



**SUSTAIN**

Sustainable tailored integrated  
care for older people in Europe

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

Lessons learned from improving integrated care in Norway



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## Contributorship

VH participated in the fieldwork and data collection with contributions from TPH. VH transcribed the interviews and EAA analysed the data. VH and EAA drafted the report with contributions from TPH. All authors approved the final report.

## Key points

- As part of its initiative to improve municipal health services and promote integrated care, the study site in Surnadal municipality in Mid-Norway successfully reorganized its rehabilitation service to be provided at home instead of in the institution. They also expanded the Day Center to accommodate more service users.
- Surnadal's managers and staff were trusted by local leaders and members of the community for their competence in delivering homecare services. This trust was extended to the improvement initiative at the site. The managers were given freedom to manage their budget and to develop and implement the initiative with little external interference—and these conditions facilitated the implementation of the improvement initiative.
- As part of its improvement initiative, the site in Søndre Nordstrand employed a senior supervisor to promote use of low-threshold services. The site also appointed a voluntary coordinator to serve as a liaison and increase collaboration between voluntary organizations and the borough's healthcare sector.
- Adequate resources (e.g., funding, skilled staff, time), good and stable leadership, and clearly defined aims and objectives for the improvement initiative are important factors for facilitating the implementation of any such initiative. The extent to which these factors were present at the sites in Surnadal and Søndre Nordstrand affected the implementation of the improvement initiatives.
- SUSTAIN served as an external stakeholder to whom the sites were accountable, and this motivated the sites to work towards their improvement goals.

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# 1. INTRODUCTION

## 1.1 Integrated care in Norway

Norway's primary healthcare services are also known as municipal healthcare services, and they are provided by the municipalities. These services, as they currently exist, started taking shape in the 1970s and included several processes that led to increased de-institutionalization, decentralization and integration. Gradually over time, some health and social care services were transferred to the municipalities—such as those for people with mental health problems and persons with intellectual disabilities, many of whom have extensive care needs. As part of these transitions, municipalities were encouraged to facilitate the provision of housing and other needed services in the community/outside of institutions. As a result of the trends in decentralization, municipalities have built up generic services that target both younger and older service users. Specialist and institutional care (e.g., nursing homes) have largely operated as stand-alone/separate units. However with decentralization, institutional care has been reduced in exchange for integrated homecare services and the enablement of new living arrangements in the community. The Norwegian healthcare coordination reform of 2012 (described below) also instigated efforts aimed at fostering a closer collaboration between specialist care and homecare services (Ministry of Health and Care Services, 2009).

The first major survey of coordinated healthcare services in Norway was commissioned by the government and carried out by the Wisløff committee. The resulting report highlighted the need for better vertically integrated care services (Romøren et al., 2011; Wisløff et al., 2005). It was also recommended that agreements between specialist and primary health services should be established to formalize procedures including for hospital admissions and discharge—with the aims of improving patient care and outcomes, and promoting efficiency in service delivery. In 2008, with the support of the Ministry of Health and

Care Services (MoHC), formal agreements were formed nationwide between municipal and specialist health services. With these foundational steps, the Norwegian healthcare coordination reform was passed in parliament and implemented from January 2012. One of the reform's aims was to promote coordinated care and in so doing ensure “proper treatment [of patients] at the right place and right time” (MoHC, 2009, preface).

The reform included three financial incentives that affected municipalities and hospitals: 1) transfer of resources from specialist care to municipalities with the aim of building up municipal acute care units (Swanson et al., 2017), 2) municipal co-financing of patients treated in the state-owned specialist healthcare services (Askildsen et al., 2016), and 3) a financial penalty paid by municipalities to hospitals and aimed at reducing the problem of “inpatient overstay” (Ambugo et al., 2018). These incentive structures further shifted the responsibility for patient care to the municipalities. The reform's success will depend not only on how well municipal and specialist care sectors collaborate, but also on the degree to which care is coordinated within municipal services. This report focuses on initiatives to improve primary health services and promote integrated care at two sites: Surnadal municipality in Mid-Norway and Søndre Nordstrand borough in Oslo municipality. These initiatives are part of the collaborative SUSTAIN project.

## 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 input 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 Table 10.1 in chapter 10 (Annexes)), 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.



**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?

### 1.3 SUSTAIN sites in Norway

Surnadal municipality was the first study site in Norway. The improvement initiative in Surnadal was part of Homecare services, which are delivered within a framework known as Holistic Patient Care at Home (HPH). HPH was launched in 2009 with the aim of developing comprehensive coordinated care for all chronically ill patients. With a focus on preventive care, Surnadal's Homecare services nurture sense of mastery and independence in activities of daily living (ADLs) and are available for all residents. Søndre Nordstrand was the second study site in Norway. As a borough in Oslo, its healthcare services are part of Oslo's municipal services. The improvement initiative in Søndre Nordstrand was affiliated with the borough's Everyday Mastery Training service (EMT). EMT provides residents with physical rehabilitation at home, and is part of the borough's 'division for prevention, voluntary work and public health (FFF). Chapters 2 and 5 of this report further describes the sites and their improvement initiatives. You can also learn more about the sites including why they were chosen and their involvement in the preparatory or baseline phase of the SUSTAIN project by seeing section 3.4 of the report by Arrue and colleagues (2016).

Chapter 4 presents the main lessons learned from Surnadal's improvement initiative. We identify factors that especially facilitated the initiative and that could be relevant for promoting integrated care in other parts of the EU. We close the chapter with our reflections on Surnadal's improvement initiative and some key points that emerged from this collaborative project. Part 2 (chapters 5-7) of the report focuses on our second site, Søndre Nordstrand. The chapters here follow the same outline as for Surnadal. Part 3 (chapter 8) features our overall national reflections where we discuss the implications of the SUSTAIN project on integrated care in Norway. We provide some recommendations for health policy makers and service providers based on findings from Surnadal and Søndre Nordstrand.

### 1.4 Reader's guide

The acronyms used in this report are defined in Table 10.2 in chapter 10 (annexes). Part 1 (i.e., chapters 2-4) of this report focuses on the first site, Surnadal. Specifically, chapter 2 provides a general description of the site and the rationale, aims and objectives of the improvement initiative. It also describes the activities that have been implemented. Chapter 3 presents the findings of the improvement initiative including a description of the activities that have improved healthcare services and care coordination, explanations for succeeding, and factors that hindered the successful implementation of certain aspects of the improvement initiative.





# **PART 1**

## **Surnadal**

## 2. SURNADAL: CHARACTERISTICS AND IMPROVEMENT INITIATIVE

### 2.1 General description of the site

Surnadal is a geographically large rural municipality in Mid-Norway with about 6,000 inhabitants. The population is spread out between the main villages, and the distance to the nearest hospital from the administrative center is 81 kilometers. Approximately 20% of the population is aged 65 years and older. Data from 2017 indicated that there were about 93 per 1000 inhabitants in Surnadal who were recipients of homecare services, and the proportion of residents ages 80 years and older who were living in an institution was about 1.25% (Statistics Norway, 2018). Surnadal's healthcare services are available for all residents. They include but are not limited to general practitioner (GP) services, emergency care, long-term institutional services, physiotherapy and occupational therapy, mental health and homecare services. Surnadal's improvement initiative was implemented within the municipality's Homecare service; and the steering group for the initiative consisted of two managers from the service. Homecare services is comprised of the following units: rehabilitation services, home nursing, day center services, and practical assistance (e.g., with household activities and ADLs).

To receive Homecare services, a resident can apply from home, be discharged from a hospital or institution (e.g., nursing home) into the service, or be recommended for the service by a healthcare professional aware of the individual's needs. Receipt of Homecare services generally begins with staff performing initial assessments of users' needs. For users discharged from hospital, a needs assessment is performed within three days post discharge, and a GP appointment is also scheduled for the user to take place within two weeks post-discharge. During the GP visit, the users' physical and psychosocial needs are reviewed and their medications assessed. Measures are then taken by healthcare staff to address any outstanding needs among users. Follow-up

assessments with users' primary contact persons (e.g., a nurse or a physiotherapist) are performed four weeks post-discharge. For users who enter the service from home, an occupational therapist usually conducts the first needs assessment. Based on the findings, users are then provided with the needed care and support (e.g., rehabilitation training, assistive equipment). For all users irrespective of how they entered the service, the staff conduct follow-up assessments after six months and then annually.

### 2.2 Rationale for improvement initiative

Surnadal's Homecare services are provided within the HPH framework. HPH is a general care pathway that follows users onwards from when they are faced with a need for Homecare services (e.g., a patient discharged from hospital who needs follow-up care in the municipality). Consistent with the aims of the Norwegian healthcare coordination reform, the HPH way of working strives to meet users' needs by providing users with the right services at the right time and place, and in a seamless manner. Undergirded by the HPH framework, the rationale for Surnadal's improvement initiative is to provide users with needed, appropriate and quality services that can enable users (especially older adults) to live safely at home for as long as possible; and to promote users' sense of mastery and independence (e.g., in ADLs). To learn more about Surnadal and the site's involvement in the preparatory or baseline phase of the SUSTAIN project, please see section 3.4.4 of the report by Arrue and colleagues (2016).



## 2.3 Aims and objectives of improvement initiative

The overall aim of Surnadal's improvement initiative was to expand and improve the quality of Homecare services provided to users, and in so doing support more users to live at home safely and promote care coordination. This aim was motivated by several factors including the Norwegian healthcare coordination reform (see section 1.1), users' own preference to live safely at home for as long as possible, the potential for reductions in costs associated with having fewer users in institutions, and Surnadal's HPH way of working (see section 2.2) and its focus on proper follow-up of users as they navigate the healthcare system. Surnadal's improvement initiative was implemented as part of the municipality's Homecare services and it comprised five improvement activities (A to E) as follows:

- A. Rehabilitation services: The objective of this activity was to discontinue rehabilitation services provided in the institution (for non-institutionalized users) and provide the services in users' homes instead.
- B. Day center: The objectives of this activity was to increase the number of users served at the Day Center, and expand the role of Day Center staff so that they could assess and inform the relevant Homecare staff about any emerging needs among users.
- C. Medication review: The objectives of this activity was to incorporate into the HPH needs assessment checklist questions that assess users' needs for medication review; and establish formal procedures for Homecare staff to facilitate the review of users' medications by GPs.
- D. Shared decision-making: The objective of this activity was to incorporate into the HPH needs assessment checklist questions aimed at involving users in identifying users' own preferences, needs and goals with regard to the Homecare services provided.
- E. Pre-emptive needs assessment: The objective of this activity was to have occupational therapists perform pre-emptive needs assessments in the homes of users who, at the time of the assessment, only had minimal needs for Homecare services (e.g., users who applied for safety alarms). The intent was to pre-identify individuals whose health and social needs portended a greater need for Homecare services in the near future. Homecare staff could then initiate preventive health measures and pre-plan for future care needs.

rehabilitation in the institution. Activity B: The Day Center, which previously served six users per day now serves 11 users per day. Additionally, to promote collaboration, staff at the Day Center are now charged with observing and communicating users' needs to the other staff in Homecare services—who then follow-up the users as needed. To aid this effort, Day Center staff now have access to users' electronic healthcare records through the Gerica database. Activity C: Review of users' medications by GPs are now based on formal procedures, which were previously lacking. Specifically, questions that assess users' needs for medication review have been incorporated into HPH's needs assessment checklist, and Homecare nurses offer to schedule and accompany users and their informal caregivers to the GP for medication reviews. Additionally, this activity on medication reviews is now overseen by health professionals trained in medication administration and safety. Activity D: In an effort to encourage users to become more involved in decisions about their healthcare, questions that address users' preferences, needs, and goals from the users' point of view have been incorporated into HPH's needs assessment checklist. The question 'What is important to you?' is an important aspect of the HPH framework and it is now part of the needs assessment checklist. In addition, efforts are ongoing to promote staff's competence in meaningfully engaging users in shared decision-making. Activity E: Occupational therapists now perform pre-emptive needs assessments in the homes of users who apply for low-threshold services (e.g., safety alarms, practical assistance with household activities).

