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Scaling Integrated Care in Context

Action Plan to create conditions for the adoption of integrated care in Norrbotten Region – Transferability of the Good Practice "Advanced Care Planning in an Integrated Care Organisation in the Basque Country"

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the Good Practice "Advanced care planning in an Integrated Care Organisation" (ACP) in the Basque Country to local settings in Norrbotten Region, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in Vitoria-Gasteiz in the Basque Country on 12-13 September 2018. The study visit was an opportunity to learn about the Good Practice and discuss its potential transferability by comparing and contrasting the requirements of the ACP Good Practice with the maturity of local health and social care system for integrated care in Norrbotten Region. As such, the Action Plan can inform the health and social care authorities about the future strategies and policies related to the ACP services in Norrbotten region. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan is co-designed jointly with the transferring and receiving region as follows:

- Section 1: Needs of the adopting region – **Receiving region**
- Section 2: Description of the integrated care solution - **Transferring region**
- Section 3: Maturity requirements of the integrated care solution – **Transferring region**
- Section 4: Benefits and opportunities of integrated care solution – **Receiving region**
- Section 5: Conditions for the adoption of integrated care solution – **Receiving region**
- Section 6: Adaptation of local environment to enable the transferability of learning – **Receiving region**
- Section 7: Priority actions to enable conditions for the transferability of learning - **Receiving region**

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1. Needs of the receiving region – Norrbotten Region

The ambition of the Norrbotten Region is to design a common system for advanced care planning where patients can take an active role and communicate with healthcare professionals as required. As a result, there is a need to educate healthcare professionals about a new way of thinking and delivering care; respecting the central position of the patients and their right to take an informative decision on the issues related to the advanced care. As such, a proper detailed review of the patients' needs and available solutions needs to be conducted and implemented. However, this requires additional flow of information to enable patients and healthcare professionals to follow through the healthcare chain. Current systems need to be changed and redesign in order to offer patients the possibility to receive a safe and coordinated healthcare, across the organisational boundaries and where the patients are seen as an obvious part in planning of care process that concern them. Social care, health care and rehabilitation models need to be changed to accommodate citizens' needs and wishes.

2. Integrated care solution to address the needs of the receiving region

2.1 Transferring region: Advanced Care Planning in the Basque Country

Advance care planning (ACP) is a voluntary process of discussion between an individual and care provider about future care, irrespective of discipline. The aim is to guarantee patients' right to take decisions about their own care as well as to have those decisions respected when time comes.

The goal of this Good Practice is to promote ACP approach to the Basque population, particularly to chronic conditions population. The idea is to adjust end of life care to meet patients' preferences and improve decision making processes.

Three stages were defined when designing the Good Practice:

- Diagnostic stage in order to identify the population that could benefit from the ACP
- Therapeutic stage in order to develop the intervention
- Evaluative stage in order to assess both the impact of the Good Practice and the Good Practice itself.

The core intervention consists of two individual semi structured interviews with the patient and one or two members of patient family and/or friends. The interviews are carried out by the patient's General Practitioner (GP) and the community nurse. The first meeting aims mainly at introducing the subject (Advanced Directives) and inviting the patient to reflect on his/her preferences regarding the care. The second interview then focuses on the discussions of the specific issues related to the patient and his/her clinical characteristics and situation. Participants write down an advance directive according to their values, health conditions and preferences. The GP and/or community nurse assist with this process.

Every healthcare professional can access the Advance Directive using the Basque Country's Integrated Electronical Health Record. As ACP is considered an evolutive process, the patient can change opinion and modify its preferences whenever is needed.

2.2 *Transferring region:* Current progress of Advanced Care Planning in the Basque Country

Challenges/problems that the Good practice is supposed to solve:

The challenges that Advanced care planning (ACP) addresses are:

- Improvement of the quality of end-of-life care, respecting patients' preferences
- Promotion of citizen participation in shared decision-making
- Improvement of care communication between patients and careers
- Increase of health, social workers and caregivers' competences regarding ACP
- Increase of patient's competences to make end-of-life/care-related decisions

The main barriers when implementing the practice were:

- Lack of information about ACP
- Workload of healthcare professionals
- Lack of healthcare professionals' training in ACP, bioethics and communication.

Key innovative elements of the Good Practice

The main innovative elements of the Good Practice are:

- Structured approach to capture and record patient's preferences in the Basque Country's Integrated Electronic Health Record (Osabide Global) which is accessible to all healthcare professionals. The Region is currently working to extend the accessibility of this Record to social sector professionals as well.
- The patients have access to their Advanced care planning through their Personal Health Folder.
- An online tool to register patient's Advanced care planning before uploading the information to the Basque Integrated Health Record and Personal Health Folder.

