ACT @ Scale

Telehealth and Care Coordination:
What we did right and what we did wrong?

Experiences on the collaborative methodology

Editor: Helen Schonenberg
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Preface

This brochure presents different aspects and lessons learned in the implementation and upscaling of health and care services, and how to further secure collaboration and knowledge transfer between different regions in Europe. The contents of this brochure are based on the presentations and discussions at an event hosted by ACT@Scale at the Week of Health and Innovation (WHINN) October 2017 in Odense, Denmark, entitled “Telehealth and Care Coordination: What we did right and what we did wrong?”. The event was a self critical reflection of the activities of the group and combined short presentations and discussion where the speakers shared their experience and learning on successful and less successful deployment of scaling up telehealth and care co-ordination. In this brochure we share our recommendations for doing telehealth and care coordination at scale.

The event was organised in collaboration with the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) and was also a result of a recently signed Memorandum of Understanding between the Scottish Digital Health and Care Institute and one of the ACT@Scale partners, the Region of Southern Denmark.

Background

ACT@Scale is an innovative partnership of leading European healthcare regions working with industry and academic partners that are committed to transform telehealth and care delivery services from pilots and experiments to services that are scaled up and integrated into routine care for the frail elderly and those with chronic conditions. The ACT@Scale project aims to develop, test and consolidate "best practice" in Care Coordination and Telehealth (CC & TH) so that the experiences of all participating healthcare regions can be leveraged by others so as to expedite the scaling-up of their services. The learning of the group is also intended to inform and assist other regions through Europe and beyond who are involved in scaling up their services.

The concepts of scaling-up of "best practice" used in ACT@Scale CC & TH is in line with the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) and the EC scaling-up strategy. The findings will facilitate decision-making at the EU policy level, and demonstrate to payers, practitioners and providers how patient care can be improved in the context of an ageing society and in the face of restricted budgets.

ACT@Scale targets integrated care in the Basque Country, Catalonia, Groningen, Northern Ireland and South Denmark. All these regions are in the process of implementing novel CC & TH processes at scale. The target groups are populations with chronic conditions and the elderly with special needs including social services, frailty and psychiatric morbidities.
A comprehensive assessment will be performed based on an agreed minimum dataset of indicators and with the support of a distributed Evaluation Engine. The ACT@Scale activity builds on the expertise and experiences of the previous ACT program and will use tried and tested collaborative methods and tools to implement improvements.

Foreword

Professor Stanton Newman
Vice-President, City, University of London

The work of participants in ACT@Scale demonstrates the noteworthy developments in telehealth and co-ordinated care in parts of Europe. One of the necessary requirements for significant development at scale in healthcare is political support along with the appropriate structures in healthcare. In England the development and progress of telehealth has slowed with the passing of the Health and Social Care Bill. Healthcare policy moved significantly away from a central direction with clear leadership to a fractured purchasing system led by approximately 200 clinical commissioning groups. This was coupled with significant reductions in the leadership from Civil servants who, in the Department of Health have been reduced by 49% since 2010.

Electronic patient records are a necessary requirement for co-ordinating care. In England the National Programme for Information Technology (NPfIT), launched in 2002 was shut down in 2011 after having mostly failed to achieve significant inroads into electronic patient records. Despite the fragmentation in the National Health Service (England) it is the one area that has received significant funding. It remains to be seen how integrated across areas the results of this funding will be.

What remains important in the attempt to achieve both better healthcare and reduced costs through digitisation is to recognise the time scales to achieve these. While clinical outcomes may be achieved after 2-3 years, it is the financial returns which will take significantly longer. Being able to take a long-term view of approximately 5 years for any financial return is necessary. To achieve this it will require politicians to negotiate widespread support as the time scale will, in most European countries, extends beyond any governments tenure. At its heart, scaling up telehealth requires political courage, wide agreement and leadership.

Collaborative Methodology

The collaborative approach is increasingly being used to carry out widespread improvements in care. This methodology requires multidisciplinary groups to come together periodically to exchange experiences and ideas about implementing change and quality improvements.