## 2.4 Explanation of the improvement initiative

Figure 1 shows the location of the improvement activities within Surnadal's municipal healthcare services. In this section, we describe the changes that were made to Surnadal's healthcare services as part of the improvement initiative. Activity A: Rehabilitation services are now provided in users' homes, and by many of the same staff who previously provided the services in the institution. Long-term residents of care institutions continue to receive

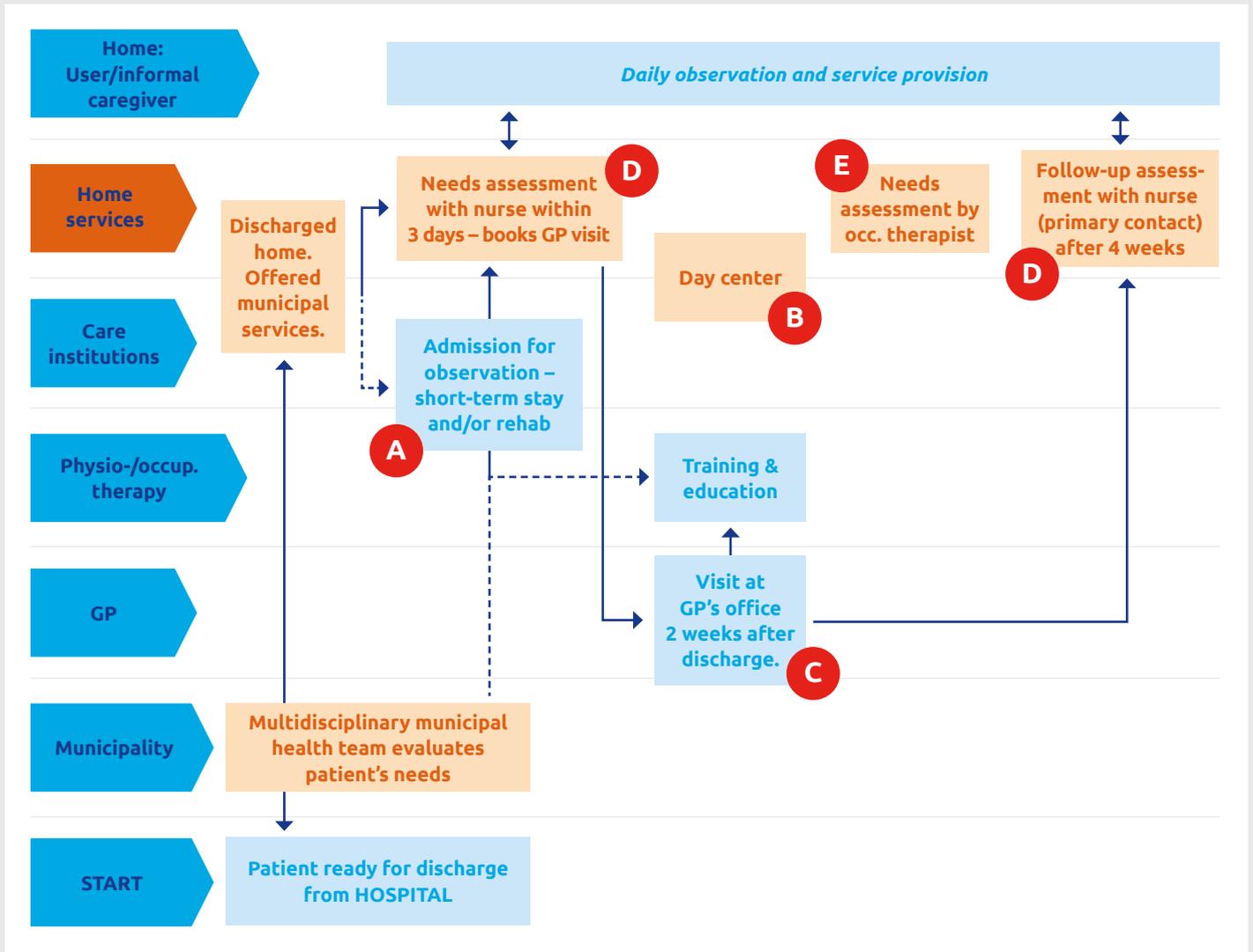


Figure 1 - Flow chart showing the point or location of improvement activities A to E within Surnadal's municipal healthcare services.





## 3. FINDINGS OF THE IMPROVEMENT INITIATIVE IN SURNADAL

### 3.1 Introduction

Ethical approval for Surnadal's participation in the SUSTAIN project was granted by the Regional Committees for Medical and Health Research Ethics (REK) of South-East Norway. Of Surnadal's five improvement activities, activity D was identified in the original stakeholders' workshop (see section 3.4.4.1 of the report by Arrue et al., 2016) whereas the others evolved gradually over time. The activities reflected local needs and priorities, and the extent to which they were successfully implemented speaks of the opportunities and constraints faced on the ground. Table 2 shows the number of study participants who were involved in data collection. **Users:** A total of 29 users participated from Surnadal, and nearly two-thirds of them were female. Most users were between ages 75-84 years, and had attained a middle-level of education (i.e., bachelor's degree or graduate certificate/diploma). The majority of the users were married and almost one-third were widowed. About two-thirds of the users lived alone at home, and one-third lived at home with a spouse. The users reported having between 2 to 11 different chronic conditions, with an average of 5.3 conditions among users. Incontinence (58.6%) and arthritis of the hip/knee (48.3%) were the most prevalent conditions, whereas COPD/asthma (6.9%) and prostrate symptoms (6.9%) were the least common.

**Carers:** Of the six carers who participated from Surnadal, one was male. Most of the carers were: between ages 75-84, married, spouses/partners of the users, and lived with the users. One-third of the carers attained a low-level of education (i.e., secondary education/vocational diploma) and the remaining attained a middle-level of education. Half of the carers also worked part-time in addition to their caregiving responsibilities. **Managers:** The two managers in Surnadal were female between 25-44 years old, employed full-time on permanent contracts, and almost all of their colleagues (98%) were female. The managers had attained

a middle or high (i.e., masters/doctoral degree) level of education. **Professionals:** At least 18 professionals were involved in the improvement initiative in Surnadal. The majority of them were between ages 35-54 years old, female, occupational/physiotherapists or nurses, employed on permanent contracts; and had attained a middle-level of education. Nursing (33.3%) was the most represented staff group and allied health professionals (11.1%) the least represented. The professionals reported that very few of their colleagues were male (2.5%). In the sections that follow, we present findings from the improvement initiative including factors that facilitated and those that hindered the initiative at Surnadal.

### 3.2 What seems to work?

#### 1. Activities that maintained or enhanced person-centeredness, prevention orientation, safety, efficiency and co-ordination in care delivery

##### Person-centeredness

As previously indicated, Surnadal's Homecare services are based on the HPH framework, and it is within Surnadal's Homecare services that the improvement initiative was implemented. It is standard for all new recipients of Homecare services to receive an initial needs assessment, and information from users' care plans and from interviews with users and carers indicated that users had received a needs assessment. Users and carers also expressed that they were involved in decisions about users' care. Their involvement was part of activity D on shared decision-making, and reflects efforts towards person-centered care.

*"I feel safe in sharing the needs I have, and I know that*



**Table 2 - Data collection at Surnadal study site in Norway.**

Data source (Professionals & managers)	# Participants	Data source (Service users & informal carers)	# Participants
Team Climate Inventory (TCI)	20	Interviews (users)	6
1 dyad-interview (managers)	2	Interviews (carers)	6
1 focus group (professionals including managers)	7	Person-Centered Coordinated Care questionnaire (P3CEQ; users)	29
		Perceived Personal Control in Healthcare questionnaire (PCHC; users)	13
		Care plans (users)	6

*if there is anything else [that] I need, I only have to call [the Homecare services office] and they will come.” (User1)*

*“...I decide what I want [to receive] help with. They could have helped me wash, but I do not want that. I prefer that [my wife] does it.” (User1)*

*“... But they [the workers] see it if I need more help, so that is not a problem. They wanted to come three times a day but I said ‘no, that is not necessary’. So I decided that - they wanted to come, but I said ‘no thank you’. But should I need more help they will come.” (User2)*

*“I like that they let me live the way I want to, and that they don’t disturb me unnecessarily.” (User3)*

*“We have not achieved this goal [i.e., shared decision-making] completely, but we are [well on our way]. We are conducting information meetings among the staff, and the question of ‘what is important to you’ has been incorporated into the check-lists.” (Manager2)*

Results from the PCHC questionnaire indicated that most users felt in control of their care, and they anticipated having good personal control of their healthcare in the future. Findings from the P3CEQ questionnaire also indicated that, on average, users felt that they were receiving person-centered care (average total score: 18.7; standard deviation: 4.03; range: 3-27). Specifically, for given P3CEQ items (range: 0-3), users felt that they were treated as a ‘whole person’ (mean=2.6), that they did not have to repeat themselves (mean=2.7) and their care was joined up (mean=2.8), and that they were receiving adequate support (mean=2.7). In addition, users expressed in the interviews that their needs were assessed properly, and met. Activity B involving the expansion of the capacity and role of the Day Center contributed positively in this area.

*Question: “Do you feel the workers are meeting your needs?”  
“Yes, when I ask for something, then they give me help. So I can’t say otherwise.” (User 2)*

*“Also, the personnel at the Day Center can have closer contact with the homecare services. They can observe the user over a longer time-period at the Day Center in addition*

*to [observing the] situation at home...since the personnel working at the Day Center also works weekend-shifts [with users at home]. They can do assessments and observations of what the user can and cannot do, and get to know the user in an entirely different way than before, when [the users] were more isolated and [staff] just delivered and picked them up from the Day Center without any further communication besides this.” (Manager1)*

Users and carers were satisfied with the way information about users’ care was communicated and explained to them. Carers also felt that staff understood users’ needs, and that, as carers, they could get support from staff if they themselves were faced with needs.

*“...if [it happens that] I [have a bad day and I’m] barely able to move, [the staff] are extra helpful and ask if there are anything more that [I need]. But of course, that varies between the different [staff] that are here.” (Carer1)*

*“I have no problems in understanding the information [the staff share with me].” (User3)*

*Question: “Do you feel you are given the right information at the right time?”  
“Yes, yes.” (User3)*

Additionally, users expressed that they were satisfied with the amount of time staff spent with them; and both users and carers mentioned that staff listened to them and treated them with respect. Users also appreciated receiving rehabilitation in the comfort of their own homes (activity A). One manager described the benefit of this service as follows:

*“...I am treated absolutely perfect. Because I am made such that I will let them know if something is not OK.” (User2)*

*“...those who earlier needed an institutional stay can now receive help at home. That means a lot to the user...Also, the changes reduce the number of transfers for the user [who] no longer has to first be transferred from hospital to an institution, and then home. Now, the user can go straight home. These transfers are not always easy, and can [impose] a lot of stress on the user.” (Manager1)*



## Prevention orientation and safety

Built into activity A (Rehabilitation at home) was an emphasis on prevention. Developing sense of mastery and independence underlay the rehabilitation training that users received in Surnadal; and by promoting users' competence in ADLs, the training likely enabled users to continue living safely and independently at home.

*"The rehabilitation at home aims at strengthening muscles and improving balance, and that is directly [focused] at prevention."* (Manager2)

*"I have been doing the same exercises every time [the staff are here]."* (User4)

*"...I am able to walk down the front-door steps [now]."* (User4)

*"...I feel that I have reached [my goals to a certain extent]. I have felt that I can do more...than I was able to do [before the rehabilitation exercises]."* (User4)

Additionally, when staff were in users' homes, they assessed the home environment for hazards (e.g., for falling). Activity B involving the Day Center was also oriented towards prevention. As previously described, Day Center staff observed users under their care and communicated any emerging needs to the relevant staff in Homecare services. In particular, as described by professionals below, the Day Center provided users with opportunities to be physically and socially active and engaged.

*"We provide physical activities every single day [at the Day Center]. We collaborate with those [who] work in the rehabilitation team."* (Professional1)

*"And the [prevention] is related to nutrition as well. Breakfast, lunch, dinner [is served at the Day Centre]..."* (Professional2)

*"We have some main challenges with the older [population]. Loneliness, fall tendencies, bad core muscles, often in relation to poor nutrition. These challenges are the three main pillars that the Day Centre is based on; food, exercise and the social [aspect]."* (Professional3)

Furthermore, by providing users with a safe place to be for part of the day, the Day Center made it possible for carers to have some respite from caregiving activities. Existing research evidence indicates that respite is important for reducing caregiving stress and its negative effects on health and well-being (Son et al., 2007). Users and carers expressed that they knew how to get help if needs arose; and users' care plans showed that many of them had received advice on how to maintain independence. As part of activity C, users received advice on medication adherence and they received support from staff and GPs in reviewing their medications. Users also reported that they were aware that they could apply for assistive equipment (e.g., mobility aids) and request adjustments to their homes—adjustments

that promote safe and independent living at home.

## Efficiency and coordination

Providing rehabilitation at home (activity A) enabled users to avoid one transfer (i.e., from hospital to an institution). It is reasonable to expect that this was not only beneficial for users, but also saved on transfer and room and board costs that would have otherwise been incurred at the institution. Similarly, the support that users and carers received from the Day Center likely enabled users to live longer at home with support from their carers. The Day Center may have therefore helped lower risk of institutionalization and its attendant costs. It is also reasonable to expect that pre-emptive assessment of users' needs (activity E) and the opportunity this facilitated for preventive measures and advance care planning contributed to better outcomes for users, and promoted efficiency in care delivery.

