Scirocco Exchange

Capacity-building for integrated care

PROJECT ASSEMBLY MEETING
22 APRIL 2021
VIRTUAL

Co-funded by the Health Programme of the European Union

The SCIROCCO Exchange project is co-funded by the Health Programme of the European Union under Grant Agreement No.: 826676 (Chafea)

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WELCOME & MEETING OBJECTIVES

Donna Henderson

Scottish Government

Co-funded by the Health Programme of the European Union

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Meeting Objectives – Day 2

- To review the project's budget;
- To discuss adaptation, expansion and exploitation of SCIROCCO Exchange Knowledge Management Hub
- To review the progress in SCIROCCO Exchange Improvement Programme and its implementation;
- To learn about other EU Health Programme projects (JADECARE; VIGOUR).

Meeting Agenda

09.30	Welcome & Meeting Objectives
09.40	SCIROCCO Exchange Project – Update on the Budget
10.00	Adaptation, expansion & exploitation of SCIROCCO Exchange Tool for Integrated Care
11.00	Coffee Break
11.15	SCIROCCO Exchange Improvement Programme
12.15	Collaboration with other EU funded projects
13.00	End of meeting

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FINANCE POSITION (END OF CLAIM 7)

- Morag Keith – Finance Manager (International Engagement Team, NHS NSS)

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Finance Position (end Feb 21)

Claims 6 & 7* (not all partners have provided period 7 claims)

	Approved	Interim Claim	R 6 & 7	Total	
Staff Costs	€ 1,902,250.00	€ 809,905.14	€ 367,831.36	€ 1,177,736.50	62%
Sub Contracting	€ -	€ -	€ -	€ -	
Travel	€ 465,000.00	€ 66,721.63	€ -	€ 66,721.63	14%
Other Goods & Services	€ 109,000.00	€ 35,738.94	€ 10,938.23	€ 46,677.17	43%
Indirect Costs	€ 173,337.50	€ 63,865.60	€ 26,513.87	€ 90,379.47	52%
TOTAL	€ 2,649,587.50	€ 976,231.31	€ 405,283.46	€ 1,381,514.77	52%
EU Contribution (60%)	€ 1,589,752.50	€ 585,738.79	€ 243,170.08	€ 828,908.86	52%

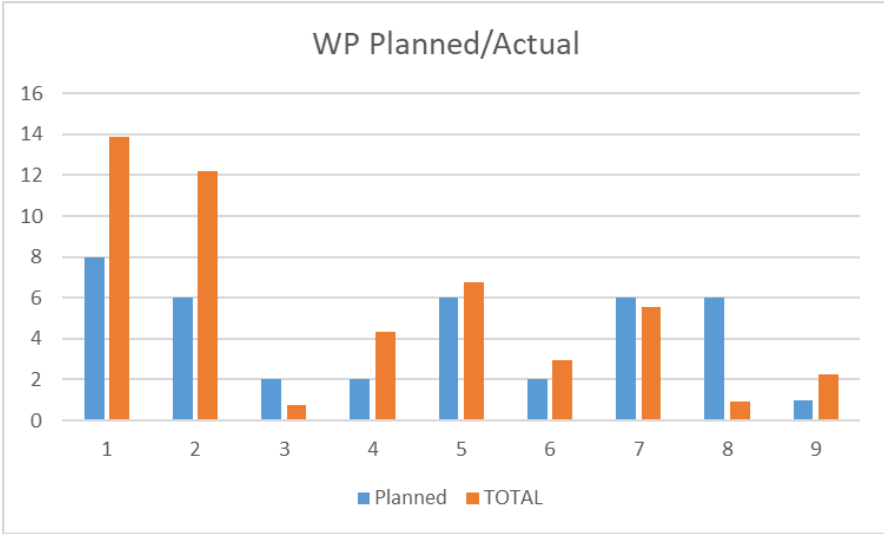
Dissemination Costs: € 175,429.53 (12.7%)

Position by Partner

P1 – Scottish Government

P1 - SG	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 241,254.00	€ 213,842.40	€ 109,598.23	€ 323,440.63	134%
Travel Costs	€ 40,000.00	€ 16,690.65	€ -	€ 16,690.65	42%
Other Costs	€ 92,000.00	€ 24,777.22	€ 8,033.43	€ 32,810.65	36%
Indirect Costs	€ 26,127.78	€ 17,871.72	€ 8,234.22	€ 26,105.94	100%
Total	€ 399,381.78	€ 273,181.99	€ 125,865.88	€ 399,047.87	100%

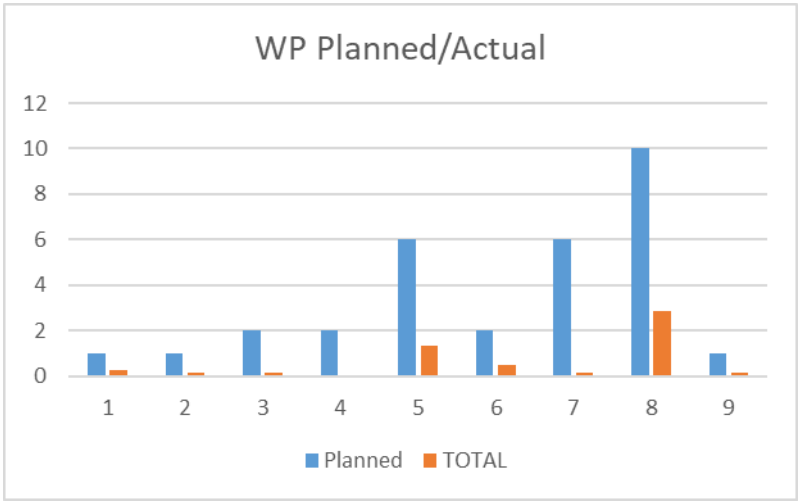
P1	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	8	7.91	5.94	13.85	173%
WP2	6	7.53	4.69	12.22	204%
WP3	2	0.77	0	0.77	39%
WP4	2	3.7	0.66	4.36	218%
WP5	6	6.77	0	6.77	113%
WP6	2	2.55	0.41	2.96	148%
WP7	6	0.8	4.75	5.55	93%
WP8	6	0.03	0.87	0.9	15%
WP9	1	1.86	0.42	2.28	228%
TOTAL	39	31.92	17.74	49.66	127%



P2 – Optimedis AG

P2 - OPT	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 217,775.00	€ 26,805.06	€ 36,538.82	€ 63,343.88	29%
Travel Costs	€ 40,000.00	€ 452.90	€ -	€ 452.90	1%
Other Costs	€ -	€ -	€ -	€ -	0%
Indirect Costs	€ 18,044.25	€ 1,908.06	€ 2,557.72	€ 4,465.77	25%
Total	€ 275,819.25	€ 29,166.02	€ 39,096.54	€ 68,262.55	25%

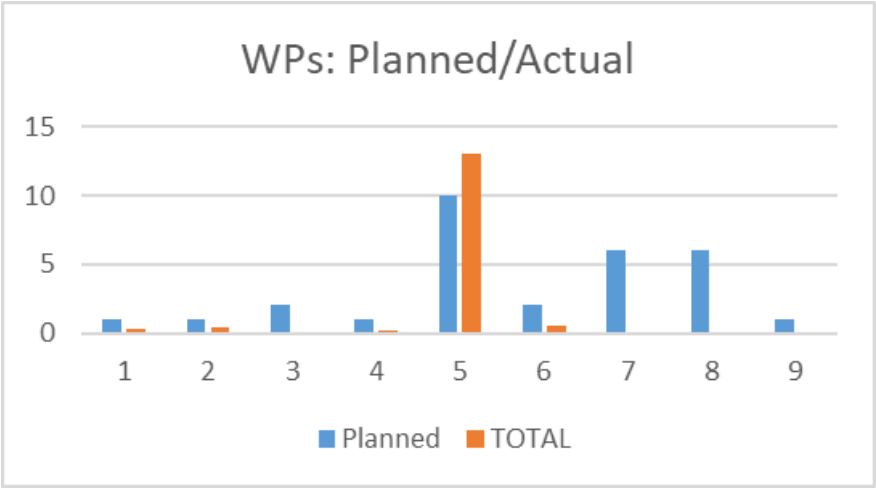
P2	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	0.14	0.1	0.24	24%
WP2	1	0.06	0.1	0.16	16%
WP3	2	0.06	0.07	0.13	7%
WP4	2	0	0.01	0.01	1%
WP5	6	0.13	1.23	1.36	23%
WP6	2	0.43	0.08	0.51	26%
WP7	6	0.04	0.11	0.15	3%
WP8	10	1.66	1.17	2.83	28%
WP9	1	0.02	0.13	0.15	15%
TOTAL	31	2.54	3	5.54	18%



P3 – ARES* at end of claim 6

P3 - ARES	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 180,000.00	€ 76,194.86	€ 6,096.87	€ 82,291.73	46%
Travel Costs	€ 40,000.00	€ 6,301.29	€ -	€ 6,301.29	16%
Other Costs	€ -	€ 35.00	€ 469.00	€ 504.00	
Indirect Costs	€ 15,400.00	€ 5,777.18	€ 459.61	€ 6,236.79	40%
Total	€ 235,400.00	€ 88,308.33	€ 7,025.48	€ 95,333.81	40%

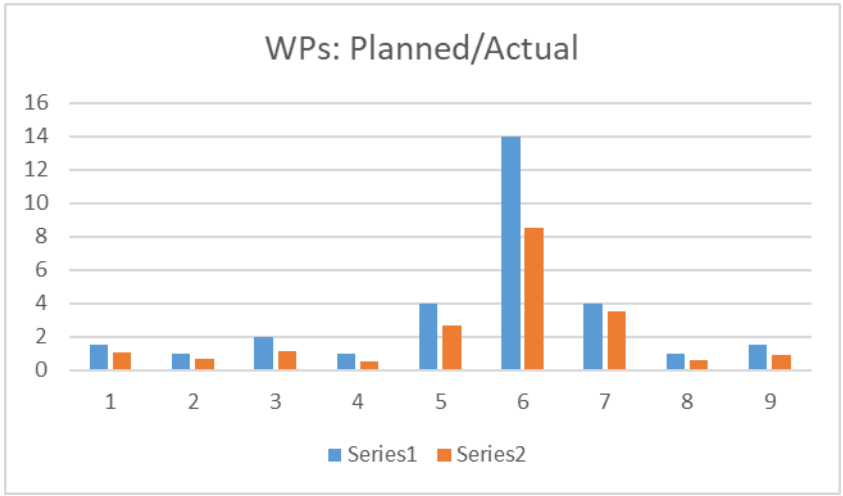
P3	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	0.24	0	0.24	24%
WP2	1	0.35	0.1	0.45	45%
WP3	2	0	0	0	0%
WP4	1	0.15	0	0.15	15%
WP5	10	12.13	0.9	13.03	130%
WP6	2	0.52	0	0.52	26%
WP7	6	0	0.01	0.01	0%
WP8	6	0	0	0	0%
WP9	1	0	0	0	0%
TOTAL	30	13.39	1.01	14.4	48%



P4 - KRO

P4 - KRO	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 153,000.00	€ 85,971.85	€ 35,239.03	€ 121,210.88	79%
Travel Costs	€ 55,000.00	€ 11,153.36	€ -	€ 11,153.36	20%
Other Costs	€ -	€ 1,873.87	€ 1,137.40	€ 3,011.27	0%
Indirect Costs	€ 14,560.00	€ 6,929.94	€ 2,546.35	€ 9,476.29	65%
Total	€ 222,560.00	€ 105,929.02	€ 38,922.78	€ 144,851.80	65%

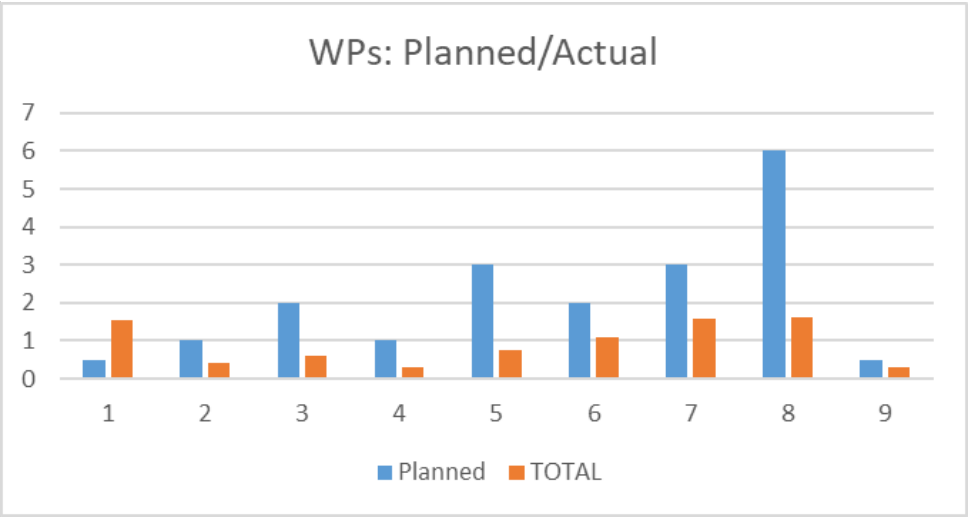
P4	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1.5	0.88	0.15	1.03	69%
WP2	1	0.62	0.03	0.65	65%
WP3	2	0.89	0.22	1.11	56%
WP4	1	0.5	0.06	0.56	56%
WP5	4	2.7	0	2.7	68%
WP6	14	6.58	1.98	8.56	61%
WP7	4	2.07	1.47	3.54	89%
WP8	1	0.5	0.1	0.6	60%
WP9	1.5	0.73	0.15	0.88	59%
TOTAL	30	15.47	4.16	19.63	65%



