
SCIENTIFIC EVALUATION OF PROJECTS

OF ALTERNATIVE FORMS OF CARE OR SUPPORT OF CARE FOR FRAIL
ELDERLY, IN ORDER TO ALLOW THEM TO MAINTAIN THEIR
AUTONOMY AND TO LIVE INDEPENDENTLY IN THEIR HOMES

“PROTOCOL 3”

CONTEXTUAL DESCRIPTION OF PROJECTS' COMPONENTS AND IMPLEMENTATION ANALYSIS

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List of abbreviations

Table 1. List of abbreviations used

Abbreviations	English	French	Dutch
ADL	Activities of Daily Living scale	Activités de la vie journalière	Activiteiten van het dagelijkse leven
BelRAI	Belgian Resident Assessment Instrument	Application web BelRAI	BelRAI web applicatie
CAPs	Clinical Assessment Protocols	Protocoles d'Analyse Clinique (CAP)	Klinische Analyseprotocollen (CAP's)
CGA	Comprehensive Geriatric Assessment	Evaluation gériatrique globale	Globale Geriatrische evaluatie
CM	Case Manager	Gestionnaire de cas	Zorgcoach, Zorgtrajectbegeleider
CMSA	Case Management Society of America		
CPS	Cognitive Performance Scale		
DRS	Depression Rating Scale		
EHR	Electronic Health Record	Dossier patient électronique	Electronisch patiëntendossier
FTE	Full-Time Equivalent	Equivalent Temps Plein (ETP)	Voltijds Equivalent (VE)
FOP	Frail Elderly People	Personne Agée Fragile	Kwetsbare Oudere
GP	General Practitioner	Médecin généraliste	Huisarts
HC	Home Care	Soins à domicile	Thuiszorgdiensten
HCCC	Home Care Coordination Centre	Centre de Coordination de Soins et de services à domicile (CCSSD)	Coördinatiecentrum voor diensten en zorg aan huis
ICG	Informal Caregiver	Aidant informel	Mantelzorger
ISHC	Integrated Services Home Care	Services Intégrés de Soins à Domicile (SISD)	Geïntegreerde Diensten Thuisverzorging (GDT / SEL))
MDM	Multi-Disciplinary Meetings	Réunions multidisciplinaires	Multidisciplinair overleg
NIHDI	National Institute for Health and Disability Insurance	Institut National Assurance Maladie et Invalidité (INAMI)	Rijksdienst Instituut Ziekte en Invaliditeitsverzekering (RIZIV)
NH	Nursing Home	Maison de repos et de soins ou maison de repos pour personnes âgées	Rust- en verzorgingstehuis of rusthuis voor bejaarden
OT	Occupational therapist	Ergothérapeute	Ergotherapeut
PC	Project Coordinator	Coordinateur de Projet	Project coordinator
PCSW	Public Centre for Social Welfare	Centre Public d'Aide Sociale (CPAS)	Openbaar Centrum voor Maatschappelijk Welzijn (OCMW)
P3	Protocol 3 Projects	Projets Protocole 3	Protocol 3 Projecten
RAI	Resident Assessment Instrument		
SW	Social Worker	Assistant social	Maatschappelijk medewerker

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1 INTRODUCTION

This part of the report provides the results of the qualitative and descriptive analyses of the projects. The main objective of this part of the research was to identify the factors that facilitated or hindered the successful implementation process of projects. Because the projects were all performed in a particular local context, we adopted the process definition as “the operational integration of an innovation in a given organisational context” (Contandriopoulos et al., 2000).

The main research question was: *What makes a project relevant and/or successful or not in a given context? Which factors can explain that some projects work, and that others do not work?*

Firstly, a brief outline of general features of the projects is reported. The projects were grouped to be able to perform meaningful analyses.

Secondly, the main sources of information are presented: yearly questionnaires, case studies and validation groups.

Thirdly, the detailed results of the qualitative analysis are given. For each group of projects, general data and the results of the in-depth case studies are provided. Also, a few general findings are discussed.

The methods and preliminary results were reported to and approved by the advisory committee.

2 METHODOLOGY

The methodology of this qualitative part of the report consists of four parts: (1) the description and classification of all the projects (2) the construction of homogenous groups of projects, (3) the case studies of a selected set of projects and (4) the supplementary role of validation groups.

For better appreciation of the qualitative data some information is reported of other parts of the analysis. The reader may find the methods used to derive these data in the part about FOPs' outcomes and the cost data).

Data collection ranged from 1st April 2010 to 15th January 2014.

2.1 THE DESCRIPTION AND CLASSIFICATION OF ALL THE PROJECTS

The main features of the projects are described in the Table below.

Table 2. Protocol3 projects are diverse. Some key figures

Characteristics/components of the projects	Expression of the variety of these characteristics /components
Geographic location	Urban, rural
Region	Flanders, Brussels, Walloon, German-speaking
Language	French, Dutch, German
Number of Full-time equivalent (FTE) staff members¹	Min 0,1; max 27,3; median: 2,5; SD: 9,3
Mono versus multidisciplinary of the staff²	Projects having just one type of profession in their staff, others up to seven (SD:2,3; median : 0,87)
Expected caseload³	Min: 2; max : 314; median: 40; SD: 57,9
Characteristics of the target population⁴	Older persons with or without dementia; their informal caregivers
Yearly project cost per FOPs paid by NIHD⁵	Min:296 €; max: 13759 €; mean: 3103 €; SD: 2825 €
Services delivered⁶	Night care at home or residential night care, day care, occupational therapy at home, alternative housing, agenda planning, respite care, psychotherapy at home, psychological support at home, set of services from the description above, case management, case management in combination with other services, alternative housing
Number of different services	1-10
Explicit or implicit mention of case	With or without individualized coordination of care

¹ Number of staff, paid by P3 financing and others: source: LimeSurvey Dec2011-2012

² Discipline of the staff: source: LimeSurvey Dec2011-2012

³ Expected caseload: source: LimeSurvey Dec2011-2012

⁴ Expected characteristics of the target population : source : submission file Dec 2009

⁵ Amount of financing by NIHD: source: LimeSurvey Dec2011-2012

⁶ Service delivered: source: LimeSurvey Dec2011-2012

management⁷	
Use of a CGA⁸	Use of BelRAI for collection of data for scientific evaluation only, use of BelRAI for making an individualized care plan, use of other standardized CGA tools

⁷ Mention of case management : source : submission file Dec 2009 or LimeSurvey Dec2011-2012or face-to-face interviews

⁸ Use of a CGA : source : Word Questionnaire Dec2011-2012

2.2 DATA FROM THE PROJECTS

Looking more closely into the key services of P3 projects a great variety can be observed (table 2). The list includes health care services, as well as support services and leisure.

Table 3. Exhaustive list of services provided by the protocol3 projects

As mentioned in the yearly questionnaires (Dec 2011-2012). Keywords were extracted from the yearly questionnaires

Services provided (listed alphabetically)		
artistic entertainment	call centre for agenda planning	care plan
case management	cleaning assistance	cooking
cooking assistance	Coordination	crisis accommodation
day care	dietary counselling	drug counselling
Education	household assistance	ICG support
Leisure	meals on wheels	medical care
multimedia activity	multisensory stimulation	music therapy
narrative care	night accommodation	night control
nursing care	occupational therapy	palliative accommodation
physical activity	Physiotherapy	psychological care
psychosocial support	Relaxation	remote assistance
respite care	Revalidation	short stay after chemotherapy
social entertainment	social support	speech therapy
technical assistance	Zoo therapy	

Only services that were constant in a project were retained for the classification, and grouped following an operational typology, according to the goals of the beneficiaries.

For a minority of “simple” projects (n = 18), the classification seemed rather straightforward, as those projects provided one health care service only (mostly occupational therapy at home or psychological support) and the wording was unequivocal. For those simple projects, the professionals delivering these services at home were compatible with the general acceptance of the adequacy of the service with the professional delivering this service: an occupational therapist for the provision of occupational therapy and a psychologist for the delivery of psychotherapy or psychological support at home.

But for the remaining projects (N=44), we had to move stepwise and check for each service the following characteristics:

1. The naming of the services (in the questionnaires, the wording was provided by the project coordinators),
2. The professional delivering the service,
3. The target population,
4. The place of delivery,
5. The frequency of the service delivery.

Three researchers, two of them fluently bilingual and familiar with the jargon used by the projects, independently coded the services described, step by step, taking into account the characteristics of the service, as shown above. All coding was cross-checked afterwards and, in case conflicting results appeared, findings were discussed until consensus was reached. Only after this step, services were grouped into **homogenous groups** of projects.

2.3 HOMOGENOUS GROUPS OF PROJECTS

Since the start of the evaluation process, the research team clustered the projects into homogeneous groups, to allow for comparisons among groups of projects. This classification process was an essential part in the building of explanatory / implementation strategies for NIHD and was approved during meetings with the scientific evaluation committee accompanying the research project. Data were extracted from (1) submission files of the projects (Dec. 2009), (2) yearly questionnaires (Dec. 2010; Dec. 2011 and Dec. 2013), (3) face-to-face interviews with a set of projects (10 in 2010; 16 in 2011-2012; 16 in 2013) (4) NIHD data about professionals in the projects (2010, 2011, 2012 and 2013) and, finally (5) data from validation groups (2011 and 2012).

Table 4. Classification of projects in subgroups, according to the constant services they provided

Project group/subgroup		ID project	Service nº1	Service nº2	Service nº3	Service nº4
CASE MANAGEMENT (CM) PROJECTS	CM only (n =4)	CMS259	CM			
		CMS204	CM			
		CMS189	CM			
		CMS145	CM			
	CM with occupational (OT) and physiotherapy (physio) (n=7)	CMOT197	CM	OT	Physio	
		CMOT178	CM	OT	Physio	Speech therapy
		CMOT199	CM	OT		
		CMOT250	CM	OT	Alarm system	
		CMOT193	CM	OT	Physio	Alarm system
		CMOT200	CM	OT		
		CMOT184	CM	OT		
	CM in a residential setting (N=6)	CMR196	CM	Short stay	Psycho	Physio OT
		CMR179	CM	Short stay	Physio	
		CMR203	CM	Short stay	OT	Physio
		CMR202	CM	Night hostel	Night care (home)	Nutritional therapy
		CMR190	CM	Night care	OT	Alarm system
		CMR185	CM	Night care	OT	
	CM with psychotherapy (and occupational therapy) (n=5)	CMPS183	CM	Psycho	OT	
		CMPS175	CM	Psycho	OT	
		CMPS198	CM	Psycho		
		CMPS144	CM	Psycho		
		CMPS186	CM	Psycho	Nutritional therapy	
NIGHT CARE PROJECTS (N=11)		NC162	Night hostel			
		NC150	Night hostel			
		NC153	Night hostel			
		NC166	Night care (home)	Alarm system		
		NC201	Night care (home)			
		NC195	Night hostel	Night care (home) 1 :1		

Project group/subgroup	ID project	Service n°1	Service n°2	Service n°3	Service n°4
	NC182	Night hostel	Night care (home) 1 :1		
	NC192	Night hostel	Night care (home) 1 :1		
	NC156	Night hostel	Night care (home)		
	NC157	Night care (home)			
	NC167	Night care (home)			
DAY CARE PROJECTS (N=10)	DC152	Daycare			
	DC151	Daycare			
	DC173	Daycare for demented			
	DC164	Daycare for demented			
	DC161	Daycare for demented	Preparation of institutional.		
	DC149	Coord in daycenter	OT (home)		
	PS172	Daycare for demented			
	DC171	Daycare for demented	Psychosocial support		
	DC158	Revalidation through daycare			
	DC146	Educative activity	Multisensory stimulation		
PROJECTS PROVIDING OCCUPATIONAL THERAPY (N=7)	OT174	OT (home)			
	OT181	OT (home)			
	OT187	OT (home)			
	OT180	OT (home)			
	OT176	OT (home)			
	OT163	OT (home)			
	OT177	OT (home)			
PROJECTS PROVIDING PSYCHOTHERAPY OR PSYCHOSOCIAL SUPPORT (N=7)	PS154	Psychos. support			
	PS155	Psychosoc support	Screening for psychotherapy		
	PS168	Psychosoc support			
	PS194	Psychotherapy	Social support		
	PS165	Narrative care			
	PS170	Psychosoc support			
	PS169	Psychosoc support			
OTHER PROJECTS (N=5)	O188	Day planning			
	O160	Medication			

Project group/subgroup	ID project	Service n°1	Service n°2	Service n°3	Service n°4
		delivery			
	O147	Alternative housing			
	O148	Alternative housing			
	O159	Respite care			

2.4 CASE STUDIES

2.4.1 WHY CASE STUDIES

In order to collect more specific and in depth information, 21 **case studies** were conducted during the entire span of the project. The three aims of the case studies were:

1. To provide a precise and narrative description of the project components (structure and process factors) that would likely lead to positive outcomes;
2. To identify the contextual factors that played a role during the implementation process of projects and the way they adapted to changes (like change of reimbursement modalities, turnover of professionals etc.);
3. To build an overall analytical framework and to identify the mechanisms relating to success or failure of projects, allowing the evaluation of the likelihood of success of the projects that were not part of the case studies.

2.4.2 SELECTING THE CASES

As the relation between the type of projects and the outcome for frail elderly was unknown from the start of the projects, cases were selected to obtain as much diversity as possible in the projects' characteristics. These features included the type of services provided, the geographic location, the size of the project (staff or intended caseload), the definition of the target population, the level of multidisciplinary, the size of the partnership, etc. The initial protocol foresaw the in-depth study of 16 cases, including 10 cases from the first call for projects and six additional cases from the second call.

After the selection of the first year (ten cases), this selection process had to start over again because two projects stopped and the second call for projects, which should have allowed the addition of 'new' cases, had not been launched yet. Therefore, some additional changes had to be made:

1. After the second year, eight new cases were selected from the first call. The selection was also validated by the accompanying committee of the research.
2. After the third year, six projects fell out of the case study evaluation:
 - Two day care projects, because changed financing (i.e. they were structurally financed by NIHDI) ;
 - One case management project, one occupational therapy project and one night care project because, despite the efforts of our team to gather accurate data, it was nearly impossible to gather clear (i.e. unambiguous) and timely information.
 - One "other" project, because the team agreed that further data collection would not provide supplementary insights into this non-complex project (i.e. involving only one type of professional for one type of intervention, namely agenda structuration).

As a result, five new projects were selected as case studies: two night care projects, two case management projects and one project providing psychological support.

A complete overview of the selected cases, classed by types of projects, is provided in below. The table also contains information about the project participating in the validation groups.

Table 5. Number of projects, per type of project, which participated in this qualitative analysis (either in a focus group of validation groups or in a case study)

Type of project	Number of projects in CS T0	Number of projects in CS T1	Number of projects in CS T2	Number of projects FG 2011	Number of projects FG 2012
<i>date</i>	<i>Nov10-Feb11</i>	<i>Dec11-Feb12</i>	<i>March-May12</i>	<i>Sep11</i>	<i>Sep12</i>
Case management + OT/physio	1	1	1	3	2
Case management + psycho/ OT	1	2	2	3	3
Case management + residential/night care	1	1	2	3	1
Case management solo	1	1	1	2	2
Day care	1	2		3	2
Night care		2	3	5	4
Occupational therapy	2	3	2	3	4
Psychological/psychosocial support	1	2	3	4	3
Others		2	1	1	1
Total	10	16	16	28	22

Of the 67 projects which were financed from 1st April 2010 on, 59 were met either during an interview for a case study, either were met by the means of focus groups. All projects completed the yearly questionnaires.

2.4.3 ANALYTICAL FRAMEWORK AND USE OF TEMPLATES

For the organisation of the data, templates were used in the case studies. They allowed for the standardised collection of data of the 21 cases among the five researchers involved in the process, as recommended by Yin (2009). Moreover, the methodology aimed at summarising in a dynamic way all the available information about each project over time. These elements of information were stored under the following headings, representing the different contextual and organisational components of the projects:

1. **The context in which the project was implemented;**
2. **The preparatory process of the project;**
3. **The description of the project as planned** including:
 - 1) **Structural components** as - a definition of a target population, - an area of activity, - an expected caseload, - core objectives, - a staff of professionals, - a partnership of organisations, - some logistic and financial means
 - 2) **Process** organizing the way the intervention was to be delivered as a sequential model of intervention, some coordination and collaboration tools.

The description of the project as planned helped to define its boundaries: where did the project stop and usual care begin?

4. **The description of the project as implemented in real-world conditions**, including the adaptive methodology of the projects, the factors having facilitated or hindered the implementation process regarding specific challenges of their context;
5. **The summary of the main “lessons learned”** or emerging themes, about the implementation process of the project, including the description of the differences between the ‘model’ of the project as planned and the project as implemented in practice.
6. **The summary of the logic of the intervention, or “programme theory”**: Which objectives were aimed by the projects? Which activities were displayed to reach these objectives? By which mechanisms the actors of the projects expected these activities to impact FOPs or ICGS’ outcomes? This information, based on the information gathered and summarized in each template, drew upon Ridde and Haddad’s article about pragmatic evaluations of complex interventions (2013).

Besides allowing a dynamic and standardized data collection about projects over time, the templates also helped in the preparation of the interview guides for interviews with projects, which focused on the missing data or on contradictions labelled as “grey zone” in the description process. These “grey zones” were translated into interview questions. This process allowed both a standardized and tailored approach of each case, and enabled a deep exploration of the data.

2.4.4 DATA SOURCES

Typically, case studies combine multiple sources of qualitative and quantitative data, used in a complementary way (Eisenhardt, 1989; Yin, 2008). Case studies used the following sources of qualitative data:

1. **Project submission files.** Submitted in December 2009 and now available on the NIHDI website. They were the basis upon which the jury decided to finance the projects during four years. Projects had to describe how they *intended* to support the maintaining at home of the frail elderly, with which means (staff and equipment).
2. **Semi structured Interviews** with the key professionals working in projects (coordinators, persons responsible of the implementation of the project and frontline workers). A first round of interviews was conducted within the first year (between December 2010 and February 2011) and especially focused on the preparation of the project and on problems the professionals faced. A second round of interviews occurred between December 2011 and February 2012, and was focused on the adaptations and changes introduced within first year since the start. A third and last round of interviews occurred in spring 2013.

All the interviews were conducted by at least two researchers, in order to harmonize the case study process. The writing of the preparatory documents (the grid of interview, elaborated in function of the grey zones identified for each project) was allocated to the researcher conducting the interview, while another researcher took field notes. In some cases, a third researcher observed the interview dynamics and took additional notes. After obtaining consent from the participants, all the interviews were recorded and transcribed, in order to analyse (code) them with the NVIVO software (NVIVO-10©). After each interview, a team debriefing was held and the templates were completed and cross-validated by at least one researcher having participated in the interview.

3. **Yearly questionnaires.** Each year, projects filled out electronic questionnaires, in order to collect data about the organisational functioning and about adaptations in the components of their projects. Researchers took the extra precaution to provide feed-back of their own understanding of the data, in order to validate it. This was done by means of telephone interviews.
4. **Documentation.** Documentation about projects was also gathered by means of documents publicly available, such as advertising flyers, projects website, etc.

It is important to highlight at this point that all these data are self-reported data, gathered by the professionals in the Protocol3 projects, except for the field notes, which were written by the members of the research team. They reflect the perception of the reality of the members of the project teams (see overall methodology).

2.5 VALIDATION GROUPS

During the first two years of the evaluation process, focus groups were organized, in order to validate some key findings from the case studies. Four groups were organized, two per language group (French and Dutch), each one with managers and coordinators, the other with front-line professionals. The rationale behind the selection of projects to be part of the focus groups was the same as for the selection of the projects for the case studies, as diversity was chosen, to enable to submit the findings of the case studies to a panel of professionals with very diverse experience. The selection of the projects to be part of the focus groups was also submitted to the accompanying committee.

In 2011, these focus groups were organized between September and October 2011; in 2012, they were organized in September.

