Caring for the Future

Cost-Effective Integrated Care Models

An Overview of

22 European Countries

EFN

Executive Summary

The Innovation Union, as one of the Europe 2020 flagship initiatives contributing to smart growth, launched a first pilot of the European Innovation Partnership focused on Active and Healthy Ageing (AHAIP), which aims to tackle societal challenges through innovation. The EFN and its members responded to the European Innovation Partnership public consultation and the EFN was nominated for the Innovation Partnership Steering Group in charge of leading the pillar 'Care and Cure', with the ambition to scale up nursing-led initiatives tackling chronic diseases and integrated care, identified as new innovative ways of delivering care.

At that moment, the work of RCN Frontline First Award 2011 Innovation Winner Dr Marina Lupari from Northern Ireland was selected as a good example on how nurses can lead innovative organisational changes for the sustainability of health systems. However, we need more existing models of **integrated care** to push forward the coordination of care between primary and secondary care and between health, social and community care, while centring on the individual.

The Strategic Implementation Plan, adopted in November 2011 by the Steering Group and recently endorsed by the European Commission in its Communication, reflects the priority actions to take forward. The six major priorities have been included in the funding programmes of the Commission for the coming years (Horizon 2020, Cohesion Policy and Health Programme 2014-2020). Largely advocated by the EFN, the identification and implementation of cost effective integrated care models is among them. As such, the 2012 Public Health Programme (DG Sanco) and the 7th Framework Programme (DG Research) are currently evaluating proposals which incorporate EFN as a key partner.

At the EFN General Assembly held in Ljubljana on 19-20 April, 2012, EFN members were asked to share examples of initiatives on integrated care at national or local level showing how new innovative ways of healthcare delivery are bringing benefits (in terms of patient outcomes and cost-effectiveness) to national health systems. **The following report is an overview of this input.**

Key Message

The 34 National Nurses Associations represented through EFN would like to:

Remind – Investing in health is the way forward!

Suggest – Adopting cost-effective integrated care models can assist Member States in giving their health systems a much needed boost during this time of economic crisis!

Warn – Unless action is taken, patient safety and quality of care will be severely compromised!

Urge – Invest in health, innovate the future, and inspire progress!

Contents

BULGARIA

Name of the initiative:

Home care for the elderly people in collaboration with the Bulgarian red cross; Home care for pregnant women, for new born babies and for small children up to 3 years in vulnerable groups of society in collaboration with the Bulgarian office of UNICEF.

Level of involvement:

Partner.

Target groups:

Elderly people with chronic conditions without relatives at the first stage; Pregnant women from vulnerable groups, their new born babies and children under 3 years of age.

Aim of the initiative:

To organise, coordinate and control the continuum of care, different from the official health care system.

Brief description of the initiative:

To propose high quality of care for the consumers of the two projects. The idea is to show to the government and society that nurses' care at home is cost effective and is very friendly to the patients. The initiative has to receive formal legal frame and be incorporated into the social and health care systems.

Outcomes:

Patient satisfaction is expected – raising awareness of the possibilities to receive information and real service when needed at home, cost effective nurses' care, ethical attitude between the patients and the nurses, special consent on patient safety, rare re-hospitalisation, serious efforts for help for independent living solutions and socialisations, according to the individual conditions.

Published information:

Nothing at this time.

CROATIA

A recent reform in Croatia has opened the door for a new strategy on healthy ageing by the school for public health. This existing model on public health is good but very expensive. A document is being prepared on home care and chronic diseases based on self-employed nurses providing home care. There are currently about 3000 nurses giving care at home. Finally, there are courses to increase the quality of education and a centre for palliative care is being opened.

CYPRUS

Name of the initiative:

Cyprus Nurses and Midwives Association (CYNMA) Consultation on: Nurses' involvement in the proposed NHS and Nurses' participation in Health and Social Care.

Level of involvement:

Participant in consultation processes of the Ministry of Health, The Ministry of Labour and the Health Insurance Organisation (joint effort supported by colleagues of respective nursing branches).

Target groups:

Elderly people and families.

Aim of the initiative:

To bring nurses in a position that will lead organisational changes for the sustainability of the proposed new health system, improve health quality care and patient safety.

Brief description of the initiative:

CYNMA supports that it is important to focus on the key role of nurses in the current and future delivery of health services. Health Authorities should take into consideration nurses' contribution when planning on resource allocation within the health care sector. Health promotion and disease prevention is an important part of the work of nurses. They are able to initiate and carry out preventive measures against health problems that may exist in families and in the community.

Outcomes:

The regulations for the elderly homes have not yet entered into force (to be submitted soon in the Health Committee of the Parliament) – CYNMA's proposals are based on nursing scientific experience and research). The process of drafting legislation for community nursing has started very recently. The extent of nurses' participation in health care delivery within the proposed national health system has not yet been finalised.