P13 - OSA

P13 - OSA	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 127,300.00	€ 56,152.82	€ 12,029.96	€ 68,182.78	54%
Travel Costs	€ -	€ -	€ -	€ -	
Other Costs	€ -	€ -	€ -	€ -	0%
Indirect Costs	€ 8,911.00	€ 3,930.70	€ 842.10	€ 4,772.79	54%
Total	€ 136,211.00	€ 60,083.52	€ 12,872.06	€ 72,955.57	54%

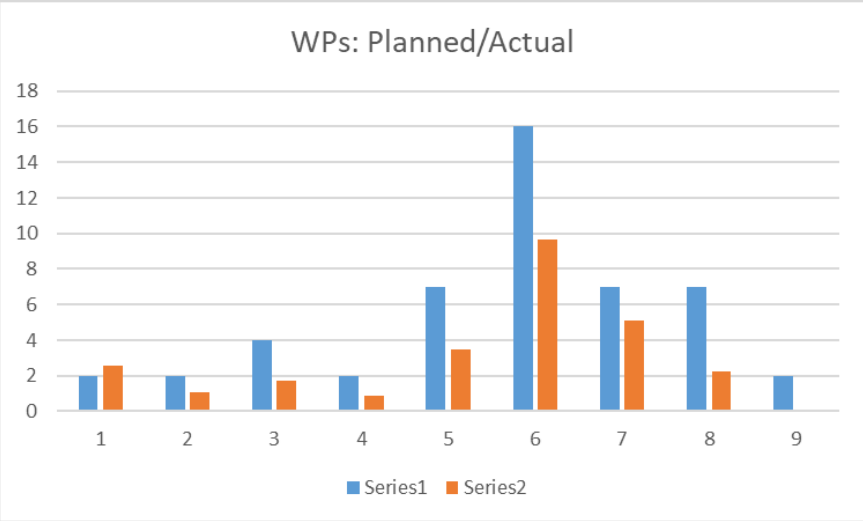
P13	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	0.5	1.55	0	1.55	310%
WP2	1	0.36	0.07	0.43	43%
WP3	2	0.44	0.15	0.59	30%
WP4	1	0.22	0.08	0.3	30%
WP5	3	0.76	0	0.76	25%
WP6	2	1.09	0	1.09	55%
WP7	3	1.04	0.53	1.57	52%
WP8	6	0.94	0.67	1.61	27%
WP9	0.5	0.23	0.08	0.31	62%
TOTAL	19	6.63	1.58	8.21	43%



P4 + P13 Combined

P4 + P13	Approved	Interim Claim	R6 & R7	Total
Staff Costs	€ 280,300.00	€ 142,124.67	€ 47,268.99	€ 189,393.66
Travel Costs	€ 55,000.00	€ 11,153.36	€ -	€ 11,153.36
Other Costs	€ -	€ 1,873.87	€ 1,137.40	€ 3,011.27
Indirect Costs	€ 23,471.00	€ 10,860.63	€ 3,388.45	€ 14,249.08
Total	€ 358,771.00	€ 166,012.53	€ 51,794.84	€ 217,807.37

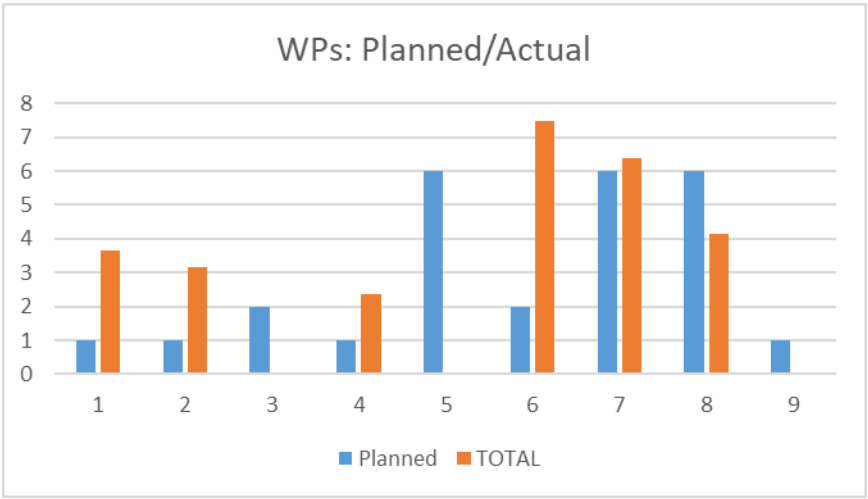
P4 + P13	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	2	2.43	0.15	2.58	129%
WP2	2	0.98	0.1	1.08	54%
WP3	4	1.33	0.37	1.7	43%
WP4	2	0.72	0.14	0.86	43%
WP5	7	3.46	0	3.46	49%
WP6	16	7.67	1.98	9.65	60%
WP7	7	3.11	2	5.11	73%
WP8	7	1.44	0.77	2.21	32%
WP9	2	0.96	0.23	1.19	60%
TOTAL	49	22.1	5.74	27.84	57%



P5 - UPJS

P5 - UPJS	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 86,600.00	€ 18,186.99	€ 19,786.86	€ 37,973.85	44%
Travel Costs	€ 40,000.00	€ 2,814.40	€ -	€ 2,814.40	7%
Other Costs	€ -	€ 570.77	€ -	€ 570.77	0%
Indirect Costs	€ 8,862.00	€ 1,510.05	€ 1,385.08	€ 2,895.13	33%
Total	€ 135,462.00	€ 23,082.21	€ 21,171.94	€ 44,254.15	33%

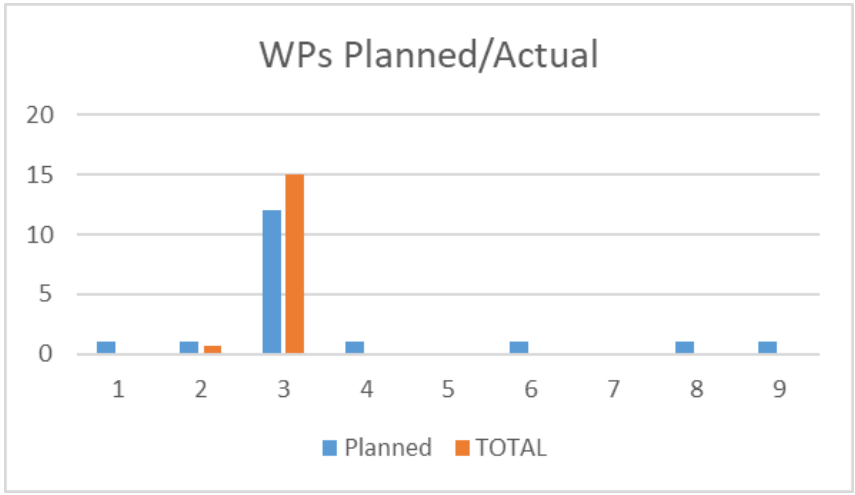
P5	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	1.13	2.51	3.64	364%
WP2	1	2.37	0.78	3.15	315%
WP3	2	0	0	0	0%
WP4	1	2.37	0	2.37	237%
WP5	6	0	0	0	0%
WP6	2	7.49	0	7.49	375%
WP7	6	0.28	6.09	6.37	106%
WP8	6	0.28	3.86	4.14	69%
WP9	1	0	0	0	0%
TOTAL	26	13.92	13.24	27.16	104%



P6 - UVEG

P6 - UVEG	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 96,098.00	€ 54,038.50	€ 28,835.76	€ 82,874.26	86%
Travel Costs	€ 20,000.00	€ 5,171.13	€ -	€ 5,171.13	26%
Other Costs	€ 2,000.00	€ 680.00	€ -	€ 680.00	0%
Indirect Costs	€ 8,266.86	€ 4,192.27	€ 2,018.50	€ 6,210.78	75%
Total	€ 126,364.86	€ 64,081.90	€ 30,854.26	€ 94,936.17	75%

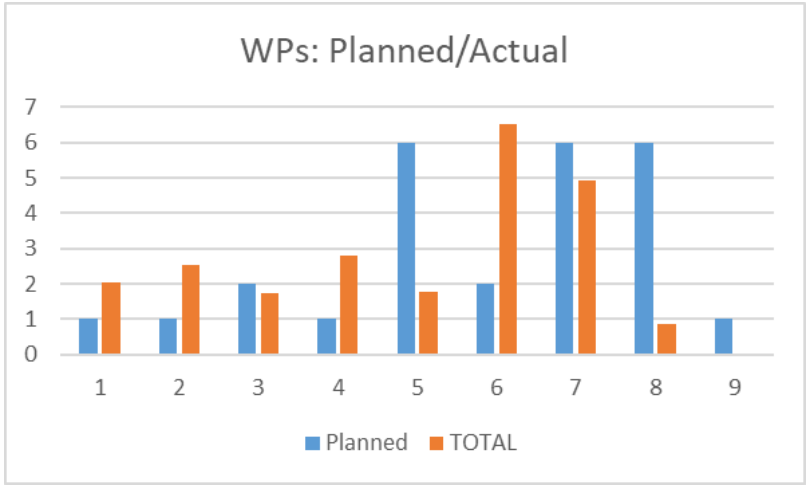
P6	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	0	0	0	0%
WP2	1	0.43	0.28	0.71	71%
WP3	12	9.92	5.13	15.05	125%
WP4	1	0	0	0	0%
WP5	0	0	0	0	0%
WP6	1	0	0	0	0%
WP7	0	0	0	0	0%
WP8	1	0	0	0	0%
WP9	1	0	0	0	0%
TOTAL	18	10.35	5.41	15.76	88%



P7 - VULSK

P7 - VULSK	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 129,012.00	€ 66,121.01	€ 32,340.18	€ 98,461.19	76%
Travel Costs	€ 40,000.00	€ 3,432.65	€ -	€ 3,432.65	9%
Other Costs	€ -	€ 349.00	€ -	€ 349.00	0%
Indirect Costs	€ 11,830.84	€ 4,893.19	€ 2,263.81	€ 7,157.00	60%
Total	€ 180,842.84	€ 74,795.85	€ 34,603.99	€ 109,399.84	60%

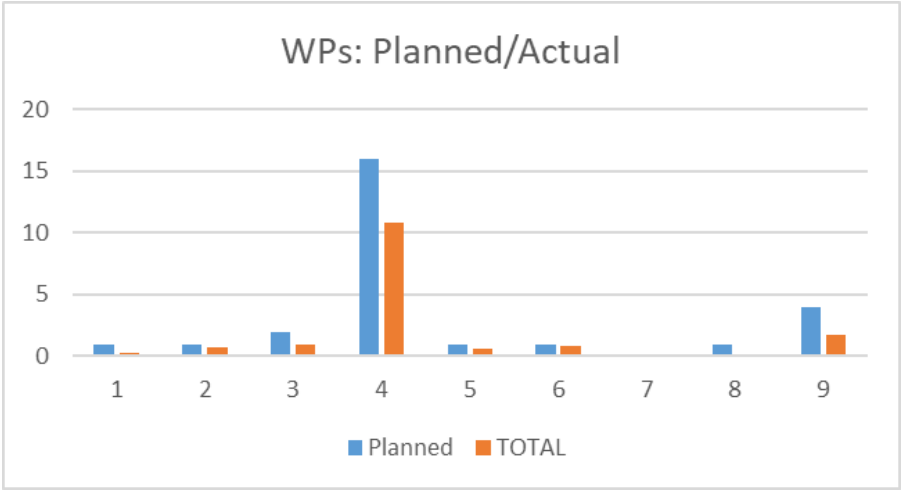
P7	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	1.46	0.57	2.03	203%
WP2	1	1.69	0.85	2.54	254%
WP3	2	1.65	0.07	1.72	86%
WP4	1	2.34	0.45	2.79	279%
WP5	6	1.79	0	1.79	30%
WP6	2	6.32	0.18	6.5	325%
WP7	6	0.1	4.84	4.94	82%
WP8	6	0	0.86	0.86	14%
WP9	1	0	0	0	0%
TOTAL	26	15.35	7.82	23.17	89%



