

# Sustainable tailored integrated care for older people in Europe (SUSTAIN-project)

Lessons learned from improving integrated care in Germany

## Colophon

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The SUSTAIN project is funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144. The content of this report reflects only the SUSTAIN consortium's views. The European Union is not liable for any use that may be made of the information contained herein.

## Key points

- Starting-point of improving care services is the strong willingness of all institutions concerned to move the innovative agenda forward. There is a clearly felt need that “something needs to be done” and all stakeholders realize the many shortcomings in the way health and social care currently organized.
- Changes take time – and one needs (financial) support from the owner of the facility where change is initiated.
- Change needs persuasion: It hinges on the personality and abilities of the leader to convince others to join.
- The supply of services is complex and open communication and involvement of all stakeholders early on is crucial.
- There is a significant element of good luck and timing: the time has to be ripe for change, the setting has to fit for the change planned, the people who to talk to have to be ready to listen.
- Service users need to be directly addressed, the organization of health and social care for each user should be coupled with information about the essentials of healthy living, prevention and self-management.

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# 1. INTRODUCTION

## 1.1 Integrated care in Germany

Integrated care ranks high in German health policy. Nevertheless, the historic separation between ambulatory and hospital care makes any comprehensive approach difficult (Amelung et al., 2012). The high level of autonomy and the self-administration between health insurers and healthcare providers add to the complexity of introducing change (Parow, 2014). Healthcare in Germany is characterized by a very comprehensive benefits catalogue, high quality standards and generally low access barriers (both financially and geographically). At the same time, however, it is one of the most expensive systems in the world, not least due to the separation of the outpatient, inpatient and rehabilitation sectors. The poor information flow between the service providers frequently leads to avoidable discontinuities in care (Busse and Stahl, 2014). In the last decade or so, the German government has introduced a number of reforms based on the core ideas of

- (i) more competition for care concepts/models of care between health insurances,
- (ii) more options for the insured and
- (iii) more leeway/wiggle room for players in the various sectors of healthcare with regard of design and financing of the services.

2017 saw the inauguration of the IQTiG (Institut für Qualität und Transparenz im Gesundheitswesen, Institute for Quality and Transparency in the Healthcare Sector), an institution to support the G-BA (Gemeinsamer Bundesausschuss, Joint Federal Committee, the key institution to specify healthcare benefits and prices) in its quest for overarching quality of care across all sectors (see [www.g-ba.de](http://www.g-ba.de)).

Numerous initiatives have been started to increase satisfaction of service users, improve the efficiency of care delivery, and reduce costs via integrated health and social

care delivery networks for the care of people with chronic diseases, focus on a team-based approach and participation of service users in care. Long-term care (LTC) has so far received far less attention and there is a clear need to start similar initiatives in this field.

## 1.2 The SUSTAIN project

SUSTAIN, which stands for 'Sustainable Tailored Integrated Care for Older People in Europe' ([www.sustain-eu.org](http://www.sustain-eu.org)), is a four-year (2015-2019) cross-European research project initiated to take a step forward in the development of integrated care. SUSTAIN's objectives were twofold: 1. to support and monitor improvements to established integrated care initiatives for older people living at home with multiple health and social care needs, and in so doing move towards more person-centred, prevention-oriented, safe and efficient care; and 2. to contribute to the adoption and application of these improvements to other health and social care systems, and regions in Europe.

The SUSTAIN-project is carried out by thirteen partners from eight European countries: Austria, Belgium, Estonia, Germany, Norway, Spain, the Netherlands, and the United Kingdom. With the exception of Belgium, in all other countries two integrated care initiatives per country were invited to participate in the SUSTAIN-project. The initiatives were already operating within their local health and social care systems. Criteria for including these initiatives, also referred to as 'sites', were defined by SUSTAIN research partners and drawn from the principles of the Chronic Care Model and related models (Epping-Jordan et al., 2004; Minkman, 2012; Wagner et al., 2005). Accordingly, initiatives should:



- Be willing and committed to improve their current practice by working towards more person-centred, prevention-oriented, safe and efficient care, which, in line with the European Commission's stipulations, are SUSTAIN's four key domains.
- Focus on people aged 65 years and older, who live in their own homes and who have multiple health and social care needs.
- Support people to stay in their own homes (or local environments) for as long as possible.
- Address older people's multiple needs, in other words, they should not be single disease oriented.
- Involve professionals from multiple health and social care disciplines working in multidisciplinary teams (e.g. nurses, social workers, pharmacists, dieticians, general practitioners).
- Be established, i.e. preferably operational for at least two years.
- Cover one geographical area or local site.
- Be mandated by one organisation that represents the initiative and that facilitates collaboration with SUSTAIN research partners.

The fourteen initiatives selected according to these criteria showed great diversity in the type of care services provided (Arrue et al., 2016; De Bruin et al., 2018). Their focus ranged from proactive primary care for frail older people and care for older people being discharged from hospital, to nursing care for frail older people, care for people with dementia, and palliative care.

In the SUSTAIN-project, we adopted an implementation science approach using the Evidence Integrated Triangle (Glasgow et al., 2012), in which local stakeholders and research partners co-design and implement improvement plans. In the first phase of the project (starting autumn 2015), SUSTAIN-partners established working relationships with the different sites, and identified relevant local stakeholders related to the initiative (i.e. managers, health and social care professionals, representatives of older people and informal carers, local policy officers). Furthermore, they carried out baseline assessments of each initiative's principal characteristics and also worked with local stakeholders to identify areas of current practice in the initiative, which might be subject to improvement (e.g. collaboration between formal and informal care providers, involvement of older people in care processes). Findings from the baseline assessments were used as inputs for workshops with key stakeholders related to the initiative at each site. The purpose of the workshops was to discuss outcomes of the baseline assessments and enable sites to determine local improvement priorities.

In the second phase of the project (starting spring 2016), local steering groups were set up. Steering groups consisted of stakeholders who participated in the workshops together with additional local stakeholders considered relevant to the initiative. These steering groups were created to design and implement improvement plans, that is, sets of improvements that apply to local, site-specific priorities. Each steering group agreed to implement their plans over the 18-month period

from autumn 2016 to spring 2018. In each initiative, implementation progress and outcomes were monitored by SUSTAIN partners using a multiple embedded case study design, in which each initiative was treated as one case study (Yin, 2013). A hallmark of case study design is the use of several data sources, a strategy which also enhances data credibility (Creswell, 2009). SUSTAIN partners therefore used a set of qualitative and quantitative data collection tools (see Appendix 10.1), allowing us to collect data from different data sources, being: surveys to users, surveys to professionals, interviews with users and carers, professionals and managers, care plans/clinical notes, field notes, notes of steering group meetings, and templates to collect efficiency data from local services, organisations or registries. Data were collected at agreed and specified times during the 18-month implementation period, using the same procedures and tools for all initiatives. In addition to a core set of data collection tools applied in all initiatives, sites were being encouraged to select site-specific tools tailored to their site-specific context and improvement priorities.

Data were analysed per site, guided by the principles of case study design. There were three steps in our analyses: 1. all data sources were analysed separately using uniform templates for analysis which were generated through a discussion among research partners; 2. for each data source, data were reduced to a series of thematic statements (qualitative data) or summaries (quantitative data); 3. an overarching site-specific analysis was done, in which all qualitative and quantitative data were coupled and underwent a process of pattern-matching across the data. This is the approach of choice for evaluating complex community-based interventions which are context bound and noted for their differences in application and implementation (Billings and Leichsenring, 2014; Craig et al., 2008). In order to be able to do a site-specific overarching analysis, we created an analysis framework which was used by all SUSTAIN partners in order to create uniformity of approach. Data were analysed against the propositions and analytical questions presented in Table 1.

### 1.3 SUSTAIN sites in Germany

We identified two sites in Germany where integration of health and social care services has been taken to a new level of innovation: the Pflegewerk Berlin and the KV RegioMed Zentrum in Templin.

The Pflegewerk Berlin combines LTC case management, discharge management, and palliative care under one roof. The purpose of its SUSTAIN improvement project was to enhance inter-professional case management, creating synergies between therapists, nurses and informal carers, while putting healthcare therapists (i.e. physical therapist / speech therapist / occupational therapist / etc.) into the driver's seat (transfer of prescription-competence from doctors to healthcare therapists according to the Social Code Book for Health; § 63 SGB V, 3b) – the so called "therapy pilots". Such inter-professional synergies and



**Table 1 - Propositions and analytical questions against which SUSTAIN data were analysed.**

Proposition 1	Integrated care activities will maintain or enhance person-centredness, prevention orientation, safety, efficiency and co-ordination in care delivery.
Proposition 2	Explanations for succeeding in improving existing integrated care initiatives will be identified.
Analytical question 1	What seems to work, in what kind of situation, and with what outcomes when making improvements to integrated care?
Analytical question 2	What are the explanations for succeeding and improving integrated care initiatives?
Analytical question 3	What are the explanations for not succeeding and improving integrated care initiatives?
Analytical question 4	Are there any factors that are particularly strong in the analysis that could be seen as having an impact on integrated care improvements?
Analytical question 5	What factors can be identified in the analysis that could apply to integrated care improvements across the EU, and be transferable?

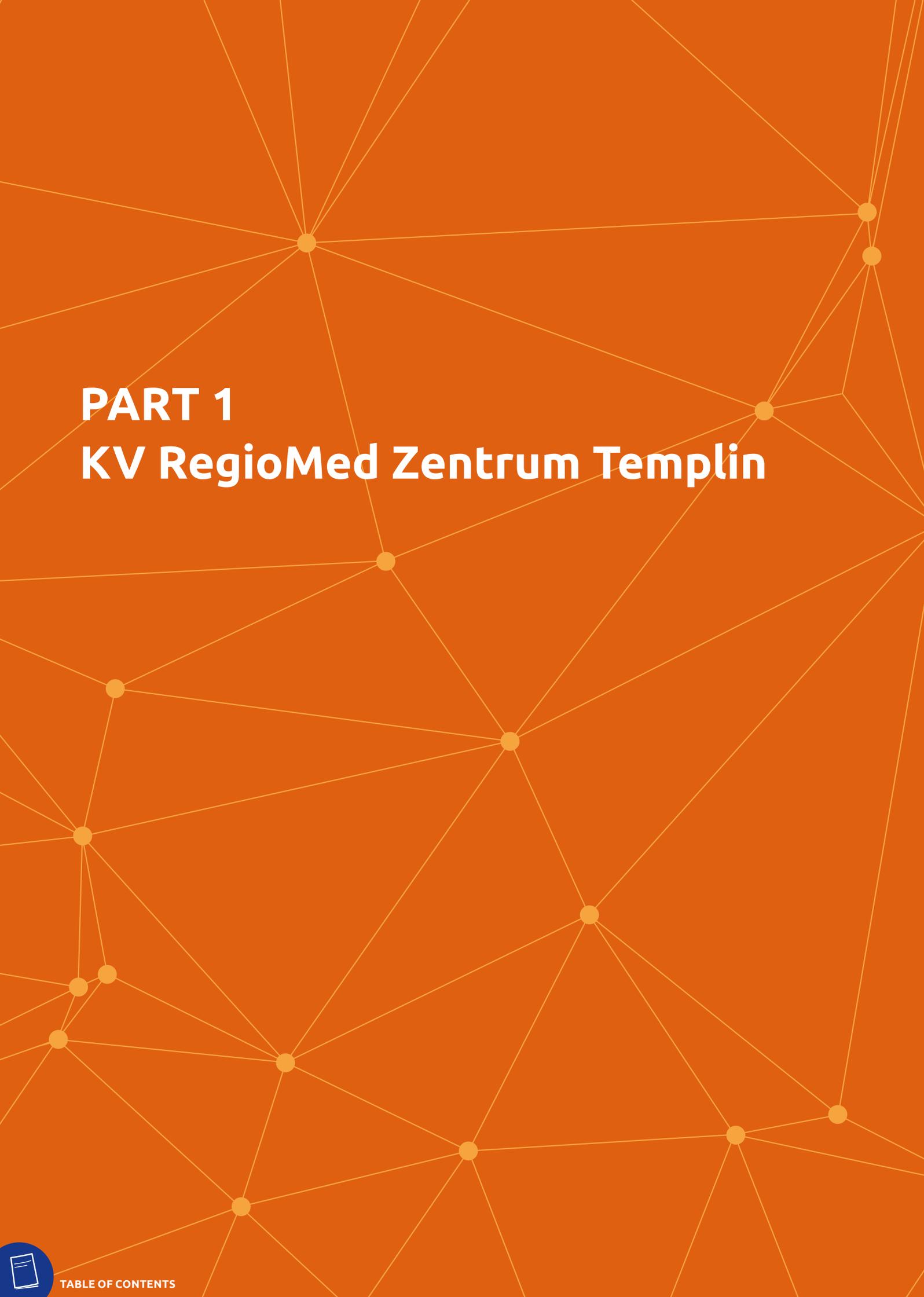
cooperation traditionally were instituted by individual healthcare providers (usually physicians, as they had the informal leverage to initiate such coordination), but have usually not been made part of an institutionalized care management arrangement.