Published information:

The drafting of regulations for elderly homes, the submitted documents by CYNMA, the minutes of the meetings with the respective authorities, and the proposal of amending certain provisions in the relevant legislation for the new national health system. The procedure for drafting a legislative proposal for community nursing is underway.

CZECH REPUBLIC

A new law has been developed at national level about health care professions which should, among other things, define which professions and which level of education will make the provision of health care the most efficient, the safest and of high quality. The preparatory work is proceeding very well and is slowly being finalised. The establishment of a chamber of health care professionals has been suggested under this new law.

Provider level: The insurance companies have started to reimburse "a remote monitoring of patients with schizophrenia". This is a preventative programme (www.itareps.com) which monitors alerting symptoms of these patients. The symptoms are reported to the physician and an early intervention prevents re-hospitalisation. There are currently attempts to implement the system of interRAI evaluation of long term care patients as well as efforts to optimise acute care.

DENMARK

Name of the initiative:

A model for chronic diseases in the North of Jutland, Denmark: "Den Nordjydske kronikermodel", 2011, head of the project, Alice Morsbøl, head of office at Region North - Ålborg. The model is based on the Danish Board of Health's "Recommendations for chronic diseases - a generic model. May 2007".

Level of involvement:

Region and communities have agreed on an overall organisation of the effort for people with chronic diseases. The terms of reference states that there should be nurses involved with different knowledge and from different areas. The nurses are members of the Danish Nurses Organisation, and therefore members of the EFN.

Target groups:

Patients with chronic diseases.

Aim of the initiative:

Ensure and create continuity and coherence for the patient; achieve high quality standards for chronically ill patients; ensure that the knowledge, skills and competencies of the health care professionals meets the needs as mentioned above.

Brief description of the initiative:

The aim is that a person with a chronic illness will be able to master life with a chronic disease. The implementation of cross-sectorial forums was particularly successful, to unite a multi professional/sectorial approach to these patients and relatives. The model ("The Nordjyske Kronikermodel") has secured a unique opportunity for the development of rehabilitation in North Jutland. It has created a forum for understanding rehabilitation, which recognises the scope, content and effect in accordance with national and international guidelines. Through dialogue, presentations and thematic meetings the model has achieved a greater acceptance and recognition of the different ways of treatment and care, and roles in the patient pathway. The overall aim has been that the patient must experience a process of good transition from hospital to home, via specialised rehabilitation (with the participation of several professional professions), and prevent the patient from being re-admitted to hospital.

Outcomes:

The patients have experienced a significant increase in terms of quality of life and there has been a decrease in admission to hospital around 20 %. Today the model includes 9 chronic diseases: Chronic Obstructive Pulmonary Disease (COPD); Type-2 diabetes, cancer, cardiovascular disease, Dementia, Osteoporosis, Allergic Diseases Musculoskeletal disorders (arthritis) and mental disorders.

Published information:

The model was presented at a conference in December 2011 in Copenhagen, held by The National Board of Health. Several models were presented at the conference.

http://www.sst.dk/publ/Publ2012/BOS/Sundhedsaftaler/Bilag2_%20Konferencerap_Implement_dec2011.pdf

FINLAND

Name of the initiative:

Case Manager in Chronic Care Model in Finnish Primary Health Care Settings.

Level of involvement:

Partner: The Finnish Nurses Association funds the programme, and owns the rights to the model.

Target groups:

Hospital care, work of professional people, self-care.

Aim of the initiative:

The Chronic Care Model brings a new Case Manager Operation Model for the most challenging client group – clients with multiple illnesses and who need a lot of support and services. A Case Manager is a nurse, a public health nurse, or a midwife with a long work experience in this branch and with the necessary supplementary education. In addition to client work, the Case Manager must develop the activity. Based on the Case Manager Approach, she or he must support the other nursing staff working in the organisation without the same supplementary education.

Brief description of the initiative:

The Chronic Care Model actively searches for patients who have the greatest ability to benefit from the services. Only the most solvent persons use new treatments and medication (first). The ability of these two groups to benefit from further efforts is often marginal. In this group, the further efforts bring the greatest health benefit.

Outcomes:

The objectives of the model: good availability of high-quality and necessary services, to improve client-centricity and freedom of choice, to secure skilful labour, to strengthen and develop management, to promote health, and to prevent illnesses.

Published information:

Mikko Nenonen, Senior Health Policy Advisor at Finnish Medical Association, Seija Muurinen, Special Researcher, National Institute for Health and Welfare, Finnish Nurses Association. “How the Case Manager Model Is Managed?” [Miten johdetaan terveyshyötymallia] Premissi 2011; 1: 54–8.

