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

Deliverable 6.1 Scaling-up Pilot Report

TABLE OF CONTENTS

- 1 Introduction.....4**
- 2 Methodology.....6**
 - 2.1 Objective and scope..... 6
 - 2.2 Reporting template..... 6
- 3 Results9**
 - 3.1 Lazio (Italy)..... 9
 - 3.2 Crete (Greece) 11
 - 3.3 Valencia (Spain)..... 15
 - 3.4 Styria (Austria)..... 18
 - 3.5 Andalucia (Spain)..... 21
 - 3.6 Lodz (Poland) 23
 - 3.7 Trieste (Italy)..... 25
 - 3.8 Trento (Italy) 28
 - 3.9 Northern Ireland (UK)..... 30
 - 3.10 Piedmont (Italy) 32
 - 3.11 Liguria (Italy) 34
 - 3.12 Campania (Italy) 36
 - 3.13 Emilia Romagna (Italy) 38
 - 3.14 Veneto (Italy)..... 41
 - 3.15 Twente (The Netherlands)..... 43
- 4 Conclusive summary..... 45**
- Annex47



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Abstract

The VIGOUR workplan was designed to support 15 health and 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 methodology included the piloting of a context-sensitive care integration approach under everyday conditions, with a view to preparing further up-scaling. This document describes how the VIGOUR pilots were implemented under local framework conditions.

Statement of originality

This deliverable contains original unpublished work except where indicated otherwise. Acknowledgment of previously published material and of the work of others has been made through appropriate citation, quotation, or both.

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Acronyms

ASSDA	Andalusian Agency for Social Services and Dependency
CGA	Comprehensive Geriatric Assessment
CHC	Community Health Centre
COPD	Chronic Obstructive Pulmonary Disease
CP	Cerebral Palsy
DM	Diabetes mellitus
EHR	Electronic Health Record
FCN	Family and Community Nurse
GP	General Practitioner
HF	Heart Failure
NCD	Non-Communicable Disease
PDTA	Percorso Diagnostico Terapeutico Assistenziale (Diagnostic, Therapeutic, Care Path)
PEHF	Personal Electronic Health File
PHC	Primary Healthcare
POC	Proof of Concept
PPE	Personal Protective Equipment
SELFIE	Sustainable Integrated Care Models for Multi-Morbidity Delivery, Financing and Performance
SOP	Standard Operating Procedures



1 Introduction

The VIGOUR project piloted integrated care schemes in the 15 European regions. Evidence clearly shows that pursuing a “one-size-fits all” health and care integration approach across the participating health and care authorities was likely to fail delivering the desired outcomes. To allow for contextualised implementation that considers the various regional framework conditions for integrated health and care service delivery the service integration strategy pursued had to be flexible both in terms of service processes and in terms of technology.

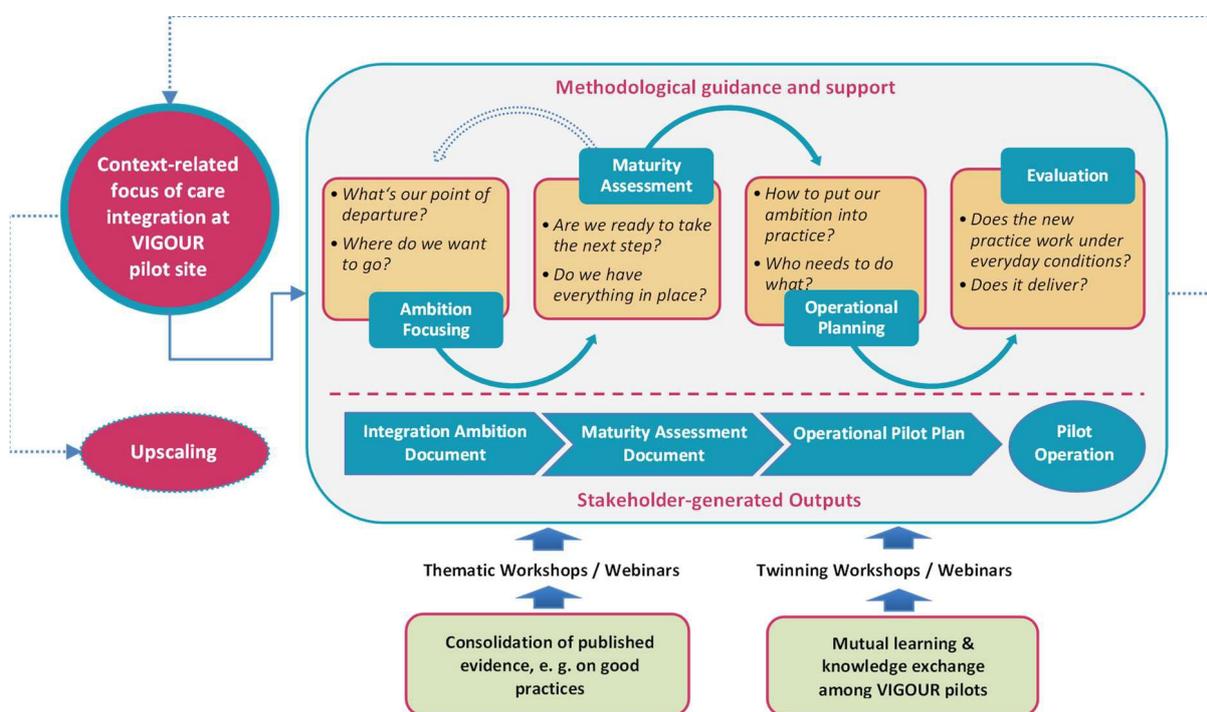


Figure 1 - The multi-staged VIGOUR support process

Against this background, the health and care authorities participating in the VIGOUR project were supported by means of a multi-staged process in defining and implementing better integrated health and care services (Figure 1). Taking the prevailing implementation conditions and current health and care process and practices as a starting point, each VIGOUR pilot site started with consolidating its initial view on how previous health and care service processes could be better integrated. This step was followed by a systematic self-assessment of the envisaged integration approach with respect to its appropriateness and feasibility under given framework conditions. On a

case-by-case basis, the results led to a critical revision of the initially stated integration ambition, e. g. if strongly inhibiting factors or even "roadblocks" were identified at this stage. In a next step, an operational implementation plan was developed as basis for piloting the previously developed integration approach under everyday conditions, with a view to preparing further up-scaling beyond the project duration. Throughout this process, an initial (first) and a consolidated (second) version of a regional scaling-up plan was developed, specifying an individual, context sensitive change management approach for each VIGOUR pilot region.

Almost by definition this process resulted in a diverse range of context-dependent models of integrated care which were ultimately piloted during the VIGOUR project. This document provides an overview of how the 15 context -related integrated care schemes were piloted in the individual VIGOUR regions. This starts with a summary of the methods and means utilised for documenting how the individual VIGOUR pilots were operationally implemented (Chapter 2). This is followed by synthesised presentation of the individual VIGOUR pilot schemes (Chapter 3). Finally, a conclusive summary is presented (Chapter 4). A common reporting template that that was used to by the VIGOUR pilot site teams to for synthesising the operational implementation of the respective pilot is annexed to the main report.



2 Methodology

2.1 Objective and scope

The approach adopted aims at analysing how the integration approaches developed in the previous steps (WP4 and 5) were implemented by each pilot site under day-to-day conditions for piloting purposes. A literature search was conducted to support the definition of implementation dimensions relevant for the successful implementation of integrated care under everyday conditions. Valuable sources of information reviewed in this context include for example the framework of the INTEGRATE project, that provided practical guidance to managers and planners. Moreover, in the context of the SCIROCCO¹ 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 care². Dimensions identified in the SELFIE study “Sustainable Integrated Care Models for Multi-Morbidity Delivery, Financing and Performance – SELFIE”³ were seen as a good fit to be used as a basis for synthesised self-reporting of the pilot operation activities by the VIGOUR pilot sites.

2.2 Reporting template

A common template was administered by the VIGOUR regions to ensure structured and comparable reporting of the pilot activities conducted by all regions (Figure 2). It includes dimensions (implementation tasks) of the Operational Pilot Plan (cf. task T4.3) as well as analytical dimensions of existing change management models derived from SELFIE.

¹ SCIROCCO Project website: <https://www.scirocco-project.eu/>

² Grooten, L., Borgermans, L., & Vrijhoef, H. (2018). An instrument to measure maturity of integrated care: a first validation study. *IJIC*, 18.

³ SELFIE Project website: <https://www.selfie2020.eu/selfie-project/>





Task dimensions

Implementation Tasks	Implementation approach		Implementation activities	
			during pilot	after pilot ?
<ul style="list-style-type: none"> • 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		
<ul style="list-style-type: none"> • Resources • Capacity building 	Workforce (A)	Team culture		
	Workforce (B)	New roles and competencies		
<ul style="list-style-type: none"> • Funding streams 	Financing	Funding typology / Innovative payments		
<ul style="list-style-type: none"> • ICT & tools 	ICT (technology & medical devices)	Collaboration support / Communication support		
<ul style="list-style-type: none"> • Risk planning • Execution monitoring & evaluation 	Information & research	Feedback loops / Continuous monitoring system		

Figure 2 - The multi-staged VIGOUR support process

To structure the reporting template, dimensions from the VIGOUR operational pilot plan were matched to the implementation dimensions which were empirically derived by the SELFIE project from successfully implemented integrated care schemes. This resulted in the following pilot implementation dimensions to be synthesised by each pilot site for reporting purposes:

1. With regards to *service delivery* (A), successful implementers commonly adopted an incremental growth model rather than a disruptive innovation approach.
2. Also - when it comes to *service delivery* (B) - they found a balance between flexibility and formal structures of integration.
3. For *leadership & governance* (A), they applied collaborative governance by engaging all stakeholders.
4. When it comes to *leadership & governance* (B), they also distributed leadership throughout all levels of the system.
5. For the *workforce* (A), 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* (B) - they 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*.

These implementation mechanisms are applicable to different local, regional, and national contexts. In this sense, they provide generic guidance for the implementation of organisational/innovative models of integrated care, independent of the structures of a given health care system. To enable other health and care authorities to learn from the VIGOUR pilots, the pilot site teams were requested reported a synthesis of their piloting activities with help of the generated reporting template (Annex).

The VIGOUR pilot operation reporting template was provided to the pilot sites for initial completion (version 1) by the end of October 2021. Two webinars were organised on 15th and 25th October 2021. During these webinars, the reporting templated was presented and questions from attendees from the 15 VIGOUR regions were addressed. A third webinar was organised on the 23rd of March 2022 in order to review and discuss with the pilot regions the contents and issues concerning an updated version (version 2), and to identify and discuss specific aspects of relevance for final reporting (D 6.1).



3 Results

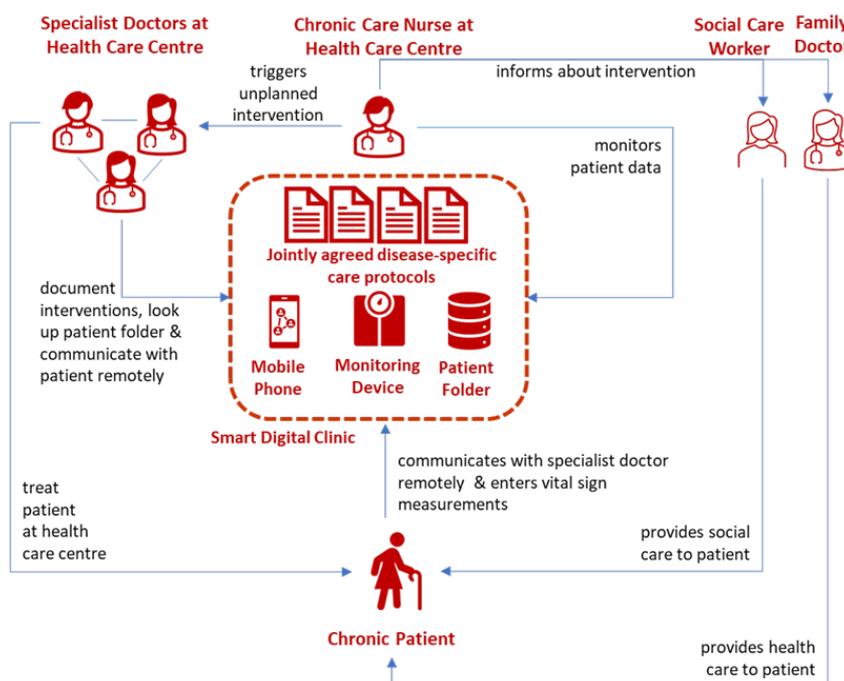
In the following subsections, the respective implementation approaches of the context-based VIGOUR scaling-up pilots are briefly described.