The integrated care programme of the KV RegioMed Zentrum is embedded in various initiatives with different players. It is based on the state-based IGiB (Innovative Gesundheitsversorgung in Brandenburg, innovative healthcare in the state of Brandenburg) and a large-scale project called StimMT (Strukturmigration im Mittelbereich Templin, structural migration in the Templin region). The improvement project provides a Coordination and Consulting centre (“service centre” or in German: “Koordinierungs- und Beratungszentrum”) which will be the central contact point for older persons with care needs in the region. The centre will have further so-called “Agnes 2” nurses (specially trained practice assistants) who will provide case management and coordination-services for the older persons. The centre will also provide consultation on health and social care issues as well as the supervision of discharge-management. These services will not be exclusively for former service users from the KV RegioMed Zentrum in Templin but will also be accessible for people from other medical-services (practitioners etc.).

## 1.4 Reader’s guide

The report is organized as follows: In Part 1 we present the KV RegioMed Zentrum in Templin, first its characteristics and its improvement project (chapter 2), followed by the main results of the improvement initiative (chapter 3) and then a discussion of the main lessons learnt (chapter 4). Part 2 is about the Pflegewerk Berlin which follows a similar structure in its chapter 5 to 7. Part 3 (chapter 8) reflects on the findings from a national perspective.



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# **PART 1**

# **KV RegioMed Zentrum Templin**



## 2. KV REGIOMED ZENTRUM TEMPLIN: CHARACTERISTICS AND IMPROVEMENT PROJECT

### 2.1 General description of the site

The integrated care programme of the KV RegioMed Zentrum is embedded in various initiatives with different players. It is based on the state-based IGiB (Innovative Gesundheitsversorgung in Brandenburg, innovative healthcare in the state of Brandenburg) and a large-scale project called StimMT (Strukturmigration im Mittelbereich Templin, structural migration in mid-level centre of Templin). Partners come from healthcare providers, social health insurers and technical experts / consultants (Sana Kliniken Berlin Brandenburg GmbH, KV Consult- und Managementgesellschaft mbH (KV COMM), AGENON GmbH, inav – Institut für angewandte Versorgungsforschung GmbH, KV Brandenburg, AOK Nordost, BARMER).

The integrated care programme of the KV RegioMed Zentrum in Templin provides a three-week complex therapy programme. During this programme service users are learning about their medication plan, falls prevention, healthy diet and lifestyles and their social needs. They receive a detailed and tailored care plan. During the time with the programme, service users are supported by the “Agnes 2” Case manager (a specially trained practice assistant).

The model project (improvement project) for a health network in the rural area of Templin is unique nationwide. It builds on the collaboration of general practitioners, hospitals and physicians, as well as related fields such as physiotherapy and nursing services with a networking approach that helps citizens find the right care solutions for their problems. The service centre is thus the interface between services and citizens. Highly qualified counsellors determine -via conversation and through home visits- the exact needs of the people seeking help and then provide

specific services to match those needs, including their social needs or more basic support to complete applications for nursing or rehabilitative care.

It is envisaged that the project's experience of making concrete changes in providing care and managing older persons could inform changes in legislation or remuneration regulations. In addition, it is expected that successful implementation tools will be transferred to LTC systems in comparable regions.

### 2.2 Aims and objectives of improvement project

The demographic structure of German society is changing as a result of a falling death rate and the simultaneous decline in the birth rate. Rural areas are particularly affected by this development. According to a forecast from the office for statistics in Berlin Brandenburg, the population in the Templin area will decrease by a fifth by 2030. At the same time, the number of residents over the age of 65 will increase by around 45 percent.

These demographic changes will also have noticeable consequences for the demand and supply of medical care with the rise in chronic diseases and multimorbidity. Demand for medical care from children and adolescents will reduce up until 2030. The changed population structure is one reason why completely new supply structures have to be developed in order to address the needs of the population.



The project IGiB-StimMT aims to adjust the regional care structures and processes in the central area of Templin to meet the needs arising from these changing demographic conditions. A key component is the integrated care programme of the KV RegioMed Zentrum in Templin, in which the inpatient and outpatient care capacities are adapted and interlinked across disciplines and institutions. This happens on several levels, including the private practices, the hospital and the nursing care.

The establishment of an external coordination and counselling centre ("service centre"; part of the IGiB-StimMT project) for individual consultation and support of service users as well as the use of modern information and communication technologies support this integration initiative. The whole IGiB-StimMT project is very complex and its evaluation takes into account this complexity by measurement and assessment at several levels. Changes in the supply processes and structures are being continuously monitored and possible effects, such as lower utilization of the emergency department, are evaluated and the satisfaction of all stakeholders is measured.

The improvement project provides a Coordination and Consulting centre ("service centre" or in German: "Koordinierungs- und Beratungszentrum") which will be the central contact point for older persons in the region. The centre will have further Agnes 2 nurses who will provide case management and coordination-services for the service users. The centre will also provide consultation on medical, health and legal issues as well as the supervision of the discharge-management. These services will not be exclusively for service users from the KV RegioMed Zentrum in Templin but will also be accessible for older people from other medical-services (general practitioners etc.).

The newly created service centre strengthens the multidisciplinary collaboration among therapists, doctors, nurses and experts (legal experts, nutritionists etc.) via regular meetings, collaborative service user care and joint care reviews. A key future goal of the service centre will be the integration of all health and care data in one integrative system under its roof.

With regards to the four focus areas of SUSTAIN, the following key aims and objectives could be identified.

#### Person-Centredness:

- Providing access to person-centred care: Through the service centre, service users will get direct access to integrated-care-services.
- Enhance person-centred care: Through the service centre, service users will get more effective information about integrated-care providers and services.

#### Prevention-orientation:

- Preventing hospitalization by providing and distributing all necessary service elements of integrated care.

#### Efficiency:

- Better alignment of activities of different professionals by improving communication and clarifying roles and responsibilities.

#### Safety:

- Ensuring that older people know who to contact in case of problems or new challenges.
- Ensuring that different professionals are aware of each other's activities and services.

## 2.3 Explanation of the improvement project

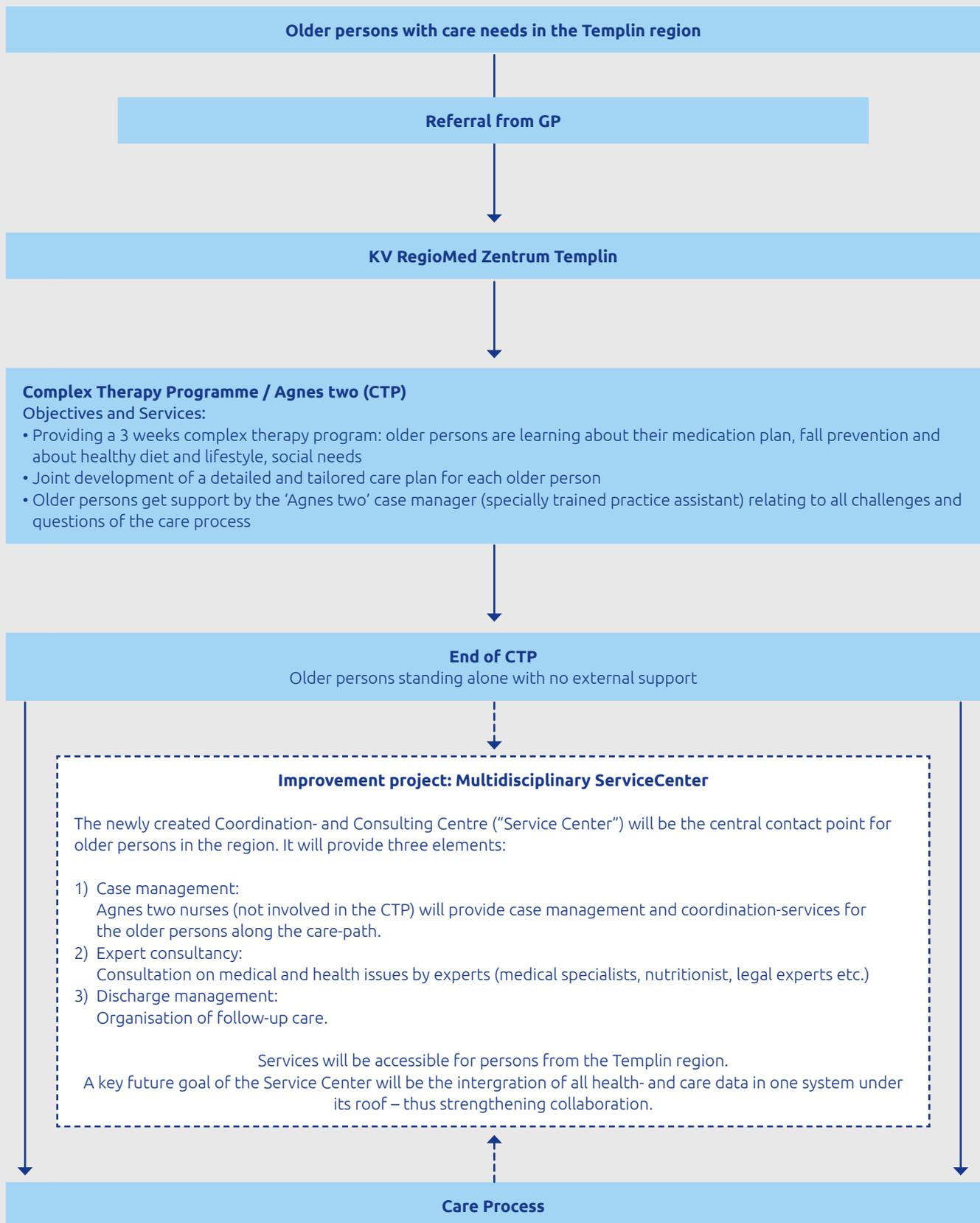


Figure 1 - Flowchart improvement project – KV RegioMed Zentrum Templin.

Existing processes      New processes through improvement project



Before implementing the improvement project, older persons in the region of Templin do not have any central guidance or contact point to go to in case they do have questions or uncertainties regarding care processes, their rights in the care system or questions in legal cases. Especially older persons which did perform the complex therapy programme of the KV RegioMed Zentrum in Templin, often do not have any help after ending this programme. Therefore the improvement project “service centre” was implemented to build a central contact point for older people with care needs in the Templin region (Figure 1).

The newly created service centre strengthens the multidisciplinary collaboration among therapists, doctors, nurses and experts (legal experts, nutritionists etc.) via regular meetings, collaborative service user care and joint care reviews. A key future goal of the service centre will be the integration of all health and care data in one integrative system under its roof. This will further formalize the multidisciplinary collaboration among all care-partners in the region, including long-term care. Such a formalized structure will also help to integrate (at least to some extent) other social care services (such as home-based care, podiatry, or training classes for seniors). Full integration will remain difficult, as those services are organized and financed differently, and overcoming these and other institutional barriers will require substantial initiative from staff.

Furthermore, a care network including a patient bus has been set up on the site extending its services to a patient bus, the social and counselling competencies of the municipality and the administration of the social health insurance funds. The overarching goal is a coordinated supply of medical, nursing services and other services, through which:

- Service users will get direct access to integrated-care-services.
- Service users will get more and effective information about integrated-care providers and services.
- Older people will be better informed about whom to contact in case of problems or new challenges.
- Hospitalization will be prevented by providing and distributing all necessary service elements of integrated care from a single site.
- Activities of different professionals will be aligned by improving communication and clarifying roles and responsibilities.
- Different professionals will be made aware of each other’s activities and services.





