#SUSTAINNeu Final Conference

*Sustainable Tailored Integrated Care in Europe*

The SUSTAIN project is funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144.
INTERACT WITH US!

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#SUSTAINeu

The SUSTAIN project is funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144.
AGENDA OF THE DAY

Usman Khan
Executive Director
European Health Management Association
SUSTAIN Final Conference

PROGRAMME

08.30 - 09.15  Registration and Breakfast

09.15 - 09.20  Agenda of the day
  ♦ Usman Khan - Moderator  
    EHMA

09.20 - 09.40  Welcome messages:
  ♦ Adam Rogalewski  
    Member of the European Economic and Social Committee
  ♦ Ana Duarte  
    Policy and Programme Officer DG RTD European Commission SUSTAIN Project Officer

09.40 - 10.10  Beyond SUSTAIN - creating the conditions for integrated care for older people
  ♦ Anne Hendry  
    Clinical Lead for Integrated Care Work Package Leader European Joint Action on Frailty (ADVANTAGE) Senior Associate, International Foundation for Integrated Care (IFIC)

10.10 - 10.25  What is SUSTAIN?
  ♦ Caroline Baan  
    National Institute for Public Health and the Environment (RIVM)

10.25 - 10.45  Improving integrated care initiatives across Europe: the SUSTAIN framework
  ♦ Jenny Billings  
    University of Kent

10.45 - 11.05  Coffee break & SUSTAIN Sites (exhibition area)

11.05 - 11.40  Integrated care ‘on the ground’: the SUSTAIN integrated care initiatives and key learnings
  ♦ Annerieke Stoop & Simone De Bruin  
    National Institute for Public Health and the Environment (RIVM)

11.40 - 12.45  Panel discussion - Insights from integrated care sites
  ♦ Julie MacInnes  
    University of Kent
  ♦ Julie Baldwin  
    Sandgate Road Surger
  ♦ Nick Zonneveld  
    Vilans
  ♦ Jillian Reynolds  
    AquAS
  ♦ Carme Guinovart  
    Hospital de la Santa Creu de Vic

12.45 - 14.15  Walking lunch & SUSTAIN Sites (exhibition area)
  From research to practice to policy: ‘walking’ the SUSTAIN roadmap for integrated care
  ♦ Seline Noteboom  
    Vilans
  ♦ Maggie Langings & Nick Goodwin  
    International Foundation for Integrated Care (IFIC)
  ♦ Gerald Wistow  
    London School of Economics (LSE)

14.15 - 15.15  Panel discussion - Beyond SUSTAIN: discussing integrated care in Europe
  ♦ Anne-Sophie Parent  
    AGE Platform Europe
  ♦ Axel Kaehne  
    Edge Hill University & EHMA SIG Integrated Care
  ♦ Jenny Billings  
    University of Kent
  ♦ Toni Dedieu  
    International Foundation for Integrated Care (IFIC)

15.15 - 16.15  Closing remarks
  ♦ Giel Nijpels  
    VU University Medical Center Amsterdam

16.15 - 16.20  Networking Reception & SUSTAIN Sites (exhibition area)

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WELCOME BY EUROPEAN ECONOMIC AND SOCIAL COMMITTEE

Adam Rogalewski
Member of the European Economic and Social Committee
WELCOME BY EUROPEAN COMMISSION

Ana Duarte
Policy and Programme Officer
DG RTD European Commission & SUSTAIN Project Officer
SUSTAIN (634144)
Final Conference

Ana Duarte
DG Research and Innovation
E.3 Fighting Infectious Diseases and Advancing Public Health

13 March 2019
Scope
As action oriented research, proposals should develop new, or improve on existing, models for health systems, in order to make these systems more patient-centred, prevention oriented, efficient, resilient to crises, safe and sustainable. The models’ applicability and adaptation to different European health systems and EU regions should be assessed, and their value, including individual and societal benefits, demonstrated.