3.1 Lazio (Italy)

PILOT SUMMARY

An ICT-based platform was set up before the VIGOUR project in order to optimise care of patients living with a chronic condition by giving different health care providers (specialist doctors, nurses) access to shared patient folders, thus providing an overview of the care process for each patient in a single ICT platform in order to avoid overlaps of diagnostics and prescribed therapies, while optimising the treatment for a single patient. Furthermore, the system allows to promote the implementation of telemedicine, home self-monitoring, and tele-assistance. The VIGOUR project offered the opportunity to scale up the platform by developing the protocols for additional chronic conditions (anticoagulation therapy, rheumatic diseases, post Covid-19), enhancing multidisciplinary collaboration between health care givers in new medical fields, and implement the related functionalities into the platform.

GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The pilot aimed to scale up the solution in terms of the target populations, reaching more patients living with a chronic condition, and improving the services offered by the platform, defining pathways for new conditions and using the information gathered to feed into a

continuous improvement. The so called 'Smart Digital Clinic' concept had been implemented as part of the services of the local health Agency and involvement of the healthcare professionals and homecare providers and is regulated by a contract. A multidisciplinary team developed protocols to include new areas and information to be collected in the platform through a flexible approach.

GOVERNANCE

The local health Agency of Viterbo was strongly engaged in promoting a collaborative governance by engaging different stakeholders (health professionals, caregivers, and patients) in disease specific collaborative teams. The management board had a strong commitment to support innovative integrated care. Performance-based management has been driven forward over the last decade, and the pilot took advantage of some of the indicators developed in this process, while new indicators are being developed as well.

HEALTH AND SOCIAL CARE INTEGRATION

Viterbo Local Health Agency optimised the delivery of multidisciplinary care towards supporting self-management, self-sufficiency, and autonomy of patients at home, closely following patients in remote areas, fostering communication between multidisciplinary professionals involved, and building an enabling environment to co-create integrated care initiatives.

WORKFORCE

The Smart Digital Clinic approach has been jointly overseen by a team of professionals from different disciplines who closely worked together. For each condition addressed by means of the Smart Digital Clinic concept, a dedicated multidisciplinary team was built defining the specific protocol, which was then implemented by means of a set of platform services (patient folders, telemedicine tools, etc.) in close collaboration with IT experts. Viterbo local health agency invested dedicated staff, who developed new competencies necessary to run the platform and enable patients to use it.

FINANCING

The development and implementation of the Smart Digital Clinic was originally financed by the local health authority with their routine funds. The original funds were limited, and some functional limitations of the original platform resulted from initial funding shortages. The VIGOUR project offered the opportunity to improve the existing solution, scaling up the platform towards new medical areas, and implementing performance indicators.

TECHNOLOGIES

The Smart Digital Clinic has been used for communication between healthcare professionals, and between them and patients. The telemedicine tools have been used for remote patient self-monitoring. Data collected in the platform at individual patient level, have been integrated with administrative healthcare data, for example relating to hospital admissions and drug prescriptions, thus providing a complete picture of healthcare services provided to a single patient. This was a



useful tool for the development of performance and outcome indicators.

COMMUNICATION WITH USERS

The VIGOUR pilot also included the development and implementation of routine performance and outcome indicators, based on the data collected in the platform. These activities were further strengthened through a regional programme which aimed at the routine evaluation of indicators based on administrative healthcare data. The results of these indicators will be used for audits and feedback with healthcare professionals.

OUTLOOK

The level of service integration achieved around the 'Smart Digital Clinic' concept in the framework of VIGOUR will be maintained in regular service provision throughout the pilot area. The emergence of the Covid-19 pandemic during the project did, however, absorb substantial staff capacities, and this is still slowing down the further upscaling process. At the same time, the pandemic has highlighted the need for better coordinating health care delivery more generally, not only in relation to those chronic conditions that were initially targeted in the context of VIGOUR. As a result, a generic patient folder was developed to support the coordination of care service provision to other patient groups as well. This has for example enabled a swift integration of procedures for the collaborative management of COVID-19 related services and remote service delivery to at-risk populations by means of the Smart Digital Clinic concept. Based on these experiences, further steps towards integrating health and social care delivery are envisaged to be taken in the future. Furthermore, feedback gathered from health professionals so far suggests that the service integration approach developed around the Smart Digital Clinic concept may in future benefit from a closer involvement of voluntary organisations in the health and care delivery process to patients living with diabetes.

3.2 Crete (Greece)

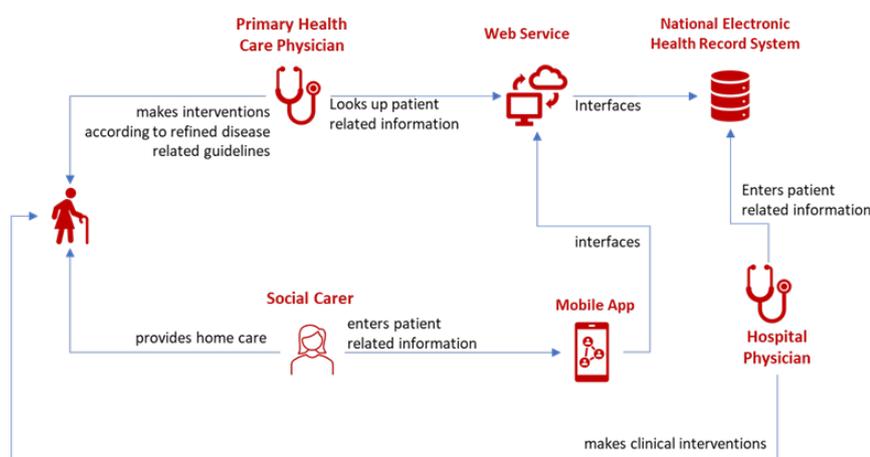
SUMMARY

Taking advantage of Crete's recent Primary Healthcare (PHC) Reform, the VIGOUR pilot aimed to promote inter-sectoral connection/interaction to implement a Personal Electronic Health File (PEHF), which was intended to conclusively replace all paper-based medical records in both the public and the private sector. VIGOUR activities in Crete focused on patients living with one or more non-communicable disease (NCD) of the PHC population, linking PHC services with hospital and social care services, through the provision of tools for comprehensive patient monitoring and personalised care,



such as the revision of the guidelines for PHC and specifically those that refer to patients with coronary insufficiency, heart failure, diabetes and depression. In addition, VIGOUR in Crete aimed to develop a digital link of social care services with those of the PHC and to contribute to the more complete information available to hospitals about their patients who are monitored and cared for at home, while reducing the risk of unnecessary hospital admissions.

GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

VIGOUR activities included Patients with multimorbidity receiving PHC services in a district in inner Heraklion, Crete. A new approach to multi-disciplinary collaboration was followed that included innovative ways of communication and stakeholder interaction as well as the set-up and testing of improved primary care service provision processes in the island of Crete.

VIGOUR activities included the development of ICT tools and use of guidelines to assist PHC professionals' decision-making system through integrated actions. The activities addressed the poor understanding of the concept of integrated ICT-supported healthcare in Greece. Patients living with multiple (chronic) conditions were granted access to a webservice application link primary with secondary health care sectors. The PEHF was expanded to allow for access of PHC practitioners to information about patients' hospital discharges, recommendations issued by the hospital physicians, visits to outpatient clinics and results of laboratory examinations performed in the hospital setting. These aimed to facilitate intersectoral communication and thus more patient-centred and integrated approach. A mobile application collected information on health status and social care needs of patients who are living at home. The app is designed to be used by healthcare and social care professionals who perform home visits and is linked to the patients' PEHF, facilitating the connection between PHC and social care. PHC guidelines have been developed for selected common chronic diseases to enhance the multidisciplinary collaboration and integration.



GOVERNANCE

The pilot attained a balance between flexibility and formal structures of integration. Collaboration of researchers and ICT from the University of Crete with local healthcare and regional administrative authorities allowed the smooth governance of the pilot activities.

HEALTH AND SOCIAL CARE INTEGRATION

The VIGOUR pilot aimed at linking various healthcare sectors and contributing to a holistic service provision approach for patients living with multi-morbidities that reduce their independency. A strong tie between primary health care and social care was created through the VIGOUR pilot in Crete. An additional achievement was the improvement of collaboration of mental health and primary care and between primary care and public health. To achieve this, attempts have been made towards the optimisation of home care services through the development of an electronic mobile application to enhance integration and assist people living with one or more chronic conditions with an ultimate goal to enhance to their autonomy capacity to self-care.

WORKFORCE

Beyond the project's lifetime, VIGOUR is expected to have a significant impact on workforce and continuing professional development since it attempts to revise the existing practical guidelines under the light of interdisciplinary collaboration and provide tools to enhance the interface between social care professionals, caregivers and PHC practitioners. In general, it attempted to inspire a new culture in working together, starting from the consensus meetings to refine the current practice guidelines with an interdisciplinary approach and continuing to the implementation of new approaches and supporting applications based on interprofessional collaboration. Through the implementation of this pilot study, new collaborations have been established with several NGOs and stakeholders, while old collaborations have been strengthened by revising and introducing new/improved roles and responsibilities. Also, the existing personnel who was participating in the pilot found a chance in resolving several technical issues in the records section mainly due the discontinuity of information of the patient's records.

FINANCING

Project resources have been allocated to development, training, and dissemination activities. Further funding opportunities for the sustainability and scaling-up of project outcomes upon VIGOUR's end have been explored in collaboration with the regional authorities.

TECHNOLOGIES

A mobile application (Android, Win10) was developed in three iterations that included: (a) The description of its content as a result of the work by an interdisciplinary team, (b) the development of its software and c) its application to patients with multimorbidity who are in need for care at home. The mobile application adds information on a patient's health and social care needs as well on activities of daily



living and is anticipated to enhance the communication and information flow between PHC providers and social care practitioners and thus to facilitate the multidisciplinary decision-making. The introduction of the mobile application improves access for patients with limited mobility to health services, and can thus be expected to improve patient health outcomes. The patient portal that has so far been used in primary care has been expanded to include relevant information from the hospital EMRs system.

COMMUNICATION WITH USERS

The established network of local stakeholders attained to develop a framework for continuous information sharing and regular monitoring of the joint activities, providing feedback to enhance the implementation of integrated care services and improve health and social care outcomes as the ultimate goal. The team worked on the process and outcome indicators. This work is also used to facilitate implementation research that the research team of the University of Crete is carrying out.

OUTLOOK

VIGOUR facilitated the development and implementation of novel approaches in primary care in Crete and provided the opportunity to develop a strong stakeholder engagement network for further support.

The further alignment of work across the various levels and domains of the health care system in particular between primary care, hospital, and social care towards the improvement of quality of care of vulnerable and multimorbid patients is the next challenge.

Activities and tools introduced by VIGOUR seem to have a substantial impact on strengthening and improving PHC workforce capacity and clinical decision-making. An exploitation of this outcome in other settings in Greece is another challenge.

Submission of the revised guidelines to the Central Health Council for approval and further dissemination across the country to share the evidence in the rest of PHC settings in Greece is planned. The revised guidelines will be included in the training curriculum of the General Practice/Family Medicine Residence program in Crete and evaluate the results.

In summary, the next steps resulting from the VIGOUR pilot project include:

- To continue the training meetings and activities of primary care and social care practitioners.
- To continue the attempts to refine the approved practice guidelines
- To expand the use of VIGOUR applications to other health care districts and prepare proposals to the Ministry of Health for funding and wider implementation.



- To incorporate VIGOUR innovations as educational standards of the under- and post-graduate medical programme and the residency programme of School of Medicine, University of Crete.