## 3. FINDINGS OF THE IMPROVEMENT INITIATIVE IN TEMPLIN

### 3.1 Introduction

Researchers worked with the project team from October 2015 on. They identified possible stakeholders, form a steering group, specify the improvement project and plan its implementation. Evaluation data was collected during two phases: July to October 2017 and December 2017 to March 2018. A summary of data is shown in Tables 2-5. The remainder of this section is based on an analysis of that data.

**Table 2 - Summary of data collected for KV RegioMed Zentrum Templin.**

Surveys	Participants
P3CEQ (person centred coordinated care experiences questionnaire)	31
PCHC (perceived control of health care)	31
TCI (Team Climate Inventory)	13
User Demographics	31
Carer Demographics	6
Manager Demographics	1
Professional Demographics	12
Interviews	
User interviews	8
Carer interviews	6
Professional interview	1
Manager interview	1
Steering group/reflective notes	
Meetings	4

**Table 3 - Summary of demographic data of users KV RegioMed Zentrum Templin.**

Characteristic	N=31
<b>Sex</b>	
Male	8 (25.8%)
Female	23 (74.2%)
<b>Age group</b>	
65-74	6 (19.4%)
75-84	18 (58.1%)
85+	7 (22.6%)
<b>Educational level</b>	
Low	27 (87.1%)
Middle	3 (9.7%)
High	1 (3.2%)
<b>Living situation</b>	
Living at home alone	20 (64.5%)
Living at home with spouse/partner	8 (25.8%)
Living at home with at least one family member	2 (6.5%)
Other	1 (3.2%)
<b>Number of medical conditions</b>	5.1 (SD 1.8)

**Table 4 - Summary of demographic data of carers KV RegioMed Zentrum Templin.**

Characteristic	N=6
<b>Sex</b>	
Male	0 (0%)
Female	6 (100%)
<b>Age group</b>	
25-34	1 (16.7%)
45-54	1 (16.7%)
55-64	1 (16.7%)
65-74	1 (16.7%)
75-84	2 (33.3%)
<b>Educational level</b>	
Low	4 (66.7%)
Middle	2 (33.3%)
<b>Relationship to user</b>	
Spouse/partner	2 (33.3%)
Daughter	1 (16.7%)
Other family member/relative	1 (16.7%)
Hired carer (paid for by the state/insurance)	1 (16.7%)
Other	1 (16.7%)
<b>Living situation</b>	
With user	3 (50%)
Close by the user	2 (33.3%)
Further away from the user	1 (16.7%)



**Table 5 - Summary of demographic data of professionals KV RegioMed Zentrum Templin.**

Characteristic	N=12
<b>Sex</b>	
Male	5 (41.7%)
Female	7 (58.3%)
<b>Age group</b>	
25-34	1 (8.3%)
35-44	5 (41.7%)
45-54	2 (16.7%)
55-64	4 (33.3%)
<b>Educational level</b>	
Low	4 (33.3%)
Middle	0
High	8 (66.7%)
<b>Staff group</b>	
Administrative & clerical	12 (100%)
<b>Area of work/care setting</b>	
Health care organisation (acute hospital)	1 (8.3%)
Health and social care—integrated organisation	1 (8.3%)
Social care/local government	6 (50.0%)
Other	4 (33.3%)

Beside these above mentioned groups, one manager was interviewed. For all data collections ethical approval was received.

## 3.2 What seems to work?

### Coordination in care delivery

Close cooperation of general practitioner and medical specialists help to optimize individual therapy, where necessary, the integration of specialists outside the region via telemedicine was sought.

Effective communication and care coordination between professionals is guided by a key person, who can be contacted directly helps enable person-centred care. This is ideally linked to external stakeholders like doctors taking part in the improvement initiative and therefore promoting its success.

Both managers and professionals indicated in the interviews that they thought that communication and collaboration between doctors, therapists and nurses were improved by the improvement project. By providing a service centre where all competencies are bundled, the coordination in care delivery is rising. Older persons, who are visiting the service centre, are getting the “whole picture” and all information needed to take next or further steps concerning the care delivery they or their relatives need.

*P: “Exactly, then there are already many discussions here. So the actors are also interested in who is the KBZ, what does the KBZ. Since there have been many discussions, just to look, what are their tasks, what are our tasks, how can you possibly work together and there are now already cooperation virtually created.” (Professional 6)*

Regarding to Coordination, the TCI was conducted at two times. Overall it can be said that the individual as well as the mean scores are a little bit lower in the second Phase (TCI total score Phase 1:4.6 (SD 0.2); Phase 2 4.3 (SD 0.2). That can be a hint that the some problems in the project implementation raised between the two different phases – like the lack of incorporation of local external stakeholders and the public.

### Person-centredness

Person-orientation is raised by the improvement project in that the service-centre is offering an easy and direct access service for the service users and is based on a care plan which is developed with and available to the user, that all professionals contribute to, which have clear goals and is accurate. Also through the service centre, older persons will get more effective information about integrated-care providers and services.

All the different elements of the improvement project are geared towards being able to access services easily when needed and making the patient feel comfortable and welcomed.



By offering an easy access service for older persons to different parts and sections of care, the Person-centredness is raised by the improvement project in Templin. This includes the coordination of individual therapy, including more prevention and health promotion and offering special consultation hours for common complex conditions such as heart disease or diabetes. Such clinical care is complemented by closely coordinated preventive and after-care following a patient's hospital stay and support from specialists to maintain at-home independence as long as possible.

*"So of course that's the ultimate goal, the focus is the patient/client and not what others want, what a particular service provider wants. Focus is the well-being of clients or their loved ones. That is the clear goal and we realize that this is well appreciated, because it is an individual care, also a neutral service (...) in the way we advise." (Manager 1)*

Users are feeling to be in the middle of attention regarding the care process. They feel that the care process is designed regarding their needs and wishes. That is also reflected by a high P3CEQ-score of 23.7 (SD 3.5) as well as a high PCHC-score of 4.5 (SD 0.3).

The high score of the individual items regarding the joint-up care and the central contact person is a good sign for the KV RegioMed Zentrum that integrated care-processes are working and deploying positive effects. Also the high mean score of items 1 and 2 indicates good processes regarding to what extent users feel that they and their needs are in the middle of attention. Valuable information at the right time is deployed and helped the older persons to work on their own health and well-being. The high score of involvement of family members (if wished by the older people) is also a good sign for the KV RegioMed Zentrum in Templin.

In general the high P3CEQ and PCHC score can partly be explained by the past socialization of the users. Growing up in the former GDR, individualized solutions and offers as well as their needs being in the focus were not part of their day-to-day live and reality. Getting individualized care and processes in the KV RegioMed Zentrum in Templin therefore is a relative new experience for them they did not use to have in their past. The excitement and pleasure of the users about the fact that their personal needs (for the first time) are in focus can therefore be an explanation for the high scores.

At the beginning there were no real reflections on the actual needs and demands of the future clients. The negative effects of this failure are a general low request of the services of the service centre. The staff is trying to catch up on this matter. A precise evaluation and reflection on the actual demands and needs of the target group is essential for the success of the improvement project.

## Prevention-orientation

Preventing hospitalization by providing and distributing all necessary service elements of integrated care – the newly created service centre seems to be an applicable way to reach that goal.

The interviews with the users and carers reflected that they know who to contact when they have health-related questions or problems. They also felt that the care and support they currently received would help them to remain in their homes for as long as possible. Nevertheless, when asked how exactly the care and support provided to them was helping with this, most users were not able to explain it.

*I: "Do you think that after these three weeks you are better able to live independently at home?"*

*U: "Yes. The hands are better now. I can also drain potatoes again." (User 5)*

## Efficiency

Raising the efficiency of care delivery is one of the key-issues of the improvement project. Bringing together all necessary competencies under the one roof of the service centre is clearly raising the efficiency. Therefore a better alignment of activities of different professionals, a better communication and clarified roles and responsibilities could be reached.

Also by working together in the KV RegioMed Zentrum in Templin, the efficiency of the care delivery is likely to be reached. Unfortunately no such efficiency-data is being collected by the KV RegioMed Zentrum in Templin.

## Safety

Safety in the care delivery and care service is being raised by the improvement project. By bundling and aligning information out of one hand, the probability is much higher that the older person is getting the right information at the right time, than it would be without the service centre. As the service centre is just relatively new, it is too early to make statements on the impacts of it concerning safety in care delivery.

The overall Safety-orientation has a big influence of the day-to-day work of the KV RegioMed Zentrum and the newly created service centre. This is why maintaining independence of users through a manifold and person-centred variety of therapy (for instance Ergotherapy, Physiotherapy, Massages, Fango, manual lymphatic drainage, and breathing therapy) is a key-focus of the work of KV RegioMed Zentrum. Therefore the PCHC subscale score "Perceived personal control in health care" is quite high with 4.5 (SD 0.4).



### 3.3 What are explanations for succeeding and improving integrated care initiatives?

Essentially, there are several factors that foster continuous improvement and were the basis for success:

(i) Clear vision and good team climate

A clear vision from the beginning and achievable – not illusory – project goals are facilitators for improving integrated care and also need to be coupled with strong political support. Also a good team-climate does make it easier for succeeding and improving integrated care initiatives. The TCI total score just differs a little bit between the two different data collection phases from 4.6 (SD 0.2) in the first phase and 4.3 (SD 0.2) in the second phase.

(ii) Strong supportive environment

The strong commitment of all institutions concerned to move the innovative agenda forward. This stems not least from a clearly felt belief that “something needs to be done” as all stakeholders had realized the many shortcomings in the way medical and long-term care had been organized so far.

The environment is to a large extent determined by the fact that the service centre is part of the project StimMT which is funded and supported by the federal government. This strong political support from national government is also helping the improvement project to overcome potential barriers and become established locally.

(iii) Coordination of service supply

There is a well-coordinated supply of services in which general practitioners and specialist physicians, hospitals, pharmacies and therapists work hand in hand for the individual patient. Service users are directly addressed by experts to not waste time with unnecessary visits to the doctor, unnecessary hospitalization, long journeys to a specialist and burdensome bureaucracy. The project (and in particular the KV RegioMed Zentrum as well as the service centre) organize medical care for each service user and at the same time inform and train him / her about the essentials of healthy living, prevention and self-management.

(iv) Clear management structures and responsibilities

A clear management structure with clearly defined responsibilities helps the improvement process. The goals of the improvement process have to be clear and have to be accepted in the project-team so that the improvements to integrated care are working.

*P: “Which also makes it absolutely easier to implement this subproject than maybe others, that, as I said, is considered to be consistently positive by all, so that it is recognized as added value by all actors here as well, by the patients, by the doctors, by others Actors throughout positively occupied and so we have it relatively easy to implement here. So here we are not running against walls or against windmills.” (Professional 6)*

At a practical level, clear, understandable and applicable management structures are supporting relevant outcomes from improvement programme. With such structures quick and effective decision making has become possible and acceptable within the project-team.

Such management structures are supported at an operational level by a good (if not excellent) team-climate (TCI scores of 4.6 (SD 0.2) in the first phase and 4.3 (SD 0.2)) and a general agreement on the goals of the improvement programme are necessary conditions for successfully improving integrated care initiatives. Furthermore, the wide spectrum of competences and knowledge in the project team beyond those required to deliver the original range of activities has proved to be very helpful in implementing such an improvement project.

(v) Thinking the project in a broader context

Thinking the (future) improvement process in a broader context is one of the key factors for a successful implementation. This will result in more possible points of references in the future and therefore a broader implementation of processes. This includes the local community which is a major factor for successfully implementing improvements to integrated care.

*I: “How long did it take for the doctors to accept the KV RegioMed Zentrum?”*

*P: “Well that’s a bit older, the RMZ. Since 2013 we have a trial run, in 2014 it was officially opened. It has already, I think, lasted about a year, until then all the doctors in the region have registered and have accepted the RMZ.” (Professional 6)*

(vi) Early public relations work

Closely related to the last point is an emphasis on early public relations work, communication with local stakeholders and a good location are crucial factors when making improvements to integrated care.

