

Collaborative methodology

Odense 9th and 10th of October 2017

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Background

ACT@Scale is an innovative partnership of leading European health care regions, industry and academia that have the true potential to transform cure and care delivery services from pilots and experiments to scaled up, routine management of frail elderly and chronically ill. ACT@Scale aims at developing, testing and consolidating “best practice” Care Coordination and Telehealth (CC & TH) concepts that can be leveraged by the participating healthcare regions to expedite scaling-up their services, but also transferred to other regions through Europe and beyond. The scaling-up of “best practice” ACT@Scale CC & TH concepts is fully in line with the EIP on AHA and the EC scaling-up strategy, will facilitates concrete decision-making at EU policy level, and shows payers, practitioners and providers how patient care can be improved in light of an ageing society and under restricted budgets. ACT@Scale is targeting integrated care good practices in Basque Country, Catalonia, Groningen, Northern Ireland and South Denmark that are all in the process of implementing novel CC & TH processes at scale. The target groups are populations of chronic patients and elderly people with special needs including social services, frailty and psychiatric morbidities. A holistic assessment will be performed based on an agreed minimum dataset of indicators and with the support of a distributed Evaluation Engine. The ACT@Scale activity builds on the expertise and experiences of the previous ACT program and will use tested and tried collaborative methods and tools to implement improvements.

The fourth General Assembly is a progress meeting (after the learning phase of the project) for all participating organisations in Odense, Denmark, thanks to the hosting of the Odense University Hospital- Region of Southern Denmark.

Linked to the General Assembly, the project organises a transferability event on 10th October 2017:
<http://www.whinn.dk/events/#ev-4137>

More information: <http://www.act-at-scale.eu>
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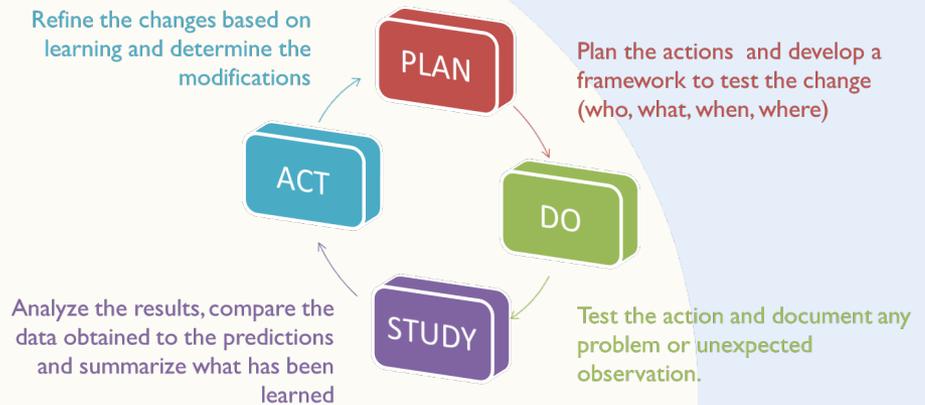


Guidance of Collaborative Methodology

The collaborative approach is increasingly used to carry out widespread improvements in care. This methodology requires multidisciplinary teams to come together periodically to learn change ideas and quality methods, and to exchange experiences with making changes.

Collaborative learning methods and change strategies with peers can stimulate rapid improvements, promote learning skills among participants and fasten the dissemination of good ideas. However, there are some key elements that have to be considered to run an effective collaborative.

1. Topic selection
2. Purpose and expectations
3. Experts recruitment
4. Enrolment of participating teams
5. Learning sessions
6. Action periods
7. Measurement and evaluation



Within ACT@Scale, this methodology, based on two Plan-Do-Study-Act (PDSA) cycles, applies multi-organizational structured collaborative quality improvement procedures, adapts them to scaling up integrated care and shares knowledge.



Lessons learned



Basque Country
CHF Telemonitoring

Tip 1 'Choose evidence based programs'

Topic selection

The particular program, which is object of improvement, needs to be supported by sound knowledge and positive results demonstrated in real-world settings. Good practices and research evidence about what is effective is crucial to engage and convince stakeholders to move on and look for improvements in the current practice.

Example: The use of the telemonitoring of congestive heart failure patients is controversial; there is not clear evidence of its benefits. Some healthcare professionals believe that the use of devices is not the most appropriate approach to remotely monitor patients and appear more in favor of other less sophisticated procedures such as regular phone calls, filling questionnaires or dedicated nursing practice. The scaling-up of this program has been considerably slowed down; only one integrated care organization has been actively deploying telemonitoring. In order to get more professionals on board the positive results of a telemonitoring experience in the Basque Country have been widely disseminated. Additionally, the technological platform used by the professionals to follow up patient's vital signs has been completely re-designed resulting in a very user-friendly and easy-to-use tool.

Transfer to another setting:

To be discussed in the workshop

ACT @ Scale

Lessons learned



Southern Denmark
Tele psychiatry

Tip 2 **‘In order to initiate a successful upscaling process, the maturity level of the service and management engagement are key aspects.’**

Purpose and expectations

The service has to be at a certain maturity level to engage in successful implementation of the collaborative methodology and consecutive upscaling process. Also, the engagement of the team and management included in the processes is key.

Example: In the Region of Southern Denmark, a telepsychiatric service was to be scaled up across the region. The upscaling process is still ongoing but the service was too far ahead in the process to implement the collaborative methodology alongside the other ACT@Scale regions. As the service was too mature, the management engagement could not be secured to fully engage the program management and the team in the ACT@Scale collaborative methodology. In the process of upscaling the service, it has become evident that the maturity level plays an important role both in terms of engaging in a successful implementation of the collaborative methodology but also the engagement of management on different levels.

