

ROADMAP

for Sustainable Tailored

INTEGRATED CARE

for Older People in Europe

A Summary



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

The content of this Roadmap reflects only the SUSTAIN consortium members' views. The European Union is not liable for any use that may be made of the information contained herein.

This summary of the Roadmap is produced on behalf of the SUSTAIN consortium:

- Austrian Interdisciplinary Platform on Ageing (OEPIA)
- AGE Platform Europe
- European Health Management Association (EHMA)
- Agency for Health Quality and Assessment of Catalonia (AQuAS)
- Praxis Centre for Policy Studies Foundation
- Stiftung Gesundheit
- University of Oslo
- International Foundation for Integrated Care (IFIC)
- National Institute for Public Health and the Environment (RIVM)
- Vilans
- Amsterdam UMC, location VU University Medical Center (VUmc)
- London School of Economics and Political Science (LSE)
- University of Kent

The SUSTAIN Roadmap

"As a family caregiver, I feel that the current system is a labyrinth, in which it is easy to lose continuity of care and enhance adverse events. With my mother, I experienced this situation, where, going to different consultations led to a failure of information and duplication of medication."

The SUSTAIN Project

From 2015 to 2019, the SUSTAIN project worked with local stakeholders from 13 initiatives (sites) in 7 countries aiming to improve integrated care. The SUSTAIN-project was carried out by 13 partners from Austria, Belgium, Estonia, Germany, Norway, Spain, the Netherlands, and the United Kingdom.

SUSTAIN's objectives were twofold:

- 1) Support and monitor improvements to established integrated care initiatives for older people living at home, and in so doing move towards more person-centred, prevention-oriented, safe and efficient care;
- 2) Contribute to the adoption and application of these improvements to other health and social care systems, and regions in Europe.

The SUSTAIN Roadmap

SUSTAIN partners worked in close collaboration with stakeholders from the 13 local sites, including health and social care staff, local authorities, managers, professional, but also users and their carers, to improve integrated care for older people.

Their experiences have been captured in the SUSTAIN Roadmap which aims to bridge the gaps between research, practice and health systems policy that impedes far too often the scaling up of innovations across Europe and transfer to other settings.

While the Roadmap is designed principally as an improvement aid to support improving integrated care for older persons living at home, it also helps readers who may not know where their site or service is in terms of the important elements of an effective integrated care service.

The roadmap is set up in five books:

- **BOOK 1** Designing Integrated Care Services
- **BOOK 2** Setting up Integrated Care
- **BOOK 3** Improving integrated care
- **BOOK 4** Context of Integrated Care
- **BOOK 5** Resources



The **online version** of the SUSTAIN Roadmap offers a comprehensive description of the different books that compose the Roadmap and provides access to the range of tools used in the framework of the SUSTAIN project.
For more information: www.sustain-eu.org