*P: “Yes. So the very first thing was that we needed a space. We also found that relatively quickly, concluded the lease and then it was also about furnishing and technology. A vehicle for the Agnes II was purchased. Everything actually went according to plan. What did we have to do now...? The announcement in public is delayed a bit. But since the beginning of the year, we have been actively involved in spreading this to the public. But otherwise we are well on schedule with the KBZ.” (Professional 6)*

In addition, the inclusion of the local community is a major key-factor for successfully implementing the services of the service centre in the sense that the community needs to be informed about the services, needs to be reminded that individual help is available and also to relate the services to their medical care provider.

(vii) Taking the regional specifics into account

In general the success of the integrated care initiative can be explained by the past socialization of the users. Growing up in the former GDR, individualized solutions and offers as well as their needs being in the focus were not part of their day-to-day live and reality. Getting individualized



care and processes in the KV RegioMed Zentrum in Templin therefore is a relative new experience for them they did not use to have in their past. The excitement and pleasure of the users about the fact that their personal needs (for the first time) are in focus therefore is a simplification and an explanation for succeeding and improving integrated care initiatives. This overall excitement can be seen at the quite high P3CEQ Total score of 23.7 (SD 3.5) and PCHC score of 4.5 (SD 0.3).

### 3.4 What are explanations for not succeeding and improving integrated care initiatives?

Challenges remain, of course. Many service users so far do not get any coordinated support after leaving this 3 week programme of the KV RegioMed Zentrum.

#### (i) Incomprehensible and unclear responsibilities

The financing of individual care from different sources still leads to significant bureaucracy in determining who is responsible for specific preventative measure, e.g. making a home accessible for people sitting in a wheel-chair could be financed by social health insurance, by social long-term care insurance or social pension scheme.

#### (ii) Upstaging from other projects

The StimMT project (a EUR14.5m initiative financed by the Innovation Fund of the Social Health Insurances) has been dwarfing all other activities. The previously distinct and highly visible RegioMed Zentrum complex therapy programme has now become a rather small component of the much broader StimMT. Nevertheless, both the complex therapy programme and the SUSTAIN component may benefit substantially from the broader context and improved funding situation. Since January 2017, a major shift at the management level has absorbed Kassenärztliche Vereinigung Brandenburg (KVBB = Regional Association of Statutory Health Insurance Physicians Brandenburg) capacities to adjust to the new context. The requirements from the larger project have led to significant time constraints and also to some fluctuation of staff and it have been found difficult to recruit the right staff in a timely manner (Steering Group Meeting July 2017).

#### (iii) Lack of awareness

Despite all information and public relation efforts, there is a lack of awareness about the KV RegioMed Zentrum and the service centre both at patient and carer level. Moreover, most carers are not involved in making decisions about the care that users are getting in the service of KV RegioMed Zentrum Templin.

*P: "Yes. So the very first thing was that we needed a space. We also found that relatively quickly, concluded the lease and then it was also about furnishing and technology. A vehicle for the Agnes II was purchased. Everything actually went according to plan. What did we have to do now...? The announcement in public is delayed a bit. But since the beginning of the year, we have been actively involved in spreading this to the public. But otherwise we are well on schedule with the KBZ." (Professional 6)*

*"So far maybe it was like that, but we are in the middle of it right now and for the first time we have been in the newspaper as KBZ. So we start now with advertisements and press articles etc. Also explicitly for the KBZ and its services. I think that will change in the near future." (Carer 6)*

#### (iv) Not incorporating external stakeholders

Stakeholders affected of the improvement process are not incorporated early and reasonable in it. This can result in resistance and opposition the improvement process.

*I: "Are there any factors that have hindered project implementation so far?"*

*M: "Yes, definitely, on the one hand, that some people are skeptical about the project as a whole, for example the medical profession, which was initially afraid that they would be patronized (...)." (Manager 1)*



## 4. MAIN LESSONS LEARNED FROM THE KV REGIONED ZENTRUM TEMPLIN

### 4.1 Working towards integrated care improvements that could have impact

The IGiB-StimMT project now receives funding from the Innovation Fund of the Social Health Insurers managed by the Joint Federal Committee (Gemeinsamer Bundesausschuss). In addition, it indirectly benefits from a regional collaboration where activities are funded by the Berlin-Brandenburg health region, and from a municipality that takes on health promotion activities (wellness region Uckermark). The project has high political visibility and support at all levels of management and service delivery.

Stakeholders affected by the improvements to providing integrated care must be engaged early in the improvement process and with respect for their perspectives and interests. Otherwise, they will feel threatened if not pushed aside. Understanding and minimising the possible, even if unintended side-effects of the improvement project for different partners, are important factors in smoothing the pathway towards improved integrated care.

Having a notable figure (champion for change) supporting the improvements to integrated care is similarly important.

### 4.2 Working towards integrated care improvements that could be transferable across the EU

A clear vision from the beginning, lots of support by the local, state and federal government and achievable – not illusory

– project goals were the three most important facilitators for improving the integrated care initiative. Lack of support from local external stakeholders (doctors, care-services), problems in reaching potential clients and high bureaucratic obstacles are the most important barriers for improving the integrated care initiative.

Stakeholders affected by the programme to improve integrated care must be included early in the improvement process or they may feel threatened and pushed aside.

Project-teams had to learn during the improvement process that raising awareness of the improvement goals also has to be initiated at an early stage of the project. In addition, the general public as well as the project's target-group have to be informed and convinced about the improvements – so "Doing good things and talking about it" is an important factor.

Important institutions or people supporting the improvements ("champions for change") are a factor which is crucial for improving integrated care. These institutions and people – even when not thematically directly related to care – are helping raising awareness and acceptance of the improvements to integrated care.

Cooperation between different professional fields (medicines, therapists, nurses, legal experts) like as in the service centre in Templin is one key point of improving integrated care activities. By not only working and talking at cross purposes, in the service centre a really culture of cooperation and alignment across all professional fields are established. These results into a really great situation for the polder persons visiting the service centre: they really get the help they need, aligned at their needs and at all possible requirements, on short notice. Therefore this integrated care activity should be really seen as transferable across the EU.

The general integrated care initiative from the KV RegioMed Zentrum in Templin (which existed before the service centre) is also transferable towards the EU. Providing a three weeks complex therapy program in which older persons are learning about their medication plan, fall prevention and about healthy diet and lifestyle, social needs and getting support by the “Agnes two” case manager (specially trained practice assistant) relating to all challenges and questions of the care process turned out to have a real positive impact on all SUSTAIN key domains.

### 4.3 Methodological reflections

Interview partners could be addressed easily with the help of the KV RegioMed Zentrum in Templin. Therefore we had no problems in getting enough information and interview partners.

Data collection out of the care-plans was quite limited because the KV RegioMed Zentrum is providing just a 3-week-long-therapy programme. Therefore a lot of information – such as details about prevention orientation or Efficiency – was not included in the care plans.

In regard of data collection through above mentioned survey and interviews there were some constraints regarding the interview partners (older persons). That means that some questions were not really understood by the older persons. The reason for that was on the one hand the mentally situation of the older persons, on the other hand some of the questions did not really fit in into the world or mind-set of the older persons. Some questions seemed to be more important in the context of science than in the context of the day-to-day routine and everyday life of the older persons.

### 4.4 Overall reflections and keypoints

The large IGiB-StimMT project has been taking over all other local innovative activities in the Templin area. The previously distinct and highly visible KV RegioMed Zentrum integrated care programme has now become a rather small (but crucial) component of the much broader IGiB-StimMT.

Having said that, both the complex therapy programme and the SUSTAIN component – building a support and safety network/service centre to secure therapeutic success and follow-up – may potentially benefit tremendously from the broader context and improved funding situation. Since January 2017, the major shift at the management level towards the larger IGiB-StimMT project has absorbed partners’ capacities to adjust to the new context and KV RegioMed activities are now being put and evaluated in a broader context.

While national policies, such as the Innovation Fund of the Social Health Insurance, are favourable and well aligned

with the SUSTAIN objectives, it will be a challenge to disentangle SUSTAIN implementation project impact vs. the impact of the much larger IGiB-StimMT project. There is a risk of getting ignored, but there is also a chance to piggyback and use the larger project as a platform to highlight the SUSTAIN contribution and its synergies to the success of the overall project. Although quantification and attribution of the SUSTAIN project within the larger IGiB-StimMT project is not possible, we perceive a quite positive impact and catalytic role of SUSTAIN within the larger framework. Focussing on the patient experiences and its elements person-centredness, prevention orientation, safety, efficiency and co-ordination in care delivery, SUSTAIN clearly supported decision-makers and operational staff to review and reflect on the patient perspective and patient experiences.

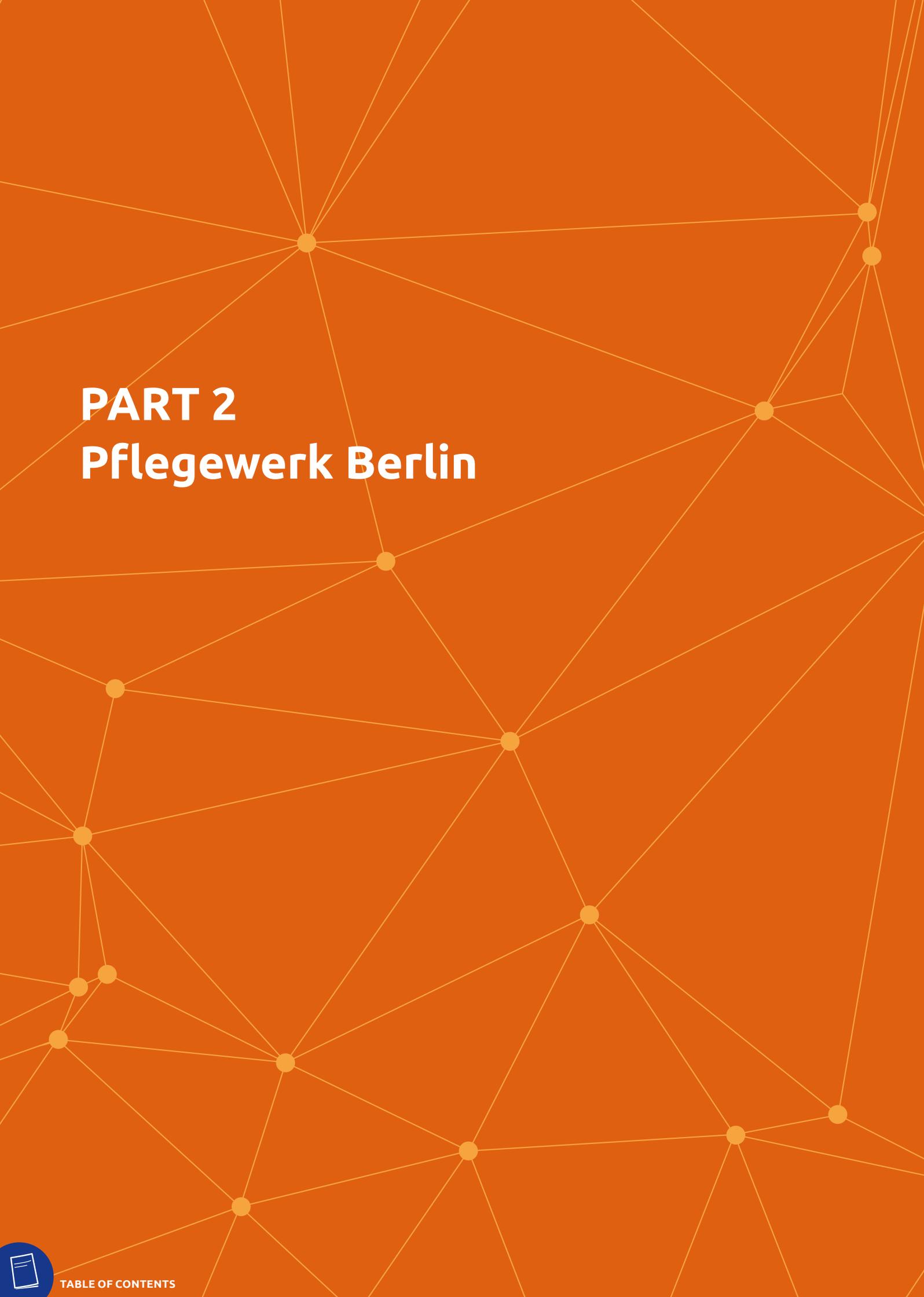
Overall, however, we strongly believe that with the new structure one comes closer to the goal to develop first-level hospitals to outpatient stationary health centres. It would be a viable and realistic alternative to closing facilities in rural areas in favour of centres, as has been suggested by various expert groups. It is also about regional availability and job creation.

