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

Lessons learned from improving integrated care in the Netherlands

Colophon

Key points

- Communication and establishing relationships between health and social care organisations and their staff are important preconditions for delivering integrated care. This also holds true for health and social care professionals and older people and their carers. Listening well to and acting upon older people's (and their carers') needs and preferences are key to a person-centred approach.

- "Unknown makes unloved", as the Dutch saying goes: unfamiliarity of health and social care professionals with each other's knowledge, skills and way of working hampers communication and collaboration.

- A shared vision is essential to keep managers and professionals committed to an improvement project.

- Improving integrated care is an incremental process which is dependent on sustainable commitment and (impartial) leadership at different layers within organisations collaborating in the integrated care network.

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1.   INTRODUCTION

1.1   Integrated care in the Netherlands

In the Netherlands, several integrated care initiatives have been established over the last years. Initially, integrated care was single disease-oriented, resulting in disease management programs, for diabetes or heart failure, for instance. To expedite the implementation of programs such as these, the Netherlands Ministry of Health, Welfare and Sport developed a new pricing model for long-term disease management known as bundled payment. This model enables all the necessary services for a disease management program to be contracted as a single package or product. In 2007, groups of affiliated health care providers known as 'care groups' began working with bundled payment arrangements for diabetes, initially on an experimental basis. In 2010, bundled payment for the management of diabetes, Chronic Obstructive Pulmonary Diseases and vascular risk management was introduced on a more permanent basis (Struijs et al., 2012).

The disease-specific programs, however, led to new challenges, such as fragmentation of care and support services and overlap between programs for people with multiple chronic conditions. Therefore, gradually, there was a shift to programs with a broader approach leading to integrated care initiatives for people with multimorbidity and frail older people (Hoogendijk et al., 2015; Metzelthin et al., 2013; Muntinga, 2015; Rijken et al., 2014; Spoorenberg et al., 2013). This process was expedited by the launch of the National Care for the Elderly Programme, a program aiming at the improvement of care for older people with complex health and social care needs (Beter Oud, 2016). Although there is much variety in the approach, scope, target groups, stakeholders and reach of these initiatives, common elements of these programs are: (i) case finding of frail older people; (ii) comprehensive assessment of needs, followed by tailor-made care and interventions, often described in a care plan, and (iii) multidisciplinary consultation meetings (Hoogendijk, 2016). Often, these programs are initiated from GP practices,

and they aim to deliver proactive care and support to older people living at home. In addition, transitional care programs (Buurman et al., 2016; Heim et al., 2016), focussing on better transitions between hospitals and the home situation of older people, were launched. After project funding from the National Care for the Elderly Programme ended, sustainability of the different programs became a challenge, and funding from other commissioners (e.g. health insurers) had to be found (Wehrens et al., 2017).

A more recent development is the implementation of population health management initiatives. Characteristics and needs of a defined population in a defined area or region are the starting-point for organising and integrating prevention, care and support. Healthcare providers, insurers and other stakeholders like municipalities and representatives of citizens or patients are working jointly to achieve better population outcomes and better quality of care, while slowing down cost growth (Lemmens et al., 2017; Struijs et al., 2015). The Netherlands Ministry of Health, Welfare and Sports has appointed nine pioneer sites, experimenting with population health management. Progress and outcomes of these initiatives are being monitored by the National Institute of Public Health and Environment (Drewes et al., 2016). Within the population health management initiatives, target groups are chosen that would benefit most from interventions integrating prevention, care and support. These target groups include frail older people (Lemmens et al., 2017).

In addition to the developments described above which mainly took place in the primary care and secondary care sector, also several developments took place in the long-term care sector that are important in the context of integrated care. In 2015, decentralisation took place of several long-term care services from the national government (Exceptional Medical Expenses Act)

to local authorities (Social Support Act), and of district nursing and personal care from the national government (Exceptional Medical Expenses Act) to health insurers (Health Insurance Act) (Van Berkel, 2006). At system level, these developments resulted in new dynamics between municipalities and health insurers. Municipalities and health insurers for instance need to collaborate more closely in commissioning and externally governing health and social care services (Vilans, 2015; Zonneveld et al., 2017). The decentralization also resulted in new interplay between health and social care professionals on a local or neighbourhood level. This is reflected by the development of social community teams, consisting of both health and social care professionals, in many Dutch municipalities (Vilans, 2016). In practice, inter-sectoral collaboration appears to be challenging. Multiple factors play a role in whether or not collaborations are successful. These factors are related to different levels of the health system. These include the national level (e.g. funding for collaboration), organisational level (e.g. shared vision, shared information system, available time, awareness of one another's roles and competences), and cultural and professional level (e.g. mutual trust, leadership, having a collaboration champion or facilitator) (Buist et al., submitted). Improvements to the current way of working are therefore deemed necessary.

1.2 The SUSTAIN project

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

The SUSTAIN-project is carried out by thirteen partners from eight European countries: Austria, Belgium, Estonia, Germany, Norway, Spain, the Netherlands, and the United Kingdom. With the exception of Belgium, in all other countries two integrated care initiatives per country were invited to participate in the SUSTAIN-project. The initiatives were already operating within their local health and social care systems. Criteria for including these initiatives, also referred to as 'sites', were defined by SUSTAIN research partners and drawn from the principles of the Chronic Care Model and related models (Epping-Jordan et al., 2004; Minkman, 2012; Wagner et al., 2005). Accordingly, initiatives should:
• Be willing and committed to improve their current practice by working towards more person-centred, prevention-oriented, safe and efficient care, which, in line with the European Commission's stipulations, are SUSTAIN's four key domains;

• Focus on people aged 65 years and older, who live in their own homes and who have multiple health and social care needs;
• Support people to stay in their own homes (or local environments) for as long as possible;
• Address older people's multiple needs, in other words, they should not be single disease oriented;
• Involve professionals from multiple health and social care disciplines working in multidisciplinary teams (e.g. nurses, social workers, pharmacists, dieticians, general practitioners);
• Be established, i.e. preferably operational for at least two years;
• Cover one geographical area or local site;
• Be mandated by one organisation that represents the initiative and that facilitates collaboration with SUSTAIN research partners.

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

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

In the second phase of the project (starting spring 2016), local steering groups were set up. Steering groups consisted of stakeholders who participated in the workshops together with additional local stakeholders considered relevant to the initiative. These steering groups were created to design and implement improvement plans, that is, sets of improvements that apply to local, site-specific priorities. Each steering group agreed to implement their plans over the 18-month period from autumn 2016 to spring 2018. In each initiative, implementation progress and outcomes were monitored by SUSTAIN partners using a multiple embedded case study design, in which each initiative was treated as one case study (Yin, 2013).

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?

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

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

1.3 SUSTAIN sites in the Netherlands

This report is dedicated to the SUSTAIN sites from the Netherlands. The SUSTAIN project originally cooperated with the initiatives "Health and social care West-Friesland" and "Walcheren Integrated Care Model (WICM)". Reasons for including these sites are reported elsewhere (De Bruin et al., 2016). Originally, the motivation to include the health and social care initiative in West-Friesland was the development and regional implementation of the Geriatric Care Model, which is a multifaceted intervention based on the Chronic Care Model (Bodenheimer et al., 2002). The Geriatric Care Model was initiated from GP practices in the West-Friesland region. It is a model for an outreaching, proactive approach of care and support for frail older people living at home in order to provide care and support that is tailored to their needs. Aspects of the Geriatric Care Model include a multidimensional assessment of older people's needs and multidisciplinary consultation meetings. Collaboration and communication between health and social care professionals within the region and insight into each other's roles and responsibilities required improvement in order to better meet the needs of their client population. Unfortunately, the WICM had to withdraw from SUSTAIN due to prioritization reasons. In June 2017, WICM was therefore replaced by 'The good in one go' initiative. This initiative, executed by an existing network of health and social care organisations in the Arnhem region, is focussing on older people with a sudden need of more intensive care in the home situation. Within the initiative, GPs, other health care professionals and social care professionals collaborate to deliver the right care in the right place at the right time for older people when a crisis situation occurs (e.g. hospital discharge after a sudden hospital admission, sudden loss of a family caregiver). This team-based response could, for instance, result in more intensive care at home, hospital admission or a temporary bed in a nursing home,

depending on the situation and the needs of the older person. To achieve this, collaboration between the involved professionals and organisations has to be improved.

1.4 Reader's guide

In this report, we present lessons learned from improving integrated care in the Netherlands. Part 1 (Chapter 2-4) of the report is dedicated to the Health and social care initiative in West-Friesland. Chapter 2 provides detailed information about the Health and social care initiative in West-Friesland and the improvement project that was implemented in this region. Chapter 3 and 4 are dedicated to the findings of the improvement of the Health and social care initiative in West-Friesland. Part 2 of the report (Chapter 5-7) is dedicated to the Good in one Go initiative in the Arnhem region, again featuring both the characteristics of this initiative and the improvement project and the findings of the implementation of the improvement project. Part 3 of this report (Chapter 8) presents some overall national reflections on the improvement projects in the two Dutch regions, followed by recommendations for policy and practice.

PART 1
Health and social care in West-Friesland

2. HEALTH AND SOCIAL CARE IN WEST-FRIESLAND: CHARACTERISTICS AND IMPROVEMENT PROJECT

2.1 General description of the site

Situated in the north-western part of the Netherlands, West-Friesland is a region with approximately 250.000 inhabitants. The region can be considered a rural environment with small towns and villages. Many people in the region live in their own homes until old age and, when needed, receive care and support from several organisations providing health and social care in West-Friesland. Over the last years, the region has been the context for various activities targeting care and support for older people living at home with complex care needs. For example, approximately half of the 108 General Practitioners (GP's) in the region, who are organised in one regional organisation, implemented the Geriatric Care Model (GCM). Based on the Chronic Care Model (Bodenheimer et al., 2002), the GCM is a model for shaping a proactive approach to care and support for frail older people living at home. Aspects of the GCM include:

1. Comprehensive geriatric assessment with the help of the Resident Assessment Instrument (RAI) performed by a dedicated practice nurse;
2. Tailor-made care plan developed by the practice nurse together with older people and their family caregivers;
3. Multidisciplinary meetings to plan the care policy and finalize care plan, involving the GP, practice nurse, elderly care physician, the family caregiver and other professionals depending on the care policy (e.g. home care nurses, pharmacists, physical therapists);
4. Regular monitoring of the agreed actions, included in the care plan, by the practice nurse.

Other activities in the region include comprehensive case management for people with dementia and their caregivers, which are provided by an organisation specialised in the delivery of care and support services to people with dementia living at home. There are also two big care organisations that deliver home care, nursing home care and sheltered housing facilities, as well as a large regional organisation providing social care.

Municipalities in the Netherlands are legally responsible for delivering social care and support services, as well as for providing instrumental needs to help people living at home for as long as possible. They collaborate with home care organisations and social care organisations in local social community teams in order to fulfil this responsibility. The municipality of Medemblik, the municipality situated in the West-Friesland that participated in SUSTAIN, has experimented with these social community teams since 2012, before these teams were structurally implemented in the Netherlands in 2015.