Expected impact
• On the basis of quantitative and qualitative indicators, evidence for new or improved patient-centred, prevention oriented, safe and efficient models for health care systems and services.
• Evidence to be used by policy makers and decision makers in making improvements to health and care systems, health and other policies.
Graph II.2.3: Projected increase in public expenditure on health care due to demographic change over 2016-2070, as % of GDP

Notes: The EU28, EU15 and NMS averages in all result tables are weighted according to GDP. The level of expenditure in 2016 is the first year of projected expenditure based on latest available data. Health care expenditure exclude long-term nursing care.

Source: Commission services, EPC.
Graph II.3.1: Total and public long-term care expenditure in the EU, as % GDP

Notes: Expenditure based only on the medical care component (HC.3) of system of health accounts data.

Source: European Commission, EPC.
Ana.DUARTE@ec.europa.eu
Programme Officer for SUSTAIN

#H2020
#HorizonEU
#InvestEUresearch
BEYOND SUSTAIN - CREATING THE CONDITIONS FOR INTEGRATED CARE FOR OLDER PEOPLE

Anne Hendry
Clinical Lead for Integrated Care
Work Package Leader European Joint Action on Frailty (ADVANTAGE)
Senior Associate, International Foundation for Integrated Care (IFIC)
Beyond SUSTAIN: Creating the Conditions for Integrated Care for Older People

Clinical Lead for Integrated Care
Advantage JA Work Package Leader
Senior Associate, IFIC
IFIC is a non-profit members’ network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice.

The Foundation seeks to achieve this through the development and exchange of ideas among academics, researchers, managers, clinicians, policy makers and users and carers of services throughout the World.
ADVANTAGE JA
A comprehensive approach to promote a disability-free
Advanced age in Europe:

❖ Policy Joint Action: Jan 2017 – Dec 2019
❖ 22 Member States and 33 organisations
❖ Co-funded by the EU and the Member States.

www.advantageja.eu
ADVANTAGE JA work packages

(Coordination WP1+ Dissemination WP2+ Evaluation WP3)

Knowing frailty at an individual level WP4

Knowing frailty at a population level WP5

Treating/approaching frailty at an individual level WP6

Models of care to prevent, delay or treat frailty WP7

Extending and expanding knowledge on frailty WP8

Develop ‘Frailty Prevention Approach’ (FPA) and build consensus on addressing Frailty in Europe
IMPLEMENTATION PHASES

Phase I (2017)
State of the Art evidence review, analysis and SoAR reports

Phase II (2018)
Survey of MS status on frailty, developing and testing a common European model to prevent and manage frailty

Phase III (2019)
draft FPA, debate with MSs on Road Maps, final FPA framework and policy recommendations.
Integrated Care for Frailty

➢ a single entry point – generally in Primary Care
➢ simple screening tools in all settings
➢ comprehensive assessment and individualised care plans
➢ tailored interventions by MDT – at home and in hospital
➢ case management and coordination across providers
➢ effective transitions across teams / care settings
➢ information sharing and technology enabled care
➢ policies and procedures for eligibility and care delivery

International Journal of Integrated Care, 2018; 18(2): 1, 1–4. DOI: https://doi.org/10.5334/ijic.4156
France: PAERPA
Italy - Sun Frail Model

Health and Social Care Services

Secondary care
- geriatricians, specialists, ...

Primary care
- general practitioners, nurses, social workers, ...

Community
- associations, pharmacy, clubs, churches, gyms, ...

possible pathways
- identification - referral
- primary prevention and promotion (physical activity, nutrition, ...)
- social activation (voluntary work, information literacy, sport, ...)
- individual, family, collective response

bio-medical response

Alert

Social response
Ireland – ICPOP Framework

10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures

2. Undertake Population Planning for Older Persons
   - Frailty Prevalence
     - 11% Severely Frail (Very High Risk)
     - 21% Moderate Frailty (High Risk)
     - 36% Mild Frailty (At risk)
     - 32% Fit (Minimal risk)

3. Map Local Care Resources
4. Develop Services & Care Pathways
   - Rehabilitation
   - Ambulatory Day Care
   - Acute Care
   - Nursing Homes
   - Dementia
   - Falls etc.

