EHTEL
EUROPEAN HEALTH TELEMATICS ASSOCIATION

Match-Making Workshop
Encourages Twinning and Coaching:
A Spinoff of the EHTEL Symposium

Organised in conjunction with the WE4AHA coordination and support action, the Reference Sites Coordination Network, and the SCIROCCO project.

Meeting held at the EU Office of the Campania Region of Italy in Brussels.

Rapporteurs: Diane Whitehouse, Marc Lange and Stephan Schug (EHTEL).

BLUEPRINT
DIGITAL TRANSFORMATION OF HEALTHCARE FOR THE AGEING SOCIETY

EIP ON AHA
RSCN

Scirocco
Scaling Integrated Care in Context

WE4AHA

The WE4AHA project has received funding from the European Union's Horizon 2020 research and innovation programme under Grant Agreement No. 769705. SCIROCCO has been co-funded by the Health Programme of the European Union under Grant Agreement No.: 710033 (CHAFEA)

EHTEL Association,
Avenue de Tervuren, 168, box 2, 1150, Brussels, Belgium Tel: +32 (0)2 230 15 30 - Fax: +32 (0)2 230 84 40 www.ehtel.eu

Table of Contents

EHTEL Symposium Spinoff Match-Making Workshop Encourages Twinning and Coaching . 1

Overview 3

Next steps for potential collaboration/partnership-building 5

A set of take-aways 6

Useful information 6

ANNEXES 7

Annex 1: Template for write-up of the successful digital service and possibilities for collaboration/partnership-building 7

Annex 2: Removal of inhibitors 8

Annex 3: Information and eHealth Services 9

Annex 4: Evaluation 10

Annex 5: Citizen Empowerment 12

Annex 6: Structure and governance 13

Annex 7: Integration of health and care records 14

Overview

On Wednesday **5 December 2018**, a spinoff workshop to the **2018 EHTEL** Symposium was hosted at the **EU Office of the Campania Region of Italy** in Brussels.[1]

This match-making event was geared to health care managers who are modernising their health care systems.

Maddalena Illario, Co-Chair of the Reference Sites Coordination Network, reflected:

> "*This is a great way to learn how regions and countries can explore together the kinds of digital health and care services people need. The tools used today can reveal really important synergies and similarities.*"

The **three-part workshop** took a look at: what people's digital health needs are, good practices in example regions, and the support offered by the SCIROCCO tool. **Thirty people from 18 countries** attended – they worked in groups to investigate a number of exciting experiences of integrated care.

The workshop was organised in three parts:

- Modelling Citizens and Patients Needs for Digital Services by using the **European Innovation Partnership on Active and Healthy Ageing (EIPonAHA) Blueprint** "**Personas"**.[2]
- Sharing **Field Experiences** in Deploying Digital Services with **Andalucía (Spain); Puglia (Italy);** and **Turkey**.
- Identifying interest in **Twinning and Coaching** on Conditions for Successful Deployments by using the SCIROCCO tool.[3]

M1[4]: The morning session started with an introduction to a set of **personas**. The personas covered examples of people of different ages and diverse phases of the life-course who have varied – mainly chronic – conditions, and who live in a range of socio-economic and geographic settings.

Examining personas like this helps to start discussions among stakeholders . As a result, health care managers – for example – are able to **understand people's unmet needs** and to **describe together the kinds of potential scenarios** that people in their local population might face. It is anticipated that the scenarios described will permit the formulation of **innovative (digital) services** that will respond to **people's health, care, and other social needs**.

---

[1] Much briefer versions of this report have been published as short articles in various settings: the Reference Sites Coordination Network December 2018 newsletter: https://ec.europa.eu/eip/ageing/news/rscn-newsletter-december-2018-issue_en; the PROGRESSIVE Winter 2018 newsletter: https://progressivestandards.org/newsletters/ and is anticipated on the SCIROCCO project website news and events section: https://www.scirocco-project.eu.

[2] The personas were designed with the objective of identifying high impact scenarios for the Blueprint, an initiative which supports the European Commission's work on digital transformation of health and care. The personas have been created by the Blueprint team of the EIP on AHA. All 12 of these recently-designed personas are now online on the EIPonAHA website. Understanding the personas, and their implications, will lead to the next step of work by the Blueprint being accomplished: this is the design of a set of user scenarios. See: https://ec.europa.eu/eip/ageing/blueprint_en

[3] https://www.scirocco-project.eu.

[4] The classification, M1, M2, and M3, relates to the allotment to the sessions given in the original workshop agenda.