Following the implementation of the GCM in West-Friesland, the regional GP organisation agreed for the West-Friesland region to be included as one of the Dutch case sites of the SUSTAIN project. However, during the first phase of the project, the GP organisation decided to withdraw from the project due to difficulties with negotiations with the health insurer. Without the GP organisation as project leader, SUSTAIN researchers approached representatives of the above mentioned organisations involved in care and support for older people West-Friesland themselves in order to get acquainted and ask for their participation in the project. A steering group was composed consisting of directors of the two big home care organisations in the region, the regional manager of the organisation providing dementia care, a regional manager of the social care organisation, a policy officer from the municipality of Medemblik and a GP representative from the municipality of Medemblik. In addition, someone representing a regional advocacy organisation for older people (i.e. the 'Elderly Panel') was included as a member of the steering group, as well as a regional 'champion' who used to be an elderly care physician in the region before retiring. Already known to and trusted by many of the professionals and managers engaged in the project, this site champion was not representing any specific organisation and could thus act

as a neutral connector between individual professionals and the management and operational levels.

2.2 Rationale for improvement project

Despite all different activities for older people living at home with complex care needs in West-Friesland, stakeholders in the region felt that care and support services could be improved. Activities are very fragmented and collaboration between GP practices, other health care organisations, social care organisations and the municipality proved complicated. During the second phase of the SUSTAIN project, the improvement process was kick-started in June 2016 with the first local steering group meeting. After further meetings with stakeholders representing both management and operational levels, a rationale for the pilot was drafted in February 2017. The members of the steering group identified two specific aspects of care and support that could be further improved. Firstly, it was deemed necessary to further align communication and collaboration between different professionals and increase their understanding of one another's roles and responsibilities. Secondly, the steering group saw that professionals often faced difficulties with putting the needs and priorities of older people at the centre of their activities. Steering group members also agreed that the second goal could not be reached without the first; in order to provide truly person-centred care, in which the older person is the centre in a network of formal and informal carers, these formal and informal carers have to collaborate as a team.

2.3 Aims and objectives of improvement project

The PIIC Plus improvement project co-designed by the After identifying the main areas for improvement, it was decided to start a small-scale, bottom-up pilot in two villages in the municipality of Medemblik. In these two villages, named Andijk and Wervershoof, an intervention would be implemented among professionals involved in delivering care and support services in those villages. The actual implementation took place from May 2017 until March 2018. The aims of the improvement project were:
• To improve communication and collaboration between participating professionals, by improving their under-standing of each other's way of working and building trust;
• To increase professional's awareness of what matters to the older person by reflecting on how they approach their older clients in their daily work;
• To use the results following from the first two aims to facilitate new collaboration agreements between participating professionals.

2.4 Explanation of the improvement project

Figure 1 provides and overview of the elements of the improvement project. The top row of the figure depicts the existing way of working before the improvement project started, showing where care and support could be improved. The second row of the figure shows the integrated care activities of the improvement project, with the third row showing the expected outcomes of the intervention. The intervention consisted of two main activities. The first activity comprised regular 'intervision meetings' organised by the SUSTAIN research team. Intervision meetings are meetings in which peer supervision and methodical discussions help participants to reflect on their personal and professional development. Guided by the Theory of Presence of Baart (Baart, 2001; Kuis et al., 2015), the meetings in this improvement project aimed to help professionals reflect on their way of working in relation to their clients. Theory of Presence addresses the ability of care providers to build an open and meaningful relationship with their clients and align care and support services to their clients' needs by being mindful of their tempo, goals, work rhythm and style, language and perspective. Professionals participating in the meeting included home care nurses, practice nurses from the GP's offices, a social worker, case managers for people with dementia, and a 'social support consultant' from the municipality. Meetings were facilitated by the site champion, who had experience with facilitating intervision meetings, and a geriatric nurse from outside the improvement project who had experience with the practical application of Presence Theory. Meetings were scheduled once every two months and were held in an informal setting, after working hours at the site champion's home. The second integrated care activity of the improvement project consisted of workplace visits. Participating professionals were encouraged to visit each other and shadow their work for a part of the day, in order to increase their understanding of each other's roles, responsibilities and expertise. These workplace visits were strongly encouraged during the regular intervision meetings, but had to be organised by the participating professionals themselves.

The idea was that following from these two activities, participating professionals would be able to identify specific areas where collaboration agreements could be made to further improve their way of working. At the beginning of the project, it was expected that these areas of improvement would focus on the way of collecting and sharing information, both between participating professionals as well as between professionals and the older person and their informal carers, and the organisation of meetings in which all relevant professionals would be represented. The following chapter describes the actual progress and impact of implementing the improvement project.

Current

| Identification of (potential) frailty or care/support required | → | Assessment of health and social care needs | → | Discuss and prioritize needs with clients and informal carer(s) | ↔ | Development of care plan | → | Care and support initiated | → | Monitoring in yearly multi-disciplinary consultations (MDC) |

Fragmented

Insufficiently tailored to clients needs and preferences

Fragmented

Social care not included

Intervention

1. Training and case reflection for professionals during regular intervision to improve person-centeredness in provider-client relationship

2. Exercises for professionals to improve understanding of roles and working relationships

3. Collaboration agreements made during meetings to improve collaboration & communication

Expected improvements

Professionals really listen to client and tailor to their personal situation

Inform each other of results of needs assessments

Alignment and assignment of roles and responsibilities

Both health and social care professionals attend MDC's

Client: improved experience and control of care

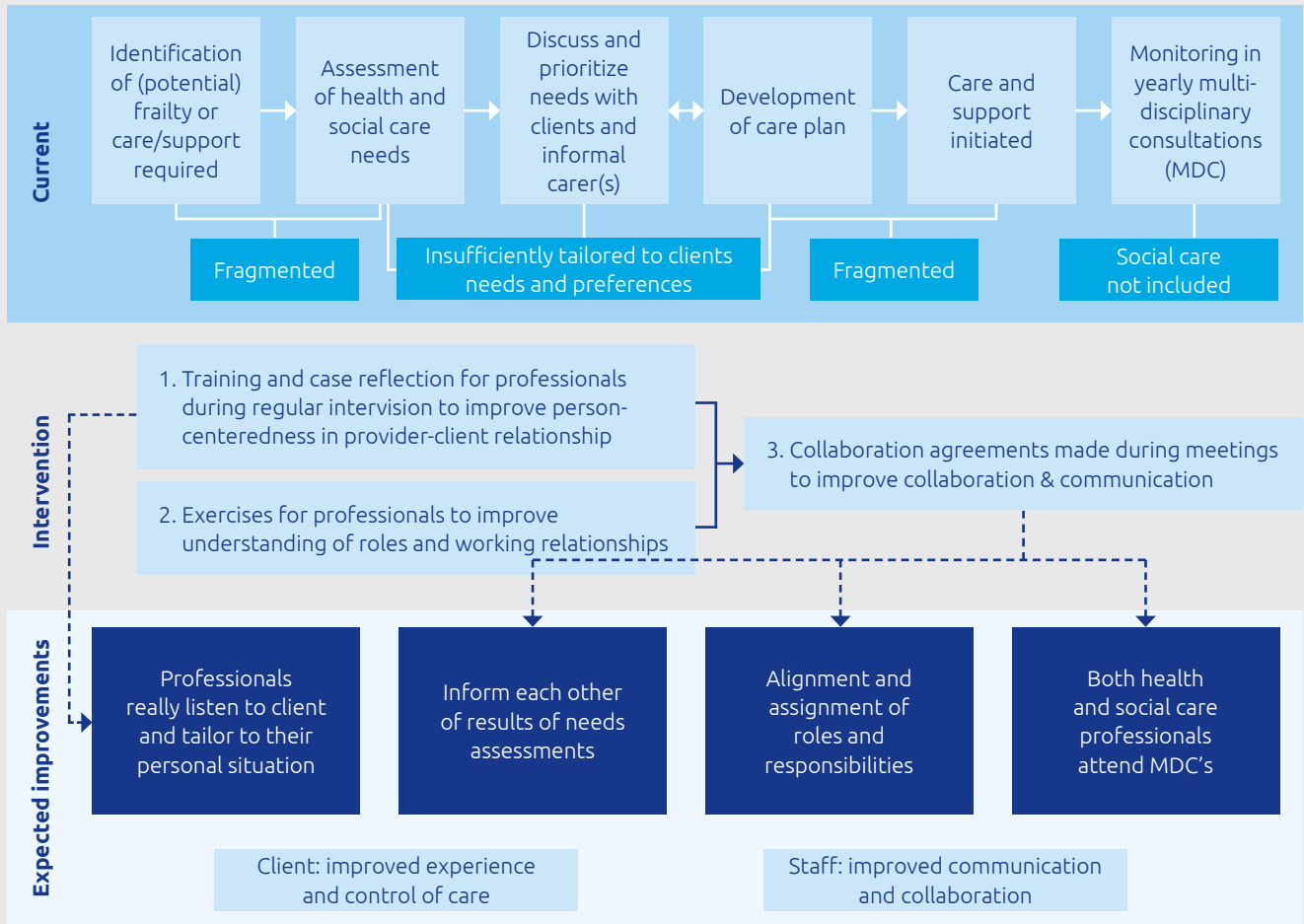Staff: improved communication and collaboration

Figure 1 - *Flowchart of the improvement project in the Health and social care initiative West-Friesland.*

3. FINDINGS OF THE IMPROVEMENT INITIATIVE HEALTH AND SOCIAL CARE IN WEST-FRIESLAND

3.1 Introduction

During the implementation of the improvement project, SUSTAIN researchers collected data in order to monitor and evaluate progress and outcomes of the improvement project. More information about the different types of data collected can be found in Appendix 10.1. The Medical Research Ethics Committee of the VU University Medical Centre in Amsterdam assessed the study proposal and concluded that the Medical Research Involving Human Subjects Act (WMO) did not apply to this study.

Table 2 provides an overview of the quantity of data collected per data source. A total of four managers and seven professionals participated in the study. Managers were aged between 35 and 64, were mostly female and were employed fulltime in different health and social care organisations. Professionals were also aged between 35 and 64 and all of them were female. They had high educational levels and were employed part-time in different health and social care organisations. In total, eleven users and six carers participated in the study. Most users were aged between 75 and 84, although some of them were aged 85 years or older. About 73% of the users included in our sample had a low educational level, which meant they had either completed primary or secondary school. It is quite common in the Netherlands for people of this older generation not to have completed further or higher education, especially for people living in a more rural area such as West-Friesland. Users had an average of 3.5 chronic conditions per person, and many of them lived alone. Most carers that participated in the study were spouses living together with the person they cared for. Two carers were a daughter who lived close-by and a son who lived further away.

This chapter describes the progress and impact of the improvement project and provides insight into which activities resulted in which outcomes, and why. Although we collected data among both service providers as well as service users, the improvement activities implemented primarily targeted the service providers (i.e. the professionals working in Andijk and Wervershoof). As such, the improvement project focused more on the processes that are conditional to delivering high-quality care and support, and less on the actual content of care delivery. Taking into account this focus, as well as the relatively short implementation period of the improvement project, it is unlikely that service users could have been impacted by the improvement project. The data we collected among service users will therefore provide limited insight into whether these improvement activities resulted in changes in their experience of care and support. However, these data do provide interesting contextual information regarding the way service users currently experience the care and support they receive. Therefore, wherever relevant, these insights will be described.