*"This is what we are working towards, to improve safety and prevention for the users. To enter earlier and to work effectively. Then it is all about mapping out what is needed, giving necessary information and developing good plans together with the users. There are many actors and thus many pitfalls in this, but I think that the systematic [way of working] makes us more efficient..."* (Manager2)

*"They have started to organize the rehabilitation differently now, they send out people [professionals] to the apartments and ask if we want to come for a walk or do some exercises in the apartments."* (User3)

Question: "And you receive this?"

*"Yes... they usually stop by once a day. So it is very nice."* (User3)

Some findings provided evidence of efforts at coordinated care in Surnadal. Overall based on data from the interviews, users perceived that the staff worked well together and shared information about users' care. This was also supported by care plan data which showed that for most users, care plans were being shared across different professionals. Findings from the P3CEQ questionnaire also showed that some users had a single healthcare professional who was responsible for their care. The improvement initiative in Surnadal did involve staff from different units within Homecare services. In administering their duties, the staff were organized in a manner that promoted a good understanding of the improvement initiative, and of the users being served and their needs. These efforts helped reduce fragmentation in the way of working and encouraged communication among staff across the different units of Homecare services.

## 2. Activities that did not maintain or enhanced person-centeredness, prevention orientation, safety, efficiency and co-ordination in care delivery

### Person-centeredness

Although efforts were made by staff to involve and engage users in goal setting and care planning (activity D), the managers and professionals observed that users did not



necessarily feel competent to contribute to such shared decision-making. In addition, it was not easy to ascertain the extent to which staff were meaningfully and skilfully engaging users in the conversations because there was no system in place to assess the staff's conversations with users (e.g., staff mostly work independently with users in their homes). Although findings from the P3CEQ questionnaire indicated that, overall, users were receiving person-centered care, low scores on some P3CEQ items, such as the question "Did you discuss what was most important for you in managing your own health and wellbeing?" (mean=1.1; range: 0-3), pointed to some weak aspects of person-centered care.

*"It is also a big difference between people in the answers they give [when you ask them that question]. It is hard to make the users define what is important to them."* (Professional2)

*"Yes, one needs to rephrase the question a bit [in order to help users convey what is important to them]."* (Professional2)

*"Also in regards to how the role of the user is changing as well. It is interesting. It is not always that people know what they want."* (Manager1)

*"We are often told [by the user] that we should answer that question, since we know best."* (Professional2)

Question: "Were you involved in developing goals for your health and wellbeing?"

*"They [the workers] allow me to participate all the time, so that is not a problem."* (User3)

Question: "Did you set any particular goals?"

*"No, nothing special. To get back on my feet."* (User3)

Question: "Did you create a plan for how to get back on your feet?"

*"No, nothing special."* (User3)

*"I think [shared decision-making] is an improvement area in which we need the most time [to work on] before we can [declare] that we have achieved it. This is an issue of a change in attitude. It is one thing to assemble information meetings and ensure that everyone attends and discusses the subject, but [it is hard] to be sure that every employee [conducting assessments with users is thinking about shared decision-making and keeping it in mind] that we are supposed to give the users options, that we are supposed to make sure that [what we provide is] what they wish."* (Professional3)

Carers expressed that their own needs were not proactively assessed by staff, and staff were also not very proactive in engaging carers and seeking their input with regard to users' care. Even though it is acknowledged that carers contribute immensely in enabling users to live at home safely, they are largely at the periphery of Surnadal's Homecare services. Users and carers would have also appreciated it if the findings from staff's review of users' progress, and the implications

of the findings for users' current and future goals and care activities, were comprehensively discussed with them. Additionally, some users found it challenging to be assisted by many different staff, a situation that can undermine users' sense of trust in the staff.

*"I would have liked to have [more information]. When they did the [final] assessment, it would have been nice to have some information about how she is [doing] now in comparison of when she began [the rehabilitation exercises]. Some sort of a closing report [or something]."* (Carer2)

*"You kind of get to know each other when [the staff] is here ten times. And suddenly, there is someone new [at our house]."* (Carer1)

Question: "Do they notify you before they change zones?"  
*"Yes, they tell us in advance. If they have their [last visit before a new one comes along]."* (Carer1)

### Prevention orientation and safety

Carers reported that staff did not proactively engaged them in discussions about potential problems or side effects of users' medications, and how they should respond should such needs arise. They also expressed that they were not offered any training in practical assistance, which might have limited their capacity to competently support users.

*"No, I have not been offered [training of any sort], [but] I know what is necessary [in order to take care of my mother]. I know what [kind of help] she has a right to, and I know what I [in my role as both a healthcare worker and a daughter] want her to receive [of healthcare services]. It would have been nice to have been offered [such training] though."* (Carer2)

Some evidence from the interviews with carers indicated a need for a prevention oriented approach that includes assessments of carers own needs. Carers are often spouses of users who are also at a stage in the life course where multiple chronic conditions begin to emerge. If carers needs are proactively assessed, staff can intervene on time for if carers are not healthy enough, they cannot support users at home. The managers strove for a prevention oriented way of working, but they faced an uphill battle advocating for prevention.

*"To invest in prevention rather than [terminal care] is something that is difficult both nationally and locally. When you have to choose, the preventive care and maintenance work is not that obvious. When there is talk of closing down institutional care [capacity], the question everyone asks is 'where is that patient supposed to go?' We try to convey that if we are able to prevent such health and care needs for seven users, we can avoid that need emerging altogether. But [for many people] it is the end point outcomes that are most important, instead of focusing on prevention."* (Manager1)

Review of users' care plans showed that falls were not being recorded. However, staff knew which users had

experienced falls. That this knowledge is informal, not recorded, may deprive other healthcare professionals of important information about users' vulnerability for falling.

### Efficiency and coordination

Most of Surnadal's improvement activities fell within pre-existing Homecare services. Even so, implementing the improvement initiative was demanding of managers' and staff's time. A cost-effectiveness evaluation is yet to be performed to assess whether providing rehabilitation at home (activity A) versus in the institution is less costly. Input from professionals painted a mixed picture. On one hand, providing rehabilitation at home reaches more users, enables them to receive training that promotes their competence in ADLs, and gives staff the opportunity to identify hazards in the home environment that can then be addressed. Together, these factors can be expected to yield positive gains in terms of users' well-being and cost savings from avoiding institutional care.

*"Now we can help between 15-20 users in a week. Previously, we had room for five patients at the institution, and not all of the patients received rehabilitation either."* (Professional3)

*"And we are able to do more preventive work as well compared to the service provided in an institution. That was more about repairing."* (Professional2)

*"And you can see more [and] detect more as well when you come home to the user. [You can] identify some elements [that need to be addressed]."* (Professional4)

*"And you are able to focus the rehabilitation on more specific daily activities that the user wants to be able to do at home."* (Professional2)

On the other hand, factors such as the following may undermine the effectiveness of providing rehabilitation at home:

*"And that of motivation. You come home to the user, and the rehabilitation provided is more on the user's premises. One has to spend much more time to motivate the user to participate in the rehabilitation. In an institution, the users that were there [ready] to rehabilitate. When they are at home, users wish to do other things as well. When the user is at an institution, there [is] a prerequisite that they are there for a short, specified time. At home, the mind-set is totally different, so one has to spend more time motivating."* (Professional3)

*"Yes, and they are not as dedicated. We might come to their house and find out that they are not [even] home."* (Professional2)

*"Less equipment. One has to be more creative in finding good rehabilitation methods and what we can use at the home of the user..."* (Professional3)

Additionally, providing rehabilitation at home may generate extra costs linked to staff's transportation and travel time

to users' homes.

With regard to coordination in care delivery, findings pointed to some areas of weakness. For example, interview data showed that carers generally had minimal contact/communication with staff. Also for many users, care plans did not indicate the role of informal carers, suggesting that carers and their contributions are not officially included as a key part of users' care and activity plans—yet carers, like users, should be a central part of coordinated care delivery. Data from interviews with managers showed that communicating with GPs and other key actors was challenging, a situation that has implications for timely and effective care delivery. For most users, care plans were not being shared across different organizations. Additionally, none of the users who completed the P3CEQ questionnaire had received services from a voluntary organization, which speaks of a missed opportunity to collaborate with this important sector.

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

The Norwegian healthcare coordination reform created an impetus for some of the improvement activities implemented in Surnadal. For example, one incentive of the reform penalizes municipalities for in-patient overstay occurring among patients declared ready for discharge and in need of follow-up care in the municipality. At the same time, the reform transferred funds from hospitals to municipalities to aid the latter in strengthening their local healthcare services.

*"The [reform] came and emphasized home-based services and municipal healthcare services as a whole. [The reform basically] describes the challenges that we are addressing..."* (Manager1)

The improvement initiative was overseen by two very competent managers with many years of experience overseeing Homecare services. They skilfully lobbied for activity A on providing rehabilitation at home, and they provided stable and adept leadership throughout the course of the improvement initiative.

*"...if we look at the first improvement point of offering rehabilitation at home, we worked on this for a year to facilitate collaboration between the homecare services and the rehabilitation department. We felt that we did not succeed in this and came to the conclusion that it would be best to just close down the rehabilitation department and move the resources to the homecare services. This faced great opposition especially from the staff and other service providers like the GPs and physiotherapists. They meant that this was reckless and [they did not like the uncertainty that this decision created]...Of course, both inhabitants and politicians [agreed with them], but we managed to*



*argue that we would create an even better offer in the home-based care, and said that if it does not work out, we can just reopen the capacity at the rehabilitation department after trying [the new organization of services] for a year or so". (Manager1)*

Findings from the Team Climate Inventory questionnaire (TCI) indicated a positive team climate overall among the staff involved in the improvement initiative. Results also showed that the team considered the initiative to be worthwhile and achievable. The managers of the improvement initiative were motivated, and both they and the staff contributed meaningfully and collaboratively to the project.

Surnadal's Homecare services are valued and considered to be of good quality, and the managers and staff are trusted in their competence by both lay persons and decision-makers (e.g., politicians). Consequently, the managers were given good freedom to manage the budget for their unit and make needed decisions, including those pertaining to the improvement initiative. These conditions, that the managers were trusted to do their work with little interference, greatly facilitated the implementation of the improvement initiative.

*"We are organized in a way that provides us grants that we are free to spend as we see fit, within that framework. We make plans as we go, based on main goals that we have agreed on. Then, we give a lot of trust and responsibility to the healthcare workers that are to face the challenges that are out in the field". (Manager1)*

The improvement initiative was also facilitated by a national activity known as The Learning Network Good Patient Pathway (GPP). The managers participated in this program and shared with other GPP participants about Surnadal's Homecare services and the HPH way of working. They in turn learned from the experiences of the other participants and were inspired to further look into their own services and scrutinize their way of working. For example, ongoing work to review HPH's needs assessment checklists to ensure that they are comprehensive and relevant was inspired in part by the GPP. The collaboration with SUSTAIN also played an important role.

*"It has been very interesting to be followed up [by SUSTAIN] in this way. It has forced us to really dig deep to provide answers. Because the days fly by and we manage somehow, but it is [important] to stop for a minute, to reflect, concretize and develop what we are doing, both in the minor and larger areas". (Manager1)*

Activity A on providing rehabilitations at home and activity B on expanding the capacity and responsibilities of the Day Center relied on staff with good pre-existing competence, a key facilitating factor.

*"What has contributed [to achieving the goal of rehabilitation at home] might be that the rehabilitation team have been previously working in the rehabilitation department. So we have experience with rehabilitation,*

*instead of spending time training [staff in how to rehabilitate], but that we instead have been able to implement it directly". (Professional3)*

Other factors that promoted the improvement initiative include HPH checklists that guided needs assessments and other processes central to delivering Homecare services; well delineated work plans for staff; and Lifecare Mobile Care (LMP), the electronic platform that made it more efficient for staff to work with users in the field by encouraging ease of communication and record keeping. In addition, activity E (pre-emptive assessment of users' needs) and its focus on preventive measures and advance care planning also helped improve Surnadal's Homecare services and promoted integrated care.

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

The initiatives that comprise Surnadal's improvement initiative took shape gradually, and after they were identified the improvement team made steady progress implementing them. Reorganizing rehabilitation to be provided in users' homes required that staff collaborate and adjust to some new ways of working, which took time.

*"...the attitudes that the personnel [i.e., rehabilitation staff from the institution] brought with them to homecare services from their local cultures and way of doing things has been a gradual adjustment [to change]. Some [of the staff] are more positive than others [to the new organization]. We have all varieties [of attitudes]. We have tried to listen to [the staff's] experiences and evaluate how things are going, and the feedback has been that things are going pretty well overall... Just to merge the two personnel groups as well; the homecare nurses that work in a fast pace and then comes the rehabilitation [staff] who have meetings on meetings and discuss [extensively] and work in a way [that can be experienced as] slow—and go on slow walks [with users], slowly up the stairs and such. So [not everyone] was so pleased as it was an adjustment". (Manager1)*

New laws and directives from the central government emerge every so often that call on municipalities to address different issues. These directives do not always take into consideration or are not always harmonized with pre-existing activities and financial conditions. They created extra pressure in the Homecare service which likely impacted the improvement initiative.