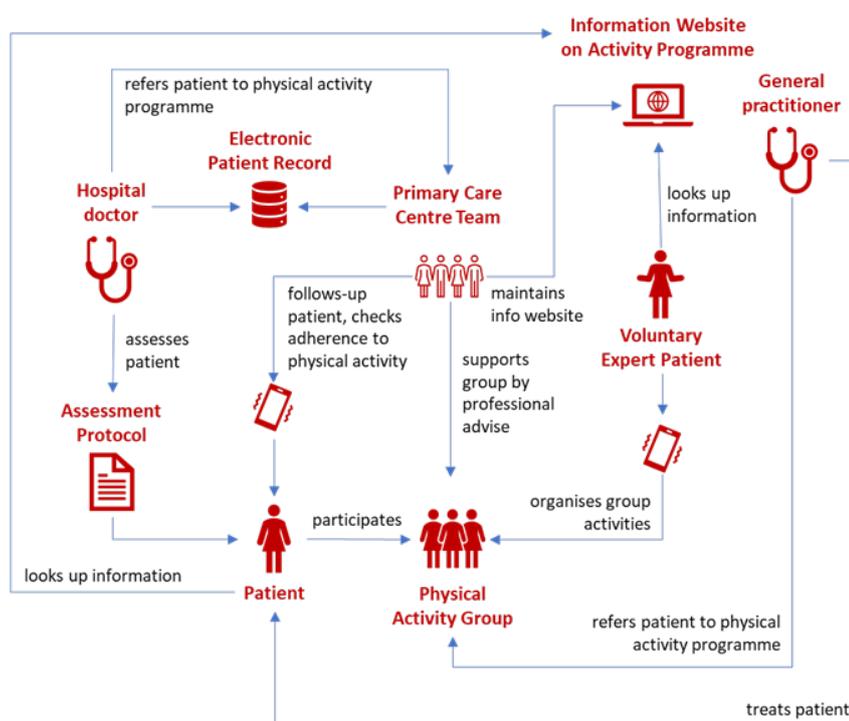
3.3 Valencia (Spain)

SUMMARY

Women's health is an overarching concept including areas related with healthy ageing. One good example is frailty, which is more prevalent in women. Scientific evidence confirms that physical activity (PA) reduces vulnerability to NCDs and frailty. Moreover, PA strengthens physical and mental health, this way considerably contributing to ageing healthily. The VIGOUR pilot activities assessed the impact of PA on a group of women based on collecting data related to general health, frailty, and psychological aspects, including cognition and mood, and quality of life. ICT has been used as a powerful tool to promote the empowerment of end-users and to strengthen adherence by providing inter-connectivity and peer support. The pilot performed a series of analyses that have shown, for example, that non-use of ICT was an independent predictor of frailty in a cohort of middle-aged and older postmenopausal women. VIGOUR pilot used ICT, telephone most frequently, to react to the challenges of the pandemic in clinical care of women in our integrated care programme by providing (parts of the) services remotely. Further analyses have confirmed a drastic increase of this form of care provision and measures of satisfaction of both the end-users and health professionals. This ICT backbone has shown adequate operability to warrant integrated care as well as to address the efforts to overcome the limitations imposed by the pandemic in our VIGOUR pilot.



GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

An incremental growth model was adopted, in search of a progressive increase of functionality, building upon what was already existing: it is a scaling-up, a gradual expansion and broadening of integrated care between different programs and initiatives incorporated into the project. In addition, educational activities have been developed, aimed at other stakeholders involved to ensure the implementation of a scaled-up integrated care programme. A person-centred approach, attending to the needs of the groups of patients who participate in the initiatives, favouring healthy ageing carried out from the primary care centres, and guaranteeing continuity. A gender dimension is emphasised. The formal structure was provided by the vertical integration programme between primary care (GPs and midwives) and hospital physicians. This was added the formal incorporation of expert patients, with a formal recognition by the health authorities, as key stakeholders.

GOVERNANCE

Collaborative governance has been established to engage the participation of different stakeholders and ensure coordination through trust-building and solid relationships. A shared governance strategy has been established in order to boost the interest and engagement of every type of stakeholders, to strengthen the capacity of individuals and groups to incorporate physical activity into their day-to-day life. From the cornerstone, the Hospital Clínico-UVEG, a network based on integrated care has been built, connecting the different realms involved (four primary care centres of the health department – Serreria, Republica Argentina, Foios and Massamagrell– and Salud de la Mujer service and website) to reach a more significant number of



patients/end-users. Leadership has been spread out among the different actors, with a significant role given to the so called “expert patients”, who organise local patient groups and have in this way substantially engaged into the programme. Also, GPs have been deepening into a progressive engagement, with a leader role in some recent activities, such as dissemination activities.

HEALTH AND SOCIAL CARE INTEGRATION

The pilot focuses exclusively on health care, within a wide conception of public health, without considering aspects of social services. Thus, a network environment is being built where the initiatives implemented by some of the primary care centres of the health department can be exported to the others. The possibility of scaling up integrated care in the community passes through citizen participation, being the expert patient one of the driving forces to promote healthy ageing in the community.

WORKFORCE

The pilot promotes information exchange between a multidisciplinary team, aware that work teams belong to different centres and, sometimes, to different areas. The figure that allows this construction is that of the “expert patient” due to changing role of patients as active partners in the care process, and the easiness by which intercommunication between patients facilitates the extension of the programmed between the primary care participating centres.

FINANCING

There is no funding stream of any kind.

TECHNOLOGIES

Electronic health records have been used along the whole programme. Telecare has been implemented by the use of telephone during the pandemic and has been maintained after the lockdown. The SaludMujer website is a tool to communicate with patients. Smartphones have been used to create group during the CARMEN programme of physical activity in 2 primary care centres, Foios and Massamagrell.

COMMUNICATION WITH USERS

Communication remains fluid through a dedicated website that maximizes permeability by providing continuous support. The other options allow implementing monitoring and feedback.

Also, holding meetings and virtual conference calls allows collaboration with the stakeholders within an online community space.

OUTLOOK

The good experience with VIGOUR needs to be consolidated and offers, when considering the future, a black and white perspective. On the one side, the ICT scaffold set in motion will maintain, since the EMRs are already solidly implemented and the telehealth, which has been reduced with the diminution of the pandemic pressure, continues being a stabilized system.



The incorporation of more sophisticated technology, including the modality of video, may extend the use. This is an area where much growth is expected given the cost-effectiveness and the multi-functionality of the rapidly growing technology.

The generated database is a solid asset because it is a source of further research projects and analyses, which will help to consolidate the experience and to extend it to other potentially interested centres.

There is a global difficulty derived from the general structure of the health system that, at both the public and the private sector, is mainly oriented to cure disease and less to promote health and prevent illness. This has created resistance at every level, nurses and physicians, and primary and specialized levels. In our program of women's health this is a difficulty, which only slowly has been allowed to get a piece of the resources in health centres.

Adherence continues being a problem at any intervention, not only physical activity, but also diet or use of medication with preventative objectives. Our experience with smart phones has been quite good, but extension to more end-users and prolongation in the long-haul, requires more commitment from health professionals that, as mentioned, only in a small part are really involved and enthusiastic with the idea.

The creation of networks between end-users provides mutual support that may help to maintain adherence. This finding is important, and either ICT, or even more, ICT plus real in-person contact has consolidated as a valuable conclusion from VIGOUR.

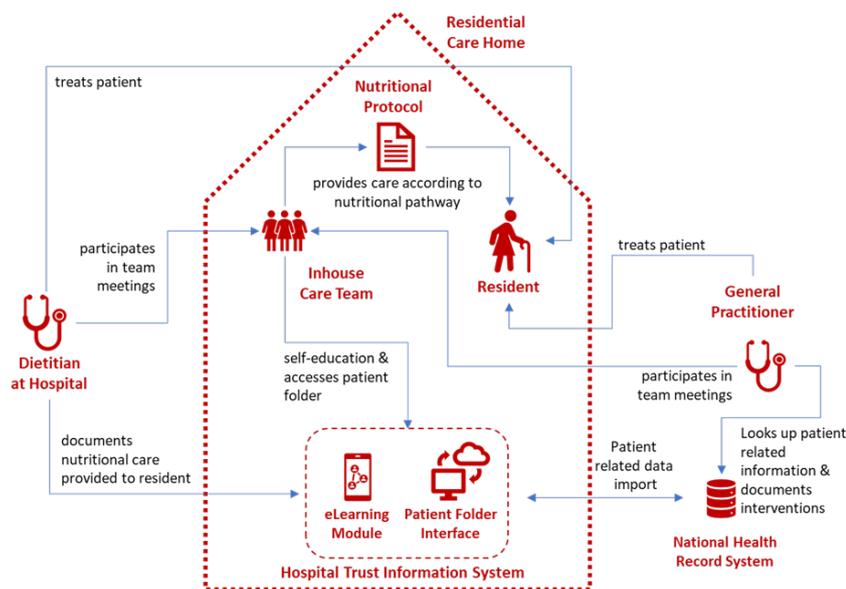
3.4 Styria (Austria)

SUMMARY

The VIGOUR pilot aimed to develop, validate, and implement an integrated nutritional care pathway with inter-professional participation of various local stakeholders involved in health and care delivery such as nursing staff of different professional levels, dieticians primarily affiliated to the hospitals Bad Radkersburg, Mürzzuschlag and Leoben and working in nursing homes on consultancy as well as GPs (General Physicians) integrating pre-existing regional capacities for more efficient care delivery.



GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The implementation approach used is based on an incremental growth model, by building on already existing capacities, processes, and resources and “turning the right screws” already available in order to enable a change process dedicated towards fostering integrated care. Individual approach of health and care integration in all three pilot locations of Styria is based on given local framework conditions and contexts (flexibility). Inter-professional nutritional care is based on already existing protocols, guidelines, and SOPs of the Styrian hospital trust KAGes and national/provincial law that build the legal and organisational basis (formal structure). The Pathway development is built on available evidence of international literature on the one hand (formal structures) and proven practices, processes and methods in the pilot locations on the other hand (flexibility).

GOVERNANCE

The VIGOUR pilot project team operates as companion of the three long-term care residences in their journey towards integrated care, the stakeholders themselves steer the pilot implementation. Leadership has been distributed by applying a bottom-up participatory approach following co-creation and shared decision-making. A particular project committee has been established in the Styrian hospital trust KAGes to enable overall supportive leadership. On micro-level, within each pilot location, roles, and capabilities as well as responsibilities of each actor are clearly described and allow for clear accountabilities and coordination.

HEALTH AND SOCIAL CARE INTEGRATION

Fostering communication between various professionals involved in the health and care process to enable an integrated, inter-professional nutritional care within residential care. The inter-professional care team already collaborates in the pilot locations, aim of the scaling-up approach is to facilitate cooperation and align capacities in order to



offer a more efficient health and care delivery and simplify day-to-day work.

WORKFORCE

Inter-professional team-meetings with the care team around the nursing home residents were held with a clear structure and a design thinking approach, facilitating discussions of challenging patient cases and inter-disciplinary knowledge transfer. Inter-professional team-meetings within the care team around the nursing home residents were held with a clear structure and a design thinking approach, facilitating discussions of challenging patient cases and knowledge transfer. Best-practices and recommendations were evolved within these interventions and allow for a transfer of proven methods and procedures across all three project locations. The development of an inter-professional pathway for nutritional care will also be based on commonly defined roles and responsibilities within nutritional care delivery in long-term care.

FINANCING

The pilot was financed from the hospital's ordinary resources

TECHNOLOGIES

There is already an ICT-platform available, where the care team can share relevant patient information openMEDOCS is the information and communication system of the KAGes trust and the health professionals in the nursing homes have access to it. Furthermore, ELGA, the electronic health file is embedded within openMEDOCS. This allows the local general practitioners, to also share patient information with the in-house team. Linkage to the in-house kitchens is provided by VESTA, the electronic meal-supply system of the KAGes trust. Within the VIGOUR project, it is planned to foster cooperation via the openMEDOCS platform.

COMMUNICATION WITH USERS

Feedback loops kept by continuous information flow among all project stakeholders involved. Stakeholders are asked to provide their feedback on every document or tool developed. Continuous monitoring will be achieved by checking if tasks or milestones for the pilot project are on track or delayed and what the cause of delay is.

OUTLOOK

All activities developed are intended to be lived beyond the pilot duration.

The e-Learning module is implemented in the existing training platform to enable long-term accessibility.

Best practices, experiences and processes developed during interprofessional team-meetings will be sustainably transformed into everyday routine.

The interprofessional care pathway is going to be implemented into everyday routine. Practical implementation will demonstrate feasibility and evince necessary adaptations.



Human resources are the key factor for implementation of scaling-up activities within the Styrian VIGOUR journey.