The impact of the project on the processes necessary for high quality care and support, as well as on the experiences of the participating service providers, are described based on the interviews with professionals and managers, the Team Climate Inventory (TCI) questionnaire, minutes of steering groups meetings, intervision meetings and project group meetings as well as other field notes.

3.2 What seems to work?

Co-ordination
Both managers and professionals indicated in the interviews that they thought that communication and collaboration between health and social care services were improved by the improvement project. They felt that the project resulted in better alignment of services and more trust. The managers indicated that the steering group meetings helped them to align their views on the core objectives of care and support for older people.

Table 2 - *Quantity of data collected per data source.*

Professionals and managers		Service users and informal carers	
Data source	**N**	**Data source**	**N**
Demographic information	Managers: 4 Professionals: 7	Demographic information	Users: 11 Carers: 6
Team Climate Inventory (TCI)	Baseline 11 Follow-up 10	Interviews users and carers	8 users 5 carers
Interviews managers	4	Person-centered co-ordinated care questionnaire (P3CEQ)	9 users
Focus group professionals	1 with 4 participants	Perceived control in health care questionnaire	8 users
Minutes of steering group and intervision meetings	10	Care plans	6 users
Field notes	1 document with notes taken during phase 1 and 2 of SUSTAIN (Dec 2015 – April 2018)		

They also indicated that trust and understanding between steering group members developed during the improvement project. This indicates that the installation of the steering group was already an 'improvement activity' in itself. Professionals stated that the intervision meetings increased their awareness of the roles, responsibilities and expertise of professionals from other organisations. The workplace visits gave them insight into the way of working of their colleagues and the kind of information that they collect from their older clients. The minutes taken during intervision meetings reflect that professionals became more understanding towards each other, started to build trust and felt more comfortable asking for help.

"It's that you feel comfortable to ask someone, because you know it's something that is probably part of their job. Otherwise, you wonder sometimes about whom to go to. Now you know a little bit of what everyone is doing. And you know each other, so it's not so bad if you ask the wrong question to the wrong person sometimes. Because then the other one will just tell you, no, you should go to him or her with that question. That is that feeling of safety and trust that you have." (Professional 6)

These qualitative findings are supported by the improved total TCI scores between baseline and follow-up. Although differences are small, total TCI score and scores on all subscales improved, with the largest increase on the subscale of participative safety. However, when these results are considered for professionals and managers separately, we see that the increase is mostly due to an increase on the part of the managers.

Person-centeredness

The planned integrated care activity that specifically focused on the person-centeredness of the way of working, was not implemented as planned (see also section 3.3. and 3.4). Nevertheless, professionals stated in the interviews to believe that with the improved communication and collaboration, the person-centeredness of their way of working had improved after all. Professionals felt more aware of the services their colleagues could provide, and felt that they could arrange the appropriate care and support quicker and could better address older people's needs.

"Definitely the collaboration with the others involved in my working area. Or OUR working area, I should say. Just that you know where to find each other. Eventually, that will benefit the patient, when you are able to make good arrangements with each other. Co-ordinate the care together, and see what is necessary from whom and tailor that to the patient's needs. I think we've achieved those things." (Professional 8)

Data collected among users and carers revealed diverse experiences with regard to person-centeredness. The overall Person-centered co-ordinated care questionnaire (P3CEQ) mean score was 16.88 on a possible score of 30, reflecting that older people experienced the care and support they received to be moderately person-centred and co-ordinated. Care plan data showed that home care nurses and practice nurses perform comprehensive needs assessments, and that these needs assessments also resulted in the formulation of goals for the older person. However, during interviews and in the P3CEQ, several users indicated not to be aware of any care plans or involvement in goal setting.

Although most users were aware of a needs assessment being done, some users indicated they were never asked about their needs, and said that if they would need anything, they would go to the doctor and ask for it themselves. With regard to needs assessments among carers, several carers indicated their needs had not been assessed. However, the carers of users with dementia felt that the case manager dementia addressed their own needs very well as well.

"Just that she [the case manager] says, she asks, and how are you doing?" (Carer 3)

"And now the GP's assistant came by a few times, that's new to me. She really comes to have a conversation with, like what I need and things, so that's something that I've never had before. […] I really like that. Just that you have the time to talk, and to elaborate on certain issues." (User 12)

The lowest score on the P3CEQ was on an item indicating that respondents did not often discuss what was most important to them in managing their health and wellbeing. During interviews, users also indicated that although service providers were very kind, respectful and listened very well, they still found it difficult to tell them when they would like to have something changed or when they are not completely satisfied. Main causes of dissatisfaction concerned the time of the day they received home care and the difficulties with getting services from the municipality. Users and carers also indicated that they saw many different faces, and professionals often have little time for them. Although they indicated to understand this and that they were fine with it, at the same time they would prefer to have more continuity and attention. While these data collected among users and carers provided insight into how they experience the person-centeredness of their care and support, it is not clear whether this has changed after implementation of the integrated care activities included in the improvement project.

"I've seen many different ladies already, but I don't mind anymore. They're a good team." (User 16)

Prevention-orientation

Although professionals indicated in the interviews that prevention-orientation probably should improve as well with the integrated care activities, they also stated it was too early to say anything about it. According to them, it was unlikely that the improvement project had influenced this yet. The field notes and minutes of the steering group and intervision meetings showed that although the professionals of the social community teams wanted to take a more prevention-oriented approach, this was hindered by a high caseload and the fact that people often contacted them when there was a need for care or support already. Furthermore, the interviews with the users and carers reflected that they knew who to contact when they had health-related questions or problems. They also felt that the care and support they currently received would help them to remain in their homes for as long as possible. Nevertheless, when asked how exactly the care and support provided to them was helping with this, most users were

not able to explain it. Carers indicated that the fact that home care nurses supported Instrumental Activities of Daily Living (IADL) activities helped them, and that the fact that their spouses went to adult day care services centres allowed them to keep on going. Some users indicated to think or worry about the future and indicated they wanted to move to another house (e.g. sheltered housing). However, these concerns were often not discussed with their care professionals. Nonetheless, users did indicate they received advice from professionals, e.g. on applying for aids and services and registering for sheltered housing.

"Yes, I think she [the practice nurse] does [help me manage at home]. I think she does, because whenever I have something I talk to her about it. And then she talks to the doctors about it." (User 10)

"Well, none of them [the home care nurses] is going on about me moving to [a sheltered housing facility]. And then they say, well, actually, you should get a personal alarm. But I really don't want to yet." (User 1)

Safety

Professionals did not seem to be aware of any specific impact the improvement project had on safety. They expressed that safety was already a natural part of their work before the project. Indeed, several users and carers stated to be aware of the need for home adaptations, mobility aids, fall prevention programs or the possibilities of having a personal alarm, sometimes indicating that professionals provided them with information about this. In addition, some users and carers already made use of these in order to improve their safety.

"And I wear an alarm around my neck. That really makes me feel safe." (User 10)

Moreover, carers mentioned that they supervised the medication their relatives were taking and some indicated that the medication distribution rolls provided by the pharmacy were very helpful. In these rolls, medication is distributed in separate "tear off" compartments per day and time of the day, so it is clearer when medication has to be taken. However, medication reviews by professionals, as an important component of patient safety, were not mentioned in the six care plans studied. In addition, the interviews with users and carers showed that some of them expressed their concerns about the medication prescribed. They wondered whether medication was still needed or were concerned about side effects. Most users and carers stated that as far as they knew a medication review was never performed. Moreover, another important aspect regarding safety is that falls do not seem to be recorded routinely in the care plans.

"So I take care of the pills, and I make sure she takes her insulin injections. She injects herself, but I make sure to remind her." (Carer 3)

"Five times I'd taken the pill, and I still had some left, but I called the doctor saying, can I quit them, because, I told him, they make me feel miserable. Well, he said, just quit them then." (User 2)

Efficiency

With regard to efficiency, it did not become apparent whether this was improved as a result of the improvement project or not. Efficiency was not specifically addressed in the interviews with managers and professionals. However, professionals did mention that after the intervision meetings they felt more able to arrange the appropriate care and support more quickly because they were more aware of the services their colleagues could provide and felt more comfortable asking them for help. As mentioned in chapter 2, the idea was that the improvement project would also result in specific collaboration agreements between professionals to further improve their way of working. Although the intervision meetings and work place visits did help to create awareness of similarities in client information collection methods or identify certain issues with regard to e.g. information sharing, this did not yet result in any specific agreements between participating professionals and organisations.

"And that the patient might be helped faster. That they're in the right place quicker." (Professional 1).

"I notice that in the social community teams. We see these kinds of situations there often, and it really helps when you're able to find each other more quickly. And that you can rely on each other. That should be the starting point. If you or you have already been somewhere and provide a report of the situation, then I should not feel like I need to do my own assessments. I need to be able to rely on your assessment blindly." (Professional 8)

Overall impressions by respondents

Overall, professionals indicated to have enjoyed participating in the project and would like to sustain the activities related to the intervision meetings. They felt that in order to sustain the achieved improvement in communication and collaboration, and continue improving, it is necessary to keep investing in regular contact and reflection. Managers, however, felt that the improvement project could have had a greater and wider number of results and expressed doubts about the sustainability of the improvements, as they are now very dependent on specific professionals and SUSTAIN project team members. In addition, they indicated that although the project did affect communication and collaboration, they were unsure whether the improvement project also resulted in improved person-centeredness, prevention orientation, safety, and efficiency. Generally, the participating users and carers indicated they were satisfied about the care and support they received. However, as the integrated care activities did not focus directly on them, these experiences can probably not be attributed to the improvement project.

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

Managers and professionals agreed that the intervision meetings and work place visits were carried out as planned, and resulted in improved communication and collaboration by enhancing alignment and trust. When looking for explanations for succeeding and improving integrated care initiatives in the data from steering group minutes, intervision meeting minutes, field notes and interviews with managers and professionals, we were able to distinguish factors on the micro, meso, and macro levels of the health system.

Micro level

On the micro level, according to the professionals, the **informal setting** in which the intervision meetings took place, i.e. shared dinners at someone's home, facilitated the process of developing and implementing the integrated care activities. These dinners helped in building personal relationships and trust. This dining at home was introduced at the second meeting and professionals valued that they were able to sit down, have dinner, and then do the meetings without the rush of their day-to-day work. Second, managers indicated that the **energy and motivation** of the participating professionals played a vital role in the success of the integrated care activities. Third, attributing to the success of the intervision meetings was **facilitation of the meetings** by the SUSTAIN project team. Professionals appreciated the SUSTAIN project team for their leadership, as they were able to motivate participants and took action upon their feedback. One example of this is the change in the focus of the meetings that was implemented by the SUSTAIN project team after the second meeting, in order to better tailor the meetings to the participants' needs. As described in chapter 2, the initial aim of the intervision meetings was to focus on the person-centeredness of professionals' way of working, guided by the Theory of Presence. Based on feedback of the participating professionals, it became apparent that they regarded this method as too theoretical and they expressed the need for a more practice-based method. The SUSTAIN project team therefore decided to let the content of the meetings be guided by the questions and needs of the participants. Although this choice meant that the focus of the meetings shifted away from person-centeredness and moved towards communication and collaboration between professionals, this choice ensured that participants felt respected and that these meetings had value to them.