As a way to invite the participants to speak about their own experiences about some specific key findings from case studies, the preliminary results of the case studies were presented sequentially to each group and discussed at each step. The descriptive results were integrated in the description of projects from different categories and the discussion elements were used in order to complete or specify the preliminary results presented in the last section.

The type of projects which participated in those validations groups are displayed in Table 5, shown above.

2.6 NORMATIVE ANALYSIS

The aim of this part of the analysis was to synthesize the information gathered from the narrative description of the 21 projects that were part of the case studies that were studied using the template. This allowed a thorough description of the projects, including how, with which means and why it tried to achieve its goals.

The next step included an across-cases analysis of the projects of the case studies, trying to identify the salient components of the projects in (1) achieving its implementation and (2) allowing for desired older persons outcomes. So-called “hard” outcomes were identified (i.e. delaying institutionalization, improving functional status and health, alleviating the burden of their informal caregivers, etc.) but also “soft” outcomes, such as enhancing coping skills, access to adequate information and service options.

As the projects were part of a complex system, it was important to highlight again the importance of these salient components of a given project to be understood in its own context. Moreover, being a complex adaptive system itself (see characteristics of complex adaptive systems in Plsek & Greenhalgh’s article, 2001), the components within the projects were also highly intertwined with each other). Those components were to be seen from a normative point of view. This means that we described how the projects expected their services to improve older people’s outcomes, if they were delivered in a logic way. Therefore, we looked into the objectives set by the projects, which activities they planned to perform to achieve these objectives and if, according to their statements, they actually did these activities.

Data of this synthetic analysis of the programme theory were gathered in three steps. Firstly, we used the data of the case study results, completed after the interviews at T1, i.e. on average, two years after the start of the projects (Dec 2011-March 2012). These data were structured following a standardized template, as described above, in order to allow homogenous analysis of the project data. Secondly, data of the yearly questionnaires at T1 (Dec 2011) and T2 (Dec 2012) were incorporated, in order to use the most up-to-date information available. Thirdly, a literature review was conducted, in order to define which components of a given intervention had to be present to yield positive outcomes.

We started a listing of the components within the projects of the case studies providing case management, whether they provided other services or case management alone. Indeed, case management projects appeared to be the most complex projects (i.e. were expected to have a high level of interaction among its professionals, being from different disciplines but were also expected to be highly embedded in the health and social system and to co-evolve).

After completing the list of components of case management projects, the same process was carried out with other types of projects (projects of night care, day care, providing occupational therapy and psychological or psychosocial support). For each of those components, relevance criteria were also listed, both based, as described above, on the results of case studies and literature review.

All these criteria were grouped along the six domains of Wagner’s Chronic Care Model:

1. Appropriateness of the workforce
2. Tailored delivery system design
3. Appropriateness of the financial incentives
4. Quality assurance
5. Decision support
6. Clinical information systems

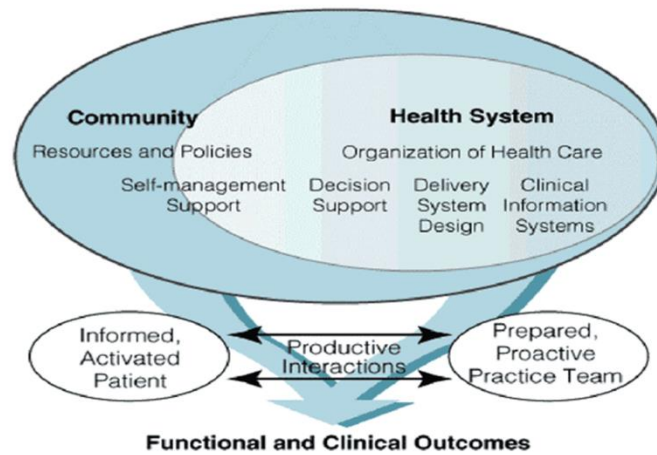


Figure 1. Wagner' Chronic Care Model (1989)

On an operational level, each researcher identified the salient components explaining the success of the project individually for one group of projects (through case study analysis, yearly questionnaire analysis and literature review). Each list of components, with its list of relevance criteria was reviewed by another researcher who had participated in the case study analysis of the same group of projects. These components were displayed along the six domains of the Chronic Care Model. When questions or dissensions arose, this was discussed amongst all researchers of the qualitative team during regular working sessions. This led to a comprehensive of items (e.g. 26 for case management projects), which made them very complicated to test. After discussion amongst the members of the research team, a smaller set was selected, which were deemed (1) to have the most weight in the success of the project, according to the actors of the projects' point of view and (2) of which the data were the most reliable (after triangulation).

A next step was to score projects in order to be able to compare them meaningfully. Two researchers independently rated the components of each project from 0 to 3, according to the list of criteria. The results were then compared and a consensus found whenever needed. The complete lists of components, along with the criteria used to score the project on each component, are provided in Annex 1.

3 DETAILED RESULTS

In a first stage, the projects were compared within a group according to the services they provided (see Table 5). In a second stage, other subgroup analyses within types of projects were performed of other projects' components, such as their embeddedness within the primary care system, use of the results of the comprehensive geriatric assessment (BelRAI and CAPs) for the elaboration and coordination of the care plan, etc.

3.1 PROJECTS PROVIDING CASE MANAGEMENT (N = 22)

A starting point was the observation, by the research team, of the somewhat imprecise definition of 'case management', as reported by the documents and project members. Two main tendencies were to be found: 1) either the project declared conducting case management as such and the terms used were rather straightforward for the **case management service** delivered ("case management", "individueel zorgtrajectbegeleiding", "proactieve screening, coördinatie en individuele opvolging") or **case manager(s)** ("geriatrische zorgcoach", "zorgcoach", "zorgtrajectbegeleider"); 2) either there was no explicit mention of such service or person(s), but essential elements of the definition of case management, as provided by the Case Management Society of America (CMSA, 2010), were found.

"a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet and individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes."

Subsequently, to discriminate case management projects from other projects, we decided to retain **four discrete and prominent features** as essential for a project to be defined as case management projects : (a) individualized needs and preferences' **assessment**, (b) **planning** of services, according to the results of this assessment, (c) patient-centred care **coordination** and (d) **re-evaluation** and adjustment of the care coordination (see the « typology » section).

In total, 22 projects which present these features were attributed to this group. When looking at the services they provide and the professionals delivering these services, a first observation is linked to the fact that 4 of these 22 projects deliver case management alone, while the remaining 18 deliver case management with some other services. One of these projects stopped because its caseload was not achieved.

The 18 projects delivering case management along with other services, were regrouped into three subclasses: Case management (CM) with occupational therapy/physiotherapy, i.e. delivering also occupational therapy (OT) and sometimes physiotherapy; CM with residential care or night care; CM with psychological or psychosocial support and occupational therapy.

A synthetic overview of all case management projects, and the service they provide, is described in Table 5. The rest of this chapter follows the case management classification per subgroup.

3.1.1 PROJECTS PROVIDING ONLY CASE MANAGEMENT

Four projects were included in this subcategory (three in the Dutch speaking part and one in the German speaking part of Belgium). Only one used the wording of *case management* for the description of its services. This project was part of the case study (see below). None of the professionals in these project delivered direct care to the FOPs whose case they managed.

3.1.1.1 THE INTERVENTION

The objective of the case management interventions

Interestingly and although these four projects provided case management, their objectives were rather diverse as, besides the “official” objective of the funding entity (NIHDI), which was to delay premature nursing home placement (one project), two projects targeted the autonomy of the FOP and/or his network, one of the latter adding the training of professional care providers and the last one specifically mentioned the use of the local resources by structural agreements and coordination after careful assessment and addressing needs.

Tools to organise the intervention.

A priori, case management aims to structure the care process and therefore requires a high level of formalization of these processes. One might therefore expect that these projects use tools to collect and share information about the FOP included.

Meetings showed to be very important to coordinate interventions, as it was the case for all case management projects. All projects mentioned that they organized multidisciplinary meetings (multidisciplinary meetings) and follow-up of the ‘cases’. However, they diverged in terms by means of frequency (monthly, every three months or ‘ad hoc’) and location (fixed location or at the FOP’s home):

- A first project mentioned 1) monthly meetings of two hours at the umbrella organisation of the project (i.e. a nursing home), with care providers, occupational therapist and project coordinator. The aim was to discuss and to plan the cases; 2) meetings for the planning of the project.
- The second project declared 1) ad hoc coordination meetings at the FOP’s home or at the place of a participant of the project. The duration was 1,5 hour, in presence of the FOP and ICG, the health care providers and the case manager; 2) bi-monthly interventions (‘intervisie team’) with the objective to discuss problematic « cases » with the coordinator and members of partner organisations.
- The third project declared 1) an inclusion meeting for each FOP, lasting on average 1,5 hour, with the case manager, the FOP and ICG, in order to tailor the intervention to the needs of the FOP; 2) multidisciplinary meetings if needed; 3) three times a year, meetings at home, lasting 1,5 hour, with the case manager and ICG, if possible, to re-evaluate and adjust the intervention.
- The last project organized also 1) multidisciplinary meetings every two weeks, lasting one hour. Participants were case managers and the project coordinator, at the project’s place ; 2) ad hoc meetings, at the FOP’s place, lasting one hour on average, with the case manager, the FOP and ICG ; 3) project meetings every two months, lasting on average two hours, between the partners and participants of the project, aiming to analyse common ‘cases’.

In all four projects, the minutes of the meetings were written down in a systematic way, in order to keep track of the cases discussed and to assess them. Overall, they were sent electronically to the participants.

All these projects used diverse **data collection tools of FOP data**, including FOP record on paper (n=2) or electronically; a notebook at home (n=1), etc. One project developed a specific software, in order to collect and share information about FOPs, whether they were included in the project or not⁹.

Table 6. Organisation of the case management around a single FOP

Criterion	CMS259	CMS189	CMS145	CMS204
Professionals filling out of the BelRAI	Project coordinator (sociologist)	Social worker or social nurse of the project	GPs and “care coach” (can be different professionals)	Nurses, OT, social workers and educators
Professionals responsible for the BelRAI and making of the care plan (if care plan present)	Nursing aids	Social worker or social nurse of the project	GPs	Under supervision of social care manager
Use of shared electronic patient file	No	Yes	No	Yes
Care plan	No	Yes, in addition of the one of the coordination centre	Yes, monodisciplinary	Yes
Remarks	Project stopped		The GPs’ input coming late, the results of BelRAI are not used	BelRAI results are not used for care planning

One of the projects mentioned they did not use a care plan, as opposed to the others. This was also the only project which did not use the BelRAI for case management’s purposes. The reason of this was because the case manager did not have access to the BelRAI application; because of legal reasons (was not a health care provider, nor social worker). This project also stopped in December 2012, and did also not reach its proposed caseload.

Duration and intensity of the intervention

The intensity of the intervention relates to the frequency of direct interactions with the FOP and/or informal care giver (ICG), on an annual basis. More pragmatically, it is linked to the frequency and number of meetings with the FOP and ICG and home visits.

Two projects out of four reported a variable and flexible frequency, related to the workload of the case managers. As to duration, all but one project declared that the FOPs remained in their projects as long as they were not definitively institutionalised. The exception is the project of the case study, described below, stating that if during a planned assessment, it appears that both parties do not perceive any added value of the project, they discuss with the FOPs to stop the intervention (e.g. when the situation is viewed as stable and only two care providers intervene with this FOP).

In one of the projects, the case manager did not have access to the BelRAI application, as he was not a health care provider, nor social worker. This project also declared not to use a care plan.

⁹ This project was part of the case study and the software will be described further in this chapter.

3.1.1.2 THE TARGET POPULATION

The capacity of the projects ranged from 53 to 189 beneficiaries. Two projects have apparently a population with low healthcare needs, as is shown by the proportion of individuals having no problems with cognition or ADLs. This might indicate that the project targets people who are not too dependent and expect to delay unwanted institutionalisation by the means of case management, offering them the reinsurance of a key reference person to help them to access adequate services, while there is still room for improvement or when the functional decline is not ineluctable because of extreme frailty.

Table 7. Expected versus recruitment of target population, including recruitment means

Criterion	CMS259	CMS189	CMS145	CMS204
Profile of <i>expected</i> target population	75+ with dementia	(1) after hospitalisation; (2) FOPs with dementia; (3) FOPs without social network	General population of FOPs	General population of FOPs
Expected caseload	no data	70	53	189
Achievement of the caseload	Not applicable (project stopped)	Yes (and exceeded)	Yes	Yes (and exceeded)
Recruitment means	ICG	hospitals and at home	at home	waiting list for NH & HC

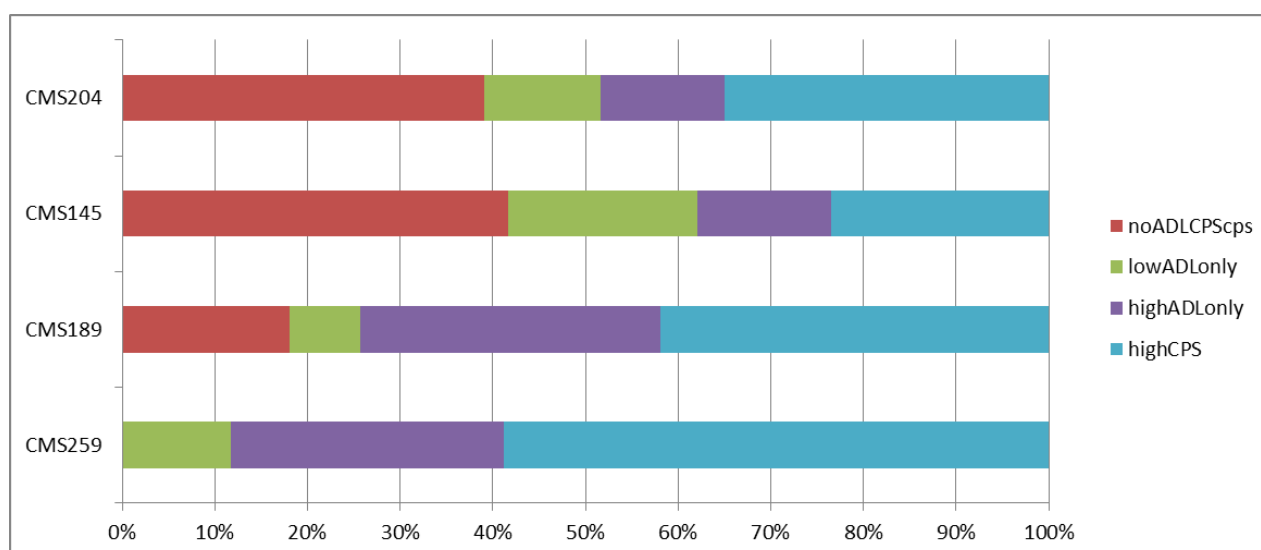


Figure 2. Profile of the population included in projects providing only case management, at inclusion

Two projects had a higher percentage of FOPs having no functional or cognitive problems than the two others. The project that stopped (CMS259) included a higher percentage of FOP having cognitive problems.

3.1.1.3 THE SKILL MIX

The profile and the training of **professionals** in these projects varied across projects and tend to be more social worker-sided (so a non-medical approach), as opposed to nursing case management. Only one project included specifically a nurse case manager. While there is no specific case management training in Belgium, one project managed to train their collaborators abroad (in Germany). This is the project that was part of the case study, described below.

The FTE case manager to FOP ratio varied from 1:11 to 1:63 in this subcategory. The project having a higher CM to FOP ratio is described in case study 1, where rationales provided for the success of this project, even with less human resources. According to the professionals of the project, the internal organisation is highly structured around homemade software, that allows fluent information flow about FOP's data and services and care needed, but also provides reminders and information about local resources. Moreover, this tool, which is constantly evolving as the project goes on, allows a careful monitoring of the functioning of the project.

Table 8. The profile of case managers and case manager to FOP ratio

Criterion	CMS259	CMS189	CMS145	CMS204
Profile of case managers in the project	No description – project stopped	Nurse + SW	SW, educators and others	SW + educators
Total FTE involved in case management	0,85	1,71	5,24	3
Ratio FTE CM:FOPs	No data	1:41	1:11	1:63

The professionals delivering case management services had very diverse profiles and diplomas, which may lead to the proposition that the projects did not define *a priori* a specific type of professional for this type of service.

3.1.1.4 THE COST OF THE PROJECTS

The cost provided here is the mean yearly cost per FOP in the project, for the part financed by the NIHDI. As is shown in Table NN, the cost of these projects is not very high (at least, for the two projects of which we have data). The cost of project CMS204 is slightly higher than project CMS189, probably because the first one included the cost linked to the making of the homemade software, which is so essential for the project and for which they need a constant updating by a computer specialist (see case study).

3.1.1.5 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

It can be expected that case management projects without additional services have more intense interactions with their local context in which they were embedded. In this aspect, two models were present; either the project was a new service of an umbrella organisation that already offered a set of services (CMS259), or as an 'organisation-neutral' service.

Three out of the four projects had interactions with the local coordination centres and centres for public welfare. Interestingly, the project that had no formal contacts with those entities had to stop because it did not achieve this caseload (see above).

Collaboration with the GPs was very diverse. In two of the projects, the GP was systematically included in the case management process. In another project, the GP was only sideways informed about the FOP being in the project. In the last project, the collaboration with the GP was described as 'difficult'. This project (CMS189) recognized that they really needed time to know the local (health) care resources, build trust and be known by the local providers and target population.

One project (CMS145) observed that the interaction with the local nurse organisation was not easy, because of overlapping coordination: when the FOPs already benefited from home nursing services, this came along with a certain level of coordination that was provided by the organisation to which this nursing service belonged. Therefore, the referral of this organisation was not so good as expected.

3.1.1.6 ADAPTIVE BEHAVIOURS

Our intention was to investigate whether the projects had the capacity to adjust to their environments, starting from the changes asked by the project and formalized through changes in the convention with NIHDI.

One project (CMS259) had to stop in December 2012, because it did not achieve its caseload. This project stated that there was no demand for the case management services they offered to the population and that they had overestimated the size of the target population. The three other projects of this category had sufficient demands, two of them having even an excessive demand, in comparison with their resources.

Project CMS145 had to adapt their intervention, because they receive more demands than expected to support the FOPs who were to be discharged from hospital.

Project CMS189 mentioned they had a very hard time to engage independent nurses and primary care physicians of the FOP to cooperate with the project and, as a consequence, had difficulty to reach its caseload. They even asked NIHDI to be allowed to decrease its caseload but cancelled this demand shortly after, because suddenly the referrals increased and the project could function as expected. The reason for this sudden 'success' was explained by the project because (1) the project needed time to get know by local care providers and that the referrals were only made after a while, but also (2) because they changed their inclusion criteria and included also FOP without a disability (FOPs with a recognized handicap was a first inclusion criteria before).