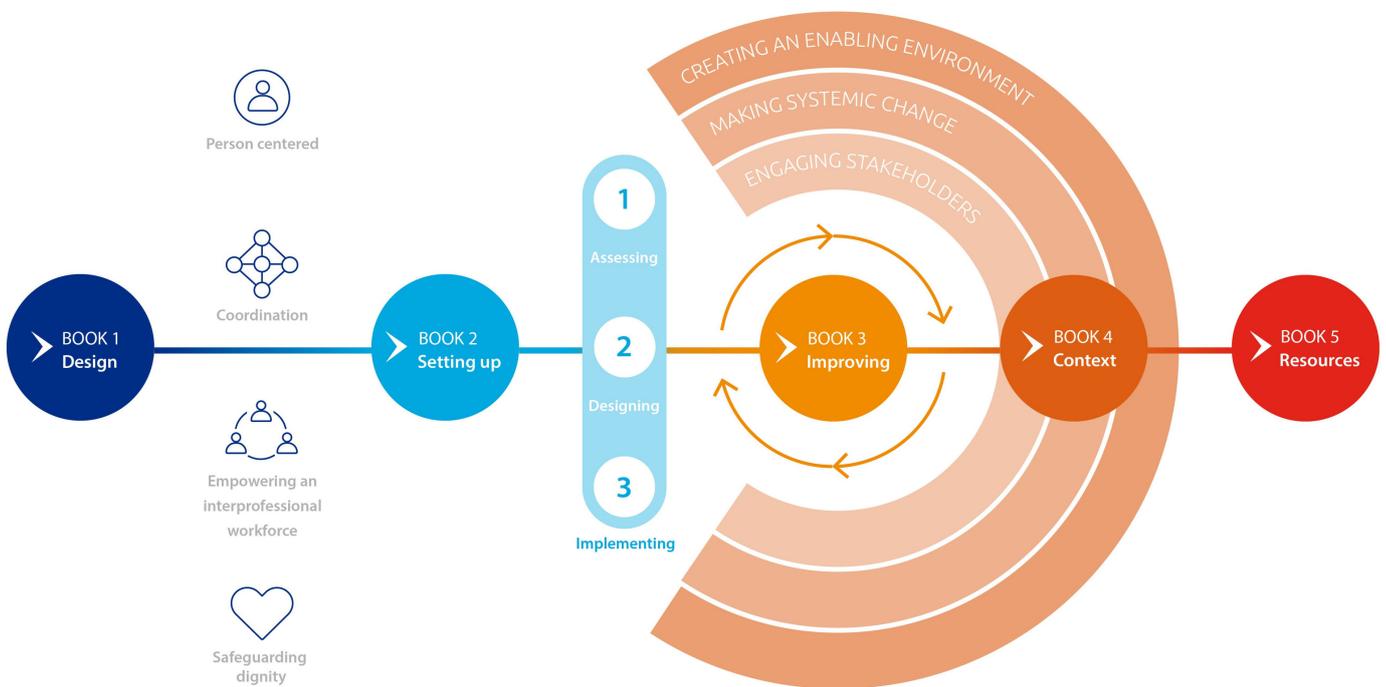


Fig. 1 - Visual of the Roadmap

BOOK 1

Design of Integrated Care

The goals of SUSTAIN were to improve integrated care initiatives, making care more person-centred, prevention-oriented, efficient and safe. As sites pursued these four goals and developed their improvement plans, the SUSTAIN project found that sites focused on four “design features” or areas as particularly relevant in achieving these goals.

1. PERSON-CENTRED CARE



Improving person-centred care means increasing the focus on orienting care around people’s individual needs, preferences, culture, capabilities and strengths, rather than their illness(es) or limitation(s). This means promoting more autonomy of the user, while still ensuring their safety.

Person-centered care is crucial as care needs of older people increase and solutions become more complex, medical errors and the risk of incompatibility or redundant interventions rise.

A range of measures that aim to promote person-centredness have been proven to have a positive impact on e.g. patient satisfaction, cost of care, length of hospital stay, functional performance and quality of care.

The following activities enable improvements in person-centred care:

- Communication and active listening;
- Shared decision making and co-production of a care plan;
- Relational continuity for the user with health and social care providers over time;
- Supported self-care.

2. COORDINATION



Coordinated care means bringing together a range of services from the health and social care sectors and enabling them to function seamlessly together. The approach ensures that the comprehensive needs and preferences of people are assessed, a comprehensive care plan is developed with the user, and that services are managed and monitored through an evidence-informed process.

Greater coordination of care has been shown to be associated with a range of benefits including: reduced hospital and care home admissions, length of stay, and re-admissions rates; improvements in recovery and quality of life.

The following activities enable improvements in coordination of care:

- Case management;
- Joint care assessments;
- Care transition management.

3. EMPOWERING AN INTERPROFESSIONAL WORKFORCE



The design feature of ‘empowered interprofessional workforce’ is devoted to outlining the activities that are necessary to ensure the workforce is supported, or enabled, to provide optimal integrated care services. The goals of integrated services will be achieved if it is understood that one cannot support users without also motivating and increasing the capacity of the workforce.

An empowered interprofessional workforce is competent and proactively tries to bridge any gaps in communication between four main divisions in care:

- Divide between health and social care;
- Divide between informal and formal care;
- Divide between care at home and in institutional settings;
- Divide between private and public provision of professional care.

A supported interprofessional workshop results in improved user experiences and use of resources, costs savings through increased productivity, motivation and reduced staff turnover.