Meso level

On the meso level, the **composition of the group of stakeholders** involved was considered as an important explanation for succeeding and improving integrated care initiatives. In both the steering group and the intervision group different disciplines, being health care, social care and the municipality, were represented. Especially the participation of the municipality in the project was deemed important, as their role was considered essential for

connecting health and social care services. The participation of a representative of older people in the steering group was regarded as a facilitator as well, as this brought in the perspective of recipients of care and support services. Managers indicated that collaboration on the organisational level also begins with **personal relationships**. There needs to be trust and understanding between representatives from different organisations before collaboration agreements are made, and dynamics between key people are therefore determinative. To achieve this trust and understanding and overcome cultural differences, it is also important to find a binding factor, which in the case of stakeholders in health and social care is often a shared compassion for the target group. Managers indicated that this user perspective helped to create shared **sense of urgency and vision** among stakeholders from different organisations. Both managers and professionals indicated they were committed to taking care of the frail older people in their region, and that connecting health and social care was important for this. Managers also indicated that the platform created by SUSTAIN was one of the platforms in which steering group members were able to align their visions.

"Absolutely, and most of all you see the divide between the doctors and the nurses versus social care and the municipality. Those really are two different worlds, and they have to grow towards each other. That's what I think was the beauty of this project." (Manager 5)

"How I see it, from what I know, is that at least at the level of the people who are in charge, so the managers and the administrators, that these people have come to find each other better and better. Of course, there were other things going on in the region that supported this, let me put it like that. But meeting each other for SUSTAIN did definitely supported that, especially in terms of vision. It is really good to see that most people on that level have similar visions. For that, this was really good." (Manager 1)

Managers indicated that **commitment and support on the managerial level** was also an important facilitator. According to them, it is essential for professionals on the operational level to achieve collaboration. This was supported by professionals, who stated that their managers allowing them to invest time in the intervision meetings and work place visits had been a key facilitator for their participation. The role of the SUSTAIN researchers as **project leaders** to guide the steering group meetings, and to motivate managers to participate in these meetings was considered an important facilitator as well.

Macro level
On the macro level, **regional policy** and initiatives to improve collaboration across organisations and domains were facilitating factors for the project's success in the specific region of West-Friesland. This policy positively influenced the stakeholders' commitment to the project. Also, the minutes of the steering group meetings reflected that connecting to existing collaborative initiatives and networks was deemed important by steering group members, as they wanted to avoid duplicate or unnecessary activities. In addition, during the time in which SUSTAIN

was active, other collaborative initiatives on related themes were started as well. According to the interviewed managers, this gave the SUSTAIN project a boost in the region.

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

Although professionals regard the improvement project as successful, managers seem to have some ambivalent feelings about this. While some managers thought that the improvement project was meaningful, albeit on a small scale, others felt the project was not a big success, especially given the amount of time invested in it. Most managers thought they could have got more out of the project, if the focus would have been broader. Initially, the idea was to further improve and expand the GCM in order to create a shared 'Geriatric Model' within health and social care to be able to work more person-centred. However, during the course of the development process, the project took a more small-scale and bottom-up approach. This was due to several reasons. Also here, we were able to distinguish explanations for succeeding and improving integrated care initiatives on the micro, meso, and macro levels of the health system.

"As I said before, what I would have preferred to get out of the project was for us to formulate together what we actually expect from the Geriatric Care Model and how we would approach that in the community together, because then we would have had something that we could all make agreements on. Like, that would mean this for this professional and that for that professional and then we would collectively commit to a model that would help us to get those older people at home in the picture. I think that would be more valuable overall compared to what we did now, connect some professionals with each other, which in the long run is not sustainable. These few people now know how to find each other, but the moment they change jobs that whole collaboration goes out the door." (Manager 3)

Micro level
On the micro level, **changes in group composition** and inconsistent attendance of both steering group and intervision meetings were mentioned as important barriers by both managers and professionals. Changes in group composition often led to changes in group dynamics, sometimes resulting in less constructive meetings due to repetition, distrust or lack of understanding of the topics discussed. Especially for professionals, staff shortages combined with high caseloads made it difficult to **invest time** in the improvement activities. The managers also mentioned the **lack of tangible results** from these kinds of improvement projects. Some had negative experiences with earlier projects that aimed to improve collaboration between different service providers, but did not succeed. Such experiences hampered their motivation and enthusiasm.

"I think that within SUSTAIN we've been searching for a long time for what it was that we would work on with each other, specifically. As I've experienced it, there would be nuances or we would suddenly be doing something different, or someone else would join the steering group which meant we were repeating a lot. Or people didn't come to the meetings or I didn't come myself. All in all, for me it never became specific enough." (Manager 3)

Meso level

An important barrier on the meso level was the withdrawal of the regional GP organisation from the project, leading to the absence of **strong leadership and ownership**. As described in chapter 2, the GCM was implemented by the regional GP organisation, and initially, the SUSTAIN project team saw them as the project leaders of the improvement project. When they withdrew from the project, none of the other organisations took ownership of the project and the leading role came to lie with the SUSTAIN project team. They were the ones to invite all stakeholders, compose the steering group and organise and facilitate all their meetings. In interviews, managers indicated that they never felt that **accountability** for the results of the project lied with them. It was not clear to them what their tasks were and how they were responsible for (parts) of the project, and they were not aware of the progress and results during the implementation. Although many things were discussed during the steering group meetings, it was challenging to come to tangible agreements between stakeholders. The SUSTAIN project team therefore took a leading role in the process, using input from the meetings to propose concrete decisions on the goals and outline of the improvement project. Although this was done for strategic (e.g. keep all stakeholders involved) or pragmatic (e.g. keeping the project going, getting things done within the timeline of SUSTAIN) reasons, it also resulted in some confusion among some managers and the feeling there was insufficient alignment with their preferences. Some managers indicated that eventually, the project did not focus on which was really important to them. For instance, the decision to change the focus of the intervision meetings (see also section 3.3) caused the steering group's goal of improving the person-centeredness of professionals' way of working to move somewhat to the background during the meetings.

"That already starts with the fact that there were a lot of changes in the steering group, but also has to do with the mandate that I have here. How big do I want this pilot to be. All of these things play a role. That also what makes me think: how much can one actually achieve in such a pilot, that's what I wonder." (Manager 2)

In addition, although steering group meetings helped stakeholders to align their visions, these meetings never resulted in actual decisions or agreements. Managers mentioned the different and sometimes incompatible agendas of steering group members, caused by **different organisational cultures and organisation interests**, made it difficult to align their ways of working.

Macro level

On the macro level, minutes of the meetings and interviews with managers and professionals reflected that communication between professionals from different organisations was made difficult by **privacy regulations**. While health care professionals were often able to find a work-around by asking the patients' permission to share information, this was not allowed in collaboration with non-medical professionals (social care, municipality). Related to this was the **lack of a shared IT system**, as different organisations used different systems, and not all data sharing was possible or allowed. Moreover, health and social care services had **different payment systems**, which hinders collaboration. As different organisations are each responsible for a small part of care and support for older people, there was no sense that they were all part of a network around the older person and as such there was no **shared accountability** either. This was also reflected in field notes from the TCI baseline data collection period, when several professionals indicated they did not consider the group of stakeholders involved in the project as a team.

4. MAIN LESSONS LEARNED FROM THE HEALTH AND SOCIAL CARE INITIATIVE IN WEST-FRIESLAND

4.1 Working towards integrated care improvements that could have impact

The activities that took place in West-Friesland seemed to have led to better communication and collaboration in the Health and social care initiative in West-Friesland, which are important elements of integrated care. Therefore, professionals and managers considered the improvement project as meaningful. At the same time, however, they acknowledged that additional steps will be necessary to further improve their way of working. As only a limited number of managers and professionals working in the West-Friesland region participated in the improvement project, the success of the project is very small-scale and continued success is dependent on several specific people. Among the limited number of participants, a number of factors seemed to have contributed to better communication and collaboration. The implemented integrated care activities resulted in regular contact between the professionals and managers in the West-Friesland region, which helped them to build and maintain interpersonal relationships and to create a team environment in which they felt comfortable and safe to discuss their concerns. This also helped to achieve trust in each other's expertise, which is essential in collaborating as a team. However, the lack of continuity in the steering group and intervision group made it difficult to build sustainable relationships and move forward, and to make substantial changes in the way of working in the Health and social care initiative in West-Friesland.

Several factors were particularly strong in affecting the implementation of the planned integrated care activities. Most important facilitators were a **broad composition** of the steering group and the intervision group as it allowed people with very different organisational cultures and backgrounds to get to know each other's language and expertise better. Also, the participation of a representative of older people in the steering group meetings was an important facilitator since this helped to keep the question 'what matters to the care recipient' at the centre of the discussions. Additionally, **motivation and commitment** throughout the project of managers as well as professionals were important. This was fuelled by a **shared sense of urgency** to take care of older people in the region and a **shared vision** about this among participants. Improved communication and collaboration were seen as essential steps in improving integrated care delivery. According to the participants, the only way forward was to working on these issues together.

An important barrier to the implementation of the integrated care activities included the lack of a **process owner** of the implementation of the improvement project from (one of) the local organisations participating in SUSTAIN. In fact, the SUSTAIN research team functioned as project leaders, and in their role it was difficult to appoint **accountability** for results of the project to the steering group. It also implied that almost all important decisions were actually made by the SUSTAIN research team. This raises some concerns about the sustainability of the improvement project. Although particularly the professionals were enthusiastic about the implemented integrated care activities, the finalization of SUSTAIN in West-Friesland implies the withdrawal of leadership. Related to the lack of leadership was the lack of **task orientation** of the steering group. In addition to creating a shared vision, the different organisations involved have to make clear agreements to really establish structural collaboration between health and social care professionals. This implies discussing and addressing the more difficult things,

such as the different and often **incompatible cultures and interests** of the participating organisations, as well. In the current steering group, this never happened. These factors also contributed to the fact, that although professionals and managers found the improvement project in itself meaningful, improvements to the current way of working in West-Friesland were small.