3.1.1.7 EXPECTED EFFECT ON THE OUTCOMES AS A RESULT OF THE NORMATIVE ANALYSIS

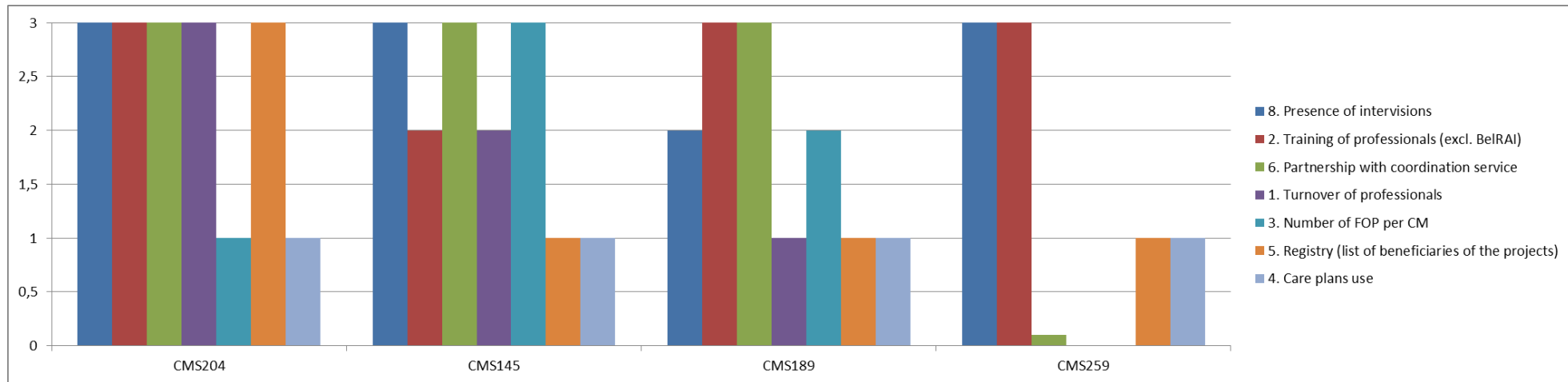


Figure 3. Normative analysis of projects providing only case management: view per project

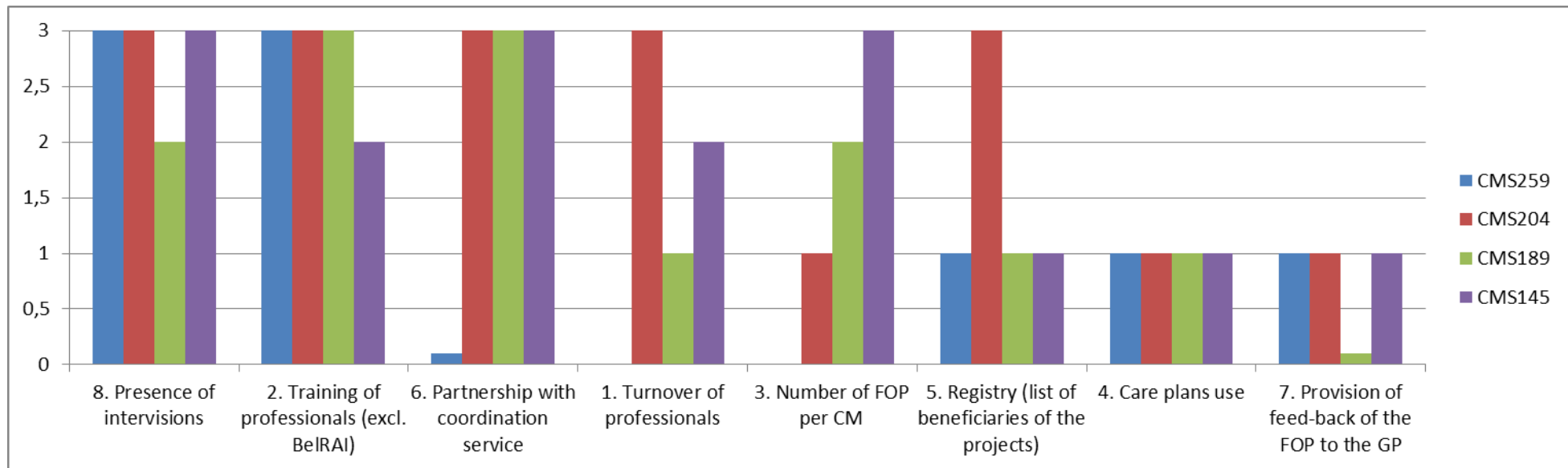


Figure 4. Normative analysis of projects providing only case management: view per item

Figures 3 and 4 show that the projects shared some similitudes but also differences in some domains:

- Interventions were present in projects, underpinning the fact that this is an important need for the professionals in this new function. In all but one project, this intervention was supervised by a professional external to the project (mostly physicians);
- Case managers were trained in all projects and in two projects, this training was given by teachers outside the project. In the case of the project of the case study, this training was attended in a foreign country, as no specific training exists to this date for this function.
- An important diversity between the projects was shown in the domain of partnership with coordination services (a proxy of the project's embeddedness in the local system). According to this data, project CMS259 had the lowest score (this project had to stop, as it did not succeed in catching its clients). This shows that the projects' embeddedness is likely to be crucial to the success of its implementation for this subtype of project.
- Except for one project (CMS204), all projects experienced a turnover of their case managers. Further analysis will show if this dimension is also crucial for case management providing also other services, as these other (direct) health care services might enable to build trusting relationships between FOPs and ICGs, but also with other professionals.
- The number of frail older persons per case manager varied also. In the three projects where the data were available, this varied from 11 to 63 per full-time equivalent case manager.
- Only one project invested in the conception and use of a tool for project management (described below in the case study);
- Those projects did not differ on the use of the results of BelRAI for care planning's purposes. One project stood out as to the organisation of the information flow amongst professionals in the project, as it had coupled its electronic health record with a software for the project's management (CMS204).
- Provision of feed-back about the observations and interventions in the project to the FOP's own GP was poor in all projects and nearly non-existent in one of them.

3.1.1.8 SYNTHETIC TABLE OF THE PROJECTS' DATA

Table 9. Synthetic table of the features of projects providing case management alone

Criterion	CMS259	CMS189	CMS145	CMS204
Objectives of the intervention	Delay premature NH placement	Support of FOPs and ICGs; training of PCGs and support of existing network	Careful assessment and addressing needs; implementation and management of care plan; local resources use by structural agreements and coordination	Case management to enhance autonomy of the FOPs
Description of services provided	Case management	Case management	Case management	Case management
Profile of professionals in the project	no	Nurse + SW	SW & others	SW + educators
Total FTE involved in case management	0,85	1,71	5,24	3
Ratio FTE CM:FOPs	No data	1:41	1:11	1:63
Profile of <i>expected</i> target population	75+ with dementia	(1) after hospitalisation; (2) FOPs with dementia; (3) FOPs without social network	General population of FOPs	General population of FOPs
Expected caseload	no data	70	53	189
Achievement of the caseload	No (project stopped)	Yes (and exceeded)	Yes	Yes (and exceeded)
Recruitment means	ICG	hospitals & at home	at home	waiting list for NH & HC
Partnership with coordination service (SISD/SEL/GDT or CCSSD)	No	Yes	Yes	Yes
Partnership with community organisations	No	Yes	Yes	Yes
Incentives for GP participation	No	No	Paid by project	No
Provision of feed-back about FOPs to the GP	About the services provided	GP takes usually part in multidisciplinary meetings	If needed	If needed
Presence of interventions/planned supervisions and MD group meetings to enhance the knowledge of case managers	Yes	Yes	Yes, and include a supervisor	Yes, and include a supervisor
Care/service plans use	No tailored approach	Yes	No	Yes
Use of BelRAI results	No	No	No	No
ICT Tool for clinical coordination	No data	EHR + for project management	EHR	EHR + for project management
Duration of the intervention	no data	no data	permanent	permanent

Criterion	CMS259	CMS189	CMS145	CMS204
Umbrella organisation	NH	HC	HC	NH
Missing elements for the project?	To be able to provide only CM	More FTE for better care	More focus on transitional care	Only useful tools to be used
Unit of activity	No data	care package	care package	care package
Nb of Units/FOP (Sept 13)		1	1	0,63
Annual cost per FOP	No data	€ 696	No data	€ 846

3.1.1.9 CASE STUDY 1

(CMS204)

This case management project was selected as case from the start of the evaluation process and followed-up during four years (2010-2013).

1. CONTEXT OF THE INTERVENTION

The submission file was proposed by a coordination centre and the administrative coordinator was employed by a nursing home; however, the operational director is responsible of a coordination centre for home care. The project was the only Protocol 3 project in its region. It was preceded by a similar project that aimed to manage the waiting list for nursing homes. The only link between both projects was related to the staff: two members of the first projects were part of the second one. Aims of this coordination centre included information, counselling and coordination of health care, for every older person (60+) living in this area. The current project coordinator designed and submitted the project, after a preliminary presentation work towards the partners of the project.

2. PROJECT AS PLANNED.

THE INTERVENTION

The objectives of the intervention were to delay unwanted nursing home and hospital admissions by the means of (1) informing the FOPs about existing services in her/his respective local context and (2) to coordinate the services required by the FOPs. The intervention was defined as « a multidisciplinary intervention with the function of case management ».

A **call centre** would dispatch the requests among the case managers, based on geographic location. This call centre would function as an integrated coordination centre for home care services.

The **intervention** focussed on the FOP and the services he/she needs, after a global assessment of the situation, by the means of the following steps:

1. Identification of a FOP, based on the referral of a professional or an ICG;
2. The inclusion was assessed to ensure that the case management would benefit the FOP and that the ICG could be involved adequately;
3. If included a notification of the inclusion was send to every health care provider involved
4. The FOP was entered into the electronic software package and one of the case managers was contacted;
5. After a first contact by phone, the case manager met the FOP at home, where an Edmonton scale was used, and BelRAI;
6. A proposal of support plan was made to the FOP;
7. If agreed, the case manager called the available services (i.e. without waiting lists), in order to respond quickly to the needs;
8. The case manager did the follow-up of the situation, by the means of home visits or, in some cases, by phone calls;
9. A FOP remains in the project as long as he/she is not definitively institutionalised, deceased or when the project is not needed any more (when there are only two care providers and the situation is stable).

TARGET POPULATION

The target population was every 60+ living in the region wishing to be in a nursing home or demanding health care support.

SKILL-MIX

The project planned to use a team of five professionals (3,5 FTE) trained as **case managers** who supported FOPs in their choices, the making and follow-up of a care plan, and the contact of the services they needed, based on her/his personal resources.

The project team was composed of a social worker, educators and nursing assistants, functioning as case managers. The **coordination** between case managers should be made possible by the means of the use of IT infrastructure and coordination meetings. The software would centralized every information about FOP, his needs, the evaluation, the care plan, as well as the services available in his immediate local area.

COST OF THE PROJECT

The annual cost agreed for this project, as financed by NIHDI, was 441924 € .

INTERACTION WITH THE ENVIRONMENT

The project relied on a partnership, composed of all care and health care providers in this area. They were formally regrouped by the means of a non-profit organisation. Almost fifty organisations were thus regrouped into eleven categories of members, which were part of the board of directors or general meeting: eight nursing homes; three centres for home health care; five sickness funds; two groups of GPs; one organisation of independent nurses; one organisation of employed nurses; two hospitals; one honorific organisation; two coordination centres; nine Public Centres for Social Help.

The management of the project rested on the work of board of directors or general meeting. Formal collaboration agreements ensured the participation of every organisation.

3. PROJECT AS IMPLEMENTED

PROMOTION OF THE PROJECT

The project started in March 2010, with some financial difficulties at the onset because of some expenses not covered by the NIHDI budget, such as the renting of the offices.

The project coordinator and different collaborators put some efforts to promote the projects by the means of flyers, articles in the local media, meetings with GPs, partners, participants, etc., in order to be able to reach FOP and different professional services involved. During this promotion phase, the coordinator faced some fears of concurrence of existing services in the region.

A facilitating factor during this phase was trust between partners and everyone's agreement that organisational neutrality was crucial to ensure the success of the project and its intervention.

THE INTERVENTION

The intervention was rapidly carried out as planned.

The project does not function with a waiting list and case managers are aware that, when there is a demand, they have to **answer it immediately**, even if the recommended service is not immediately available. Central to their approach is the patient-centeredness; this can be seen in (conflictual) situations between ICG and FOP, where their role is to be the FOP's advocate. They allow themselves to take the necessary time to identify latent needs and to help in negotiations, if necessary. For this project, it is important to seek the best possible solution, given the situation and this might imply to recommend institutionalisation. Institutionalisation might be a successful outcome, if the FOP agrees to it willingly, after a supportive intervention of the case manager. This is especially the case when maintaining the FOP in her home is at her own (very high) expenses.

The **added value of case management** is essentially seen in complex situations; either when there is no ICG or if the ICG is overburdened or has not the time to intervene adequately. An essential mechanism in this aspect is

the fact that there is a trustworthy person (the case manager) who was identified by the FOP (and his/her ICG). For the ICG, emotional support is crucial.

ORGANISATIONAL FEATURES

The **coordination of the interventions** rested on the following: 1) home visits and meetings, 2) encoding of the FOP in a specific software, 3) coordination meetings « around the FOP » between the case manager, care providers and FOP. All decisions relevant to the involved care provided were made as a team and included in the software. The coordination meetings took place every two months around a single FOP and lasted two hours.

The **software** held a centralized place in this project. It enabled the following

- a. At the FOP's level
 - a. Collection of all information about a FOP, under the form of an electronic patient record;
 - b. Automatic generation of an individualized support plan (as opposed to "care plans", since this project does not support the idea of case management being "care");
 - c. Support for the coordination of interventions at the FOP's level;
 - d. Enabling continuity of care and support, even in absence of the case manager of the FOP.
- b. At the project's level
 - a. Timely information about the availability of services in a given area;
 - b. Providing warnings about the planned home visits;
 - c. Linking home visits with case managers' schedule;
 - d. Assessing very quickly the intensity of case management needed. For instance, they estimated the percentage of FOP requiring intensive case management at 15/189.

TARGET POPULATION

After several months of functioning, the project reached easily its expected **caseload** of 189 FOP and had to reduce the intensity of their interventions. The success of the project with the population forced the project to replace a home visit by phone calls, when a home visit was not found indispensable.

Overall, the FOPs seem to be referred by structures (hospital, nursing homes...) or by professionals (family help, household support, social worker, nursing assistant, dietician, home attendant, etc.).

SKILL-MIX

The project recruited seven **professionals** (one social worker, one nurse, one occupational therapist, and two educators), working as case managers, plus one coordinator of the project and one secretary for the call centre.

Table 10. Evolution of the skill-mix of project CMS204

Profile of the professional	Planned (FTE)	Time 0 (Dec 2011)	Time 1 (Dec 2012)
Social worker	0,55	1	0,5 (1) + 0,75 (2)
Nurse	0,85	0,5	0,5
Occupational therapist	0,75	0,75	0,5
Educators	0,80 (1) + 0,55 (2)	0,75 (1) + 0,50 (2)	0,75 (1) + 0,50 (2)
Administrative worker	0,5	0,5	0,75
Coordinator	1	1	1
TOTAL	5	4,25	5,25

Because of the high pressure related to the workload, it was not possible to attend external trainings at the onset of the project. Later the collaborators attended external trainings in Germany, where specific case manager training exist (as opposed to what exists for the moment in Belgium). Collaborators having attended external trainings were requested to diffuse the information among their colleagues.

The project management was done by the means of director's board meeting, twice a year. Work meetings were organized four times a year, and they related to themes linked to the current problems with partners of the project.

In comparison to the start of the project, the occupation of different professionals changed slightly: increasing of the working time by the social worker and decreasing of the working time of the nurse to meet the needs of the activities required by the case management activities. Indeed, the type of case management carried out is more of social nature.

The main coordinator and the case managers were all responsible for the introduction of data about every FOP and **were the only ones to be able to access it**, by the means of a secured access portal. This software grew with the project and, three years after the start of the project, the coordinator was fully satisfied with its functioning. The improvement and management of this software represents a workload of +/- 2 days/month for an ICT technician.

The size and activity zone of the project being very large, it was divided among **five case managers**, each being responsible for her own zone. This allowed an in-depth knowledge of the local offer of services. The referrals are sent to the different case managers by the means of the call centre.

A hindering factor was the fact that some case managers did not have access to BelRAI application. To address this difficulty, they had to ask a colleague working in the same building, but outside the project, to help them to access the database with the help of his e-ID card.

COST OF THE PROJECT

The project asked for and obtained an increase of its financing in December 2012, from 441924€ to 467704€, due to the initial underestimation of the cost of the data encoding (BelRAI). Data about the repartition of the cost is provided in the cost analysis part but it is worth mentioning that this project used an important part of its resources for the making and updating of the ad hoc ICT tool (+/- 2 days/month of a computer technician).

4. ADAPTATIONS

Challenges faced and adaptation strategies adopted by the project are displayed in the table below.

Table 11. Challenges and adaptive strategies of project CMS204

Challenges	Adaptive strategies
The low level of GPs' engagement	Improved communication strategies towards FOPs' PCP, by systematically provision of feed-back about the FOP being in the project
The fear of concurrence, expressed by the geriatric team of the local hospital	The social services of the hospital is engaged in the process, as an intermediate figure between the FOP and the PCP Formalisation of role definition between care providers, with the support of the software
FOPs' social, psychological and cultural barriers to ask for help	Take time to study all the needs of the FOPs, including latent needs, and seek acceptable solutions, taking into account the priority of FOP's autonomy in decision-making.

Project evaluation is done during project meetings every three months, with all partners and participants.

5. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

Eventually, Figure 5 summarizes the logic of the intervention in this case study, along with the activities used by the project and the description of the mechanism by which the project expects to achieve its expected outcomes in its given context, by the means of Ridde and Haddad's description of the programme's theory (Ridde and Haddad, 2013).

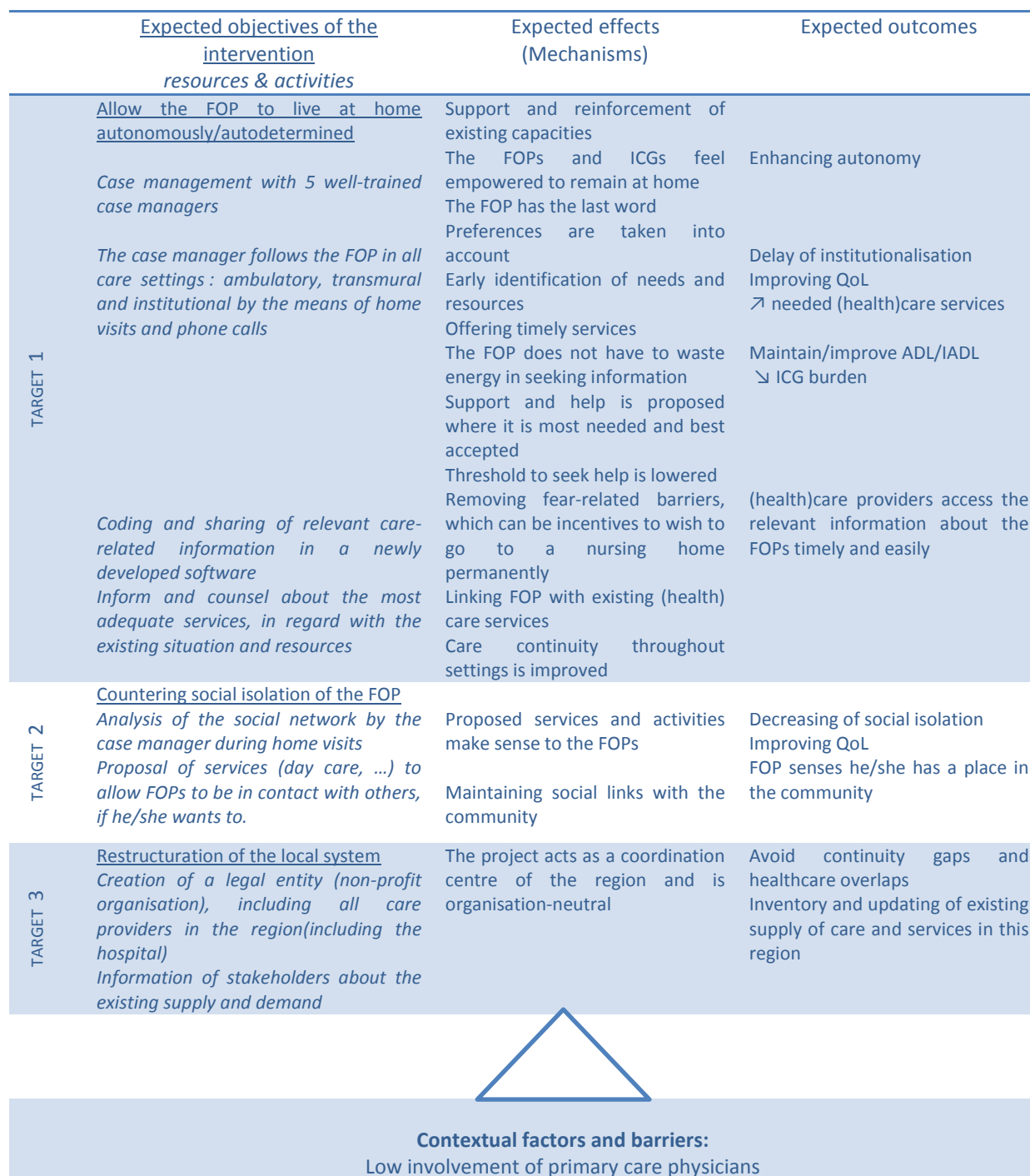


Figure 5. Programme theory of project CMS204

6. KEY ELEMENTS FOR THIS PROJECT ARE

1. The expertise built upon the previous project, as the collaborators remained the same;
2. The legal entity built to formalise the agreements between all health and care providers in the region and ensure in this way the project neutrality;
3. The central role of the software, which was organised to meet the specific needs of the project and allowed the organisation and sharing of the information about the FOPs and the local resources in order to manage the project by the means of a tight supervision by the project manager;
4. The level of agreement between the collaborators of the project, about the type of case management provided, by the means of the continuous specific case management training abroad.