3.5 Andalusia (Spain)

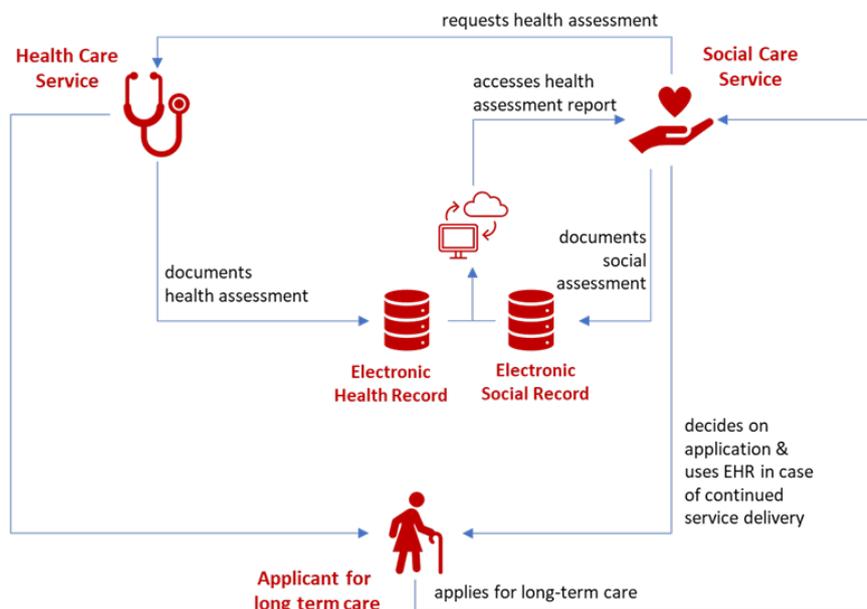
CARE PRACTICE

Coordination between health and social services for recognition of the situation of dependency in the region

SUMMARY

In VIGOUR, Andalusia planned to deploy a better coordination between health and social care services to improve the procedure for the recognition of the situation of dependency citizens in the region. This dependency situation recognition is requested by citizens through community social services, starting an administrative procedure managed by the Andalusian Agency for Social Services and Dependency -ASSDA-. The procedure includes an assessment of the health status and a health report, produced by the professionals of the Andalusian Healthcare Service -SAS-. The Andalusian pilot includes the development and implementation of the health report within the corporate electronic health record Diraya, as well as a direct request and retrieval process between the ASSDA IT system and Diraya.

GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The interventions for the implementation of the VIGOUR pilot in Andalusia focused on a better communication between and connection of health and social care services. Currently, after the initial request by the citizen, a formal internal request for the health report elaboration in the Andalusian Health Service (in primary healthcare centres) is launched by the Andalusian Agency for Social Services and

Dependency -ASSDA- territorial delegations, using a dedicated platform. A new system has been designed by ASSDA for the management of the process of assessment of the situation of dependency to be connected with the health corporate health information system, Diraya.

GOVERNANCE

On 1st December 2020 an Agreement at the Regional Government level established the creation, functioning and members of Health and Social Coordination Commissions both at regional and at provincial level. Each entity participating in the pilot is responsible for the specific actions to be carried out in the health and social care services area. During the pandemic, the Regional Ministry of Health and Families has had a leading role.

HEALTH AND SOCIAL CARE INTEGRATION

Specific working groups have been organised to agree on the items to be included in the health report and for connecting the IT systems in both health and social care services agencies.

WORKFORCE

Meetings between health and social care services professionals have been organised to agree on the internal procedures.

FINANCING

Own resources plus the project contribution are the funding used in the Andalusian pilot.

TECHNOLOGIES

Development of the health report using the “report manager” within the corporate eHR-Diraya system is in production. Implementation of the health report feature in the electronic health record 'DIRAYA (Centralised clinical data -DCC-) is in pre-production. Implementation of the health report feature in the electronic health record DIRAYA (Centralised clinical data -DCC-) is in production.

COMMUNICATION WITH USERS

Currently, there is a digital platform for the communication of the request and response of the health report for the process of dependency situation assessment. This health report is not stored in the citizen's electronic health record system.

OUTLOOK

The connection between health and social care services IT systems facilitated in VIGOUR will be enlarged and expanded to the entire region of Andalusia. It will be the routine procedure for the recognition of the dependency situation.

The emergence of the Covid-19 pandemic during the project absorbed substantial staff capacities, and this has slowed down the full deployment of all services and the upscaling process. However, the pandemic has also accelerated the establishment of Coordination Commissions between health and social care services both at regional and at provincial level. VIGOUR has been addressed in several meetings at the Regional Commission, facilitating the collaboration as a step forward in the integration journey.



Healthcare professionals have been impacted by the Covid-19 pandemic, experiencing heavy work overload. The new health report developed in VIGOUR has proven to facilitate their daily work, as the information is kept in the electronic health record and can be retrieved whenever needed.

The integration of procedures across health and social care services is a challenge, in particular when services are governed by different authorities and financed through different funding streams. During the VIGOUR pilot a step towards closer collaboration was made in terms of facilitating the request and elaboration of the reports needed in the procedure of recognition of the dependency situation. Based on experiences gained so far, further steps towards better collaboration and 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 be extended and monitored. Access to dependency situation and social services granted will be in the scope of future extension of exchanges.

3.6 Lodz (Poland)

CARE PRACTICE

Integrate medical and social care for older adults at risk of frailty syndrome

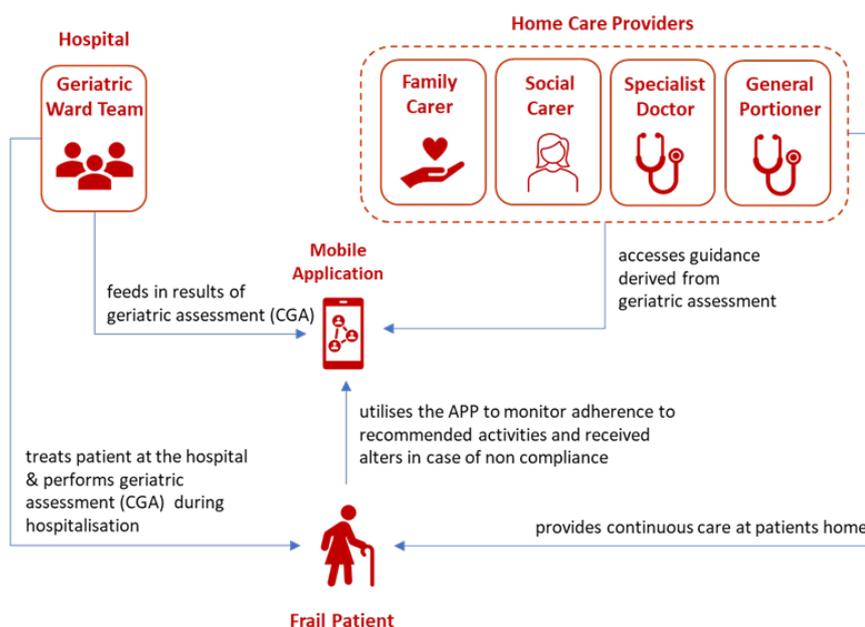
SUMMARY

The aim of the pilot study carried out in Poland was to integrate medical and social care for an older adult at risk of frailty syndrome. This integration has been performed using an application that decodes the results of examinations of patients hospitalised at the Geriatrics Clinic of the Medical University of Lodz. The results, traditionally received by the patient in the form of a discharge report from the hospital, were integrated into the application thus obtaining a broader and friendlier interpretation of them along with guidelines for further long-term care in the home environment. The information contained in the application helped in determining the patient's needs and, with his consent, was also used to provide improved support services for formal and informal caregivers. The created application through an appropriate decoding system allowed indicating the patient's needs and helped to develop the system and scope of long-term care, thus contributing to reducing the risk of the occurrence or exacerbation of the frailty syndrome. The development of the application created a bridge between medical care and social care,



thus allowing better planning of long-term care services provided at community dwellings or in the home environment of older adults.

GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The pilot allowed transfer of health information on the patient, acquired during the CGA (that includes a set of tests validated for the Polish population, assessing physical, mental and functional fitness, mental condition, risk of falls, and nutritional status) to the patient’s environment through a user-friendly application used directly by the patient and people around them. After the pilot the inclusion of the application in a platform, allowing for interactive information exchange, remote consultations, as well as extending the scope of care to other types of diagnostics is foreseen. Furthermore, it is planned to evaluate whether the use of the application improves the effects of care in the home environment.

GOVERNANCE

One of the goals of the pilot carried out under the VIGOUR project is to create a lasting relationship between specialist healthcare services such as in the in the field of geriatrics, and the patient’s environment.

HEALTH AND SOCIAL CARE INTEGRATION

The social welfare and healthcare system in Poland are not connected, but the implemented pilot is an attempt to develop a platform of understanding between medical care and social care. Ideally, the the application will in the future be added to medical (such as IKP) and patient social data management systems.

WORKFORCE

An important effect of the pilot project is to indicate to social care workers, but also to people from the patient’s home environment, how the results of a comprehensive geriatric assessment can be used to provide better care and its further monitoring and reporting. Parties that have been involved in the coordinated care process are:



1. Geriatricians, physiotherapists, nurses, nutritionists. First contact doctors
2. Social workers
3. Patients, their formal and informal caregivers, patients' families
4. Academic/educational institutions
5. Local Health and Social Care Associations.

FINANCING

The VIGOUR Project financial resources have been allocated for the successful implementation of the pilot

TECHNOLOGIES

Creation of an application under an open license, allowing the decoding of the results of a comprehensive geriatric assessment (CGA).

COMMUNICATION WITH USERS

A constant exchange of information between stakeholders particularly between representatives of medical and social care.

OUTLOOK

Activities aimed at promoting the application as a platform connecting medical care with care provided in the home environment.

Searching for new solutions that would allow for an improved integration of health and care services provided to patients, especially patients at risk of frailty syndrome, prefrailty and with frailty syndrome.

Searching for partners and solutions enabling the application to be included in the "Internet Patient Account" (IKP) platform. As well as determining the possibility of extending the application with additional functions and usability.

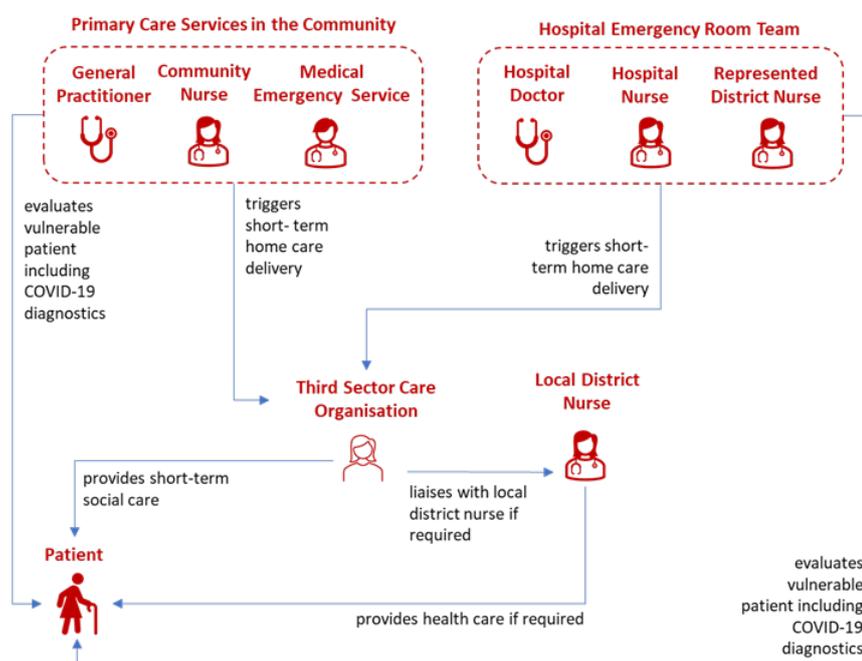
3.7 Trieste (Italy)

SUMMARY

The pilot activities had the primary objective of strengthening integrated care delivery by providing a rapid personalised assessment of patients' specific needs. VIGOUR Pilot Action has been further scaling up integrated care by fostering actions needed for the personalised assessment and for the definition of priorities for care pathways. Moreover, specific needs, such as reduced mobility and loneliness, have been considered to ensure better continuity of care and longer-term benefits.



GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The pilot provided the creation of a protocol for the continuity of care service at the Emergency Room and beneficiary's inclusion into an integrated short term home care pathway until long term care can be agreed.

GOVERNANCE

Staff from different districts have been working jointly to transfer knowledge and experiences from the most advanced Districts to the less advanced ones. Integrated care included the coordination between Districts and the Directorate General to harmonise implementation of the pilot, and the negotiations with municipalities and territorial services to expand social services organisations' intervention.