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

All three integrated care activities of the improvement project could theoretically be transferable across the EU. These activities can be used to enhance communication and collaboration, which in their turn can facilitate further improvement of integrated care. However, our project also shows some essential preconditions that should be met in order to successfully implement these activities. First of all, a **facilitator** to guide the intervision meetings with the professionals from different health and social care organisations is necessary. This facilitator can tempt professionals to abandon their comfort zone and to look beyond their own expertise. Secondly, our project shows that the **focus of the intervision meetings** should reflect both the aims of the improvement project as well as the daily practice of the professionals involved. Moreover, one has to think carefully about the **setting** in which the meetings are held. The informal atmosphere in which the intervision meetings took place in this project facilitated the process of getting to know each other, creating a safe environment and building trust. Furthermore, **commitment in different layers of organisations** is necessary, both among professionals and managers. We also saw that continuity in participants was important in successfully creating a safe and trusting environment. However, in reality there is often a high turnover rate in the workforce, which could impede this process. A barrier to transferability could be that the SUSTAIN researchers had a large role in the project. From this project we have, however, learned that strong leadership is necessary to develop and implement sustainable improvements. So without project leadership from a team, such as the SUSTAIN research team, leadership and process ownership should come from or organised by the participating organisations.

4.3 Methodological reflections

As explained in section 1.2, for SUSTAIN we consulted several data sources to evaluate progress and outcomes of the implementation of the improvement project. In the Health and social care initiative in West-Friesland, we experienced some challenges with data collection. It appeared to be very time-consuming to recruit older people to participate in our study. For the health and social care professionals, being responsible for recruitment,

recruiting older people was not at the top of their priority list due to a heavy workload. In addition, older people were hesitant or unwilling to participate, because they had already participated in earlier studies and were therefore not motivated to participate in another study. Some recruited older people only wanted to participate in an interview, but preferred not to complete the surveys. This resulted in a low number of completed surveys. Those older people that were willing to complete a survey, found the questions too difficult, too repetitive, or insufficiently aligned with their situation. Also the retrieval of care plans appeared to be challenging; some older people were not aware of the existence of a care plan, were not willing to share it, or no care plan appeared to be available.

The SUSTAIN project team also encountered some challenges with data collection among professionals and managers. Hours spent on the intervention for instance were not routinely recorded by professionals, which resulted in the project team providing estimates to the professionals, asking them to complement and approve. Most professionals and managers who were asked to participate in interviews and complete the survey did so. However, numbers were still low due to the small number of professionals and managers partaking in the project, especially towards the end. As a consequence of these challenges, the analysis of the case study relied heavily on qualitative data. However, in line with the principles of case study design, we were able to retrieve these data from different types of respondents and therefore to capture different perspectives.

4.4 Overall reflections and keypoints

The ultimate goal of the improvement project in West-Friesland was to improve the delivery of health and social care services to older people living at home. More specifically, the goal was to provide person-centred care by putting their needs and priorities at the centre in the delivery of care. Although first steps in the direction of improved delivery of care have been taken, that is communication and collaboration have been improved, the ultimate goal has not yet been reached. This is mainly because the improvement project was not entirely carried out as originally planned. The improvement plan merely focused on important preconditions for delivering high-quality care and support (i.e. improving communication and collaboration), rather than on the actual content of the care delivery. This explains why it has been difficult to affect outcomes in service users at this stage. Nevertheless, there seems to be potential to positively impact outcomes on the service user level. When teams have booked progress with communication and collaboration, intervision meetings could also be used to reflect on how to better meet needs of older people. Managers and professionals all seem to agree with the idea that professionals should build relations with and develop a network around the older person, to ensure the older person is central.

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It should further be acknowledged that the improvement project was designed and rolled-out during a turbulent time in West-Friesland. Organisations were dealing with various issues, from difficulties with negotiations with health insurers to the decentralisation of care and support from the national government to municipalities and from merging social care organisations to staffing shortages. Improved communication and collaboration at the management and professional level seem to be the most visible outcomes of the improvement project. Managers had more expectations of the project. They found that the improvement project was more small-scaled than they would have preferred. At the same time, however, there were not enough leadership, ownership and task orientation among these managers to make the improvement project more substantial than it now was.

PART 2
'Good in one go': person-centered health and social care services for older people in Arnhem

5. 'GOOD IN ONE GO': CHARACTERISTICS AND IMPROVEMENT PROJECT

5.1 General description of the site

In the Eastern part of the Netherlands, the Arnhem region (Arnhem, Wageningen, Renkum), several organisations work together to deliver person-centered health and social care services for older people. The 'Good in one Go' improvement project, specifically focused on crisis situations of frail older people living at home. In the project, organisations collaborated in an informal network which means that organisations did not have any formal agreements, but aligned their activities in order to provide a comprehensive range of health and social care services in the region. The project was initiated by Zinzia Zorggroep, a care organisation which offers a broad range of health and social care services on a regional level: home care, rehabilitation care, temporary stay and adult day services. Furthermore, the network consisted of a coalition of GPs, a hospital and a social care organisation in the region.

'Good in one Go' was led by an independent external project leader selected by Zinzia Zorggroep, based on her strong personal connections in the region. A steering group, consisting of a board member and a manager of Zinzia Zorggroep, supervised the progress of the project. Furthermore, there was mutual exchange on a regular basis between the 'Good in one Go' steering group and regional and national interest groups that address the same issue as 'Good in one Go'. The 'Good in one Go' project was mainly about issues in transferring frail older people between different services (home care, hospital care, temporary stay, nursing home). These services were sometimes offered by the same organisation. In this report, we refer to the specific types of services when describing the projects, findings and lessons learned.

5.2 Rationale for improvement project

The stakeholders, mentioned in the prior paragraph, collectively identified the main topic of the improvement project: clarification and alignment of the various scenarios for older people in crisis situations at home. Zinzia Zorggroep took a co-ordinating and leading role in the identification of this topic. The motivation of the improvement project was the observation of the stakeholders that when a crisis (e.g. a fall or increased caregiver burden) in the home situation of a frail older person occurs, often a temporary bed in a nursing home or a hospital admission is requested by a GP after a home visit. However, according to the main stakeholders, a temporary bed is not always the best solution for the older person since it may lead to disruption in the life of the older person. Additionally, it is not financially sustainable, because unnecessary admissions to temporary care or hospitals lead to high costs.

Next to a temporary bed in a nursing home or a hospital admission, other possible scenarios can be more appropriate for the older person and his/her family. To make good decisions in such a situation, it is important that the GPs, health and social care professionals in the network take a comprehensive approach to the older person and his/her family. This means they have to take the specific situation and needs of the older person and his or her family into account. Not only a medical perspective is required, but a social perspective and the perspective of the family of the older person are just as important in making the best decision. The best decision could also be, for instance, more intensive care at home, hospital admission or indeed a temporary bed in a nursing home, depending on the situation and the needs of the older person. Research showed that there was vagueness in practice about the availability of the multiple different scenarios (Ubink-Bontekoe and Spierenburg, 2018).

5.3 Aims and objectives of improvement project

The 'Good in one go' project aimed to clarify and align the various scenarios of a sudden need for more intensive care of a person living at home in a crisis situation (such as dementia or brain injury). This also includes their implications for older people, their families and professionals; from a broad and multidisciplinary point of view and taking the perspectives and needs of the older person and it family into account. Ultimately to deliver the right tailored care in the right place at the right time. In order to achieve this, improved cooperation between the multiple professionals and organisations in the network is necessary. The main overarching objectives of the improvement project were:

1. delivering better co-ordinated, tailored and person-centered care for older people living at home in a crisis situation (person-centeredness).
2. keeping older people at home safely for as long as possible (safety);
3. and reducing the number of unnecessary hospital and temporary stay admissions (prevention-orientation, efficiency).

5.4 Explanation of the improvement project

The 'Good in one Go' project consisted of a number of core elements (Figure 2). First of all, in order to clarify and align the various scenarios and implications of a sudden need for more intensive care in a crisis situation at home, a more comprehensive perspective is necessary. The 'Good in one Go' project introduced an elderly care physician provided by Zinzia Zorggroep into the triage process of an older person in an acute crisis at home, in addition to the GP, nurse or social worker (in some cases). The elderly

care physician analyses the situation compre-hensively (with input of older people and their family), in order to guide the older people to a suitable and person-centred solution. This comprehensive assessment is made at the older person's home or in the emergency room at the hospital, in collaboration with the GP and possibly other professionals, and forms the basis for a tailored care plan.

Next to this comprehensive perspective, in the 'Good in one Go' model the elderly care physician and the GP involve the older person and his/her family as much as possible, in order to comprehensively identify their needs and preferences. By doing this, the cooperating professionals develop a broader understanding of the older person's situation, living conditions and their physical, social, socio-economical, biomedical, psychological, spiritual and emotional needs. Both in the comprehensive assessment and in the development of the care plan, the older person and his/her family are asked for their input and preferences. Care plans are being developed in co-creation between the elderly care physician, the GP, the older person and his/her family.

By using this approach, the number of people and perspectives involved in the assessment of a crisis situation has increased. This means that co-ordination between the GP, the elderly care physician and the older person and his/her family is necessary. In the new process, this co-ordination takes place in the assessment phase and during the development of the care plan. The elderly care physician and the GP visit the older person together at home or at the ER in the hospital, and carry out an assessment. After that, they develop a care plan in co-creation with the older person and his or her family to make sure their needs and preferences are incorporated in the care plan. The involved professionals receive a short training about the way of working, but merely learn by doing and trial and error.
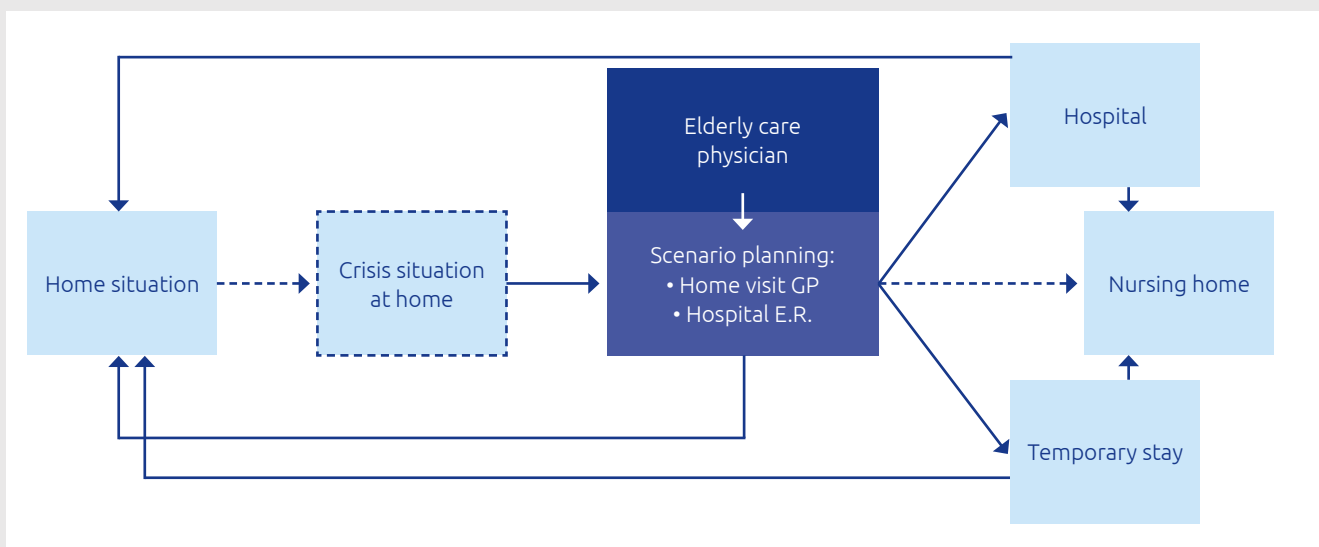

Figure 2 - *Flowchart of the improvement project 'Good in one Go' in the Arnhem region.*

6. FINDINGS OF THE IMPROVEMENT INITIATIVE 'GOOD IN ONE GO'

6.1 Introduction

In this chapter, the findings of the improvement project 'Good in one Go' will be explained. In this case study, a set of qualitative and quantitative data collection tools was used (see chapter 2.1 and Appendix 10.1). Our study population included five service users, six carers, eight professionals and two managers, making a total of 21 respondents (Table 3). The Medical Research Ethics Committee of the VU University Medical Centre in Amsterdam assessed the study proposal and concluded that the Medical Research Involving Human Subjects Act (WMO) did not apply to this study.