GERMANY

In Germany, there is an official programme on integrated care but so far it has not had much success. Mostly, it consists of examples of hospitals and general practitioners working together because the divide between the two is still pretty severe. Of the existing models, 5 out of 700 include nurses. Also, hospitals have started establishing community nursing themselves and people are increasingly living in shared flats instead of nursing homes. While successful, the challenge remains how to safeguard quality of care and patient safety as the involvement is private, not public. Finally, one of biggest health insurance companies in Germany is now financing family health nurses.

GREECE

Name of the initiative:

Hellenic Red Cross is a volunteer organisation with a great contribution in the field of chronic diseases and elderly care.

Level of involvement:

Hellenic Nurses Association supports and promotes the works of Hellenic Red Cross.

Target groups

Elderly, chronic diseases, immigrants, homeless and poor, prisoners and other vulnerable groups of people.

Aim of the initiative:

The Red Cross is one of the largest non-governmental organisations in Greece with a complex project based on voluntary action and the immediate response of the citizens. Mobilises and always aims to alleviate human suffering in times of war and peace, supporting wounded, the sick, refugees, elderly, and people with financial difficulties and people from each vulnerable population group.

Brief description of the initiative:

Training
Service "Health Education"
Services for Primary Health Care
Service "Gerontology"
Service “Home Care"
Volunteer Nursing

Outcomes:
The results of the action of this organisation have a major impact on public health and the sustainability of health systems, especially to coordinate the care between primary and secondary care and between health, social and community care.

Published information:

Websites: http://www.redcross.gr/ and
http://www.samarites.gr/?section=983&language=en_US

More general examples of nurses involved at organisational level for the implementation of integrated care in chronic diseases are the following:

1. Hellenic Nurses Association is involved as associate partner in an EU Project for heart failure nurses. The aim of this project is to implement an e-platform for education, supporting and counselling heart failure nurses while they provide integrated care models in home settings and while they coordinate between primary and secondary care.

2. There is an initiative (called GALILEE) from the Greek Church, a hospice programme coordinated by a volunteer organisation led by an administrative board in which there aren't nurses, but nurses have a very important role at organisational level and for providing integrated care models for elderly people with chronic diseases in home settings. Hellenic Nurses Association supports and promotes this programme. However, it is not active nationwide (More info in website: http://www.galilee.gr/)

3. There is a non-profit organisation called "MERIMNA" which provides integrated care models in children with chronic diseases (cancer) in home settings. This organisation is not led by a nurse but by an administrative board in which there is a nurse. Nurses have a very important role at organisational level and for providing integrated care models in children with cancer and coordinating between primary and secondary care. Hellenic Nurses Association supports and promotes this programme. This is an organisation whose main purpose is caring for children and families facing a serious illness, a loss or death. The company was founded in 1995 by nine experienced scientists from the wider field of health and education, who work on interdisciplinary implementation of the objectives of Welfare. It is not currently active nationwide. (More info in website: http://www.merimna.org.gr)

4. The Ministry of Health announced recently that it is going to establish a national system called "Help at home" which will be staffed by health professionals (included nurses) in order to provide integrated care models for chronic diseases in home settings. Nurses will play a very important role in this initiative, coordinating between primary and secondary health care.

5. There are some patient organisations providing integrated care models for children with chronic diseases (cancer) in home settings. These organisations are not led by a nurse but by an administrative board without a nurse in it. Nurses have a very important role to play in providing integrated care models for children with cancer. The Hellenic Nurses Association supports and promotes these. They are not active nationwide. (More info in websites: http://floga.org.gr/, http://www.elpida.org, http://www.pisti.gr/).

ICELAND

Name of the initiative:

The transfer of services for the elderly from the state to the municipalities.

Level of involvement:

The Icelandic Nurses´ Association (INA) appointed one member (out of 14) in the committee preparing the transfer.

Target groups:

Elderly individuals, directors of nursing homes, local boards of municipalities, Ministry of Welfare.

Aim of the initiative:

The main objectives of the action are to: increase the quality of and to individualise the service to the elderly; link the health service and social service; bring the governance of the service closer to the ones who need it; strengthen the municipalities; simplify the division of tasks and responsibility between the state and the municipalities.

Brief description of the initiative:

Since early 2009 the government has been preparing a major transfer of tasks to the municipalities. This regards the service to disabled and/or elderly individuals, and the primary health care. The governance of service to the disabled was transferred from the state to the municipalities in January 2011. The Minister of Welfare is now preparing the next step, the transfer of the service to the elderly, with the objectives outlined above. The Minister has emphasised that the transfer should take place in January 2013.

Outcomes:

Hopefully, these changes will lead to a better service for the elderly. It will be easier to plan and combine both the health care service and the social service to each individual, when the responsibility and authority is all in one hand. It will for example be easier to organise home visits, whether regarding health care or social service, so that they will be distributed over the week as is best for the individual. Task shifting will also be easier and should increase the cost-effectiveness. The INA has stressed the importance of nurses administering the service in the municipalities and emphasized the legal responsibility of nurses over nursing. In the April volume of the Icelandic Journal of Nursing, the president of the INA challenged nurses

to stand for a seat in the local boards in the elections 2014, with the aim of ensuring nurses' authority over nursing service for the elderly.