5. Develop New Ways of Working
   - New roles including care management approach for long term complex needs
   - In-reach and outreach

6. Develop Multidisciplinary Teamwork & Create Clinical Network Hub
   - Co-ordination between care providers

7. Person-centred Care Planning & Service Delivery
8. Supports to Live Well
   - Enable older persons to live well in the community
     - Community Transport
     - Social Activities
     - Home modifications & handy person
     - Medication Management
     - Shopping
     - Harness Technology
     - Support carers
     - Information & Advice
9. Enablers
   - Develop workforce
   - Align finance
   - Information systems
10. Monitor & Evaluate
    - Track service developments
    - Measure outcomes
    - Staff and service user experience
Scotland: Reshaping Care Programme

<table>
<thead>
<tr>
<th>Preventative and anticipatory care</th>
<th>Proactive care and Support at home</th>
<th>Effective care at times of transition</th>
<th>Hospital and care home(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Build social networks and opportunities for participation</td>
<td>- Responsive, flexible, self-directed home care</td>
<td>- Reablement and rehabilitation</td>
<td>- Urgent triage to identify frail older people</td>
</tr>
<tr>
<td>- Early diagnosis of dementia</td>
<td>- Integrated case/care management</td>
<td>- Specialist clinical advice for community teams</td>
<td>- Early assessment and rehab in the appropriate specialist unit</td>
</tr>
<tr>
<td>- Prevention of falls and fractures</td>
<td>- Carer support</td>
<td>- NHS24, SAS and out-of-hours access ACPs</td>
<td>- Prevention and treatment of delirium</td>
</tr>
<tr>
<td>- Information and support for self-management and self-directed support</td>
<td>- Rapid access to equipment</td>
<td>- Range of intermediate care alternatives to emergency admission</td>
<td>- Effective and timely discharge home or transfer to intermediate care</td>
</tr>
<tr>
<td>- Prediction of risk of recurrent admissions</td>
<td>- Timely adaptations, including housing adaptations</td>
<td>- Responsive and flexible palliative care</td>
<td>- Medicine reconciliation and reviews</td>
</tr>
<tr>
<td>- Anticipatory care planning</td>
<td>- Telehealthcare</td>
<td>- Medicines management</td>
<td>- Specialist clinical support for care homes</td>
</tr>
<tr>
<td>- Suitable and varied housing and housing support</td>
<td></td>
<td>- Access to range of housing options</td>
<td>- Carers as equal partners</td>
</tr>
<tr>
<td>- Support for carers</td>
<td></td>
<td>- Support for carers</td>
<td></td>
</tr>
</tbody>
</table>

**Enablers**
- Outcomes-focused assessment
  - Co-production
  - Technology, eHealth and data-sharing
  - Workforce development, skill mix and integrated working
  - Organization development and improvement support
  - Information and evaluation
  - Commissioning and integration resource framework

*Longwood Publishing Corp. Healthcare Quarterly Vol.19 No.2 2016*
• **Continuity of care:** the degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time, and consistent with their health needs and preferences.

• **Care coordination:** a proactive approach in bringing care professionals and providers together around the needs of service users to ensure that people receive integrated and person-focused care across various settings.

WHO Global Framework on Integrated People Centred Health Services

Vision for a future where

- all people have equal access to quality health services, supporting the achievement of universal health coverage;

- services are produced and provided in a way that meets people’s life course needs and respects their preferences;

- services are coordinated across the continuum of care and are comprehensive, safe, effective, timely, efficient, and acceptable;

- all health workers are motivated, skilled and operate in a supportive environment.

The European Framework for Action on Integrated Health Services Delivery

**PEOPLE**
- Identifying health needs
- Tackling determinants
- Empowering populations
- Engaging patients

**SERVICES**
- Reorienting the model of care
- Organizing providers & settings
- Managing services delivery
- Improving performance

**SYSTEM**
- Rearranging accountability
- Aligning incentives
- Preparing a competent workforce
- Promoting rational use of medicines
- Innovating health technologies
- Rolling out e-health

**CHANGE**
- Strategizing with people at the centre
- Implementing transformations
- Enabling sustainable change

[http://www.euro.who.int/en/health-topics/health-systems/health-services-delivery/publications](http://www.euro.who.int/en/health-topics/health-systems/health-services-delivery/publications)
CHANGES REQUIRED

PROMOTE AND ACHIEVE TRUE INTEGRATED HEALTHCARE SYSTEM

• **Active policies** to boost cooperation between social and healthcare systems.