The service users that we interviewed were all men. Three users were aged between 65-74 years, the other two were aged between 75-84. The participating service users had an average of 3.2 different medical conditions, including dizziness with falling, prostate problems, hearing problems, heart failure, and stroke. Of the six carers that we interviewed, five were female. Four of the carers were spouses aged between 55-64 years (n=1), 65-74 years (n=2), and 75-85 years (n=1). The other two carers were children, one of which was aged between 45-54 years and one of which was aged between 55-64 years. The eight professionals involved in the study, working in the same multidisciplinary team, were all women. Members of the multidisciplinary team widely differed in their ages. Most professionals were aged between 25-34 years or between 55-64 years. Lastly, our study population included two managers who were both female, one of which was aged between 45-54 years and one of which was aged between 55-64 years.

All respondents were, or are, involved in the care services Zinza Zorggroep has on offer. During the interviews, the respondents were asked to elaborate on what kind of integrated care activities maintained or enhanced person-centeredness, prevention orientation, safety, efficiency and co-ordination in care delivery. In addition to the interviews,

we used field notes, steering group meeting minutes and the reflective notes from the researchers for this analysis (Appendix 10.1). All data have been collected between June 2017 and March 2018.

6.2 What seems to work?

Co-ordination

When it came to the co-ordination of care delivery, the interviewed users focused on whether they knew who to contact and on the co-ordination experienced between different service providers. The service and co-ordination between the different professionals and services in the network was mainly seen as sufficient. All users indicated that they knew who to contact in case of a change in care needs. In the experience of most users the transition from the temporary stay facility to home was well planned and communicated with them. The co-ordination between the hospital and the home care organisation and short term stay facility was however perceived as lacking by some users.

> *"They arranged all referrals for us. For the physiotherapist, the GP and for the medication from the pharmacy. They just give you all of these, that was very well arranged."*
> (User 4)

The carers indicated, when asked about co-ordination of care, that the information they received was consistent, that they were able to easily contact the professionals and that the received care was organised well. There were different ways and channels through which the carers can communicate with the professional; by phone, face-to-face, during care activities and through digital systems. All carers perceived it as positive that there were various means of communication and that the nature of the contact was flexible.

Table 3 - *Quantity of data collected per data source.*

Professionals and managers		Service users and informal carers	
Data source	**N**	**Data source**	**N**
Team Climate Inventory (TCI)	NA	Interviews users and carers	5 service users 6 carers
Interviews managers	2 managers	Person-centered co-ordinated care questionnaire (P3CEQ)	N/A
Focus group professionals	8 professionals	Perceived control in health care questionnaire	N/A
Minutes of steering group meetings	4	Care plans	N/A
Field notes	1 document with field notes and 1 document with reflective notes taken in the period between (Jun 2017 – Mar 2018). 1 additional research report (Feb 2018)		

"They call me, or I call them. Because of the digital care file it's possible to read everything. And I think that is comfortable, you don't feel like you're too much of a burden." (Carer 5)

In those cases where the co-ordination between the different care services and professionals did not work as intended and the information provided was insufficient, the carers and users experienced that they had to repeat themselves often. The carers found that it was difficult to contact professionals directly and felt that they had to take the lead in the co-ordination and support for the user. At the same time the carers acknowledged that the nature of the contact between users and workers varied from person to person and that it was not always possible to find a perfect fit. However, this was not perceived as negative.

"I notice that I have to be pro-active during this whole process, you have to take action. I think that they should guide you better." (Carer 1)

"One is very nice and sweet and the other acts differently and does not always connect with my mother. It just depends on who does it, everybody is different." (Carer 6)

The managers and professionals indicated that the co-ordination in care delivery benefited from good collaboration and communication between the different care initiatives active in the integrated care activities. They found that collaboration and communication improved when the different actors in the network valued each other and had a mutual understanding of what the user needed.

Examples of this were the positioning of an elderly care physician in the network, better communication between hospital and the care provider and better collaboration between the different involved actors (GP, hospital, home care organisation and temporary stay facility).

"The biggest strength of this project can be found in the collaboration between hospitals, GP's and elderly care homes, all with their own expertise." (Manager 1)

Because of the differences in the organisational structure and culture between the hospital, home care and temporary stay provider, the managers found that collaboration between these services proved to be more difficult than originally intended in the integrated care activities. The users and carers confirmed this. Whereas the collaboration between the short stay facility and home care was perceived as positive, the collaboration between and transfers from and to the hospital were perceived as inadequate. The users and carers indicated that they experienced miscommunication, a lack of information sharing and unnecessary transfers between facilities.

"Now we're in the emergency room for the third time. There has to be something here they can look at, where all the known information is? So they don't look at the person, they only do what is formally asked of them." (Carer 5)

At the same time, the carers experienced that when professionals co-ordinated care between different services they mainly exchanged clinical information and did not focus on the person as a whole and/or the needs of the user. They

thought that in this case a case manager could help professionals work together and communicate.

"The best thing would be if there was a case manager above all parties who is able to take control when needed." (Carer 5)

Person-centeredness
During the interviews, the users were asked about different aspects of person-centred care. All users indicated that for them person-centeredness is mainly about being satisfied with the amount of time the professionals spend with them and the assessment of their care needs. The analysis showed that the users find there was a consistency in the professionals that provided support and care, something that was seen as very positive. The users were content with the provided care and the time spent with them and they felt comfortable to explain their needs and wishes to the professionals.

"In 2013, I was temporarily admitted in a care facility and when I came back home I asked for support. And now I need more assistance and it is possible to keep the same person and the same organisation that have always helped me." (User 4)

"Well, there is enough time. There even are some who stay for coffee." (User 5)

The users experienced difficulties in those cases where there were many changes in the staff of the care organisations. New staff members were often not well informed and were perceived as strangers by the users and the carers. At the same time, the users and carers experienced that when there were many changes in the staff the care they received was not primarily focused on their needs and wishes.

"It is difficult for the organisation to replace their staff. But that is how it goes in an organisation, it's very tight with the staff and the new staff are not always up-to-date on what they should do." (Carer 1)

The carers indicated that a person-centred approach in the delivery of care for them was achieved when they felt that they were treated well, taken seriously, respected and understood. Most carers did feel that their needs were taken into consideration and were met. The carers were, for example, able to join the users to their appointments with professionals and found that the received support was not only practical but also focused on their wellbeing.

"When I feel guilty because I think that I didn't do enough and that can do better [help providing care], I can talk to the professionals about that. That is very nice." (Carer 6)

Another indication for person-centeredness from the perspective of the carer was the involvement in care planning. Most carers felt that they were able to indicate and discuss what kind of support the user needed. However, only few have had an active role in the formulation of (care)goals. The analysis showed that

the carers who were involved were also more satisfied with the received care than the carers who were not involved. However what this involvement entailed differs for each individual. Some carers preferred an active role in care planning and others were satisfied with knowing they could consult the professionals when needed. It was therefore seen as important that the professional encouraged this involvement with an open attitude towards the carer. This can also be achieved through multidisciplinary consultations or a case manager.

"I was always involved, yes we also talked about what could be better, what goes wrong and what could be different. So actually, all those people, they have always involved me. Or I involved myself through contacting them when there was something to talk about". (Carer 6)

At the same time, most carers indicated that they found it difficult to find the best place to stay for the user. This resulted in more transfers between different care arrangements (home, hospital, short stay facility, long-term care facility) than necessary. Something that was not found to be beneficial for the wellbeing of the user. In addition, most carers noticed that when professionals communicated about the user, they mainly exchanged clinical information and did not focus on the person as a whole.

"They're not paying attention to the person as a whole. Their focus is on the care protocol." (Carer 5)

The carers experienced that, mainly in the home care and nursing home settings, the professionals had enough attention for the user and that the needs of the user were often met. Some carers attributed the visible improvement of the health situation of the user to the attention and time invested in them. The carers also found that in the nursing home, the need of the users to involve social contacts were met by the professionals.

"We could celebrate the birthday of our daughter here in the care facility, we were with the whole family and they have had arranged everything for us so [the user] could be there." (Carer 3)

Carers noticed a lack of personal attention to the user in those cases when there were shortages in staff and resources. It is experienced by both the users and the carers that in these situations the staff can be un-responsive, absent, distant and defensive. The carers and users also noticed that in these situation decisions were made without consulting them. This often resulted in increased pressure for the carer. Simultaneously the user would not receive the desired quality and kind of care.

"At home the amount of time spent on [the user] was sufficient and the communication was good. In the healthcare facility now, it is much more difficult because there are more people who need attention." (Carer 6)

When asked, the managers indicated that person-centeredness would fit from an approach to care in which the perspective of the user is the point of departure. The integrated care activities showed that jointly (the user, carers and professionals) discussing the options in a crisis and the addition of professionals with a different viewpoint made that the perspective of the user was taken into account.

"I think that the biggest lesson we've learned is that you should not approach it from a product perspective, but from the perspective of a frail older person." (Manager 1)

Prevention-orientation and safety

When the users were asked about how prevention-orientation and safety in the delivery of care were enhanced and/or maintained they mainly focused on how they were prepared to go back home. The measures taken to increase their independence and whether they have had sufficient help to make the necessary adjustments to their living situation were part of this. The users indicated that the professionals at the initiative stimulated them to do as much as possible independently and that the initiative facilitated the necessary adjustments in their home situation. For example through the visit of an occupational therapist. Because of these measures, the users who lived at home had the confidence and the right support to live independently or with their carers.

"After you get home you'll get scared for a while, at least that's what they say, that it takes a while t o get settled again. But I do feel safe here." (User 4)

The carers experienced that safety was enhanced through the advice and assistance they received in making the necessary adjustments for the user to live independently at home. However, most of the respondents already lived in an adjusted house. These respondents indicated that not that many adjustments were needed.

"They came here and assessed everything. But everything was already adjusted, that has been the case for years." (Carer 2)

Some of the carers and users experienced passivity from the professionals when it came to the guidance and support in the transition to home. They felt that there was not enough attention for the independence and safety of the user and that the user was not provided with the right information to make adequate decisions about their healthcare needs. At the same time, the users perceived some of the suggested adjustments not as relevant for living independently.