Published information:

Nothing at this time.

IRELAND

In Ireland a Quality and Clinical Care Directorate was established in 2010 to help improve the patient journey through the health system. 20 integrated patient care programmes were established under the leadership of a multidisciplinary team of clinical professionals including General Practitioners, Clinical Nurse Specialists, Consultants and Allied Health Care Professionals. The programmes are focussed on improving care, significantly reducing waiting times, cutting out inefficiencies and being cost effective. This is a joint initiative with professional training colleges and is based on a very successful cancer care programme which was implemented in Ireland in 2007. The programmes include such areas as heart failure, stroke, acute coronary syndrome, COPD, asthma, rheumatology, primary care, epilepsy, care of the elderly and emergency medicine. Clinical Nurse Specialists and Advanced Nurse Practitioners are working with the multidisciplinary teams and will play a lead role in rolling out these programmes. Chronic diseases cause 70% of deaths internationally and 70% of Western health care spending is on chronic diseases and 50% of people internationally take the correct treatment for their condition. The focus will be on primary care, self- management, health promotion and disease prevention which is an area where nurses and midwives will play a key role. The implementation of nurse and midwifery prescribing in 2007 has led to greater efficiencies and effectiveness in patient care management with improved patient compliance in the area of medication management. Nurse and midwife prescribers undertake a six month education programme and currently over 700 nurses and midwives have been funded to undertake the prescribers course. Nurse and midwife prescribers now work in 48 acute hospitals and 115 primary and community services in Ireland. It is acknowledged that medication management will play a key role in the integrated patient care programmes and the implementation of nurses and midwife prescribing in Ireland has proved very successful and of great benefit to patient care. The Irish Nurses and Midwives Organisation lobbied for nurse and midwife prescribing and were involved in the discussion on legislation and the implementation of the initiative. The INMO is fully supportive of the implementation of the care programmes and believe that nurses and midwives have the knowledge, skills and competencies to play a key role in this initiative.

National Clinical Programmes: http://www.hse.ie/eng/about/Who/clinical/

Nurse and Midwife Prescribing:

http://www.hse.ie/eng/about/Who/ONMSD/practicedevelopment/NursePrescribing/

ITALY

In Italy, having complete information on who is doing what with regards to integrated care models is very difficult. The Italian Nurses Association is organising a national conference in Rome in October of this year to show the crucial role that nurses play and to demonstrate that there is no future without nurses. In addition to this, there will be a literature review to assess how nurses influence education and policy at national level. Finally, there is an initiative in Tuscany which is looking into the collaboration between nurse pharmacists and doctors.

LITHUANIA

There are no cost-effective integrated care models at this time in Lithuania. There is no positive progress in the development of primary health care. There was a political initiative to transfer home care from state sector to local municipalities. The representatives of the Lithuanian nurses' organisation took part in discussions organised on this issue. The main obstacles of implementation of such a proposal are lack of finances and absence of concrete vision for actions. Because of the impact of the financial crisis on the economy of the country it is hard to initiate any discussions and positive actions in the area of nursing. The national nursing organisation is following the news in this area very closely but emphasizes the necessity to develop primary health care in all the discussions with the hope of having better services for the Lithuanian population and better working conditions for nurses.

MACEDONIA

Name of the initiative:

Assessment programme for community nurses.

Level of involvement:

The Macedonian Association of Nurses and Midwives has been nominated by UNICEF to participate actively in all stages of research methodology and to assist in the drafting of the assessment programme.

Target groups:

The target groups for this programme are the community, mothers, and the elderly.

Aim of the initiative:

This innovative programme has been presented to the Macedonian Ministry of Health in order to push for financing from the national healthcare fund. Primary health care nurses are sent out as patronage nurses to present the needs of the population and how these needs can be met by policies.

Brief description of the initiative:

It is hoped that by evolving patronage services to be cost-effective and to be integrated with social care will promote leadership in nursing and care. It will also promote links with other service providers and the qualitative and quantitative research covers many groups.

Outcomes:

The main outcome of the assessment programme will provide a clear picture of the reforms needed in terms of research and human material for cost-effectiveness. This includes decreasing hospital stays and improving efficiency and the quality of patronage services.

Published information:

No research has been published at this time.

MALTA

The Malta Union of Midwives and Nurses is planning to launch a project based on what Commissioner Dalli is doing in the European Innovation Partnership on Active and Healthy Ageing. It will focus on early discharge for patients without compromising patient safety and quality of care. The aim is to better understand what is happening in the hospitals as opposed to in the community with regards to continuity of care. Findings show that there is more leadership in primary care following discharge while keeping patients in the hospital is very costly. In view of this, and given the decreasing number of hospital beds in Malta, strengthening primary care is the way for the future. While there is a tendency for doctors to be responsible for coordination-related tasks, this project shows that nurses are the primary profession group to take on these tasks. Moreover, this initiative shows a lot of potential for cost savings, better use of beds, and increasing quality and patient safety. The project is being supported by the EU through the social cohesion funds.