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

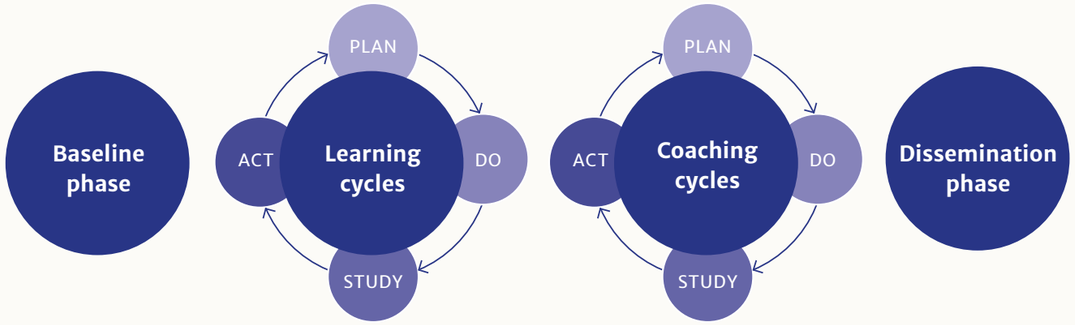
1. Topic selection
2. Purpose and expectations
3. Experts recruitment
4. Enrolment of participating teams
5. Learning sessions
6. Action periods
7. Measurement and evaluation

ACT@Scale applies multi-organisational structured collaborative quality improvement methods, adapts them to scaling-up integrated care, and shares knowledge. The key advantage of the collaborative methodology is that, by ensuring an adaptive and flexible collaborative model, it enables similar processes to be considered for all regions whilst at the same time enabling adaptation to the particular features of practice at the local level.

The starting point for the collaborative methodology in ACT@Scale is:

- Each region selects its good practices to scale up.
- Each region works on at least two drivers (key areas): (1) stakeholder management and change management; (2) optimization of recruitment-service selection and service adaptation; (3) sustainability and business case; and (4) citizen empowerment.
- At least two regions work on the same area during the timeframe of the project to facilitate collaborative work between regions.

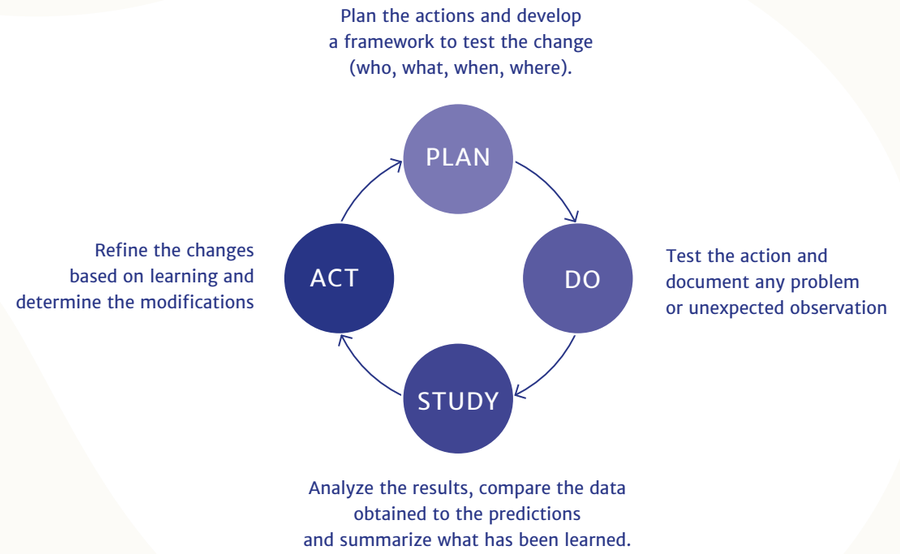
ACT@Scale applies the collaborative methodology in four project phases:



Regions focus on sustainable transformations by integrating the methods and the changes into routine practice. They identify achievable targets that have a direct correlation with the aim of scaling-up. They motivate and empower the team leaders, project managers, opinion leaders, clinicians, and other specialists. There are dedicated resources for data collection, analysis and interpretation. Every Plan-Do-study-Act (PDSA) PDSA stage is documented to ensure quality of information to facilitate organisational learning locally as well as transferability of learnings to other regions.

Baseline phase

During the baseline phase the multidisciplinary team is set up according to the areas selected on which the region will work to facilitate program up-scaling. Although teams can vary in size and composition, each region is required to include the relevant persons in the multidisciplinary group so as to ensure the success of the collaboration. During this phase, the team is required to define the following points: the key driver, the improvement area, the objective of the improvement, the changes to be implemented, and the indicators to monitor success of the changes applied.



Learning cycle

Key changes defined during the baseline phase are then implemented in cyclical iterations, based on the PDSA framework. The learning cycle is the first iteration. The lessons learned will be shared in the collaborative.

Coaching cycle

The lessons learned about the drivers of improved changes of the first PDSA cycle serve as a basis for the second PDSA cycle, which is performed during the coaching period.

Dissemination phase

During the final phase of the project, specific activities on dissemination and knowledge transferability will be carried out at the consortium meetings and other local and international meetings.