Three main types of personas were explored:

- **Healthy personas:** These personas are societally active. In some cases, they need lifestyle support to continue to be empowered, remain healthy, and become either or both digitally literate and health literate.
- **Chronic personas**: These personas are often on the look-out for support for their self-management of health, care, and other conditions.
- **Personas with complex needs**: These personas often need support to encourage their adherence to complex treatments and maintain a good quality of life. An associated objective is to lower any stress placed on their caregivers.

Digital solutions are certainly needed in these circumstances. However, solving these challenges is not only about finding appropriate technologies that will match the needs of the personas but also about providing them with suitably **innovative services and care processes**.

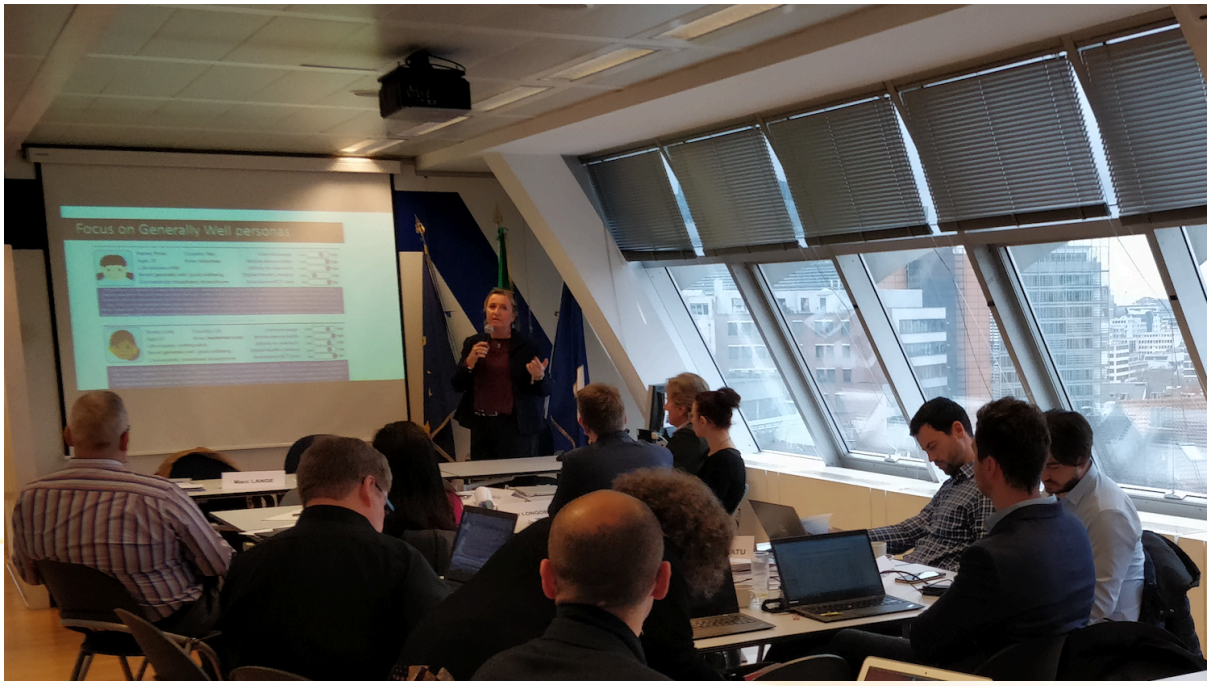

Photo: Maddalena Illario launches the workshop with an overview of digital personas

M2: The workshop attendees were introduced, in a structured way, to **three examples of digital services** that have been deployed "in the field" and at scale. As a result, the attendees learned about some example services that have been actually deployed, for whom, and with what objectives. The three examples were: **Hospital@Home**; an **eHealth strategy and system**; and a **personal health record**. Details about each of the three presentations follow:

- **Hospital@Home (Puglia, Italy)**
  - Enables "protected discharge" procedures for frail but stable patients.
  - Includes bed-based devices (an electrocardiogram; devices for blood pressure; and temperature measurement).
  - Is monitored by a control room in a hospital.
  - Has the objective of lowering all patients' risk of infection.
  - Has been piloted with 61 patients.

