MATURITY REQUIREMENTS OF GOOD PRACTICES

B3 ACTION GROUP MEETING
16 MAY 2018
BRUSSELS

@ SCIROCCO_EU

INTRODUCTION TO THE SESSION

ESTEBAN DE MANUEL KEENOY
KRONIKGUNE

Objectives of the session

- Introduce the SCIROCCO project
- Show the SCIROCCO Tool and how can it help on:
    - The transference of Good Practices between regions, by assessing the maturity requirements of good practices
    - Identification of transferable elements of good practice/intervention for scaling-up
- Share two examples of the application of the methodology in two Scirocco partner regions

Session outline

- Introduce the SCIROCCO project and the Tool Methodology for the Assessment of Good Practices
- Assessment of Good Practice in Olomouc Region
- Assessment of Good Practice in the Basque Country
- Demo video on how to use the tool for the assessment of good practices
- Q&A

SELF-ASSESSMENT TOOL FOR INTEGRATED CARE

STUART ANDERSON

EDINBURGH UNIVERSITY,

@ SCIROCCO_EU

SCIROCCO Project

EU Health Programme (CHAFEA)

- **Budget:** €2,204,631.21
- **Start:** 1 April 2016
- **10 Partners:**

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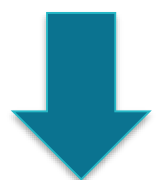
Why SCIROCCO?

Challenges of scaling up:

- Systematic use of different types of evidence to maximise the use of existing knowledge and encourage exchange of good practices
- Understanding the context of scaling-up – features of the intervention need to "fit" into the context appropriately;
- Identification of transferable elements of good practice/intervention for scaling-up;
- Flow of appropriate information between adopting and transferring entities

Lack of tools / frameworks that can help us to understand how to move towards more sustainable health and care systems; how to support implementation, scalability and transferability of integrated care solutions in Europe.



SCIROCCO Tool for Integrated Care

Development of Sirocco Tool

- Based on the **Maturity Model** developed by the Action Group on Integrated Care of EIP on AHA

European Innovation Partnership on Active and Healthy Ageing

- Eases the adoption of Integrated Care by:
  - Defining **Maturity** to adopt Integrated Care
  - Assessing the **Maturity** of Healthcare Systems
  - Assessing **Maturity Requirements** of Good Practices
  - Supporting **Twinning and Coaching** to transfer good practices

From Conceptual Model to an Online Self-Assessment Tool for Integrated Care

CAPACITY BUILDING

READINESS TO CHANGE

INNOVATION MANAGEMENT

STRUCTURE & GOVERNANCE

BREADTH OF AMBITION

INFORMATION & eHEALTH SERVICES

EVALUATION METHODS

FINANCE & FUNDING

CITIZEN EMPOWERMENT

STANDARDISATION & SIMPLIFICATION

POPULATION APPROACH

REMOVAL OF INHIBITORS

EIP on AHA B3 Maturity Model

- Dimensions were developed by clustering issues arising from semi-structured interviews in 12 EU regional health systems.
- Each Dimension has a short narrative and a list of "indicators" of maturity in that dimension.
- This was then extended with scoring scales for each dimension.
- A Delphi process involving 55 experts provided evidence of face validity for the Model:
  - Strong agreement on the relevance of the dimensions, and
  - The coherence of the grading scales for each dimension

The Maturity Model

- Dimensions are heterogeneous
- They identify key areas where there are significant barriers and facilitators towards achieving integrated care.
- They are grounded in direct experience of Health Systems in attempting to implement integrated care
- Dimensions are not independent, there is dependency and synergy between the dimensions

Population Approach: Narrative

Integrated care can be developed to benefit those citizens who are not thriving under existing systems of care, in order to help them manage their health and care needs in a better way, and to avoid emergency calls and hospital admissions and reduce hospital stays. This is a practical response to meeting today's demands. Population health goes beyond this, and uses methods to understand where future health risk (and so, demand) will come from. It offers ways to act ahead of time, to predict and anticipate, so that citizens can maintain their health for longer and be less dependent on care services as they age.