Costs/investments needed for the deployment of the Good Practice:

The Good Practice is mainly focused on promoting a cultural change in the healthcare context; however, it is anticipated that it will presumably reduce the costs related to patients' non-chosen treatments.

There is no need for large volume of resources considering a quite substantial improvement of patients' quality of life (and end of life) and care improvement. Providing professionals with the opportunity to access training and the support is certainly an important success of the Good Practice, especially from the long-term perspective and sustainability of such a cultural change.

In terms of the human resources needed, the Good Practice requires:

- One Medical Doctor part-time working as programme coordinator, initial interview conductor, trainer and facilitator
- Four training sessions for interested healthcare professionals
- Time spent in patient-healthcare professional interviews.

Impact/outcomes observed:

The Good Practice has not yet been formally evaluated. Nonetheless, taking into considerations the views and perceptions of participants in the ACP (patients, families, GPs and community nurses), it seems that the Practice has proven to be invaluable. As a result, all stakeholders involved share a common view and perspective on the patients' preferences for the end of life care.

The interviews to reflect and discuss patients' values and preferences have now been systematically introduced into some of the Community Care Teams' agendas.

Healthcare professionals working at secondary/tertiary levels (mainly hospitals) are starting to be familiar with the ACP approach and benefiting from the information about patient's preferences captured in the Integrated Electronic Health Record.

For a full description of the Good Practice:
https://www.scirocco-project.eu/basque-country-b3-advance-care-planning-in-an-integrated-organisation/

3. *Maturity Requirements of Advanced Care Planning Good Practice in the Basque Country*

3.1 ***Transferring region***: Maturity requirements for the adoption and transferability of the Advanced Care Planning (ACP) Good Practice is illustrated in the spider diagram and Table below:

Figure 1: Maturity requirements of ACP Good Practice

Dimension	Score	Description	Features of the Good Practice
Readiness to Change	3	Vision or plan embedded in policy; leaders and champions emerging	It is necessary to recognise the need for change; have a defined plan and clear leadership to promote the implementation.
Structure & Governance	2	Formation of task forces, alliances and other informal ways of collaboration	It is necessary to have some degree of functional integration between health care levels; working groups in place with clear leadership.
eHealth Services	3	eHealth services to support integrated care are piloted but there is no yet region wide coverage	It is necessary to have and use a fully integrated Electronic Health Record that is accessible to all professionals and the whole population in order to allow interaction between the citizens/patients and healthcare professions. In addition, the use of tele-consultations between primary care and the hospital is required.
Standardisation & Simplification	3	A recommended set of agreed technical standards at regional/national level; some large-scale consolidations of ICT underway	There is a broad development of corporate platforms (databases, platforms for clinical history) in place. The capability to integrated multiple sorts of data from the Integrated Electronic Health Record is required to allow inter-consultations between primary and specialised care.
Funding	1	Funding is available but mainly for the pilot projects and testing	There needs to be some funding available to plan and implement the intervention.
Removal of inhibitors	2	Awareness of inhibitors but no systematic approach to their management is in place	There needs to be a strategy to anticipate and remove the inhibitors.
Population Approach	1	Population-wide risk stratification considered but not started	It is necessary to prioritise the appointments and request for screening according to the patient's morbidity risk
Citizen Empowerment	3	Citizens are consulted on integrated care services and have access to health information and health data.	The Personal Health folder is used as a tool for patient empowerment as it allows patients' interaction with clinicians thus replacing some face-to-face consultations.
Evaluation Methods	2	Evaluation of integrated care exists, but not as part of a systematic approach	It is necessary to evaluate the reduction of the demand on the service, the number and quality of inter-consultations/
Breadth of Ambition	3	Integration between care levels (e.g. between primary and secondary care) is achieved	There needs to be a cohesive structure between primary and specialised care and common communication channels and tools in

Dimension	Score	Description	Features of the Good Practice
			place. In the ideal scenario, social sector would also be integrated.
Innovation Management	2	Innovations are captured and there are some mechanisms in place to encourage knowledge transfer	It is necessary to have some interest of healthcare professionals in innovation to consider the implementation of the Practice, including the enhancement by the decision-makers.
Capacity Building	3	Learning about integrated care and change management is in place but not widely implemented	The system has to provide means for the development and use of the tools to allow training and coaching.