• **Involving hospitals**, promoting a change in hospitals' views on their relationship with other healthcare providers.

• **Process redesign in hospitals to face multi morbidity chronic patients**, along with social needs.

• **To favour empowerment of patients**: highly involved patients, institutionally involved patients in decision making. **Patients needs should be the driver and boost hospital reorganization.**
ENABLING FACTORS

• **Payment system**: to link payments for multiple services and shared objectives between healthcare providers. Co-sharing objectives and risk about results it is an efficient way to involve all healthcare providers.

• **Education of Health professionals**: revision of education curriculum of health professionals as well as major efforts to help existing health professionals to adopt a paradigm shift in health care.

• **Information system**: shared clinical records and information is a cornerstone for integrated health services. This will be possible with electronic health records that are fully own by the patient but accessible by any health provider.
Success factors
### World Report on Ageing and Health

<table>
<thead>
<tr>
<th>Conventional care models</th>
<th>Older person centred and integrated care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focuses on a health condition (or conditions)</td>
<td>Focuses on people and their goals</td>
</tr>
<tr>
<td>Goal is disease management or cure</td>
<td>Goal is maximizing intrinsic capacity</td>
</tr>
<tr>
<td>Older person regarded as a passive recipient of care</td>
<td>Older person is an active participant in care planning and self-management</td>
</tr>
<tr>
<td>Care is fragmented across conditions, health workers, settings and life course</td>
<td>Care is integrated across conditions, health workers, settings and life course</td>
</tr>
<tr>
<td>Links with health care and long-term care are limited or non-existent</td>
<td>Links with health care and long-term care exist and are strong</td>
</tr>
<tr>
<td>Ageing is considered to be a pathological state</td>
<td>Ageing is considered to be a normal and valued part of the life course</td>
</tr>
</tbody>
</table>
**WHO iCOPE**

Community level interventions to manage declines in intrinsic capacity

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**Recommendations for managing declines in intrinsic capacity in older people**

### Improve musculoskeletal function, mobility and vitality

1. **Multimodal exercise,** including progressive strength resistance training and other exercise components that improve flexibility and aerobic capacity, should be recommended for older people with declining physical capacity, measured by gait speed, grip strength and other physical performance measures.

2. **Osteo-vascular nutrition** with dietary advice should be recommended for older people affected by osteoporosis.

Less of muscle mass and strength, reduced flexibility, and problems with balance can all impact mobility. Nutritional status can also be affected negatively by psychological changes, particularly depression and anxiety, which can lead to muscle wasting and weakness. General physical activity interventions that improve nutrition and encourage physical activity, when integrated into care plans and delivered together, can slow, stop or reverse declines in intrinsic capacity.

### Prevent severe cognitive impairment and promote psychological well-being

3. Cognitive impairment can be offered to older people with cognitive impairment, with or without a formal diagnosis of dementia.

4. **Cognitive exercises** can be offered to older people with cognitive symptoms that are limited by the limitations and capabilities of older people with cognitive impairment.

Cognitive impairment and psychological difficulties often occur together. They impact on people's ability to manage daily activities such as finance and shopping and may affect social functioning. Cognitive rehabilitation therapy, which is a programme of different forms of cognitive training that is beneficial to older people, can be offered to older people with cognitive impairment when required.

### Maintain sensory capacity

5. **Older people should receive routine screening for visual impairment in the primary care setting,** and timely provision of comprehensive eye care.

6. **Screening followed by provision of hearing aids should be offered to older people for any identified functional and management of hearing loss.**

### Manage age-associated conditions such as urinary incontinence

7. **Prompted toileting** for the management of urinary incontinence can be offered for older people with cognitive impairment.

8. **Public, floor, and seat training** should be offered to older people with cognitive impairment, which is recommended for older people with urinary incontinence.

### Prevent falls

9. **Medication review and individualized fall prevention or careful monitoring should be recommended for older people at risk of falls.**

10. **Multifactorial interventions** for reducing the risk and incidence of falls may be recommended for older people at risk of falls.