*"I feel that there is a disparity between the order from central authorities through laws and regulations. Then there is a demand that we have to meet, and expectations of how everything should be... We have actually managed pretty well, but at the same time there are many different areas where we see that we have not been able [to meet the requirements]... The municipalities are expected to take*



*on more responsibility and deliver higher quality care with less resources... I think one issue is that we try to achieve a lot of goals at the same time, and then the tasks are [actually a bit too big]. With these White Papers and laws and regulations and guidelines together – just the tasks the homecare services are supposed to solve - [it is way too much]. In all the different areas, there are big fat stacks [describing] what issues we are supposed to address". (Manager1)*

Additionally, Homecare services was short-staffed such that some elements of the improvement initiative were implemented intermittently and in competition with other tasks. Efforts were ongoing to recruit and hire additional healthcare professionals but given Surnadal's rural location, it could take a little time to recruit new employees. The improvement team made a good effort on the improvement activities, but time constraints persisted as a challenge.

*"I feel that the issue of time is [an important barrier]. We are able to do a lot of course, but we would like more time in order to [really] complete the improvement initiative. We initiate new actions, and then they lie there and wait [for us to continue the work] the next time we might have the time for it". (Manager1)*

The managers expressed that it would have been beneficial if municipal service units (e.g., Homecare services and the safety or information technology units) were strategically co-located. This might have encouraged collaboration in goal setting and problem-solving, and promoted knowledge sharing and efficiency in service delivery. However, it remained a challenge for GPs to communicate effectively and in a timely manner with Homecare staff. When problems arose, it was often because communication was one-way as expressed below, and this could undermine proper and efficient delivery of services.

*"We often send [requests and reports] to the GP but get [little information] back...this puts limitations on the collaboration". (Manager2)*

Even though Homecare services are valued, key decision-makers at the upper levels of the leadership hierarchy in the municipality appeared to not be very attentive to Homecare services and their gains and accomplishments, or their needs and challenges.

*"...I feel that I can just go to the [chief municipal executor] and discuss with him...[because]...there is a high degree of trust. At the same time, his knowledge...understanding and insight of what we are doing [could be better]. That is thus also a part of my job, to emphasize the complexity [of our field]. The personnel are highly educated...so we are comparable with any [specialist] company in other industries. But these receive more acknowledgement I think... Without sounding bitter of course but it is a bit typical. I have tried to demonstrate [what we do] through media coverage and show that we work well and [achieve what we set out to do, and receiving recognition] could have been better. I [think] this is a general issue [throughout the nation]". (Manager1)*

The managers felt that despite their efforts, they did not have the ears of key decision-makers, and this could have implications for Homecare services and the improvement initiative (e.g., in the area of municipal budget allocations). The managers thus suspected that their sector (i.e., Homecare/municipal health services) was not equally valued as other sectors, which was discouraging. Even though activity B on increasing the capacity at the Day Center was achieved, there remained ample demand among users for the Day Center, but a larger physical space is needed if more users are to be served.



## 4. MAIN LESSONS LEARNED FROM SURNADAL

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

In collaboration with the SUSTAIN project, the managers of Surnadal municipality's Homecare services spearheaded efforts aimed at improving Homecare services over an 18-month period from autumn 2016 to spring 2018. They focused on five initiatives as follows: providing rehabilitation services in users' homes, expanding the capacity and role of the Day Center, implementing procedures for the review of users' medications, engaging users in shared-decision making, and conducting pre-emptive needs assessments for users who may be at risk of needing more extensive Homecare services in the near future. In this section, we describe the lessons learned from Surnadal's improvement initiative and factors that can promote integrated care improvements here in Norway and in the EU.

Surnadal's Homecare services and the HPH way of working are supported by extensive use of checklists. The checklists ensure that important care-related assessments are made at the right time. They also provide procedures for carrying out needed care-related activities. Proper follow-up of service users is a central element of integrated care, and checklists have helped facilitate this activity in Surnadal. It is generally understood that integrated care systems should foremost serve users, and to do so effectively, these systems have to meaningfully engage users. The process of engaging users starts by listening to them and treating them well, because doing so can help users feel that they are a part of the integrated care system, and encourage their involvement in it. Promoting efficiency is another important consideration in integrated care. Surnadal made efforts towards this by providing rehabilitation at home,

which reduced the number of transfers experienced by users. Most importantly, the cornerstone of Surnadal's successful implementation of many elements of their improvement initiative is the fact that their team was led by competent, experienced, and motivated managers who firmly believed in the importance of the initiative.

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

Promoting sense of mastery and independence among users was an important factor underlying Surnadal's improvement initiative. It served as a basis for the question asked of users: "what is important to you?" Encouraging users to be engaged in, and to meaningfully contribute to, discussions and decisions about their care acknowledges users' as important actors in the process of delivering integrated care. Countries across the EU can strive to promote sense of mastery and independence among users as an important part of improving integrated care.

The initiative in Surnadal was designed in a manner that capitalized on the existing skills and competencies of staff (i.e., the skills that the trained nurses at the Day Center, and that the physiotherapists in the rehabilitation unit, already had). This was a useful strategy that others in the EU can adopt. Additionally, other EU countries can



also learn from the incentive structures of the Norwegian healthcare coordination reform, which have provided a strong impetus for reorganizing healthcare services and increasing collaboration in Surnadal—as reflected in the improvement initiative. It goes without saying that good leadership is essential for effectively implementing any improvement initiatives. The managers in Surnadal were experienced and led their teams competently. Equally important, they were trusted by their superiors and given room to implement the improvement initiative with minimal interruption, a factor that greatly facilitated their work and is a model that other countries in the EU can benefit from.

### 4.3 Methodological reflections

The uncertainty surrounding the improvement initiatives at Surnadal during the initial period of the project made it challenging for us, the researchers, to communicate effectively with the sites. We were thus not well informed about the activities taking place on the ground. This situation, however, improved when the sites gained a clear understanding of their initiatives. The managers made concerted efforts to mobilize their teams, and together they contributed substantially to the collaborative project with SUSTAIN—including serving as respondents for data collection and helping recruit users and carers for data collection. Overall, Surnadal met its target for data collection among users and carers. With regard to users' experiences with the P3CEQ questionnaire, some of the questions only had four answer choices: "1: not at all, 2: to some extent, 3: more often than not, 4: always". Some of the users wanted a fifth choice between "2: to some extent" and "3: more often than not", but instead had to select the closest choice from among the available four. The P3CEQ questionnaire could be improved in this area. Many of the questions also did not give users the choices: "don't know" and "refused", which should be standard answer choices in questionnaires. In the PCHC questionnaire, question 24 "In the event that my mind deteriorates, I can make the necessary preparations beforehand so that I can remain in control (such as recording my wishes in writing..., or end of life wishes)" was uncomfortable for some of the users to think about/contemplate given that they were at a vulnerable stage in life.

The users in Surnadal did not have hard copy care plans, but we managed to access users' electronic care plans by talking to healthcare professionals knowledgeable about the users' care. Time constraints faced by the managers and their improvement team made it difficult for each of the staff involved to continuously monitor and record efficiency data (e.g., the extra hours spent by the staff on given improvement activities). For this reason, the managers provided us with efficiency data based on their best approximations, which are therefore not very precise. Surnadal's steering group consisted of the two managers of Homecare services and therefore lacked diversity. The improvement initiative in Surnadal would have been enriched if the steering group included more

participants from relevant and diverse sectors. Aside from these deficits, it is our view that the improvement team at Surnadal made a good effort in their involvement and contributions to the improvement initiative, especially considering that the site did not have sufficient funds to support the additional tasks linked to the improvement activities.

### 4.4 Overall reflections and key points

Experiences from Surnadal with improving integrated care indicated that the first step of identifying the improvement initiative takes time. Proper assessments should be performed to identify areas in need of improvements in the healthcare service, and the chosen improvement initiative should reflect local priorities. For Surnadal, no extra funds were provided for the improvement initiative. The managers worked within the available budget, and because the resource-demanding activities A and B were implemented as within pre-existing Homecare services, the managers succeeded in implementing these activities with limited financial constraints. Adopting new work cultures and procedures as part of the reorganization of services and staff presented a challenge that Homecare services is gradually overcoming. While it is positive that Homecare services and the improvements activities therein largely focused on users, improvements to integrated care for older adults living at home should also focus on carers—on whom users depend, and increasingly so as users age. In addition to providing carers with respite when users are at the Day Center, which is an important service that Surnadal provides; greater efforts are needed to meaningfully engage carers in discussions about their own needs as carers and their experiences with caregiving. In addition to the Day Center, more opportunities should be identified to further support carers in Surnadal because well-supported carers are more likely to provide users with good support at home, and for longer. Some key points from Surnadal for site managers looking to improve integrated care include:

- If you do not have extra funding to support your improvement initiative, identify and focus on initiatives that can be implemented within the existing care system, and by employing the expertise of the available staff.
- Mobilize broad support for the improvement initiative, especially among key decision-makers and the staff who will be charged with implementing the improvement initiative.
- Provide the improvement initiative team with competent, engaged and supportive leadership; and invite staff to be engagement in the improvement initiative in a manner that gives them ownership of the work.
- Seek a stakeholder (e.g., your funder, a collaborator like SUSTAIN) to be accountable to. This will motivate you to take stock of your accomplishments, reflect on and reassess your way of working, and encourage you forward towards your goal.



# **PART 2**

## **Søndre Nordstrand**



## 5. SØNDRE NORDSTRAND: CHARACTERISTICS AND IMPROVEMENT INITIATIVE

### 5.1 General description of the site

Søndre Nordstrand is the largest and youngest borough in Oslo municipality. It has approximately 38,000 residents of whom approximately 5.3% are ages 65 years and older. Additionally, over half of the borough's residents are of an immigrant background. The improvement initiative in Søndre Nordstrand was implemented as an affiliate project of the Everyday Mastery Training (EMT) service. EMT is part of the borough's "division for prevention, voluntary work and public health (FFF)", and provides rehabilitative care (including training in ADLs) to users in their homes for 4-8 weeks. The health and social care services provided in Søndre Nordstrand are part of Oslo municipal services. They include but are not limited to emergency care, GP services, nursing homes, Day Center, senior center, homecare services, mental health services, and rehabilitation including EMT. If we focus on users of EMT as the target group for this site, we can describe them as all of the borough's residents ages 18 years and older who apply for the service. The users who participated in SUSTAIN were recipients of EMT services and were ages 65 years and older.

Søndre Nordstrand's improvement initiative was overseen by a steering group comprised of two managers from EMT, the assistant director of the borough, an administrator from the borough's application office (i.e., office that handles residents' applications for services), a staff member from the borough's voluntary office (part of FFF), and staff from other units within the borough's homecare services. Contact with the EMT service can be initiated by users themselves, the GP and other healthcare professionals, and by the hospital as part of discharge planning. If initiated by the GP or hospital, the municipality is informed of the user's needs via a report or a message relayed through e-link, which is an electronic communication service. After the user has made contact directly or indirectly (e.g., via the GP) with the municipality, the borough's

application office determines the user's eligibility for EMT. A physiotherapist or nurse then conducts the first needs assessment with the user at home, the results of which determine whether or not EMT services will be provided and the intensity and duration of the service. A care plan (i.e., rehabilitation and action plan) are then developed and registered in the electronic database Gerica, which is accessible to other healthcare staff. During an intensive 4 to 8-week rehabilitation period with EMT, staff informs the user about the available low-threshold and volunteer services that can help promote and maintain the user's health and well-being. Both EMT staff and other healthcare personnel working in the borough can help the user access other relevant and desired services. For example, the user may get a place or be put on the waiting list for the service Senior Exercise.

### 5.2 Rationale for improvement initiative

In order to reduce users' reliance on traditional health services (e.g., home nursing), Søndre Nordstrand depends on well-functioning and volunteer-supported low-threshold services. Users and other residents in the borough should know about and participate in these services if the expected gains of the services (e.g., promote physical and social functioning and engagement) are to be achieved. It has been challenging for the borough to establish and maintain a fruitful collaboration with its voluntary organizations. Both parties recognized that a closer collaboration would be mutually beneficial, but they lacked a common platform that would enable them to work together effectively. Søndre Nordstrand's improvement initiative therefore



emerged primarily to better support and promote users' well-being through low-threshold services encompassing the voluntary sector. To learn more about the site in Søndre Nordstrand and its involvement in the preparatory or baseline phase of the SUSTAIN project, please see section 3.4.5 of the report by Arrue and colleagues (2016).