P8 – UEDIN* at end of claim 6

P8 - UEDIN	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 189,023.00	€ 100,699.77	€ 26,989.39	€ 127,689.16	68%
Travel Costs	€ 15,000.00	€ 7,389.96	€ -	€ 7,389.96	49%
Other Costs	€ -	€ 1,437.58	€ -	€ 1,437.58	0%
Indirect Costs	€ 14,281.61	€ 7,666.91	€ 1,889.26	€ 9,556.17	67%
Total	€ 218,304.61	€ 117,194.22	€ 28,878.65	€ 146,072.87	67%

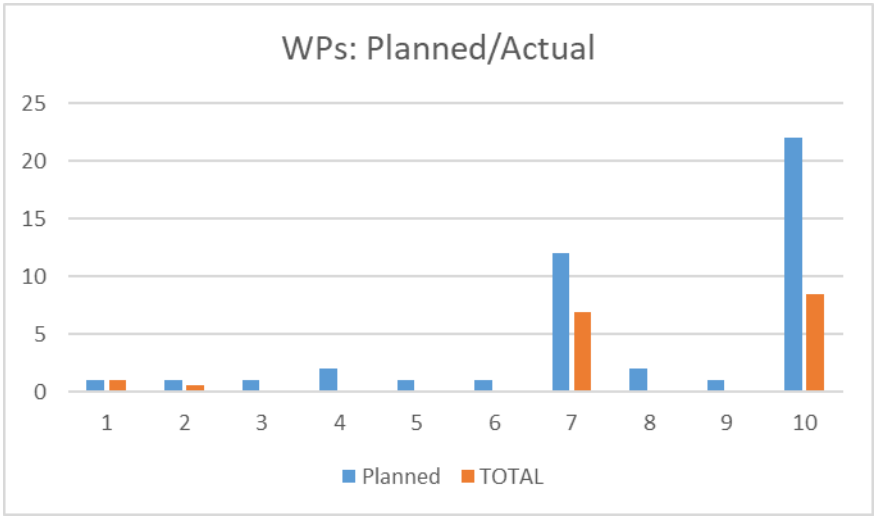
P8	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	0.33	0	0.33	33%
WP2	1	0.53	0.21	0.74	74%
WP3	2	0.56	0.36	0.92	46%
WP4	16	7	3.8	10.8	68%
WP5	1	0.56	0	0.56	56%
WP6	1	0.78	0	0.78	78%
WP7	0	0	0	0	0%
WP8	1	0	0.11	0.11	11%
WP9	4	1.6	0.12	1.72	43%
TOTAL	27	11.36	4.6	15.96	59%



P9 - AER

P9 - AER	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 112,400.00	€ 29,400.00	€ 20,578.68	€ 49,978.68	44%
Travel Costs	€ 40,000.00	€ 1,775.24	€ -	€ 1,775.24	4%
Other Costs	€ -	€ -	€ -	€ -	0%
Indirect Costs	€ 10,668.00	€ 2,182.27	€ 1,440.51	€ 3,622.77	34%
Total	€ 163,068.00	€ 33,357.51	€ 22,019.19	€ 55,376.69	34%

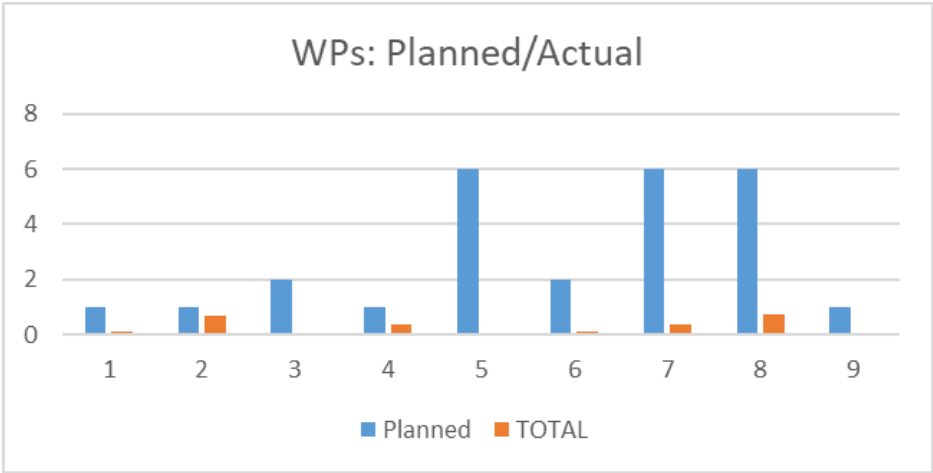
P9	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	0.08	0.93	1.01	101%
WP2	1	0.43	0.2	0.63	63%
WP3	1	0	0	0	0%
WP4	2	0	0	0	0%
WP5	1	0	0	0	0%
WP6	1	0	0	0	0%
WP7	12	4.34	2.53	6.87	57%
WP8	2	0	0	0	0%
WP9	1	0	0	0	0%
TOTAL	22	4.85	3.66	8.51	39%



P10 - NFZ

P10 - NFZ	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 52,520.00	€ -	€ 8,176.48	€ 8,176.48	16%
Travel Costs	€ 40,000.00	€ -	€ -	€ -	0%
Other Costs	€ -	€ -	€ -	€ -	0%
Indirect Costs	€ 6,476.40	€ -	€ 572.35	€ 572.35	9%
Total	€ 98,996.40	€ -	€ 8,748.83	€ 8,748.83	9%

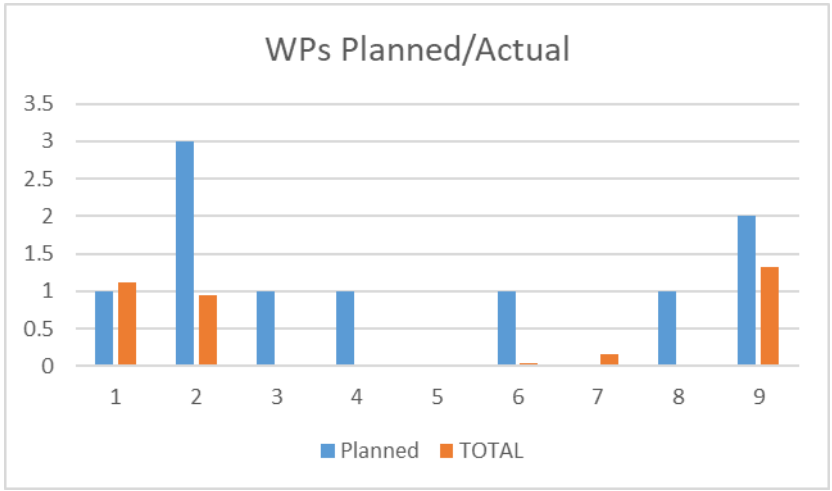
P10	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	0	0.13	0.13	13%
WP2	1	0	0.66	0.66	66%
WP3	2	0	0	0	0%
WP4	1	0	0.36	0.36	36%
WP5	6	0	0	0	0%
WP6	2	0	0.1	0.1	5%
WP7	6	0	0.38	0.38	6%
WP8	6	0	0.72	0.72	12%
WP9	1	0	0	0	0%
TOTAL	26	0	2.35	2.35	9%



P11 - EHTEL

P11 - EHTEL	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 89,875.00	€ 29,740.63	€ 13,265.94	€ 43,006.57	48%
Travel Costs	€ 15,000.00	€ 6,256.27	€ -	€ 6,256.27	42%
Other Costs	€ 15,000.00	€ 4,751.00	€ 1,298.40	€ 6,049.40	0%
Indirect Costs	€ 8,391.25	€ 2,852.35	€ 1,019.50	€ 3,871.86	46%
Total	€ 128,266.25	€ 43,600.25	€ 15,583.84	€ 59,184.10	46%

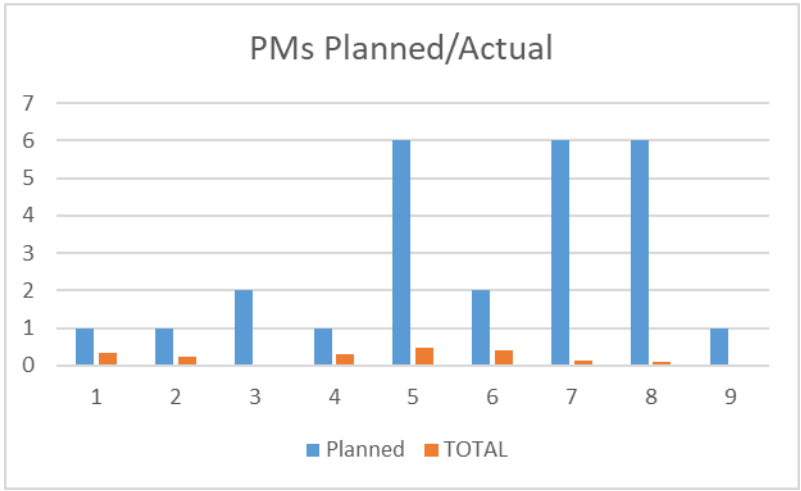
P11	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	0.75	0.37	1.12	112%
WP2	3	0.63	0.32	0.95	32%
WP3	1	0	0.01	0.01	1%
WP4	1	0	0.01	0.01	1%
WP5	0	0.02	0	0.02	0%
WP6	1	0.03	0.01	0.04	4%
WP7	0	0.13	0.03	0.16	0%
WP8	1	0	0.01	0.01	1%
WP9	2	0.72	0.6	1.32	66%
TOTAL	10	2.28	1.36	3.64	36%



P12 - VLO

P12 - VLO	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 141,593.00	€ 10,810.77	€ 3,068.64	€ 13,879.41	10%
Travel Costs	€ 40,000.00	€ 1,604.82	€ -	€ 1,604.82	4%
Other Costs	€ -	€ -	€ -	€ -	0%
Indirect Costs	€ 12,711.51	€ 869.09	€ 214.80	€ 1,083.90	9%
Total	€ 194,304.51	€ 13,284.68	€ 3,283.44	€ 16,568.13	9%

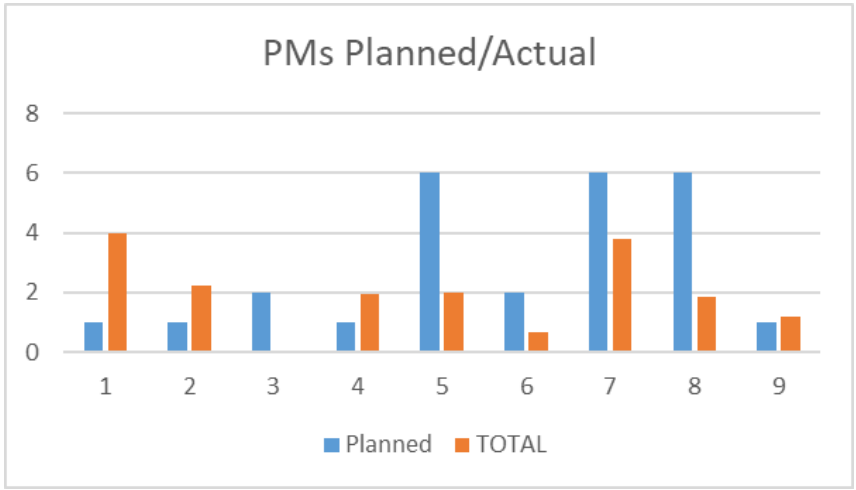
P12	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	0.27	0.07	0.34	34%
WP2	1	0.1	0.14	0.24	24%
WP3	2	0	0	0	0%
WP4	1	0.3	0	0.3	30%
WP5	6	0.45	0.02	0.47	8%
WP6	2	0.37	0.04	0.41	21%
WP7	6	0	0.14	0.14	2%
WP8	6	0	0.09	0.09	2%
WP9	1	0	0	0	0%
TOTAL	26	1.49	0.5	1.99	8%



P14 - IRSSV

P14 - IRSSV	Approved	Interim Claim	R6 & R7	Total	
Staff Costs	€ 85,800.00	€ 41,940.45	€ 15,286.51	€ 57,226.96	67%
Travel Costs	€ 40,000.00	€ 3,678.96	€ -	€ 3,678.96	9%
Other Costs	€ -	€ 1,264.50	€ -	€ 1,264.50	0%
Indirect Costs	€ 8,806.00	€ 3,281.87	€ 1,070.06	€ 4,351.93	49%
Total	€ 134,606.00	€ 50,165.78	€ 16,356.57	€ 66,522.35	49%

P14	Planned	Interim Claim	R6 & 7	TOTAL	%
WP1	1	2.5	1.49	3.99	399%
WP2	1	1.83	0.39	2.22	222%
WP3	2	0	0	0	0%
WP4	1	0.76	1.18	1.94	194%
WP5	6	1.98	0	1.98	33%
WP6	2	0.03	0.61	0.64	32%
WP7	6	2.44	1.35	3.79	63%
WP8	6	0	1.84	1.84	31%
WP9	1	1.17	0	1.17	117%
TOTAL	26	10.71	6.86	17.57	68%



Update:

- **Individual calls held with each partner, following the interim claim.**
- **Review position and discuss actions to be taken to ensure project achieves objectives and spend.**
  - Reflect time extension of the project
  - Consider use of underspend in travel budget.
  - Is time/effort being accurately recorded against WPs?
- **Highly efficient at completing the claims! Low error rates now.**

Thank you – any questions?