3.1.1.10 KEY POINTS FOR PROJECTS DELIVERING ONLY CASE MANAGEMENT

- The profile of the case manager was very diverse and tended towards social workers, influencing the type of case management provided, where the central functions were more oriented towards improving health literacy, counter social isolation and supporting the FOP in the orientation into the health care system than biomedical or psychological support. This finding is supported by the fact that (1) none of these projects used the BelRAI for making a care plan and (2) that, with the exception of one project, the interaction with GPs was poor, suggesting a cleft between biomedical and social care.
- Due to the fact that this category of projects did not provide extra services along with case management, the role definition of the case managers might have been facilitated, in comparison with projects where case managers were also providing usual care.
- For the same reason (no other services provided), the level of embeddedness of this type of projects, defined by the level of interaction with other local organisations, especially entities that were likely to provide a type of coordination, such as coordination centres (SISD/GDT or SEL/CCSSDs), independent nurses or GPs was very important. This interaction allows the fluent referral of possible candidate FOPs to be included in the projects. For this motive, we postulate that this is one of the reasons one project had to stop, having never succeeded in reaching its caseload.
- All these projects used a structured tool to share data about the FOP in the project among project collaborators, with the exception of the project that stopped, of which we do not have data for this item. Data of the case study showed that this was central for the working of the project.
- Except for the project that stopped, the umbrella organisation was a centre for home (health) care organisation; the project that had to stop had a nursing home as umbrella organisation; it is possible that this might have affected the credibility of this projects towards possible referrers, strengthened by the fact that this project had no structural relationships with coordination or community centres.

3.1.2 PROJECTS PROVIDING CASE MANAGEMENT IN COMBINATION WITH OCCUPATIONAL AND PHYSIOTHERAPY

3.1.2.1 THE INTERVENTION

These seven projects declared that they provide case management in the first place, even if in very diverse wordings : « *Pro-actieve opvolging van fragiliteit* » ; « *Intake, advies en screening/ Zorgbegeleiding en afstemming* » ; « *Zorgcoördinatie* » & « *Création d'un plan de soin via l'outil BelRAI + renfort de la coordination pluridisciplinaire et du réseau psycho médico-social* », etc.. The diversity of these wordings asked for a more precise description of the service. Firstly, we verified if, as described in the introduction of this section, they really provided case management, by the means of (a) use of the results of the BelRAI to make a care plan in collaboration with the FOP and, if possible, with her/his ICG ; (b) coordination of the care provision, in collaboration with the (health) care provided, as required by the needs and preferences assessment ; (c) evaluation and reevaluation the care provision and coordination's adequacy and (d) adjustment if necessary. Secondly, we provide a description of the **professionals** delivering this service, the **training** they attended for this specific function and the **intensity** of the services (frequency and duration) allowed a fine-tuning of the model of case management provided.

Services provided along with case management

Occupational therapy

In those seven projects, occupational therapy (adaptation of the home, falls prevention, help with mobility) is provided by occupational therapists. The intensity of the services varies from 'irregular' to 'once a week'.

Physiotherapy

Besides delivering case management AND occupational therapy, four projects deliver also physiotherapy and this service is provided by a physiotherapist (kiné), paid by the project. This physiotherapy is delivered on an irregular basis or once month, in every case at the FOP's home. The main aim is to support the FOP's autonomy.

Speech therapy

Three projects in this category also offer speech therapy and the speech therapists are paid by the projects. Those speech therapy sessions can be provided in addition to case management and occupational therapy and, for one project, with physiotherapy. The content of the therapy aims at supporting meal times (swallowing disorders) and delivered at home, on an irregular basis (2 projects) or monthly (1 project).

Duration and intensity of the interventions

All interventions in this subgroup include FOPs as long as they are at home, i.e. not definitively institutionalised.

Among those seven projects, the intensity of the case management and other services provided varied strongly, from 21 h/year to 187h/year (median = 53). One project declared to deliver a care trajectory, without specification of the number of hours spent in care. The projects state that they adapted the intensity of case management and other services to the needs of the FOPs, for instance, in transitional or crisis situations, they felt that their intervention should be more frequent and in stable situations, they could intervene less often, or through phone calls.

An overview of these components is displayed in Table 13.

In these seven projects, the intervention starts with and is articulated around case management that contains *de facto* a coordination component¹⁰. Moreover, the seven projects declare to systematically include the ICG during the meetings at home. This was verified further when analysing FOP data.

Out of the seven projects, six declare to use BelRAI results to identify the needs of the FOP (CAPs and results of scales) and all make up a care plan, which is evaluated at 'regular' intervals (at least every six months, which corresponds to the NIHDl requirements in the scope of the scientific evaluation).

Multidisciplinary meeting holds also an important place for coordination. The seven projects organize this type of meeting at the FOP's home, in presence of the frontline workers of primary care, GP included. This meeting is organized at least once yearly. The projects meet more frequently (i.e. in between) about complex situations, in absence of the FOP or her/his ICG. In that case, multidisciplinary meetings are hold at the umbrella organisation or, for one of the projects, at the region's level, in an ever changing place.

The information flow about a single FOP occurs mostly through informal channels, such as phone and email, and the notebook at the FOP's home.

Four out of the seven projects declare spontaneously that they miss a shared FOP record, common to all health care and care providers around a FOP.

3.1.2.2 THE TARGET POPULATION

Out of the seven projects, three aimed at recruiting FOP with or without dementia. Only one project (which was the project under case study) aimed specifically FOP with dementia and her/his ICG. Three of the seven projects recruit FOP on a waiting list for nursing homes.

Concerning inclusion criteria for the project, it is unclear which criteria are used, besides the mandatory ones of the NIHDl, to define if and how the intervention offered by the project is adequately linked to the needs of the FOP. In other words, evidence-based recommendations (but also common sense ...) claim that case management is of particular benefit for people in complex care situation. Therefore, one might expect the complexity is acknowledged by the projects. This is not the case.

The profile of the population included is displayed in Figure 6 below.

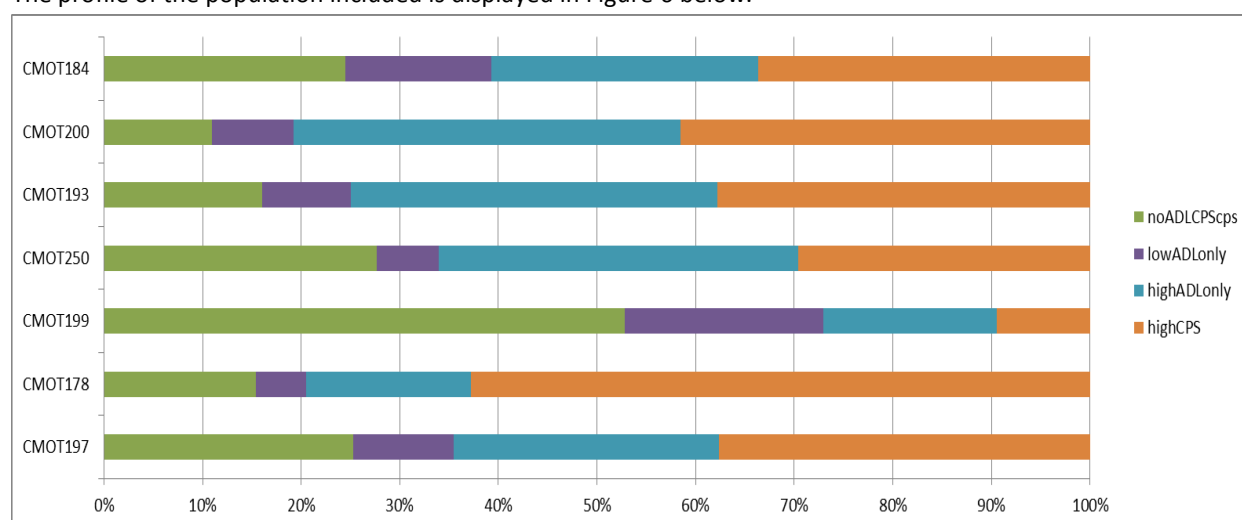


Figure 6. Profile of the population at inclusion in projects providing case management with occupational and/or physiotherapy

¹⁰ It could be interesting to try to find out if projects deliver services in an organisational logic (i.e. delivering the services because the organisation offers it), or if it is really FOP-centred.

3.1.2.3 THE SKILL MIX

The profile of the case managers

In these projects, case management is carried out by nurses (2 projects); a team of nurses and occupational therapists (1 project); nurses and social workers (3 projects) or social workers and occupational therapist (1 project). In case of need, e.g. maternity leave, other professionals may take on this role (e.g. occupational therapists and physiotherapists). In that case, this was done at the expense of the services the latter had to provide, i.e. occupational therapy¹¹ and physiotherapy¹².

Only one project did not include nurses for case management (CMOT199). The data of the case studies (below) show that the projects preferred to recruit **experienced** nurses. This experience may be related to the work with frail older persons and/or cared for at home, or with case management. Indeed, an important feature of this case management service delivery relies on the coordination of interdisciplinary work among health care providers at the primary care level. An in-depth knowledge of the network of health and social care is reported as being valuable. At the opposite, when the project had to function temporarily without those experienced professionals, this was perceived as a drawback at the case management level. They prefer then to switch the content of experienced professionals, which have this 'network knowledge', but are not nurses, instead to hire a non-experienced nurse. Indeed, if the latter has been trained to advocate a global approach of the FOP's needs, the lack of familiarization with the local network is an important gap to make this case management function work properly.

The FTE case manager to FOP ratio varied from 1:9,6 to 1:67 in this subcategory (median = 1:18). Detailed information can be found in Table 13.

The project having a FTE case manager to FOP ratio of 1:67 (the first project of the case study) estimates that this number is too high and that they are not able to perform case management in optimal conditions. Indeed, to be able to face the high workload that is a consequence of too many cases per case manager, this project reduced the number of contacts with FOP, in order to allow them to be maintained in the project, even at a suboptimal level. Unsurprisingly, this is also the least expensive project.

Occupational, speech and physiotherapy were delivered by dedicated professionals. Interestingly, the median caseload of these projects is visibly higher than in other case management projects (107 versus 70).

Training for case management

In order to be able to manage the complex situations these professional encounter, three out of the seven project organized internal trainings in case management, focusing on the use of the results of the global individualized assessment in a patient-centred care plan during intervision sessions held at the provincial level. Another project organized intervisions, but not specifically aimed at improving case management skills. One project that did not organize such training recruited since the start, and purposefully, an experienced, highly skilled geriatric nurse. As she had formerly a leading role in the internal geriatric liaison team in a teaching hospital, she experienced the implementation of the comprehensive geriatric assessment tool (BelRAI) before, which was highly valued by the project coordinator who recruited her.

¹¹ Occupational therapy and occupational therapist = 'ergotherapie'/'ergotherapeut' (NL) or 'ergothérapie'/'ergothérapeute' (FR)

¹² Physiotherapy and physiotherapist = 'kinesithérapie'/'kinesithérapeut' (NL) or 'kinésithérapie'/'kinésithérapeute'. NOT to be confused with the Belgian appellation of « Physiothérapeut/Physiothérapeute », which is a medical subspecialization ('Geneesheer-Specialist voor fysische geneeskunde en fysiotherapie' 'Médecin spécialiste en rhumatologie et physiothérapie')

3.1.2.4 THE COST OF THE PROJECTS

Looking at table NN, project CMOT197 is a project with a low cost, in comparison with the other projects in this subgroup. This could probably be explained by the high FTE CM to FOP ratio of this project. The project, which is part of the case study, articulates strongly its intervention around the use of BelRAI into structured care plans from start and could rely on the expertise of the nurse coordinator (and case manager of the project), which explains probably the adequate use of resources since start. In the working of this project, they identify FOP with a stable situation (i.e. needing a less intensive follow-up of their 'case', even by phone) and FOP with an unstable situation, for which they plan an intensive (i.e. sometimes weekly monitoring).

3.1.2.5 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

All seven projects seem to have some interactions with the local coordination centre (SISD/GDT) they are part of, except for one project, where the case managers attended coordination meetings initiated by the coordination centre. This project mentions interoperability issues between the BelRAI and the software of the coordination centre, which is a barrier to information flow between the project and the coordination centre. Four other projects declare receiving the support of a coordinator of a sickness fund to help them in their case management care delivery.

At the level of coordination around a single FOP, the collaboration with the GPs was quite diverse. Two projects report that their collaboration with the GP was very low and two others, that it was satisfactory. For the latter, this can be verified by the systematic attending of multidisciplinary meetings by GPs at FOPs' home. One project seems to be tightly (exclusively ?) linked to the umbrella organisation and only mentions meetings with representatives of this organisation for coordination, while a project signals that they attend meetings, which are organized at the hospital, before discharge of the FOP.

Those two latter projects merely interact with the Social Centre for Public Support and sickness funds, which might be seen as a proxy of a higher level of embeddedness in the local network. It is noteworthy that one of the projects which declared a low level of embeddedness (and is part of the case study), declares also that its intervention is perceived as too intrusive by the other disciplines.

3.1.2.6 ADAPTIVE BEHAVIOURS

As project coordinators were eager to recruit professionals who were more likely to support successful case management, some projects delayed the start of their intervention.

The intensity of the intervention is systematically adapted to the needs of the situation; there is no such thing as "one size fits all" activities of case management. We have some hunches that the intensity was also lowered when the workload was too high, as during interviews, the members of the projects switched from systematic home visits to phone calls to monitor the situation.

3.1.2.7 EXPECTED EFFECT ON THE OUTCOMES AS A RESULT OF THE NORMATIVE ANALYSIS

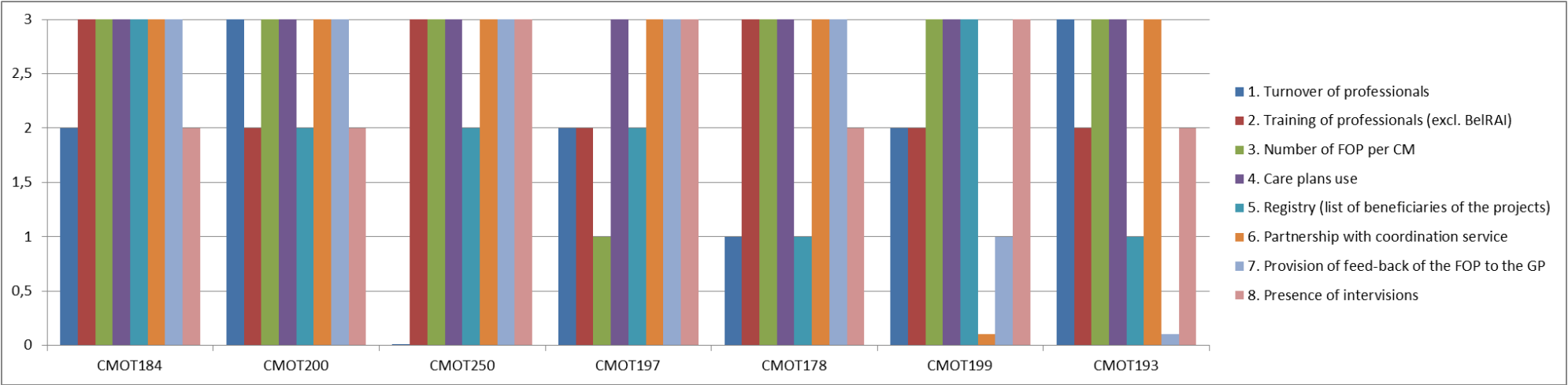


Figure 7. Normative analysis of projects providing case management with occupational therapy (and physiotherapy): view per project

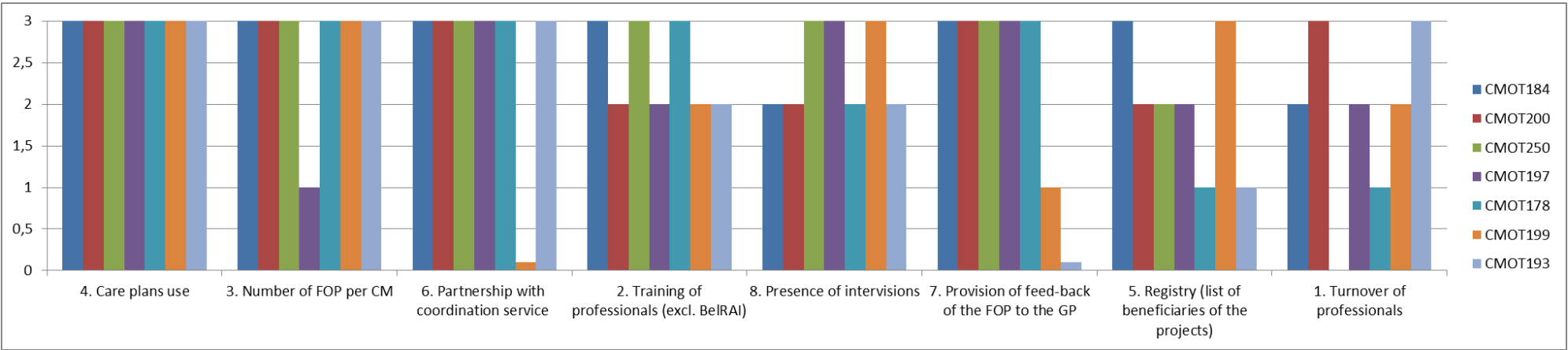


Figure 8. Normative analysis of projects providing case management with occupational therapy (and physiotherapy): view per item

According to figures 7-8, care plans were used by all projects and included the results of the BelRAI, which reflects the evolution of the perception of the actors of the projects because at onset, they declared to be reluctant towards the use of the tool, considered too time-consuming.

The number of frail older persons cared for by full-time equivalent case manager was below the cut-off of 40 in all but one project, which is part of the case study. This project reported indeed a high workload and, as a result of this, the need to decrease the intensity of their interventions by monitoring the situation by phone instead of home visits.

Partnership with coordination services was planned and carried out by the means of regular meetings between partners in all but one project, which is described in the second case study. This project reported having a non-medical type of case management, focusing on the coordination of the care and service plan situated on a functional independency level.

On average, the training of professional was specific for the meeting the needs of the target population in three of the projects.

Closely linked to this item, the presence of interventions as a means of continuous training was present also in three of the projects, which were not necessarily the same as the ones in which specific training was provided.

The projects provided extensive feedback to the individuals' GPs in five projects. This was not seen in two projects, of which the non-medical type of case management project described above and in the case study.

Two projects reported having a ICT tool to facilitate the information flow about the coordination management of the care needed.

Only two projects did not report any turnover of their case managers.

(for more details, the reader is invited to go to Table 12).