### 5.3 Aims and objectives of improvement initiative

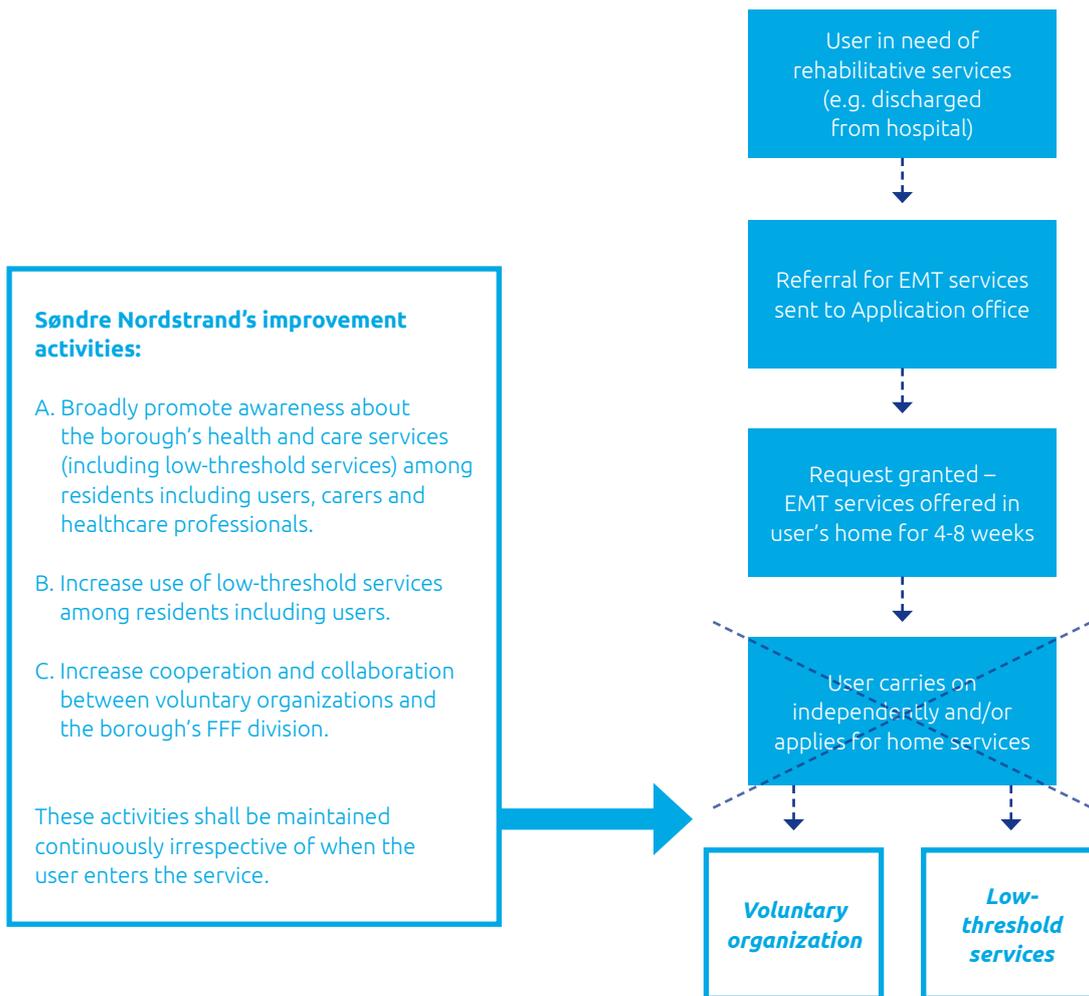
The overall aim of Søndre Nordstrand's improvement initiative is to promote use of low-threshold and voluntary services among users as a means of supporting and maintaining users' overall health and well-being, including their sense of mastery and independence in ADLs. In so doing, users may become less reliant on the borough's traditional healthcare services (e.g., home nursing). Users' uptake of low-threshold and voluntary services should encourage physical and social participation among users. As such, these services could lower risk of loneliness and sedentary lifestyles—which are factors linked to poor health outcomes (Penedo and Dahn, 2005; Tomaka et al., 2006) and can increase dependence on traditional health services. As an affiliate project of EMT, Søndre Nordstrand's improvement initiative included three improvement activities (A to C) as follows:

- A. Broadly promote awareness about the borough's services (traditional healthcare services, low-threshold and voluntary services) among residents, especially service users, carers and healthcare staff. Low-threshold services are non-healthcare related activities that encourage social participation (e.g., elderly residents meeting to socialize and exercise at the senior center). If users, their family carers and other key persons around them (e.g., staff) are aware of and inform users about the range of services available in the borough, users are more likely to seek out these services. The objective of activity A is to use information screens in high impact areas in the borough (e.g., grocery stores) to broadcast information and promote awareness of the borough's health and social care services.
- B. Increase use of low-threshold services among EMT users and other residents. The objectives of activity B are to: employ a senior supervisor to work closely with the senior center to increase use of low-threshold services among the elderly, including EMT users; and engage volunteers to offer low-threshold services to users and other residents.
- C. Increase cooperation and collaboration between voluntary organizations and FFF (the borough's division for prevention, voluntary work, and public health). The objectives of activity C are (to): (1) appoint a resource person within each of the units involved in the collaboration between voluntary organizations and FFF. These individuals would help facilitate communication across the different units and thus promote a closer collaboration; (2) employ the application office to link users to low-threshold and voluntary services. The application office is in charge of processing applications

for municipal health services, including EMT; and (3) develop collaboration agreements between voluntary organizations and FFF.

### 5.4 Explanation of the improvement initiative

Figure 2 shows the location of the improvement activities within Søndre Nordstrand's EMT care pathway. In this section, we describe the changes that were made to Søndre Nordstrand's services as part of the improvement initiative. Activity A: The borough has installed several information screens in high impact public areas (e.g., grocery stores, Senior Center). The screens broadcast information about the borough's health and social services. Activity B: A senior supervisor has been hired. This step has contributed significantly to promoting awareness about, and increasing the use of, different services in the borough for older adults. The senior supervisor contacts as many residents as possible in the borough who are aged 80 years and older and informs them about, and also helps them get in touch with, services that match their needs. The borough has also successfully implemented a new program called Senior Exercise. As part of this popular service, elderly residents can participate in exercise sessions together with their mates at given times during the week and under the guidance of an instructor. Additionally, a volunteer coordinator (part of activity C) has established a service called Senior Info where older residents in the borough can drop by and ask questions about available services, and also receive guidance and support on using computers and searching for information online. Activity C: A resource person has not been appointed within each of the units involved in the collaboration activity between voluntary organizations and FFF. It is in the planning phase. The idea of employing the application office to link users to low-threshold and voluntary services has been discontinued. Developing collaboration agreements between voluntary organizations and FFF has been initiated but not completed. A volunteer coordinator has been appointed to function as a contact person between the voluntary centrals in the borough and FFF. Another key task of the volunteer coordinator is to recruit volunteers to help with the low-threshold services.



**Figure 2 -** Flow chart showing the location of improvement activities within Søndre Nordstrand's EMT care pathway.



## 6. FINDINGS OF THE IMPROVEMENT INITIATIVE IN SØNDRE NORDSTRAND

### 6.1 Introduction

Ethical approval for Søndre Nordstrand's participation in the SUSTAIN project was granted by the Regional Committees for Medical and Health Research Ethics (REK) of South-East Norway. Of Søndre Nordstrand's three improvement activities, activity A was identified at the original stakeholders' workshop whereas the others evolved gradually over time. The initiatives reflected local needs and priorities, and the extent to which they were successfully implemented was indicative of the opportunities and constraints faced on the ground. Table 3 shows the number of study participants who were involved in data collection. **Users:** A total of 11 users participated from Søndre Nordstrand, and nearly two-thirds of them were female. Most users were between ages 65-74 years old, married, and had attained a middle-level of education (i.e., bachelor's degree or graduate certificate/diploma). Slightly more users lived at home with a spouse/partner (54.6%) compared to those who lived at home alone (45.5%). The users reported having between 2 to 12 different chronic conditions, with an average of 5.1 conditions among users. Persistent back pain (54.6%) was the most prevalent condition whereas anxiety/panic disorder, depression, osteoporosis and prostate symptoms were the least common (each reported by 9.1% of users).

**Carers:** Only two carers participated from Søndre Nordstrand's, a male and a female both in the age-group 75-84 years. The male carer attained a high-level of education and the female attained a low-level of education. Both carers were married/cohabiting and lived with their spouses/partners, who they were caring for. Neither of the carers had paid work, and they served as caregivers full-time or around the clock. **Managers:** The two managers in Surnadal were male and female in the age groups 25-34 and 45-54 years. They both attained a middle level of education, had permanent employment contracts, and

worked full time. The managers reported that most of their colleagues were female (85%). **Professionals:** At least 12 professionals were involved in the improvement initiative in Søndre Nordstrand. The majority of them were between ages 35-54 years old, female, employed full-time on permanent contracts, were occupational/physiotherapists or leaders/administrators in the healthcare sector, and had attained a middle-level of education. Allied health professionals (50%) was the most represented staff group and nursing (8.3%) the least represented. The professionals reported that most of their colleagues were female (78.8%). In the sections that follow, we present findings from the improvement initiative including factors that facilitated and those that hindered the initiative at Søndre Nordstrand.

### 6.2 What seems to work?

#### 1. Activities that maintained or enhanced person-centeredness, prevention orientation, safety, efficiency and co-ordination in care delivery

##### Person-centeredness

User and carers from Søndre Nordstrand expressed that staff treated them well, and that they were satisfied with the way important information about users' care was explained to them. EMT staff also became knowledgeable about low-threshold services available in the borough (activity A) and were informing users about them.

*"[The workers were] terrific people. Very friendly ladies that were here. There were two men here as well. [They were both very thoroughly]. [Every worker] that were here behaved [outstanding] So [the service] was ['top-notch']."*  
(User2)



**Table 3 - Data collection at Søndre Nordstrand study site in Norway.**

Data source (Professionals & managers)	# Participants	Data source (Service users & informal carers)	# Participants
Team Climate Inventory (TCI)	14	Interviews (users)	4
1 dyad-interview (managers)	2	Interviews (carers)	2
1 focus group (professionals including managers)	4	Person-Centered Coordinated Care questionnaire (P3CEQ; users)	11
		Perceived Personal Control in Healthcare questionnaire (PCHC; users)	7
		Care plans (users)	3

*"We are always aware of low-threshold services and volunteer... We are always considering if they have any services that could be beneficial for the users. We have become more aware of these options and they are a part of our daily discussions involving users. Even though we might not have suitable offers, the options are at least discussed actively. The 'Senior Exercise' program is what we are definitely using the most..." (Manager2)*

Carers felt confident in the ability of the staff to assist users with their care needs, and users and carers perceived that staff worked well together. They shared information and were knowledgeable about users' care needs such that users did not have to repeat themselves.

*"I don't know what the criteria are, but we felt very well taken care of by the professionals that were here." (Carer1)*

*"...they [EMT staff] were very thorough in following up what they said. They didn't just tell her [the user] what to do, she had to do it as well." (Carer1)*

*"I think they worked well together and had good contact amongst themselves." (User2)*

*"I just want to add that when they came here, the non-therapist staff, they knew everything that had happened here. At least that's how I felt it." (User2)*

Sharing of information among EMT and other Homecare staff was also facilitated by staff's access to the Gerica database that holds users' electronic care plans, and also by regular staff meetings and staff's access to users' folders with information about their rehabilitation plans.

Users' needs for rehabilitation were assessed, and users reported being involved in setting their goals for rehabilitation. Care plan data also indicated that most users' needs had been assessed and users' goals and care activities described.

*"I was involved to the degree I was able [in developing my care goals]." (User2)*

*"They asked me about my goals, yes. [All of my goals and the help I got shown] in the exercise form that I have been given. [I worked on] strengthening of thighs and calves and increasing my balance. The [specific goal was to be able to] stand up from [my] chair and to improve my balance while standing up." (User1)*

Users were able to continue living at home with the support they received from carers, family and staff. Both users and carers knew how to contact staff if needs arose, and results from the P3CEQ questionnaire suggested that, overall, users considered their care to be person-centered and coordinated (average total score: 18.8; standard deviation: 6.9; range: 3-27). Specifically, for given P3CEQ items (range: 0-3), users felt that they did not have to repeat themselves (mean=2.4) and their care was joined up (mean=2.6), and that they were receiving adequate support (mean=2.4).

*"[The staff] have absolutely helped me in all ways [to live independently]." (User2)*

*"...I have been happy. I didn't have high expectations. I had heard that Søndre Nordstrand wasn't that good, but I think it is and I have been positively surprised by the quality [of care] in all ways. ...[the staff] have been concerned about my health and that I take care of myself." (User2)*

Evaluation of users' status with training showed that they were making progress towards their rehabilitation goals. Overall, users also felt that they had good personal control of their healthcare, and they expected the same in the future.