MONTENEGRO

Given that Montenegro is currently in a transitional period with regards to EU accession there is no regulatory body for nursing, only a national law. However, it is hoped that a regulatory body and chamber will be set up this year. In light of this, there are currently no models, definitions, or guidelines for carrying out nursing care in Montenegro.

NETHERLANDS

While some work is being done in the Netherlands on conditions for nurses, the national health sector does not see the added value of integrated care and thus, it is not being incorporated into the current health system. Health care insurers in the Netherlands are important as they are the official requirement making decisions with other parties regarding health services. Therefore, more support is needed from them. Some pilots on diabetes, chronic obstructive pulmonary diseases and cardiovascular diseases have started and the first research results are expected in a couple of years.

NORWAY

Name of the initiative:

THE ELIN-K PROJECT, Electronic interchange of health information in community care. A project instigated by the Norwegian Nurses Organisation.

Level of involvement:

Norwegian Nurses Organisation is the instigator and responsible for the project together with The Norwegian Association of Local and Regional Authorities (KS).

Target groups:

Nurses and GPs.

Aim of the initiative:

The aim of the project has been to: develop national standards for electronic information exchange (electronic messages) between community care services, hospitals and GPs; test and pilot the solutions in all major electronic patient record systems in Norway. Vision: Correct health information, to the right person, at the right time. Goal: Development, implementation, testing and achieving widespread use. To reach these goals the electronic health care communication solutions must be based on common standards, common professional content and structure.

Brief description of the initiative:

Health care providers do not have access to accurate patient information when needed. The methods of communication have been paper-based, or through meetings and telephone calls. The content of the information has not been standardised. There are a countless number of different paper based transmission notes between hospitals and community care services, and it has been up to individual hospitals or individual municipalities to determine their content. Nor has there been sufficient focus on what type of information health professionals need to provide quality health care. In 2002 and 2003 the Norwegian Centre for IT in health and social services (KITH) developed templates for the content of medical information in the so-called “good discharge summary” and “the good referral note" on behalf of the Norwegian Directorate for Health. These templates provide a recommendation for the medical content and structure to be included in physicians’ electronic discharge summaries and referrals. Such recommendations were not developed for nursing and other health-related content and structure in electronic messages. Therefore the Norwegian

Nurses Organisation initiated this project in 2005 to standardize the electronic interaction between the community care sector and its partners

Outcomes:

We have developed a set of electronic messages to be used when patients are hospitalised and discharged or when nurses in home care and GPs need to communicate about a patient. The electronic messages are:

From community care to GPs: Messages, orientation about community care services, updated nursing and health information to the GP, medications list, requests for renewal of prescriptions, booking doctor's appointment.

From GPs to community care: Updated medical information, medications list, response for requests of renewal of prescriptions, notification of doctor's appointment, from community care to hospitals, admission summary.

From hospitals to community care: Admission message, ready for discharge, cancellation of ready for discharge, discharge message, application for community care services, interdisciplinary discharge summary.

Nurses who have tested the e-messages report of more timely and precise health care information, with fewer errors in prescribed treatment and medication. They also report the use of less time in the transmission of information, and there are fewer telephone calls and meetings. By using e-messages, in contrast to previous practice where oral communication was the common method of information exchange; most of the information exchange is now documented. This could indicate that the solutions lead to improved working processes. It is expected that electronic information exchange leads to fewer mistakes and unforeseen events, more time directly to patients and increased patient safety. The solutions are now about to be implemented in the health care service in Norway. At this point 64 % of the municipalities in Norway are implementing or in the process of planning to implement the solutions.

Published information:

Moelstad K, Lyngstad, M, 2010, Case study 16 C, National Leadership in eHealth: The Norwegian Case, Weaver et al. 2010, Nursing and Informatics for the 21st Century. An International Look at Practice, Education and EHR Trends. HIMSS

Lyngstad M, Hellesø, R., Mølstad, K., Skarsgaard, S., Dønåsen, M. From Technology Driven to User Driven Development of ICT Solutions in the Health Care Sector – the ELIN-K Project. 8th European Conference of ACENDIO; Madeira 2011. 2011. PwC (Pricewaterhousecoopers), & Norwegian Association of Local and Regional Authorities 2012, Electronic Message Exchange

in Municipalities – Cost and Benefits, English Summary page 6. (In Norwegian: Elektronisk meldingsutveksling i kommunene – Kostnader og gevinster.

http://www.ks.no/PageFiles/23028/Elektronisk%20meldingsutveksling%20i%20kommunene%20-%20kostnader%20og%20gevinster_v08%2011.pdf

PORTUGAL

Name of the initiative:

Community Health Care Unity (Portuguese acronym - UCC)

Level of involvement:

No direct involvement of the Ordem dos Enfermeiros (OE). Nevertheless, the OE is participating in the policy process of the ongoing Primary Health Care Reform, where the UCCs were one of the initial flagship initiatives. The OE has also provided support to all the colleagues that have presented applications and has created an observatory to monitor continuously the development and results of the process.