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

Population Approach: Scoring Scale

- **0: Population health approach is not applied to the provision of integrated care services:** This response should be chosen if there is no evidence of the use of population-based approaches in the system.
- **1: A population risk approach is applied to integrated care services but not yet systematically or to the full population:** This is the appropriate response if there is evidence of an understanding of the use of a population approach but its application is patchy.
- **2: Risk stratification is used systematically for certain parts of the population (e.g. high-use categories):** This response is appropriate if there is good evidence of systematic use of population approaches to selected populations but the rationale for which populations are chosen for the approach is not clear or systematic.
- **3: Group risk stratification for those who are at risk of becoming frequent service users:** This response is appropriate if a population approach is not universal but there is a clear rationale for the selection of target populations.
- **4: Population-wide risk stratification started but not fully acted on:** This response is appropriate if there is a full-population approach to risk stratification but the results have yet to be fully integrated into decision taking.
- **5: Whole population stratification deployed and fully implemented:** This is the appropriate response if a full-population approach to risk stratification is implemented and the results are used systematically in the health system.

Population Approach: Discussion

- This dimension focusses on the capacity of the organisation to identify demand and us that to meet demand effectively.
- Places many demands on the other dimensions:
  - This needs good data and so there are implications for the ICT infrastructure.
  - The organisation needs to be ready to change repeatedly to meet changing patterns of health demand
  - Innovation needs to be well managed to enable the adoption of new practice.
  - Citizen empowerment needs to be develop to engage citizens in achieving change in services

Using the SCIROCCO Tool

http://scirocco-project-msa.inf.ed.ac.uk/login/

New Maturity Model Questionnaire

Please reply to all of the questions

Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10 Q11 Q12

2. Structure & Governance * Required

- Fragmented structure and governance in place
- Recognition of the need for structural and gove
- Formation of task forces, alliances and other inf
- Governance established at a regional or nationa
- Roadmap for a change programme defined and
- Full, integrated programme established, with fu

If someone asked you to justify your rating here wh
short sentences):

How confident are you of your rating?

Who do you think could provide a more confident judgement?

Q2. Structure and Governance: Objectives

The broad set of changes needed to deliver integrated care at a regional or national level presents a significant challenge. It needs multi-year programmes with excellent change management, funding and communications, and the power to influence and (sometimes) mandate new working practices. This means alignment of purpose across diverse organisations and professions, and the willingness to collaborate and put the interest of the overall care system above individual incentives. It also means managing the introduction of eHealth services to enable integrated care in a way that makes them easy to use, reliable, secure, and acceptable to care professionals and citizens alike.

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

Ok

CAPACITY BUILDING
READINESS TO CHANGE
STRUCTURE & GOVERNANCE
INFORMATION & eHEALTH SERVICES
STANDARDISATION & SIMPLIFICATION
FINANCE & FUNDING
REMOVAL OF INHIBITORS
POPULATION APPROACH

Questionnaire name: *

ALEC DEMO

Save questionnaire

New Maturity Model Questionnaire

Your questionnaire was successfully saved

Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10 Q11 Q12

1. Readiness to Change (to enable more integrated care) *

- ○ No acknowledgement of compelling need to change
- ○ Compelling need is recognised, but no clear vision or strategic plan
- ○ Dialogue and consensus-building underway; plan being developed
- ○ Vision or plan embedded in policy; leaders and champions emerging
- ● Leadership, vision and plan clear to the general public; pressure for change
- ○ Political consensus; public support; visible stakeholder engagement

If someone asked you to justify your rating here what would you say (please provide a few short sentences):

There are policy documents in place, the minister is prepared to speak on this matter. However the organisations who will implement have not fully adopted the approach and it is patchily represented in their plans

How confident are you of your rating?

Moderately confident

Who do you think could provide a more confident judgement?

XXX who leads on Change Mar

Questionnaire name: *

ALEC DEMO

Update questionnaire

Maturity Requirements

- Good practices depend on **features** in the surrounding context.
- This dependency means good practices have Maturity Requirements – a health system has to have a certain level of maturity in order that is is likely to have a particular feature.
- The tool structures discussion and consensus reaching around dependencies and encourages documenting necessary features in the justification of a Maturity Requirement.