### **Prevention orientation and safety**

Promoting sense of mastery and independence is an important part of EMT and the improvement initiative. Low-threshold services like Senior Exercise (activity B) promote physical and social participation, both of which are important for users' health and well-being.

*"The low-threshold services represent to a large extent the public health and preventive measures implemented. ... To invest in prevention rather than the heavier health and care services. This is something we are working towards on*



*a daily basis. This is a long-term goal among everyone. ... And we can see that the effects of the low-threshold services are positive. So then we need to dare to re-prioritize the resources to strengthen these kinds of services.” (Manager2)*

According to healthcare professionals knowledgeable about users’ care, GPs reviewed users’ medications, and users also had access to safety alarms, mobility aids and medication dispensers. Furthermore, users and carers expressed that they could request for adjustments to be made to users’ homes to improve safety; and they could apply directly to the ‘aid central’ if users’ needed to borrow equipment (e.g., wheelchairs, canes, special toilet seats).

*“There is a person I have contacted a couple of times and I have received very good help from her... I have her number and she is immediately helpful with whatever I ask about.” (Carer1)*

*“...we have been granted handicap parking, and we have been given a TT card [i.e., a voucher for transportation], and we have been given access to the aid central. It was also arranged so that the [assistive equipment] from the municipality was available to us on a permanent basis and the municipality brought it here to us. We have been given everything we need. It has been very good.” (Carer1)*

Users’ care plans indicated that they have received advice on how to maintain independence. Efforts have also been initiated to record falls and fall tendencies among users. This is an important step towards a prevention oriented way of working.

### **Efficiency and coordination**

A senior supervisor was hired as part of activity B and a voluntary coordinator was appointed as part of activity C. That these full time positions have been filled has greatly promoted the improvement initiative. These individuals are focused and committed to developing low-threshold and voluntary services, and encouraging use of these services among users. As these services take root and more users get involved, it can be expected that the services will help reduce users’ reliance on the borough’s traditional healthcare services.

*“We have hired a senior supervisor who is currently working full-time. This has worked very well. That person has done a great job and is a driving force for coordinating [and expanding] the low-threshold services.” (Manager2)*

*“We are able to recruit to a much larger extent when we have a senior supervisor with a full-time position working with the elderly... This results in more recruitment [of the elderly] to the low-threshold services and to the everyday rehabilitation perhaps. [Seen] from the public health perspective, there is a wish to engage the elderly at an earlier stage to such services, so that [in the long-run] we have fewer that are in need of compensating actions.” (Manager2)*

Through their work, the senior supervisor and voluntary coordinator are promoting a closer collaboration between low-threshold/voluntary services and FFF including the EMT service.

*“Senior Info is operated by the [voluntary coordinator], so that is [a part of the improvement point of increased collaboration with voluntary organizations] that we have achieved actually. So, the library at Holmlia has given us access to their premises and volunteers are operating “Senior Info” [i.e., being available and answering questions from the elderly at the library]”. (Manager2)*

*“...Even though there are not many new changes [since we entered the Sustain project], there has been many positive developments. There is a much closer collaboration with the voluntary centrals, and they have become more positive to working closely with the boroughs as well. In addition, there is [now] closer follow-up at the Senior Center regarding more use of volunteers and such. Both the senior supervisor and the voluntary coordinator are much more closely engaged there [in increasing the collaboration with the voluntary organizations]”. (Manager1)*

Additional findings provided evidence of efforts at coordinated care in Søndre Nordstrand. In the interviews, users and carers expressed that staff shared information with one another and were knowledgeable about users’ care needs. Findings from the PCHC questionnaire also indicated that, overall, users could navigate with ease the areas of organizing professional healthcare and contacting healthcare professionals. It was also expressed in the focus group discussions that the improvement initiative has encouraged closer communication between professionals and service users and their informal carers. Additionally, care plan data showed that for most users the care plan was being shared across different professionals and organizations.

## **2. Activities that did not maintain or enhanced person-centeredness, prevention orientation, safety, efficiency and co-ordination in care delivery**

### **Person-centeredness**

Even though findings from the P3CEQ questionnaire indicated that, overall, users were receiving person-centered care, low scores on some P3CEQ items (range: 0-3), such as the questions “Did you discuss what was most important for you in managing your own health and wellbeing?” (mean=1.1; range: 0-3) and “Did the healthcare staff involve your family/friends/carers as much as you wanted them to be in decisions about your care?” (mean=1.6; range: 0-3), pointed to some weak aspects of person-centered care. Users would have appreciated a little more time with staff. They and the carers perceived that the staff were busy and lacked extra time to spend with them and support them adequately (i.e., staff are in-and-out when assisting users).

*“Yes, I have been given a form [with information about] the exercises. So [even with the limited time, the exercises] went well. But, instead of doing [the exercises] three times [with] ten [repetitions, the workers had only time for] one time [with] ten [repetitions]. They did have little time, and I do manage to do the exercises by myself. They wished to be brief in order to help others. And that was fine”. (User1)*



*“Mostly [the time staff spent with the user felt] sufficient. Some occasions though, [it] felt really really brief. Some [staff] were here a long time, and others were here very briefly”. (Carer3)*

Users were not meaningfully or adequately engaged in discussions about their goals and what was important to them. Users reported not knowing how often their needs were assessed, and some users and carers felt that their needs were not assessed properly.

*“I felt that [during the rehabilitation the EMT workers did not] assess my needs. They came, went through the exercises with me, and then they left. It was only [the EMT worker] that was here today [that]...added an extra exercise to my form” (User1)*

*“My shoulder is in such a state that it needs surgery. It has [undergone one previously]. But as long as [the user] is as he is, I cannot [undergo that surgery] because there is such a long rehabilitation [period] afterwards, and then I cannot use my arm [at all]. So I feel that [the EMT workers] could not help me with anything else. What I would have needed was a [spot in a rehabilitation facility for a period after such a surgery], and then [the user] would be alone at home and that would not be good. We have not discussed any sorts of respite for me.” (Carer3)*

*“We have not discussed any goals of any sort to set for me. Everything has sort of been met with the motto ‘[I, the user’s carer] will fix it’. So then I just try to stretch as far as I can.” (Carer3)*

*“It would have been good if [my wife] had someone to talk to that could advise her of what to do. In case her shoulder gets even worse, and she is unable to drive and such. What happens then? Such a conversation would be good.” (User1)*

Carers also reported that they did not have care plans, which is not surprising considering that users are the primary focus of the EMT service. Evidence from the data gathered in Søndre Nordstrand (e.g., from users, carers and managers) points to the need for the homecare service sector to pay closer attention to the condition of carers. Carers’ own needs should be proactively assessed and efforts should be made to promote carers’ own health and well-being, without which carers cannot support users at home.

Users’ care plans are recorded electronically in the Gerica database but hard copies of the care plans are generally not available to users. This can undermine person-centered care as important information about users’ care is not readily available to them and their carers. Some users expressed that they did not receive consistent or adequate information from staff regarding their care, others did not feel adequately supported by staff to engage in some of the planned activities for their rehabilitation, and still others reported poor care-transition or follow-up (e.g., at the end of EMT).

*“...regarding the rehabilitation team [EMT] that was here for 8 weeks, they have not contacted us afterwards... So it feels maybe a bit like a loss, the fact that they haven’t*

*followed-up on the work that was done here. Maybe they are informed on the situation by the others that stop by here, but when it comes to [the user’s training] and progress, after they tested [the user] at the end of the program [in relation to] the goals that they set, there has been no more follow up. I think I miss that a little bit - that they [should] show interest in how things are going afterwards now that we have started with physical therapy up here at Mortensrud.” (Carer1)*

*“You don’t know what you are missing [when you don’t know what kind of opportunities are out there]. I am sure that I would say ‘yes, thank you’ to such services, but I don’t know what they are.” (Carer3)*

*“I do not know if you can call it [inadequate information], but there is something else that is missing... It would have been good to have some information regarding for instance if [my wife] has an operation or some treatment for her shoulder. Can we move her to a nursing home? Can we receive some additional help [for me] so she could have treatment? Such kind of information would be very welcomed.” (User1)*

In addition, some users also experienced that that when their progress was evaluated (e.g., during or at the end of EMT), the results of the evaluation were not always communicated clearly or comprehensively to them. The findings here suggest that there is room for Søndre Nordstrand to make improvement to some important aspects of person-centered.

### **Prevention orientation and safety**

Carers reported that they had not received training in practical care and may therefore lack some of the skills needed to properly care for users. As previously noted, users would have appreciated it if staff helped them plan ahead for their care after completing their rehabilitation training with the EMT service. Lack of proper arrangements to help users maintain their progress post-EMT could threaten the very gains achieved from the EMT service. Time constraints faced by staff has meant that some users have not been adequately supported in their rehabilitation training. Additionally, users reported that they had not engaged in comprehensive discussions with staff about safety issues broadly defined.

*“[Someone] was supposed to come here and assess our bathroom but that never happened. We had an appointment on a Monday, and that is a long time ago now.” (Carer3)*

*“[The healthcare staff who assessed the user’s needs] suggested that someone should come here and do an assessment [of the bathroom], but since no one came we found out that we could do it ourselves.” (Carer3)*

These deficits do not promote prevention-oriented and safe care. Fortunately, the improvement initiative’s emphasis on low-threshold and voluntary services will play an important role in providing users with needed social and physical engagement and follow-up post EMT.



## Efficiency and coordination

Søndre Nordstrand received limited funding to support the improvement initiative. The improvement initiative has therefore added to the time constraints faced by the managers, who have struggled to balance between the improvement initiative and their other responsibilities.

*“Financial issues [has had a big influence]. We have not really had [extra resources]. We have been working overtime in order to run this improvement initiative. We have had to use resources we do not have, [which] has definitely been a [challenge]. If we had a project manager who could dedicate [undivided] time to the improvement initiative, we would have...had a better outcome. So the financial framework has definitely [been a contextual factor with an impact] on the improvement initiative...” (Manager2)*

*“[The improvement initiative manager was first] hired in a temporary position... Then as he did not have a permanent position, he was offered employment somewhere else [and left the improvement initiative]. Later, he was offered the possibility of a permanent position [in the borough and he came back]. We have many temporary positions in our borough, and because of this, we create this problem for ourselves, that we either lose people or have little continuity. I think this is something we should work on – to have more permanent positions.” (Manager2)*

That the improvement initiative has lacked stable leadership is a challenge linked to the financial situation in the borough, a problem that has undermined the effective and efficient implementation of the improvement initiative by creating knowledge gaps and poor follow-up of the improvement initiative.

With regard to coordination in care delivery, findings described below and in other sections of the report pointed to some areas of weakness. For example, interview data showed that for some users, care goals in terms of rehabilitation were not meaningfully discussed and outlined in collaboration with the users. Most users' care plans did not indicate the role of informal carers, suggesting that carers and their contributions are not officially included as a central part of users' care and activity plans. Yet carers, like users, should be a central part of coordinated care delivery. None of the users who completed the P3CEQ questionnaire had received services from a voluntary organization, which spoke of a missed opportunity to collaborate with this important sector. It is however encouraging that efforts are underway (e.g., as part of the improvement initiative) to strengthen collaboration with the voluntary sector.

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

Hiring a senior supervisor for activity B and a volunteer coordinator for activity C who could focus on promoting

these initiatives is the overriding factor that facilitated the implementation of these two components of the improvement initiative. Members of the improvement team also drew motivation for the improvement initiative from participating in external working groups such as the GPP.

*“What I have noticed with the volunteer coordinator is that she has accomplished a much closer collaboration with the voluntary centrals. [Now] they are a lot more positive to having a closer collaboration with the borough. So things are progressing, but they take time...” (Manager1)*

*“[It is] when we finally landed on what kind of direction we wanted to go, or what kind of areas where we saw improvement potential that things fell into place. Then we collaborated with [the improvement areas] with the Good Patient Pathway (GPP) network as well. [The team from here met] in Trondheim together with those from Surnadal in December 2016... I feel that that was when things really fell into place for most of the participants [in the improvement initiative]. They became much more enthusiastic [to the improvement initiative after that assembly with the GPP]...” (Manager1)*

*“We have gotten a kick in the butt from [the Sustain partners], which is often a positive thing. We have had requirements and expectations of results that we have [tried] to deliver—that we are to achieve an improvement within certain deadlines.” (Manager1)*

As mentioned above, collaborating with and being followed-up by SUSTAIN also facilitated the implementation of the improvement initiative by providing the team with 'someone' to whom they could be accountable. Input and feedback on the initiative from SUSTAIN encouraged the managers to look into EMT's way of working and identify areas in need of improvements (e.g., users' care plans).

EMT and other Homecare staff had some shared tools for their work, namely: the Gerica database of users' electronic care plans, folders with information about users' rehabilitation plans, and regular staff meetings. These resources facilitated collaboration and promoted the improvement initiative.