3.1.2.8 SYNTHETIC TABLE OF THE PROJECT'S DATA

Table 12. Synthetic table of the features of projects providing case management with occupational and/or physiotherapy

Criterion	CMOT197	CMOT178	CMOT199	CMOT250	CMOT193	CMOT200	CMOT184
Objectives of the intervention	Support of FOPs by the means of CM and support of care; main focus is proactivity, information to ICGs & PCGs; psychosocial support	Tailored care; support of ICGs and provision of adapted services	Supporting network & case management for visual impaired FOPs; enhancing autonomy is crucial	Support of intramural and extramural care; tailored care by the means of case management & multidisciplinary meetings	Support for and tailored care; coordination of existing care	Support of intramural and extramural care; tailored care by the means of case management & multidisciplinary meetings	Support of existing care; provision of non-reimbursed nursing care (CGA & monitoring); support of ICGs
Description of services provided	Nurse : CM & Psychosocial support of FOP or ICG; OT: Counselling about the home adaptation by OT; Physiotherapist: Falls prevention (home) & group sessions	Nurse: CM & PS support of FOP and ICG; Nurse assistant: PS support to FOP and respite to ICG at home at night OT: ADL assessment & counselling of FOP by OT at home; Physiotherapist : Coordination of physiotherapy & falls prevention; Master Family Sciences: CM; Group session for socialization; Speech therapist: Screening and treatment of speech or swallowing disorders	Nurse : BelRAI completion and psychosocial support; OT: ADL assessment & training at home; counselling; Orthoptist: Demonstration of low-vision aids ; SW: Making of a psychosocial care plan; Speech therapist : Screening and treatment of swallowing disorders	Nurse: CM & Day control visit OT: ADL-training & home adaptation; memory training; SW: CM & PS Support by social worker Nurse assistants: ADL-support at home	Nurse: CM & Day control visit OT: ADL-training & counselling about the home adaptation Group sessions -FOP Entertainment Physiotherapist : Coordination of physiotherapy & falls prevention SW: CM & PS Support by social worker Speech therapist : Cognitive stimulation & Memory training	Nurse : CM & Day control visit; OT: ADL-screening & counselling about the home adaptation; memory training; SW: CM & PS Support ; Speech therapist : Group sessions for speech therapy; Screening and treatment of speech or swallowing disorders; Nurse assistants: ADL-support by nurses or nurse assistants at home; Dietician : Nutritional education	Nurse: CM and monitoring; OT: Assessment & counselling about the home adaptation by OT

Criterion	CMOT197	CMOT178	CMOT199	CMOT250	CMOT193	CMOT200	CMOT184
Profile of the CM	Nurse	Nurse + OT	SW + OT or other	Nurse + SW	Nurse + SW	Nurse + SW	Nurse
Total FTE involved in case management	2,25	3,65	3,2	5,57	9,4	9	3,1
Ratio FTE CM:FOPs	1:67	1:16	1:37	1:24	1:9,6	1:14	1:34
Profile of <i>expected</i> target population	General population of FOPs	FOPs on a waiting list for NH admission	FOPs with visual impairment	General population of FOPs	General population of FOPs	General population of FOPs	General population of FOPs
Expected caseload	150	60	120	100	90	130	107
Achievement of the caseload	Yes (and exceeded)	Yes (and exceeded)	Yes (and exceeded)	Yes	Yes	No; asked decrease of 10% of the planned caseload	Yes (and exceeded)
Recruitment means	HC services & hospital	Waiting list for NH	HC services	waiting list for NH & HC services	waiting list for NH & HC services	waiting list for NH & HC services	HC services
Partnership with coordination service (SISD/SEL/GDT or CCSSD)	Yes	Yes	No	Yes	No	Yes	Yes
Partnership with community organisations	Yes	Yes	Yes	Yes	Yes	Yes	No
Incentives for GP participation	No	No	No	Paid by project	Paid by project	Paid by project	No
Provision of feed-back about FOPs to the GP	Yes	Only in case of need	Only in case of need	Yes	Yes	Yes	Yes
Presence of interventions/planned supervisions and MD group meetings to enhance the knowledge of case managers	Yes, and include a supervisor	Yes	Yes, and include a supervisor	Yes, and include a supervisor	Yes	Yes	Yes
Care/service plans use	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Use of BelRAI results	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ICT Tool for clinical coordination	EHR + for project management	EHR	EHR + for project management	EHR + for project management	EHR	EHR + for project management	EHR + for project management
Duration of the intervention	permanent	200 days	permanent	permanent	245 days	permanent	permanent

Criterion	CMOT197	CMOT178	CMOT199	CMOT250	CMOT193	CMOT200	CMOT184
Umbrella organisation	NH	NH	HC	NH	NH	NH	HC
Missing elements for the project?	More collaboration with GP	More FTE logo	Need for better definition of the role of CM	More time for coordination	organisation of transport; more coordination with partners	More time for coordination	
Unit of activity	1 care-hour	3,8h or 1/2 day	1 care-hour	1 care-hour	1 care-hour	care package	care-hour
Nb of Units/FOP (Sept 13)	20,92	13,93 (=53h)	80	52,06	187,61	1,02	53,03
Annual cost per FOP	€ 801	€ 2.760	€ 2.761	€ 2.502	€ 3.799	€ 2.815	€ 2.215

3.1.2.9 CASE STUDY 2

Case Management project providing also occupational and physiotherapy (CMOT197)

The project is evaluated as case study since the onset of the evaluation and was followed for four years (2010-2013). It started the 1st October 2010 and is composed of two main strains: 1) Psychosocial support of FOP with dementia and their ICG + 2) Screening and follow-up of frailty ("*vorm van trajectzorg*").

The project has two locations: (1) a medium-sized city and (2) a rural town. The main location is situated in the city.

1. CONTEXT OF IMPLEMENTATION

The project is born out of the intuition of the project coordinator, who happens to be the director of three nursing homes and claims to be very concerned with the problem of dementia in FOP. He participates in self-support groups for ICG of FOPs with dementia, instigator of many projects around respect for demented persons, etc. In short, an engaged person. From the PC's point of view, there was a dearth of services for FOP with dementia: lack of information, access to relevant services, coordination, etc.). Therefore, he started a project six years ago, which lasted three years, around support for FOP with dementia living at home. This project stopped because of financing: it was completely self-supporting. This experience learned two important facts: (1) there is a need for this type of support (cf. furious phone calls when the previous project stopped and (2) this type of project needs time and energy before people know about it. The Protocol3 project may build upon the network that was created in the previous project.

From the project's point of view, this implementation process is a really learning opportunity, in order to prepare a vision for the future *woonzorgzone*¹³. (litt. Living and caring zone)

2. THE PROJECT AS PLANNED

THE INTERVENTION

The project is based on the assumption that proactive screening is needed for older persons, in order to be able to identify needs, preferences and resources of the FOPs and his informal caregiver and offer the possibility of access to adequate options and care in a timely manner. The project plans this to be done by the means of a nurse case manager, after first discussion by the case manager at home and planning of further home visits, in order to complete the information after a trusting relationship will be built. Based on this information, the BelRAI will be completed, which will allow checking CAPs and results of scales. Out of the activated CAPs, three will be chosen which are to be presented to the FOP. Priority will be given to CAPs where an improvement can be expected. A very important part of the intervention is aimed as to provide intensive support to the ICG, especially when the FOPs has a dementia problem.

The case management function will be completed by two other functions, namely occupational therapy and physiotherapy, expected to have an important effect on the delay of institutionalisation, by the means of physical activity in group, which is supposed to be an important component to counter loneliness and social isolation.

Two ways of referral will be possible: either by a colleague (occupational therapist, working part-time) in a geriatric ward of the local hospital, or by means of a primary care worker. If the FOP is still at the hospital, a first screening will be performed there, by the colleagues in the hospital, to which the inclusion criteria will be transmitted. If positive, the FOP will be referred to the project and the informed consent signed.

¹³ This living and caring zone can be a neighborhood, a municipality and aims at promoting the wellbeing of the residents in that area in such a way that everyone, even older persons and beneficiaries may remain at home. A specificity is the care node, where residents can address their care question and where they can get the care they need. This has to be accessible for everyone, with streets and squares without obstacles, enough residences and services designed for all.

TARGET POPULATION

The type of FOP is everyone coming from the catholic 'pillar': Christian Mutuality, family help, etc. They have much less collaboration with other sickness funds. Other FOP will be coming from the Social Centre for Public Support. The choice to include FOPs from two locations was motivated by the expected diversity of the population (urban and rural), in order to have more diverse observations of what type of case management would be more relevant for which populations.

SKILL-MIX

To start the project, the project coordinator wanted to hire at least one experienced nurse (geriatric nurse with an extensive experience with the use of BelRAI assessment), one less experienced nurse, but with a social background (community nurse), a physiotherapist and an occupational therapist.

COST

The expected yearly financing by NIHD is 154935€

INTERACTIONS WITH THE CONTEXT

They expect a high level of interaction with the FOPs' GPs, considered as crucial partners in the primary care. The other partners of the project are a centre of mental health, a circle of general practitioners, a local general hospital and a coordination centre (SEL). The partners were chosen on the grounds of their potential for collaboration, more specifically on the grounds of their capacity to refer FOP towards the project.

3. THE PROJECT AS IMPLEMENTED

THE INTERVENTION

The intervention was carried out as expected, except for the psychosocial support of the ICG, which was one of the main objectives of the project. This could not be carried out easily, because they observed that the presence of the FOP hindered, in many cases, a free discussion with the ICG. This was the reason why the service tried, when possible, to come with two care providers to support the ICG, where, for instance, the occupational therapist worked with the FOP, while the nurse or case manager had a discussion with the ICG. This is of course time-intensive. Moreover, they noted a tension between the expectations of the informal caregivers (e.g. descendants), who ask for more household support and less activities with the FOP (e.g. memory training by a family help).

The project noted also that the requests for case management often come too late, when the ICG is already overburdened: after a hospital admission or a meeting with the coordination centre. Even the GP asks too late for them.

In most cases, the home visit occur after planning, excepted in the cases where unannounced visits are requested, such as in cases of suspected neglect, disturbed day-night rhythm.

Tools for case management include FOP records and notebooks, as well as informal means (phone calls). The FOP, his/her ICG (mostly descendants) are highly involved in the making of the care plan.

Tools for the intervention. Intake with a computer at home was difficult because, when questions were asked with the computer, the people were reluctant to speak: they think they are a generation too early. This was the reason why BelRAI was firstly done on a paper version and then quickly encoded in the application, in order to be able to extract the results of the CAPs and scales.

Multidisciplinary meetings occur mainly at home, but the project stressed the fact that it was often difficult to find a moment to meet all partners at home, because of conflicting agendas. The project adapted its time schedule by expanding working hours, in order to be able to meet ICGs (twice a week they worked later).

The notebooks at the FOP are indeed a minimum, but the projects stated that this was not enough. For instance, if they estimated that the FOP needed a physiotherapist from outside the project, there was no follow-up and other means had to be used (phone calls or emails).

Information from geriatricians occurred **verbally** and this was also the case of information from social service of the hospital.

In the local area, there is a shared medical file, where the care provider is allowed to add a word document. This software is not compatible with the BelRAI software. Moreover, the GPs are reluctant to use BelRAI.

TARGET POPULATION

They claim that 75% of their FOP has a cognitive disorder but that not everyone of that group has a diagnosis. They observe that there are not so many FOPs in the rural area: in this case, they are often coming from farmers' families, where the children are much more present. In the urban zone, there are also less ICGs.

They note also a difficulty to sign the informed consent because the content is mostly incomprehensible, especially for FOPs with cognitive problems. This is never done during a first meeting. Mostly descendants sign the form. When asked if the profile of the FOP signing the informed consent is different from the FOPs not signing it, the projects seems to consider that the FOPs coming from labour classes have a very hard time understanding the meaning of the informed consent.

SKILL-MIX

To be able to organize the case management interventions, it was planned to hire two case managers, (two bachelors in nursing), ¼ FTE physiotherapist, ¼ FTE occupational therapist and ¼ FTE speech therapist. The project did not have any recruitment problems but had to start later than expected, because of the fact that PC wanted absolutely to hire an experienced nurse. This case manager is considered as the central axis of the current project. She is trained as a geriatric nurse and was actively involved in the unfolding of the geriatric liaison function in a teaching hospital, using the BelRAI as comprehensive assessment and case management tool. According to the project coordinator, the profile needed to be able to carry out case management in this project is a nurse or nursing assistant, with experience with geriatric patients.

The two case managers are responsible for the organisation of the case management pathways, while the three others work within their domain of expertise. In order to reach the caseload of 140, the physiotherapist and occupational therapist had to function as a case manager in the starting phase. The idea to hire a speech therapist was not carried out, because it was found less needed than expected and, if required, it is always possible to hire an independent speech therapist.

Therefore, the project asked to switch the ¼ FTE speech therapist at a ¼FTE nurse. This was accepted by the NIHD and the convention changed accordingly. The physiotherapist works ¼ FTE in the project, but also ¾ FTE in a nursing home. The nursing assistant had also already an experience with this population, as she worked formerly in a nursing home. Finally, the occupational therapist works ½ FTE in a geriatric ward in the referring hospital.

Since the expected caseload is not achieved for now, they remain with 2 FTE nurses, instead of the planned 2,25 FTE. In December 2011, PC considered a change of convention but in 2012 this was not done. Reasons for this are unknown.

Because of a long-term sick leave and maternity leave of one of the nurses, new nurses had to be recruited. The turnover of nurses puts a heavy burden on the caseload and is also an issue for continuity of care. The entry time of a new nurse is estimated to be at minimum three to four months, even more if she works part-time. Normally, recruitment should not have been problematic but it was for the project because of two reasons. Firstly, because of nurses' shortage, secondly, the 'new' framework of the project provides a sense of insecurity. Working as a nurse in a hospital is perceived as more 'safe': in the current project, you have to work with new people, you have to start from scratch, which can be considered as threatening.

In the basic training, there is a chronic lack of training about care for older persons. In this context, they need even more training about the making of a meaningful, evidence-based care plan. Because of the high pressure because of the workload, it was not possible to attend external trainings.

Additional training of the case managers is done by the means of weekly interventions. Each collaborator, on turns, gathers the necessary literature to prepare those interventions.

ORGANISATIONAL FEATURES

There was a very high pressure, from the project itself, to reach the caseload of 140. This caseload was proposed initially, but appeared quickly unrealistic. In October 2011 there were 114 in the BelRAI app, which was low, considering that this project used actively the BelRAI for care purposes. In order to maintain this number of FOPs, the interventions became less intensive and case management was done by phone calls in some cases. There were even FOPs in the project, which did not need any intervention. As says one of the members of the project: *"It is sufficient to know that it is possible to count on the project ..."*

The coordination of the project occurred by the means of a monthly meeting in the nursing home. It lasted two hours and the minutes of this meeting are introduced in a sharepoint that every collaborator has access to. Care providers were also present and the decisions made collegially.

AUTO-EVALUATION OF THE PROJECT

The project did not proceed to self-evaluation, but the coordinator expects this to be done by the scientific team. Overall, the project finds that the case managers are very well received by the FOP.

INTERACTIONS WITH THE CONTEXT

Meetings with external partners around a single FOP occurred at the coordination centre or at the sickness fund's location, when initiated by the latter. This happened often when the FOP was admitted in a hospital, in order to check whether the transition to home care is doable.

Once a month, the case manager was invited to attend the multidisciplinary meetings at the mental healthcare centre, in order to discuss individual problems of FOP.

One of the biggest barriers is that there is a risk of overlapping with the work field of other care providers, especially for care providers delivering care at home.

Another main difficulty was the existence of waiting list for services the FOP needs immediately, especially services to support the burden of the ICG. Waiting lists are not confined to nursing homes, primary care services also have waiting lists and, when a place becomes free, it is more than often too late.

The added value of the project team is being recognized by other primary care providers (GPs, professionals of sickness funds, etc.), because they learn to know other aspects of the needs of the FOP, which are largely understated for now.

The project fills out the whole BelRAI and does not, as it is sometimes the case in other projects, entrust it to other nurses from employers' organisations. GPs are very reluctant towards the use of BelRAI, which explains that this part is not filled out if one of the project members does not do it. The project provides feedback to GPs, when there is a problem. In this case, this is done by phone. It may happen that some FOP do not want the case manager to warn the GP. It is very difficult to find a balance between what the FOP desires and what is desirable for the FOP. This is the case when the FOP needs help (based on the needs assessment form), but refuses it. In that case, they provide the minimal care delivery, in order to maintain a meaningful relationship:

Case manager : *« I am allowed to enter the house and if more intrusive activities are required, it happens during my absence, e.g. cleaning in the home of a FOP living in a 'dirty' environment. »*

The case manager makes a schedule manually of the FOP needing a re-evaluation after six months, etc. .

A year after the start, the collaboration with two of the partners is suboptimal: (1) collaboration with GPs is very poor, except for five of them (2) centre for mental health: despite requests for support in difficult

situations, there are few answers. Two years after start, some partners refer FOPs as expected and they observe that the geriatricians and neurologists of the local hospital are the main referrers (90% of the FOPs of the project).

At the onset, there seemed to be fear for concurrence, from the physiotherapists in the coordination centres and sickness funds. The project coordinator had to justify the precise boundaries of the physiotherapy intervention in the project. In this case, the physiotherapists in the project only conducted the geriatric assessment, not the activities of the nomenclature. Moreover, they observed that the FOPs of their project were more dependent than the beneficiaries cared for by the other partners.

INNOVATION WITHIN INNOVATION ?

« I think we cannot do as if this does not exist and only consider frailty, when isolation problems are so huge. » (PC, interview 2011)

This project tried out sessions of physical activities two afternoons per week, in patients with Parkinson disease, in order to counter isolation in this population groups. Moreover, they wanted to restore continuity of exercise programs, initiated in hospitals. During these sessions, the ICGs would have met the case manager, in order to monitor the follow-up of the care. This initiative was discontinued, because of parking problems, but restarted after several months, with a smaller group.

The coordinator considers the current Protocol3-project as a learning opportunity and tries different modalities within the project, such as fitness for older persons. They will try this another way later on.

4. ADAPTATION STRATEGIES

- The project started later than expected, because the main coordinator wished absolutely to recruit a geriatric nurse with experience. She had to give notice at her previous work. This might probably have an impact on the achievement of the caseload in the time required by NIHDI.
- At this time, there is still no change of the caseload. This is indeed a surprising decision, as the recommended FTE CM to patient ratio is 1:40. The project prefers not to lower the caseload, but to lower the intensity of the interventions or replace face to face contacts by phone calls. Here there is a risk on the quality of the case management process and overburdening/demotivation of the CM, but also on the intensity of the care provided.
- Lowering of the intensity of the care provided, because of the high caseload. The face-to-face contacts may be replaced by phone calls. This raises concern on the quality of the care and even on the impact of patient outcomes.
- Changes in the type of care provided by the physiotherapist, organising care for more dependent patients, as not to concurrence the work done by the physiotherapist of the Christian Mutuality.
- For the previous cited reason (fear of concurrence), multiplication of meetings with other care providers
- Staff turnover in nurses because of long sick leave and maternity caused other care providers to playing the role of CM (occupational therapy and physio). As a result, the care plan could not be implemented as wished.
- 0.25 FTE intended speech therapists became 0.25 FTE nurse, because the project thought this profile more relevant. Speech therapist are used, but outside the project (independents).
- Changes of working hours, as to offer the possibility to informal caregivers to be reached, outside office hours. This shows a level of flexibility of the project, as to adapt to the needs of the informal caregivers.
- Less training than expected, because there was not time for this, because of the turnover of the nurse and the high case manager to frail older person ratio. As a result, the skills of this nurse did not meet the expected standards for eliciting and carrying out the care plan.

5. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

Mechanisms through which the project expects to achieve positive outcomes

Social isolation of the FOP and ICG, together with reactive care, is at the basis of the risk of institutionalisation. If this is adequately identified and supported, the likelihood of countering functional decline is important. The intervention of the case manager aims at starting early adequate care, via the BelRAI CAPs and results of scales. By these interventions, the social network can be (re)activated, but also provide physical activity and adaptation of the home environment.