Basque Country

CHF Telemonitoring

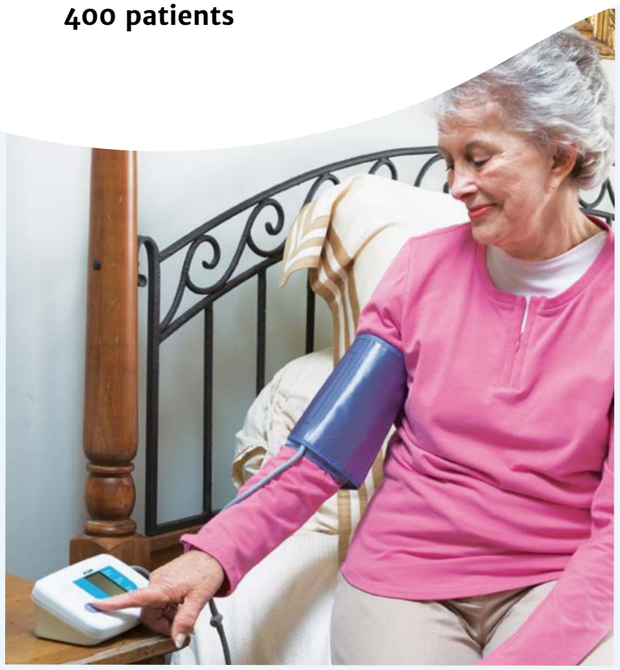
Cluster: Chronic - Cardiac
Target group: Heart Failure patients

Partly due to an ageing population, chronic heart failure (CHF) is becoming more common. It will become increasingly difficult to maintain the quality of care given the general constraint on health finances in most countries. Home telemonitoring is a promising solution to this increase in demand. It has the potential to allowing healthcare professionals to follow up a patient's health status more closely and facilitate early symptom detection. Patients transmit their parameters at least once per week by means of the telemonitoring devices that send the data to the gateway in the patient's home. The data is then transmitted to the Telecare Centre, where the operator checks the data. When clinical parameters are out of range, the operator verifies the alarm by a phone call to the patient.

The Telecare Centre also resolves any technical problems arising in the use of devices. The numbers of patients included in the program to date is 241 and the aim within the ACT@Scale programme is to reach 400.

Current coverage:
220 patients

Aim to scale to:
400 patients



The use of telemonitoring in congestive heart failure s is not without controversy as there is no clear evidence of its benefits. Some healthcare professionals therefore prefer to remotely monitor patients with less sophisticated equipment and procedures such as regular phone calls, filling questionnaires or dedicated nursing. The scaling-up of this program has been delayed due to technical reasons and, currently, only one integrated care organization is actively deploying telemonitoring. Positive results of a Basque telemonitoring experience have been widely disseminated to get more professionals to support the programme. During the programme, the technological platform used by the professionals to follow up patient's vital signs has been completely re-designed resulting in a very user-friendly and easy-to-use tool.

Topic
Purpose
Experts
Team
Learning
Action periods
Evaluation

Lessons learned

Tip 1:

'Select a program with convincing evidence.'

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

Transfer to another setting:

- Search the literature for evidence from a trusted source, that has good methodology and has been performed in a similar setting (e.g. geographical, private / public system) to convince professionals and specialists.
- Create a smoother, more efficient workflow, supported by user-friendly tools to engage the staff.
- Integrate the new way of working in the day-to-day practice, otherwise it will not be sustainable.
- Inform patients what they will gain from the initiative and ensure it is supported by user-friendly tools.

"The program needs to be supported by sound knowledge and positive results demonstrated in real-world settings."

Southern Denmark

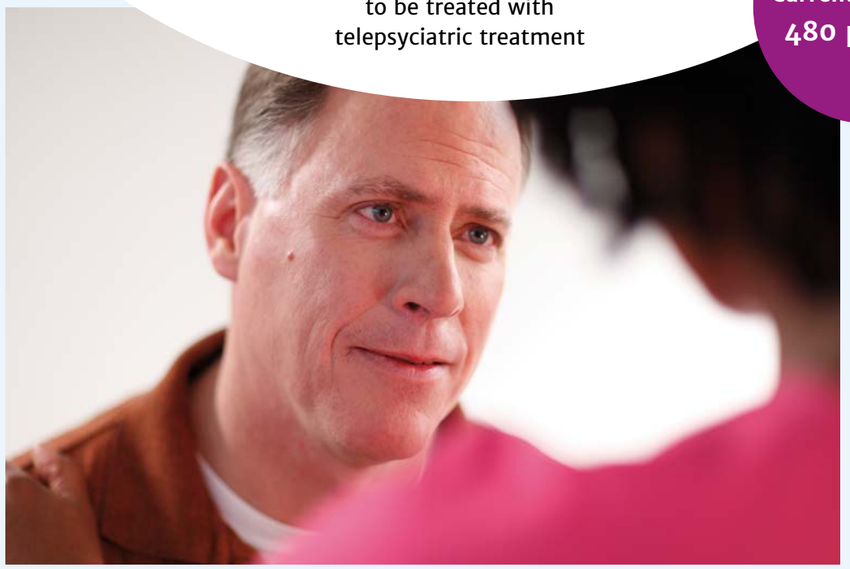
Tele psychiatry

Cluster: Mental Health
Target group: Citizens eligible for telepsychiatric treatment