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

Søndre Nordstrand's improvement initiative evolved gradually over time. Consequently, for some time, the aims and objectives of the improvement initiative were not well defined, and members of the improvement initiative team lacked clearly delineated roles and responsibilities. Furthermore, that the improvement initiative lacked stable and consistent leadership further hindered the project.

*“...we struggled quite a bit in the beginning, both in figuring out what we were participating in, and in defining the*



*different roles [in the improvement initiative]. We spent a lot of time on this.” (Manager1)*

*“For me, [the improvement initiative] has, because of the staffing situation, had its ups and downs. With its changing of project leaders [and staff], it has been difficult to maintain the continuity of it all. That has been something that has influenced the whole [improvement initiative]. That we, from the beginning have not had continuity in leadership and continuity in the knowledge bearers.” (Manager2)*

*“[The successful implementation] becomes very person-dependent [as well]. How much progress we make is dependent on people actually taking action. But this requires that responsibility is clearly defined and delegated.” (Manager2)*

*“...It [lack of continuity in leadership] has made it difficult for us to align ourselves internally, which might be the reason why some of the improvement areas have fallen short. No one has been held accountable to ensure results. It is always the implementation part that faces [the biggest] challenges.” (Manager2)*

Lack of adequate funding underlay the challenge the improvement initiative faced with regard to unstable leadership, and which in turn led to knowledge gaps and poor follow-up that negatively affected the implementation of the initiative. Funding and time constraints also meant that the acting managers who oversaw the initiative could not meaningfully and consistently support it. It was challenging for the managers to balance between their core responsibilities and the added demands of the improvement initiative. Additionally, some activities that were part of Senior Info (activity B) were delayed due to lack funds for needed computer software.

*“I have been invited to many of these volunteer meetings centrally. In periods with heavy workloads, I have declined invitations to these meetings. [It is important to attend these meetings though, in order to ensure] that all of us receive the same information [and] engage more...” (Manager1)*

*“This is because of the lack of resources, that we have to prioritize and thus decline invitations to such meetings. This is a problem throughout the whole borough.” (Manager2)*

The managers also experienced that the collaboration with SUSTAIN, though beneficial, was also very demanding. Additionally, due to lack of proper leadership and planning, the improvement initiative was not well defined for some time and was thus not meaningfully championed in the borough.

*“I feel that it [SUSTAIN] has been a bigger burden than a help to be [completely] honest, but this is because we have struggled to motivate people in the [rehabilitation] team to recruit interview candidates, for instance. I feel that we have struggled to clearly explain [to them] why we are participating [in this improvement initiative]. This makes it hard to feel ownership [of the project] and to be fully*

*[enthusiastic]. This might make people experience the project as an extra work load.” (Manager1)*

*“...the work has been demanding. Reporting to SUSTAIN, doing measurements, gathering employees and such.” (Manager2)*

Activity C on increasing cooperation between voluntary organizations and FFF was challenging to implement partly because it fell outside EMT/Homecare services. Voluntary organizations operate within the borough and Oslo municipality at large, but they are not part of Søndre Nordstrand’s public services and are thus not managed by the borough. For this reason, it has been a slow, challenging and ongoing process for the improvement team and the voluntary sector to identify common and mutually beneficial goals, prioritize the goals, and develop good guidelines and procedures for achieving the goals and working towards a closer collaboration. For example, it was difficult to recruit volunteers to assist with the borough’s low-threshold services due to factors including: lack of consensus between voluntary organizations and FFF regarding the role of volunteers, the preference of volunteers to work with as much independence or freedom as possible, and some volunteers’ hesitation to be involved in activities that might take a lot of time (e.g., most of the day).

*“You ask why it is such a challenge to recruit volunteers that [can help in these areas]. There is consensus that there is no [clear answer] of how one is supposed to use the volunteers... The public sector is supposed to take care of everything. However, we have reached a point where we cannot do that anymore. [Moreover], it is new for us to work in this way [i.e., collaborate with the voluntary sector]. All voluntary work is mainly towards sports and such. The volunteers do not want to be managed. They want to do things according to their vision.” (Manager2)*

With regard to users’ and carers’ experiences with EMT services, staff made efforts to encourage user participation. However, meaningfully engaging users in discussion about their care and what is important to them was challenging.

This may reflect the persistence of traditional patient-provider orientations whereby healthcare professionals knowing or unknowingly act like they know best, and are also perceived by users to know best. Such orientations can promote passivity among users and undermine person-centered care.

*“Yes, I don’t think I can say otherwise [i.e., that I was not involved as much as I wanted in decisions about the user’s care]. I think I have been a bit spoiled and they have taken care of me, and I agree with what they decide. They are trained professionals, and I am not, and what they have done has been ok with me and I don’t feel set aside in any way regarding what has been done here with [the user] by the team.” (Carer1)*

Data from users’ care plans showed that the care plans did not record the roles of carers in relation to users’ goals. This suggests that, while carers as a group are recognized



to be an essential support system for users, their roles and contributions are considered to fall outside the traditional healthcare system that serve users. It will require concerted efforts to conceptualize users and carers as a single unit—at least in the case of users who live at home with and are dependent on their carers. Healthcare managers, professionals, and other key stakeholders and decision-makers should recognize that neglecting these carers could have major ramifications for users and their ability to live at home safely.





## 7. MAIN LESSONS LEARNED FROM SØNDRE NORDSTRAND

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

In collaboration with the SUSTAIN project, the managers of Søndre Nordstrand's EMT service are overseeing efforts to increase awareness about and use of low-threshold and voluntary services among users. These efforts are key components of the improvement initiative in the borough, and are aimed at supporting and maintaining users' overall health and well-being and reducing their reliance on traditional healthcare services. In this section, we describe the lessons learned from Søndre Nordstrand's improvement initiative and factors that can promote integrated care improvements here in Norway and in the EU.

Person-centered care is a key element of integrated care that depends on meaningful engagement of users in goal setting and care planning. Users and carers in Søndre Nordstrand expressed that they were treated well and with respect by staff. This is an important foundation upon which improvements to person-centered care can be made. Establishing a closer collaboration with the voluntary sector is an important activity that can meaningfully serve users in Søndre Nordstrand for a long time. In light of this, it may be worthwhile to develop a shared database for the borough's healthcare sector and the voluntary sector. Such a database would make it easier for these sectors to communicate with each other and share information, which is also an important feature of integrated care.

Like healthcare staff, carers play a central role in enabling users to live safely at home, but they are not given enough attention in integrated care systems including in Søndre Nordstrand. Improvements to integrated care systems should also address the needs and challenges faced by

carers. It is also crucial that the aims and objectives of the improvement initiative, and the roles and responsibilities of the improvement initiative team, are clearly identified. These elements of Søndre Nordstrand's improvement initiative were not identified early and therefore hindered effective implementation of the improvement initiative. This too should serve as cautionary advice for others considering improvements to their integrated care system.

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

That Søndre Nordstrand's improvement initiative is focused on low-threshold and voluntary services is very important. Doing so recognizes the limitations and constraints of efforts to meet users' health and care needs through traditional healthcare services; and the opportunities available if low-threshold and voluntary services are effectively incorporated into integrated care systems. Even though Søndre Nordstrand's improvement initiative is not fully operational, the idea of it (i.e., low-threshold and voluntary services as important components of healthcare/integrated care systems) is worth adopting in other parts of the EU. Adequate resources are needed if an improvement initiative is to be effectively and efficiently implemented, including competent, committed and motivated managers and staff who have time for the improvement initiative.



Lack of these resources hindered Søndre Nordstrand's the improvement initiative and should serve as cautionary advice for both Norway and the EU. When faced with limited resources (e.g., funds, manpower, time), it may help to focus on a small improvement initiative that capitalizes on existing resources and staff competencies, and implement it within established departments within the integrated care systems. Such an improvement initiative may or may not be especially innovative; it may or may not have a huge impact, but it is more likely that it would be implemented successfully.

### 7.3 Methodological reflections

The uncertainty surrounding the improvement initiatives at Søndre Nordstrand during the initial period of the project made it challenging for us, the researchers, to communicate effectively with the sites. We were thus not well informed about the activities taking place on the ground. This situation, however, improved when the sites gained a clear understanding of their initiatives. Amidst unstable leadership, the acting managers at Søndre Nordstrand made concerted efforts to mobilize their teams, and together they contributed substantially to the collaborative project with SUSTAIN—including serving as respondents for data collection and helping recruit users and carers for data collection. Søndre Nordstrand, however, did not meet its data collection targets for users and carers, even after we extended the data collection period to the maximum amount of time possible. These difficulties in recruiting users and carers in the borough were due to Søndre Nordstrand's younger and more diverse population—with implications such as language barriers for some of the elderly. With regard to users' experiences with the P3CEQ questionnaire, some of the questions only had four answer choices: "1: not at all, 2: to some extent, 3: more often than not, 4: always". Some of the users wanted a fifth choice between "2: to some extent" and "3: more often than not", but instead had to select the closest choice from among the available four. The P3CEQ questionnaire could be improved in this area. Many of the questions also did not give users the choices: "don't know" and "refused", which should be standard answer choices in questionnaires. In the PCHC questionnaire, question 24 "In the event that my mind deteriorates, I can make the necessary preparations beforehand so that I can remain in control (such as recording my wishes in writing..., or end of life wishes)" was uncomfortable for some of the users to think about/contemplate given that they were at a vulnerable stage in life.

The users in Søndre Nordstrand did not have hard copy care plans, but we managed to access users' electronic care plans by talking to healthcare professionals knowledgeable about the users' care. Time constraints faced by the managers and their improvement team made it difficult for each of the staff involved to continuously monitor and record efficiency data (e.g., the extra hours spent by the staff on given improvement activities). For this reason, the managers provided us with efficiency data based on

their best approximations, which are therefore not very precise. It is our view that the improvement team at Søndre Nordstrand made a good effort in their involvement and contributions to the improvement initiative, especially considering that the site did not have sufficient funds to support the additional tasks linked to the improvement activities.

### 7.4 Overall reflections and key points

Experiences from Søndre Nordstrand with improving their healthcare services to promote integrated care indicate that the first step of identifying specific improvement activities can take time. Needs must be properly assessed and the activities identified should reflect local priorities, fit with the available resources (e.g., operational costs including staffing), and they should be implemented at the right time when there are not too many competing demands or projects. Unstable leadership, time constraints, and an improvement initiative situated outside EMT and Homecare services are factors that hindered the improvement initiative. Even so, Søndre Nordstrand's improvement initiative is now at a point where many of the unknowns have been identified and working relationships with project partners are maturing. The initiative is thus poised to make some good gains in activities B and C. Some key points from Søndre Nordstrand for site managers looking to improve integrated care include:

- Invest good time and effort at the outset in identifying your improvement initiative. If needed, err on the side of a smaller less ambitious improvement initiative.
- Invest in a competent and motivated project manager who is committed to seeing the project through and effectively lead the improvement initiative team, including supporting and motivating them well.
- Take the time to develop good working relationships with your project partner/s for this will set a good foundation for implementing the improvement initiative.
- Seek out a key stakeholder (e.g., your funder, a collaborator like SUSTAIN) to be accountable to. This will motivate you to take stock of your accomplishments, reflect on and reassess your way of working, and encourage you forward towards your goal.



# PART 3



## 8. OVERALL (NATIONAL) REFLECTIONS

### 8.1 Introduction

Surnadal municipality in Mid-Norway and Søndre Nordstrand borough in Oslo municipality are the two sites from Norway that participated in the SUSTAIN project. As part of Surnadal's improvement initiative, which was implemented within its Homecare services, rehabilitation services were reorganized such that they are now provided in users' homes. The Day Center has also been expanded to serve more users per day, in addition to its staff being charged with observing and communicating users' needs to other relevant staff in Homecare services for follow-up. Systematic procedures have also been developed to support users with medication reviews and to involve them more meaningfully in shared decision-making. Pre-emptive assessments of users' needs are also being conducted to identify opportunities for preventive care and facilitate care planning. All of Surnadal's five improvement activities are operational, and efforts are ongoing to further improve upon them. Søndre Nordstrand's improvement initiative is affiliated with the borough's EMT service and includes three improvement activities. To broadly promote awareness among the residents about the borough's traditional healthcare services, low-threshold services and voluntary services, information screens broadcasting relevant information have been installed in high impact public areas in the borough. To increase the use of low-threshold services among users, especially the elderly, a senior supervisor has been hired to work closely with the senior center. The improvement initiative also sought to increase cooperation and collaboration between voluntary organizations and the borough's FFF division and to this end, a voluntary coordinator has been appointed to serve as a liaison between the voluntary centrals and the FFF division. Søndre Nordstrand's improvement activities are also underway and developing gradually.

In this section, we share some overall reflections and the knowledge gained from the two sites in implementing improvements to primary healthcare services to promote integrated care.