SCIROCCO engagement & sustainability

smartcare

- Australia
- Flanders, Belgium
- Sofia, Bulgaria
- Canada
- Region of Southern Denmark
- Gesundes Kinzigtal, Germany
- Saxony, Germany
- Attica, Greece
- Carinthia, Greece
- Iceland
- India
- Campania, Italy
- Lombardy, Italy
- Kaunas, Lithuania
- Amadora, Portugal
- Asturias, Spain
- Badalona, Spain
- Catalonia, Spain
- Extremadura, Spain
- Murcia, Spain
- Valencia, Spain
- Skane, Sweden
- Northern Ireland, UK
- Scotland, UK
- Wales, UK

Summary

- Based on practice and validated to some extent
- Tool has good support for the management of questionnaires:
  - Flexible ownership and access model that supports different processes
  - Support for repeated assessment to capture change
- Provides support for different perspectives and capture of consensus negotiation and justification
- “Features” help make requirements more concrete.
- Wide range of uses of the tool
- Growing user base
- **SICROCCO Exchange** will support the creation of an open hub for sharing resources

www.scirocco.eu

soa@staffmail.ed.ac.uk

METHODOLOGY FOR THE ASSESSMENT OF GOOD PRACTICES

JON TXARRAMENDIETA
KRONIKGUNE

@ SCIROCCO_EU

Maturity requirements of Good Practices

Definition of Good Practice

CORRECT Criteria*

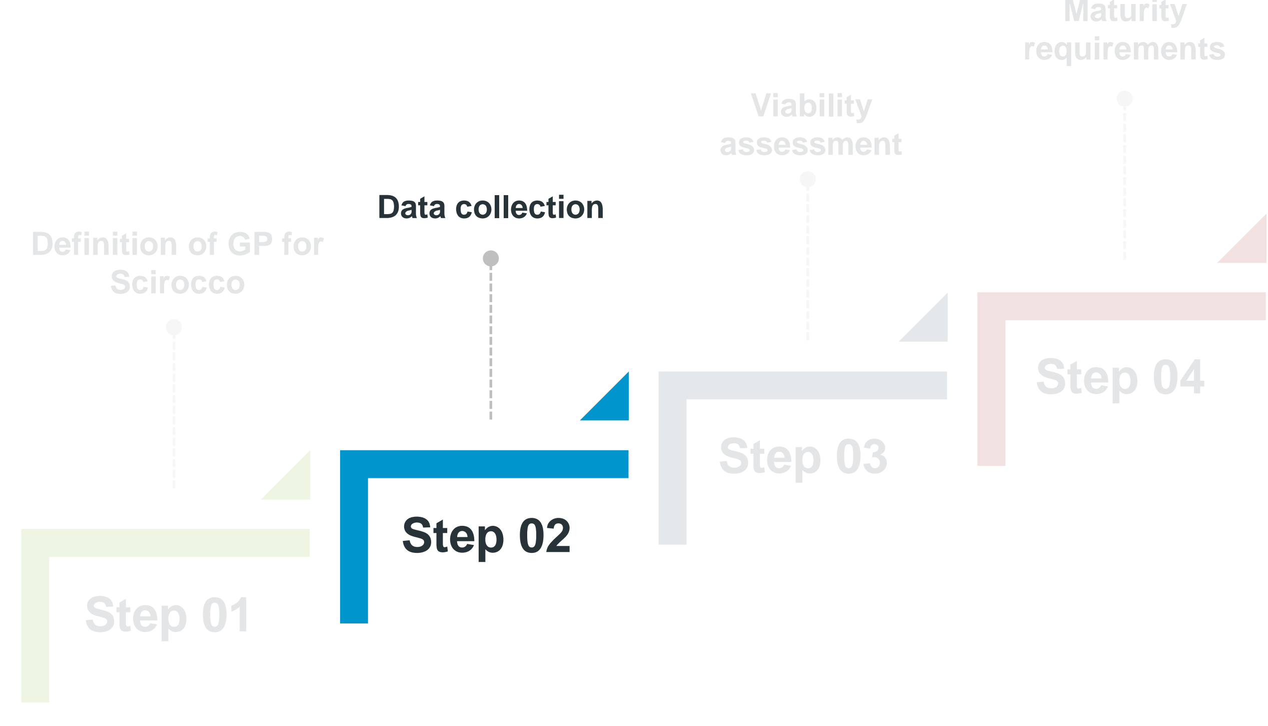
Credible	In that they are based on sound evidence or advocated by respected persons or Institutions.
Observable	To ensure that potential users can see the results in practice.
Relevant	For addressing persistent or sharply felt problems.
Relative advantage	Over existing practices so that potential users are convinced that the costs of implementation are counteracted by the benefits.
Easy to install and understand	Rather than complex and complicated.
Compatible	With the potential users' established values, norms and facilities; fit well into the practices of the national programme.
Testable	Without committing the potential user to complete adoption when results have not yet been seen.