HEALTH AND SOCIAL CARE INTEGRATION

Collaboration processes among different health districts, the public health authority and the third sector providing social care has been improved. As the services in the pilot action took into account the health and social needs of patients, to ensure patient well-being, external social cooperatives have been brought in to provide personal care services when needed.

WORKFORCE

The pilot aimed to further increase the competences of all stakeholders involved via knowledge transfer and training activities. Multidisciplinary meetings involving different Districts' representatives, as well as representatives of the social cooperative involved have been organised to better train all involved stakeholders on the reciprocal competences and responsibilities needed for integrated health and care provision.



Moreover, the skill set of health care professionals further improved in the framework of the training and exchange activities. Thanks to VIGOUR activities, the Local Health Authority planned to launch a training program (training sessions and workshops) addressing all competences required to foster integrated care and continuity of care within emergency services in all territorial areas in FVG

FINANCING

To promote the scaling-up of integration within the region, the coordination activities at both Local Health Authority and regional level to increase the health budget funds to the areas that have reduced funding and require additional resources.

TECHNOLOGIES

The pilot explored the possibility of using an ICT tool for the creation of a common database for all Districts showing the services offered within the scope of the pilot action, the timing of these services and all additional relevant information related to the end user's health and crucial details to ensure continuity of care.

COMMUNICATION WITH USERS

All information on the patients of the pilot action services has been exchanged via common communications tools and software.

OUTLOOK

After adapting the implementation approach to account for the characteristics of the Isontino area, the Pilot Action has been successfully implemented in the city of Gorizia— with available information highlighting the effectiveness of the service in avoiding multiple unnecessary hospitalizations and increasing the access of the target population to the services offered by social cooperatives.

Thanks to VIGOUR the Local Health Authority will further strengthen its pathways for integrated care— with a dedicated strategy for avoiding unnecessary hospitalisations and fostering homecare service delivery— updating its current procedures and formalising its long-term cooperation with social cooperatives.

The Region has decided to continue providing the services started in VIGOUR— and ASUGI will start including the service in its annual plans after the end of the project. To finalise the process, the Local Health Authority is defining the organisation's objectives and the dedicated budget to be invested for the upcoming annual plan.

To foster the effectiveness of service delivery in all Districts— especially in the Isontino where the personnel had less experience with Pilot Action activities— the Local Health Authority is launching a training program comprising two workshops addressing all competences required to foster integrated care and continuity of care within emergency services in all territorial areas. The training programme will also include local visits within the Region for the involved health care professionals to promote knowledge transfer



within and outside their District— while also providing valuable information on the specific District's necessities and areas for improvement.

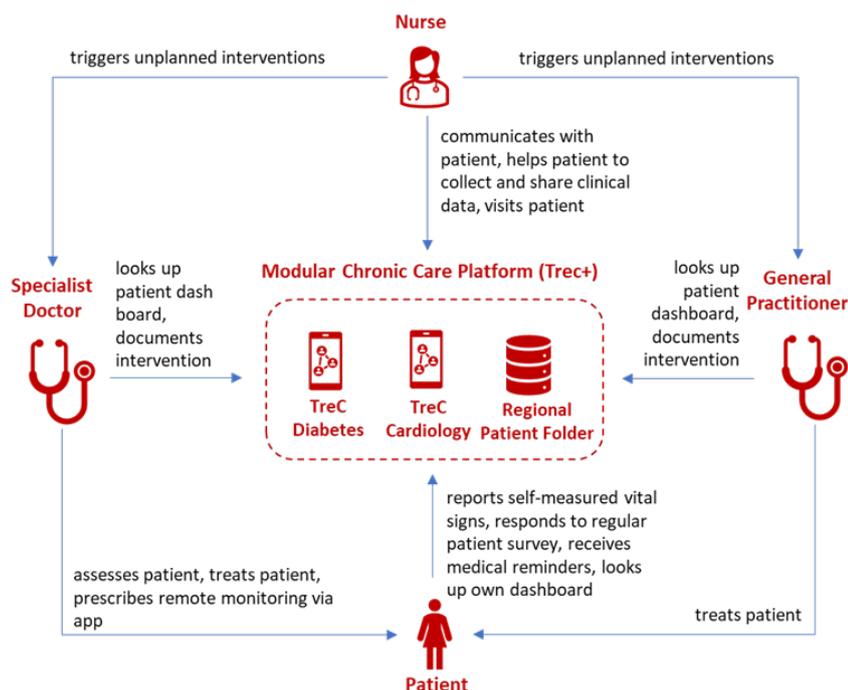
As VIGOUR is planning to address possible additional ICT solutions— especially mobile applications— in support of its activities, the Region will start the assessment of different solutions to be integrated in the continuation of the activities after the end of the pilot action,

3.8 Trento (Italy)

SUMMARY

In VIGOUR, the Autonomous Province of Trento aimed at extended use of technological innovations and organisational aspects, to promote healthy lifestyles and an efficient management of patients living with diabetes and heart failure (HF).

GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

New organisational assets and procedures to manage patients with diabetes, supported by new technologies were established.

GOVERNANCE

Specific strategies have been adopted to promote shared decision-making, a culture of shared vision and coordination tailored to complexity.

To promote consensus-oriented multidisciplinary decision-making and solid relationships between professionals, stakeholders and the management/policy makers, a model of working groups and joint labs



has been put in place to divide tasks in multidisciplinary – albeit coordinated – working teams and ensure consensus among different parties and across different topics. Moreover, focus groups and in-depth semi-structured interviews have been designed and implemented to collect needs and inputs from i) patients (target groups, including NGO representatives), ii) healthcare professionals, iii) healthcare managers.

HEALTH AND SOCIAL CARE INTEGRATION

Periodical meetings have been established to ensure that health care, public health, and health services issues were considered as relevant part in the pilot action.

WORKFORCE

Healthcare staff has been involved since the beginning in the design and piloting (POC) of the VIGOUR action. Working groups and joint labs have been put in place, involving patients, IT and healthcare workers and proper training has been delivered to the healthcare professionals who were dealing with the technological platforms. Among the overall goal of the POC and pilot actions there was also the promotion of new competences among healthcare staff.

FINANCING

The pilot was financed from the Health System's ordinary resources.

TECHNOLOGIES

TreC Diabetes and TreC Cardiology are sustained by the 'TreC' (the Trentino Citizens Clinical Record) platform, a pillar for the long-term strategy of healthcare digitalisation and a tool for accessing healthcare system.

COMMUNICATION WITH USERS

Proper monitoring and assessment of the TreC Diabetes and TreC Cardiology actions within the VIGOUR project have been ensured by the coordination board composed by members of the three institutions (Health Authority, Local Health Agency and FBK (Public R&D Organisation)), responsible for i) planning the overall actions and ii) monitoring & assessing the progress of the pilot's implementation, providing guidance and support.

OUTLOOK

From a patients' perspective, the platform has proved to be useful in terms of fostering communication between multidisciplinary professionals (IT and healthcare staff) and patients as well, in a context of "augmented communication".

The number of patients supported through the TreC Cardio is constantly increasing, whilst for TreC Diabetes, initially applied to patients with gestational diabetes, the platform has proved to be potentially viable for DM1 and DM2 patients as well. From a general perspective, the technological asset has been co-designed with patients, and technology appear to be user-friendly.



Personalisation of the digital solutions was perceived as beneficial for healthcare professionals, whilst the enrichment of data collected by the patient was considered as vital to triangulate information already available (lab data) with patient-generated health data (PGHD).

In line with the van Dyk framework (van Dyk, 2014), policy readiness deals with policies, at the government and institutional level, which are in place to address common issues, such as licensing, liability, and reimbursement. From this perspective, the piloted practices were perceived as key actions to test and assess the use of digital technologies supporting novel organisational models. From this perspective, policy actions (nomenclature sanitario / healthcare services sheet) were coordinated with organisational asset of the services to make telemedicine services part of the formal standard care services delivered by the healthcare staff, confirming the interest and efforts to encourage telehealth innovation.

The core steps forward will be two areas. In relation to TreC Cardiology, the steps forward are i) the process of embedding the service into the broader TreC+ platform (single point of access to the digital services of the Trento Province healthcare system) and ii) to expand the connection/connectivity with other devices (e.g., medical devices, smartwatch, etc.).

Scale up is also foreseen in terms of expanding the use of the platform beyond the province (TreC, TreC Diabetes and TreC Cardiology). Several requests of re-use were received and the actual reuse of the platforms in other Italian regions is currently being prepared.

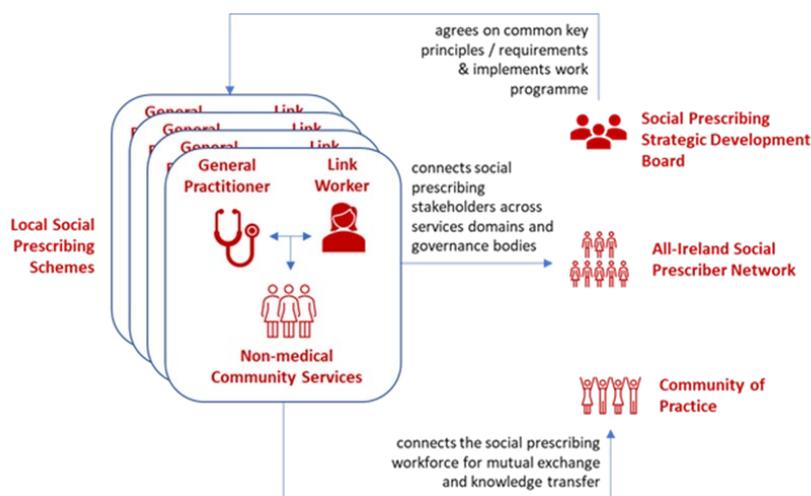
3.9 Northern Ireland (UK)

SUMMARY

This project aimed to scale up and spread social prescribing across Northern Ireland. Through use of the VIGOUR methodology and collaboration with stakeholders, Northern Ireland has put in place a framework which will address the key project domains and will provide the basis for social prescribing to be implemented in an evidence based and co-ordinated way.



GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The pilot aimed to connect the social prescribing workforce through a community of practice using Project ECHO as the platform and from a range of sectors and backgrounds through the setup of an All-Ireland Social Prescribing Network and the Social Prescribing Board.

GOVERNANCE

The pilot has built regional collaborative leadership across a range of sectors. A Social Prescribing Strategic Development Board was established to bring together senior leaders and managers from across a wide range of sectors and government agencies to agree key principles of SP to inform its scale up and spread.

HEALTH AND SOCIAL CARE INTEGRATION

The work to establish a Social Prescribing Strategic Development Board has involved connecting with many leaders from outside health and social care (e.g., local councils, Department for Rural affairs, Dept. for Communities, the voluntary and community sector).

WORKFORCE

Significant work has been done to develop more of a sense of team among social prescribers across the region. They have been connecting in a learning environment monthly for two years and their shared focus has helped build that community.

A community of practice to bring together people currently carrying out the new role of social prescriber has been established and has been underway for two years.

FINANCING

The pilot has been financed with the VIGOUR Project budget. Further understanding of the current finance model for social prescribing and of the opportunities to develop a more innovative and joined up funding model have been implemented during the pilot.

TECHNOLOGIES

Working to gather information to identify opportunities in light of the pandemic for optimising appropriate use of digital health tools that can enhance the provision of integrated care through social prescribing in all aspects.



COMMUNICATION WITH USERS

The Board worked directly with the social prescriber’s community of practice which is ensuring there is a feedback mechanism with those delivering the service.