The Region of Southern Denmark (RSD) has a Health Agreement with its 22 municipalities that focuses on cross-sector treatment involving access to telehealth solutions. It states that emphasis should be placed on citizens in need of psychiatric treatment regardless of their social status. The Centre for Telepsychiatry at the psychiatric department in Odense is an example of how the Health Agreement is implemented in day-to-day practice. The Centre has a number of projects in the field of telepsychiatry, i.e. the delivery of psychiatric treatment and expertise at a distance. These include telemedical treatment, telecommunication between the patient, the GP and the psychiatric hospital, as well as between doctors. A joint competence centre is being developed via which knowledge can be shared. Telepsychiatry has been shown to contribute to improved patient adherence without compromising quality of care.
Technology such as video conferencing, iPads, 'The Care Phone', internet-based treatment and patient apps, enable more targeted and flexible treatment. In ACT@Scale, the Region of Southern Denmark will focus on upscaling telehealth treatment for psychiatric patients. This is a priority for the region and by 2019 around 2,000 people will have been offered telepsychiatric treatment.

Aim to scale to:
2.000 citizens
to be treated with
telepsyciatric treatment

Current coverage:
480 patients



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

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Lessons learned

Tip 2:

'The maturity level of the service and management engagement are key.'

The service and the organization have to be at a certain maturity level to engage in successful implementation of the collaborative methodology.

Transfer to another setting:

- You need organizational acceptance to apply the collaborative methodology along with management support, and you need the people involved to agree to use the methodology.
- The service should be mature enough with studies showing supportive evidence for the service.
- The service should not be too mature such that there is little or no room for change. Staff and management should feel that change can be achieved.

"People loose faith if you're always changing the technology."

Basque Country

Multimorbid Integration

Cluster: Chronic - Multimorbid
Target group: Complex multimorbid patients

This multimorbid program has been developed by a multidisciplinary team formed by primary healthcare professionals, specialists, and managers with expertise in the design and development of new pathways to care for older people with complex health and social care needs. These people are at high risk of hospital or care home admission.

This is achieved through Information and Communication Technology (ICT) enabled health and social care service coordination, monitoring, care involvement, and patient self-management. ICT-based platforms have the potential to improve treatment compliance; enhance self-management, and increase patient and healthcare professionals understanding. The program is designed to improve clinical outcomes and enable people to lead more fulfilled lives. The program aims to provide multimorbid patients with integrated care facilitated by distinct ICT solutions. The program is in place in 4 Integrate Care Organizations (ICOs).

Current coverage:
4944 patients

Aim to scale to:
18.000 patients

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

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Lessons learned

Tip 3:

'Be effective in running the collaborative meetings'.

The collaborative meetings have to be chaired by experts in improvement methods and group dynamics to ensure motivation of the participants and the best use of their knowledge and time.

Transfer to another setting:

- You need someone that is capable of leading a good group discussion and make the interaction in the multidisciplinary teams proactive, creative, constructive.
- A facilitator will need to create space for critical feedback; it should be an expert in the methodology being applied as well as in group dynamics.
- This person will need to have adequate time to prepare for the meetings, and in the meeting offer points of discussion, create the right atmosphere and bring together and summarise what has been said at the meetings.

"Use facilitators to organize and lead effective collaborative meetings."

Northern Netherlands

Asthma / COPD

Cluster: Chronic - Respiratory
Target group: Patients suffering from asthma and / or COPD

In order to improve daily clinical practice in the diagnosis and management of patients that are suspected to have or do have asthma or COPD, the Groningen Research Institute for Asthma and COPD (GRIAC) in cooperation with the primary care laboratory Certe, the pulmonary department of the Delfzicht hospital and local general practitioners have developed and tested a structured diagnostic and management system for patients with respiratory problems. This diagnostic model, called the Asthma/COPD (AC) telehealth service, has been implemented since 2007 in the northern part of the Netherlands. This telehealth management support service assists GPs by examining patients and providing detailed advice from pulmonologists. To date, over 17.000 patients in more than 50 general practitioner offices have been recruited. Following the implementation of the AC telehealth service, significant improvements in patient reported outcomes measures (PROMs) have been found. For example, an evaluation of the feasibility and effectiveness of the program with 11,104 patients, revealed significant reductions in the number of exacerbations and decreased numbers with unstable COPD or uncontrolled asthma.