    - Involves no major organisational changes in the care model (at either regional or hospital levels).
    - Involves a single supplier.
- **E-Nabiz Personal Health Record (Turkey)**
    - Involves generic data sharing.
    - Involves the sharing of data under a patient's control.
- **Diraya Integrated care (Andalucía, Spain)**
    - Is the corporate electronic health record system of the Andalucían Public Healthcare System.
    - Integrates all the healthcare information of each patient, from all health care levels: primary health care, hospital, outpatient clinic, emergency department, private pharmacy in the region (the e-prescription module) and is accessible for patients through secure web access via ClicSalud+.
    - Is based on a single health record number for each patient, and includes e-prescription, e-dispensation, images, laboratory tests, and appointments.
    - Is also connected to telemedicine services (e.g., tele-dermatology) and mHealth services.

M3: Attendees worked with the three Reference Site presenters to examine what are the **main conditions** that made the **deployment at scale successful** in the three regions.

To understand the fundamentals of the sites and the applications, the attendees used **SCIROCCO Maturity Model**.[5] This Model is now a proven methodology and, more than that, an online tool. It was originally developed by the B3 Action Group for Integrated Care of the EIPonAHA. It has now been transformed into an online tool by the SCIROCCO project.

The attendees explored together **seven** out of the 12 **specific dimensions** of the SCIROCCO tool: evaluation methods; information and eHealth services; innovation management; population approach; removal of inhibitors; standardisation and simplification; structure and governance. Five dimensions were analysed in detail by the attendees (see ANNEX).

Next steps for potential collaboration/partnership-building

The attendees agreed that it would be **good for "*the regions that are at a point of rolling out shared health and care records for citizens/patients*" to work together and collaborate**, so as to be able to understand their commonalities.

A two-step process could be considered:

- The Reference Sites were keen to see the **relevant good practices entered in the "EIP on AHA Repository of Innovative Practices"**[6] in order that some regions could consider **"study visits" (twinning and coaching) about shared health and care records**.
- Other attendees present were keen to see **a more concrete set of activities** e.g., perhaps **a shared project or a shared initiative**.

[5] https://www.scirocco-project.eu
[6] https://ec.europa.eu/eip/ageing/repository

All attendees showed a keen willingness to:

- **Work together**.
- **Bring together groups of people/sites** that have tested or trialled approaches to shared health and care records to collaborate.
- Focus on **a single dimension/good practice**.

A set of take-aways

Overall, the conclusions of the match-making meeting were as follows:

Attendees benefitted from a**n exchange of mutual knowledge** about what elements of field experiences would benefit from their collaboration. They spotted some **good opportunities** to partner with others on integrated care-related activities, that will particularly involve **twinning and coaching**.

Many attendees were keen to explore how **health care and social care records** can be shared among a wide range of stakeholders.

Concretely, discussion of the **SCIROCCO dimension of shared governance** led to statements being made about several needs. These include the need for: appropriate **innovative practices** to be entered on the EIPonAHA Repository[7]; **twinning and coaching schemes** to be explored; and **a concrete exploration of how to share health and care records** among a suitable range of countries and/or regions, including how **interoperable** they are and in what **languages** they need to be displayed.

Useful information

For related information on the tools used and useful background, see:

Blueprint: https://ec.europa.eu/eip/ageing/blueprint_en

Personas: https://ec.europa.eu/eip/ageing/library_en

Reference Sites: https://ec.europa.eu/eip/ageing/reference-sites_en

SCIROCCO: https://www.scirocco-project.eu

[7] https://ec.europa.eu/eip/ageing/repository

ANNEXES

Annex 1: Template for write-up of the successful digital service and possibilities for collaboration/partnership-building

1) What were the **3 domains** and **key features** for the **adoption of digital service** that were discussed in your group?

2) Summarise the **compatibility of features** for the adoption of digital services with **local settings** in **different health and social care** environments, i.e.,:

2a) Were the **features generally recognised** in other regions/organisations?

2b) Were there any particular **features which would be difficult to transfer**?

3) Highlight any potential features of a digital service which can provide **a basis for further collaboration and partnership-building**.

Annex 2: Removal of inhibitors

"Removal of inhibitors" is one of the 12 dimensions of the SCIROCCO model.

The removal of inhibitors was a key feature in the **Hospital@Home** use case.

The use case was scored with a '5', because **no change was required in daily routine**. However, there was the need for **a communication campaign** to create a **change in culture**, i.e., to explain to patients and health professionals that the new system was good for patients and that it provided better care to patients without adding more risks.

There were **no financial inhibitors**, since the regional budget covers a combination of caring for both in-patients and out-patients.

Because of the **existence of a control room**, safety and liability issues were not a blocking factor.