11. **Psychosocial interventions,** training and support should be offered to family members and other informal caregivers of care-dependent older people, particularly but not exclusively when the need for care is complex and extensive in the management of cognitive impairment.

### Support caregivers

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**WHO** defines intrinsic capacity as the composite of all the physical and mental capacities of an individual, and **functional ability** as the combination and interaction of intrinsic capacity with the environment a person inhabits.
WHO Global Strategy and Plan of Action on Ageing and Health

Five Strategic Objectives

1. Commitment to action on Healthy Ageing in every country
2. Developing age-friendly environments
3. Aligning health systems to the needs of older populations
4. Sustainable and equitable systems for long-term care (home, communities, institutions)
5. Improving measurement, monitoring and research on Healthy Ageing

2016 – 2020

- Evidence-based action to maximize functional ability that reaches every person.
- Build readiness, evidence and partnerships to support a Decade of Healthy Ageing
Active and Healthy Ageing in Scotland

• “I want to have fun and enjoy myself”

• “I wish to remain connected to my community and friends”

• “Don’t talk about me without me”

• “I wish to be able to contribute to society for as long as I want and to be treated with respect”

Scottish Older People’s Assembly
Person Centred

National Voices and Age UK

National Council for Palliative Care / National Voices
“Every Moment Counts” 2015
Source: WHO Regional Office for Europe (2016).
The SUSTAIN Roadmap

SUSTAIN
Sustainable tailored integrated care for older people in Europe

A movement for change
The SUSTAIN Community

Policy-makers | Doctors | Family and carers | Politicians
---|---|---|---
Health Managers | | | 
Regional authorities | Civil society groups | Patients | Nurses

Change agents: unique roles in transforming services

Advantage JA  #faceuptofrailty
Webinar Series and Topic Resources
www.integratedcarefoundation.org/scotland

Special Interest Groups (SIGs) hosted on IFIC website:
- Polypharmacy and Adherence
- Intermediate Care
- Palliative & End of Life Care
- Self Management and Co-production
- Compassionate Communities
- Frailty

https://integratedcarefoundation.org/ific-membersnetwork/groups/
Thank You

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IFICscotland@integratedcarefoundation.org
www.advantageja.eu
WHAT IS SUSTAIN?

Caroline Baan
National Institute for Public Health and the Environment (RIVM)
The SUSTAIN-project: supporting integrated care in Europe

CAROLINE BAAN
ON BEHALF OF THE SUSTAIN CONSORTIUM
The SUSTAIN consortium
Challenges of health systems

Increasing number of people with chronic conditions and/or health and social care demands → increasing need for health and social care.

Health systems often poorly planned and coordinated → health and social care needs are commonly insufficiently addressed.

Self-responsibility, self-efficacy, and self-management are increasingly important → people involved in decisions affecting their health and treatment (patient-centred care).
Integrated care to optimize health systems

- Proactive assessment
- Involving older people
- Multiple disciplines
- Coordination
- Set of interventions

CORE ELEMENTS INTEGRATED CARE
Challenges related to integrated care

- Best way to design integrated care?
- Effective?
- How to implement integrated care?
- How to make integrated care sustainable?
- How to transfer successful initiatives?
SUSTAIN aims

1. To **support** and **monitor improvements** to established integrated care initiatives for older people living at home with multiple health and social care needs;

2. To **contribute** to the **adoption** and **application** of these improvements to other health and social care systems, and regions in Europe.
SUSTAIN core domains

Person-centredness

Prevention-orientation

Efficiency

Safety
Overall structure

Phase 1
Preparation

WP3
Preparative activities to improve existing integrated care initiatives

Phase 2
Implementation research to improve existing integrated care initiatives at selected sites

WP4
Design, implementation and evaluation of improvements of integrated care initiatives

WP5
Overarching analyses of experiences of all integrated care initiatives

Phase 3
Translation to products and impacts

WP6
Roadmap development
**Proactive primary care**
- Geriatrics Osona (CAT)
- Social/healthcare integration Sabadell (CAT)
- Geriatric Care Model (NL)
- Over 75 Service (UK)