The aims of the improvement project regarding person-centredness could have been realized. Through the service centre, service users will get direct access to integrated-care-services and also will get more effective information about integrated-care providers and services.

Regarding Prevention-orientation the aims of the improvement project also could be reached. By providing and distributing all necessary service elements of integrated care possible hospitalization can be prevented or managed much more accurate.

A better alignment of activities of different professionals by improving communication and clarifying roles and responsibilities and therefore a higher efficiency also could be reached.

The service centre is a possible solution for more safety by ensuring that older people know who to contact in case of problems or new challenges and that different professionals are aware of each other’s activities and services.

The background of the page is a solid orange color with a network diagram overlay. The diagram consists of numerous small yellow circular nodes connected by thin, light-colored lines, forming a complex web of interconnected points across the entire page.

# **PART 2**

## **Pflegewerk Berlin**



## 5. PFLEGEWERK BERLIN: CHARACTERISTICS AND IMPROVEMENT PROJECT

### 5.1 General description of the site

The Pfliegewerk Berlin (Care-Works Berlin, CWB) serves a varied population in less affluent parts of the city. It has a number of facilities in different parts (both East and West Berlin) of the once-divided Berlin and thus caters to people who had been growing up in different socioeconomic environments. In the integrated care initiative of Pfliegewerk Berlin nurses, medicines and therapists are involved. Furthermore, the Pfliegewerk has to deal with different payment arrangements, ranging from self-funded service users to those covered under social long-term care insurance and those who need support from the social services department.

Berlin-Marzahn, located in the east of Berlin and characterized by a mix of still existing quasi-village structures and standardized high-rise buildings, has about 256,000 population, among them 92,000 older people, of which 12,000 are estimated to have long-term care (LTC) needs. The percentage of older people with LTC needs is rapidly growing, although in recent years more young people have also moved to Marzahn.

About 3,300 people receive home healthcare or care in nursing homes. CWB has 300 clients using therapeutic services on an outpatient basis and 400 clients receiving LTC services in this neighbourhood from multiple LTC, therapeutic, and home healthcare providers.

### 5.2 Rationale for improvement project

CWB is already highly innovative and integrated in that it combines LTC case management, discharge management, and palliative care under one roof. CWB's budget comes from multiple funding sources:

- SGB V Statutory health insurance, for medical care, therapy, home healthcare (175,000 €, medical aids and devices (90,000€)).
- SGB IX Rehab and aids for disabled people (approx 250,000 €).
- SGB XI LTC insurance: LTC, nursing assistance. This is CWB's biggest source, amounting to 380T.

This overall financial situation of CWB is acceptable, but in general the legal and administrative framework does not encourage initiatives to change the way services are provided – most stakeholders essentially just want to get by and manage with the limited resources they have. It is thus a great advantage that the private owner of the Pfliegewerk is not focusing on the rate of return on its financial investment, but encourages quality improvement initiatives and is willing to actively invest here.

The staff employed by the Pfliegewerk is its key asset. The managing director of the Pfliegewerk puts special emphasis on the recruitment, continuous professional education and retention of staff. Nevertheless, capable staff are scarce and thus there are chronic time constraints faced by nursing and therapeutic staff as well as (some) fluctuations in staff numbers – although at a rate far below other LTC facilities. There was no single (or pressing) rationale for Pfliegewerk to engage with SUSTAIN, the key idea was to use the project in fostering further improvement and continuous learning, utilizing SUSTAIN knowledge and instruments to feed into a process of improvement.



## 5.3 Aims and objectives of improvement project

The purpose of the SUSTAIN improvement project was to enhance inter-professional case management, creating synergies between therapists, nurses and informal carers, while putting healthcare therapists (i.e. physical therapist / speech therapist / occupational therapist / etc.) into the driver's seat (transfer of prescription-competence from medical doctors to healthcare therapists according to the Social Code Book for Health; § 63 SGB V, 3b). Such inter-professional synergies and cooperation traditionally were instituted by individual healthcare providers (usually physicians, as they had the informal leverage to initiate such coordination), but have usually not been made part of an institutionalized care arrangement.

This new role for healthcare therapists is aimed at improving multidisciplinary collaboration between medical doctors and healthcare therapists/nurses and allowing for more therapeutic autonomy for non-medical staff. At CWB, care coordination across professions is already well established and endorsed by the management, as is the involvement of the structured volunteer service. However, given the high workload, the key challenge remains the lack of time and space for exchange (information about clients, good practice...) and education, as staff do not always perceive such coordination as an intrinsic part of their job description but rather as an (unwanted and distracting) add-on.

*I: "Was there anything that could not be implemented at all, in your opinion, where you ran against a wall or what was impractical - something?"*

*M: "Maybe the fact that not every therapist wants to and can be a pilot." (Manager 1)*

With regards to the four focus areas of SUSTAIN, the following key aims and objectives could be identified:

Person-centredness:

- Increasing decision-making competence and self-management via higher-decision competence of their therapists.
- Focusing on service users competencies and participation rather than just providing care to them.

Prevention orientation:

- Improving care outcomes through multi-professional teams (medical doctors, therapists, nurses) guided by therapists leading to fewer hospital admissions and re-admissions, i.e. efficiency gains.
- Improving the flow and exchange of information across different professions (physiotherapists, speech therapists, nurses) creating synergies and increasing work satisfaction).

Efficiency:

- Reducing status hierarchies between professions.
- Strengthening context orientation (therapists have more understanding of the context of the service users situation than medical doctors) in addition to guideline and fixed orientation.

Safety:

- The service verbally emphasises safety – service users feel more protected and safe.
- It also provides closer coordinated mechanisms to respond to critical situations such as falls, disorientation and non-adherence to pharmaceutical therapy.

## 5.4 Explanation of the improvement project

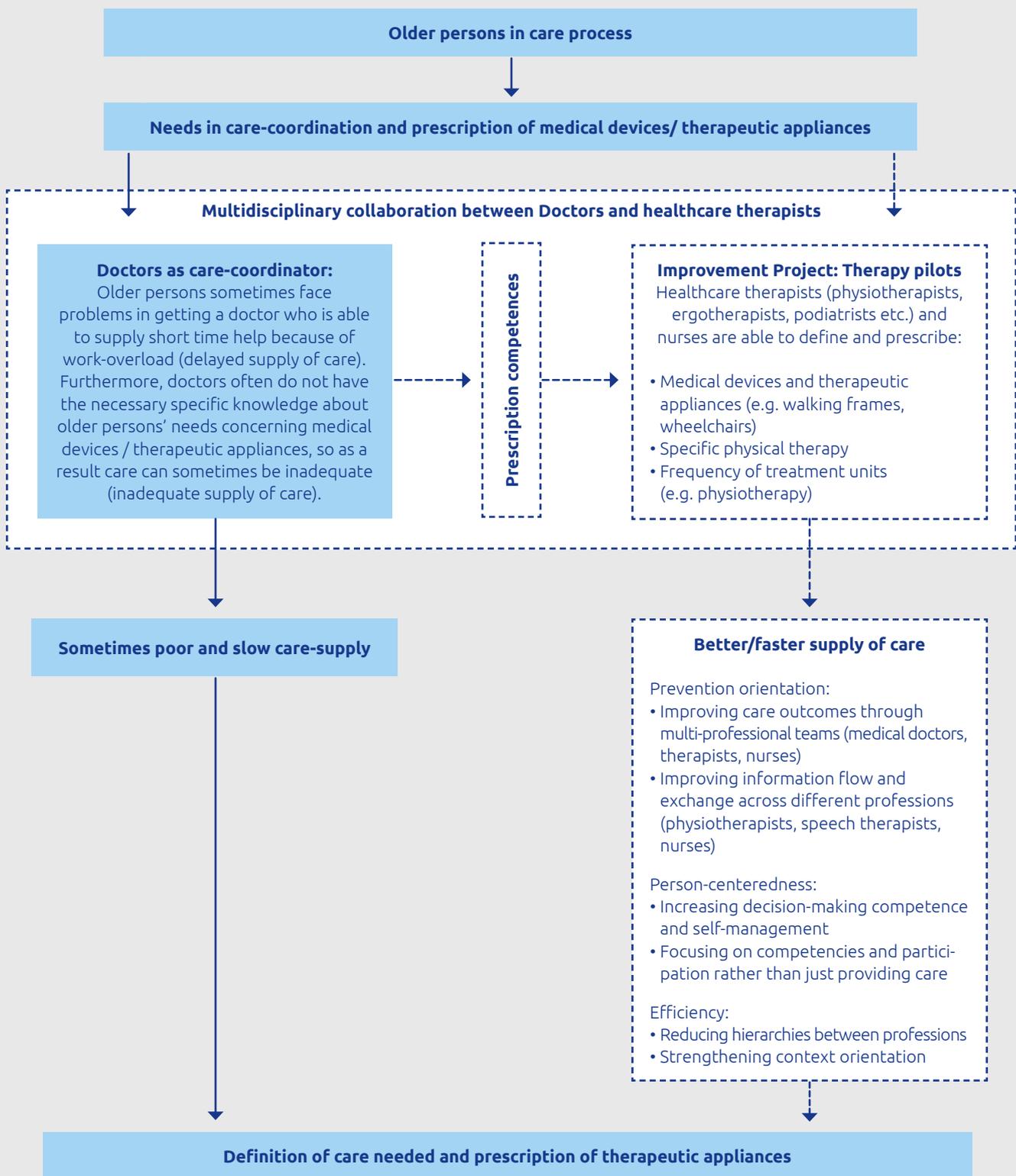


Figure 2 - Flowchart improvement project – Pflgewerk Berlin.

■ Existing processes      □ New processes through improvement project

If older persons in Germany need new medical devices, therapeutic appliances or special therapies they regularly have to go to their doctors who will prescribe these kind of activities or devices. The key problem is that older persons sometimes face problems in getting a doctor who is able to supply short time help because of work-overload (delayed supply of care). Furthermore, doctors often do not have the necessary specific knowledge about older persons-needs concerning medical devices / therapeutic appliances, so as a result care can sometimes be inadequate (inadequate supply of care).

There the improvement project faces these kind of challenges and is transferring the prescription competencies from the doctor to the so called "Therapy pilots". The doctors are providing a plain prescription to the therapists. (Figure 2) Therefore the therapists are now able to define and prescribe medical devices and therapies. The improvement project therefore has the aim to supply better/more accurate care in a shorter time period.





## 6. FINDINGS OF THE IMPROVEMENT INITIATIVE IN PFLEGEWERK BERLIN

### 6.1 Introduction

Researchers worked with the project team from October 2015 on. They identified possible stakeholders, form a steering group, specify the improvement project and plan its implementation. Evaluation data was collected during July to October 2017 and December 2017 to March 2018. A summary of data is shown in Tables 6-9. The remainder of this section is based on an analysis of that data.