OUTLOOK

Work will continue beyond the VIGOUR project to

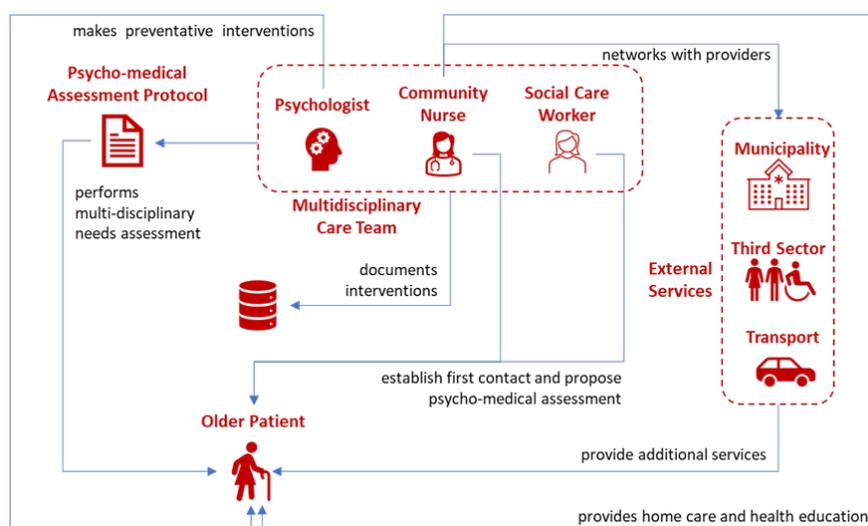
- Try to address immediate funding and sustainability challenges
- Finalise the minimum outcomes framework
- Demonstrating and communicating the outcomes and impact
- Agreed core competencies for social prescribing link workers
- Support further integration of SP models into statutory sector and across care pathways

3.10 Piedmont (Italy)

SUMMARY

The VIGOUR pilot in the Piemonte region has involved four services of the Vercelli’s LocalHealth Unit (LHU), aiming to deliver preventive and health promotion intervention in a small sample of older people who are lonely by improving the integration of services provided. Specifically, the pilot has focused on delivery of structured psychological interventions following proven protocols and guidelines, on community networking building, as well as on the formalisation of collaborations among professionals and organisations and strengthening of the multidisciplinary team for chronic care management.

GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The Vigour pilot has been a booster for creating new direct professional relations on multilevel vertical structure: on the basis of the pilot’s target population needs, different LHU services started to share common goals and tools with the creation of a more solid network and the final aim to provide more integrated services to patient and citizens

GOVERNANCE

The pilot aimed to reinforce the pre-existing relationships between professionals and services that before were not formally established



and recognised by institutions, through agreements between services to manage social assistance and care to the target population. More concretely, tasks, activities, and processes have been formalised in a protocol of proactive interventions aimed to loneliness prevention and delivered by a multidisciplinary team.

A coalition team of multidisciplinary professionals and services has been built to:

- -Raise awareness of professionals to integrated care,
- -identify common goals,
- -share vision, ambitions, and values,
- -discuss about limits and external barriers,
- identify common solutions to overcome limits and barriers,
- -planning common interventions and integrated practices.

HEALTH AND SOCIAL CARE INTEGRATION

The pilot aimed to support the collaboration with external organisations to deliver integrated care and assistance with health and social care professionals relying on a jointly defined protocol.

WORKFORCE

The pilot built a multidisciplinary team to share knowledge and to promote the tools exchange, as well as the data and methods (those normally used by the different professionals). Co-design has been encouraged. Roles and competences have been integrated with joint visits and co-design among professionals.

FINANCING

The VIGOUR Project financial resources have been allocated for the successful implementation of the pilot.

TECHNOLOGIES

During the first phase of the pilot, a system was designed and developed to support data and information exchange and to facilitate communication among professionals.

COMMUNICATION WITH USERS

The pilot contributed to share clinical and personal data of patient, activities and intervention delivered by each professional, calendars of appointments, scores, and assessments results, among healthcare professionals and the patients.

OUTLOOK

The VIGOUR pilot Team is now discussing to include the experience into the Local Prevention Plan of Vercelli's LHU. This enhances this experience as a starting point to future planning with an integrated approach for the LHU, and open new possibilities for agreements with external stakeholders (like external social services and volunteer organizations) of the LHU area.

Other future steps include:

- Progressive inclusion in the team of external organisations (municipality social services, general practitioners, and local volunteering organizations for social promotion and assistance).



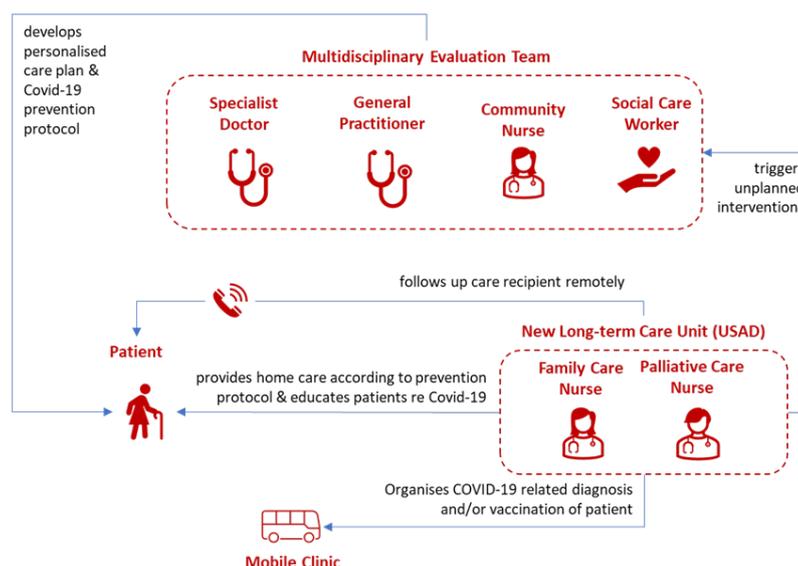
- Major inclusion of GPs in the multidisciplinary team (in the co-planning and co-working). GPs so far tended to be reluctant to become involved in the integrated care approach tailored around the Smart Digital Clinic concept.
- Planning of other preventive and health promotion interventions with the collaboration among services and organisations.
- Experiment a service of telemonitoring and telemedicine with devices already available in Vercelli’s LHU in the same target population.
- Identification of similar, further target population for scaling-up these experimental practices.

3.11 Liguria (Italy)

SUMMARY

The Ligurian pilot was strongly influenced by the situation emerging with the accelerating Covid-19 pandemic: Personal Protective Equipment (PPE) were lacking and there was a general need to reduce the risk of spreading COVID-19 between professionals in the territory and patients. The reply was given by delivering the needed territorial services in a new “problem-centred” approach based on the emerging needs. Two new units (USADs) have been created, identified as “special Homecare and Home Palliative Care units” consisting of two nurses: a FCN (Family and Community Nurse) an Home/Palliative Care nurse.

GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The implementation of USADs services allows to: reduce the risk of spreading COVID-19 between professionals operators in the territory and patients; tailor personalised care plans involving

different professionals under the “key connection role” of a specialised nurse (FCN); shape integrated hospital-territory pathways; take care of individuals (or entire families) throughout the overall period of COVID-19 positivity; tackle actual users’ needs emerging during the evolution of the emergency; acting as a “IH&HPC Network hub” in rural areas, promoting health education.

GOVERNANCE

The implementation of the Ligurian pilot required the collaboration among different services and authorities at regional level, delivering social- health interventions: the central coordination authority (A.Li.Sa. – Ligurian Healthcare Authority), ASL4 (a Local Health Authority), 3 Social Health Districts, the Primary Care Department (coordinating Homecare Service and Palliative Care Service), USCA – Special Units for the Continuity of Care and the Multidisciplinary Evaluation Teams working on the territory. To this end, different stakeholders in the regional health system have been involved in the coordination of the new service tailored to complexity.

HEALTH AND SOCIAL CARE INTEGRATION

Work alignment among different authorities and offices at regional and local level involved in the pilot was fundamental for its proper implementation. In particular, it was crucial to align USADs with Multidisciplinary Evaluation Teams working on the territory, Social- Health care services (such as Homecare and Palliative care) and the offices who are supposed to take in charge users potentially or actually affected by COVID-19.

WORKFORCE

Multi-disciplinary teamwork has been identified by Liguria Region as a top priority in order to foster a proactive approach to prevention and a systematic approach to frail, chronic and disabled citizens care focused on user-centred services at community level. The need for multidisciplinary person-centred care need has been emphasized by the current COVID-19.

FINANCING

The Ligurian pilot has been framed into the actions implemented by the Regional Health System in order to manage the COVID-19 pandemic emergency. Thus, it has been financed through national and regional institutional funds, both ordinary and extraordinary ones.

TECHNOLOGIES

Portable ultrasound machine which can be used by nurses (after a short training) directly at users’ home, during the USAD intervention. Such last generation ultrasound scans allows to identify COVID-related pneumonias, avoiding possible complications.



COMMUNICATION WITH USERS

The monitoring of the pilot's activities has been constant, and qualitative/quantitative data (distribution of users' types, formalized individual assistance plans, time required by the service provision, types of services provided) have been collected throughout its implementation; at the same time, there has been a continuous analysis of expressed and unexpressed health needs in order to adapt the response capacity of the USADs.

OUTLOOK

Due to the positive evaluation of the pilot experience, the “problem-centred” model of USADs will be taken as a reference for the management of IH&HPC services during epidemic emergencies, such as the “infection peaks” during flue epidemics.

Thanks to VIGOUR the Local Health Authority will further strengthen its pathways for integrated care— with a dedicated strategy to improve the proximity of health services in inland areas of the region acting as a “IH&HPC Network hub” in inner/rural areas, promoting health education and promoting early identification of frailty

Tailor personalized care plans involving different professionals under the “key connection role” of a specialized nurse (FCNAs) VIGOUR is planning to address possible additional ICT solutions— especially mobile applications— in support of its activities, such as remote monitoring, remote medical consultation

All data gathered at the end of the pilot action implementation phase will be analysed to integrate the current analysis with additional information— especially qualitative information regarding the situation of beneficiaries post service delivery.

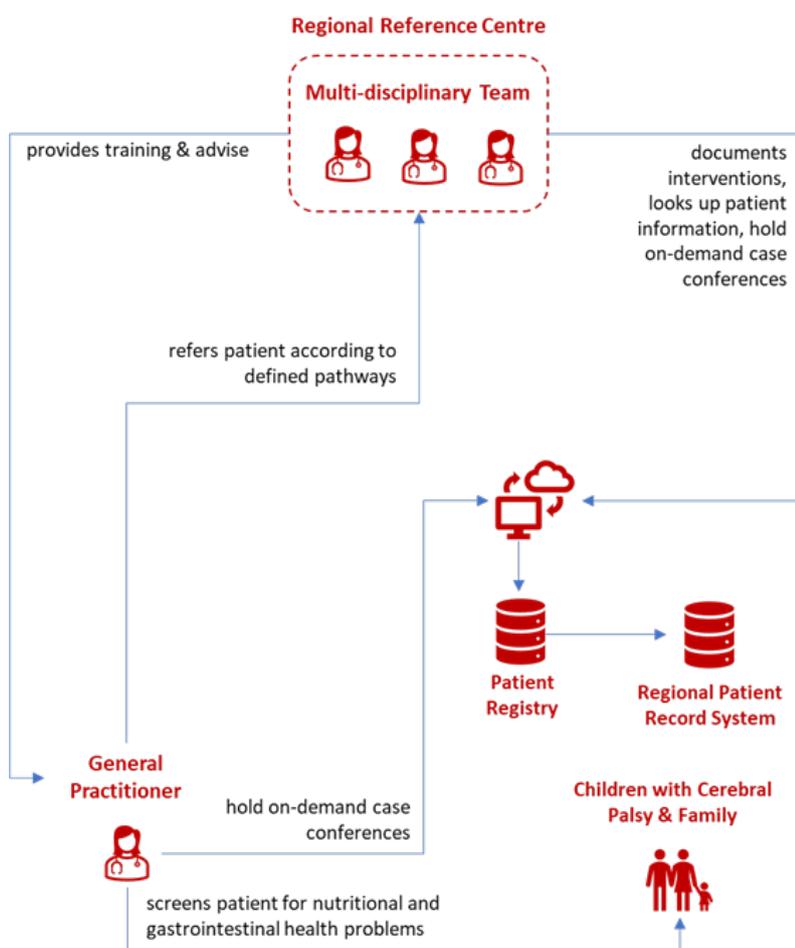
3.12 Campania (Italy)

SUMMARY

The VIGOUR project allowed the creation of a regional network for the diagnostic and therapeutic management of paediatric Children with Cerebral Palsy (CP) suffering from gastrointestinal and nutritional issues, including a regional reference centre (HUB centre),



GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

Campania Region adopted an incremental growth model approach. Due to the lack of a well-defined health-care network and of standardized regional diagnostic, therapeutic assistance pathways (PDTA), management of paediatric patients with CP and gastrointestinal/nutritional issues is extremely variable throughout the regional territory. The Region adopted a balance between a formal structure and a flexible approach. In fact, the network of care was defined and structured. The clinical approach has been personalized and patient-centred, flexible and tailored to patients' need.