(*) Glaser EM, Abelson HH, Garrison KN. Putting knowledge to use. San Francisco: Jossey-Bass Publishers; 1983. Cited in: World Health Organization and ExpandNet. Nine steps for developing a scaling-up strategy. Geneva: WHO; 2010 [cited 2015 Nov 10]. Available from: www.who.int/reproductivehealth/publications/strategic_approach/9789241500319/en

Definition of Good Practice

Scirocco Good Practices (GPs) are inspiring real-life examples of successfully applied innovations in integrated care

Maturity requirements of Good Practices



Data collection - Template

EIP on AHA

31 Questions
4 Sections

CORRECT
Items*

Scirocco
Scaling Integrated Care in Context
Template

43 Questions
5 Sections

* *Items adapted from "Practical Guidance for Scaling Up Health Service Innovations" by WHO 2009*

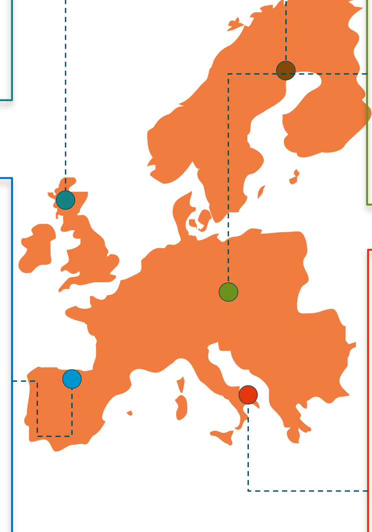
Data collection - GPs

Scotland, UK (6 GGPPs)

- Building Healthier and Happier Communities
- Home & Mobile Health Monitoring
- Collaborative Commissioning of Care at Home Services
- Technology Enabled Care Programme
- Reshaping Care for Older People
- cCBT in Scotland

Basque Country, Spain (7 GGPPs)

- Malnutrition in the elderly and hospital stay
- Transversal approach of the pain from a pain unit
- Advance Care Planning in an Integrated Care Organisation
- Telemonitoring COPD patients with frequent hospitalizations.
- Design and implementation of interventions aimed at improving the safety of prescription.
- Care plan for the elderly
- Integrated care process for children with special needs



Norrbotten, Sweden (6GGPPs)

- My plan
- Care Process schizophrenia and schizophrenia -like state
- Distance spanning healthcare
- The patient journey through emergency medical care
- An effective palliative care process
- Shoulder rehabilitation via distance technology

Olomuc, Czech Republic(4 GGPPs)

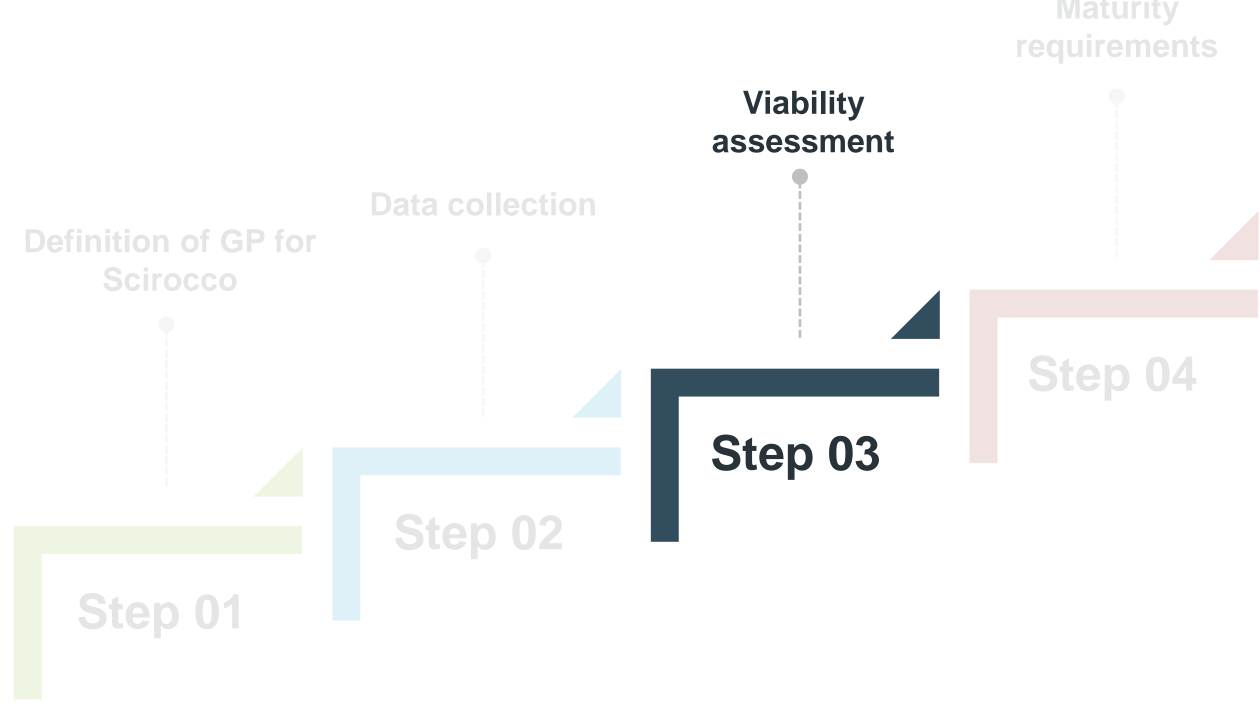
- Integrated health and social care/services in the Pardubice region
- Improved management of visits in Home Care
- Telehealth service for patients with advanced heart failure
- Tele-monitoring of patients with AMI and in anticoagulation regime