Aim to scale to:
30.000 patients

Current coverage:
17.000 patients

With the right information at the right time at the GP office, exacerbations can be avoided. Innovative programs have been developed to achieve this. While new generation of GPs have been exposed to innovations in healthcare in their training, when they start their own practice, they often need to convince some colleagues and other stakeholders and indicate the overall vision being provided by government. The GPs and pulmonologists don't feel ownership and as a result transfer of this program to other settings might not be straightforward as ambassadors may not be easily identified. This was found to be the case in the Rotterdam area .

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Lessons learned

Tip 4:

'Make sure you have sufficient ambassadors to promote the program.'

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

Transfer to another setting:

- GPs need to be supported by an overall integrated care vision.
- Ensure a well-developed training program for making an accurate diagnosis is in place. Reduce the burden on primary care by taking over the initial diagnosis of suspected asthma and COPD patients.
- GP and pulmonologist need to be rewarded to feel ownership of any programme being introduced.

"Inclusion of ambassadors is a recipe for successful implementation."

Catalonia

Chronic Care

Cluster: Chronic
Target group: Complex chronic and frail patients

Badalona Serveis Assistencials (BSA) is an integrated private care organisation, entirely funded by public capital. It manages the Hospital Municipal de Badalona, the Homecare Integrated Service, the Socio Health Centre El Carme, seven Primary Care Centres and the Centre for Sexual and Reproductive Health, providing care to a population of 419,797 inhabitants. Social services provision started in 2000 and full integration of health and social services has been in place since 2003.

Its objective is to focus on identifying, preventing and treating in advance acute episodes to avoid further hospitalisations; design and implement individual integrated care plans based on the evaluation of needs and a general geriatric evaluation; promote independent living while maintaining good quality of life; and coordination of the work of the interdisciplinary teams doing the interventions.

Current coverage:
445 patients

Aim to scale to:
800 patients

The aim of the BSA program is to build an urban age-friendly city. It is an integrated approach to citizen-centered innovation that covers the service provision for an ageing population with an increasing number of elderly and complex chronic individuals. There is vertical integration of the healthcare services (hospital, specialized care, primary care, social care) and horizontal integration of various health services, social services, housing, employment, and culture & leisure services. In the vertical integration it was a priority to include the GPs on board as gatekeeper. In Badalona it proved possible to organize all services under one umbrella organization.

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Lessons learned

Tip 5:

'Build a collaborative team representative of all stakeholders'.

The multidisciplinary team has to be formed of representatives of all the stakeholders relevant for the intervention to be implemented.

Transfer to another setting:

- Use participatory design to involve the right stakeholders from all levels at the beginning of the programme to address their particular needs and ensure acceptance of the programme.
- Plan the implementation with all stakeholders, gain agreement on what needs to be done, when and how. Maintain their involvement and motivation by keeping them engaged.
- A major stakeholder is the patient. You can't guarantee implementation if the patient isn't willing to join. Don't assume they understand your proposition at the outset.
- Share results and ask for input from all levels of the organizations.

"Involve all stakeholders to create a sense of belonging."

Catalonia

Physical Activity

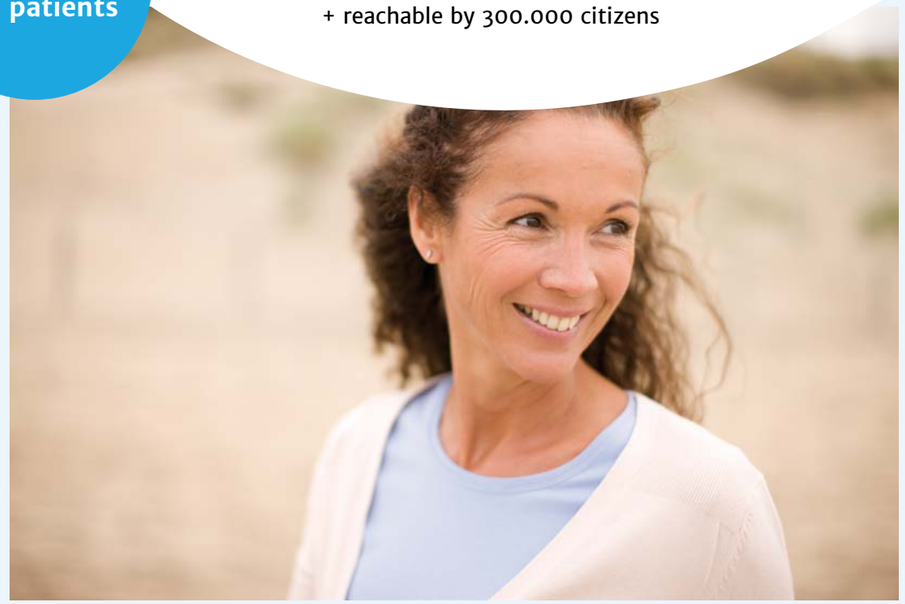
Cluster: Chronic
Target group: Chronic patients in need of physical activity