**Rehabilitative care**
- Careworks Berlin (DE)
- Surnadal Holistic Patient Care at Home (NO)
- KV RegioMed Zentrum Templin (DE)
- Søndre Nordstrand Holistic Care at Home (NO)

**Dementia care**
- Gerontopsychiatric Centre (AT)

**Home nursing**
- Alutaguse Care Centre (EST)
- Medendi (EST)

**Transitional care**
- Good in one go (NL)
- Swale home first (UK)
Main deliverable

Roadmap

Improved integrated care

Tips and tricks

Indicators/data collection tools

Good practices

Solutions for implementation issues

Instruments to develop improvement project
The value of international collaboration

• **Access** to experiences of other countries

• **Learning** from experiences of other countries

• **Get to know and understand** other countries

• Insight into **generic vs. context-specific** factors

• **Knowledge and uniformity** of indicators for evaluating integrated care

• **Translating** scientific knowledge to practical recommendations

**Ultimately: better care and support services, and better outcomes across the EU!**
Enjoy Today!
IMPROVING INTEGRATED CARE INITIATIVES ACROSS EUROPE: THE SUSTAIN FRAMEWORK

Jenny Billings
University of Kent
Phases of SUSTAIN and Methodology

JENNY BILLINGS ON BEHALF OF THE SUSTAIN CONSORTIUM
Overarching analyses of experiences of all integrated care initiatives

Preparative activities to improve existing integrated care initiatives (6 months)

WP3

Implementation research to improve existing integrated care initiatives at selected sites (12 months)

WP4

Implementation and evaluation of improvements of integrated care initiatives

WP5

Overarching analyses of experiences of all integrated care initiatives
Implementation Science
Evidence Integration Triangle
(Glasgow 2013)

Intervention
Improvements to integrated care services

Evidence

Stakeholders

Participatory Implementation Process
Stakeholder engagement; cyclical evaluation

Multi-Level Context

Practical Measures:
Case study design
Qualitative and quantitative indicators,
Process evaluation

Feedback
Phase 1: Preparation

Stakeholder analysis at the 14 sites

Initial assessments and stakeholder workshops

- Identification of projects for improvement
- Development of improvement plan
- Setting up of steering group
- Establishing working relationships
- Develop evaluation method and practical measures
Phase 2: Implementation and Evaluation
Case Study Design (Yin 2009)

**SUSTAIN UNIT OF ANALYSIS:**
**SET OF IMPROVEMENTS FOR INTEGRATED CARE INITIATIVE**

**Qualitative indicators:**
- surveys to users (n=210) and staff (n=140-280)

**Quantitative indicators**
- (set of 14 per site)

**Dyad (n=168) or single interviews with users (n=84) and carers (n=84)**

**Documents:**
- care plans (n=84) and steering group discussions (all)

**Interviews with managers (n=14)**

**Focus groups:**
- professionals/agency representatives (n=84-140)
SUSTAIN propositions

Integrated care activities will maintain or enhance person-centredness, prevention orientation, safety and efficiency in care delivery.

Explanations for succeeding in improving existing integrated care initiatives will be identified.

What works?

How and why?

What doesn’t work?

Why?

What can we transfer?
Qualitative indicators

Perceived Control of Health Care (users)

Control over organising health care, contacting and communicating workers, organising care in the future

Person Centred Experiences of Coordinated Care (users)

Goal setting, independence and empowerment, care coordination, involvement in decision making

Team Climate Inventory (professionals)

Vision, task orientation, support for innovation
## Quantitative Indicators per SUSTAIN theme

### PERSON-CENTREDNESS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Users with a needs assessment</td>
<td></td>
</tr>
<tr>
<td>Care plans with activities already actioned or being actioned</td>
<td></td>
</tr>
<tr>
<td>Care plans shared across different professionals</td>
<td></td>
</tr>
<tr>
<td>Care plans shared across different organisations</td>
<td></td>
</tr>
<tr>
<td>Carers with a needs assessment</td>
<td></td>
</tr>
</tbody>
</table>