4. Benefits and opportunities of the adoption of Advanced Care Planning in Norrbotten Region

The adoption of Advance Care Planning (ACP) Good Practice in Norrbotten Region would enhance a new way of working in planning and implementation of health and social care interventions for patients in a need for advanced care planning. It would improve the opportunities for the patients to make their own decisions on care, including end-of-life care. This approach would complement new Strategy of Norrbotten Region: The Road to the Future Health and Care[1] which outlines a paradigm shift for healthcare from citizens' perspective. The approach will change working methods and create new services that shape a new care delivery; a healthcare that meets the needs of each person on equal basis. The new ways of working will also facilitate the provision of new skills required for such a change.

1 The road to the Future Health and Care; https://www.norrbotten.se/Vagen-till-framtidens-halsa-och-vard---2035/

5. Conditions for the adoption of Advanced care Planning in Norrbotten Region

5.1 Maturity of local health and social care system in Norrbotten Region

Receiving region: Maturity of Norbotten Region's health and social care system for the adoption of Advanced Care Planning, highlighting the strengths and weaknesses of the local system.

Figure 2: Maturity of healthcare system in Norrbotten Region

5.2 Conditions enabling the adoption of Advanced care Planning in Norrbotten Region

Receiving region: Maturity of healthcare system in Norrbotten Region and maturity requirements of the Advanced Care Planning Good Practice in the Basque Country:

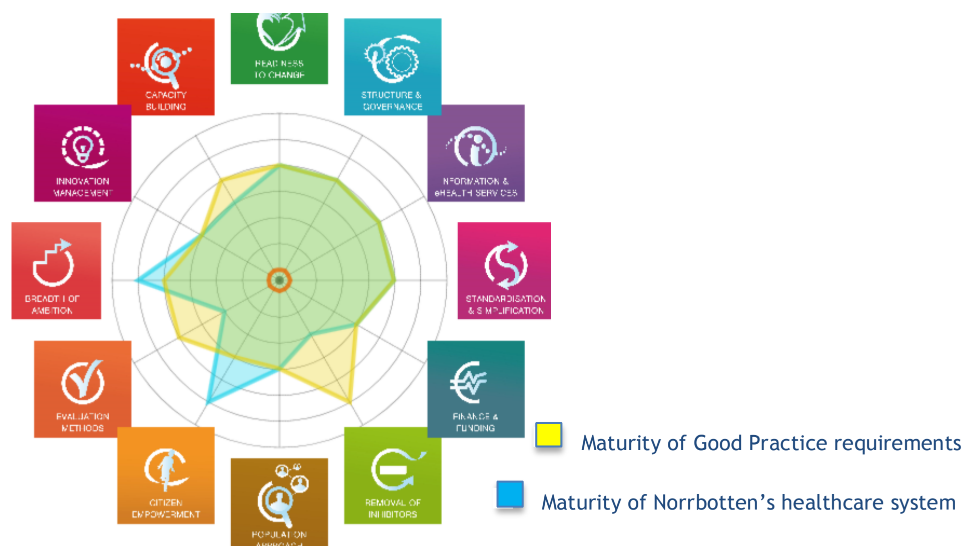

Figure 3: Comparison of maturity requirements of Good Practice with maturity of Norrbotten Region's healthcare system

5.3 *Feasibility of the transferring the learning about Advanced Care Planning Good Practice to local context in Norrbotten Region*

Dimension	Score Basque Country	Feature(s) of the Good Practice	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of the transfer and rationale
Readiness to Change	3	It is necessary to recognise the need for change; have a defined plan and clear leadership to promote the implementation.	3	Many small projects concerning integrated care are running but there is a lack of collaboration and learning between the projects which often result in the different levels of existing knowledge and performance of integrated care in the region. Models for managing change are established. There is a clear recognition of need for change. From a political point of view there is an acknowledgement of the unsustainability of current healthcare system and visions and policies to address the need to change have been adopted to some extent. Also, on an operational level several initiatives have been implemented and are running.	Yes; the transferability is feasible with lot of efforts. It is necessary to have a legal framework for integrated care solutions and ethics committees in place in order to ensure that new methods are in line with Norrbotten's values and professional ethical codes for employees. In addition. the Good Practice to be implemented needs to be included into the policies and have the driving leaders who recognise the need for change.
Structure & Governance	2	It is necessary to have some degree of functional integration between health care levels; working groups in place with clear leadership.	3	A national strategy for eHealth has been developed and implemented; the Region has progressed well concerning eHealth solutions but there is a need for the municipalities to reach the same level of progress to be able to reach the good results of integrated care and overcome organisational boundaries. There is a structure for collaboration between the region and the municipalities. Further development of eHealth is defined in regional programmes such as the Regional Development Strategy, and the Regional Innovation Strategy. However, the Strategies still exist only at a strategic level and implementation is lacking. A clear roadmap and specific mandates are needed to ensure their implementation.	No; the transferability is not feasible. The implementation of these features in the local context of Norrbotten would require a legal protection that promotes the exchange of information between patients and different social and healthcare providers. It would also need professionals who are motivated and have clear leadership in place who have knowledge of the benefits of more involved patients.