**Table 6 - Summary of data collected for Pflegewerk Berlin.**

Surveys	Participants
P3CEQ (person centred coordinated care experiences questionnaire)	30
PCHC (perceived control of healthcare)	30
TCI (Team Climate Inventory)	20
User Demographics	30
Carer Demographics	7
Manager Demographics	2
Professional Demographics	19
Interviews	
User interviews	8
Carer interviews	3
Professional interview	1
Manager Interview	1
Steering group/reflective notes	
Meetings	4

**Table 7 - Summary of demographic data of users Pflegewerk Berlin.**

Characteristic	N=30
<b>Sex</b>	
Male	7 (23.3%)
Female	23 (76.7%)
<b>Age group</b>	
65-74	9 (30.0%)
75-84	6 (20.0%)
85+	15 (50.0%)
<b>Educational level</b>	
Low	19 (63.3%)
Middle	10 (33.3%)
High	1 (3.3%)
<b>Living situation</b>	
Living at home alone	27 (90.0%)
Living at home with spouse/partner	2 (6.7%)
Living at home with at least one family member	1 (3.3%)
<b>Number of medical conditions</b>	4.2 (SD 2.6)

**Table 8 - Summary of demographic data of carers Pflegewerk Berlin.**

Characteristic	N=7
<b>Sex</b>	
Male	2 (28.6%)
Female	5 (71.4%)
<b>Age group</b>	
25-34	4 (57.1%)
45-54	2 (28.6%)
65-74	1 (14.3%)
<b>Educational level</b>	
Middle	5 (71.4%)
High	2 (28.6%)
<b>Relationship to user</b>	
Hired carer (paid for by the state/insurance)	1 (14.3%)
Hired carer (paid for by the state or other insurance)	6 (85.7%)
<b>Living situation</b>	
Close by the user	1 (14.3%)
Further away from the user	6 (85.7%)



**Table 9 - Summary of demographic data of professionals Pfl egewerk Berlin.**

Characteristic	N=19
<b>Sex</b>	
Male	2 (10.5%)
Female	17 (89.5%)
<b>Age group</b>	
18-24	1 (5.2%)
25-34	16 (84.2%)
35-44	1 (5.2%)
45-54	1 (5.2%)
<b>Educational level</b>	
Low	2 (10.5%)
Middle	10 (52.6%)
High	7 (36.8%)
<b>Staff group</b>	
Allied health professionals	19 (100%)
<b>Area of work/care setting</b>	
Health care organisation (acute hospital)	11 (57.9%)
Health care organisation (primary care)	7 (36.8%)
Health and social care—integrated organisation	1 (5.2%)

Beside these above mentioned groups, one manager was interviewed. For all data collections ethical approval was received.

The key to pushing for successful change lies in a combination of factors, but essentially is driven by the will and perseverance of CWB’s managing director. It confirms a widely held notion that change in people-based businesses (such as LTC) is not only driven by technology, but to a large extent is also driven by intrinsically motivated individuals who want to make a difference and have the ability and power to implement and sustain change.

Such change is being implemented despite a challenging financial situation, where CWB’s budget is entirely made up from reimbursement for services provided (see above) with virtually no leeway to initiate any additional services or changes in the way business is conducted. In order to make progress, CWB will need additional revenue streams to support the additional costs of providing improved coordination and person-centred care. So far no reimbursement is available to finance the improvement project.

## 6.2 What seems to work?

### Coordination of care delivery

The types of services offered remain essentially the same, although more emphasis is put on assessing how an individual service user could effectively be cooperatively treated and this might lead to changes in defining responsibilities, range of services offered and mode of cooperation.

Improving care outcomes were mainly achieved through multi-professional teams guided by therapists. By providing more decision-making authorities to therapists, there is also a need to better coordinate and cooperate between doctors, nurses and therapists.

*“Well, I also think that this has become more of togetherness than working side by side, because the therapists are there all the time, so that it is much easier to communicate.”*  
(Professional 1)

Some stakeholders (nurses) are seeing the new processes of the improvement project as a threat to their interests and territory. Scepticism and caveats from external stakeholders (doctors, care-services, nurses etc.) were underestimated at the beginning of the improvement process. That leads to some difficulties in implementing the improvement project.

*M: “Yes, exactly for the same group of people - as I have already indicated – it is a bit of a dilemma for the caregivers, (...) worrying about being unable to bill for certain services that are economically important to them.”* (Manager 1)

The TCI was conducted at two times. Overall it can be said that the individual as well as the mean scores are equal in the first second Phase (TCI total score 4.2 (0.3). This is a hint of a really good and consistent coordination concerning the improvement project.

### Person-centredness

Engaging service users, their families and communities: There is a focus on service user’s competencies and participation: the service user is primarily viewed as a competent individual requiring specific support rather



than just a person who will be taken care of. Based on such an approach, decision-making and self-management in clients / service users is viewed as being highly desirable and to be enhanced in such decision-making and self-management processes.

The delivery of care with regard of the improvement project is based on context orientation rather than guideline orientation in the sense that each service user will be individually assessed and a care concept/plan developed which suits the individuals needs whilst the cornerstones of multi-modal, therapist-led care remain the backbone of each care concept/plan.

*I: "How does that work best, this conviction, in your opinion?"*

*P: "Just start and demonstrate. Showing how the first steps are, make it as specific as possible." (Professional 2)*

*"Especially by the orientation in the field of everyday activities, the patient also has a great added value..." (Professional 2)*

Users are feeling to be in the middle of attention regarding the care process. They feel that the care process is designed regarding their needs and wishes.

The PCHC total score was 3.8 (SD 0.8) - a quite good score and a hint that users feel themselves relatively strong and able to control their healthcare together with the support of the Pfliegewerk.

The P3CEQ total score was 18.7, meaning that older people had relative good experience with person-centred care. However there are several items (1, 7a, 7b, 7c, 7d and the joint mean score on item 7a, 7b, 7c and 7d) which are relatively low compared to the other items. This could be a hint to needs of improvement to be more responsive to the personal needs in health and well-being. The availability and visibility of the care plan also should be improved. The relative low confidence on self-managing health and wellbeing should be a warning signal for the Pfliegewerk – but also can be a hint to the good care-service provided by Pfliegewerk.

The high score regarding the joint-up care and the central contact person (item 5 and 6) is a good sign for Pfliegewerk that integrated care-processes are working and deploying positive effects. Also the high mean score of item 9 indicates good processes regarding to what extent valuable information at the right time are deployed and helped the older persons to work on their own health and well-being. The high score of involvement of family members (if wished by the older people) is also a good sign for Pfliegewerk.

In general the high P3CEQ total score can be explained by the past socialization of the users. Growing up in the former GDR, individualized solutions and offers as well as their needs being in the focus were not part of their day-to-day live and reality. Getting individualized care and processes in the Pfliegewerk Berlin therefore is a relative new experience for them they do not used to have in their past. The excitement and pleasure of the users about the fact that their personal needs (for the first time) are in focus can therefore be an explanation for the high P3CEQ total score.

*M: "So the generation that is currently in need of care is the generation that was typically born towards the end of World War II or shortly thereafter. This is a generation that has not necessarily learned in its childhood to have the right to speak openly and clearly what it needs." (Manager 1)*

Although older people indicated to not have access to their care plans, they also indicated that they didn't care. They were not aware of having a care plan and some of them were not interested in the information that was written in it.

Relatives seemed to be the first and best reference for the older people. But some of older people explicitly do not want to get their relatives involved into the care process ("They have their own live").

### **Prevention-orientation**

Improving care outcomes through multi-professional teams (medical doctors, therapists, nurses) guided by therapists leading to fewer hospital admissions and re-admissions, i.e. efficiency could be reached.

By putting the therapists into the driver-seat of care a higher prevention-orientation could be reached through the improvement project. Because therapists do know the situation of the older persons much better than a doctor, they can make more accurate decisions regarding the care delivery and needed medical devices.

*P: "I think you can also say that again, when the therapist (...) for example, eat with a patient at noon, because they have been prescribed a swallowing-therapy for the patient and then notice, that the neighboring patient sits there and does not eat or swallowed constantly, that because of this therapy-pilot concept we can also be get more quickly to the care nurses and talk to them like: >>Hey, the neighbor patient; does he have a bad day or is it always like that? Then maybe you have to put on a therapy, then you have to talk to the doctor or we'll do it.<<." (Professional 2)*

And finally, prevention orientation in care delivery is a major guiding principle in the sense that the "nihil nocere" (do not harm) defines the range of services / therapies applied. This could mean, for example, that gatherings of service users might be coupled with a walk in the neighborhood or that physical therapy is specifically aimed at fall prevention.

### **Efficiency**

Raising the efficiency of care delivery is one of the key-issues of the improvement project by reducing status hierarchies between professions. Improving care outcomes were mainly achieved through multi-professional teams guided by therapists. There are two major goals with this approach (i) improved, i.e. more timely and person-centredness quality of care and (ii) reduced hospital admissions and re-admissions, i.e. efficiency gains. Furthermore, improving information flow and exchange across different professions should ideally lead to process synergies including reduced administrative time required, joint learning on each case and increased work satisfaction.

*"I think that we have done very well and achieved very well. So there are many more people who are now getting therapies, occupational therapy, physiotherapy and speech therapy. So we did it." (Professional 2)*

Strengthening context orientation (therapists have more understanding of the context of the service users situation than medical doctors) in addition to guideline and fixed orientation and therefore increasing efficiency is also being reached by the therapy-pilots.

### Safety

*I: "Are safety aspects taken into consideration and how exactly?"*

*C: "So we start in the room: we tell the relatives that they forgo on carpets so that no sources of stumbling arise; bring a night light or ABS socks. And that is pursued very well." (Carer 35)*

Connected with the promotion of therapy-pilots through the improvement project, there is also a higher cooperation and more intense communication between all doctors, nurses and therapists. This leads to much better safety in the care delivery process by avoiding wrong diagnosis, incorrect drug-prescription and by providing the right devices in a shorter period of time.

*"If care-workers do have all the necessary information to support the users to live independently depends on the care-workers. The majority of the care-workers do have the information." (Carer 3)*

It also provides closer coordinated mechanisms to respond to critical situations such as falls, disorientation and non-adherence to pharmaceutical therapy. The service verbally emphasises safety – service users feel more protected and safe.

## 6.3 What are explanations for succeeding and improving integrated care initiatives?

Most importantly, CWB is working on a notion that things can be changed for the better. The leader of CWB has a clear and easy-to-communicate vision and has been successful in bringing together stakeholders from various backgrounds and aligning their interests. Medical doctors would like to shift tasks and leave day-to-day management to the therapists. Therapists feel more empowered and can adjust the care they provide to the identified needs of the service users. Insurers are not involved (and do not want to get involved) as long as they feel the outcome achieved is at least similar or even better than before. The resource is patience, perseverance and ability to convince others.

In addition, CWB employed (and still employs) a mix of activities and specific approaches that helped to explain success. For these items, listed below, it is difficult to establish how these factors specifically contributed to

improvements to integrated care. The authors believe that the whole set of activities made the difference, and even a single activity did not work particularly well, the perception that "CWB is moving forward, they are doing something" was the overriding message.

### (i) Clear vision of the management

Probably most important for any care improvement project is a visionary manager who lives the project and is promoting and defending it (internally and externally) and pushes for a comprehensive and integrated approach. Strong commitment of the management, from the professional level as well as from the company level of Pfliegewerk has been a positive contextual factor for the improvement process.

### (ii) Early incorporation of all relevant stakeholders

All relevant stakeholders affected by the improvements in integrated care must be incorporated early on in the improvement process. Otherwise they might feel threatened in their professional role and might get the impression some external idea is imposed on them. Unanimously, managers as well as professionals stated that an earlier incorporation of the stakeholders would have made things easier. Similarly, it is important to convince external stakeholders (like doctors, nurses) to take an active part in the improvement process, thereby bringing in their expertise and promoting the project's success. The widely felt limitation of resources in the healthcare system generally promoted openness and willingness to consider new approaches brought in by the improvement project. Setting good examples, leading the way and keeping up regular contacts are additional measures to convince sceptical stakeholders. This goes hand in hand with keeping up the attention and motivation of external as well as internal project parties (doctors, nurses, therapists) as a major key success factor for the improvement process.

### (iii) Having staff who are paving the way

Having experienced staff serving as a role model and setting good examples for the new processes of the improvement project is really an important issue for succeeding and improving integrated care initiatives.

*I: "How does that work best, this conviction, in your opinion?"*

*P: "Just start and demonstrate. Showing how the first steps are, make it as specific as possible." (Professional 2)*

*I: "think the employees who are with us for a longer time for them it is in their second nature, and they in turn start to lead the new employees and sell the new processes as well as we would. Of course, it is important for the new employees to repeat the same over and over again, giving examples or helping with problem solving. So communication is always important, because you can never say: Hey, now I've talked enough about it, let's open another topic." (Professional 2)*

### (iv) Improving performance of staff

Defining the whole care-process not on quantitative but on qualitative aspects. Therapists are more able to do that because they are much closer to the needs and the day-to-day care of the service users than the doctors.

*“Well, I also think that this has become more of togetherness than working side by side, because the therapists are there all the time, so that it is much easier to communicate.”*  
(Professional 1)

Reluctance and resistance of internal care-staff when doing improvements to care delivery is a crucial and important point which has to be addressed.