GOVERNANCE

The collaboration between the regional government and the different healthcare levels was crucial for the maintenance of the established clinical network.

HEALTH AND SOCIAL CARE INTEGRATION

Work alignment between the regional authorities and the local healthcare providers was crucial for the implementation of the network of care.

WORKFORCE

Multidisciplinary teams were identified in all the centres involved in the care of paediatric patients with CP in order to:



- standardize clinical management
- guarantee an evidence-based management of comorbidities
- perform a multidimensional assessment of patients
- and define personalized treatments.

FINANCING

The pilot was co-financed through national and regional institutional funds, both ordinary and extraordinary ones.

TECHNOLOGIES

The VIGOUR pilot included the use of an integrated regional telehealth platform with adaptation of the current IT systems available in the regional territory.

All the actors involved in the networks have been connected via the internet to a single cloud repository / public connectivity system (PCS).

COMMUNICATION

A constant monitoring of the activities was performed through regular meetings. Specific outcome indicators have been identified to evaluate the performance

OUTLOOK

After adapting the implementation approach, the pilot action has been successfully implemented in the Campania, allowing the creation of a registry of patients that will be progressively expanded with new cases identified with diffusion of the screening procedures

Thanks to VIGOUR, the local health authority will further strengthen its pathways for integrated care, with a dedicated strategy to reduce extra-regional mobility

The Region will continue providing the services started in VIGOUR after the end of the project.

A training program will be launched, comprising a distance education and training material specifically targeted for general pediatricians.

As VIGOUR is planning to address possible additional ICT solutions, especially mobile applications, in support of its activities, a dedicated mobile application is envisaged to be created to allow patients' empowerment

3.13 Emilia Romagna (Italy)

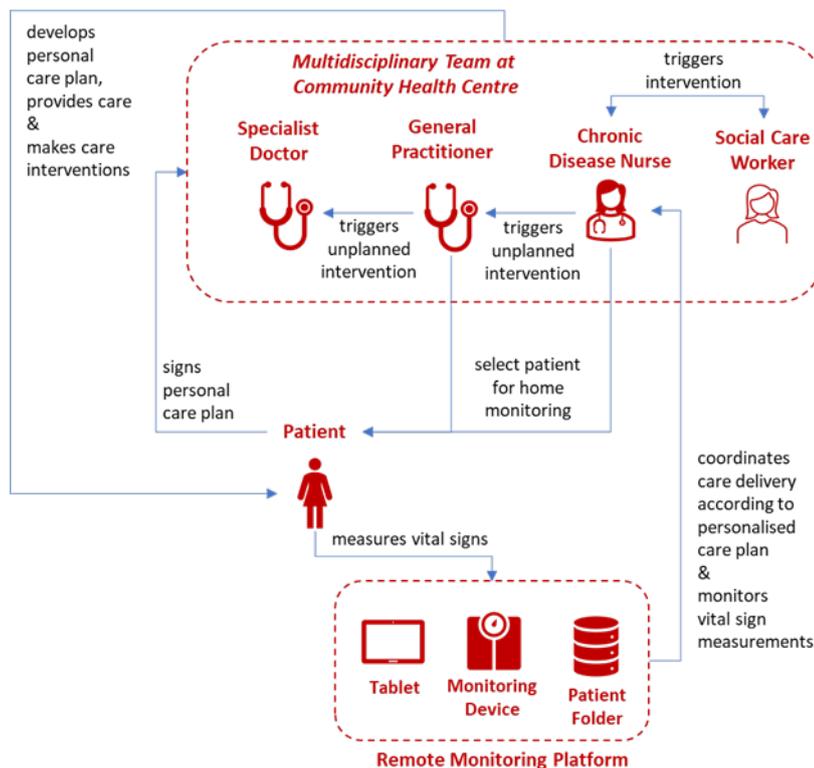
SUMMARY

The VIGOUR pilot built on a telemedicine project aimed at introducing patient telemonitoring in the organizational and functional model for the management of complex patients with type II diabetes mellitus (DM), heart failure (HF) and chronic obstructive pulmonary disease (COPD) through community health centres. Two CHC of the Local



Health Authority of Parma have been engaged in the VIGOUR project to introduce telemonitoring intervention in their practices. Multidisciplinary teams made up of chronic disease nurses, general practitioners, specialists, social workers and other health care professionals have taken in charge of frail people through CHC ambulatory for integrated chronic care.

GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The Emilia-Romagna pilot was implemented with an incremental growth model approach. The remote monitoring of patients who live in areas that are difficult to reach. In this sense, VIGOUR represents an additional tool to the already active path of taking care of frail people by Community Health Centres.

GOVERNANCE

The Project envisaged the involvement of the various actors at the local level: general practitioners, chronic ambulatory care nurses, the community health centres referents, the heads of the district nursing service, the directors of the primary care department, the district directors and the information services and medical devices heads.

HEALTH AND SOCIAL CARE INTEGRATION

Health and social care integration, prevention, promotion and equity, participation, quality and proximity of care represented the driving forces behind the VIGOUR pilot, as set out in the 2015-2018 Regional Plan for prevention and the 2017-2019 Regional Social and Health Plan. The project aimed to reach people living in remote areas, enhance CHC multidisciplinary teams and involve patient and/or caregivers in the process of care.



WORKFORCE

The introduction of periodic meetings between professionals of the network for the discussion of the most complex clinical cases, has shown how fundamental is the presence of all the various figures, to guarantee the standardization of the clinical-assistance activities in the various areas of the company territory. In fact, on some occasions, when not all the professionals involved were present, there were difficulties in ensuring an effective and efficient level of caregiving.

FINANCING

Apart from European funding national funding was available. The national funding was used to purchase medical device and a software platform..

TECHNOLOGIES

Patients were equipped with medical devices (tablets, electronic weight scales, blood pressure monitors, pulse oximeters, activity trackers) in order to transfer their physiological data from their home to the community health centre, allowing the case-manager nurse to monitor them.

COMMUNICATION WITH USERS

A constant monitoring of the activities was performed through regular meetings..

OUTLOOK

The level of integration of services achieved between GPs and nurses will be maintained in the regular provision of services in the pilot area and extended to other Community Health Centers.

Healthcare specialists and social care professionals will be more involved in CHC multidisciplinary telemedicine teams.

GPs and specialist access to the platform and teleconsultation will be encouraged and promoted.

The digital link between Community Health Centers and Hospitals will be strongly developed and new medical devices will be integrated.

Telemonitoring will be a tool to strengthen the integration of service delivery processes across established health and social care boundaries: social workers will be more involved in CHC

The long-term clinical and organizational impact of the telemonitoring service will be assessed.

The involvement of voluntary organizations in the care delivery process will be considered.

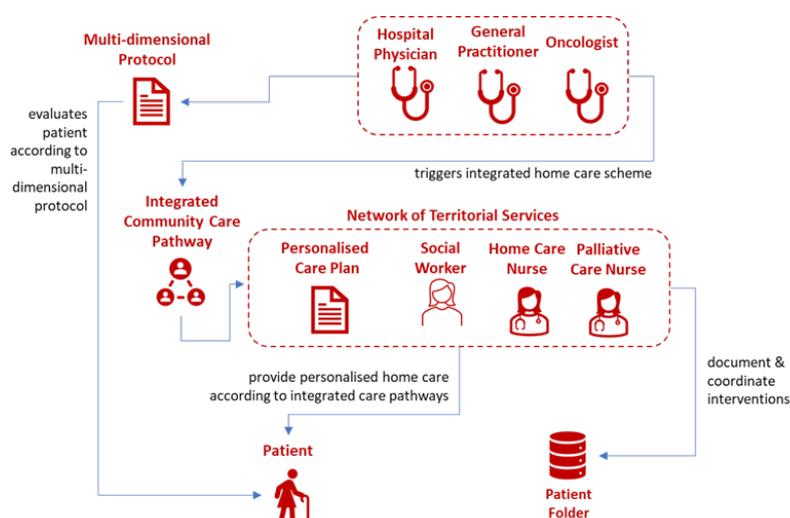


3.14 Veneto (Italy)

SUMMARY

The target population included patients with single and/or multiple chronic non-communicable diseases (including cancer) enrolled in regional social-health home services (integrated home care and palliative home care) through the request of the general practitioner, from the oncology DH service or a post-discharge hospital pathway. Home care services that are typically involved in the clinical-care process of patients during the different phases of their disease trajectory were integrated, in line with the strategic priorities set out in different resolutions of the Veneto Regional Council.

GRAPHICAL SUMMAR OF THE INTEGRATION MODEL



SERVICE DELIVERY

The adoption of the model of integration between the two home services (ADI and Palliative Care) of the territorial network of the health authority Azienda Ulss4 Veneto Orientale has allowed health professionals to experience how fundamental the shared use of clinical and care protocols is, supported by common tools for continuous evaluation. This allowed to provide an assistance more and more centered on the person, the caregiver and the family, ensuring at each stage of the disease the care setting and the most appropriate professional.

GOVERNANCE

The operational procedures built with the participation of the various stakeholders foresee continuous feedback between the professionals of the different services who share the clinical-assistance pathway of the same patient (doctors, nurses, psychologist, etc.). At specific moments in the patient's illness trajectory, a joint assessment by health professionals of the different territorial services at home was foreseen which, by aiming at strengthening the recognition of reciprocal roles and

specific competences, facilitated communication and relations between them over time.

HEALTH AND SOCIAL CARE INTEGRATION

The coordination of all the professional figures working in the territorial services has not been centralised yet, also because they belong to different operational structures. This is currently carried out separately at the level of each single service for its own patients in charge. This reorganisation effort aims to overcome bureaucratic-functional barriers and to identify and plan the operational paths to be implemented across the board for the effective integration between all levels of the various territorial services.

WORKFORCE

The aim of the actions that have been planned in the framework of the reorganisation of the territorial services has been to better interlink social care professionals and health care professionals.

FINANCING

The Italian universal health system is financed by public funds divided among the various Regions which are responsible for managing health policy.

TECHNOLOGIES

The implementation of IT tools has been gradually increased over the years with the maximum possible involvement of all those intended to use it. To support the process of integration between the various professionals working at a territorial level, the design and implementation of a single regional computerized file is planned.

COMMUNICATION WITH USERS

The implementation of new operational protocols and shared clinical-assistance paths has imposed an effective and efficient communication between the different social and health stakeholders. The introduction of the "Operational Process Management" unit at local level also has the task of implementing and managing the incoming and outgoing data flow of the clinical-assistance processes provided by the various territorial teams.

OUTLOOK

The level of integration achieved with the project will be extended to further areas in the territory.

To assess the long-term impact of the level of integration between the various care settings and to maintain a high level of interest among the various stakeholders, periodic meetings have been planned for the discussion of specific clinical-assistance cases deemed to be of particular interest or complexity.

Another aspect will be the introduction of the new figure of the Family and Community Nurse, envisaged by the Veneto Region



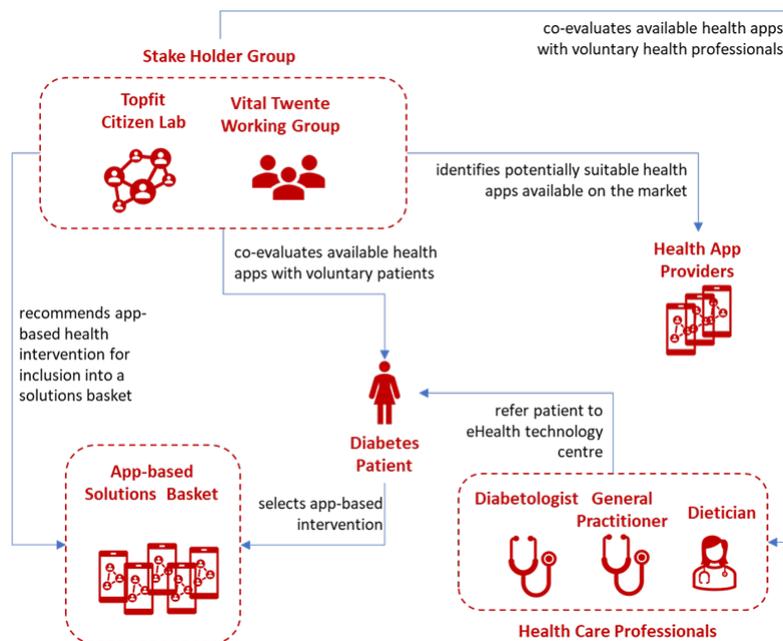
Regional Council Resolution 782/2020 and Decree 71 of 2022. This figure will become the facilitator for an early intake of needs at all levels, not only health but also social needs of the person and his or her family.