This is a community-based service to promote physical activity (PA) in the healthcare sector of Barcelona-Esquerra (AISBE). It has shown that tailored self-management programs with remote professional support can lead to behavioural changes that are sustained over time leading to healthier life styles. The program covers the following items: (1) workflow design of the PA service to engage both patients and health professionals; (2) definition and development of ICT requirements; (3) development of an evaluation strategy based on PDSA iterative cycles including collection of structured indicators; and (4) deployment of the novel service in the healthcare sector including innovative reimbursement incentives.

The goals of this novel PA service are twofold: (1) to generate sustained enhancement of PA with an impact on health-related quality of life in those with chronic conditions; and (2) to have a cost-effective impact on multi-morbidities by preventing re-occurrence. The outcome will constitute a roadmap to assess novel collaborative self-management PA services in an urban health sector of Barcelona (300,000 citizens).

Current coverage:
250 patients

Aim to scale to:
10.000 active citizens
+ reachable by 300.000 citizens



The Prehabilitation program has been deployed, as planned, in a local context. Program efficacy has been demonstrated in a recent RCT. Moreover, we have identified high potential for cost-effectiveness as well as potential to develop a peri-surgical care program. New strategies are necessary to implement this program in Catalonia. Full maturity of the service should be achieved through: (1) evaluation of the prehabilitation unit at the Hospital Clínic in Barcelona; (2) development of an ICT platform integrated with current healthcare providers, and (3) refinement of the business service workflow. The latter has been done in three workshops: refining the service design, redefining regional extension, and identification of business models to provide sustainability.*

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Lessons learned

Tip 6:

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

The priorities and strategies of implementation process should be adapted to support organizational change, ICT development and for a clear business model.

Transfer to another setting:

- Use the collaborative methodology to clearly define the objectives, what to scale, what adaptations to the service are required, and ensure you address organizational changes necessary.
- You need a framework for rapid improvement, using the collaborative methodology will enable a way to do it in small iterations and keep progressing.
- You need a clear evaluation to decide if your project was a success or not.

"Even if you have evidence in a concrete setting, in scaling you face (organizational) challenges you were not expecting."

Northern Netherlands

Effective Cardio

Cluster: Chronic - Cardiac
Target group: Complex Heart Failure patients

Chronic Heart failure (CHF) Programs in the Netherlands demonstrated that optimizing the care pathway integrated with telehealth in 6 hospitals as reported in 2014, results in 52% fewer total hospital admissions, 57% fewer total hospital days and more than $213K Euro savings in costs as reflected in reductions in claims to insurance company*.

The Effective Cardio program has continued to expand at the Scheper hospital in Emmen, setting the standard in optimizing care delivery for CHF using telehealth. A clinical hub it is promoting the scaling up of services to other locations and conditions, integrating technology into the care pathway and not as an add-on component. The technology supports self-care and remote management in order to respond quickly to exacerbations, by treating and managing patients out of hospital and in the home setting as much as possible.

Current coverage:
200 patients

Aim to scale to:
300 patients
+ extension to primary care

*Effective Cardio, The Path to Long-Term Heart Failure Care: A practical study of the optimization of the chronic heart failure care path using telemonitoring.
November 2014 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4446277/

Nurse practitioners remotely monitor vital signs and have been given extended responsibilities for patient management, such as changing medications, only referring for specialist consultation in case of emergencies. This way the care professionals can manage large numbers of patients remotely in a fraction of the time which would otherwise have been spent in face-to-face meetings. The program has been deployed at a relatively small scale and has demonstrated positive results. However, the current financial models underlying the Dutch healthcare system will have to change to provide secondary care with compelling incentives to foster large-scale implementation.

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Lessons learned

Tip 7:

'Implement the program into the existing care model using substitution of pathway elements.'

An innovative program should substitute current care pathway elements such as the scheduled outpatient clinic visits, thereby truly transforming healthcare practice from an existing base.

Transfer to another setting:

- Make sure people at all levels of the organization are willing to change and integrate the innovation.
- Create ownership among healthcare professionals; ensure they believe that this is the way forward.
- Make a manager and/or a leading organization responsible for the programme.
- Develop a convincing business case.

"Substitution of care is an important prerequisite for successful implementation."