Dimension	Score Basque Country	Feature(s) of the Good Practice	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of the transfer and rationale
Information & eHealth Services	3	It is necessary to have and use a fully integrated Electronic Health Record that is accessible to all professionals and the whole population in order to allow interaction between the citizens/patients and healthcare professions. In addition, the use of tele-consultations between primary care and the hospital is required.	3	There are national ICT solutions to increase the patients´ access to their medical records; regional ICT solutions to share patient related information between different care providers - "1177.se" where patients can read their own healthcare data. The Region has also very well progressed with building on existing platforms and infrastructure and creating new services to empower patients and ensure their ability to participate in the decision-making on their care as well as supporting self-care. However, scalability of these solutions remains the issue.	Yes; the transferability is feasible with no need for major adaptation There is an integrated infrastructure in place to allow sharing of clinical information between the different levels of care in Norrbotten. There is also integrated electronic health record in place.
Standardisation & Simplification	3	The capability to integrated multiple sources of data from the Integrated Electronic Health Record is required to allow inter-consultations between primary and specialised care.	3	There is a lack of common standards between the healthcare providers at local and regional level and often even among the providers at the same level.	Yes; the transferability is feasible with lot of efforts. The Advanced Care Plan needs to be adapted in order to have homogeneous technical standards in all organisations involved. The document needs to be accessible by patients and all healthcare professionals involved.
Finance & funding	1	There needs to be some funding available to plan and implement the intervention.	2	External funding is most often limited to pilot projects rather than up-scaling. Internally, within the organisation, the budget is set for a year. The primary focus is on savings rather than spending. However, sometimes there is an opportunity to receive funding for early phases of the projects externally and internally but mostly for testing and piloting of the services.	No; the transferability is not feasible. There is a limited funding available for the implementation of innovative solutions. In addition, to keep the ACP approach sustainable, the system needs to support time release and time dedication of healthcare professionals to conduct the service but also undertake education and training which would be a challenge for the Norrbotten's healthcare system.

Dimension	Score Basque Country	Feature(s) of the Good Practice	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of the transfer and rationale
Removal of Inhibitors	2	There needs to be a strategy to anticipate and remove the inhibitors.	1	There is no specific model or existing project in Norrbotten with a clear mandate to remove inhibitors; there are different models used with different results. The collaboration between the municipalities and the region is in place that facilitates the removal of inhibitors.	No; the transferability is not feasible. There is no strategy or plan in place for the removal of inhibitors. The dedication and continuous training of healthcare professionals seem to be crucial inhibitor in the Norrbotten's local context.
Population Approach	1	It is necessary to prioritise the appointments and request for screening according to the patient's morbidity risk	2	Models to identify patients at risks are applied in Norrbotten and standardised care plans are implemented for some categories of patients. Both the population health unit as well as care divisions in the Region continuously perform certain risk analysis, followed by statistics and particular types of actions.	Yes; the transferability is feasible with no need for major adaptation. The stratification process has been initiated n Norrbotten in order to identify patients at risks.
Citizen Empowerment	3	The Personal Health folder is used as a tool for patient empowerment as it allows patients' interaction with clinicians thus replacing some face-to-face consultations.	4	Citizens do have access to health information and health data through "Health care in numbers and open comparisons', but this solution is not used systematically for decision-making. Not all data is made available yet.	Yes; the transferability is feasible with some efforts. Citizens have access to their health data; the involvement of patients and citizens organisations needs to be better recognised in Norrbotten's local context.
Evaluation Methods	2	It is necessary to evaluate the reduction of the demand on the service, the number and quality of inter-consultations/	1	No common evaluation model is used in Region Norrbotten. There are some evaluations methods applied, but not as a part of a systematic approach.	Yes; the transferability is feasible with lot of efforts. In order to successfully implement ACP Good Practice, there needs to be a system that supports a systematic evaluation.
Breadth of ambitions	3	There needs to be a cohesive structure between primary and specialised care and common communication tools in place. In the ideal scenario, social sector would also be integrated.	4	There is fully integrated health and social care services with collaboration established on all three levels of care, but the services can still be improved.	Yes; the transferability is feasible with no need for major adaptation. There is integration between primary and hospital care levels.