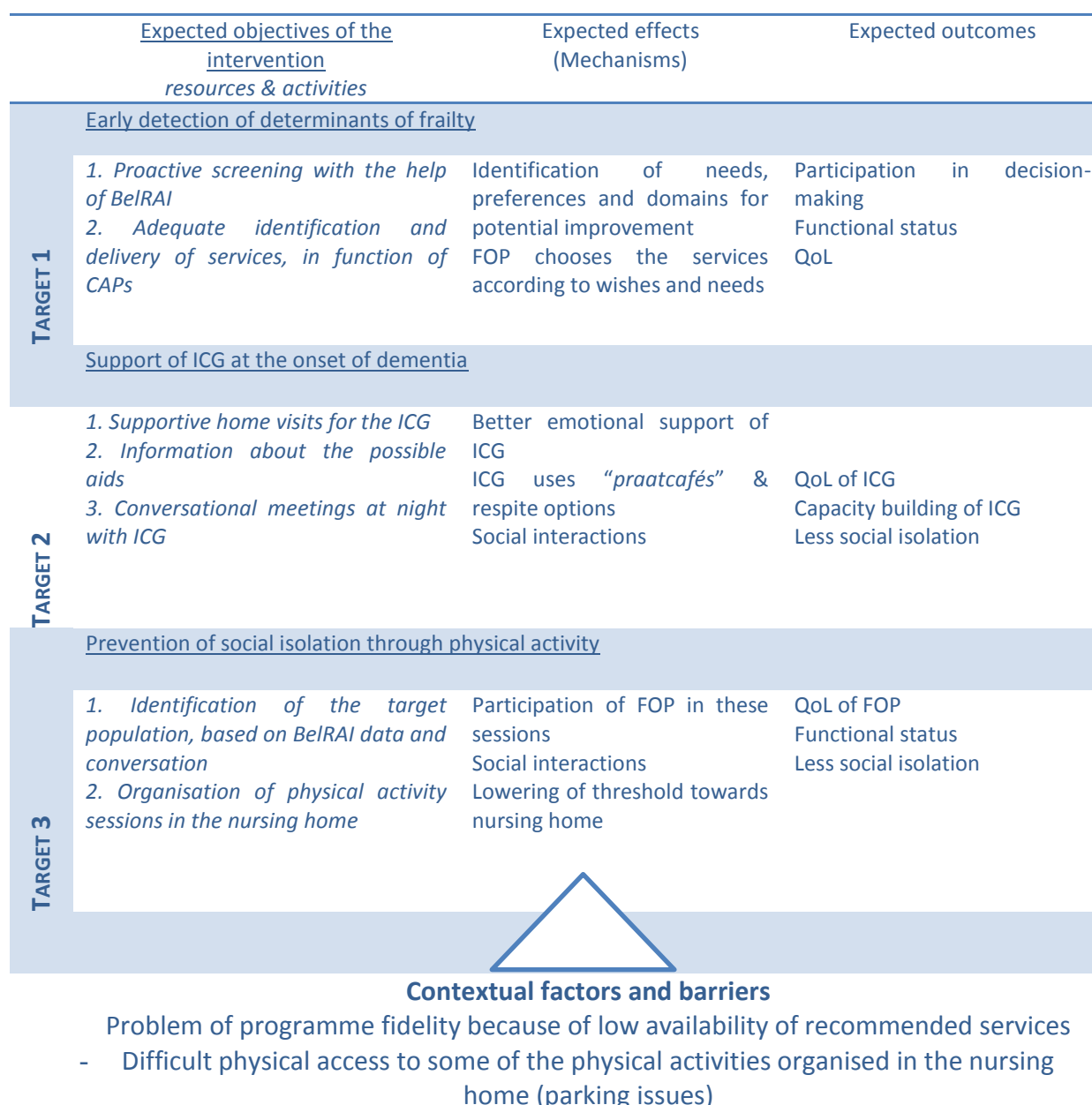


Figure 9. Programme theory of project CMOT197

6. KEY RESULTS FOR THIS PROJECT ARE

- Previous knowledge of the precise needs of the target population, because of a similar project who stopped two years ago. This enabled to fit the project design exactly to the needs.
- Recruitment of the elderly by the occupational therapist, who works part-time in a geriatric ward (main referrer).
- Barriers diminished by the geographical (at home) and financial (free) accessibility for the elderly.
- Elderly assessment: comprehensive assessment by the elderly by a trained geriatric nurse, who has also a good knowledge of the potentialities of the BelRAI in its use for planning, carrying out and evaluation of the case management.
- Care is tailored to the individual needs of the older population, by the means of BelRAI.
- Improvement in care coordination. As the care is tailored to the needs to the older person and his informal caregiver and this is carried out by a single case manager, it may be expected that gaps and overlaps will occur less.
- Dynamism of the main coordinator, who considers this project as a learning opportunity.
- Benefits of participation of other care providers are unclear. Specifically, the GPs involvement is poor. Moreover, there is a fear of overlapping/concurrence because other professionals perceive the intervention of the CM as intrusive.
- The case managers are under a lot of pressure due, at the one hand to the central role of the case manager added to the high burden of the BelRAI and, at the other hand to the stress achievement of the caseload, makes that if the case manager is at risk of burn-out or If she quits the project or is absent, this project risks a severe drawback.
- The (too) dynamic director risks to take initiatives that put too much pressure on the professionals of the project: e.g. setting knowingly the ratio elderly to case manager too high (literature recommendations = 40 :1 ; project = 63 :1). Another example is the testing of physical exercise for Parkinson patients in the frame of the current project, which is an extra activity in an already overburdened time schedule.
- The level of collaboration with the GP is lower than expected and the project does not seem to undertake extra steps to face this concern.
- The other services, to which the CM should want to refer the elderly, are very often full and the elderly cannot benefit from the services he needs.
- The tool used by the circle of GPs is not compatible with the BelRAI.
- High administrative burden because of the BelRAI.
- For the future, the case managers expect to be able to work more in-depth with the care plan, especially when all collaborators will be fully operational, and to work more proactively in this topic.

3.1.2.10 CASE STUDY 3 (CMOT199)

The project proposes a care pathway support to older persons with visual impairment. The project was used for a case study till 2012, at which date we discontinued the in-depth data collection because of (1) the long delays to obtain data and (2) the difficulties to obtain clear answers from the project as to their functioning and use of resources (see comment on the remaining “grey zones” after the interviews).

1. CONTEXT OF IMPLEMENTATION.

The project coordinators observed that eight out of ten people with visual impairment became visually impaired after 60. This population gets too fast in residential facilities, where they do not belong and which they do not need. At the one hand, visual impairment is an important frailty factor and, at the other hand, institutionalization is, especially in this context, a very negative experience, because of the withdrawal of any spatial recognition point. The conceiver of the project had a long expertise in the field of visual impairment and observed an important gap in the health care system for this population. This observation was further confirmed by research and action research in Belgium and the Netherlands.

2. THE PROJECT AS PLANNED

The aim of the project is not to be necessary in long term anymore, when every partner in the health care system will have the necessary expertise to include those older persons in the mainstream health care but, in the meanwhile, the overall aim of the project is to support FOPs with visual impairment, in order to allow them to stay at home, through intense collaboration with diverse care providers. They state that the specific aim is to enhance FOP's autonomy, even if, as will be described further, they aim to enhance independency . This project is dispersed in the whole Flanders' region (seven locations). The support of the pathway is delivered with the help of involved actors coming from different disciplines and expertise groups, usually coming from outside the health care sector (social workers). Those care providers usually work in dyads and provide a tailored pathway support in collaboration with partners with and without this disability sector.

THE INTERVENTION

It was expected that, after screening for meeting the inclusion criteria, a set of older people the professionals of the charity fund already care for, would receive a more intensive intervention than the one they already received by the means of their existing network. Concretely, the interventions of the project are bundled in a tailored package, based on the needs of the FOPs, in domains where improvement might be expected, in discussion with the frail older person and his informal caregiver. This package is carried out by the means of a plan and may be composed of the following interventions:

- Social support: facilitation to access to social network, social status, countering of social deprivation, which is very common to this population;
- Psychological support: sessions with psychologists;
- Home adaptation;
- Presentation and education about equipment for supporting ADL and IADL;
- Occupational therapy at home;
- Learning of transfer techniques, including to leave or to go into their homes;
- Training of other primary care (health) care providers about caring for people with visual impairment.

On an operational level, they planned to work in two distinct phases .

During phase one, they would provide care path support with a small MD team. This team should consist of the coordinator of the project and the dyad social worker/occupational therapist. If this small team should observe, with the help of the assessment tools that more support is needed, the intervention would be enhanced by the input of a psychologist.

During the second phase, this team would propose a care plan to the FOP, which should be designed with the FOP and contact the other primary care providers, such as nurses, family aid and other household support. Continuity and tight coordination are aimed.

TARGET POPULATION AND CASELOAD

The expected target population was home-dwelling people of 60 years and older with visual impairment, living in the whole Flanders region. They aimed at a caseload of 120 persons.

SKILL-MIX

The submission file mentions the hiring of 6,5 FTE occupational therapists, 6,5 FTE social workers and 1 FTE psychologist.

INTERACTION WITH THE CONTEXT

The organisation to which the conceiver belonged could not submit a proposal, because it was a charity fund. For this reason, they looked for a nursing home as partner. They chose a partnership with the nursing home with which they already had other projects.

The other partners are (a) another charity fund; (b) a users' association; (c) a social care organisation at home; (d) a low-vision centre; (e) supported living for visual impaired people (f) a coordination centre. The main role of these partners is referral and provision of expertise. They will participate in the steering committee.

The participants of the project are (a) a hearing library; (b) a network of expertise for low-vision; (c) three visual revalidation centres of teaching hospitals; (d) an advisory centre for low-vision; (e) a social profit organization for individual and collective transition management; (f) a university in the Netherlands (participate in parallel scientific study).

COMMENTS OF THE JURY

"The underlying concept of the project is useful and relevant for the society but may be too specific and bounded to be considered as innovative. The role of the main partner (nursing home) is unclear. The target population is very specific and bounded, the decision tree of the conceptual nota is not mentioned. The jury has questions about the calculation of the client hours, are these not estimated too low? They wish to have the figures about the financing coming from other structures than NIHDI.

The part 'programmability' is not filled out. However, the operational feasibility of the care provision and the accessibility for the patient are sufficiently mentioned in other parts of the document."

3. THE PROJECT AS IMPLEMENTED

The objectives of the project did not change since the start.

THE INTERVENTION

The project started 1st April 2010 and experienced very quickly difficulties with the access to the BelRAI web application, because among the profile of the care providers (occupational therapists and social workers), social workers were not part of the list of professionals having access to the application (art 78 of RD 1967). The interventions were mostly provided as planned, except for the support of primary care providers. Firstly, the screening was very selective, because the demand was high and they could only provide tailored care packages for 120 people. They could only accept one in six demands (Int12). The decision to include the FOP in the project was made between the FOP, the project coordinator, and the dyad that made the first screening.

The duration of a care pathway in this project went, on average, from three months for non-successful projects, to five years. The majority of the duration is around two years (Int12) but the FOP could stay in the

project as long as they were not institutionalised. Reasons for discharge of the project were nursing home admission (20%) and death (10%).

In the beginning of the inclusion, the social worker provided information about possible refunding etc. and explained the pathway. Afterwards, she assessed the needs and resources of the FOP regarding the possibility to stay at home, made the care plan with the FOP and contacted the network. This plan was monitored and adapted, if needed. She organised also coordination meetings with other care providers at least once per six months. This plan was carried out by dyads of social workers and occupational therapists, if necessary supported by nurses and psychologists.

For handicap-specific interventions, e.g. provide new equipment, the occupational therapists come at home and taught them how to use the equipment and supervise the use of it. This required at least two or three visits, more if the equipment was complex. Besides, compensation techniques were learned, to adapt to the low-vision situation, such as echolocation, walking with a stick, It appeared very important that this learning was done at home, in real-life situations (YQ13). Moreover, FOP learned ITC for visual impaired, such as audio books, magnifying software, adapted mobile phone and GPS). These tools are very useful to counter social deprivation (YQ13) and are handed out in collaboration with an orthoptist.

Psychological and psychosocial support was provided by psychologists. This is important for this population of which the diagnoses of visual loss was recent, in order to help them to live with this impairment. This was done by the means of sessions, which could be held either at home or in the partner nursing home. The frequency varied between every other week and monthly.

They estimated that there were around 15 face-to-face contacts with FOP per year (Int12) and 29.25 hours/FOP/year (NIHDI doc1212). They planned to train and sensitise the ICG and the primary care providers but this was not carried out as planned, because they underestimated the budget needed for this (Int12).

THE TARGET POPULATION

The people included in the project are persons of 60+, living with a severe visual impairment or with a prognosis of irreversible vision loss in the short-term. In any case, a medical diagnosis (or prognosis) was asked. They mainly contact the project themselves, or their ICG does, upon suggestion of a primary care provider .

In many cases, the network of these persons was very frail or non-existent, what lead to social isolation. They were dispersed through the whole region and are already part of the handicap-specific network and are already benefiting of some kind of intervention (once or twice per year). The pre-inclusion of FOP (see below "intervention as implemented") was very slow, because of the very high demand of this population. All demands have to be treated, even if the FOPs were not included in the end. Some of the included FOPs were also part of other P3 projects, which the NIHDI only rarely accepted. This non-acceptation was not very well understood by the project collaborators.

It happened that, although the dyad observed that the FOP could have benefited from their intervention; the latter refused the tailored package. They only wish help to be still able to read the newspaper or to go to and from the bakery (Int12). Overall, the frequency of the intervention is more or less once per month, duration of the intervention depends on the type of intervention and moment of intervention.

THE SKILL-MIX

According to the interviews, 30-35 professionals were working in the project, but only some of them were mentioned in the questionnaires and in NIHDI data (see Table 14 below). These inconsistent data could not be answered by the project, what might be explained by the fact that the boundaries of this project were fuzzy.

Table 13. Professionals paid by Protocol 3 since start

	SF	Dec 2010	Dec 2012
OT	3	2.45	2,8 (of which 0.3 for project coord)
SW	4	3.05	3,2 (of which 0.7 for project coord)
A1		0.9	0,4
A2		0.3	0
Orthoptist		0.2	0,6 (or 1?) inconsistent data between YQ12 and NIHDI change of convention (also 12/12)
Psy	1	1	1 (or 0?) inconsistent data between YQ12 and NIHDI change of convention (also 12/12)
Accountant		0.2	0,1 (or 0?) inconsistent data between YQ12 and NIHDI change of convention (also 12/12)
Dir home care		0.2	0,1 (or 0?) inconsistent data between YQ12 and NIHDI change of convention (also 12/12) Is this professional paid twice?

The profile of the professionals of the project explained why they had no access to the BelRAI web application in the early stages of the project. Coming mainly from outside the health care sector, they had to wait till NIHDI provided the files with authorized professionals (authentication files), before being able to fill out BelRAI data. Moreover, those professionals could not be client managers (In10).

The **profile** of the case manager was someone possessing a good knowledge in low-vision issues and the social network of a given region. He or she had also to know the core business of the professionals of the other organizations, be able to exert a leadership, out of his specific expertise, able to work autonomously, tenacious and able to build bridges between people and organizations (Int 12).

Recruitment: in a first stage, six professionals having an expertise in vision-related problems were recruited. This resulted in shifts inside the manpower amongst partner organizations. Only one freshly promoted professional was recruited in the pool, but this person already had an experience in elderly care in residential settings. In each team, one of the professionals had to act as liaison.

Turnover. The project observed a high level of turnover of their professionals because of the workload and the administrative workload related to BelRAI. Newly recruits were sometimes of an inadequate profile, e.g. when they hired a professional who had a diploma of family sciences and who appeared not to possess the knowledge needed for the care coordination function. At the other hand, in other places, new recruits could rapidly become very positive workforces. Replacement was also hindered because of the shortage of nurses in some regions.

One of the project coordinators was on long sick leave in 2011, which impaired the launching of the project and caused delays (e.g. for the filling out of the yearly project questionnaires). The delay of the return of yearly project questionnaires was also caused by the will of the main coordinator to collect all data himself, while the latter were not always immediately available (e.g. human resources costs).

TRAINING

Professionals of the project had to be trained further in the vision-related area and for the specific purposes of case management. For the specific training in vision problems, all project professionals were trained in orientation and mobility-related techniques. Two times per year, they received an update of the information about visual aids and are trained about aspects of acceptance of loss. The project included a psychologist, who was able to support the teams about the management of clients experiencing vision loss. Competencies about a care plan were also enhanced by the means of specific trainings. Knowledge transfer towards other primary care professionals was done informally, around practicalities such as the importance of order and regularity, oral communication ("When you leave the room, you express this vocally to the FOP."), the importance of

marking some of the appliances, because this allowed the FOP to perform IADL and maintain or recover their autonomy.

Training about the use of the BelRAI was way too early, because they could not access the web application at that time.

ORGANISATIONAL FEATURES

COORDINATION OF THE CARE

Coordination of the care around an individual FOP was done, as described earlier, by dyads of social workers/occupational therapists, with the help of nurses and psychologists. Decisions were made as a team. In the first phase of the project, they searched how to best coordinate the care, without using the BelRAI data (Int10). A lot of time was needed to be able to use the BelRAI (learning and difficult access because of eHealth issues). The BelRAI was filled out by the social worker and the occupational therapist, with the help of nurses of partner organizations. They found it difficult to use the CAPs in the care plan. However, they decided to use them after two years of the project, because of its usefulness. They observed that the BelRAI was not a relevant tool for their target population, for whom the frailty is merely influenced by the vision impairment. If the FOP has a light mental disability, or light level of cognitive impairment or a falls problem, the visual impairment adds to those other problems and cannot be assessed separately. In the BelRAI, those problems are assessed as if they existed separately, while they reinforce the frailty.

They try to delegate, whenever possible, the filling out of the BelRAI, to partner organizations. This was the case with the newly included sickness fund partner (see “partners of the project”).

The care plan was evaluated once a year, sometimes more frequently if another primary care provider asked for it. Coordination of the care with the GP of the FOP was difficult and is only done by phone if the FOP agreed to it. For the project, the problems of the FOPs were not of such nature that the GPs had to be involved. The project only mentioned to the GP that the FOP was included. In very complex situations, it may happen that there was a MD meeting, but the project members were not always invited. No feedback about the intervention of the project was provided to other care providers .

The project had its own paper and electronic patient record with intervention minutes. Those minutes were accessible to the FOP and other care providers. In case the FOP had a notebook at home, they used it. Purposefully, they did not use new tools and prefer to rely on tools of other organizations for sharing the information about an individual FOP (Int12). Additionally, they used MD care plans, to be able to coordinate the care efficiently with handicap-specific experts. They missed a centralized patient file, to be able to share the information about a FOP efficiently .

COORDINATION OF THE PROJECT

The coordination of the project was done by the means of a member of the umbrella organization, who supervised the work of the regional coordinators. The planning between those different coordinators and other professionals of the project was done by the means of a shared calendar .

The main communication flow occurred by the means of meetings, minutes of meetings, results of BelRAI, phone and email . They relied on specific “protocols” (“a set of agreements about the process of screening, support and discharge” . The coordination of the care was done with the help of a software, who allowed to have a view on the interventions.

The coordination between dyads in a given region was done by the means of a bimonthly meeting where the referral of clients, etc, was discussed.

The coordination of the project was sustained by a monthly management meeting, where any aspect of the operational management was discussed, in presence of the regional coordinators and the main coordinator of the project. These meetings were very time and money consuming but, however, necessary because they

allowed an openness towards the other partners and a vision on the working of the whole project. Additionally, they organized meetings with the care coordinators four times per year, to discuss operational and structural aspects of the project. All professionals involved attended these meetings. A steering committee was held four times per year, with all partners. They observed that the fact of working only with three levels internally had a positive effect on the quality of the information flow within the project (Int 12).

The project mentioned internal differences among the working of the different locations of their project. Some locations were very dynamic, others were not. This dynamism expresses itself in the instream of new FOP and the intensity of the network.

Other locations were more difficult, because project collaborators relied too much on their own forces.