Northern Netherlands

Embrace

Cluster: Elderly care
Target group: Citizens above the age of 75

The Embrace program aims to deliver demand orientated, preventive and proactive care to elderly people living at home. They will be supported by an elderly care team consisting of a general practitioner, elderly care physician and district nurse. Depending on the level of frailty, customized management plans are developed in co-creation with the elderly person and supported by a multidisciplinary team. Developing an integrated elderly care model from the perspective of the end-user is an important factor for successful implementation. The needs of older adults can be best met by creating an elderly care team consisting of a general practitioner, district nurse and elderly care physician, and other professionals.

Current coverage:
150 patients

Aim to scale to:

5000 older adults in 50 GP offices

with 100 elderly participants per office across multiple regions

The early results of the program show reduction of healthcare problems and high satisfaction among participants. Taking a long-term perspective, the overall outcomes for older adults in terms of quality of care, care consumption and costs are positive. Older adults that receive support from an elderly care team appear to benefit from such an approach. A published business case indicates the potential to reduce annual healthcare costs per older adult by up to 274 euros. However, the cost-effectiveness of the program has yet to be demonstrated and is currently hindered by fragmentation of funding sources and a focus on delivering short-term results.

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Tip 8:

'Make use of proven care models such as the chronic care model.'

Install a multidisciplinary team of professionals, led by the GP, around the needs of elderly living at home, based on frailty level to decrease complexity of care needs, increase well-being and potentially reduce overall healthcare costs.

Transfer to another setting:

- Although most people may believe the program can reduce long term care needs, increase participants safety and lead to improved quality of live, it is also important to show cost reductions. The evaluation period of 1 year was too short to demonstrate financial reductions.
- One challenge is to find sustainable payment system for integrated care. In the Netherlands the payments for care are fragmented. The current financial system is not appropriate and it will be necessary to get all payers and providers to agree a new model.
- Capitation and fee for service do not support the scaling-up of integrated care programs. More appropriate is a lump sum payment.

"It's all about money."

Epilogue

Other leading healthcare regions and programs were invited to the event to share their experiences and lessons learned. We conclude this brochure by presenting a compilation of the guest presentations.

Marketing

Chris Wright, NHS 24 Service Development Manager

Communication is a vital element of any project or service implementation process. Marketing is coordinated communication and the single most important task in the development and successful implementation of a service or project. Marketing should be considered a long-term aspiration. It starts early and continues during the full lifespan of the implementation process; from service design, to implementation, to improvement, to sustainability.

"The wider the communication spread, the more knowledge of the project, the greater the impact."

Marketing strategy tips:

- Early engage senior staff members (e.g. senior clinicians, policy makers) who have the right level of influence to create long-term sustainability.
- Develop a key message that includes strong clinical evidence, responds to patient's needs, ease of access, research data, and national targets, agenda and strategies. Ensure everyone involved in the service understands this message and is able to communicate it.
- Vary what and how you are delivering in the key message, while maintaining clarity of what you are trying to achieve, using multiple contacts points (newsletters, advertisement, face to face, presentations, ...)
- Marketing strategies were a key success factor in the MasterMind project.

One of the biggest issues, in particular when engaging with GPs is confusion about the process and what the service does, because they have many services they can refer to. Marketing has helped to ensure the service matched the expectations and referrers continued to refer at increased levels. This generated goodwill and belief in the service and word of mouth recommendations between GPs.

Create a story telling umbrella to deliver the key message

Develop a story telling umbrella that covers the full strategy inside and outside the organization. Identify a reason why innovation is needed; identify a key challenge that creates the need to move forward.

Jordi Piera, Chief Information and R&D Officer

Have evidence from the data to support your story

Tell the right story. Be careful when you defend your project or define it as success; there should be substance and evidence from the data. Select your drivers with care. Be honest, be open, get criticism, learn and move on.

Jakob Uffelmann, Chief of Innovation at Sundhed.dk

Evaluate by defining what you expect, but don't set the target too soon or raise the expectations too high, or else you will fail. AGILE approaches usually work on short-term value and are difficult to apply in this setting.

Peter Julius, Founding Partner in Public Intelligence

One size does not fit all. You cannot standardize information exchange while the market is changing so fast. Do not try to standardize everything, it won't work. If you want to have the data, you need to manage the diversity.

Jakob Uffelmann, Chief of Innovation at Sundhed.dk

Manage all stakeholders

Identify and involve your decision makers, you need them on board to make organizational change happen as well as changes in workload and changes in funding. You need a sustainable solution that does not solely rely on clinical champions. EU project funding help.

Dr. Esteban de Manuel Keenoy, Director at Kronikgune

Ownership is often unclear. It is not the citizen, but is it the supplier, the municipality, the hospital, or the GP? Try to get the municipality and healthcare representatives talking together. This is not easy and may take several years.