Dimension	Score Basque Country	Feature(s) of the Good Practice	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of the transfer and rationale
Innovation management	2	It is necessary to have some interest of healthcare professionals in innovation, including the enhancement by the decision-makers.	2	There is no very much formalised innovation management process. Procurement is very much removed from the process today.	Yes; the transferability is feasible with some efforts. The implementation of the Good Practice requires recognition of the need for innovation and new way of working. There needs to be some improvement in developing mechanisms to support innovations and transfer knowledge as necessary.
Capacity Building	3	The system has to provide means for the development and use of the tools to allow training and coaching.	2	There is still at the point where we need better support for creating a learning organisation and supporting "change managers" continuously.	Yes; the transferability is feasible with lot of efforts. The need for continuous learning needs to be embedded in the routine practice.

5.4 Priority areas for the transferability of learning

Receiving region: List of the prioritised features to be considered for the transferability of learning about Advanced Care Planning Good Practice is outlined in the table below:

List of the prioritised features of the Advanced Care Planning Good Practice
Readiness to Change • Recognised need for change; • A defined plan for implementation of Good Practice • A clear leadership to promote the implementation of Good Practice eHealth services • Use of a fully integrated Electronic Health Record that is accessible to all professionals and the whole population in order to allow interaction between the citizens/patients and healthcare professions • Use of tele-consultations between primary care and the hospital

6. Adaptation of local environment to enable the transferability of learning

Receiving region: List of suggested changes to enable the creation of conditions for the adoption of learning about Advanced Care (ACP) Planning Good Practice to the local context of Norbotten Region is outlined in the Table below:

Features of the ACP Good Practice	Adaptation of the features to Norrbotten's context
Readiness to Change • Recognised need for change • A defined plan for implementation of Good Practice • A clear leadership to promote the implementation of Good Practice	• Develop Implementation Plan for the adoption of ACP, endorsed by the policy-makers, including the clear assignments of roles and leaderships of all stakeholders involved in the implementation of new ways of working. • Raise awareness about the benefits of the ACP approach to Good Practice leaders and implementers. • Support the need for a change with empowering of healthcare professionals to implement ACP Good Practice through training and education.
eHealth services • Use of a fully integrated Electronic Health Record that is accessible to all professionals and the whole population in order to allow interaction between the citizens/patients and healthcare professions • Use of tele-consultations between primary care and the hospital	• There is a need for a development of new Health and Social Care Plan and the documentation system that allows citizens and healthcare professionals accessing and developing their health care and social plan that provides a greater scope for patients to decide on coordinated efforts involving several partners.

7. Priority actions to enable conditions for the transferability of learning

Receiving region: List of the proposed actions to enable conditions for the transferability of learning about Advanced Care Planning (AC) Good Practice to the local context of the Norrbotten Region, including objectives, anticipated outcomes and policy implications is outlined in the Table below:

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration.
Develop an implementation plan for the ACP	Introduce new way of working that extends the current organisational barriers, including responsible actors, leadership, processes and anticipated duration.	Clear leadership in implementing new ways of working	In order to implement the ACP Good Practice, the following policy actions need to be considered: 1. the Good Practice needs to be embedded in the existing policies and strategies related to integrated care and digital healthcare in order to secure the leadership for its implementation. The new way of working could be well integrated into the operating care model in Norrbotten Region and as a part of new Strategy for Future Health Care. 2. Adaptation of the Advanced Care Plan to comply with the technical standards across the different organisations. New guidelines and standards are required for the entire nation, to facilitate regional decisions on changing methods. 3. Adaptation of the funding system to support the time release of healthcare professionals. Current system is based primarily on the number of visits needs to change to calculate the value for the patient. This is a system shift that takes time in a hierarchical organisation. First, the systems need to be changed and implemented and after that, managers and employees must be educated and the new approach have to be launched and communicated with citizens.
Improve education of healthcare professionals	Join the efforts in providing the same level of education and training to all healthcare professionals involved.	Common vision, skills and support to implement new way of working	
Introduce a new Health and Social Care Plan	Improve citizen empowerment and engagement in the decision-making processes in the planning and implementation of health and social care interventions.	Implementation of person-centred, coordinated health and social care interventions	

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