3.15 Twente (The Netherlands)

SUMMARY

The VIGOUR pilot aimed to set up a regional stakeholder network for harnessing technology supported lifestyle interventions for supporting people living with Type 2 Diabetes Mellitus. Different existing initiative were brought together including care organisations, insurance companies, educational institutes, and patient representatives. 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 people living with chronic conditions within the structures of the existing health care system.

GRAPHICAL SUMMARY OF THE INTEGRATION MODEL



SERVICE DELIVERY

The pilot used a stepwise innovation approach involving all stakeholders (i.e. patients, GPs, nurses, doctors, insurance companies, lifestyle counsellors, paramedics), to design eHealth-supported (blended) care approaches, that have been selected and tested with patients and professionals.

GOVERNANCE

A so called ‘Stake Holder Group’ is at the centre of the governance structure. It brings together two existing initiatives in the framework of VIGOUR. ‘Vital Twente’ is a regional network organisation



involving many stakeholders in the regional healthcare system, e.g. care organisations, insurance companies, educational institutes and patient representatives. Stakeholders were actively engaged. The “TOPFIT Citizen Lab” is an initiative bringing together care professionals and companies to work with scientists with a view to developing and utilising technological innovations in the health and social care domains.

HEALTH AND SOCIAL CARE INTEGRATION

The pilot aimed to build an enabling environment to co-create technology- supported integrated care initiatives, together with patients and other stakeholders.

WORKFORCE

‘Vital Twente’ stimulated meetings with professionals and managers from different disciplines and organisations. Co-creation took place as all stakeholders were actively invited to think along in the setting up of the Vitality Chronically Ill program. Especially co-creation with patients was stimulated with the involvement of the ‘Topfit Citizenlab’. Unique, new ways of collaborating with patients were introduced in collaboration with the ‘Topfit Citizenlab’.

FINANCING

‘Vital Twente’ is funded by a regional prevention fund, making it possible for stakeholders to be reimbursed for the time they spent on participating in the ‘Vitality Chronically Ill’ working group (incentives to collaborate)..

TECHNOLOGIES

Technologies include stand-alone technologies, while other interventions are blended care approaches in which eHealth technology was combined with (remote) digital or face-to-face (lifestyle) support.

COMMUNICATION WITH USERS

Involved patients were invited to test the eHealth technology focused on lifestyle management of their choice and provide their opinions on how to integrate eHealth and lifestyle management/coaching in their treatment plans

OUTLOOK

The ambition is to further implement an integrated care pathway where preventive, primary and secondary care providers can refer patients to who are open for digital (stand-alone or blended care) approaches for personalized and self-managed care of diabetes. However, regional commitment to this approach is currently pending. The project is to be continued beyond the VIGOUR project duration.



4 Conclusive summary

The concept of "integrated care" has been commonly used as an umbrella term that leaves room for quite different definitions. In a broader sense, the concept refers to the set of methods, processes and models that seek to achieve greater efficiency and value in health systems by effectively addressing fragmentation of patient services and enabling better coordinated and seamless care.⁴ By actively developing the organisational and technological capabilities of existing services, health and social care authorities can enable linking or coordinating services and providers along the continuum of care⁵.

The VIGOUR pilots show that, in addition to healthcare professionals, also informal caregivers and third sector organisations can be successfully integrated into the care cycle. Overall, the different VIGOUR regions have developed care integration approaches that involve a variety of stakeholders, including for instance health and social care authorities, various types of health and social care provider organisations and patients. Given the diversity of pilot implementation approaches summarised in this report, the VIGOUR pilots suggest that the viability of integrated care approaches depends not least on a context-sensitive implementation strategy and a carefully tailored digital support infrastructure.

In general, digital technologies can provide an effective means of making information available to social workers and health care professionals as well as to voluntary carers and patients. Nevertheless, the use of IT systems to enable collaboration between professionals from different organisations can be quite challenging, for example due to legacy systems that are difficult to integrate. Long-term investments by health authorities are often required to remedy this situation. As confirmed the VIGOUR pilots as well, simply adding ICT to existing service processes does not automatically lead to sustainable integrated care services. Typically, a context-sensitive and multidimensional approach to innovation is required that pays equal attention to the ICT applications to be used and the corresponding adaptations of the workflows to be supported in order to achieve the desired results.

The VIGOUR pilots also shed light on the importance of integrating clinical, public health and other services if the needs of patients are to be met to a reasonable extent. Where integration is to be achieved by means of care pathways involving different stakeholders, a clear definition of some sort of 'workflow management role' that activates the different resources when they are needed deserves appropriate attention. Apart from pathway

⁴ Goodwin, Nicholas & Stein, Viktoria & Amelung, Volker. (2017). What Is Integrated Care? DOI: 10.1007/978-3-319-56103-5_1.

⁵ Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27(3):759-769. doi:10.1377/hlthaff.27.3.759



management in terms of workflow related aspects, such a role should also encompass resource planning in cooperation with the individual health and/or social care services that may be involved. In practice, different ways to formalise such a role within a given care eco-system are possible.

The occurrence of the Covid-19 pandemic has affected each VIGOUR pilot sites in different ways. To begin with, the pandemic has absorbed substantial staff capacities and slowed down the upscaling process in every VIGOUR region, ultimately causing health and social care professionals experiencing heavy work overload. At the same time, the COVID-19 pandemic has led some VIGOUR regions to expand their initially anticipated efforts to better integrate existing care processes to include COVID-19 patients or at-risk groups as a new target group. Apart from this, the pandemic has highlighted the need for better coordinating health care delivery more generally. After all, the VIGOUR pilot sites could accomplish their goals despite the accelerating pandemic. In this sense, the activities implemented during the project have been inspired and stimulated by new challenge associated with this unexpected situation. The integrated care concepts piloted under the influence of the pandemic, thus, contribute to more resilient care beyond the VIGOUR project duration.

There is, indeed, a wide willingness and commitment to proceed in the same direction and foster the steps achieved during the pilot implementation processes, extending the reach and capacity of the outcomes in terms of time (planning future activities) and space (adding level/subjects involved). The VIGOUR pilots have proven to facilitate day-to-day work by encouraging stakeholders to take a step towards closer collaboration between different health professions even across sectoral boundaries, and to implement the best practices, experiences and processes adopted on this journey into daily routine.

Thanks to VIGOUR, participating health authorities have made substantial progress on their specific journey towards integrated care, which will be continued in each case. In some cases, future resources have already been planned to extend the service integration steps achieved in the VIGOUR pilots to other areas of health care. Although the approaches to integrated care in the VIGOUR regions may differ in detail, participation in the VIGOUR project was a valuable experience for all pilot regions, not least through mutual learning and a valuable exchange made possible by the project.



Annex



VIGOUR

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

Task 6.1 “Local scaling-up pilots”

REPORTING STRUCTURE



Content

- 1. Introduction..... 3
- 2. Summary of the integrated care practice(s) piloted in VIGOUR..... 6
- 3. Description of implementation approach and activities..... 7
 - 3.1 Service delivery A (incremental vs. disruptive approach) 7
 - 3.2 Service delivery B (flexible vs. formal structures) 8
 - 3.3 Leadership & governance A (collaborative governance) 9
 - 3.4 Leadership & governance B (leadership distribution) 10
 - 3.5 Health and social care system 11
 - 3.6 Workforce A (team culture) 12
 - 3.7 Workforce B (new roles and competencies) 13
 - 3.8 Financing 14
 - 3.9 ICT (technology & medical devices) 15
 - 3.10 Information & research 16



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

SELFIE project dimensions

Task dimensions

Implementation Tasks	Implementation approach		Implementation activities	
			during pilot	after pilot ?
<ul style="list-style-type: none"> • 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		
<ul style="list-style-type: none"> • Resources • Capacity building 	Health and social care system	Alignment work		
	Workforce (A)	Team culture		
<ul style="list-style-type: none"> • Funding streams 	Workforce (B)	New roles and competencies		
	Financing	Funding typology / Innovative payments		
<ul style="list-style-type: none"> • ICT & tools 	ICT (technology & medical devices)	Collaboration support / Communication support		
	<ul style="list-style-type: none"> • 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 publication⁶ produced in the framework of the EU-funded Horizon2020 project “Sustainable Integrated Care Models for Multi-Morbidity Delivery, Financing and

⁶ 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>



Performance – SELFIE⁷. The Project has deepened several European Projects and related deliverables. As well as the framework of the INTEGRATE Project, which provided practical guidance to managers and planners. Moreover, in the context of the SCIROCCO⁸ 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 care⁹.

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:

11. With regards to *service delivery*, successful implementers (a) commonly adopted an incremental growth model rather than a disruptive innovation approach.
12. Also - when it comes to *service delivery* - they found (b) a balance between flexibility and formal structures of integration, as follows.
13. For *leadership & governance*, they (a) applied collaborative governance by engaging all stakeholders.
14. When it comes to *leadership & governance*, they (b) also distributed leadership throughout all levels of the system.
15. For the *workforce*, successful integrated care implemented were able to build a multidisciplinary team culture with mutual recognition of each other's roles.
16. Moreover – with respect to the *workforce* - they (b) stimulated the development of new roles and competencies for integrated care.
17. With respect to *financing*, secured long-term funding and innovative payments were applied as means to overcome fragmented financing of health and social care.
18. Successful implementers emphasised the implementation of ICT that was specifically developed to support collaboration and communication rather than administrative procedures (*technology & medical devices*),

⁷ SELFIE Project website: <https://www.selfie2020.eu/selfie-project/>

⁸ SCIROCCO Project website: <https://www.scirocco-project.eu/>

⁹ Grooten, L., Borgermans, L., & Vrijhoef, H. (2018). An instrument to measure maturity of integrated care: a first validation study. *IJIC*, 18.



19. They also created feedback loops and a continuous monitoring system (*information & research*).
20. As an overarching mechanism, successful implementers engaged in alignment work across the different components and levels of the *health and social care system*.

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.



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
<ul style="list-style-type: none"> Target population Interventions Pathways Readiness to change <p>(NOT TO BE FILLED)</p>	<p>Incremental growth model vs disruptive innovation approach? (Please describe the approach adopted) </p>

Implementation activities



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

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
<ul style="list-style-type: none"> • Target population • Interventions • Pathways • Readiness to change <p>(NOT TO BE FILLED)</p>	<p>Balance between flexibility and formal structures of integration (Please describe the approach adopted)</p>

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



3.3 Leadership & governance A (collaborative governance)

This process of engaging different stakeholders, building trust and solid relationships is known as collaborative governance.¹⁰

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
<ul style="list-style-type: none"> Target population Interventions Pathways Readiness to change <p style="color: red; font-weight: bold;">(NOT TO BE FILLED)</p>	<p>Collaborative governance by engaging stakeholder (Please specify the kind of collaboration established)</p> <p>...</p>

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

¹⁰ 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
<ul style="list-style-type: none"> Target population Interventions Pathways Readiness to change <p>(NOT TO BE FILLED)</p>	<p>Distribution leadership throughout all levels of the system (Please specify the way leadership has been distributed)</p>

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



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 home¹¹ / 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
<ul style="list-style-type: none"> Target population Interventions Pathways Readiness to change <p>(NOT TO BE FILLED)</p>	<p>Work alignment (Please describe the approach adopted)</p> <p>.....</p>

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

¹¹ <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
<ul style="list-style-type: none"> Resources Capacity building <p>(NOT TO BE FILLED)</p>	<p>Team culture (Please describe the approach adopted)</p>

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
<ul style="list-style-type: none"> Resources Capacity building <p>(NOT TO BE FILLED)</p>	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
<ul style="list-style-type: none"> Funding streams <p>(NOT TO BE FILLED)</p>	<p>Funding typology / Innovative payments (Please specify the type of funding/innovative payments if applicable) </p>

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.¹² 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
<ul style="list-style-type: none"> ICT & tools <p>(NOT TO BE FILLED)</p>	<p>Collaboration support / Communication support (Please specify the support provided by ICT tools)</p> <p>.....</p>

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

¹² 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
<ul style="list-style-type: none"> • Risk planning • Execution monitoring & evaluation <p>(NOT TO BE FILLED)</p>	<p>Feedback loops / Continuous monitoring system (Please specify the approach adopted)</p> <p>.....</p>

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



End of Document