PARTNERS OF THE PROJECT

The partners present from the start continued their collaboration. The main partner, which was the mandatory nursing home, was responsible for the central coordination and contacts with the NIHDI. He was a main partner in the network around older persons and provided expertise in this domain. The project mentioned also a non-for-profit organization in low-vision care, who was main partner. This organization provided low-vision care coordinators and was spread out over the whole region. Their professionals were embedded in the local teams and were in most cases, responsible of the BelRAI assessment. Besides, there were other partners (a) from non-for-profit organizations, with expertise in low-vision care, (b) user's organizations which organized events for this population and facilitated sharing of experiences, (c) organization for social care at home that referred clients.

Two new partners joined the project (a) a home care organization, for the coaching in the quality of the care and referral of FOP and (2) a mutuality, who provide social workers for the project, helped to fill out the BelRAI and, occasionally, lead the MD coordination. Additionally, one of the participants, a nursing home in Brussels, left the project in a very early stage, because it was not interested any more.

The project did not use quality indicators.

They were involved in a parallel scientific research, around depression, affordability and community based care. This should provide NIHDI extra information about their population, without additional costs (Int11).

They wished that the evaluation of the project should not be based on qualitative ('arbitrary') indicators, but that process indicators should be used, i.e. quality and quantity of collaborative links (Int12).

Interaction with the context

INFLUENCE OF THE PROJECT ON THE HEALTH CARE CONTEXT/SYSTEM

The project coordinator observed that the impact and the range of this project is much more than what can be read in the submission file and yearly questionnaires, because of the networking of the partners. The latter required more training about caring for the visually impaired (i.e. transfer techniques and adaptation of the home). The service centres (dienstencentra), linked to the mutualities asked for specific training for their elderly clients.

THE VISION OF THE FUTURE ABOUT THIS PROJECT AND ITS IMPACT ON THE HEALTH CARE SYSTEM.

The project expected that in a near future (i.e. 3-4 years) they would not be needed any more, as there would be a knowledge shift within the professional sector outside the handicap, especially knowledge about the transfer of visually impaired (Int 11).

4. ADAPTATION STRATEGIES OF THE PROJECT

Profile of the case manager: had to know the core business of other services, along with the social networking in his region very well

- 1) Working in couples, in order to be able to access the BelRAI

- 2) One of the main coordinators was on long sick leave, this was a drawback for the coordination of this geographically very spreaded project. The result was a delay of implementation.
- 3) BelRAI is not a relevant instrument for this target population. In reaction to this, they asked after 18 months if there was a specific addendum to the BelRAI-HC
- 4) They wish, in the future, to continue the delegation of the filling out of the BelRAI to other partners

5. KEY RESULTS FOR THIS PROJECT ARE:

KEY SUCCESS FACTORS

- 1) Very formal structuration of the entities (important geographical spread over whole Flanders) and sub-entities
- 2) Number of partners, with which there is a lot of collaboration, with the exception of the GP
- 3) Flexible intensity of interventions, in order to be able to follow the demands of the population. There is a lot of time needed for the elderly to accept and to learn how to use the specific tools and strategies.
- 4) Provide a lot of time and support for disability-specific training of their members

CONCERNS FOR THIS PROJECT

- 1) Implementation and use of the CGA was more difficult than expected
 - a. Technical difficulties of the BelRAI at the start;
 - b. Time needed to learn how to fill out the BelRAI and to use the CAPs in the care plan;
 - c. Difficult to fill out some domains in the BelRAI because of legitimacy; if social workers or occupational therapists come to the FOP because the latter expects some help in space orientation, the FOP does not expect him to be questioned about incontinence or mood;
 - d. Partners are not able/willing to fill out the BelRAI because of privacy issues
- 2) High level of centralization of the internal organization. Everything has to be approved by the main coordinator, which causes delay in the flow of information.
- 3) Some of the elderly are part of different P3 ; this raises incomprehension with the collaborators
- 4) Some of their patients do not need the care provided. They feel the “object” of a MD team. In some cases, they refused the project .
- 5) Unclear whether this is a project for disabled persons, who happen to be old, or a project for older persons who become visually impaired.
- 6) Not so much collaboration with the GP. They do not seem to take interest in the comprehensive care of the patient. The service delivery is focused on domains for which the professionals in the project are expert in: occupational therapy, psychologist and social worker. Only in the situations they call ‘complex’, the GP knows that the patient is in the project and in this case, they ask to organize the care coordination.
- 7) The boundaries of the project are unclear (30-35 professionals in the project, which pays 6 FTE).
- 8) High turnover of case managers because of the workload and the load of the filling out of the BelRAI
- 9) Systematic underrating of the time needed for the administrative tasks and the difficulties in delegating these tasks.

Grey zones still remaining after the interviews and questionnaires

The boundaries of the project remained unclear, e.g. they were training 55 professionals (YQ11), who were not mentioned elsewhere. Responses to questions related to this point were unclear or contradictory. Moreover, we were not able to know the profile of the professionals at a given time in the project. For instance, a psychologist was mentioned in the service delivery in the project and in the yearly questionnaires (LimeSurvey 2012), but not in the convention with NIHDI (collected simultaneously). Financing of a director of a nursing home was done by the means of the financing of P3 , which would not be possible in the current Belgian health care system. Because of the recurrent lack of clarity in the responses, we decided, after discussion with civil servants of NIHDI, to drop this project of the case study selection in January 2012.

6. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

Older persons with visual impairment or experiencing a vision loss can become highly dependent if they are not correctly supported by an experienced team, willing to target the specific needs of this population. Adequate support will enhance or restore independence for the ADL and IADL and counter social deprivation, mediator of depression and frailty.

Secondly, training of the professionals outside the handicap sector will enhance their capacity to provide adequate care to this population, so as to make this project useless in a near future.

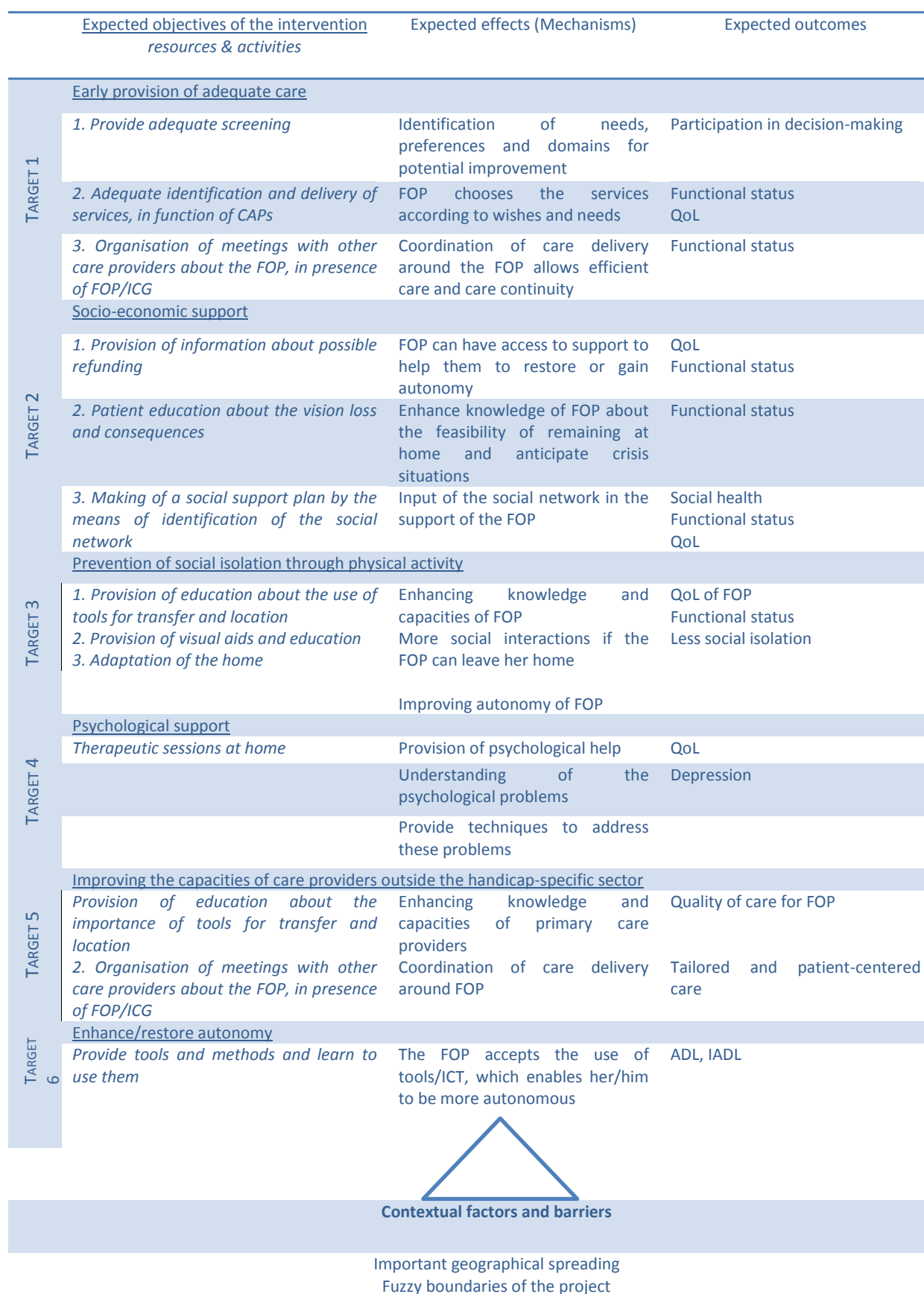


Figure 10. Programme theory of project CMOT199

3.1.2.11 KEY POINTS OF CASE MANAGEMENT PROJECTS DELIVERING OCCUPATIONAL AND/OR PHYSIOTHERAPY

- Case management is made explicit and central in those seven projects.
- Allocation criteria to case management care (as opposed to routine care) are unclear.
- In six projects, nurses provide case management; only in cases where the number of FOP per nurse is momentarily too high, another professional might take on the role of case manager.
- Internal training for case managers is explicitly provided in ¾ of the projects.
- Case managers are preferably recruited amongst experienced primary care providers.
- Overall, the duration of the case management lasts as long as the FOP is in the project.
- The intensity of the case manager intervention decreases as the number of FOP in the project increases. Some case managers continue the follow-up by the means of phone calls.
- Six out of the seven projects claim they missed sharepoint software for information flow about FOP information and project management purposes.
- Collaboration with GP is perceived good only for two out of the seven projects.

3.1.3 PROJECTS PROVIDING CASE MANAGEMENT IN COMBINATION WITH RESIDENTIAL OR NIGHT CARE

Six projects were allocated to this group. All of them were situated in Flanders and two of them were part of the case study approach.

3.1.3.1 THE INTERVENTION

DESCRIPTION OF SERVICES DELIVERED AND PROFESSIONALS DELIVERING THOSE SERVICES

Besides delivering case management, those six projects have in common that they provide health care services in a setting outside the FOP's home ; either revalidation services in a short term accommodation (2 projects), respite in a short term accommodation (2 projects) or night care (2 projects). Moreover, three of those projects are delivering occupational therapy and one, nutritional support.

Case management

As opposed to the category of projects delivering case management and occupational therapy/physiotherapy, case management is explicitly provided only by four of those six projects. Nevertheless, the reason why these two projects were allocated to the category of case management projects is that they are conducting multidisciplinary assessments of needs, proposing a care plan in collaboration with the FOP, coordinating this health care and, eventually, evaluate this coordination. This case management service is provided at home for four projects and in another setting, for two projects. For the latter, case management is provided in a revalidation service.

The intervention is provided through different modalities from project to project and can last from two weeks to a permanent duration (i.e. the case management intervention lasts as long as the FOP is in the project).

Three projects declare adapting the intensity of the intervention of the project following the needs of the FOP. One project declares providing case management every day in a residential setting. In this project, the FOP remains, on average, 26 days in the project.

ADDITIONAL SERVICES PROVIDED, ALONG WITH CASE MANAGEMENT

(a) Residential and/or night care

Among the six projects, all deliver health care services in a residential setting, except one project, delivering night care at home. Those services are delivered by a team, except for two projects. In the latter projects, one project delivers night care by the means of volunteers, the other delivers night surveillance by the means of nursing assistants. In-depth study of the night care projects provided information about the fact that, for these projects, the night care accommodation was relatively poorly used and served the purpose of 'crisis accommodation'. Overall, the FOPs seem to prefer to remain at home during the night, if possible, as reported by the project members.

Projects CMR196, CMR179 and CMR203 can be considered as a subgroup within the group of projects providing case management with night/or residential care, as they specifically target FOP recently discharged from a hospital and with a intervention duration less than one month.

(b) Occupational therapy

Along with the delivery of case management and residential and/or night care, three projects also deliver occupational therapy as well and, in that case, the occupational therapy is delivered by an occupational therapist, which is paid by the project. Out of these three projects, two deliver this occupational therapy at home, while occupational therapy is provided outside the home for one project. This raises some questions about the possible adaptation of the home, which is one of the main purposes of the service.

(c) Psychological or psychosocial support service

The project delivering this service targets FOP which underwent chemotherapy or, for a limited period, FOP in crisis situation. This service is provided by a psychologist, paid by the project.

(d) Physiotherapy

Three of those projects also deliver physiotherapy, either in group sessions in a residential centre, or through individual sessions, for falls prevention. Those three projects have a strong rehabilitation focus, as they exclusively recruit FOP from hospitals, have a short duration (max 31 days and a very low case manager to FOP ratio), as will be described below

(e) Nutritional support

One project hired a dietician (0.25 FTE) to deliver nutritional support to FOP being at risk of under nutrition or under nourished.

Table 14. Objectives of the interventions and services provided

Criterion	CMR196	CMR179	CMR203	CMR202	CMR190	CMR185
Objectives of the intervention	Tailored care for support for FOPs & ICGs after hospitalisation or at home.	Transitional and rehab after hospitalisation	residential CM after discharge from hospital	CM with supportive services	Stimulation of autonomy; CM and supportive services, including crisis accommodation	Tailored care through CM and supportive services
Description of services provided	Nurse or nurse assistant: CM and PS support, monitoring OT: ADL-training in institution; Group sessions -FOP Entertainment & relaxation; Memory training Physiotherapist: Physiotherapy in revalidation centre Psychologist: Psychological support consultations for FOP and-or ICG	Nurse : ADL-support by nurses or nurse assistants in day care Physiotherapist :Coordination of physiotherapy & falls prevention SW: CGA & CM	Nurse: CM, monitoring & ADL-support in revalidation centre SW: CM OT: ADL-training Physiotherapist :Falls prevention & physiotherapy	Nurse: CM & Night surveillance in an institution or at home; Psychosocial support of FOP or ICG OT: ADL-training SW: Making of a psychosocial care plan Dietician: Assessment of food intake & Nutritional education	Nurse : CM; Psychosocial support of FOP or ICG OT: ADL-training & Counselling about the home adaptation; Memory & spatiotemporal training Nurse or nurse assistant: ADL-support by nurses or nurse assistants at home	Nurse: CM OT: ADL-training & Living environment assessment, Falls prevention SW: Participation in MD meetings Nurse or nurse assistant: Monitoring of vital signs Nurse assistant: ADL-support at home during night & Night surveillance at home

3.1.3.2 THE TARGET POPULATION

Data in table 15 show that the group shows two distinct target groups: projects CMR196, CMR179 and CMR203 aim at FOP with a rehabilitation profile, recruit the FOPs in hospitals and have a population with a low level of frailty. It is not very clear how we will be able to evaluate the impact of the project on the functional, depressive and cognitive status of these persons, as this proportion of the population does not seem to be affected by losses in these domains.

The other three projects have a more mixed population of overall FOP and their caseload is much higher. Turnover of FOP in the project is lower, as shown by the longer duration the project.

Table 15. Characteristics of the target population

Criterion	CMR196	CMR179	CMR203	CMR202	CMR190	CMR185
Profile of <i>expected</i> target population	FOPs with cancer, fractures, MS, ALS, ...	FOP with rehab profile	(1) FOPs discharged from hospital needing transitional/ rehab care; (2) failure of home care after discharge; (3) readmission of FOPs of the same project	General population of FOPs	Chronic evolutive FOP 20%, dementia 25,38%, Functional loss after trauma 13,08%, Frailty 25,97%, palliative 0,77%, psy 3,85% - social isolation: 39.12%, partners 50%	General population of FOPs
Expected caseload	16	4	27	314	130	66
Recruitment means	Mainly hospital	Hospital	Hospital	at home	waiting list for NH & HC	HC services

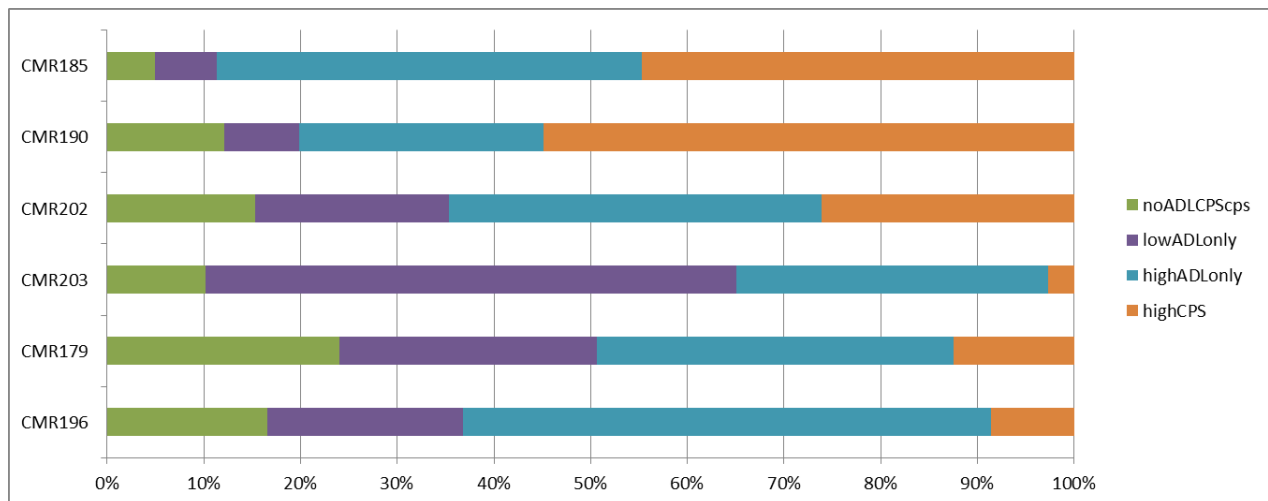


Figure 11. Profile of FOP at inclusion in the projects providing case management, along with night care or in a residential setting

The profile of the population was very dissimilar across projects regarding the percentage of FOP with a CPS ≥ 3 .

3.1.3.3 THE SKILL-MIX

The profile of case managers. Case management was delivered either by a nurse (two projects), or a team composed by a nurse + social worker (4 projects).

Training for case management. Only one project declared having organised – and is still organising - a specific training for the use of the results of BelRAI (CAPs, scales and health profiles) for case management's purposes (together with two other Protocol3 projects). A more 'basic' training has also been provided for case managers, for this project, relating to the multidisciplinary use of the BelRAI. Moreover, interventions, organized at provincial level are also found very useful in this aspect. This project is providing a continuous coaching of project collaborators, in order to streamline multidisciplinary practices.

Out of the six projects, three declare the use of a part of the Protocol3 financing for administrative support' purposes (by an accountant, a secretary or even a social worker). In the other projects, it is not known whether this administrative part is taken up by health care providers (e.g. nurses), or by a professional of the umbrella organisation. In the latter case, these are not mentioned here.

In the three projects taking care of FOPs who were recently discharged from hospitals, the FTE case manager to FOP ratio was significantly lower than in the other projects of this subcategory (1:2 versus 1:20), probably explained by the significantly lower duration of the intervention (less than one month versus permanently included) and thus, a very high patient turnover rate.

ORGANISATION OF INTERVENTIONS

All six projects have an important 'coordination' output. This might be explained by the fact that they offer an important set of different services, needing *de facto* an adjustment among professionals within the project. Accordingly, the organisation and coordination of the health care around a given FOP is done already during hospitalization for two of these projects; another project does this coordination in a residential setting. For the other projects, except one, the meetings conducted for the organisation and coordination of health care is done at the FOP's home. For the last project, no meeting around an individual patient was reported. The informal caregiver is involved in any case, when possible, during coordination meetings.