*I: “Was there anything that could not be implemented at all, in your opinion, where you ran against a wall or what was impractical - something?”*

*M: “Maybe the fact that not every therapist wants to and can be a therapy pilot.”* (Manager 1)

(v) Clear roadmap from the beginning

A clear roadmap for the improvement project from the beginning, an intensive exchange with and convincing of external stakeholders (doctors) and a clear and understandable communication with and convening of internal stakeholders (therapists) seem to work for the implementation process.

(vi) Taking the goals of users into account

At the user level, all care plans should contain the goals the user wants to achieve and should describe which professional will do what to help the user achieving these goals. The roles of informal carers in relation to the goals should also describe in all care plans. Although this sounds obvious, the experience of the improvement project showed otherwise. Good planning and appropriate goal-setting for each patient in a readily accessible format is an essential tool for continuous and high-quality care.

(vii) Effective and efficient work streams

CWB employs a range of tools to enhance effectiveness and efficiency in its work streams:

Marketing and information

- E-mail to convene steering group meetings and inform staff.
- CWB produced a flyer to communicate participation in and endorsement of SUSTAIN project.
- Regarding communication with outside stakeholders, CWB has presented its approach of therapists in care at a national LTC conference.
- CWB director published article in LTC magazine featuring LTC pioneers and creative solutions.

Expand patient base

- Increase collaboration with local GPs.
- Meet and inform residents and carers.
- Create space for therapists and nurses to regularly exchange and educate each other (ICF training, synergies LTC/rehab, overlapping tasks).
- Establish periodic exchange / meetings between volunteers and carers.
- Communicate concept of therapists in LTC to broader LTC / policy community at regional and national levels.

Continuous quality improvement

- Contact and meet with all stakeholders (heads of departments, CWB managers = multidisciplinary steering group).

- Continue implementation of improvement measures with feedback mechanisms and regular review sessions.
- Put a focus on further improvement of doctor-therapist-relations and communication.

(viii) Organization of providers / management of service  
Reducing hierarchies of status between professions, in particular reducing the dominance of the medical profession which is always in danger to do more harm than good if the other professions are not enabled to reflect and feedback on the individual care plan – because the medical professions are not very deep into the day-to-day care routine and its needs. Therapists as used as care-manager in the sense that the therapist (i.e. physical therapist / speech therapist / occupational therapist / etc.) is put into the “driver’s seat” and a transfer of defined prescription-competence from medical doctors to healthcare therapists (“Therapielotse” =therapy-pilots) takes place. This enables therapists to define the care-process and the detailed content of care (in cooperation with the relevant medical specialty, usually the General Practitioner, but also a specialist where appropriate)

*“I think that we have done very well and achieved very well. So there are many more people who are now getting therapies, occupational therapy, physiotherapy and speech therapy. So we did it.”* (Professional 2)

## 6.4 What are explanations for not succeeding and improving integrated care initiatives?

There are a number of areas where, financial, psychological, or management obstacles remain.

(i) Legal and administrative

Some aspects of the improvement project are touching legal prohibitions/legal grey areas – such as cooperation prohibition between doctors and therapists. This can be a potential hindrance for the improvement process. This even more so, as the general lack of a political and institutional framework in Germany that encourages innovation and change, or the only very few experiences on which the improvement project can rely on is one explanation for not succeeding and improving integrated care initiatives. The Social Code Book (SGB Sozialgesetzbuch) has in recent years been developing legal clauses for more innovation and cooperation in the area of medical care, but such changes are yet to happen in the legal framework concerning LTC. Thus, in some instances, Pflegewerk enters “unchartered terrain” and operates in a not well defined legal / reimbursement environment.

Ideally, the project should be accompanied by a switch from paper documentation to digital information systems. However, a key obstacle is provided by the various social insurance funding streams requiring different reporting tools and templates, which so far have remained unaligned.



As of now, there is a considerable administrative and procedural gap between healthcare, LTC, and pension schemes. All of which could in principle coordinate their activities and would most likely improve effectiveness and efficiency. To give an example: if / when a home needs to be altered to cater for the needs of the aging residents, there is often a lengthy debate about which of the different branches of social security should pay. It often requires local engagement and well-connected doctors and / or social service workers to make things happen.

#### (ii) Human resources

The improvement project's strong reliance on the passion and perseverance on Pfliegewerk's managing director is a concrete danger to the improvement process as a whole. At CWB, care coordination across professions is already well established and endorsed by the management, as is the involvement of the structured volunteer service. However, given the current heavy workloads, the remaining challenge continues to be carving out time and space for exchange and education, staff are not always perceived as an intrinsic part of their job description but rather as an add-on. In short, staff lacks time.

*"Problems are always communication, the care and the doctors have to understand what we want to do there (...)." (Professional 2)*

Staff shortage, fractious doctors with no commitment to cooperation and the resistance of relatives who do not see any benefits of the new processes are the three most important barriers for the improvement project. Staff shortage is probably the single most challenging element in Pfliegewerk's continuous improvement process. In Germany, there is a serious shortage of care nurses (Wisdorff, 2014) and Pfliegewerk is affected as anyone else in this business. The high need for qualified staff can be the Achilles' heel of the improvement project because staff turnover is quite high in the German care system. The number of fractious doctors is probably very small, but anecdotal evidence suggest that even a small number of uncooperative providers has a significant negative effect on daily operations. Discussion with colleagues and other staff in most instances help to reflect on these attitudes and concerns related to therapist-led care. Resistance from relatives occurs occasionally, mostly because of lack of knowledge about the complexity of LTC and the administration involved. In almost all instances this can be settled amicably, but it requires time and effort on behalf of the staff involved.

Although there is a formalized routine (weekly meeting, case conferences), the degree of joint working between different staff depends on the individual motivation of the care-staff and collaboration between different care-workers is seen as variable by the users.

I: *"How do you generally feel about the amount of time people spend with you - are they rushed? Do they have enough time or is it all more like shuffle, hurry - fast, fast?"*  
U: *"It's individual. There are some who are very rushed because they really look after everything. And there are those who pass the work without batting an eyelash." (User 25)*

*"All the staff is pressed in time. Often they are in a rush. But they are always friendly and treat me with respect." (User 5)*

The manager underestimated the fact, that not every therapist can or wants to fulfil the role as needed for the improvement project. The degree of scepticism and limited engagement found among some therapists was underestimated at the beginning of the improvement process. That led to some difficulties in implementing the improvement project but they have now been successfully addressed for the most part.

I: *"Was there anything that could not be implemented at all, in your opinion, where you ran against a wall or what was impractical - something?"*

M: *"Maybe the fact that not every therapist wants to and can be a pilot." (Manager 1)*

Some stakeholders (nurses and other care services) are seeing the new processes of the improvement project as a threat to their interests and territory.

*"(...). We do not want to take anything away from anyone, just add something, but the other colleagues feel threatened. We should have explained it much more from the beginning, because we do not want to sell therapy, we just want to bring therapy to the patient and then it's actually pretty much irrelevant which organisation is carrying out the therapy. (...)" (Manager 1)*

Again this is a perception that reflects reluctance from some therapists, nurses and doctors to change and is also based to some extent on hearsay without having any real-world experience. Similarly, external stakeholders, such as medical practitioners or specialists, who are at least partially affected by the improvement process, are not engaged early enough and with sufficient recognition of its perceived threats to some stakeholder interests. This can result in resistance and opposition the improvement process. Such delays and difficulties in communication towards external doctors and care-services are a significant problem in the improvement process.

#### (iii) Service users and relatives

Although older people indicated to not have access to their care plans, they also mostly indicated that they didn't care at all if they have such a care plan. They were not aware of having a care plan and some of them were not interested in the information that was contained in it. This could be a hint that this aspect is more a desire to satisfy professional requirements than the users' desires. (16 out of 30 of P3CEQ respondents stated that they do not know and do not care whether they do have a Care plan or not.) Moreover, service users, relatives and the financing institutions either do not see the changes brought about by the improvement project or they do not value those changes and their (potential) impact on the quality and safety of care. It is likely that such attitudes prevail in most facilities and it seems reasonable enough to assume that patient interests focus far more on the fulfilment of immediate daily needs that mid- to long-term planning.

(iv) Lack of financial support

The lack of financial support from major players (like health insurances) which at present do not support the improvement project is one explanation for not succeeding and improving integrated care initiatives. This is because Pflégewerk does not have any major institutional or structural link to important stakeholders in the German healthcare system. Because of that they more or less are standing alone with their improvements efforts.

*“Of course, that sounds like ... well, we’re in such a position that we always like big names and that also creates a bit of security when you say: Hey, they as well think the project is really great. That certainly opens a few more doors than if you arrive there and say: We have an idea and we would like to implement it with you.” (Professional 2)*





## 7. MAIN LESSONS LEARNED FROM PFLEGEWERK BERLIN

### 7.1 Working towards integrated care improvements that could have impact

Once the key operational steps of the improvement project have been realized, the successful working of the therapy-pilots work will hinge on a number of key factors:

- Identification of doctors who are willing to transfer defined prescription-competence to therapists – as said above, some doctors are fractious, the majority is neutral, but willing to accept change and try new approaches, and some doctors are enthusiastic and could act as champions for change. Focussing on those doctors, developing visible success stories will be an important lever to get those with a neutral stance fully on board and convince those who are critical.
- Collaboration with a dedicated website ([www.ambulanzpartner.de](http://www.ambulanzpartner.de)) to coordinate and transparent document long-term care needs for therapy and medical devices. This website is in the making, but several interview partners were convinced that it will foster collaboration and will build on the current work mode, while improving efficiency and possibly also serving as a marketing instrument.
- Definition of processes between doctors and therapists. Based on the experiences described above, a clear delineation of processes and in particular competencies (who is responsible for what?) will further support a change in providing LTC and establish therapist-led care. All stakeholders will have a jointly developed, clear and ideally unambiguous approach with defined division of labour.
- Process of transition of care / discharge of service users from doctors to therapists. This would be last in a chain of conceptual and preparatory steps and will be a temporary (probably during a 6-12 month period) change in the way LTC is provided. After that period it is hoped that the

new system would be firmly established and most criticisms will have been successfully met.

Every three months there is an evaluation and review of patient-focussed health and care-processes by all professions, which forms the basis for continuous service improvement, enabling better communication and intensified collaboration of therapists with doctors-practices.

In addition, it is envisaged in the medium term to move from paper documentation to digital information systems. This, however, remains a challenge as the key obstacles to such a harmonized and aligned flow of information and documentation are the various social insurance funding streams requiring different reporting tools and templates.

In order to maximize impact, it is deemed essential that stakeholders affected by the proposed improvements in integrated care be involved early and appropriately in the improvement process. Otherwise, they might feel threatened in their professional role and pushed aside. Such early and proactive communication and widespread involvement should also take into account the possible but not intended side-effects of the improvement project (which are beyond its initial sphere) and early recognition of such problems and rapidly addressing them is an important factor for improving integrated care.

Furthermore, promoting and raising awareness of improvements to integrated care is a crucial success factor. Closely related to this factor is a clear and effectively communicated vision as well as a leading manager who lives that vision and has sustained involvement.

Finally, support at all levels is important. The support of top-level management and giving the project-team the freedom to design and to carry out the improvement process does have a positive impact on integrated care improvements. Strong support of external institutions will have a positive impact on integrated care improvements.

## 7.2 Working towards integrated care improvements that could be transferable across the EU

Based on the findings above, the following key success factors were identified that might be transferable across the EU.

Crucial to a functioning Therapy pilot project is a good and regular consultation between therapists and doctors as well as the agreement on common goals and treatment-forms. Therefore this kind of integrated care activity is transferable across the EU.

Also the larger incorporation of the broad knowledge and practical experiences of therapists could be transferable across the EU. Broadening the competencies of therapists concerning the care-process can help to relieve doctors and also can support better and more accurate decisions for the older persons with care needs.

At the user level, all care plans should contain the goals the user wants to achieve and should describe which professional will do what to help the user achieving these goals. The roles of informal carers in relation to the goals should also describe in all care plans. Although this sounds obvious, the experience of the improvement project showed otherwise. Good planning and appropriate goal-setting for each patient in a readily accessible format is an essential tool for continuous and high-quality care.

## 7.3 Methodological reflections

Interview partners could be addressed easily. Therefore we had no problems in getting enough information and interview partners.