Target groups:

The people that are usually considered the most frail, vulnerable or at risk or with high levels of dependency in the community.

Aim of the initiative:

To provide, ensure and increase the access to health and social care to the population in their communities, especially those that are considered most frail or at risk.

Brief description of the initiative:

The Community Health Care Unity (Portuguese acronym - UCC) is a formal unit, created by governmental law, with a formal contract comprising a package of health services to be delivered and with indicators of quality to be achieved. The UCC is led by a specialist nurse and is constituted by a multidisciplinary group (dentists, nurses, physicians, physiotherapists, psychologists and support staff). The objectives are to ensure care to the most frail, vulnerable or at risk people or with high levels of dependency in the community. And also to promote health and provide health education, integrate family support networks and implement mobile health units, while coordinating with the other primary health care units, and local stakeholders.

Outcomes:

Not available yet. Although the initiative was quite successful in terms of adherence as a high number of applications were submitted (255) and presently 158 are operating with perceived success. However, the OE is apprehensive regarding the effects of the introduction of user fees to the delivery of nursing care. This measure that can also be seen as the

recognition of the worth of nursing and nurses is, probably, going to have a detrimental effect on the care provided, as in a time of great economic crisis people can refrain due to the incapacity to pay for the care they need.

Published information:

Nothing yet.

ROMANIA

Name of the initiative:

Home care - On April 7, 2003, by Order No. 318 "Norms for the organization and functioning of home care" was approved, and authorisation was given to the companies and individuals who provide these services. This was issued by the Ministry of Health. The providers of home care are authorised by the Ministry of Health and Family. In Romania, foundations, NGO's, and SRL which provide home care. All these work as private providers of home care. Some of them signed a contract with the Health Insurance House at county level but there is not always sufficient money to pay for the home care services. At present, in some counties, the Health Insurance House only pays services for patients with severe neurologic diseases, and oncology patients (terminally ill). In this situation, the providers of home care work in the private system (like private business owners), but some patients don't benefit from it because they don't have the money to pay for it. Some of these foundations, NGO's, and SRL are led by nurses which are members of the national nursing organisation. Some of them have had to stop home care activities for two or more months, sometimes years, because they don't have the money to pay the nurses who provide the care or don't have the necessary materials. Although in Romania there are rules for the organisation and functioning of home care, standards of quality for elderly home care services and residential centers for older people, and standards for accreditation of home care providers, the home care system is poorly set up. The number of foundations, NGO's, and SRL is not enough to meet and satisfy the needs of patients in the community; the people are poor and cannot pay for home care. The main problem in Romania remains lack of finances.

Published information:

Order No. 318 of April 7, 2003 "Norms for the organization and functioning of home care", and the authorization to companies and individuals who provide these services. Issued by: Ministry of Health Published in: Official Gazette no. 255 of April 12, 2003.

Order no. 246 of March 27, 2006 approving specific minimum quality standards for medical care services home for the elderly and residential centers for people elderly Issued by: Ministry of Labor and Social. Published in: Official Gazette no. 344 of April 17, 2006.

Decision no. 249 of 30 May 2003 - Standards for the accreditation of providers for medical home care. Issued by: National Health Insurance Home: Official Gazette no. 410 din 11 June 2003.

SERBIA

Given that Serbia is currently in a transitional phase with regards to EU accession, there are currently no models, definitions, or guidelines for carrying out nursing care. While there are no national strategies, the Serbian Nurses Association is currently working on strategies through a national Commission, of which it is a member.

SLOVENIA

The Nurses and Midwives Association of Slovenia is very proud of the Slovenian primary care system. There is a strong focus on community and family nurses and this seems to be the right model. There is a new project with the general practitioners and registered nurses: the registered nurse takes care of prevention and education because of the shortage of doctors. In a few years, all general practitioners will also have a registered nurse. Moreover, nursing departments are expected to be placed in the hospitals. Finally, Slovenia has just opened its first birth house where midwives take care of the entire birthing process.