### PREVENTION-ORIENTATION

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Users receiving a medication review</td>
<td></td>
</tr>
<tr>
<td>Users received or receiving advice on medication adherence</td>
<td></td>
</tr>
<tr>
<td>Users received or receiving advice on self-management and how to maintain independence</td>
<td></td>
</tr>
</tbody>
</table>

### SAFETY

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Users received safety advice (home security, falls prevention)</td>
<td></td>
</tr>
<tr>
<td>Users with falls recorded in the care plan</td>
<td></td>
</tr>
</tbody>
</table>

### EFFICIENCY

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency hospital admissions of user (during evaluation period)</td>
<td></td>
</tr>
<tr>
<td>Length of stay per emergency admission of user (during evaluation period)</td>
<td></td>
</tr>
<tr>
<td>Hospital readmissions of the user (during evaluation period)</td>
<td></td>
</tr>
<tr>
<td>Staff hours dedicated to initiative (per staff member)</td>
<td></td>
</tr>
</tbody>
</table>
Overview of what was collected when

Timeline

**Phase 1:**
- 0-6 months
- 6 months

**Team Climate Inventory (TCI); quantitative indicators**

**Discussion with steering group:**
- Assessment and planning

**Phase 2:**
- 6-12 months
- 12 months
- 12-18 months
- 18 months

**P3CEQ, PCHC, Quantitative indicators**

**EIT: Evidence Feedback to steering group:**
- Assessment and planning

**User and carer interviews**

**Document analysis/care plans**

**P3CEQ, PCHC, TCI**
- Quantitative indicators

**Manager interview**
- Focus group
- User/carer interview
- Document analysis/care plans

**EIT: Evidence Feedback for final assessment and future planning**
Approach to analysis (Yin 2009)

Step 1
All data sources analysed separately

Step 2
Data reduced to a series of thematic statements
Structured analytical frameworks and guidance for each data source provided

Step 3
Pattern-matching across the data using the thematic statements and our propositions
Search for rival explanations
Accommodating the methods

Practical Measures
Complex interventions and the developmental nature of methods

Analysis
Indicators
Recruitment
Researcher role
Coffee Break
Join us outside & discover the SUSTAIN sites!

The SUSTAIN project is funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144.
INTERACT WITH US!

@SUSTAINeu

#SUSTAINeu

The SUSTAIN project is funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144.
INTEGRATED CARE ‘ON THE GROUND’: THE SUSTAIN INTEGRATED CARE INITIATIVES AND KEY LEARNINGS

Annerieke Stoop
National Institute for Public Health and the Environment (RIVM))

Simone de Bruin
National Institute for Public Health and the Environment (RIVM))
Integrated care ‘on the ground’

The SUSTAIN integrated care initiatives and key learnings

SIMONE DE BRUIN AND ANNERIEKE STOOP
ON BEHALF OF THE SUSTAIN CONSORTIUM
13 initiatives in 7 countries
Proactive primary care
- Osona Program for Geriatrics (CAT)
- Sabadell Social/healthcare integration (CAT)
- Geriatric Care Model (NL)
- Over 75 Service (UK)

Rehabilitative care
- Pflegewerk Berlin (DE)
- KV RegioMed Zentrum Templin (DE)
- Surnadal Holistic Care at Home (NO)
- Sondre Nordstrand Everyday Mastery Team (NO)

Dementia care
- Gerontopsychiatric Zentre (AT)

Home nursing
- Alutaguse Care Centre (EST)
- Medendi (EST)

Transitional care
- In één keer goed! (NL)
- Swale home first (UK)
Challenges

Coordination and collaboration

Competences, motivation and workload

Communication and information

Person-centred working

Resources and support
Improvement projects

Collaboration, communication and coordination

Actual care delivery process
Examples of integrated care activities

- Needs assessments and care plans
- Location of care delivery
- Training and advice
- Building multidisciplinary teams
What seems to work?