Disclaimer

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Scirocco Exchange

Capacity-building for integrated care

ADAPTATION, EXPANSION & EXPLOITATION OF SCIROCCO EXCHANGE TOOL

Marc Lange & Tino Marti

EHTEL

Co-funded by the Health Programme of the European Union

The SCIROCCO Exchange project is co-funded by the Health Programme of the European Union under Grant Agreement No.: 826676 (Chafea)

EXPANSION OF SCIROCCO EXCHANGE

TINO MARTI - EHTEL

Expansion matrix

- Topic: integrated care or other
- User: integrated care stakeholder or other

Topic / User	Incumbent user	New user
Incumbent topic		
New topic		

- Adapted original model

Six expansion cases

I. **Drill-down expansion**: Scaling-up telemedicine services (Momentum)
II. **User expansion**: Long-term care policy in Estonia (policy-makers),
III. **Topic expansion**: Open innovation (ACSELL), Goal-oriented care
IV. **Full-blown expansion**: Digital neighbourhoods
V. **Adapted MRL**: Integrated care in nursing homes in Catalonia

Methodology for expansion

1. Identify the scope and purpose of the expansion
2. Specify objectives and needs for the expansion
3. Identify stakeholders participating in the assessment
4. Select type of use (single, continued)
5. Co-design the adaptation of the model: dimensions and maturity scales
6. Validate the adapted survey
7. Implement the expansion
8. Evaluate the implementation process and outcomes

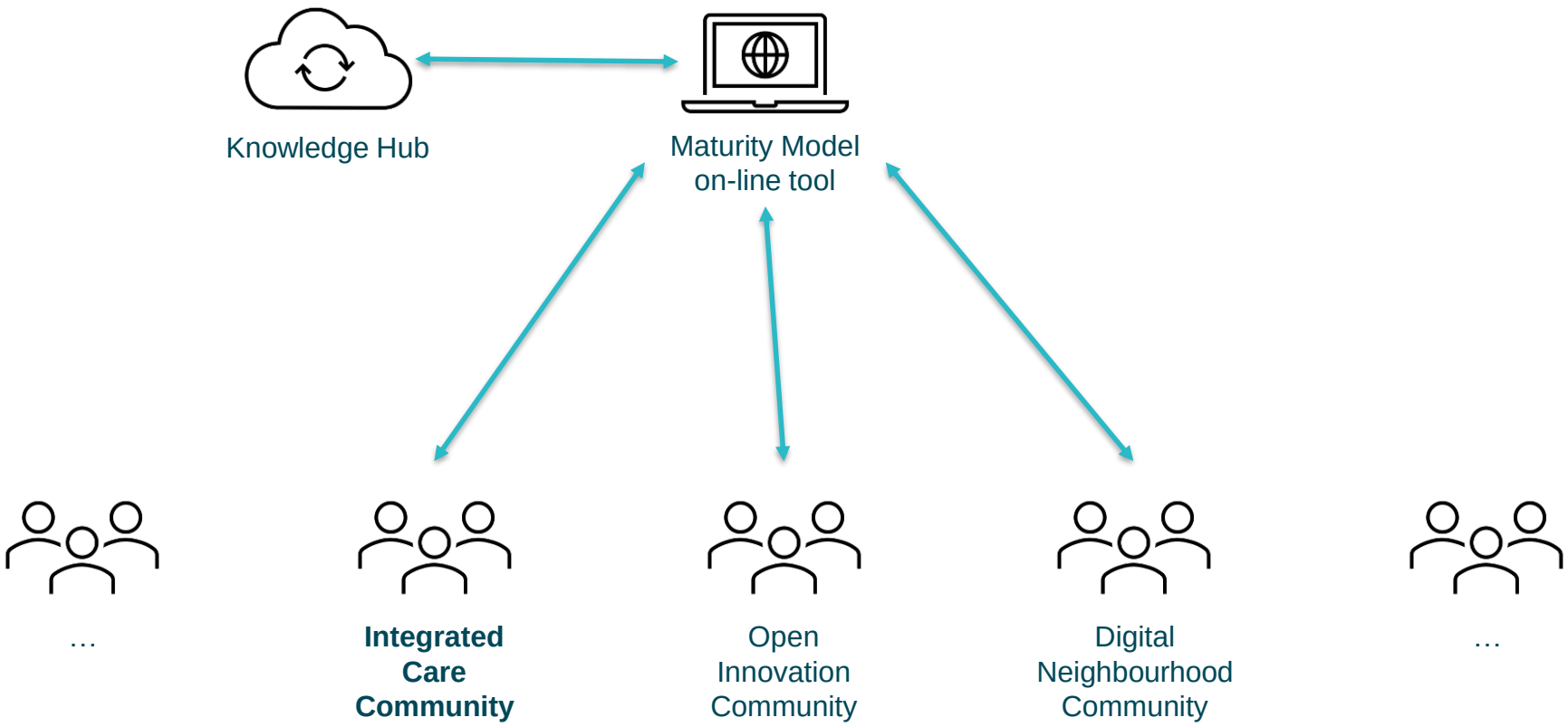
Work in progress

1. Document all 6 expansion use cases.
2. Interview the implementation leads following the methodology for expansion to capture user insights.
3. Develop a Guideline for expanding the Scirocco Model based on the lessons learnt of the use cases. Goals:
   - Streamline the expansion process
   - Support the exploitation work