The following activities enable improvements in empowering an interprofessional workforce:

- Trust building and strengthening care networks;
- Interprofessional culture of care;
- Continuous interdisciplinary learning;
- Leadership opportunities;
- Competency-based recruitment and performance management;
- Fostering integrated practice environments.

4. SAFEGUARDING DIGNITY



In consultations with older people across Europe, it was concluded that a focus on dignity in care can enhance the design of integrated care services beyond person-centredness, coordination and empowering inter-professional workforce.

As stated in the European Charter of the rights and responsibilities of older people in need of care and assistance, “human dignity is inviolable. Age and dependency cannot be the grounds for restrictions on any inalienable human right and civil liberty acknowledged by international standards and embedded in democratic constitutions”. Limited emphasis on dignity in care has already been shown to contribute to continued violence, abuse and neglect of older people in various care settings, leading to elder abuse. Dignity is therefore a design feature that needs to be continuously discussed and integrated into the provision of care by both professionals and non-professionals.

The following activities enable improvements in safeguarding dignity:

- Conflict management
- Communication and active listening;
- Ensuring access to information about health and wellbeing;
- Fostering dignified environments of care;
- Community consultation and outreach;
- Promoting reflective practice and positive attitudes.

BOOK 2

Setting up Integrated Care



Achieving integrated care for older people at home requires a coherent change management strategy including both implementation followed by an improvement cycle. The implementation steps presented here alert decision-makers to the key issues that need to be addressed if the improvement cycle is to be achieved successfully.

The implementation of integrated care in a specific country or region requires policymakers, leaders and managers to plan and invest in an effective implementation strategy, with dedicated time and resources.

This book is focused on the initial steps required to facilitate implementation. The purpose is to provide a simple step-by-step guide for key decisionmakers to support the often complex process of initially implementing integrated care for older people living at home before steps can be taken to improve integrated care (see Book 3).

STEP 1 ASSESSING NEEDS AND PRIORITIES



A critical first step in the implementation process is for the different key stakeholders to develop an in-depth understanding of the health and social needs of older people in their community. Assessing population health needs helps to establish a ‘common cause’. Ultimately, the purpose of a population health needs assessment is to gather the information necessary to understand the type and distribution of services required to support people’s needs:

- Assess the level of need for care services in people’s homes;
- Describe the current pattern of care delivery and/or level of supply to meet these needs;
- Identify the gap between need and supply.

Traditionally, epidemiological, comparative and corporate approaches are undertaken for a needs’ assessment.

One of the most pressing concerns during the first stages is to build a ‘value case’ for integrated care in terms of the benefits to older people, carers and local communities.

The results of the needs assessment and the value case will be one important piece of information to inform decisions about priorities. They should give an indication of the size and impact of a problem in health and social terms to further prioritise investments.

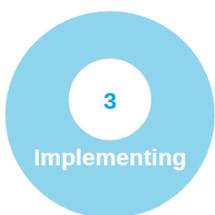
STEP 2 DESIGNING AND PLANNING OF SERVICES



Effective strategic planning for care delivery needs to shift from organisationally-led programmes with rigid norms to “smart” capacity planning, based on the needs of older people. At this point, new models of care need to be designed, implementing the core elements examined in Book 1 of this roadmap, to determine what type of services should be offered, where, how and to whom they should be provided.

The design of new service models must create the right opportunities for intersectoral action at a community-level and prioritise comprehensive primary and community care services to support older people’s health and wellbeing in the home environment.

STEP 3 IMPLEMENTING INTEGRATED CARE

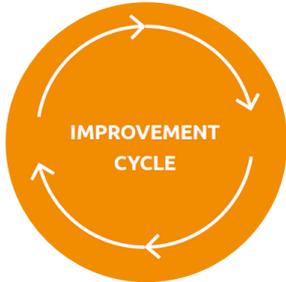


Policy-makers need to recognise that new skills and capabilities will be required for professionals to work with and alongside older people and communities, in team-based settings that better co-ordinate care in and around people’s homes. Strengthening governance requires a participatory approach that is transparent, inclusive, and reinforced by mutual accountability among policy-makers, managers, providers and users.