Person-centredness

Prevention-orientation

Safety

Efficiency

Coordination
Explanations for (not) succeeding

Micro level

Meso level

Macro level
Recommendations to improve integrated care

Policy recommendations

Recommendations for service providers

Recommendations for the research community
PANEL DISCUSSION – INSIGHTS FROM THE SUSTAIN INTEGRATED CARE SITES

Carme Guinovart
Santa Creu University Hospital of Vic

Julia Baldwin
Sandgate Road Surgery

Julie MacInnes
University of Kent

Jillian Reynolds
AQuAS

Nick Zonneveld
Vilans
Lunch Break
Join us outside & discover the SUSTAIN sites!

The SUSTAIN project is funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144.
INTERACT WITH US!

The SUSTAIN project is funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144.
FROM RESEARCH TO PRACTICE TO POLICY: ‘WALKING’ THE SUSTAIN ROADMAP

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International Foundation for Integrated Care

Seline Noteboom
Vilans

Nick Goodwin
International Foundation for Integrated Care

Gerald Wistow
London School of Economics
SUSTAIN
Sustainable tailored integrated care for older people in Europe
What is the roadmap?

An open-access and easy to use resource to plan, design and implement integrated care to older people living at home with complex care needs

Objectives

☐ Integrate, translate and customise work done in WP3-5
☐ Develop a step-by-step guide to support successful adoption
☐ Co-designed with the case sites and end users - iterative development from implementation science approach
☐ Enabling dissemination and exploitation of results as defined in WP7
How did we get to this design?

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Sketch 1 of the story
Sketch 2 of the story

Implementation Steps

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2. [Diagram]
3. [Diagram]
4. [Diagram]

Improvement Cycle

Creating an enabling environment
Managing change across systems
Engaging stakeholders
The final storyline
Please open the roadmap on your laptop

SUSTAIN
Sustainable tailored integrated care for older people in Europe
Person-centred
Coordinated
Empowering an interprofessional workforce
Safeguarding dignity
Person-centred
Coordinated
Empowering an interprofessional workforce
Safeguarding dignity
ASSESSMENT TOOL

INTRODUCTION

In this section a simple self-assessment tool is designed and implemented to support older people in describing and improving their personal care needs. Core characteristics of care include: empowering older people, a simple five point scale strengths of the current care plans, and the listed components of decision making. The introduction outlines the following characteristics of personal care: care professionals exhibit active listening and communicate effectively so that older people understand the information that is provided to them; they are better able to make decisions; they are able to communicate in a clear and non-judgmental manner with the user's ability to maintain their independence and self-management skills; and care professionals are able to clearly identify strategies that improve user outcomes.

APPLICATION

The self-assessment tool is designed and administered through a questionnaire to provide the scores at both stages. The purpose of the exercise is then to utilise the information and discuss and debate the existing perceptions and weaknesses. Its purpose is to stimulate interest in how to improve the design of care services and strategies.
Person-centred Coordinated Empowering an interprofessional workforce Safeguarding dignity

BOOK 2 Setting up

1. Assessing
2. Designing
3. Implementing

BOOK 3 Improving

BOOK 4 Context

BOOK 5 Resources
Person-centred
Coordinated
Empowering an interprofessional workforce
Safeguarding dignity

BOOK 1: Design
BOOK 2: Setting up
BOOK 3: Improving
BOOK 4: Context
BOOK 5: Resources

1. Assessing
2. Designing
3. Implementing

CREATING AN ENABLING ENVIRONMENT
MAKING SYSTEMIC CHANGE
ENGAGING STAKEHOLDERS
Person-centred
Coordinated
Empowering an interprofessional workforce
Safeguarding dignity

BOOK 1
Design

BOOK 2
Setting up

BOOK 3
Improving

BOOK 4
Context

BOOK 5
Resources

1. Assessing
2. Designing
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BOOK 1 Design
BOOK 2 Setting up
BOOK 3 Improving
BOOK 4 Context
BOOK 5 Resources

Creating an enabling environment
Making systemic change
Engaging stakeholders
Implementing
PANEL DISCUSSION – BEYOND SUSTAIN: DISCUSSING INTEGRATED CARE IN EUROPE

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CLOSING REMARKS

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THANKS FOR JOINING THE SUSTAIN FINAL CONFERENCE!

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The SUSTAIN project is funded under Horizon 2020 – the Framework Programme for Research and Innovation (2014-2020) from the European Union under grant agreement No. 634144.