A few other elements – about **facilitating measures** – emerged from the exploration of this dimension of the SCIROCCO model:

- As a predecessor development, the **successful deployment of tele-cardiology** helped to facilitate the adoption of the Hospital@Home venture.

Other comments/questions raised by attendees involved various facts and possibilities:

- An innovation like this one helps hospitals to **reach quality targets faster**.
- Some kind of **"legislation"** should recognise/endorse this innovative service.
- It is possible that this innovation **could be less risky** when it is use with/introduced with **patients who are not frail**.
- It is possible that, having only on single supplier of the service, could limit its extension when attempting to scale up the service further.

Annex 3: Information and eHealth Services

"Information and eHealth Services" is one of the 12 dimensions of the SCIROCCO model.

In relation to information and eHealth services, short notes were made on two of the use cases presented, that of **Diraya Integrated Care** and of **E-Nabiz**.

Diraya Integrated Care scored a '5' on information and eHealth services, because **all primary care services are connected**, although stakeholders' views about this connectivity may differ between the general practitioner, nurses, and specialists.

A few other elements emerged from the conversation:

- As a **central electronic health record for all services** (i.e., integrated care):
  - The **objective** is to **offer the same core information to all**, but not necessarily to give all the information to all. (It is considered that a decentralised infrastructure would be less successful.)
  - In order to obtain access to their own data, **patients have encouraged doctors to use the service** (the same kind of "push" has occurred in Maccabi [Israel]).
- **Citizens' trust in the system is high**. (Diraya has a long and positive history of eHealth, which started with the roll-out of ePrescriptions more than 10 years ago.)

E-Nabiz Personal Health Record scored a'5' on this dimension because today many (160) hospitals in Turkey have reached EMRAM stage 6[8]. The system was a World Summit Award winner in 2016, in the Mobile category[9].

A few other elements emerged from the conversation about this dimension:

- Electronic health records/personal health records became **a political objective some years ago in Turkey**. (An eHealth Directorate has been created in the Turkish Ministry of Health.)
- **eHealth is indispensable** for coping with the increased workload of the healthcare system.
- The personal health record **supports chronic disease management and self-management**.

The conclusions of this discussion was that ***"the eHealth infrastructure is there, but what comes next?"***

- In **Andalucía**: It is about **connecting the community**.
- In **Turkey**: It is about **deploying telemonitoring** and other telemedicine solutions.

[8] https://www.himss.eu/healthcare-providers/emram
[9] https://www.worldsummitawards.org/winner/turkish-national-personal-health-record-system-e-pulse/

Annex 4: Evaluation

"Evaluation" is one of the 12 dimensions of the SCIROCCO model.

In relation to evaluation, two Reference Sites, **Puglia** and **Turkey**, presented their use cases.

Hospital@Home (Puglia, Italy)

Today, a systemic evaluation system is in place in Puglia. Historically, Puglia has emphasised the **importance of evaluation** since, in the past, there were problems with the quality and the costs of healthcare. It was observed that – while high funds were invested – health care was of low quality, indicating that the use of resources was inefficient. Since that time-period, a thorough evaluation system has been established that has supported by investments. The resulting evaluation system has been improved continuously over time.

The evaluation system is supported by **a dedicated department in the health administration**. It has the following tasks:

- Delivery stratification.
- Health impact.
- Funds.
- Benchmarking against other regions.[10]

Evaluation results are published regularly: Puglia understands this is a means to safeguard transparency and trust.

E-Nabiz Personal Health Record (Turkey)

Like Puglia, Turkey has set up **a dedicated evaluation department**. Evaluation in healthcare is one of the tasks of the **Evaluation Ministry**, which is responsible for evaluation tasks related to the whole government.

Evaluation tasks and performance in Turkey include:

- Health Technology Assessment (HTA).
- Publication of annual results.

Some evaluations suffer from the fact that **official statistics are published only once a year** retrospectively. Moreover, the officially published parameters are limited.

- There is no access to data needed for any form of short-term evaluation in the current year.
- Scientific publications usually limit themselves to official statistics. In this way, authors avoid having to send additional inquiries to Evaluation Ministry to obtain customised data.

Round table dialogue on evaluation

The Region of **Campania** introduced briefly some facts on evaluation in its area:

- **Evaluation** in Campania is **strictly limited to medical outcomes** i.e., figures on diagnoses and procedures. As a result, the system is not yet ready to support the evaluation of innovations in health and social care.
- Moreover, **the separation of financing into two budgets**: a budget for healthcare and a budget of social care means that there are limitations on how the systems' data can be used and its evaluation.