Puglia, Italy (8 GGPPs)

- Telemonitoring, t-consultation and t-care for patients with CHF, COPD and Diabetes
- Telemonitoring, t-ssistance and t-consultation for patients with CHF and COPD
- MARIO: Managing active and healthy aging with use of caring service robots
- CKD integrated-care
- DIAMONDS (DIgital Assisted MONitoring for DiabeteS)
- Smartaging mindbrain
- Remote monitoring in heart failure outpatient
- RITA: Radiofrequency-induced thermal ablation of liver tumors

** 2 GGPPs from the B3 Action Group of the EIP-AHA*

Maturity requirements of Good Practices



Viability assessment

1. What is the time needed for the practice to be deployed?
2. What is the investment per citizen / service user / patient?
3. What is the evidence behind your practice?
4. What is the maturity of your practice?
5. What is the estimated time of impact of your practice?
6. What is the level of transferability of your practice?

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Viability assessment - Selection

Score

25
20
15
10
5
0

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Basque Country
Olomuc
Norrbotten
Puglia
Scotland

Maturity requirements of Good Practices

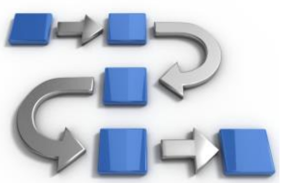
Rationale

- Maturity requirements are what a good practice needs from its environment in order to carry out (“***blossom”***)
- A GP will *require* some **features** in the environment
- A feature is a concrete thing what is it in the environment that is needed by the GP. If we ask the question:
  - Would the GP be possible if this feature were absent from the environment?
  - And we get the answer NO, then the feature is required by the GP
- There is a set of features *required* by the GP for each dimension, as reflected/explained in the justification of the score given in each of them: Justification=features

Assessment team

- Multidisciplinary team composed by members that bring different perspectives
  - A "*practitioners group*" who know in detail about the particular practice (ideally practitioners)
  - A "*managerial group*" who understand how the good practice is supported by the health system (or at least know the characteristics of the health system)

Assessment process



1. **Select a Good Practice viable to be transferred**

2. Identify the two sub-groups
4 people. 2 from the context, 2 from the practice

3. Introductory meeting
Meeting to introduce the project and the Scirocco Tool

4. Individual self-assessment surveys (4)
Using the current online version of the Scirocco Tool

5. Workshop
Consensus scores & features and discussion

ASSESSMENT OF A GOOD PRACTICE IN THE BASQUE COUNTRY

JON TXARRAMENDIETA
KRONIKGUNE

Assessment process

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Basque Country's Health System

- Population: 2,17M
- Financed by taxes: 3.422M€ in 2016
- Universal Healthcare coverage
- Healthcare providers
  - Basque Public Health Service-Osakidetza
    - 13 Integrated Care Organisations (ICO)
      - 14 Acute Hospitals, 313 Primary Care Centers
      - +30.000 Healthcare professionals
    - 2 Sub-acute Hospitals
    - 3 Mental Health Nets
  - Private health centres