In regard of data collection through above mentioned survey and interviews there were some constraints regarding the interview partners (older persons). That means that some questions were not really understood by the older persons. The reason for that was on the one hand the mentally situation of the older persons, on the other hand some of the questions did not really fit in into the world or mind-set of the older persons. Some questions seemed to be more important in the context of science than in the context of the day-to-day routine and everyday life of the older persons.

## 7.4 Overall reflections and keypoints

Essentially, there are three main issues that came up during the collaboration with Pflegewerk. These can (to some extent) be influenced by careful preparation and upfront strategic planning, but one can certainly expect unforeseen events and vicissitudes. It might be advisable to have those three issues clearly in mind when developing any concept for integrated care.

1. Change takes time – and one needs (financial) support from the owner of the facility where change is initiated.
2. Change needs persuasion: It hinges on the personality and abilities of the leader to convince others to join.
3. There is a significant element of good luck and timing: the time has to be ripe for change, the setting has to fit for the change planned, the people to talk to have to be ready to listen.

Although the project had no defined measurable indicator that need to be met, the overall project objectives of stimulating debate between different stakeholders, bringing in new impulses and providing concrete support in reviewing human resources were clearly met. These inputs and possibly having lowered interprofessionell barriers by stimulating debate will probably be sustained at least in the short to mid-run and might help Pflegewerk in reviewing its organisational and financial constraints and develop concrete strategies. The relationship between the care sites, Pflegewerk management and the researchers can be judged as having been open, cordial and defined by mutual respect and willingness to move the agenda forward.

# PART 3



## 8. OVERALL (NATIONAL) REFLECTIONS

### 8.1 Introduction

German society is changing: A falling death rate and a simultaneous decline in the birth rate characterize this development, referred to as demographic change, in Germany. Rural areas are particularly affected by this development. Thus, there is a clear need for innovative projects which at the same time relate to the existing legal and financial requirements and try to do things differently in the sense that they go beyond traditional form of providing long-term care.

So far, there is no framework for financing and managing improvement projects and usually there is no dedicated budget available. Changing LTC and therapy regulations at national level, while overall showing a positive development, absorb capacities at local level as they require adjustments and responses to the changing legal and financing framework.

We start this chapter with a section on the lessons that Germany can learn from both Care-sites and their improvement projects (section 8.2). Based on the lessons learned, we have formulated policy recommendations and recommendations for service providers, which are outlined in sections 8.3 and 8.4 respectively. We finalize this chapter with an overall conclusion (section 8.5).

### 8.2 Implications of SUSTAIN for integrated care in Germany

In both improvement projects, it became clear that not only outpatient and inpatient care will need to be closely interlinked, but also fundamentally rethought. This finding reverberates with a number of results from studies throughout the system, indicating a tension

between the current way care is financed and provided (based on a conceptual framework developed in the 19th century), and alternative concepts based on a modern and comprehensive understanding of disease and the need for LTC. (Amelung et al., 2012, Busse and Stahl, 2014) Any approach to provide interdisciplinary care via an outpatient-inpatient centre will need to combine on-site coordination and clear delineation of responsibilities in the care of patients and case management. Such management innovations will then have to be coupled with a reimbursement mode compatible to the existing financing structures. In addition, all doctors should ideally be integrated in the care process through some form of regional medical network. Financing and reimbursement should, however, eventually reflect such fundamental changes in structures and processes in the German care-system.

The findings from both sites indicate the need for flexibility and locally adapted initiatives. Eventually, local champions and intrinsically motivated persons will be those pushing matters forward and ideally create momentum which will stimulate others to start similar initiatives.

### 8.3 Policy recommendations

The key for a successful form of collaboration and integration of services is the overall will of all parties to overcome institutional barriers. The experience in the care sites clearly show that even in an advanced social security system that is entrenched in the process of service provision, “turf wars” and an often prevailing attitude of “us” versus “them” can be overcome. Institutional collaboration is a first crucial step, but it needs to be “lived” by key staff on a day-to-day basis.



From a policy perspective these findings indicate two major thrusts:

The staff needs to be selected, specifically trained and supported in their varied and complex functions. Specific funding and other modes of support should be made available in order to foster such exchange, training, and improved human resource management. The current “Innovation Fund” provided by the Social Health Insurers and managed by the Joint Federal Committee could in principle serve as such an instrument.

Financing institutions, such as the Gemeinsamer-Bundesausschus (G-BA), should ideally be pushed from politics for more flexibility in reimbursing new forms of care and external monitoring and evaluations critical in ensuring that positive as well as negative experiences are documented for others to learn from and to make selective and locally adapted use of tools. This would probably require legislative action and would thus only be achievable in the mid- to long-run.

## 8.4 Recommendations for service providers

Strong leadership from the project leader as well the whole management level of the service provider is essential. This includes quick decisions, clear delineations of roles and responsibilities, public promotion of the improvement project and managing the many stakeholders that are involved in the project.

The collaboration between institutions (e.g. the hospital, social health insurance funds, and associations of statutory health insurances physicians) should also extend to individual health providers (doctors, therapists, long-term care nurses). These individuals also need to understand and support the demands of integration and collaboration. For this to happen, local structures of exchange and discussion between all affected stake holders are vital, alongside training.

Staff involved sometimes reported serious time constraints, at present there is only one Agnes 2-nurse available. There also has been some fluctuation amongst staff, not least due to the new tasks ahead and the well-known phenomenon that changes in routine work cause stress in some staff which may induce them to change jobs. There is no easy solution to this and a number of policies can be recommended here: more specialist staff like Agnes 2 and / or staff retention policies and / or workload assessments with readjustments where necessary. Recruiting of staff for the innovative care form might be difficult, as this involves a certain degree of uncertainty, increased responsibility and willingness to adapt to changing circumstances.

## 8.5 Conclusion

Reviewing the experiences in Berlin and Templin, the authors conclude that it was less technical components or organisational or procedural details that had most impact on changing the way LTC provided, but rather developments in mental attitude, management and communication.

A clear and promotable vision, flexible, but nevertheless thorough planning, a proactive human resource management, early incorporation of stakeholders, promoting and raising awareness of improvements to integrated care and a dedicated (if not enthusiastic) management were the basis for the initiatives to enhance person-centredness, prevention orientation, safety, efficiency and co-ordination in care delivery.

Initial funding is crucial; this might come from external source (public or private) or could come from re-allocating internal funds. Although funds are in principle available, innovative solutions that might require more explanation and are not immediately understood by third parties will face considerable difficulties gaining support, but even in a difficult environment, there are usually ways and means to obtain support by the local, state and federal government. This is usually achieved against high bureaucratic obstacles. National laws might significantly affect local innovations, e.g. limitations coming from the general data protection requirements impede effective processes in the improvement project.

Important and notable institutions or people supporting the improvements are a factor which is crucial for improving integrated care. These institutions and people – even when not thematically directly related to care – are helping raising awareness and acceptance of the improvements to integrated care. The public as well as the target-group have to be informed and convinced about the improvements – so “Doing good things and talking about it” is an important factor.

Integrating the new services into the existing healthcare- and care-processes will most certainly need more time than expected. Social services are by their very nature inert and slowing adapting – people need reliable support and clearly communicated access to specific services. Doctors will be crucial for achieving sustainability, but their support is often hard-won, so LTC initiatives should eye them early on and develop a communication and persuasion strategy.





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## 10. ANNEXES

### 10.1 Practical measures for monitoring outcomes and progress of the implementation of the improvement plans.

Item	Data collection tool	Short description
<b>DEMOGRAPHIC INFORMATION</b>		
Socio-demographics of older people (users)	Demographic data sheet – older people, administered to older people	Survey developed by SUSTAIN researchers requesting information on age, gender, education, marital status, living situation and self-reported medical conditions
Socio-demographics of informal carers	Demographic data sheet – carers, administered to informal carers	Survey developed by SUSTAIN researchers requesting information on age, gender, education, marital status, relationship and distance to older person (user), paid work and caregiving activities
Socio-demographics of professionals	Demographic data sheet – professionals, administered to professionals	Survey developed by SUSTAIN researchers requesting information on age, gender, nationality and occupation
Socio-demographics of managers	Demographic data sheet – managers, administered to managers	Survey developed by SUSTAIN researchers requesting information on age, gender, nationality and occupation

Item	Data collection tool	Short description
<b>OUTCOMES</b>		
<b>Person-centredness</b>		
Patient perceptions of quality and coordination of care and support	The Person Centred Coordinated Care Experience Questionnaire (P3CEQ) (Sugavanam et al., under review), administered to older people	Survey measuring older people's experience and understanding of the care and support they have received from health and social care services
Proportion of older people with a needs assessment	Care plan template (in case sites do not work with care plans, information will be retrieved from clinical notes or other documentation)	Template developed by SUSTAIN researchers for predetermined content analysis of care plans of older people
Proportion of care plans actioned (i.e. defined activities in care plan actually implemented)		
Proportion of care plans shared across different professionals and/or organisations		
Proportion of informal carers with a needs assessment and/or care plan		
Perception and experiences of older people, informal carers, professionals and managers with person-centredness	Semi-structured interviews and focus group interviews with older people, informal carers, professionals and managers	Interview and focus group schedules developed by SUSTAIN researchers including interview items on perception and experiences with receiving person-centred care
<b>Prevention orientation</b>		
Perceived control in care and support of older people	Perceived Control in Health Care (PCHC) (Claassens et al., 2016), administered to older people	Survey addressing older people's perceived own abilities to organise professional care and to take care of themselves in their own homes, and perceived support from the social network
Proportion of older people receiving a medication review	Care plan template (in case sites do not work with care plans, information will be retrieved from clinical notes or other documentation)	Template developed by SUSTAIN researchers for predetermined content analysis of care plans of older people
Proportion of older people receiving advice on medication adherence		
Proportion of older people receiving advice on self-management and maintaining independence		
Perception and experiences of older people, informal carers, professionals and managers with prevention	Semi-structured interviews and focus group interviews with older people, informal carers, professionals and managers	Interview and focus group schedules developed by SUSTAIN researchers including interview items on perception and experiences with receiving prevention-oriented care



Item	Data collection tool	Short description
<b>Safety</b>		
Proportion of older people receiving safety advice	Care plan template (in case sites do not work with care plans, information will be retrieved from clinical notes or other documentation)	Template developed by SUSTAIN researchers for predetermined content analysis of care plans of older people
Proportion of older people with falls recorded in the care plan		
Proportion of older people with falls recorded in the care plan	Semi-structured interviews and focus group interviews with older people, informal carers, professionals and managers	Interview and focus group schedules developed by SUSTAIN researchers including interview items on perception and experiences with receiving safe care, and safety consciousness
<b>Efficiency</b>		
Number of emergency hospital admissions of older people	Care plan template (in case sites do not work with care plans, information will be retrieved from clinical notes or other documentation); template to register staff hours and costs	Template developed by SUSTAIN researchers for predetermined content analysis of care plans of older people; template developed by SUSTAIN researchers to collect data on costs and the number of staff hours from local services, organisations or registries
Length of stay per emergency admission of older people		
Number of hospital readmissions of older people		
Number of staff hours dedicated to initiative		
Costs related to equipment and technology or initiative		
Perception of older people, informal carers, professionals and managers with efficiency	Semi-structured interviews and focus group interviews with older people, informal carers, professionals and managers	Interview and focus group schedules developed by SUSTAIN researchers including interview items on perception and experiences with receiving efficient care, and finances
<b>IMPLEMENTATION PROGRESS</b>		
Team coherence of improvement team (professionals)	Team Climate Inventory – short version (TCI-14)	Survey developed by SUSTAIN researchers requesting information on age, gender, education, marital status, living situation and self-reported medical conditions
Perception and experiences of professionals	Focus group interviews with professionals and minutes from steering group meetings	Focus group schedule developed by SUSTAIN researchers including interview items on experienced factors facilitating and impeding outcomes and implementation progress  Minutes cover progress, issues and contextual issues impacting on outcomes and implementation progress
Perception and experiences of managers	Semi-structured interviews with managers and minutes from steering group meetings	Interview schedule developed by SUSTAIN researchers including interview items on experienced factors facilitating and impeding outcomes and implementation progress  Minutes cover progress, issues and contextual issues impacting on outcomes and implementation progress