"We have had a visit from an occupational therapist but I didn't think she provided sufficient guidance. She told us that some things were too dangerous and that we needed adjustments, but she didn't say how we could arrange these adjustments. I thought that was inadequate." (Carer 1)

Overall perspectives

Looking at the gathered and analysed data on the experiences with person-centeredness, care co-ordination, prevention-orientation and safety in the integrated care activities some overall perspectives can be formulated. The users mainly indicated that they were content with the care delivered, something that was enhanced when there was a consistency in the professionals and when they felt they were listened to and taken seriously. The carers affirmed this, however, they also indicated that there were some needed improvements when it came to involvement in care planning and co-ordination between services. Because of the nature of the integrated care activities the users and carers were not able to compare the received care to the situation before the intervention. The managers however were able to compare. They indicated that the intervention did lead to a more person-centred way of working and better collaboration and communication between the different services.

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

The integrated care activities in the Arnhem Region focused on an intervention in which the elderly care physician focused on a comprehensive perspective and involved the older person and his/her family for as much as possible. The rationale behind this intervention was to deliver care in the right place at the right time. During the analysis of the data gathered amongst users, carers and professionals who were involved in the integrated care activities, different explanations for succeeding and improving integrated care in general and for the improvement project specifically came to light.

Micro level

The **existing trustful connections** of the project manager resulted in a smooth implementation process. These pre-existing connections, in combination with the independent position of the project manager, made that the project manager could communicate quickly and directly with the other stakeholders in the network and had access to information when needed.

"If they did not trust me like this, they would never have allowed me at the E.R., looking in all the systems." (Manager 2)

Another important facilitator for the successful implementation of the integrated care activities was the **enthusiasm of the involved professionals**. At the start of the project, the staff needed to be convinced of the value of the project. However, in one-on-one conversations most of the staff developed an enthusiastic and helpful attitude towards the implemented integrated care activities and the project leader. Additionally, the field notes showed that when the staff experienced positive results during

the implementation process they quickly became enthusiastic about the project. This positive and enthusiastic attitude of the professionals was vital for the success of this integrated care initiative.

> *"When we talked to the staff one-to-one, and included them in the bigger picture, they quickly became enthusiastic."* (Manager 2)

The gathered data showed that it is valuable to **jointly discuss roles, tasks and boundaries at case level**. This made it easier to collaborate between different professionals, care services and organisations. Simultaneously, when jointly discussing a case it proved to beneficial for the collaboration to take the perspective of the user as a point of departure. The integrated care activities showed that jointly discussing the options in a crisis and the addition of an extra professional with another view, in this case the elderly care physician, contributed to a comprehensive approach.

> *"Well, what it brought me, is that the expertise of the elderly care physician has added value. We knew that already of course, but also at the E.R. Because it are other professionals, looking from another perspective at frail people. And that is where the added value is."* (Manager 1)

The **support and commitment of the board and management** of the Zinzia Zorggroep and of the collaborating organisations (the hospital and home care providers) was an important facilitator for the improvement project. In the first phase of the project, the staff were asked by the board and management to facilitate the project and to cooperate. The commitment of the collaborating organisation made that inter-organisational collaboration became possible. All organisations were willing to work together and share thoughts and information.

All organisations in the network should be involved from the beginning of an improvement project in order to facilitate integrated care activities. It is important that this **involvement happens at all layers of the organisation**. In this project, the hospital (both process management and the health professionals) were involved in the improvement project. However, they were involved in a later stage, rather than right at the start, therefore it proved to be difficult to overcome differences in vision between the hospital and the other organisations. Resulting in a more difficult improvement process.

Meso level
The interviews, field notes and steering group minutes showed that the improvement project was helped by the **independent position** of the, externally hired, project manager within the network. This leadership factor was experienced as an important facilitator for the improvement project since there were no conflicting interests with the participating organisations.

Finally, the **high sense of urgency** concerning the theme of the improvement project is seen as an important facilitator for succeeding. This sense of urgency, encouraged by policy changes and the political agenda on the subject of elderly care, resulted in highly intrinsically motivated people at the hospital and the home care and temporary stay providers

> *"Well, I think that the fact that it is just such an issue, that urgency everywhere after the summer, that... that certainly helped. [...] The idea arose; something has to happen now."* (Manager 2)

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

Micro level
The managers mentioned that the **time investment and effort** needed to make the integrated care activities a success is a barrier for the implementation. The organisations had to invest their own time and money, next to the costs of their regular services. Because of these financial and time issues there was not enough workforce when needed. Due to this lack of staff less people have been exposed to the intervention than initially planned.

> *"It was a very intense period. Intense in the sense that we have had to align a lot of things, we had many meetings and phone calls. Huge attacks on my calendar."* (Manager 1)

Meso level
The stakeholders indicated that for the continuation of the improvement project **stronger (public) leadership and ownership in the network of organisations** will be necessary. The field notes showed that a lack of specialized knowledge of the staff involved (community nurses, nurses, elderly care physicians, behavioural specialists) threatens the further continuation of the integrated care activities.

Due to differences in organisational cultures, the professionals involved experienced a **lack of alignment and connection** between the home care organisation, the temporary stay provider, GP's and the hospital. **Insufficient exchange of user and carer information** between these organisations resulted in a slowly executed intervention at the case level. Simultaneously the professionals of the hospital, the home care organisation and the temporary stay provider experienced problems with the exchange of information. This was due to non-communicating IT systems, used by the different organisations involved.

> *"You just noticed, once we came close to hospital processes, there is actually too little space and too little time, the disciplines are too far apart to implement the intervention really all the way."* (Manager 1)

Another identified barrier that hindered the project during the whole implementation process was **insufficient funding** of the integrated care activities. The organisations involved in the network experienced the current funding options as insufficient, unstable and not sustainable enough to continue the integrated care activities or similar projects on a longer term. The sustainability of the implemented improvement is under pressure due to financial instability.

Macro level

Next to the perceived lack of alignment on the organisational level, the field notes also showed a lack of alignment with, and connection to, the municipal's Social Support Act related services. This hindered the integrated care activities on a case level when home support materials and collective services funded by the municipality were needed. Simultaneously the target group of the integrated care activities often switched between different services, funded by different acts. The steering group experienced **legal and financial silos** between these different acts and funding on a national as well as on a local level. The members of the steering group experienced that these silos complicated and hindered the integrated care activities and other similar initiatives, because funding is not well aligned and connected.

7. MAIN LESSONS LEARNED FROM 'GOOD IN ONE GO'

7.1 Working towards integrated care improvements that could have impact

The 'Good in one Go' improvement project consisted of a number of innovative ingredients compared to the usual way of working. An elderly care physician was added to the triage process and a more comprehensive involvement of older people and their families in the assessment phase was organised, aiming for a more comprehensive approach in crisis situations at home. A number of factors influenced the improvements in the Arnhem region.

Our analysis shows that appropriate **leadership** was a driving force behind the implementation of the improvements in multiple ways. This is specifically reflected in the role, position and behaviours of the leading people in the network. The **impartiality** of the externally hired project leader was frequently highlighted as a factor of success. In a complex integrated care delivery network, with mutual dependencies and different interests between the actors, appointing an autonomous project leader that stands above and is neutral towards the parties is important. The absence of possible competing interests, a hidden agenda and/or a focus on making a profit could positively influence the improvement process in integrated care networks.

This is also reflected in the high value place on **trust**. Besides the impartiality of a project leader, establishing and maintaining interpersonal relationships could also lead to more trust. The integrated care activities in the Arnhem region, for example, benefited from the existing personal relationships of the appointed project leader. On the other hand, one should also be aware of the impact of existing relationships in creating environments of mistrust, due to past experiences. Another identified leadership related factor that could have impact on integrated care improvement is **commitment in all layers of the organisation and the network**. Our analysis shows that the support, commitment and enthusiasm of the professionals involved (for instance the elderly care physician and nurses), managers and board members was an important factor of success. The 'Good in one Go' project in the Arnhem region benefited from the support of these different individuals. It is important to be aware that these individuals depend on each other. The board members depend on the professionals for the actual execution of the integrated care activities. Vice versa, the professionals involved had to be facilitated by their board. The managers functioned as a lynch pin. The development of commitment in these different organisational layers demands certain leadership skills and competencies.

Next to factors related to leadership, trust and commitment, our analysis also shows a number of **contextual factors** that could have influenced the improvement of integrated care. The project in the Arnhem region concerned a relevant topic of interest of the media, on both a regional and national level. This resulted in a growing **sense of urgency** in the network, but also broader in society. The high sense of urgency regarding crisis situations of older people at home motivated the stakeholders to let the project succeed. Another influencing factor that arose from our analysis was the contrast between the **organisational cultures and structures** of the organisations in the network. In the 'Good in one Go' project, the stakeholders encountered both a gap between the different cultures and structures in of the home and temporary care deliverers, the hospital and municipal services. The stakeholders experienced differences concerning hierarchy (horizontally and

vertically organised), autonomy (less or more freedom in daily activities), political dynamics, guiding principles and working processes. These differences were experienced as an obstacle for the implementation of the integrated care improvements. Furthermore, the **legal and financial silos** on the Dutch national level were mentioned as a major factor of impact. The integrated care activities in the Arnhem mainly covered the transfer of frail older people between different health and social care services. With the transfer between services, this group of individuals also transfers between different acts and financial funds: the Social Support Act (in Dutch: Wmo), the Long-term care Act (in Dutch: WLZ) and the Health Insurance Act (in Dutch: Zvw). The improvement project showed that it is difficult the fund comprehensive support for this group of people, because the three financial funds are not aligned.

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

As mentioned, the main focus of the 'Good in one Go' project in the Arnhem region was to provide older people in a crisis situation a broader, comprehensive perspective by adding an elderly care physician to the triage, in order to take the needs and preferences of the older person and its family better into account. Ultimately the goal was to make the best possible decision for the older person and its family about what to do in a situation of crisis. Our analysis showed that users and carers found it very important to be taken seriously, respected and understood. The addition of a professional with a comprehensive view, in this case an elderly care physician, could be an improvement that contributes to that. So, the addition of an extra broader oriented professional that takes the preferences of the service user into account could be an integrated care improvement that could be transferable across the EU.

When looking at the process of the implementation of integrated care improvements in the Arnhem region, the project showed that the role, position and behaviour of the person that is assigned responsibility to lead the integrated care activities could also be considered as a major influencing factor. Other integrated care initiatives across the EU that want to improve their services could benefit from the insight that a project leader that is impartial, broadly trusted and has the ability to build commitment and motivate people in multiple organisational layers, has shown to be successful in the Arnhem region. However, for the aim of sustainability this also makes a project potentially vulnerable whereas project leaders can leave. Also, projects do have limited timespans and the aim is eventually to integrate the new ways of working into daily routines and existing governance.