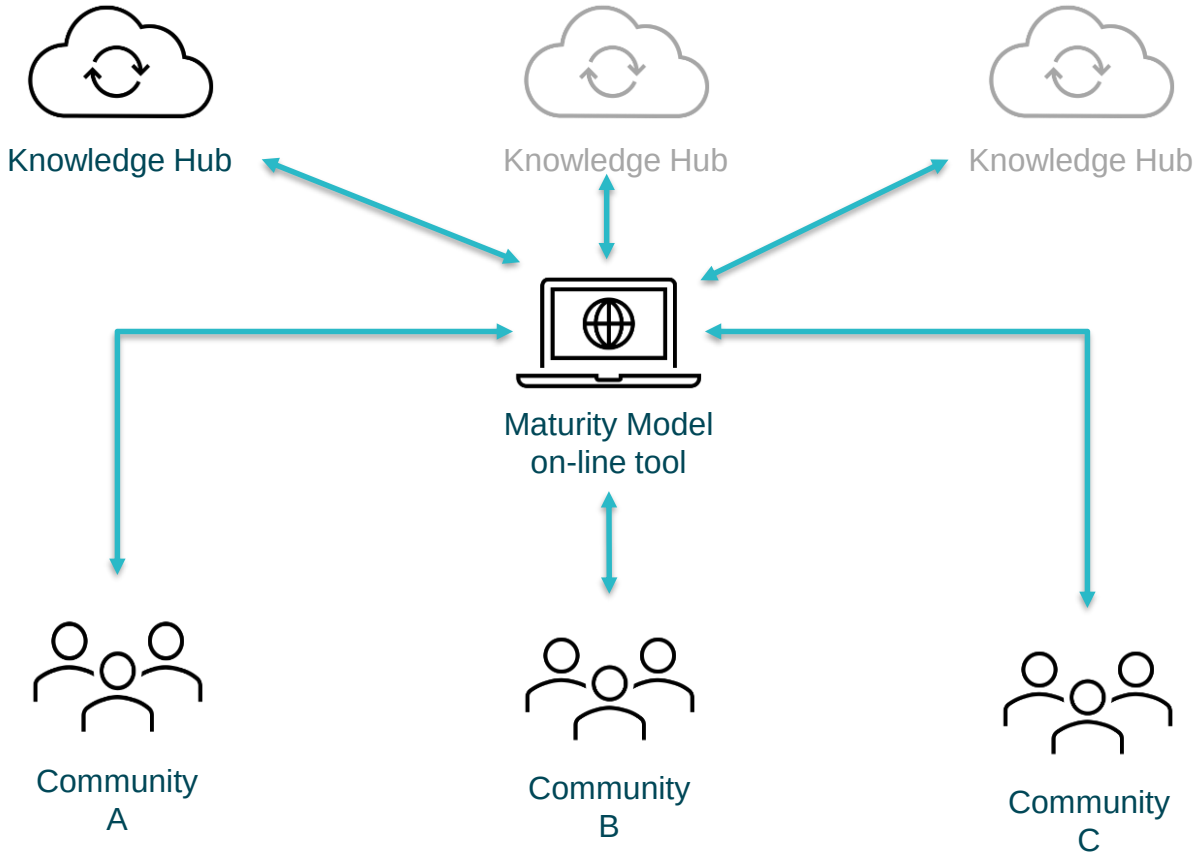
STRATEGY AND APPROACHES TO EXPLOITATION

MARC LANGE - EHTEL

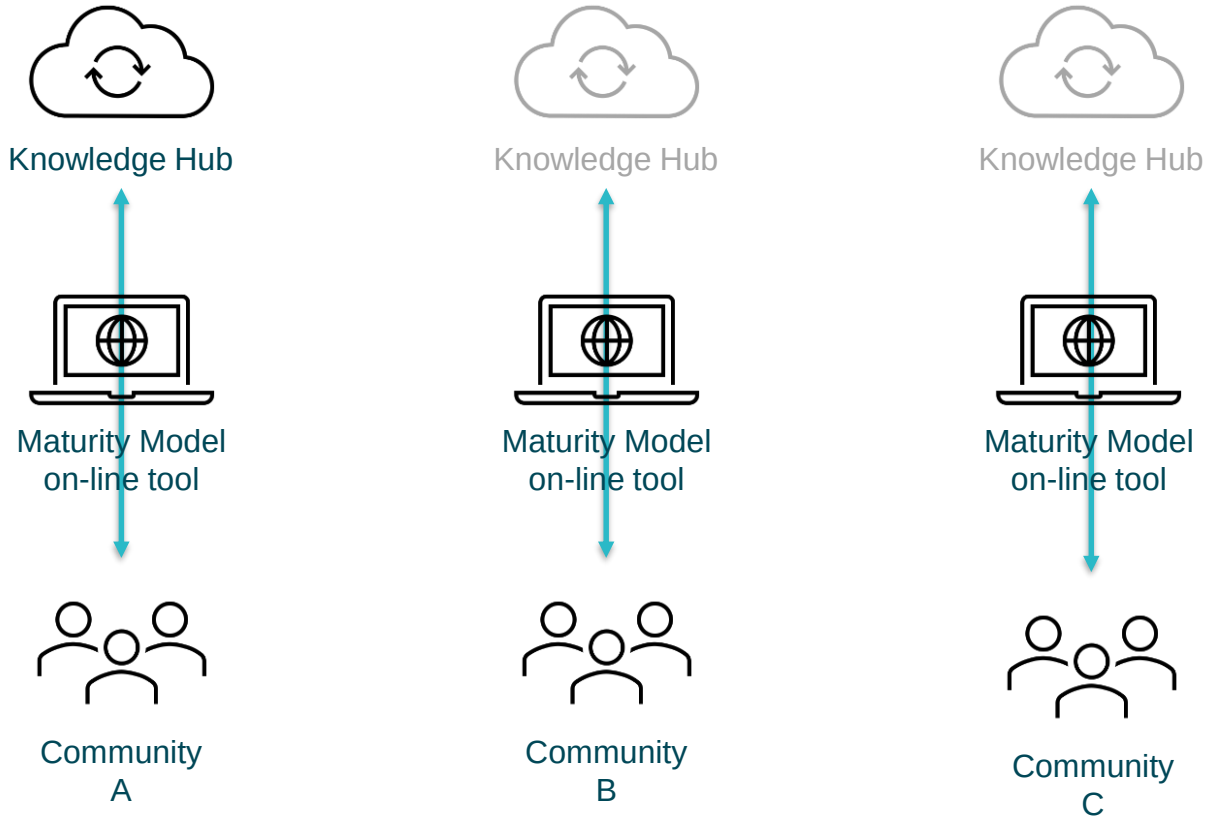
As is situation



Approach A for post-project exploitation

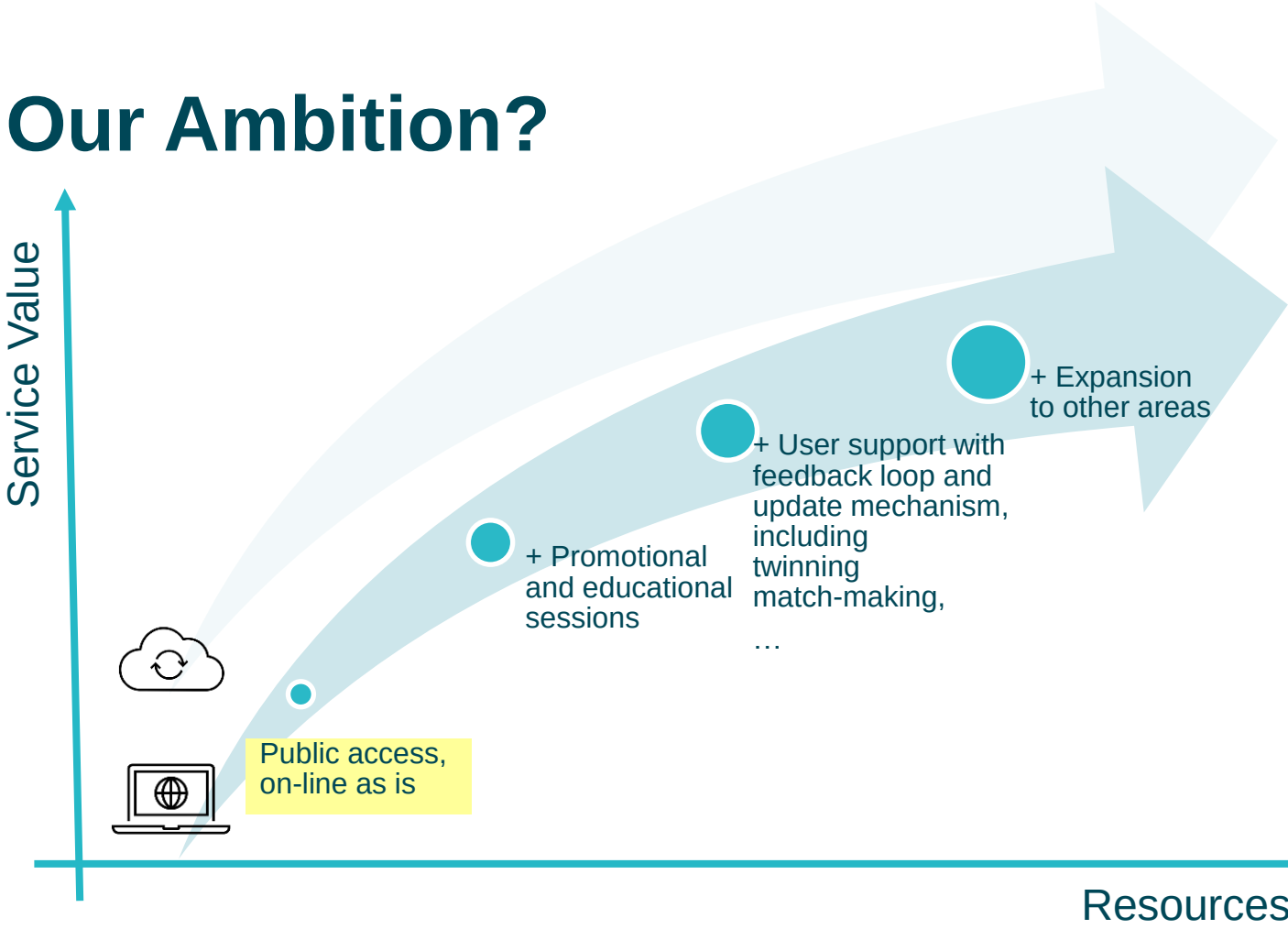


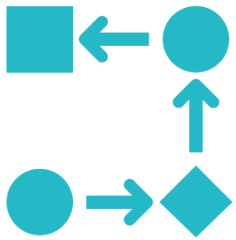
Approach B for post-project exploitation



DISCUSSION WITH THE CONSORTIUM

Our Ambition?





If dreaming for the moon,
what needs to be done a minima to enable the journey?

What we have learned so far

The online tool (and the knowledge hub) can serve

- **Academic objectives**
  - Comparing and contrasting
  - Better understanding the conditions for success
- **Policy objectives**
  - Building consensus on an “As Is” situation and “To Be” objectives
  - Measuring progress towards the “To Be” objectives

What we have learned so far (…)

- **The tool need to be maintained**
  - back-up, CMS version management …
- **User growth doesn’t happen autonomously**
  - Gaining new users requires promotion
- **New users need some support**
  - Education, a kind of help desk
- **…**

How to find a host for our assets?

- **Three main options**

1. EC or one of its agencies

   HaDEA, JRC …

2. An business-minded organisation

   Example of Open Evidence with MAFEIP

   IFIC, a research centre …

3. An open platform

Exploitation Action plan

1. **Creating a WG of volunteers to work on these questions and prepare recommendations**
   - Bi-weekly or monthly calls

2. **Engaging the Advisory Board to partner with the WG**

To be updated

Organisation	Contact person	Designation	Country
CORAL (Community of Regions for Assisted Living)	Allan Nordby Ottesen	Co-Leader	Region of Southern Denmark
ECHA (European Connected Health Alliance	Brian O'Connor	Chair	United Kingdom
ERRIN (European Regions Research and Innovation Network	Lars Holte Neilsen	Chair	Brussels
EUREGHA (European Regional and Local Health Authorities)	Nick Batey	Chair	Belgium
EUPHA Section on Chronic Diseases	Iveta Rajnicova Nagyova	Chair	Netherlands
IFIC (International Foundation for Integrated Care)	Nick Goodwin	CEO	United Kingdom
John Matheson, CBE	N/a	Ex-Director of Finance, SG	United Kingdom
Norbotten Region	Lisa Lundgren	Director of Projects	Sweden
RSCN (Reference Sites Collaborative Network)	Maddalena Ilario	Co-Chair	Belgium
WHO	Nuria Toro Polanco	Technical Office	Switzerland

Scirocco Exchange
Capacity-building for integrated care

Thank you!

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11.00-11.15 COFFEE BREAK

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Capacity-building for integrated care

SCIROCCO EXCHANGE IMPROVEMENT PROGRAMME

- Sophie Wang & Oliver Groene
- OPTIMEDIS

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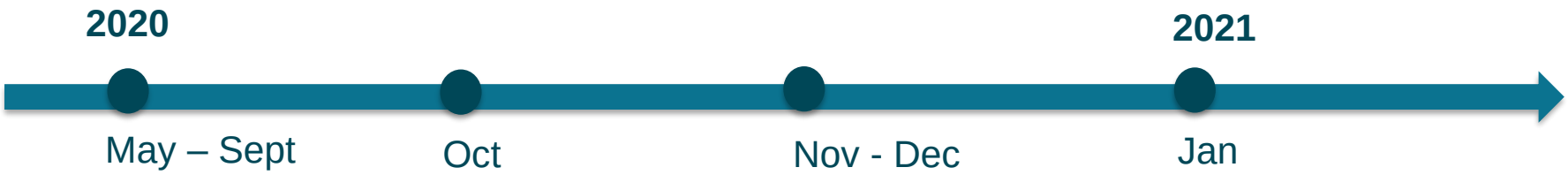
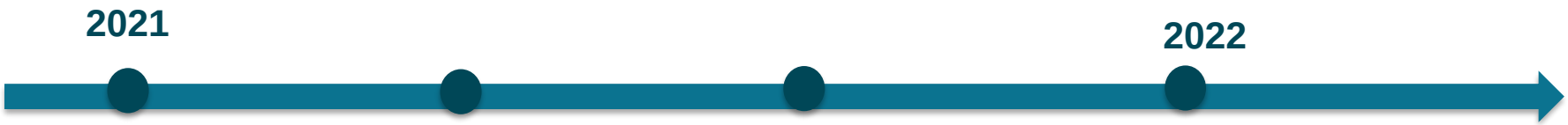
Let’s review the timeline

WP8 Improvement Planning Timeline



	May – Sept	Oct	Nov - Dec	Jan
WP 8	Template for existing improvement strategies Review of current QI tools	Logic Model Workshop at Project Assembly Review of current QI tools	Review of current QI tools at the international level for 8.1	Reviewing and synthesizing 8.1 regional assets
Regional Leads			8.1 Regional template	Finalizing 8.1 Regional template Reviewing Logic Model template

WP8 Improvement Planning Timeline



	Feb - Apr	May - Aug	Sept – Dec	Jan – Feb
WP 8	Facilitating bilateral calls with regions to solidify logic model	Facilitating bilateral calls with regions to refine final logic model	Synthesizing results from MA, KT, logic model, existing improvement strategies	Personalized improvement plan dissemination and implementation support
Regional Leads	Regional Logic Model workshops	Logic Model completion	Presentation of regional logic model at Project Assembly	

WP 8 Progress

Process for Improvement Planning

Introductory call

Establish a common understanding of regional priorities for improvement planning

1st Logic Model Working Meeting

Pre: Review logic model documents to prepare discussion points
Operational meeting to co-develop a draft logic model

2nd Logic Model Working Meeting

Pre: Circulate draft logic model with relevant stakeholders
Refine logic model

Improvement Plan and beyond

Synthesize improvement plan for each region
Collaborate on further improvement activities as opportunities allow

Process for Improvement Planning

9/9 **Introductory call**

Establish a common understanding of regional priorities for improvement planning

3/9 **1st Logic Model Working Meeting**

Pre: Review logic model documents to prepare discussion points
Operational meeting to co-develop a draft logic model

0/9 **2nd Logic Model Working Meeting**

Pre: Circulate draft logic model with relevant stakeholders
Refine logic model

0/9 **Improvement Plan and beyond**

Synthesize improvement plan for each region
Collaborate on further improvement activities as opportunities allow

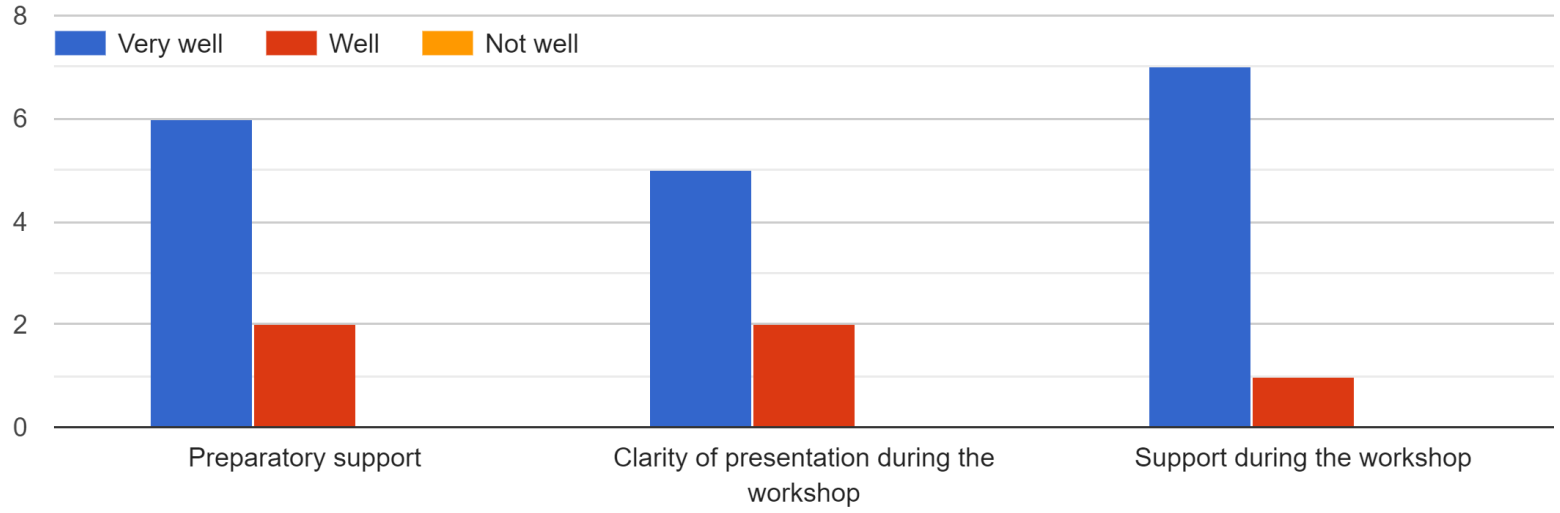
Preliminary findings

Areas of focus

Region	Improvement Focus
Basque Country, Spain	Citizen empowerment
Flanders, Belgium	Goal-oriented care
Poland	Citizen empowerment
Slovakia	Capacity building
Lithuania	Multimorbidity model pilot
Midlothian, Scotland	?
Trbovlje, Slovenia	Long-term care improvement
Werra Meißner Kreis, Germany	Digital infrastructure and process coordination
Puglia, Italy	Funds development

Logic model session reflections

How well did we meet your expectations for this logic model working meeting?



N=8

Logic model session reflections – what went well?

- Structure of the sessions
  - Guiding questions posed during the facilitated session was clarifying
  - Process was clear and easy to follow
- “Hands-on” approach
  - Co-creation process was helpful
- Sounding board
  - Verifying the outputs and intended results
- Preparation
  - Assumptions checking

Logic model session reflections – what can be improved upon?