ICO Araba

- Population 400.000
- More than 40 primary care centers
- 3 Hospitals
- Pain clinic

Herramientas Página 1-2 de 2 Opciones de vista Cerrar

From: ENRIQUE MANUEL BAREZ HERNANDEZ
ent: **Wednesday, March 26, 2014 9:27 PM**
ROBERTO SANCHEZ SANCHEZ; ANA MARIA PEREZ FERNA
Cc: M.CARMEN ITURRICASTILLO PEREZ; ENRIQUE MANU
AGUIRRE OTEIZA
Subject: Comienzo de trabajo en el HUACE, situación ac

Estimadas compañeras.

Aprovechando que estoy de guardia y tras analizar la de
email.
En primer lugar quiero agradecer el esfuerzo de cambio
en el HUACE, algo totalmente nuevo para todos.

También me gustaría transmitir que tras **citación a huec**
vistas o citadas todas las solicitudes (**teníamos 237 vola**
2014). **Se comenzó por los 47 Preferentes y se continuó**
Ordinario. Espero que con esto lleguen menos solicitud
llegaban a ritmo de uno semanal +ó-).

Por meses, empezamos a ver pacientes **remitidos en Marzo de 2013** y en este mes nos hemos colocado en Septiembre de 2013, quedándonos por atender (repito que ya están citados) unos 95 pacientes de 2013. No hay demora de Preferentes (hay huecos libres cada semana), y han llegado unos 28 pacientes en 2014 de priorida

La citación de CNP desde Primaria va según l
están todos citados.

Están bloqueadas todas las consultas de HUA
hasta conocer la disponibilidad tanto del pers
Dolor. Cuando sepamos si podemos abrir esas
citados en esas tres semanas y adelantar algú

Desde febrero de 2014, tenemos las agendas
Estas dos últimas son iguales y aprovecho par
mejorando la demora, sobretodo de sucesivas
antiguo que os pido que no volváis a utilizar.
las 9h y en esa hora hay que estar en la sesión
consultas en la misma agenda, empezando a l
pendientes de cita sucesiva deben ser enviad
establecido y no otro. Cada día queda un hue
inesperados.

Es prioritario que antes de Semana Santa tengamos citados a TODOS los pacientes

pendientes de cita sucesiva. Por favor Ana, mándaselos a Loli Pereiro para que los vayan citando, como ha hecho hasta ahora con los anteriores.

o que debe estar claro que las agendas
previsto, evitando cambios de ningún
1 siempre. Si tras la distribución de
egunda consulta (y esto solo lo
drá citar sobre la agenda de Santiago 2,

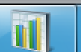
r algo ajeno al servicio de Anestesia, y
nes de trabajo. Debe quedar claro que a
de consulta disponible (una consulta
la Unidad del Dolor estamos de
estros puestos de trabajo. Es decir, que
bren las guardias o URPAS o tardes el
punto.

te también se deben respetar sin
modificar. Si nos vamos de vacaciones o de congreso, o si estamos entrantes o salientes de
ardia, también nos cubrimos entre nosotros. Por lo tanto el quirófano que coincide con el
ngreso de Toledo lo asumiremos los que estamos ese jueves, en lugar de hacer cambios. Así
pierde ese quirófano y no cambiamos agendas. Por lo tanto no es necesario hacer ningún
mbio.

estés libre de carga de
lo dices) para quedar con
o antes, por favor, porque
el HUACE (llega a poner 25 ó
o días puedes mejor.

March 2014. They had a serious problem: more than 230 patients to be attended as first consultations and no time or place to serve them.

So they agreed to change the management model.

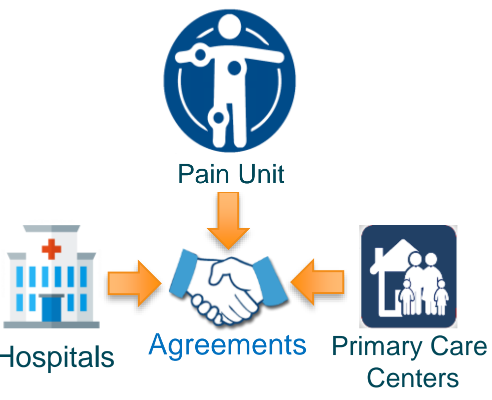


18:50
26/11/2014

Integrated Approach in Pain Management

Improve patients pain management, coordinating the conventional care with various forms of non f2f services