Peter Julius, Founding Partner in Public Intelligence

Join us?

Engage with us as collaborating partner

We invite you to join us to get a platform to enlarge your visibility at international level to engage political and/or industrial support. You can learn from other's good practices and experiences and collaborate with other sites working on service re-design and validation of innovative care services and expanding their services to larger population without any additional investment

There are two ways to engage with us as collaborating partner.

- As an observer site you have access to our programme results and you can participate in our project meetings.
- As an evaluation site you have the additional benefits of having access to the ACT evaluation engine and you can fully participate in the evaluation process and best practice selection, to get evidence and benchmarking of your solution under the review of key international experts.

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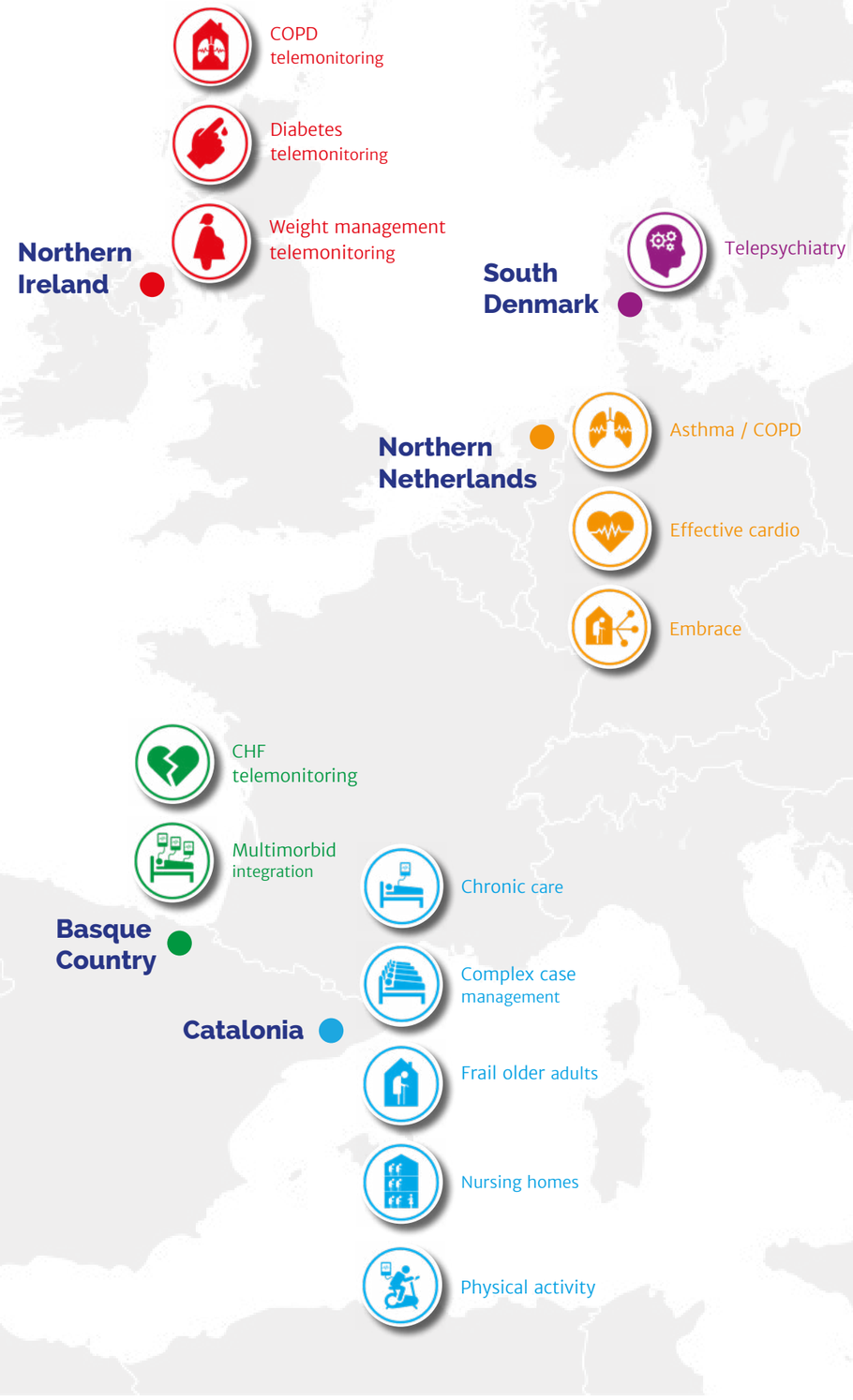
Programs



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https://www.act-at-scale.eu

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European Innovation Partnership on Active and Healthy Ageing