7.3 Methodological reflections

When reflecting on the methodology used in our study, a number of methodological considerations can be made. Since the number of older people in crisis situations in the Arnhem region is relatively low and the project was incrementally implemented on a smaller scale, the number of participants in this study was also relatively low (five service users, six carers, eight professionals, two managers). At the same time, it appeared to be very time-consuming to recruit older people for our interviews. For the health and social care professionals, being responsible for recruitment, recruiting older people was not at the top of their priority list due to a heavy workload. Older people were hesitant or unwilling to participate. Reasons mentioned included that participation would be too burdensome for this frail population. As a result, in the Arnhem region no surveys (i.e. P3CEQ and PCHC) were completed. Furthermore, no care plans were retrieved. People were either not aware of the existence of a care plan, were not willing to share it, or no care plan appeared to be available. As a consequence, the analysis of the case study heavily relied on qualitative data. Although face-to-face in-depth interviews were conducted, the relatively low number of participants and the lack of surveys and care plans makes that more research is necessary to develop a more solid base of knowledge.

7.4 Overall reflections and keypoints

The 'Good in one Go' project addressed a topical and relevant problem. Because of the ageing population in the Netherlands and because of the focus on living independently for as long as possible there is an increase in the crisis situations that occur at home. Subsequently, the stakeholders active in the project felt a sense of urgency regarding crisis situations of older people at home. This urgency stimulated the stakeholders to form a network and focus in improvement in transferring frail older people between different health and social care services.

It should be taken into account that the numbers of older people in a crisis situation in the Arnhem region are relatively low in comparison with the demand for other health services. At the same time, the project has only been recently implemented. Therefore it is difficult to draw solid conclusions on the user level. We can, however, learn from the intervention itself and the process of implementation. The implementation of the improvement was an incremental process. In practice, this means that the new way of working developed gradually, and that there was no clear moment when the improvement was fully implemented or not implemented at all.

When reflecting on this project, it is important to highlight the role of the project leader. Her impartial position and existing connections and relations in the region were an important factor in the implementation and succeeding of the project. Furthermore we have seen that trust between individuals and organisations and commitment to the project are important factors for succeeding. Most results, insights and lessons learned concerning this improvement project, relate to care co-ordination, multi-professional collaboration, organisation and policy. However, the conclusion is that the intervention that is carried out in the Arnhem region seems to be successful. There is more attention to a comprehensive view in which the need and wishes of the user and his/her (informal)caregiver are the main point of focus. Next to this, the co-ordination and collaboration between organisations and individuals has benefitted from the intervention. Furthermore, our analysis showed that the explanations for (not) succeeding related to factors on a micro and meso levels, and that the explanations for not succeeding additionally related to the macro level of the health system.

PART 3

8. OVERALL (NATIONAL) REFLECTIONS

8.1 Introduction

In the previous chapters, we described the experiences that we obtained with improving integrated care in the Health and social care initiative in West-Friesland and the Good in go initiative in the Arnhem region. In both regions, the aims were to improve communication, collaboration and/or co-ordination of care, taking into account the perspectives and needs of frail older people and their families. Where the Health and social care initiative in West-Friesland focused on frail older people living at home in general, the Arnhem initiative focused on frail older people living at home with a sudden need for more intensive care specifically. This chapter brings together some of the lessons learned from both sites, looking at similarities and differences (section 8.2). Based on the lessons learned, we aimed to formulate policy recommendations and recommendations for service providers, which are outlined in sections 8.3 and 8.4 respectively. We finalize this chapter with an overall conclusion (section 8.5).

8.2 Implications of SUSTAIN for integrated care in the Netherlands

In both Dutch improvement projects it was confirmed that communication is a very important precondition for delivering integrated care (Valentijn et al., 2013). A lack of communication between organisations and health and social care professionals in integrated care networks will negatively affect the delivery of person-centred care. In addition, communication and treatment of older people by health and social care professionals, i.e. listening well to what is of importance to them and showing empathy for their situation, is an important precondition for delivering integrated care. The importance of good communication

is emphasized in both the SUSTAIN sites and in other Dutch regions. At the same time, however, professionals and organisations are struggling with how to improve communication. The integrated care activities undertaken in the Dutch SUSTAIN sites may be of inspiration for other integrated care sites facing similar challenges.

In the SUSTAIN site in Arnhem, it was further reconfirmed that co-ordination of health and social care services between organisations and professionals in integrated care networks is of vital importance. The project showed that there is a lot to improve when it comes to co-ordination in the Arnhem region, and presumably in other integrated care initiatives in the Netherlands as well. The SUSTAIN site in Arnhem showed that co-ordination of care for older people can be improved by adding an elderly care physician to the triage process. Not only does this support care co-ordination, it also ensures a person-centred perspective in which the needs and preferences of the service user and its caregivers are taken into account. These are relevant findings, since they fit well in current debates on how to put new 'broader' health concepts that focus on a person and one's abilities rather than on one's disease and disabilities into practice. Although the SUSTAIN project in Arnhem took place on a relatively small scale, it had implications for the regional position of the elderly care physician, for prioritizing communication and care co-ordination and for acknowledging the importance of a person-centred approach in care for older people. These local/regional implications can, in time, help in further prioritizing these components of integrated care on the national health and social care agenda.

It should further be noted that there are future plans to further improve and expand the Geriatric Care Model, which is part of the Health and social care initiative in West-Friesland, to fit the needs of all organisations participating in the care network. There is a collaboration

agreement between the regional GP organisation, the two large home care organisations in the region and the organisation providing dementia care to do so. The idea is to experiment with this adapted GCM in several pilots, to be started in 2018. These activities provide opportunities to incorporate and build on the results of the SUSTAIN pilot. Furthermore, the regional support foundation for primary care (ZonH) has received funds from the health insurer to investigate how the integrated care activities implemented in West-Friesland could be expanded to other regions in the province of North-Holland in which the West-Friesland area is also situated.

In addition to implications for the organisation of integrated care in the Netherlands, the SUSTAIN project also has implications for research on integrated care. SUSTAIN made an effort in taking innovative approaches to measuring outcomes. For instance, instead of general health outcomes (e.g. health status, physical functioning, quality of life), we aimed to include outcomes that might be more appropriate for vulnerable target groups such as older people (e.g. perceptions of older people of quality and co-ordination of care and support; perceived control in care and support of older people). Additionally, since evaluations in integrated care often merely focus on quantitative outcomes, we decided to take a mixed methods approach, using different data sources and taking into account the perspectives and experiences of different stakeholders involved in integrated care. This was done since we thought that such an approach would be more appropriate in evaluating complex interventions such as integrated care. The experiences we obtained with these methods are relevant for the scientific community in the Netherlands, but also for other stakeholders such as policy-makers and decision-makers. In SUSTAIN, we further aimed to create as much as uniformity in data collection, analysis and interpretation as possible. This uniformity will help to make meaningful comparisons between countries. This in turn, may make lessons learned in one country easier transferable to another country. Although we took an innovative approach in evaluating progress and outcomes of SUSTAIN, at the same time we should acknowledge that researchers in both sites, as also described in sections 4.3 and 7.3, faced several challenges in data collection.

8.3   Policy recommendations

As discussed in Chapter 1, in the Netherlands, the responsibilities for the delivery of health and social care can be found on both the national and the local government level. This is why recommendations are formulated for the national government as well as for municipalities.

In the West-Friesland and Arnhem regions, legal and financial silos were perceived as major obstacles in the implementation of integrated care improvements. Potential solutions may be more collaboration and alignment between the commissioners of health and social care services, i.e. municipalities and health insurers.

Based on the experiences in West-Friesland and Arnhem, we further recommend local governments (municipalities) to provide more support to local stakeholders in integrated care networks (e.g. service providers, client organisations). When local governments encourage and/or take on a more entrepreneurial attitude, the legal and financial silos can be bridged. Another policy recommendation is to identify and share good practices on integrated care, and to facilitate knowledge exchange. Other regions and stakeholders can learn from these initiatives (e.g. how to overcome financial barriers, how to build relationships, how to organise person-centred care and support) and this knowledge and apply lessons learned in their own context.

In this report, we only addressed the Dutch SUSTAIN sites. However, as also mentioned in Chapter 1, SUSTAIN was also carried out in Austria, Estonia, Germany, Norway, Spain and the United Kingdom. Although there are differences in the integrated care services delivered in the different countries, the Netherlands can nevertheless learn from these experiences. All countries and integrated care sites are experiencing similar challenges in delivering and improving integrated care. SUSTAIN has provided insight in the solutions countries found for these challenges. Dutch policy-makers and decision-makers are therefore recom-mended to look beyond their regional or national borders. Experiences from other countries can be inspiring for the Netherlands, and may prevent 'reinventing of the wheel'.

8.4   Recommendations for service providers

Based on the experiences in both SUSTAIN sites, we recommend service providers to take the service users' situation, needs and preferences as a guiding principle for organising their services. This implies that service providers should have a broader perspective than their organisational boundaries. Too often the focus of delivery of care and support is still too much on health care needs, and insufficiently on social care needs. Which, in turn, negatively affects person-centeredness and quality of care. A shift is needed from 'what is the matter with you' to 'what matters to you'. The result may be that a different operationalisation of 'person-centredness' in integrated care is needed. Do older people really want a care plan? What do they think of shared decision-making? What is really important to them when it comes to integrated care?

Secondly, service providers are advised to organise and co-ordinate care services in close collaboration with other network partners, like the community, service users, informal caregivers, municipalities, health insurers and other providers of care and support. When looking at communication between these network partners, an important recommendation is that organisations and professionals speak a similar language and make agreements on how to improve the actual health and social care delivery. This to ultimately positively affect outcomes and experiences of the care users. Important in this process

is to also discuss the different organisations' visions on **how** to improve health and social care delivery. From the Health and social care initiative in West-Friesland we learned for instance that, although different organisations hold a similar vision (i.e. improved communication and collaboration were seen as essential steps in improving integrated care delivery), the ideas and views on how to realise this differed. These differences were never discussed and remained a so-called 'elephant in the room' throughout the project. Because of this, a further improvement of the current way of working stagnated. Service providers are therefore recommended to tackle any differences in views to achieve their common goal in order to make real change.

Finally, based on our analysis we strongly advise care services providers to pay attention to the implications of appropriate leadership for the organisation and improvement of services in an integrated care network. Since leadership is no 'one size fits all' matter, one should look for a suitable match between leader(s) and the network.

8.5 Conclusion

Improvement projects in both Dutch SUSTAIN sites mainly focused on the improvement of communication, collaboration and co-ordination of health and social care services, on the level of professionals. As a result, older people and their carers so far, haven't noticed much of the changes that were implemented. Professionals and managers from both sites found the improvement project meaningful, but at the same time acknowledged that more steps will be necessary to really improve integrated care. And, more importantly, to make a change for the service users and their carers. Improving integrated care is an incremental process in which small steps are perceived as more feasible than a radical change of processes. Improving care takes time and is dependent on sustainable commitment in all layers of the organisation and the network.

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10. ANNEXES

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

Item	Data collection tool	Short description
DEMOGRAPHIC INFORMATION		
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
OUTCOMES		
Person-centredness		
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

Item	Data collection tool	Short description
PREVENTION ORIENTATION		
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
SAFETY		
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
EFFICIENCY		
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

Item	Data collection tool	Short description
IMPLEMENTATION PROGRESS		
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

SUSTAIN

Sustainable tailored integrated
care for older people in Europe