Suggestions	Our approach
"…more examples on the various aspects that we need to define would help, but I am sure this will be covered through the process, because it was just a initial logic model development meeting."	Compile the logic model as discussed post-discussion with detailed feedback and comments on the gap analysis
"clarification what the model should be aimed at"	<u>2 step process:</u> 1. Agree on the goal of improvement in the initial introductory call 2. Prior to logic model call, to define the improvement goals in the context of (1) geographic scope (2) target population and (3) time horizon

Logic model as a tool for quality improvement

- Initiated discussions on causal pathway leading to intended change
  - Helped to identify gaps along the causal chain
- Provided space to challenge and verify current design of program/process
- Clarify intended changes and unify a vision among stakeholders

Looking ahead

Process for Improvement Planning

9/9 **Introductory call**

Establish a common understanding of regional priorities for improvement planning

3/9 **1st Logic Model Working Meeting**

Pre: Review logic model documents to prepare discussion points
Operational meeting to co-develop a draft logic model

0/9 **2nd Logic Model Working Meeting**

Pre: Circulate draft logic model with relevant stakeholders
Refine logic model

0/9 **Improvement Plan and beyond**

Synthesize improvement plan for each region
Collaborate on further improvement activities as opportunities allow

Personalized improvement plans

- Build on drafted logic models to provide individualized support for improvement planning (and implementation as opportunity allows)
- Areas to support regions in:
  - Defining/refining indicators
  - Recommendations or PREMs/PROMs measures
  - Devising evaluation frameworks to support ongoing improvement
  - Data system organization
  - Etc.?

Scirocco Exchange
Capacity-building for integrated care

Thank you!

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Capacity-building for integrated care

COLLABORATION WITH OTHER EU FUNDED PROJECTS

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JADE CARE

Joint action on implementation of digitally enabled integrated person-centered care

THE JADECARE JOINT ACTION

Jon Txarramendieta,

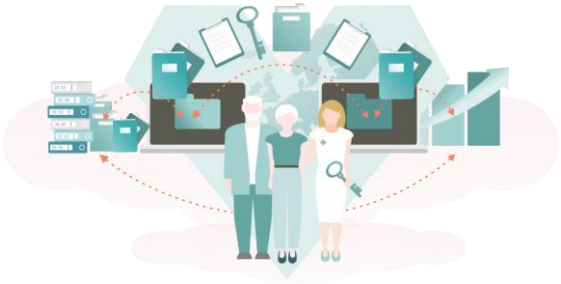
Kronikgune Institute for Health Services Research

22nd May 2021

www.jadecare.eu

Co-funded by the Health Programme of the European Union

This document was funded by the European Union's Health Programme (2014-2020) under Grant Agreement 951442.



NAME: JOINT ACTION ON IMPLEMENTATION OF DIGITALLY ENABLED INTEGRATED PERSON-CENTERED CARE (JADECARE)

PROJECT NUMBER: 951442

FUNDING BODY: HaDEA

WEBSITE: https://jadecare.eu/

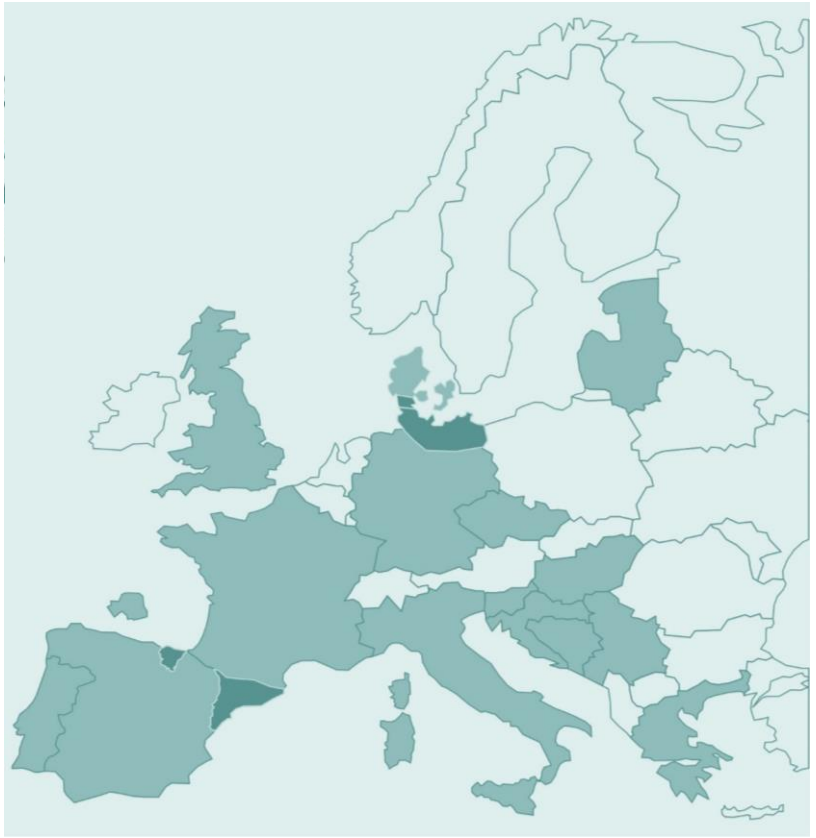
DURATION: 1st of October 2020 till 30th of September 2023

PROJECT COORDINATOR: Kronikgune Institute for Health Service Research

Scirocco Exchange

JADECARE Consortium

- 17 Competent Authorities
- 31 Affiliated Entities
- 23 Next adopters from 15 European Countries
- Health systems from all Europe covering different funding systems
- Regions with different level of penetration, adoption and maturity of integrated care



Scirocco Exchange

Aims and goals

Aims

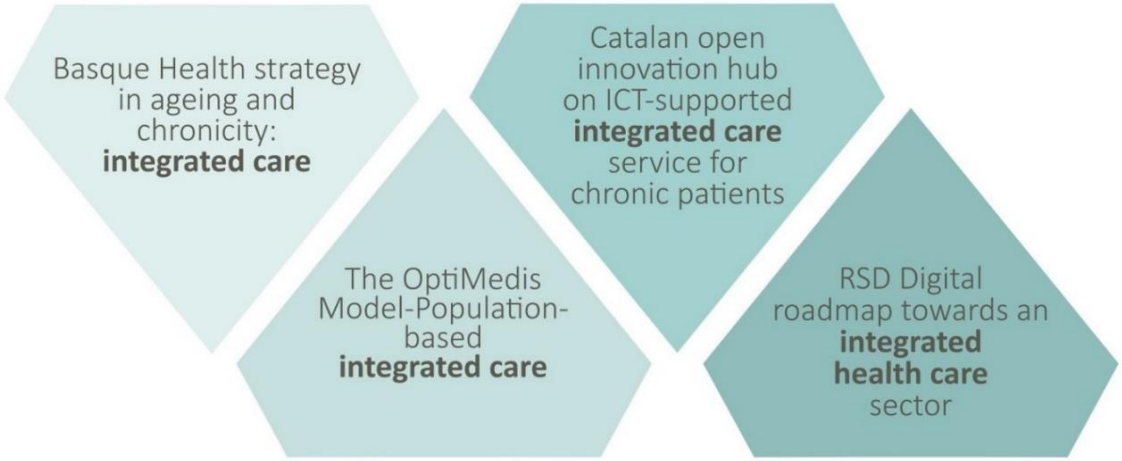
- Contribute to innovative, efficient and sustainable health systems, **providing expertise and sharing good practices** to assist the Member States in undertaking health system reforms
- **Enable national authorities**, **to benefit from efficient solutions** in digitally enabled integrated person-centered care

Goals

- **Reinforce the capacity of health authorities** to successfully address important aspects of health system transformation, in particular the transition to digitally enabled, integrated, person-centred care
- **Support the best practice transfer** from the systems of the “Early adopters” to the ones of the “Next adopters”

Original Good Practices

Four original “Good Practices” (oGP) support participating regions of member states to transfer the successful practices and generated knowledge into the healthcare systems of the participating partners.



Original Good Practices

8 Next Adopters from 7 countries

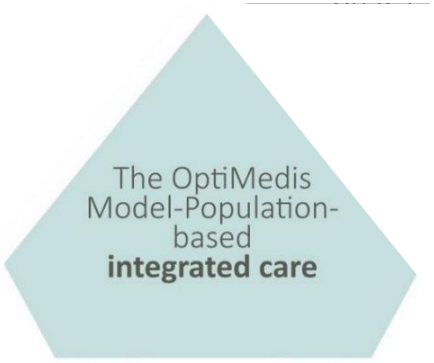
Intends to improve health and quality of life of the population, enhance the health system quality, efficiency and sustainability and the collaboration with Social services and the Community. The approach focuses on risk stratification, digitally-enabled integrated care and patient/citizen empowerment, by means of new organizational models, professional roles, pathways and processes and digital tools and analytics.

Original Good Practices

5 Next Adopters from 4 countries

Network of entities that promotes synergies among relevant stakeholders of the health and social care system. It places the focus on people and guarantees the healthcare continuum with support of digital tools, complementing the individual approach with a population-based perspective.

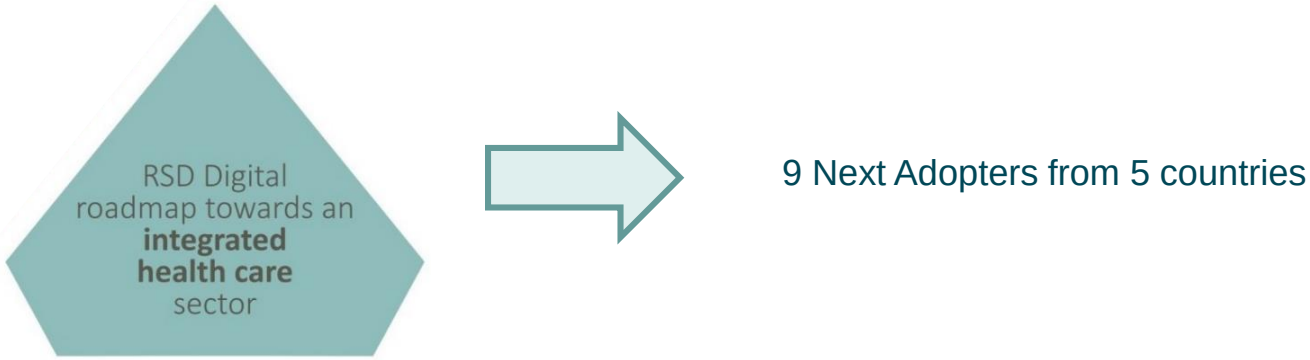
Original Good Practices



6 Next Adopters from 5 countries

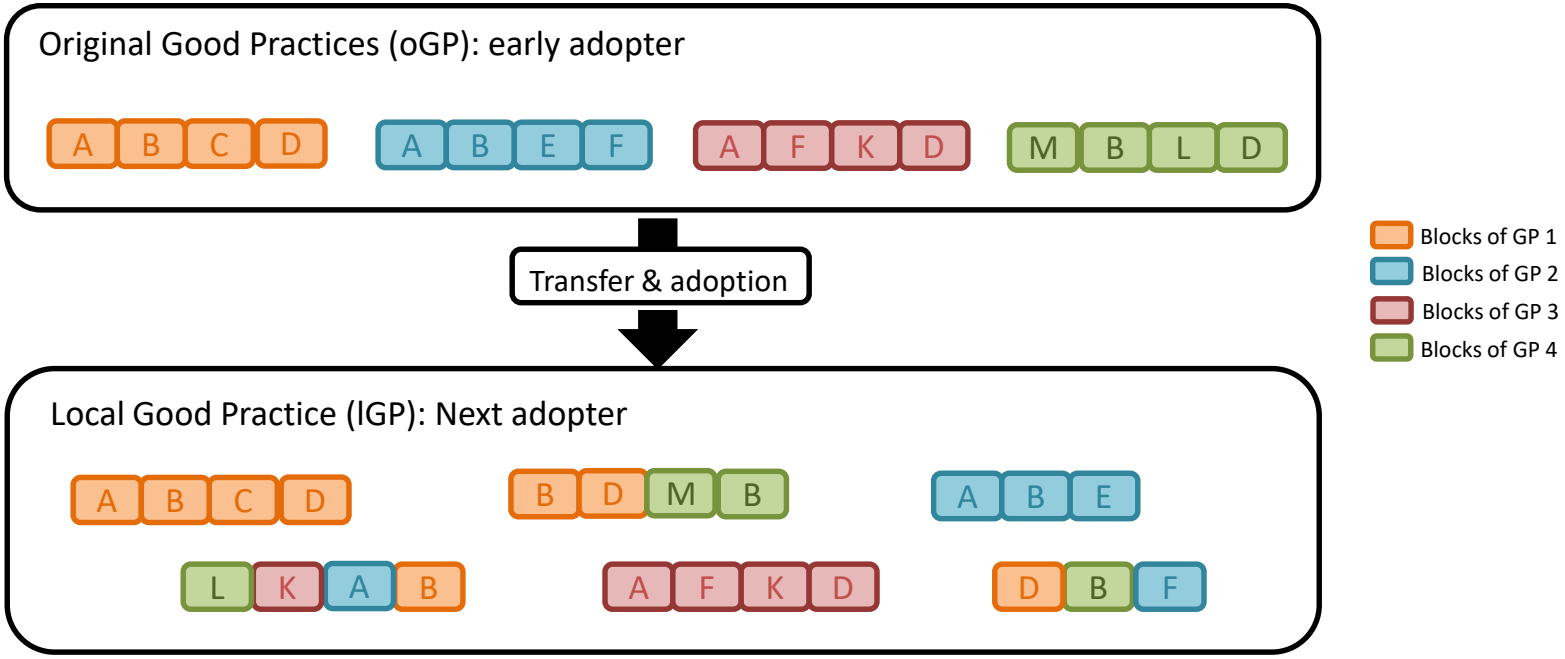
Targets simultaneously better population health, an improved patient experience of care including increased service quality and higher patient satisfaction and reduced per capita costs of health care by increasing system efficiency.