SPAIN

In Spain, there is one of two projects in place: after a law on nurse prescribing was approved, a platform was put in place to support this new role for nurses. Moreover, a course is being provided for free for nurses (for nurse prescribing purposes), they must acquire a license to utilise the IT platform and the Ministry of Health is in charge of accreditation. The second project, as part of the defence of a PhD thesis, relates to the role of link nurses and their contribution to healthcare systems. A network of nurses linking with patients who need home care has been set up, specifically for link nurses in charge of coordinating interventions to be carried out for patients. The task of link nurses is to coordinate with doctors on pc and to handle any appointments that a patient may need for specialised care, or hospitalisation, if needed. One of the roles of link nurses is to concentrate on minimising the number of days in hospital or the need for hospital stay for patients, in coordination with family care givers. This initiative is very useful as nurses are also getting the necessary instruments for their daily activities. It has also proven a very interesting experience as it has shown to decrease costs. The Spanish General Council of Nursing is therefore eager to have the projects fully implemented, particularly in view of the fact that around 15000 nurses are still unemployed in Spain.

SWEDEN

Name of the initiative:

The Swedish Association of Health Professionals (Vårdförbundet) has presented 4 examples of integrated care: 1) National elderly care coordinator, 2) Healthcare coach, 3) "The Hip Line", 4) Systematic Improvement work.

Level of involvement:

1) National level, commissioned by the Government, 2) + 3) County/regional level, 4) Directly on activity level in the health care.

Target groups:

1) The most sick elderly in the population, 2) The most sick individuals, 3) Especially the elderly and the disabled, 4) The direct patient care in health care activities.

Aim of the initiative:

1) Improving and ordination the health care for the most sick elderly

2) Improve the health care chain and enhance efficiency in health care for chronically ill patients, often the elderly

3) For better treatment of hip fractures in the care chain with direct admission from the patient's home to a hospital ward and the streamlining of costs associated with treatment of hip fractures

4) Improve the direct patient care in a structured manner.

Brief description of the initiative:

1) The Government invested 4.3 billion Swedish kronor during the electoral period, in order to improve health care and care for the sickest elderly. A senior coordinator has been appointed to submit proposals on how to better coordinate care. The goal is to get the care of the elderly to interoperate better, in home health care, primary care, elderly care, the clinic, and in the hospital services.

2) A small group of patients with many diagnoses account for a quarter of all acute admissions to acute hospitals. Within a research-based development project, Stockholm County Council offers a Care coach to support and follow the most ill patients. The purpose of the healthcare coach system is to improve the quality of life and security of the most seriously ill and most care heavy patients. The care coaches are specially-trained nurses. They can support the patient to better understand their symptoms, their disease and its

treatment. The goal is to prevent deterioration of the disease and help patients with the right care at the right time. Only the most seriously ill patients are offered to participate in the project. Patients are selected after rigorous analysis in order to identify patients at risk of abandonment and deterioration that can be prevented if proper actions are placed in the right time. Today 10% of the patients in Sweden account for almost 80 percent of the cost of care. Out of these, one percent accounts for a quarter of all acute admissions. An initial assessment shows that patients who have a "vårdcoach" experience a higher quality of life and a better social and physical life.

3) The "Hip line" started in order to reduce unnecessary emergency waiting times. The patient is placed directly into a care unit after x-ray and determined diagnosis. This has proven to save costs. The method is developed by a care team, under the supervision of a nurse (Ami Hommel) whose Ph.D was about the method, see website below. Ami Hommel was awarded with "Salu-Ansvars award" (20000 euro) for the good results.

4) Systematic improvement work is made in a structured way in many places in the Swedish health care system today. It ranges from pharmaceutical inspection to time flows at a reception as well as nursing measures for various medical treatments. In Sweden, we have a national platform for the dissemination improvement knowledge (FBK), (http://www.lj.se/infopage.jsf?nodeId=39588). The platform is a forum and a meeting place that aims to establish improvement knowledge relevant to educations, to disseminate and develop knowledge on a national, regional and local level. Its member organisations all contribute to the building of networks. The national platform also acts as a driving force to develop improvement knowledge, not only on different levels but also between organisations, professions, academia, and healthcare activities. Examples of activities are: arrangement of workshops and meetings on different themes between practitioner educators, leaders and researchers, investigating the current status of the subject "improvement knowledge" in undergraduate education, further explorating the scientific and ideological underpinning of improvement knowledge in a Swedish context. The Platform has gained interest and engagement among patients, students, educators, clinicians, researchers and organisations with special interest in the area and can be described as a network of networks.

Outcomes:

1) The work of the national elderly care coordinator is too early in the process to measure any results yet. 2) The care coach has proved to be beneficial for both the economy and for the patient's wellbeing. 3) The "Hip line" has also proved to be beneficial financially as well as for the patient's wellbeing. 4) Improvement work has a positive impact on the patients, on the economy as well as on the working environment.