Moreover, health care teams need to be jointly accountable to older people, their carers and the local community. In order to implement integrated care, information systems are an essential component since they enable monitoring of outcomes and cost-effectiveness, promote inter-professional working and act as an essential interface between older people and care providers. These information systems also enhance approaches to: prevent ill-health (e.g. through forms of supported self-care); improve diagnosis and treatment (e.g. through decision-support tools); and enable the real-time monitoring of people’s health status to influence health and well-being.

BOOK 3

Improving Integrated Care



The SUSTAIN integrated care sites used the Evidence Integration Triangle (EIT) to guide the design, implementation and evaluation of care/ service improvements. The EIT emphasizes engaging key stakeholders, using scientific evidence, and attending to the context in which a programme is implemented. It helps us to ensure the intelligence, sensitivity, responsiveness and adaptiveness of our approach to integrated care improvement. As complex interventions rarely proceed through neatly

organized and linear stages, SUSTAIN researchers supported the sites at different points in their development that can be summarized across 4 key phases of a continuous improvement cycle.

PHASE 1 PREPARATION

The first step of service or care improvement is to take stock of what is currently being done in the integrated care service. In a second step, consensus is developed around the need for and purpose of improvements, using workshops and meetings to discuss outcomes, think about how to practically improve services and to establish and build stakeholder engagement. Thirdly, from these early meetings, hopefully a project steering group emerges that responds to and acts on priorities, maintaining the momentum of the group.

Visit the **EU Baseline Assessment Reports** on www.sustain-eu.org to learn more about:

- How to take stock of what is currently being done in the integrated care service;
- Experiences from SUSTAIN workshops to organize Phase 1 “Preparation”.

“This step is most important to understand where people stand, what are their challenges and opportunities.”

SUSTAIN CONSORTIUM
MEMBER

PHASE 2 DESIGN

The second phase of the improvement cycle is to design the improvement project that will address the concerns and priorities of the stakeholders, and achieve the objectives articulated by the steering group. This requires a process of collective decision-making. In SUSTAIN, the overarching framework was provided by the key domains of person centredness, prevention-orientation, safety, coordination and efficiency. Several documents produced by the SUSTAIN project i.e. the seven country-specific reports might provide inspiration when setting up an improvement project. Flow Charts can then help clarify the courses of action and produce a visual presentation of the project.

Visit the **SUSTAIN country reports** on www.sustain-eu.org to learn more about these flow charts.

“Think big, start small, (and then escalate).”

SUSTAIN CONSORTIUM
MEMBER

PHASE 3 IMPLEMENTATION

The third phase of the improvement cycle is to implement the improvement plans designed in phase 2. This might involve securing additional investments, developing or securing materials, and bringing about changes in current ways of working. This phase also involves establishing monitoring processes and the collection of data for evaluation (forming the groundwork for phase 4). Key-success factors for implementation are:

- Providing adequate time and resources;
- Set-up regular steering group meetings to keep members motivated;
- Have regular “one to one check-ins” with steering group members to gain insights into the progress of the improvement project;
- Communicate progress, highlighting the difference the change makes, to motivate staff and foster co-ownership.

“It is the ideal way of working. The problem is that we do not have the environment nor the usual working way allowing us to do it. It means an extra effort, extra hours... coordinating with social services. Of course this requires time. Work schedules need to be made compatible.”

PROFESSIONAL AT
SUSTAIN SITE

PHASE 4 MONITORING, EVALUATION AND FEEDBACK

Monitoring and evaluation are a vital aspect of the improvement cycle. A clear plan and agreement of the steering group facilitate the evaluation process. In SUSTAIN, we monitored both processes and outcomes of improvement, as it is important to understand how things are working in practice, how the context affects implementation and outcomes but also to see the extent to which integrated care has become more person-centred, prevention-oriented, safe and efficient.

*Visit the **SUSTAIN country reports** on www.sustain-eu.org to learn more about the methodological reflections, experiences and challenges of the tools and instruments used.*

“To know that you’re doing a good job because you don’t often get told that you’re doing a good job. But to come to a meeting and know that actually the service that you’re providing is having an impact is quite a nice thing.”