Transfer to another setting:

To be discussed in the workshop



Lessons learned



Groningen
Effective cardio

Tip 3 **‘Implement the program into the existing care model using substitution of pathway elements.’**

Purpose and expectations

The innovative program should substitute current care pathway elements such as the scheduled outpatient clinic visits, thereby truly transforming healthcare.

Example: The effective cardio program has demonstrated that using telemonitoring in stead of regular outpatient clinic visits can significantly reduce length of hospital stay, hospital admissions and outpatient clinic visits. Patients are given devices and tools to self manage basic vitals signs coupled through IT systems allowing intensive monitoring and management by healthcare professionals. Part of the implementation process, in this case the nurse practitioner has been given extended responsibilities such as changing patient medications in order to manage large numbers of patients himself and only asking consultation of the medical specialist in case of emergencies. As such the care professional can manage large numbers of patients at a distance taking up a fraction of the time otherwise spend on face-to-face meetings. The program has been deployed at a relatively small scale hence showing large potential for future costs savings and cost-effectiveness. However, current financial models underlying the Dutch healthcare system have to change in order to provide secondary care with compelling incentives to foster large-scale implementation.

Transfer to another setting:

To be discussed in the workshop



Lessons learned



Basque Country
Multimorbid Integration

Tip 4 'Build a collaborative team representative of all stakeholders'

Enrollment of participating teams

The multidisciplinary team has to be formed by representatives of all the stakeholders relevant for the intervention to be implemented. If all perspectives and expectations are considered, the intervention will meet all needs and sense of belonging will be increased among team members.

Example: In the Basque Country, the collaborative team working in the scaling-up of the integrated care for multimorbid patients was composed by stakeholders of distinct levels (macro, meso and micro), with varied roles and representatives of all organizations where the intervention was expected to be implemented. In particular, the Healthcare Directorate represented the policy makers of Osakidetza (macro), whereas Medical and Nursing directors provided meso-level managers' opinion. Primary care (GPs, GP practice nurses) and secondary care (internists, hospital nurses) professionals represented front line staff's views.

Transfer to another setting:

To be discussed in the workshop

Lessons learned



Groningen
Asthma / COPD

Tip 5 'Build a collaborative team of ambassadors from all relevant stakeholder groups'

Enrollment of participating teams

True transformation of care management requires ambassadors from academia, healthcare and industry in order to implement innovative programs successfully.

Example: The asthma and COPD telehealth program has been developed in order to improve communication between primary and secondary care and thereby improving diagnosis and treatment of patients. A true transformation of early diagnosis and management of asthma and COPD patients has been deployed, already at scale offering services to over 17.000 patients and reaching more than 50 general practitioner offices. Although local implementation have been demonstrated, the business model has not been made because of a lack of available costs data hampering for instance studying the cost-effectiveness. Also, transfer to other settings might not be straightforward as ambassadors may not be easily identified, which is the case in the Rotterdam area.

Transfer to another setting:

To be discussed in the workshop

Lessons learned



Basque Country
Multimorbid Integration

Tip 6 'Be effective in running the collaborative meetings'

Expert recruitment

The collaborative meetings have to be chaired by experts in improvement methods and group dynamics to ensure that participants keep motivated and the best use of their knowledge and time. Empowering collaborative team members on improvement application facilitates the success in the implementation of changes in local settings.

Example: In the Basque Country, a dedicated expert team was responsible for the preparation and running of the group meetings. This team planned and organized the meetings carefully and beforehand (set objectives, define group activities, prepare material) enabling very productive and focused discussions during the meeting. These experts documented and shared with the multidisciplinary team the objectives, actions and conclusions agreed boosting internal discussion and team cohesion.

Transfer to another setting:

To be discussed in the workshop

Lessons learned



Catalonia
Physical activity

Tip 7 'Adaptation of priorities and strategies in program's implementation process (Do Phase).'

Action periods

Organizational changes, ICT development and business models issues, could induce that the priorities and strategies of implementation process should be adapted.

Example: The prehabilitation program has been deployed as planned in a local context. Demonstration of efficacy has been demonstrated in a recent RCT published in the Annals of Surgery (A Barberan-Garcia, 2017). Moreover, we have identified high potential for cost-effectiveness as well as potential to evolve toward a perisurgical care program. But, a new strategy it is necessary because this program will be implemented in Catalan Region. First, full maturity of the service should be achieved through: (1) Refinement of the business service workflow. It will be done with three workshops: refining the service's design, redefine regional extension, identification of business models to provide sustainability (2) evaluation of the the prehabilitation unit at Hospital Clínic; and, (3) development of an ICT platform integrated with current healthcare providers.

Transfer to another setting:

To be discussed in the workshop

Lessons learned



Groningen
Embrace

Tip 8 'Organize all relevant care providers around the needs of the elderly'

Measurement and evaluation

Centering care- and well-being delivered by a multidisciplinary team of professionals around the needs of elderly living at home decreases complexity of care needs, increases well-being and has the potential to reduce overall healthcare costs.

Example: The Embrace program aims to deliver demand-orientated, preventive and proactive care to elderly living at home, supported by an elderly care team consisting of a general practitioner, elderly care physician and district nurse. Depending on the level of frailty, customized management plans are developed in co-creation with the elderly and supported by a multidisciplinary team. The first results of the program have been promising, showing reduction of experienced healthcare problems and high satisfaction among participants. A previously published business case shows the potential to reduce healthcare costs up to 274 euros annually, per older adult. However, the cost-effectiveness of the program has yet to be demonstrated, currently hindered by fragmentation of funding sources and a focus on delivering short-term results.

Transfer to another setting:

To be discussed in the workshop