Published information:

1) National elderly care coordination, http://www.sweden.gov.se/sb/d/14471/a/185123
3) Summary of Ami Hommels doctoral thesis in English
http://www.lu.se/o.o.i.s?id=12588&postid=548642
4) Information about improvement knowledge on Qulturums webside
http://www.lj.se/infopage.jsf?nodeId=31736

SWITZERLAND

There are no cost-effective integrated care models at this time but a position paper on new roles for nurses and collaborations has been developed. There is also a political initiative on nurse prescribers which two committees in the European Parliament are supporting. The Swiss Nurses Association is also participating in different initiatives to develop integrated care while the Swiss Ministry of Health is working on an initiative on nurses' collaboration with doctors and new models in primary care. A report was published in February of this year.

UK

EXAMPLE NO.1

Name of the initiative:

Establishing a frail elderly assessment unit (FEAU) in University of North Staffordshire NHS Foundation Trust, England.

Level of involvement:

This integrated care model was submitted to the RCN through the Frontline First nursing innovation website. The RCN is a supporter of this initiative but has not been directly involved in its implementation.

Target groups:

Frail elderly patients who are admitted into the emergency department and often due to lack of adequate specialist services made to endure multiple patient transfers, long lengths of stay and delays in meeting with the appropriate specialist team or geriatrician.

Aim of the initiative:

The FEAU is a new approach to collaborative working practices between the acute and community trusts in order to provide a seamless specialist care service.

Brief description of the initiative:

The FEAU specialist team will screen elderly frail patients in the ambulance triage bay when they arrive in the emergency department and transfer them immediately to the unit to be thoroughly assessed by a multi-disciplinary team. The main aim is to deliver timely and appropriate transfers of care to either a specialist acute elderly care ward or an appropriate community setting/ specialist team. All patients accepted to this unit have an acute medical need. This initiative helps to encourage early decision making and ensures that the right team is put in place to care for these patients. This approach has helped to reduce unnecessary hospital admissions. At the time of assessment, a care plan is drawn up; estimated date for discharge is provided and follow-up care plans are delivered by a specialist team. Any patients who are assessed and do not have a medical need are reviewed and assessed by community nurse assessors or social care teams to expedite a rapid discharge to community care services within 24 hours of admission. In the past, these patients would have been admitted into acute trust care while waiting for a community service referral.

Outcomes:

At present there isn't any quantifiable cost-effectiveness or monetised evidence to demonstrate this initiative's return on investment, however there are anecdotal examples (staff and service users) to show that this frail elderly assessment unit has improved patient experience and quality of care; reduced hospital length of stay; avoided unnecessary hospital admissions; and encouraged direct admission to community services. Since the unit opened in 2010, there has been a drop in the length of stay across elderly care within the trust, from 28 days to approximately 14 days. The specialist team seek to return these frail elderly patients to their optimum functional capacity as soon as possible or to put the necessary support structures in place to facilitate this outcome.

Published information:

Nothing at this time.

EXAMPLE NO.2

Name of the initiative:

Single entry point into practice: adult integrated community mental health and social care team initiative at South Staffordshire and Shropshire NHS Foundation Trust, England.

Level of involvement:

The RCN is supportive of this initiative. This case study was featured in the RCN's briefing 'Community nursing: transforming health care' published in November 2011.

Target groups:

Adults with mental health problems living in the community.

Aim of the initiative:

To offer a range of health and social care services for adults with mental health problems.

Brief description of the initiative:

This integrated community mental health and social care team assists adults with chronic and debilitating mental health problems by providing a range of health and social care services. Service users are offered a choice of either seeing a doctor or a nurse prescriber or nurse-led clinics and service users work in partnership with the specialist team to develop their own care plans and pathways. The team works closely with other health organisations to provide high quality care, often taking referrals from GPs, health visitors, district nurses and local authorities. They also offer support and education for families and carers on how to care for patients suffering with schizophrenia. This team also receives referrals from midwives and health visitors with cases of newly delivered mothers suffering from post-natal depression or where safeguarding children issues are evident. The team also helps service

users to develop work related skills, for example, service users are encouraged to sit on the interview panel when recruiting new health professionals to the team.

Outcomes:

This initiative has helped to reduce clinic wait times and improve continuity of care. The team's specialist nursing roles have proven to be clinically cost-effective. Unfortunately, robust monetised evidence to demonstrate cost-effectiveness of this model is not available.

Published information:

This case study was featured in the RCN *Community Nursing: Transforming Health Care* briefing. http://www.rcn.org.uk/__data/assets/pdf_file/0010/415918/004165.pdf

FURTHER INFORMATION:

The Royal College of Nursing (RCN) Frontline First Innovation Award won by Dr. Marina Lupari in 2011 showcased a cost-effective model of chronic illness case management service for managing patients with long term conditions. The chronic illness case management service (CICM) was established with successful results and patient outcomes. For more information on the CICM model please see

http://www.rcn.org.uk/__data/assets/pdf_file/0009/319644/2010_RCN_research_6.3.1.pdf

http://www.rcn.org.uk/__data/assets/pdf_file/0011/389189/Frontline_First_award_-_3_finalists.pdf

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