Original Good Practices



Consists of the SAM:BO agreement that connects the sectors digitally supplemented by a number of projects in the area of digitally enabled integrated care.

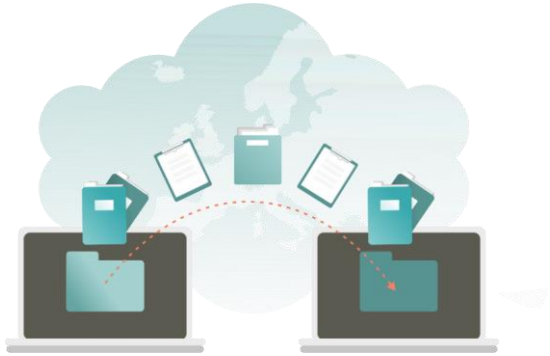
Transfer Strategy



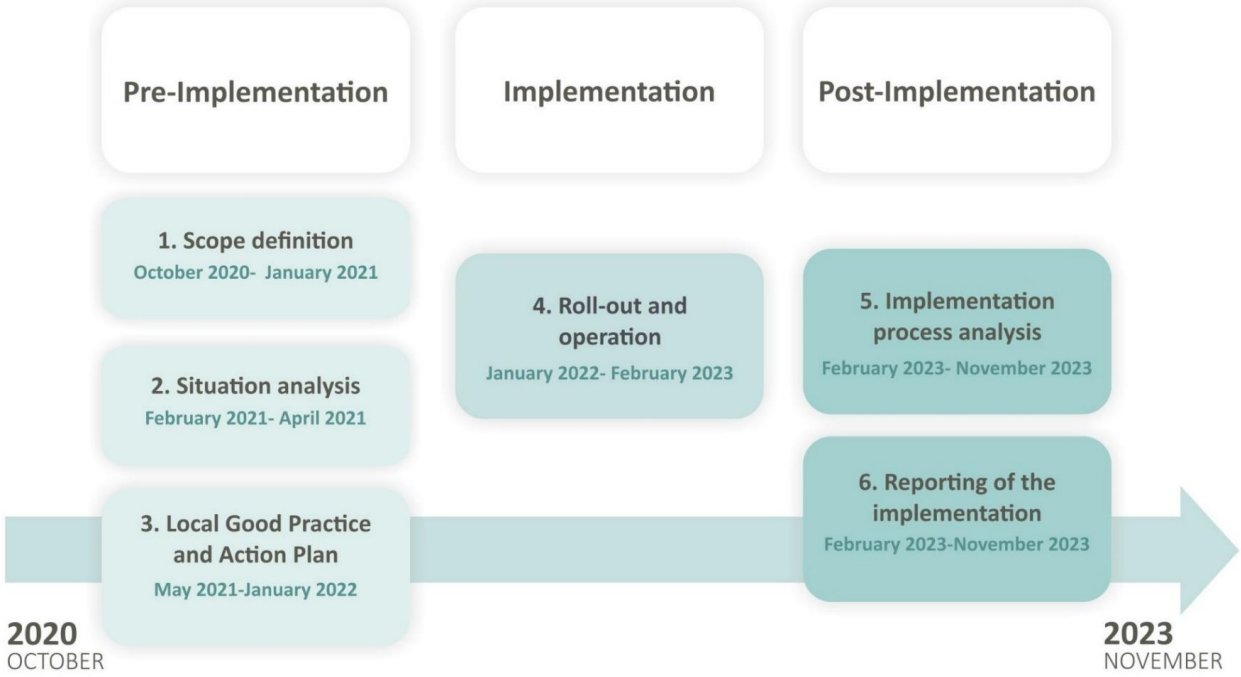
Implementation strategy

The transfer of oGPs will focus on the situation and preparation of the local environments of the adopting participants for the implementation. A three-step implementation strategy will be used for oGP transfer:

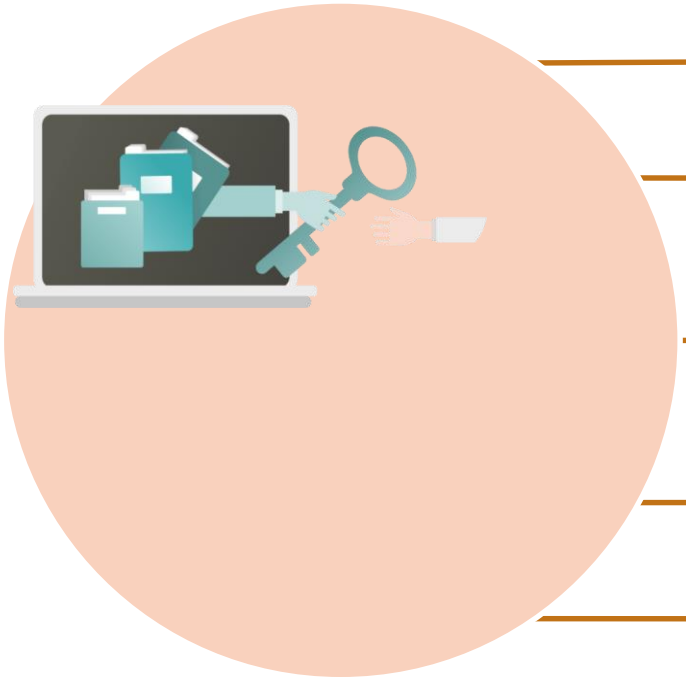
- Pre-implementation: planning and preparation of the action plans
- Implementation: roll-out and operation based on PDSA cycle methodology (Plan,Do,Study,Act)
- Post-implementation: impact assessment and learning



Implementation strategy



Transfer support activities



oGPS data collection and analysis(core features, implementation process, sustainability basis, etc.)

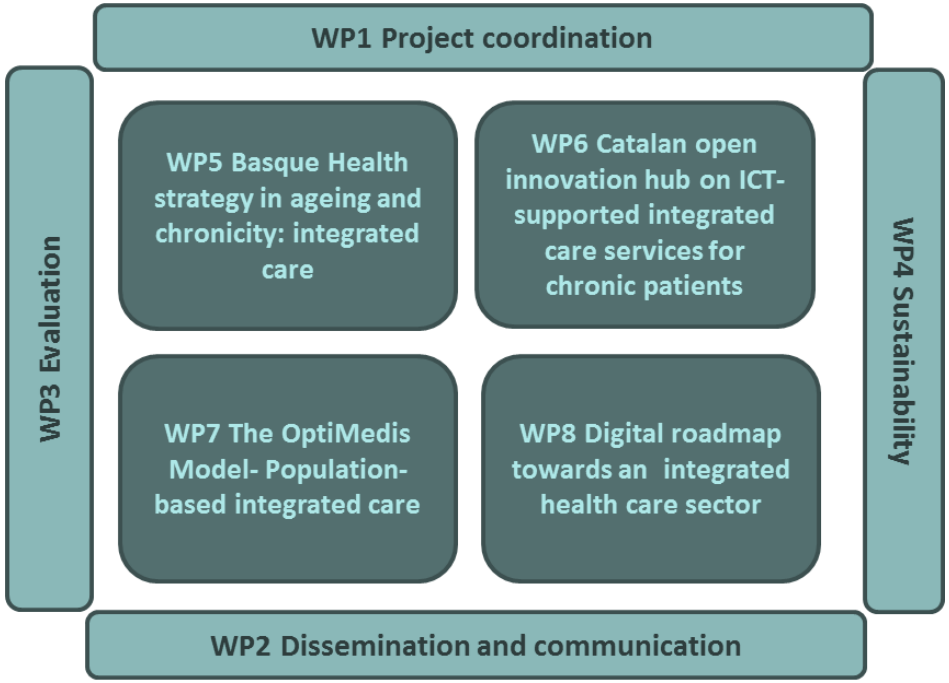
Analysis of the contexts of early adopters and next adopters to

Virtual study visits to learn about the experiences of the good practices

Thematic workshops during the implementation

Webinars, follow up meetings, technical support, guides for implementaion, etc.

JADECARE structure



EXPECTED OUTCOMES

1. To contribute to the creation of innovative, efficient and sustainable integrated health care systems focused on the individual person
2. To achieve the digital transformation of health services in which professional end users, care users or citizens, health providers, digital solutions providers and governments will have a key role.
3. To encourage innovation, enhance the sustainability of health systems, and improve their health care performance and outcomes.

JADECARE will improve collaboration and trust among participating stakeholders, support knowledge transfer and learning, and generate evidence on integrated care, that will produce benefits beyond the time frame of the Joint Action.
JADECARE will share its main findings and ensure the sustainability of policies at local, regional and national levels.

JADE CARE

Joint action on implementation of digitally enabled integrated person-centered care

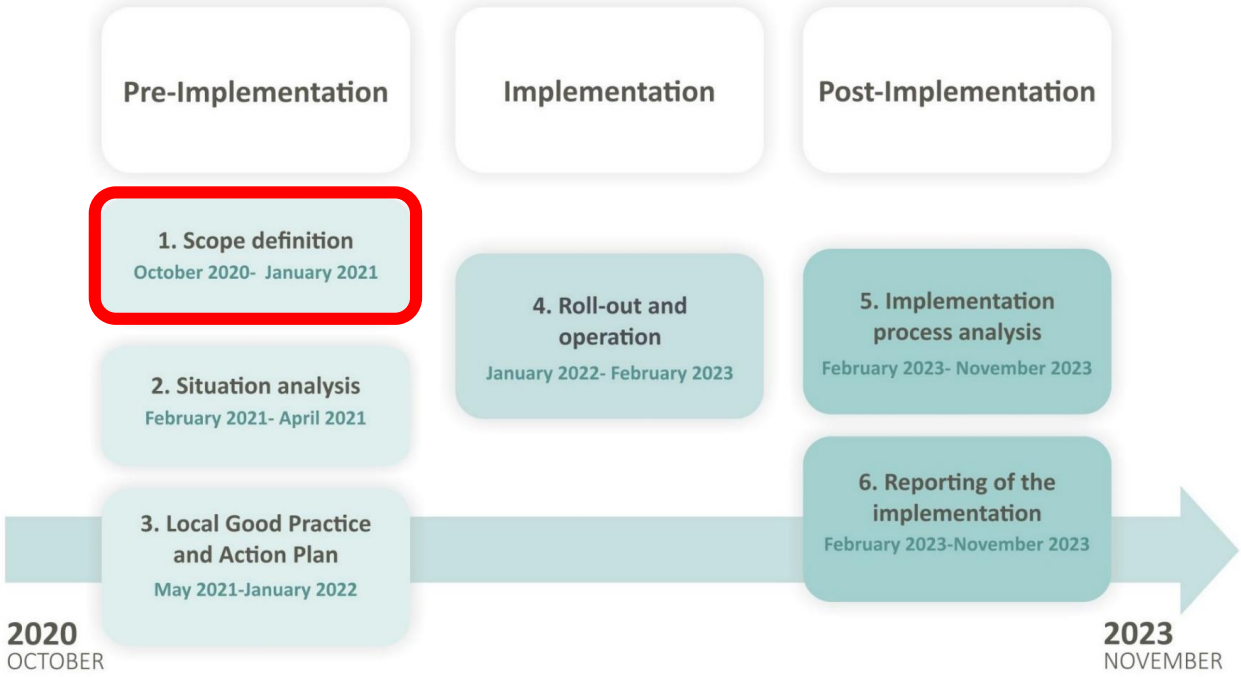
USE OF THE SCIROCCO TOOL IN THE PRE-IMPLEMENTATION PHASE OF JADECARE

Assessment of the maturity requirements of the JADECARE oGPs

The aim was to assess the Maturity Requirements of the four JADECARE oGPs, in order to Next Adopters analyze their feasibility to implement oGP's core features in the local settings

It was planned as a consensus exercise to get a common answer that assesses the minimum requirement so as that the Good practice can be successful. It was not intended to be an academic exercise

Implementation strategy



In short… each oGP team…

- Shared the analysis with Next Adopters to analyze the feasibility of implementing oGP's Core Features in their local settings
- Identified which of these maturity requirements is required in each of the Core Features
- Assessed the maturity requirements of their oGP through a consensus process by using the Scirocco online self-assessment Tool

Assessment process

1. Select the multidisciplinary team to carry out the assessment

2. Each member do an individual assessments (scores and requirements)

3. Consensus exercise to combine individual answers int common agreed responses

oGP teams used the Scirocco Online tool

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Identifying the maturity requirement for oGPs' Core Features - Example

		B1 – Risk Stratification			B2 – Integrated Care			B3 – Patient Empowerment	
		B1- CF1- Stratification Data extraction process and construction of dashboard	**B1-CF2- Classification of patients**	**B1-CF3- Stratification in the framework contract**	**B2- CF1- Creation of Integrated Healthcare Organizations**	**B2- CF2- Deployment of integrated communication and information systems**	**B2- CF3- Care coordination and communication between health providers**	**B3- CF1- Deployment of a School of Health**	**B3- CF2- Empowerment programs for chronic and/or multimorbid patients**
D1: Readiness to change	Maturity Requirement 1	x			x				x
	Maturity Requirement 2	x	x	x	x	x	x		
	…				x			x	x
D2: Structure and Governance	Maturity Requirement 1	x					x		x
	Maturity Requirement 2			x	x	x	x	x	
	Maturity Requirement 3		x			x			
	Maturity Requirement 4			x	x	x	x		x
	…								
⋮	…								
D12 – Capacity Building	Maturity Requirement 1	x			x	x	x	x	
	Maturity Requirement 2		x	x	x		x		x
	…								

Some results

Basque oGP

Catalan oGP

Optimedis oGP

RSD oGP –SAMBO Agreement

JADE CARE

Joint action on implementation of digitally enabled integrated person-centered care

THANK YOU!