[10] Other Italian regions are historically better in terms of quality and outcomes.

A representative from the **Puglia** Region specified that, instead, the province aims to publish evaluation data and to make its messages understood by citizens:

- Puglia **organises information seminars for groups of citizens** where they can learn to understand regularly published HTA reports. Each year, the effectiveness and efficiency of many (digital and other) interventions are assessed. There is, however, no full online publication of evaluation reports and data.
- In the future, Puglia plans to establish more transparency on the quality and success indicators for providers and health professionals through **the publication of rankings**.

A colleague from Assuta, **Israel**, suggested that it is important to discriminate between measurements that take place on the (macro) health system level compared with the targeted programme evaluation. As a principle, in Israel, **all healthcare programmes are evaluate**d by measuring selected outcomes.

Campania underlined that **different types of evaluation**, whether internal, public-scientific or public-citizens oriented all build on or **start from the same "data lake".**

The Region of **Andalucía** runs **regular assessments** of a limited number of **the most important services**. Overall, not enough priority is given to evaluation in Andalusia.

What is next for eHealth?

- With its Diraya system, **Andalucía** plans to connect the homes of patients and patient entry of data.
- **Turkey** has 160 hospitals that are EMRAM6 approved, and one hospital at EMRAM7. The country plans to modernise and further digitise its hospitals.

Annex 5: Citizen Empowerment

"Citizen empowerment" is one of the 12 dimensions of the SCIROCCO model.

In relation to citizen empowerment, one use case was presented by **Turkey**. In Turkey, **full citizens' engagement** has been, and continues to be, established through:

- Provision of the eHealth platform.
- Permanent availability of the eHealth platform.
- Fostering the use the eHealth platform.
- Patients doing everything by themselves.
- The eHealth Platform enabling patients to know their health status.
- The eHealth Platform empowering patients to manage their own health.
- Turkey seeing the platform as a key enabler in the provision of comprehensive patient information.

Nevertheless, a number of reality checks demonstrate that there is **room for improvement**. For online booking of appointment e.g., it was observed that **patients** remain waiting in a queue when they **would be entitled to faster treatment**, given their online appointment.

Campania commented that such an observation warrants the need for **group education of patients to adopt new habits**: this method is well practiced in Campania.

A representative from Scotland observed that **cultural issues** must be recognised. Patients may like the ceremonial aspect of being in a waiting room, for example.

Turkey closed this discussion on this SCIROCCO dimension by making additional references to two European Union-funded projects in support of patient empowerment that are taking place in the country: this explained the rating of '5' that was given for citizen empowerment. Ongoing television campaigns inform viewers about managing their health – thereby leveraging synergies for the use of eHealth services.

Annex 6: Structure and governance

"Structure and governance" is one of the 12 dimensions of the SCIROCCO model.

This discussion led to a very **concrete statement by the regions and people present** that they wished to move forward on **collaborating on next steps together**.

Background

The whole group discussed the SCIROCCO dimension of **"structure and governance"** and how it could be seen in all three of the good practices (Andalucía, Turkey, and Puglia).

Examples covered:

- In **Andalucía,** there was a strong leadership that included deputy Ministers allotted to specific responsibilities; a chief executive officer/general manager; a Directorate for Information Technology Solutions; a focus on services(s); budgets that were supplied by European projects and by European structural funds. The integration of care had been a key focus in the region for a substantial period of time. When speaking of **the integration of health and care**, Andalucía noted that care had been integrated over **a three-year period (2012-2015)**. The two relevant regional Ministries (i.e., health care and social care) had worked together in close collaboration, based on a single record and a single identity system.
- **Turkey** highlighted that the Ministry had a clear mandate, with two well-established programmes, and available funding. Ambitiously, Turkey suggested that the intention was to **move the country towards the integration of care within a single year**.
- **Puglia** emphasised the ways in which **hospitals and** municipalities need to work together, since **data may be spread over two (separate) institutional levels and budgets.**

The discussion focused in-depth on some specific challenges related to **standards** associated with **languages and semantics** (see Annex 7).

Annex 7: Integration of health and care records

Discussion also covered **an examination of up to 13 regions** that have worked on **international classifications of data** (e.g., SNOMED CT[11]) that can be **useful in cross-border situations and the exchange of services**.

A **representative from Scotland** remarked that, overall, it seemed as though the only region working on integrated (care) records is **Catalonia** (specifically Badalona near Barcelona), although **Finland** has made a start and **Israel** is also working on similar challenges.

[11] http://www.snomed.org