservices

☐ Objectives/activities

✓ Highlight the potential of ICT/teleservices to underpin the delivery of integrated care and to realise service efficiencies/cost-effectiveness (Action Plan, 2012)

✓ Improve the effectiveness of health and social care ICT systems and data sharing by identifying solutions which improve interoperability between record systems and data sharing (Action Plan, 2012)
B3 Action Area 7 ICT and Teleservices

Mapping of ICT solutions

Electronic care records
Personal health records
Aligning existing projects (epSOS, Calliope)
Common security processes (identification, authentication, authorization and patient consent)
Teleservices

Increased levels of integration of clinical and social data
Increased implementation of electronic consent and share record capabilities
Availability of functionality in Electronic Health/Care Record

Toolkit for Electronic Care Records/ICT/Teleservices:

Approaches to managing regulatory issues, security, privacy, liability, confidentiality and interoperability
Reductions of risk and time to market costs for industry
Model business cases to support implementation and scale up
European Initiative Service Specification for the development of personal digital health records

Increased implementation of teleservices as part of Integrated Care Programmes
B3 Action Area 7 – Work Plan for 2013

- **Work package description WP7-1**
  - Map of ICT solutions focusing on how services for chronic disease management or integrated care are being supported by common eHealth infrastructure

- **Task Description T7-1**
  - T7-1-1 Definition of services for integrated care and chronic disease management
  - T7-1-2 Analyse the compatibility of services with the outcomes of other existing European projects (e.g. epSOS, Calliope)
  - T7-1-3 Validate the outcomes of T7-1-2 through the practical workshop
  - T7-1-4 Develop indicators for ICT solutions
  - T7-1-5 Evaluate models of ICT solutions supported by common eHealth infrastructure
Service
✓ “the capacity held by a group of people to carry out an activity that benefits some other person or group (meet the patient of the patient or care-user)”

Definition of services with the potential to:
✓ Contribute to vertical integration between secondary/primary/home health and care
✓ Contribute to horizontal integration across existing service delivery organisations: social/health/assisted living
✓ Combination of one of the listed services with another open up new integration potential

Classification of services
✓ Direct services (e.g. personal care records, assessments, care planning)
✓ Governance and audit services (e.g. managing identities of individuals)
B3 Action Area 7 – Get engaged!

How we work together?

• Task co-ordinators
  T7-1 – Stuart Anderson (University of Edinburgh)
  T7-2 – Bruno Jean Bart (Trialog); Cecilia Vera (UMP-LST)
  T7-3 – Marc Lange (EHTEL)
  T7-4 – Enrico Maria Piras (Fondazione Bruno Kessler FBK);
          Giorgio Vezzani (ASSRRERIT); Cecilia Vera (UMP-LST)
  T7-5 – Bruno Jean Bart (Trialog); Cecilia Vera (UMP-LST)

• Task-contributors
  - 35 organisations (April 2013); 55 individual members
Thank you very much for your attention!

Q&A
European Innovation Partnership on Active and Healthy Ageing

B3: Integrated Care Collaborative

Action Area 8: Finance and Funding

Brian O’Connor
European Connected Health Alliance
B3 Action Area 8 Finance and Funding

- Objectives/activities

  ✓ Align currently available and future finance and funding sources to facilitate shift towards integrated care *(Action Plan, 2012)*

  ✓ Identify approaches to procurement to support adoption of integrated care by more Regions *(Action Plan, 2012)*
B3 Action Area 8 Finance and Funding

WP8-1 Map of existing and future funding instruments

- Research current sources of funding
- Develop questions for Regions regarding use of funding
- Hold practical workshops to share information gathered
- Showcase best practice examples to highlight use of different funding streams

Toolkit for Finance and Funding
B3 Action Area 8 – Work Plan for 2013

- **Work package description WP8-1**
  - Map of existing and future funding instruments and how they align to integrated care programmes and decision making processes.

- **Task Description T8-1**
  - T8-1-1 Gather information about existing funding models and sources deployed by regions and organisations implementing integrated care
  - T8-1-2 Analyse and group information to identify funding requirements, challenges, what would help.
  - T8-1-3 Hold practical workshops to share findings
  - T8-1-4 Showcase best practice examples of effective use of different funding instruments
B3 Action Area 8 - Update on progress (T8-1)

- 1\textsuperscript{st} Task Co-ordinators planning telecon held.

- EUREGHA will supply research already undertaken in this area and will gather and analyse examples from B3 members and other sources.

- Industry members are preparing information on their existing Risk Sharing Outcome Based Contracts which may encourage some Regions to experiment along similar lines.

- Bleddyn Rees, ECHA, is preparing a paper outlining innovative approaches to funding integrated care, including social bond issues, social enterprises and community interest companies.
B3 Action Area 8 – Get engaged!

- How we work together?

Task co-ordinators

T8-1 – EUREGHA
  John Hanson (NHS Yorkshire and Humber)
  Bleddyn Rees (ECHA)

T8-2 – Post vacant

T8-3 – Post vacant

T8-4 – Post vacant
Thank you very much for your attention!

Q&A
European Innovation Partnership on Active and Healthy Ageing

B3: Integrated Care Collaborative

Action Area 9: Communication and Dissemination

Donna Henderson, NHS 24
Orsi Nagy, European Commission
B3 Action Area 9 Communication and Dissemination

- Objectives/activities

☑ European Integrated Care Collaborative functions effectively and accountably for all members (*Action Plan, 2012*)

- B3 activities are disseminated across EU regions and delivery organisations to:
  - encourage recruitment and retention of collaborative partners;
  - encourage regions and organisations in Europe to scale up the adoption of chronic care and integrated care programmes. (*Action Plan, 2012*)
B3 Action Area 9 Communication and Dissemination

An operational Integrated Care Collaborative, focused on promoting service improvement and the delivery of the B3 Action Plan

B3 activities are disseminated across EU regions and delivery organisations
B3 Action Area 9 – Work Plan for 2013

- **Work package descriptions**
  - **WP9-1** An operational integrated Care Collaborative, focused on promoting service improvement and the delivery of the B3 Action Plan.
  - **WP9-2** B3 activities are disseminated across regions and delivery organisations

- **Task Descriptions**
  - T9-1-1 Develop a Memorandum of Understanding for the B3 Integrated Care Collaborative
  - T9-2-1 Produce a Communication and Dissemination Plan for the Collaborative
  - T9-2-2 Develop an online, interactive repository to host the deliverables/outputs from the B3 Action Plan
B3 Action Area 9 - Update on progress

- T9-1-1 – A memorandum of understanding was developed and agreed in October 2012.

- T9-2-1 – Communication Plan has been produced
  - The B3 Yammer online network was set up to facilitate communication and dissemination
  - B3 core powerpoint presentation and information leaflet produced for use in local and regional awareness activities
  - presentations given at high profile events and presentations shared via Yammer

- T9-2-2 – Commission is developing new online repository
B3 Action Area 9 – Get engaged!

- Post information about events – European, regional and local – on Yammer
- Share your presentations and awareness raising materials on Yammer
- Promote B3 Action Group and activities wherever and whenever you can
- Let us know how we can help – new materials, support with presentations, etc
Thank you very much for your attention!

Q&A