Olomouc Region, Czech Republic: Integrated health and social care services in Pardubice region (AZASS)

Part 1: General Information

Publication on EIP on AHA Portal	Yes
Copyright	No
Verification of the Good Practice	No
Evaluation of the Good Practice	Yes
Type of the Good Practice	Good practice

Part 2: Description of the Good Practice

Name of the Good Practice	Integrated health and social care services in Pardubice region
Short name (Acronym)	AZASS
URL of the Good Practice	www.azass.cz
Geographical scope	Regional level
Country	Cezch republic
Region(s) involved	Pardubice region (Policsko, Novomestsko)
Status of the Good Practice	Completed
Stakeholders involved	• Hospitals • Primary care centres • Home care centres • Specialised physicians • Nurses • General Practitioners • Nursing homes • Informal caregivers • Housing organisations • NGOs • Local public authorities • Other (social services; retirement homes; home help services)
Size of population covered	10,000 - 99,999
Targeted audience	Irrelevant

Scirocco
Scaling Integrated Care in Context

Summary of the Good Practice General and specific objectives of the practice is to provide holistic set of support/care/services (health and social care) tailored to the needs of people with reduced self-sufficiency due to illness, disability or frailty and to support their carers so that they can stay at home or in their community as long as possible. It includes close interdisciplinary cooperation within AZASS facilities and services (post-acute and long-term care hospital, primary care physicians/specialists, social rehabilitation and occupational therapy as well as home care, respite and residential services for elderly and housing) to assure person centred and continuous support to those in need in the region. Main methods, processes and organisation. The services operate through Association of all local/regional municipalities that joined together to create association of 27 municipalities "AZASS" to share decisions, strategy, property and services. The structure was designed to assure stability, subsidiarity, democracy and to face instability of political cycle. AZASS owns the hospital and all the services mentioned previously that have one executive leadership. Each municipality has proportioned vote according to number of citizens, but none can have a majority (so they need to look for common agreement). Executive board (5 mayors) manages and set rules for the director of the services. Supervisory board is formed by professionals (doctor, economist) and 3 mayors. Ad hoc commissions are formed to prepare strategic projects, so that experts and public can participate to create solutions for local problems. The director is negotiator in all those activities, suggest and recommends to mayors, but has to respect their final decision. Key aspects that can be transferable: • Structured rules of cooperation on the development of AZASS shared by municipalities • Intense personal cooperation and communication with stakeholders and municipalities • Whole person approach to planning and provision of care/services including caregivers (carers) and their environment • Close ties to the region and its citizens (inhabitants)
Key words: Inderdisciplinarity, community based care, structured cooperation;
Good practice being part of the larger programme No.
Challenges / problems addressed by the good practice 1. Inaccessibility of health and social care/services/support delivered in continuum and holistic manner in the region (fragmented care, no support for carers and families) 2. Small municipalities unable to solve the overall situation by their own means as their professional and financial capacity is too low. 3. Transformation of acute hospital (that went bankrupt) to post-acute and long-term care

facility (hospital) with cooperating primary care and some specialist physicians complementing the post-acute/long- term care unit.
4. No systematic support for patients to transfer from hospital back home or to their community.
5. Low quality of life of people with long-term care needs, reduced self-sufficiency due to disability/illness and their families due to lack of support/services enabling to stay at home or in the community as long as possible.

Importance of the challenges / problems before starting to implement good practice

Challenges were immense as there were practically no (long-term care and social) services available for local population due to the bankruptcy of private hospital and underdevelopment in other provision of other health, social or home care services. Separate municipalities were too small to be able to provide these services and citizens had to travel either to different regional hospitals or the families of patients/dependent members of the family had to deal with the situation without sufficient support.

Environment before the good practice was implemented

Scorched earth, problems were not dealt with, property that we currently use was meant to be abolished as hospital went bankrupt and no one wanted to take responsibility for its operation, no social services or residential place for frail elderly or people with disabilities, carers etc. People travelled to other regional cities to obtain usually acute or post-acute care.

Key innovative elements of the good practice and how the good practice improved situation compared to previous practice

1. We cover the majority need of social and long-tem care/rehabilitation services by the local population.
2. Accessible network of post-acute, health, long-term care and social services that are interlinked and interdisciplinary reacting to the needs of people and local community (creation of entirely new services).
3. Intense and structured, legally based cooperation of municipalities on the development and sustainability of services provided - Municipalities are forced to communicate and cooperate on the development (increases the amount of cooperation and solidarity among municipalities, more civilised discussion among municipalities that are not otherwise motivated to cooperate/provide services for their inhabitants).
4. Increase in quality of provided services, increased quality of life of those with long-term care needs and their carers.
5. Stable and 2nd largest employer in the Polic□ka region.

Part 3: Transferability of the Good Practice

<table>
<tr><td>Cost-effectiveness of the good practice (including all kind of costs and outcomes such as better health, quality of life or other resources)</td><td>Equal costs, improved outcomes</td></tr>
<tr><td colspan="2">Resources required for the deployment of the good practice (personnel, equipment, facilities, ICT and other resources required.