Jon Txarramendieta

jtxarramendieta@Kronikgune.org

DISCLAIMER

Evidence-based Guidance to Scale-up Integrated Care in Europe

Project Overview

SCIROCCO Exchange General Assembly

22nd April 2021

Lutz Kubitschke, empirica

vigour-integratedcare.eu @VIGOUR_EU

Co-funded by the Health Programme of the European Union

The project in a nutshell

VIGOUR

Evidence-based Guidance to Scale-up Integrated Care in Europe

- Consortium: 29 beneficiaries and affiliated parties from 10 countries

- Duration: 42 Months Start Date: 1.1.2019
- Budget: €3,04 Mio; co-funded by the Health Programme of the EU

vigour-integratedcare.eu @VIGOUR_EU

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The wider background

"The home care program clearly demonstrates the importance of the close integration of clinical, public health, and other services if the needs of chronic disease patients are to be met to a reasonable degree"

Burney, L. E. (**1954**). Community Organization - An Effective Tool. American Journal of Public Health, 44(1), 1–6. doi:10.2105/AJPH.44.1.1 PMID:13114477, p.6

Integrated care has been a constant theme on the agendas of policy makers and practitioners for decades:

- improve patient experience
- improve outcomes of care
- improve efficiency of health systems
- improve work force satisfaction

"*Any integrated model development is strongly contextually-bound, nearly impossible to replicate and can only be successful if it does account for unique needs and characteristics of the population it aims to serve.*"

WHO Regional Office for Europe (2016): Integrated care models: an overview. Health Services Delivery Programme, Division of Health Systems and Public Health, Working Document, p. 21

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Practical challenges

Implementation challenges typically faced in practice:

- **Coping with contextual diversity** - The challenge of contextualizing generic models for implementation purposes
- **Orchestrating stakeholders' efforts** - The challenge to arrive at a common "vision"
- **Exploiting digital solutions** - The challenge of pursuing a multi-pronged innovation approach

How can the "Gordian Knot" of contextual diversity, operational complexity and systemic inertia be cut to make integrated care a reality in everyday practice?

Conceptual approach

Take care authorities from where they currently stand & take the next step on their own journey towards integrated care:

e. g. type of care integration

Linkage | Coordination | Full Integration

e. g. level of care integration

Organisation-level | System-level

e. g. form of care integration

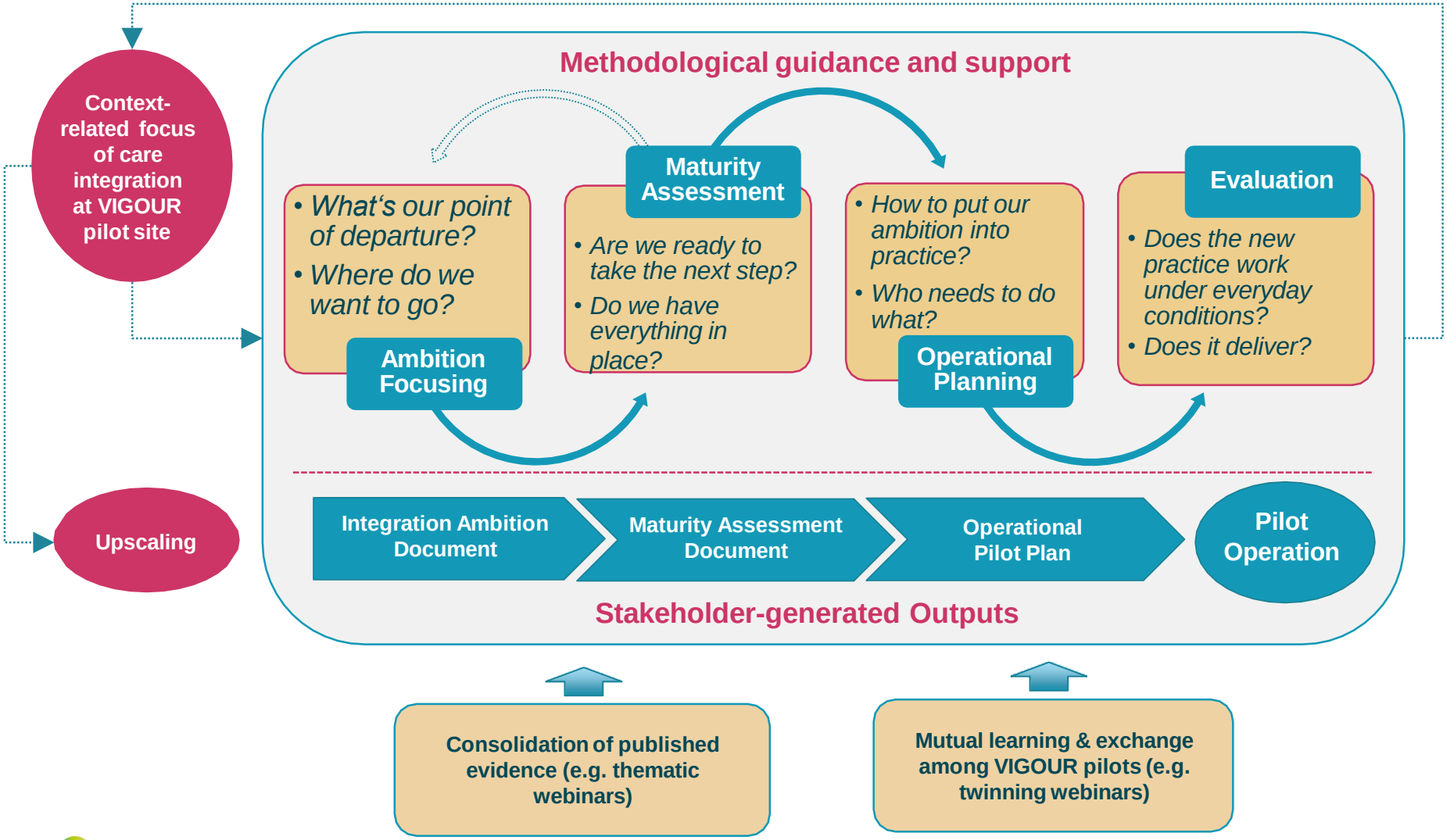
Vertical | Horizontal

See: MacAdam, M. (2008): Frameworks of Integrated Care for the Elderly: A Systematic Review. CPRN Research Report

Set-up a common support mechanism for conceptually designing, operationally planning and running scaling-up pilots

Derive lessons learned throughout this process for further utilisation by others beyond the project duration

The VIGOUR support process in a nutshell



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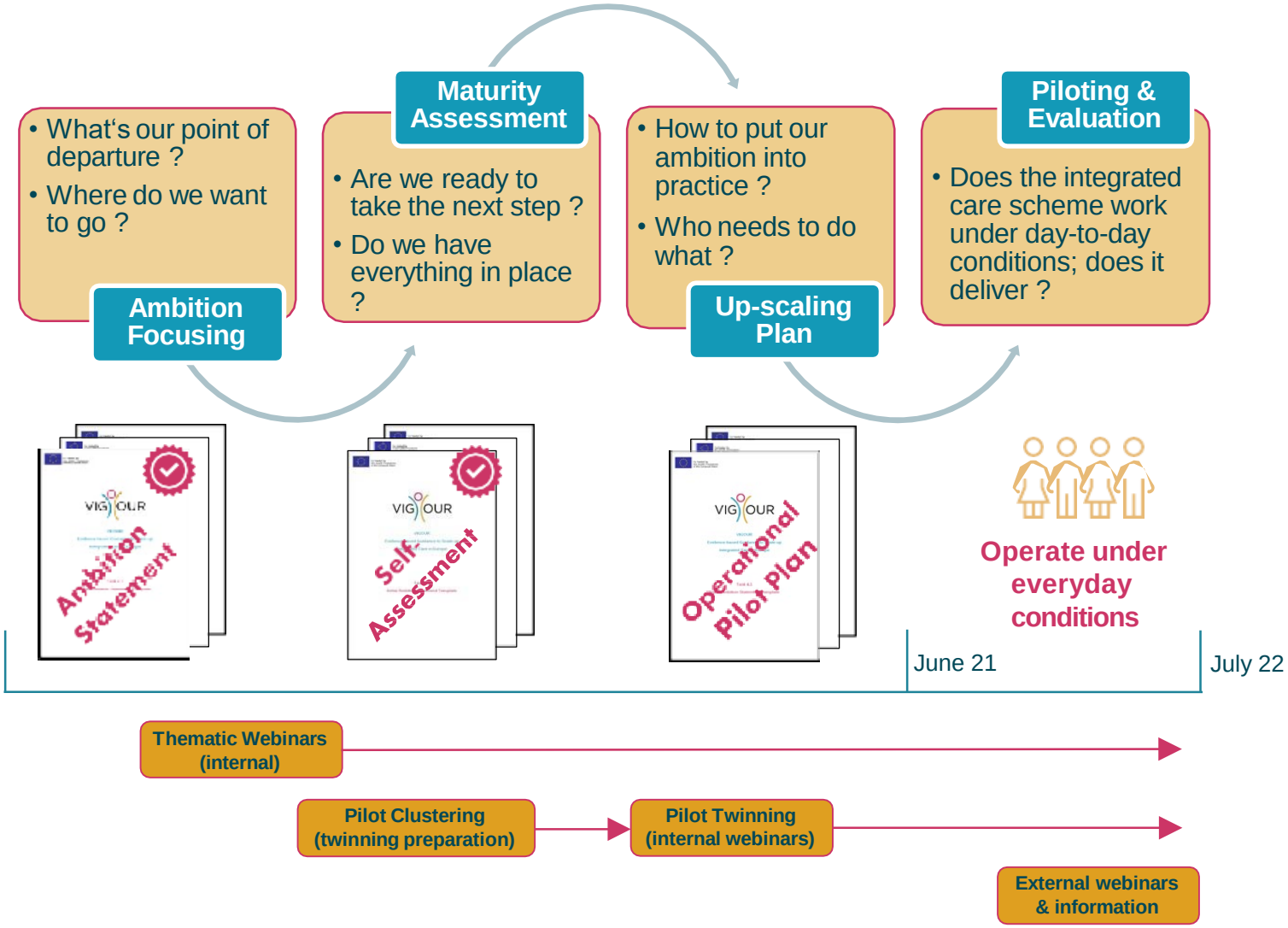
Where are we currently at in the project?



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Some lessons learned so far

- Integration efforts made before VIGOUR have an impact on “what” is to be integrated next:
  - “Needs” dimension: e. g. disease, dependency situation, …
  - “Intervention” dimension: e. g. prevention, care transition, …
  - “Pathway” dimension: e. g. appointed case manager, multi-professional teams, …
  - “Technology” dimension: e. g. electronic health record, eHealth platform, …
- The Covid-19 pandemic:
  - absorbs significant resources of the VIGOUR regions & hampers (on-site) stake holder collaboration in completing project tasks
  - reinforces the perceived importance of further integration efforts at the part of the stake holders:
    - e. g. “technology” perspective: remote service coordination/delivery
    - e. g. “intervention” perspective: cross-service guidelines for home isolation fostering physical activity and mental resilience

Thank you!

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END OF MEETING

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