Change Pain Management Model



Integrated care approach

- Joint management Primary Care & Pain Unit
- Stratification
- Non face-to-face care
    - Teleconsultations and real-time sharing of patient information
        - Primary Care, hospitals and the pain unit
    - Electronic health folder
- Personalised Management Plan
- Electronic prescription

Challenge Addressed by the Good Practice

Improve the sat

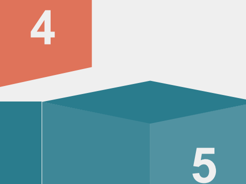
Decrease the d

Avoid unnecess

Enhance trainir

Improve the sat

The delay for first ordinary and regular consultations has gone down from
more than 100 days in 2011 to
11 days in 2014,
17 days in 2015 and
16 days in 2016.
Two days for preferentials.



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Individual self-assessment surveys

Managerial

Personal Health folder's manager

Director of integration of the ICO

Practitioner

Head of the Anaesthesiology Department

Head of the Pain Unit

Assessment process

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Workshop

System team

- Personal Health folder's manager
- Director of integration of the ICO

Practice team

- Head of the Anaesthesiology Department
- Head of the Pain Unit

The key requirements for the implementation & transferability of Pain Clinic

Good Practice in the Basque Country identified by SCIROCCO Tool

- The use of a fully integrated EHR that is accessible to all professionals
- The use of tele-consultations between primary care and the hospital
- The use of a Personal health folder, accessible for the entire population, which allows intercommunication between them and the health professionals

- Have cohesive structures between primary and specialized care and common communication channels and tools.
- It would be desirable to have integrated the social sector.

- The Personal health folder is used as a tool for patient empowerment. Using it, patients can interact with the clinicians. This procedure replaces some face-to-face consultations

Implementation & transferability - Not as relevants

READINESS TO CHANGE

CAPACITY BUILDING

STRUCTURE & GOVERNANCE

INNOVATION MANAGEMENT

INFORMATION & eHEALTH SERVICES

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EVALUATION METHODS

FINANCE & FUNDING

CITIZEN EMPOWERMENT

REMOVAL OF INHIBITORS

POPULATION APPROACH

- Some functional integration between health care levels
- To have working groups, with certain order and leadership

- Have some funding to plan and implement the intervention

- Screening request and appointments prioritisation according to the patient's morbidity risk

THANK YOU!

CZECH NATIONAL E-HEALTH CENTER

MATURITY ASSESSMENT OF GOOD PRACTICES IN THE CZECH REPUBLIC

EIP on AHA AG B3 May 16, 2018

Zdenek Gütter, PhD

GOOD PRACTICES AND ASSESMENTS

- 2 clinically driven good practices (GP) enhancing care of patients managed by (regional) University Hospital Olomouc (AHA Ref. Site, SCIROCCO partner):
  - with advanced heart failure,
  - diabetes and/or on anticoagulation treatments
- One good practice for Improved management of visits in Home Care (Prague)
- 2 subgroups due to different nature of the GPs in Olomouc and Prague and involved stakeholders
- SCIROCCO Methodology for assessing of GPs was applied

EXPERIENCE AND OBSERVATIONS FROM THE ASSESSMENTS

- **Low score in all 12 dimensions - all 3 GPs are initiatives „from the bottom“, conditions for their operation is not yet embedded in national healthcare system (esp. reimbursement).**
- **Relatively smooth execution of all the assessment tasks by healthcare system authorities (ministry, health insurance).**
- **Misunderstanding and hard response from clinicians who are normally not involved in system oriented discussions (integrated care, maturity model). They had problems to answer in most of the 12 dimensions. Integrated care concept is necessary to outline, current description in the model was not sufficiently instructive for them.**
- **Both groups expressed view that national healthcare system (Bismarckian) would need more adjusted score descriptions if a GP is assessed. Features effectively comprise the requirements of the GP, with lower relation to the scores in various dimensions.**
- **More precise granularity in low scores (0,1,2) that would better reflect conditions in which GPs are run.**

EXAMPLE OF THE CONSENSUS DIAGRAM (GP IN PRAGUE)

Consensus: all dimensions with score 1

CZECH NATIONAL EHEALTH CENTER

University Hospital Olomouc

www.ntmc.cz

gutter@ntmc.cz