MANAGER AT
SUSTAIN SITE

BOOK 4

Context of Integrated Care

The purpose of integrated care in SUSTAIN is to deliver person-centred, prevention-oriented, safe and efficient care across multiple health and social care professionals, organisations and sectors. Underlying this simply stated purpose, however, is a great deal of complexity. Successful improvement will rely on the appropriate interaction between the objectives or purposes of integrated care, the process and the context. Key contextual themes identified within SUSTAIN as being important for the design, implementation, evaluation and outcomes of improvement projects were: governance arrangements, leadership, accountability, policy issues, organisational issues, collaboration, interpersonal relations, availability of resources, and financial issues.

LAYER 1 ENGAGING STAKEHOLDERS

Stakeholders include individuals, stakeholders at local, regional, national and maybe even international level. SUSTAIN has mapped stakeholders and their different sets of interests in six dimensions ('hexagon of integration') free of hierarchy, to appreciate all interests equally. Building relations and creating a safe space free of blame is crucial in stakeholder engagement.

LAYER 2 MAKING SYSTEMIC CHANGE

Person-centred integrated care requires a strategic approach that plans and delivers change in a 'systemic' way, requiring excellent stewardship. Stakeholders need to understand the whole picture and harmonize their goals to reach a sense of shared organisational responsibility.

LAYER 3 CREATING AN ENABLING ENVIRONMENT

As implementation will always be affected by its context, it is crucial to facilitate honest interaction between stakeholders to see how to change the environment in a positive way. Key drivers and resistors to creating an enabling environment are:

- Adequacy and location of resources
- Training and the professional regulation of staff
- Information governance and technical IT barriers
- Accountability frameworks - market-based systems, elections, direct incentives or professional oversight - to determine priorities, allocate resources, monitor progress and ensure delivery

In summary, there appear to be more health system resistors than drivers, reflecting degrees of institutional inertia as well as barriers emanating from challenged interests.

BOOK 5

Resources

The roadmap builds on a diversity of resources, which are accessible for further use and for the development of research and policies for integrated care.

ADVOCACY TOOL

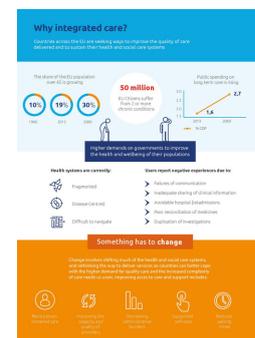
The focus points and infographic in this section provide you with key arguments and figures why implementing integrated care should be a priority.

The **focus points** are key arguments that build the case for the development of integrated care:

- The ageing population and accompanying increase in people with multiple chronic conditions has changed and increased the demand for health and social care;
- While the demand on governments to improve the health and wellbeing of their populations is rising, so is the demand for better care;
- Health care spending is expected to increase;
- Something has to change. Countries across Europe and the world are seeking ways to improve the quality of care delivered and sustain their health and social care systems.

The **infographic** presents visually the case for urgent action to reform care systems, and the top 6 reasons to develop integrated care:

- Takes the user's perspective;
- Improves people's experience of care;
- Improves people's health;
- Helps those that are most vulnerable;
- Can represent better value for money;
- Fosters a motivated and satisfied workforce.



ASSESSMENT TOOL

This is a simple self-assessment tool to enable decision-makers to take an informed view of their current capabilities when designing and improving approaches to integrate care that support older people to live at home. The approach to the self-assessment uses a simple five-point scale so that key informants can rate the relative strengths of the current design of their integrated care programmes. The self-assessment process is not a 'tick-box' approach, but a tool to bring people together and examine and agree where key issues for prioritisation exist that would help to strengthen elements in integrated care design.

CASE STORIES

The roadmap builds mostly on the improvement programmes implemented across sites in 7 European countries. Book 5 offers access to concise presentations of all 13 case sites and to factsheets that present their context, the challenges they faced in improving integrated care and the results obtained. These resources are particularly relevant to understand both common and context-specific barriers and enablers, and to encourage similar initiatives elsewhere in Europe.



SUSTAIN

Sustainable tailored integrated care for older people 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.