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

Norway is a social democratic welfare state whose primary (i.e., municipal) and specialist healthcare services are publically funded. The Norwegian healthcare coordinated reform was implemented from January 2012 and it gave municipalities greater responsibility for treating patients. These added responsibilities in the face of a growing elderly population with multiple health and care needs requires that municipalities work more effectively and efficiently if they are to address the twin challenge of curtailing costs and safeguarding patient outcomes. The improvement initiative in Surnadal and Søndre Nordstrand sought to address this same challenge to some degree. The SUSTAIN project, with its aim "...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-centered, prevention-oriented, safe and efficient care" (See Section 1.2), is very relevant for integrated care in Surnadal and Søndre Nordstrand, and for Norway as a whole. For some time now, Norway has been moving away from institutional long-term care to home-based care. As such, SUSTAIN's focus on older adults with multiple health and social care needs living at home is very pertinent to Norway.



Experiences from the improvement initiatives in Surnadal and Søndre Nordstrand showed that while some important gains have been made in promoting home-based care, efforts are needed to: prudently expand the HPH framework and other tried and tested tools to other parts of the country, whilst continuing to improve and refine them; meaningfully engage users and carers in service planning and delivery; and to better involve/integrate the voluntary sector with the healthcare sector, just to name a few.

Even though the Norwegian system differs from that of the other countries participating in SUSTAIN, some lessons from those countries on improving integrated care could inform the efforts in Norway. Additionally, SUSTAIN has focused on the universally relevant themes of person-centered, prevention-oriented and safe care, and in so doing it has helped identify some areas in need of improvement within Surnadal's and Søndre Nordstrand's services. SUSTAIN's focus on efficiency is perhaps the most consequential because it underlies the other areas (e.g., person-centered care). For example, inefficiency leads to financially unsustainable healthcare systems with staff shortages and other vulnerabilities, all of which undermine person-centered, prevention-oriented and safe care. Norway should certainly be interested in the informative lessons about promoting efficiency in care delivery from the other countries in the SUSTAIN consortium.

### 8.3 Policy recommendations

The following recommendations for policy makers emerged from Surnadal's and Søndre Nordstrand's experiences of implementing improvements to their healthcare services to promote integrated care:

1. Meaningful and impactful improvements to integrated care cannot be successfully undertaken without a clear, well-resourced and reinforced mandate from policy makers at high levels of the decision-making hierarchy.
2. To craft such a mandate, policy makers should work closely and get input from the frontline stakeholders (e.g., healthcare professionals and managers; service users and their carers) regarding local needs and priorities, and potential factors that might facilitate or hinder the implementation of the mandate.
3. Having crafted such a mandate, policy makers should give the team charged with implementing the mandate good space and enough time to implement it. However, it is important for policy makers to maintain interest in the project without causing interference. The policy makers should be open to hearing about the experiences of the frontline actors, including the progress they are making and the challenges they are facing.

### 8.4 Recommendations for service providers

The experiences from Surnadal and Søndre Nordstrand also generated the following recommendations for service providers interested in implementing improvements to their services to promote integrated care:

1. The improvement initiative should be led by a competent and experienced leader who is motivated about the improvement initiative and is committed to seeing it through.
2. The persons initiating the improvement project (e.g., healthcare managers or professionals) should identify partners for the project, including the steering group. They should carefully assess the partners' motivation, commitment and capacity to carry out the improvement initiative. The steering group should also develop clear guidelines to inform/steer the collaboration with the improvement initiative partners.
3. An external stakeholder should be identified by the steering group to hold the improvement team (i.e., frontline staff charged with implementing the improvement initiative) accountable for implementing the initiative as planned.
4. The leader and other members of the steering group should invest the needed time to identify and clearly define the aims and objectives of the improvement initiative.
5. The improvement initiative's aims and objectives should be clearly presented, by the leader of the improvement team, to the improvement team. The leader should also champion/build enthusiasm or motivation for the improvement initiative among the improvement team (e.g., what makes this a meaningful and impactful improvement initiative).
6. The improvement initiative team should have enough time and resources (e.g., funds, staff, equipment) to implement the improvement initiative. The implementation plan should take into consideration and make allowances for unexpected changes or constraints.
7. The leader should be trusted to carry out the improvement initiative, and s/he in turn should trust his/her team (e.g., healthcare staff) to carry out the improvement initiative. At the same time, the leader should provide the team with good and stable guidance and support.
8. Users and carers should be meaningfully involved in the improvement initiative to the extent possible and as is appropriate. Meaningful involvement includes getting users' and carers' input (e.g., views, recommendations, feedback) on the improvement activities at the planning stage and throughout the implementation process.



## 8.5 Conclusion

During an 18-month period starting from autumn 2016, Surnadal municipality in Mid-Norway and Søndre Nordstrand borough in Oslo undertook various activities to improve their healthcare services so as to promote integrated care. During this period, and to the extent possible given their local opportunities and constraints, they worked with us (SUSTAIN researchers)—informing us of their accomplishments and also of their struggles. There were periods of uncertainty regarding the improvement initiatives (e.g., identifying specific activities for the initiatives; working effectively with project partners; shortages in funding, staffing, time). Even so, the teams at both sites made some good efforts on the initiatives. Specifically in Surnadal, all of the site's five improvement activities were implemented and efforts were underway to further refine them. Activity D on shared decision making was expected to require some extra time to mature because the staff needed competence training in motivational interviewing. Even so, Surnadal's aims and objectives were met overall. In Søndre Nordstrand, activity A was fully implemented and activity B was partially implemented. Specifically for activity B, volunteers were yet to be fully involved in the borough's low-threshold services. Activity C had been initiated, and some positive steps which were not in the original plan had been implemented (e.g., appointing a volunteer coordinator). However, some core elements of activity C had not been implemented (e.g., developing collaborative agreements with voluntary organizations). Overall, Søndre Nordstrand's aims and objectives were only partially met. That said, both sites laid the foundation upon which their improvement initiatives can mature into important and solid services in the community. SUSTAIN has played an important role, through its collaboration with the sites, advocating for users to be at the center of service planning and development. It has been good to see the sites rise to this challenge where there were deficits. It is also very encouraging that the managers at both sites expect that the work they began with their improvement initiatives will continue into the future.



## 9. REFERENCES

- Ambugo, E. A., Hagen, T. P., & Melberg, H. O. (2018). Introducing a fee for hospital overstay and its links to adverse events among patients hospitalized for hip fracture, heart failure, stroke, and chronic obstructive pulmonary disease or asthma. *Manuscript submitted for review*.
- Anderson, N., and West, M. (1994). *Team Climate Inventory: manual and user's guide*. Windsor, UK: NFER-Nelson.
- Arrue, B., Ambugo, E., Baan, C., Barbaglia, G., Billings, J., De Bruin, S., . . . Zonneveld, N. (2016). Integrated care for older people living at home: current situation and ambition of sites participating in the SUSTAIN project. Vienna: Austrian Interdisciplinary Platform on Ageing / OEPIA.
- Askildsen, J. E., Holmås, T. H., Kaarbøe, O., & Monstad, K. (2016). Evaluering av kommunal medfinansiering. *Tidsskrift for omsorgsforskning*, 2(02), 135-141.
- Billings, J., and Leichsenring, K. (2014). Methodological development of the interactive INTERLINKS Framework for Long-term Care. *International Journal of Integrated Care*, 14, e021. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/25120413>
- Claassens, L., Terwee, C. B., Deeg, D. J., Broese van Groenou, M. I., Widdershoven, G. A., and Huisman, M. (2016). Development and validation of a questionnaire assessing the perceived control in health care among older adults with care needs in the Netherlands. *Quality of Life Research*, 25(4), 859-870. doi:10.1007/s11136-015-1124-2
- Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., Petticrew, M., and Medical Research Council, G. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *British Medical Journal*, 337, a1655. doi:10.1136/bmj.a1655
- Creswell, J. (2009). *Research Design: Qualitative and Quantitative and Mixed Methods Approaches*. London.
- De Bruin, S. R., Stoop, A., Billings, J., Leichsenring, K., Ruppe, G., Tram, N., . . . Paat-Ahi, G. (2018). The SUSTAIN project: a European study on improving integrated care for older people living at home. *International Journal of Integrated Care*, 18(1), 6. doi:10.5334/ijic.3090.
- Epping-Jordan JE, Pruitt SD, Bengoa R, and Wagner EH. (2004). Improving the quality of health care for chronic conditions. *Quality and Safety in Health Care*, 13(4), 299-305. doi:10.1136/qshc.2004.010744
- Glasgow, R. E., Green, L. W., Taylor, M. V., and Stange, K. C. (2012). An evidence integration triangle for aligning science with policy and practice. *American Journal of Preventive Medicine*, 42(6), 646-654. doi:10.1016/j.amepre.2012.02.016
- Kivimaki, M., and Elovainio, M. (1999). A short version of the Team Climate Inventory: development and psychometric properties. *Journal of Occupational and Organizational Psychology*, 72(2), 241-246.
- Ministry of Health and Care Services (MoHC), Norway. . (2009, 19 June). The coordination reform: Right treatment at the right place at the right time (Report# St.meld. nr.47) [Samhandlingsreformen: Rett behandling - på rett sted - til rett tid]. Retrieved from [https://www.regjeringen.no/no/dokumenter/stmeld-nr-47-2008-2009-/id567201.c1?q=samhandlingsreformen#match\\_0](https://www.regjeringen.no/no/dokumenter/stmeld-nr-47-2008-2009-/id567201.c1?q=samhandlingsreformen#match_0)
- Minkman, M. M. (2012). Developing integrated care. Towards a development model for integrated care. *International Journal of Integrated Care*, 12.
- Penedo, F. J., & Dahn, J. R. (2005). Exercise and well-being: a review of mental and physical health benefits associated with physical activity. *Current Opinion in Psychiatry*, 18(2), 189-193.
- Romøren, T. I., Torjesen, D. O., & Landmark, B. (2011). Promoting coordination in Norwegian health care. *International Journal of Integrated Care*, 11(Special 10th Anniversary Edition).
- Røthing, M., Malterud, K., and Frich, J. C. (2015). Family caregivers' views on coordination of care in Huntington's disease: a qualitative study. *Scandinavian Journal of Caring Sciences*, 29(4), 803-809. Doi: 10.1111/scs.12212
- Son, J., Erno, A., Shea, D. G., Femia, E. E., Zarit, S. H., & Parris Stephens, M. A. (2007). The caregiver stress process and health outcomes. *Journal of Aging and Health*, 19(6), 871-887.
- Statistics Norway. (2018, May). Municipality facts [kommunefakta]: Surnadal – 1566 (Møre og Romsdal). Retrieved from <https://www.ssb.no/kommunefakta/surnadal> and <https://www.ssb.no/statbank/table/12003?rxid=da74bd03-2f94-4307-adf0-13a934aa928f>

Sugavanam, P., Byng, R., and Lloyd, H. (under review). Identifying and modifying a measure to tap individuals' experiences of person centred and coordinated care: the development of P3C-PEQ. *BMC Health Services Research*.

Swanson, J., & Hagen, T. (2016). Reinventing the "community hospital": Did implementation of municipal acute bed units reduce the demand for hospital admissions. *British Medical Journal Open*, 6, e012892.

Tomaka, J., Thompson, S., & Palacios, R. (2006). The relation of social isolation, loneliness, and social support to disease outcomes among the elderly. *Journal of Aging and Health*, 18(3), 359-384.

Wagner, E. H., Bennett, S. M., Austin, B. T., Greene, S. M., Schaefer, J. K., and Vonkorff, M. (2005). Finding common ground: patient-centeredness and evidence-based chronic illness care. *Journal of Alternative and Complementary Medicine*, 11 Suppl 1, S7-15.

Wisløff, N. F., Agledal, S. A., Hillesund, E., Lurås, H., Buschmann, E., Windspoll, R. J., Sellæg, W. F., Haga, D., Kolås, G., and Åm, T. (2005). Fra stykkevis til helt: En sammenhengende helsetjeneste (Report# NOU 2005:3). Lobo Media AS: Norway. Retrieved from <https://www.regjeringen.no/no/dokumenter/nou-2005-03/id152579/>

Yin, R. K. (2009). Case study research: Design and methods (applied social research methods). *London and Singapore: Sage*.





## 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		
Perception of older people, informal carers, professionals and managers with safety	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) (Anderson and West, 1994; Kivimaki and Elovainio, 1999), administered to professionals	Survey measuring vision, participative safety, task orientation and experienced support for innovation of the improvement team
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

## 10.2 Acronyms used in this country report for Norway

ADL	Activities of daily living
EMT	Everyday Mastery Training
FFF	Søndre Nordstrand's division for prevention, voluntary work and public health
GP	General practitioner
GPP	The Learning Network Good Patient Pathway
HPH	Holistic Patient Care at Home
MoHC	The Norwegian Ministry of Health and Care Services



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