• Equipment – for healthcare facilities 128 mil CZK, social care 262 mil CZK,
• Facilities –120 beds post-acute care/nursing health care, 119 places in residential retirement home, 15 long-term care beds, 6 beds for respite care, 5 beds for accommodation of carers, family members etc.
• Other capacities – social rehabilitation, rehabilitation, occupational therapy training flat, homecare etc... cooperates intensely with inpatient services
• ICT –healthcare information system (hospital, outpatient specialists, complement – laboratory, screenings, patient transport etc.) Social care information system, administrative/management support system.</td></tr>
<tr><td>Total budget of the Good Practice</td><td>Mora than €5M</td></tr>
<tr><td>Source of funding</td><td>European funding, otherwise operation covered from health insurance funds and social care funding.</td></tr>
<tr><td colspan="2">The main actions that have to be done to deploy the Good Practice

1. Setting up Association of municipalities.
2. Creating strategy and vision of services for region and to communicate it to all stakeholders.
3. Transform the acute care hospital into post-acute and long-term care hospital (some acute wards cancelled, all outpatient specialties remained and complement inpatient care).
4. Professional roles - staff policy - individual approach to different category of employees (motivation through new specialization for some physicians – form internists to geriatrician, diabetes specialist, “psychotherapist”, etc., joining of work at inpatient and outpatient services, clinical days in other hospitals, research involvement). Middle medical staff underwent training for post-acute and long-term care specialisation (pain management, palliative care, respite care etc.). Different types of social services were all newly built/introduced with new/retrained employees.
5. Interdisciplinary working is enhanced by interdisciplinary teams, complementary competencies/roles management, joint working in outpatient and inpatient services, whole persona approach to out patients/clients and our mission. Sharing of information about patients/clients: health documentation has social aspects part, social services documentation has relevant information about health related status, inpatient social services has both parts - social and health status.
6. New services Health services – new post-acute, long term care wards, outpatient specialities, one-day hospitalization in surgical specially Social services – all new: nursing home, long-term care, retirement homes, home care, social rehabilitation, social activation</td></tr>
</table>

and respite care services. 7. Assuring cooperation and solidarity among municipalities All decisions are based on principles of participative democracy, subsidiarity, consensus and voting rules that assure equal position and simple majority decision making (as described previously). Solidarity of municipalities (contributing to services no matter what municipalities users come from) and service responsiveness to local needs is evaluated and addressed. This proportion of contribution is achieved through intense communication, negotiations, and consensus.
Issues during the implementation of the Good Practice 1. To eliminate prejudices and stereotypes (unwillingness to confront with illness and death by general public e.g. when opening up of facilities and gardens to the public, unwillingness to be proactive and to do things that are not within given work duties – "the others/government are responsible approach"). 2. To persuade local/municipal representatives that to provide community based social care/services/support might be part of municipal identity, sign of their quality and is important that they deal with/take interest in it despite not being obliged to do so by law/regulation. 3. Legal and financial constraints in insurance and financing of social services (strictly divided financing of social and health services, crossing these artificially made borders). 4. To eliminate negative effects of policy cycle (pre-electoral and post-electoral pressures and changes). 5. Insurance policy politics with regard to provision of relevant types of care including home health care.
Additional resources required to scale up Good Practice No.
Basis to support sustainability of the Good Practice • To sustain the structured and joint cooperation of municipalities within AZASS. • To sustain awareness of municipalities that it is their project, which serves their inhabitants (and continuous support of culture of solidarity and cooperation among them). • To sustain structure and financing of the currently provided services. • To sustain coherent leadership of the AZASS and its services. • To obtain contract with health insurance fund to provide of relevant types of care including home health services
Evidence to observe the Good Practice www.azass.cz

Part 4: Viability assessment of the Good Practice

Time needed to deploy the Good Practice

More than three years. Before it was implemented - Long term strategy in 1999 (4 features: 1.to transfer of acute care hospital to post-acute and long-term care hospital, development of residential and community-based services that were missing in the region; 2. to assure social services and home care services that were insufficient or missing in the region; 3. Integration of health and social care for the patient and his environment (home, community) and lifetime approach (whole person approach); 4. Lifetime approach to community environment and its development, to continuously influence and cooperate with the community and to remove barriers within it.
Investment per citizens / patient / client in terms of financial resources No available calculation.
Evidence behind the Good Practice Apparent evidence. Evidence is based on qualitative success stories
Maturity of the Good Practice The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Estimated time of impact of the Good Practice Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began.
Impact observed Better health (societal)
Transferability of the Good Practice Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way.

Part 5: Your organisation

Name of the organisation	Svazek obci AZASS
Address of the organisation	Palackeho namesti, 160, 57201 Policka
Type of organisation	Local public authorities
Name of the contact person	Mgr. Ing. Libor Stráník - director
Email address of the contact person	l.stranik@tiscali.cz