All six projects claim to use the results of BelRAI to identify FOP's needs (CAPs and results of scales) and all make care plans, that are 'regularly' monitored (at least every six months, except for one project, which claims to do it only yearly).

The information flow around an individual FOP occurs mainly by means of informal circuits, such as by telephone or email, along with the notebook at the FOP's home. Out of the six projects, three have an electronic patient record, allowing the sharing of information within the project. Three projects claim that they miss a shared patient record, among healthcare providers working with the FOP (across organisations).

Table 16. Coordination meetings around a single patient

Criterion	CMR196	CMR179	CMR203	CMR202	CMR190	CMR185
Name of the meeting	Meeting with patient	Intake & discharge of FOP	Multidisciplinary meeting	Partner meeting	Transdisciplinary meeting	Consultation meeting
Frequency	Weekly	Unclear	Weekly	At least monthly	Ad hoc	Ad hoc, min/ 6 months
Duration	15'	45'	1h	15-30'	1-1,5 h	1-1,5 h
Presence of FOP or ICG?	Yes	Yes	No	No	Yes	Yes
Invitation to of FOPs' GP?	No, receives minutes	No, receive minutes	No, receive minutes	No	Is systematically invited	Is systematically invited

COORDINATION AT THE MESO-LEVEL

All projects in this subgroup organize meetings involving project members to define day-to-day tasks to make the project work at an operational level. Themes include as well follow-up of the group of FOP (n=4), as interventions (n=2). Details are shown in Table 18 below.

Table 17. Coordination meetings at the project level

	CMR196	CMR179	CMR203		CMR202		CMR190	CMR185
Name of the meeting	multidisciplinary meetings	Psychosocial meetings	Meeting GP and project	Meeting head nurse and case manager	Daily management	Working group	Intervention (for CM, OT & coordinators)	Intervention
Content	Evolution of the FOPs	Psychosocial well-being of FOP.	Missions and tasks of GPs in project	Discussion operational items and watching project	Follow-up of project	Operational management of the project	Intervention	Organisation of care around all FOP
Participants	Nurse, nursing assistant, psychologist	Social worker, coordinator, CM, psychologist, reference person dementia	GPs of project + direction of partners	Head nurse + master in management health care	Three partners	Frontline workers and partners	Members of the provincial cell	Head nurse, case manager and nurses
Location	project	project	project	project	Alternatively, at one of the 3 partners'	One of the partners	Changing	Project
Frequency	weekly	/2 weeks	Ad hoc	/month	1x/month	1x/ 3 months	/3 month	/month

3.1.3.4 THE COST OF THE PROJECTS

The main yearly project cost per FOP in this category was extremely diverse:

- In the first subgroup of three projects providing residential case management for recently discharged FOPs, the costs rated from 1470€ to 2849€, the second using more diverse professionals and were more likely to offer more professional services than the first.
- One project can be considered as very cheap for the NIHDl (CMR202), as the services they provided were paid by their partners and they only count 18h/year per FOP, which is low in comparison of project CMR185, described hereafter.
- Projects CMR190 (5740€) but certainly project CMR185 (13759 €) were particularly expensive. A possible explanation for the second one is the high number of hours per year (86h/patient). For the first one, it was not possible to know the number of hours per years of care delivery, as the project expressed their intensity of care in a package.

3.1.3.5 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

Out of the six projects, only three projects have structural links with a coordination centre (GDT/SEL). Of the three projects having no structural links with such a centre, two also do not have a link with a centre of public welfare, what might indicate the low level of embeddedness in the local network.

Concerning interaction with the GP of the FOP, four claim to have a close interaction with the latter; one project did not provide the necessary information and one project only gives information to the GP of the FOP being in the project.

MEETINGS WITH PARTNERS

The number of formal meetings in this subgroup was impressive and probably justified by the number of services provided in the project, but paid by the partners.

Table 18. Type of meetings with partners of the six projects of this subgroup

	CMR196	CMR179		CMR203			CMR202		CMR190				DC171	
Name of the meeting	Meeting with partners	Steering committee	Advisory committee	Steering committee	Workgroup transmural care	Advisory committee comité	Daily management	Steering committee	Steering committee	Operational committee	Steering committee	Provincial group	Steering committee	Evaluation committee
Content	Evolution of the project, care offer	Follow-up of project	Information about the project	Follow-up of project + assessment of results	FOP flow	Follow-up of project	Follow-up of project	Follow-up of project	Strategic follow-up	Operational follow-up	Follow-up of all P3-projects in Flanders, interaction with SEL and residential care decree ('woonzorgdecreet')	Les 4 projects élaborent des outils communs (procédures, formations et interventions)	Follow-up of project	Organisation of care
Participants	Home care professionals, Public Centre for Social Action, hospital	Collaborators of 3 partner organisations (hospital, sickness funds, nursing home)	Participating associations + steering committee	All partners	Hospital, partner organisations	All partners and participants	Trois Partners : centre for nursing care at home & 2 nursing homes	All partners	Partners	Partners & participants	Partners province +	nursing care at home & nursing homes	Partners, collaborators & GPs	Collaborators
Frequency	1-2x/year	4x/year	2x/year	4x/year	Ad hoc	2x/year	1x/month	1x/month	/2 month	/6-8 weeks	/2 month	2x/ month	2x/year	4x/year

3.1.3.6 ADAPTIVE BEHAVIOURS

Only two projects in this category revealed no major changes in their project. For the remaining four projects, the adaptive processes have been classed by themes:

Changes in the partnership

One project included an extra participant to be able to organize night care (night care at home, project CMR202).

For another project it is now the partner which is financing the occupational therapy.

Profile of professionals

In two projects, the main coordinator changed. One of these projects hired a second case manager as the project unfolded, because and when the expected caseload was achieved.

Another project stated having a lot of difficulties to recruit nurses and hired nursing assistants instead. This project counted on the fact that nurses from outside the project would deliver health care to the FOP in the residential setting, which proved to be impossible. This same project hired an occupational therapist and nursing assistants during the starting period, instead of a physiotherapist.

One project asked NIHDI to be permitted to hire an extra collaborator to fill out the BelRAI, which was refused by the NIHDI.

Financial problems

Three projects asked significant changes of the budget of the project.

Project CMR203 asked for a more important financing for filling out the BelRAI, from 2011 on, which was refused. Also, they underestimated the costs related to the renovation of rooms for the project, costs related to manpower and, as a consequence, this project has a deficit of 80 000€ in 2011. For this reason, they increased the daily patient participation from 35€ to 45€ in February 2011.

Project CMR202 was invited in January 2012 to advocate its file at NIHDI. They calculated 29€/FOP to fill out the BelRAI, instead of 148,05€, which was of course insufficient. They wanted to receive the amount of money they did not receive nor spend.

A last project asked for and obtained a recalculation of the financing of a nursing assistant, which had been underestimated.

Developing tools

The four projects in East-Flanders are supervised by a 'kerngroep' (core group), which guided and supports them for the elaboration of common tools (procedures, training...), for which they think they are insufficiently financed, while to them, this is being very useful.

3.1.3.7 EXPECTED EFFECT ON THE OUTCOMES AS A RESULT OF THE NORMATIVE ANALYSIS

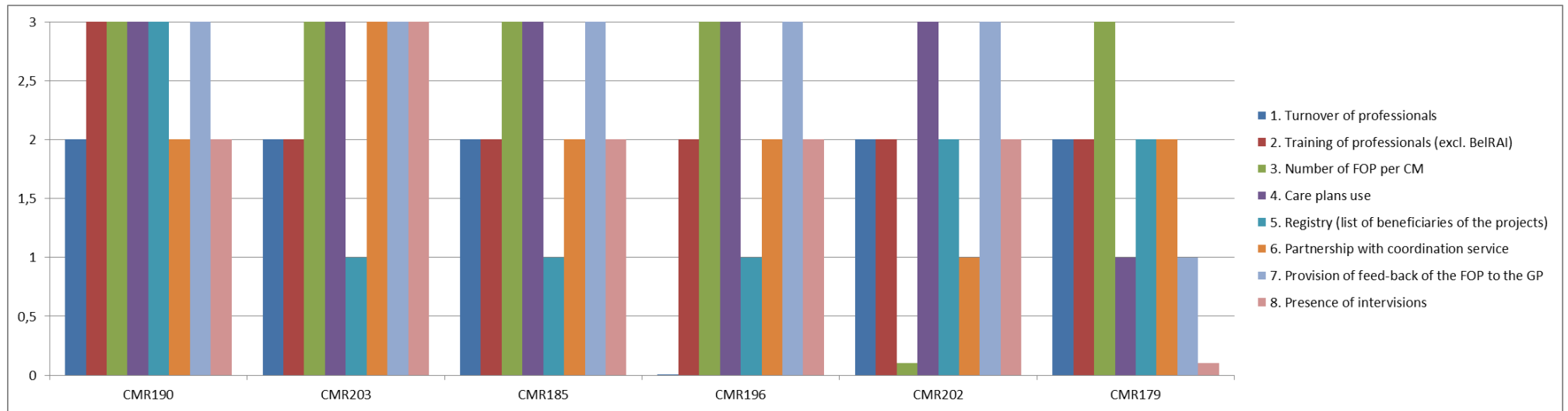


Figure 12. Normative analysis of case management projects delivering night and/or residential care: view per project

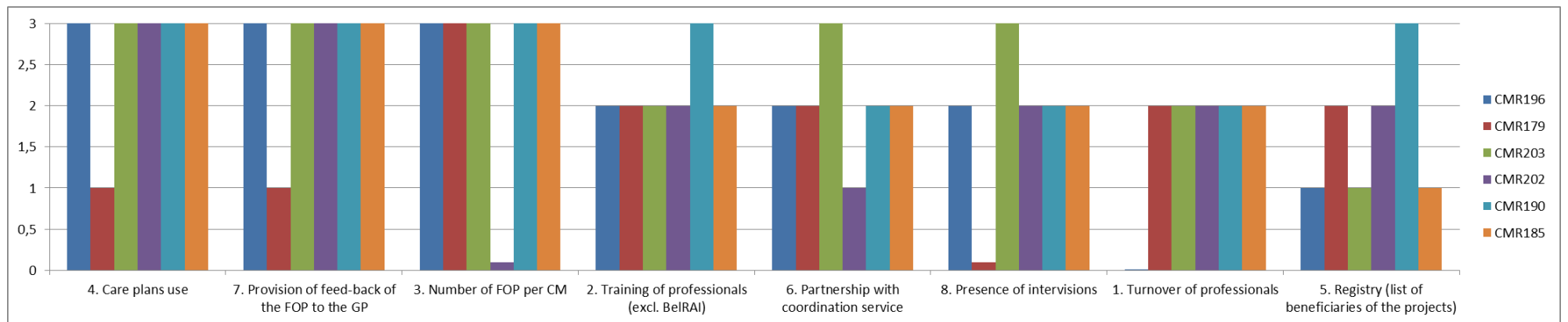


Figure 13. Normative analysis of case management projects delivering night and/or residential care: view per item

All but one projects in this category reported the use of the BelRAI for making the care plan. The project that did not was a project with a very short inclusion time (14 days) and they reported that the use of the BelRAI was very time-consuming and not relevant for their intervention. This was also the project who had very little interaction with the individual's' GP, as is shown by the lack of provision of feedback to this professional.

The active caseload per full-time equivalent case manager was lower than 40 in all but one project.

All projects in this subgroup reported a turnover of professionals, which can be seen both as a result of unattractive working conditions and a barrier to successful case management, as the projects report that they need time to build trustful relationships before being able to engage FOP in the process. All projects were engaged in training of their case manager, but in only one project, this training was specifically provided for geriatric care.

These projects had little partnership with coordination services, showing a low level of embeddedness in the local care system.

Finally, only one project had an ICT tool enabling them to manage the coordination of the care and the information flow about the services needed by the frail older persons.

3.1.3.8 SYNTHETIC TABLE OF THE PROJECTS' DATA

Table 19. Synthetic table of the features of projects providing case management with residential and/or night care at home

Criterion	CMR196	CMR179	CMR203	CMR202	CMR190	CMR185
Objectives of the intervention	Tailored care for support for FOPs & ICGs after hospitalisation or at home.	Transitional and rehab after hospitalisation	residential CM after discharge from hospital	CM with supportive services	Stimulation of autonomy; CM and supportive services, including crisis accommodation	Tailored care through CM and supportive services
Description of services provided	Nurse or nurse assistant: CM and PS support, monitoring OT: ADL-training in institution; Group sessions -FOP Entertainment & relaxation; Memory training Physiotherapist: Physiotherapy in revalidation centre Psychologist: Psychological support consultations for FOP and-or ICG	Nurse : ADL-support by nurses or nurse assistants in day care Physiotherapist :Coordination of physiotherapy & falls prevention SW: CGA & CM	Nurse: CM, monitoring & ADL-support in revalidation centre SW: CM OT: ADL-training Physiotherapist :Falls prevention & physiotherapy	Nurse: CM & Night surveillance in an institution or at home; Psychosocial support of FOP or ICG OT: ADL-training SW: Making of a psychosocial care plan Dietician: Assessment of food intake & Nutritional education	Nurse : CM; Psychosocial support of FOP or ICG OT: ADL-training & Counselling about the home adaptation; Memory & spatiotemporal training Nurse or nurse assistant: ADL-support by nurses or nurse assistants at home	Nurse: CM OT: ADL-training & Living environment assessment, Falls prevention SW: Participation in MD meetings Nurse or nurse assistant: Monitoring of vital signs Nurse assistant: ADL-support at home during night & Night surveillance at home
Profile of the CM	Nurse	Nurse & SW	Nurse & SW	Nurse + SW	Nurse + SW	Nurse
Total FTE involved in case management	8,5	1,75	12,99	4,46	7,46	3,15
Ratio FTE CM:FOPs	1: 1,9	1: 2,3	1: 2	1: 70,4	1: 17,4	1: 21
Profile of <i>expected</i> target population	FOPs with cancer, fractures, MS, ALS, ...	FOP with rehab profile	(1) FOPs discharged from hospital needing transitional/rehab care; (2) failure of home care after discharge; (3) readmission of FOPs	General population of FOPs	Chronic evolutive FOP 20%, dementia 25,38%, Functional loss after trauma 13,08%, Frailty 25,97%, palliative 0,77%, psy 3,85% -	General population of FOPs

Criterion	CMR196	CMR179	CMR203	CMR202	CMR190	CMR185
			of the same project		social isolation: 39.12%, partners 50%	
Expected caseload	16	4	27	314	130	66
Achievement of the caseload	Yes (exceeded)	Yes	Yes	Yes	Yes	Yes
Recruitment means	Mainly hospital	Hospital	Hospital	at home	waiting list for NH & HC	HC services
Partnership with coordination service (SISD/SEL/GDT or CCSSD)	Yes	No	Yes	No	No	Yes
Partnership with community organisations	Yes	No	Yes	Yes	No	Yes
Incentives for GP participation	No	No	No	Paid by the project	Paid by the project	Paid by the project
Provision of feed-back about FOPs to the GP	Yes, weekly	Yes	Yes	No	Yes	Yes
Presence of interventions/planned supervisions and MD group meetings to enhance the knowledge of case managers	Yes	No	Yes, with supervision	Yes	Yes	Yes
Care/service plans use	Yes	No	Yes	Yes	Yes	Yes
Use of BelRAI results	Yes	No	Yes	Yes	Yes	No
ICT Tool for clinical coordination	EHR	EHR + for management of the project	EHR	No	EHR	No
Duration of the intervention	31 days	14 days	28 days	314 days	permanent	permanent
Umbrella organisation	Rehab	NH	NH	NH	NH	HC
Missing elements for the project?	More coordination with partners; risk for	No	No	Need for more coordination; lower	More FTE & more ICT	More focus needed on adapted day care;

Criterion	CMR196	CMR179	CMR203	CMR202	CMR190	CMR185
	disguised NH placement			caseload		do not understand why hospitals do not refer FOP
Unit of activity	1 care-day	1 care-day	1 care-day	1 care-hour	care package	1 care-hour
Nb of Units/FOP (Sept 13)	32,79	14,3	23,41	18,03	0,96	86,2
Annual cost per FOP	€ 2.849	€ 1.470	€ 2.348	€ 789	€ 5.740	€ 13.759

3.1.3.9 CASE STUDY 4

(CMR190) This project was included in the set of case studies in 2013 because during the analysis of the questionnaires and data provided by NIHDI, it appeared that they succeeded in implementing their innovative services by cooperating intensively with similar projects in their region, which we wanted to investigate more in-depth. This is the reason why, for this case study, we only have data of one interview.

1. CONTEXT OF THE IMPLEMENTATION

In the nursing home, to which the main coordinator belongs, they were used to work in an interdisciplinary, patient-centered way, for which they developed a TRABB-model (transdisciplinaire bewonersgerichte basishouding). Moreover, the main coordinator was willing, from the start, to work with similar projects in the same province (of the home care sector –social and healthcare – and of the residential sector – nursing homes), which was not an easy task. (Int2013)

2. THE PROJECT AS PLANNED

THE INTERVENTION

The project offers integrated supportive care services to older people on a nursing home waiting list and other older people for who the limits of qualitative home care are reached. With this 'tailor-made care program' the project wants to stimulate self-care so that a nursing home admission can be postponed or avoided. The integrated care is realized through structural cooperation between the inpatient (intramural) and outpatient (extramural) sector. The freedom of choice and the care management of the elderly are important values for all partners in the project. Therefore, the FOPs and his environment are involved in the interdisciplinary team meeting and the composition of the 'tailor-made care program'. The principle of 'Negotiated care' provides the best guarantee for success of the realization of the projects' goals. With this 'tailor-made care program' the project wanted to stimulate self-care so that a nursing home admission could be postponed or avoided. Also, they wanted to optimize the quality of life of the older people by social activation. Additionally they wanted to strengthen the coping capacity of the informal caregiver.

At meso-level, the project aimed at creating a seamless continuous care trajectory for the older people.

TARGET POPULATION

The expected target population consisted of 1) older people on a nursing home waiting list, 2) older people for who the limits of qualitative home care are reached and 3) older people in an acute but temporary crisis situation to avoid a 'social' hospital admission.

Recruitment of users should be done by six of the projects' partners. It is not clear which partners exactly. Following partners have 'intake' in their task description (submission file).

The project expected to include 144 users on a yearly basis. On average 12 users every month. The 6 partners mentioned above will each provide on average 2 users per month. One care trajectory will take 203 hours.

The area of activity is limited to a certain perimeter around the main nursing home in the project. By doing so, the project wants to guarantee the efficiency of displacements en time investment of the staff. In this area are 8 municipalities, which already form a linked and coherent area of activity in the region.

INTERACTION WITH THE ENVIRONMENT

The mandatory partner of the project is a home care nurses organisation (Wit-Gele Kruis Oost-Vlaanderen vzw). Their tasks are: Intake of users, Filling out the BelRAI, Participation in interdisciplinary meetings and follow-up, case management, Nurse performances not included in existing nomenclature

Besides the mandatory partner, the project has 8 other types of partners:

- (1) nursing homes; their roles are Intake of users; Occupational therapy and physiotherapy screening, interventions and follow-up at the FOP's home; Other paramedic interventions at the FOP's home; Participation in interdisciplinary meetings and follow-up; case management; Crisis accommodation in acute situations; Night hostel
- (2) day care centers involved. Their tasks are: Regular home care support service; Crisis accommodation in acute situations; Explore the possibility of night care in the infrastructure of the day care center; Explore the possibility of transportation service
- (3) center for general welfare. Their tasks are: referral of users; Participation in interdisciplinary meetings and follow-up
- (4) Regional service centers. Their tasks are: The home care coordinator whose task is to prepare, lead and follow-up the interdisciplinary meetings; The basic home care services in the tailor-made care trajectory
- (5) Services for family care and additional home care. Their tasks are: The basic home care services in the tailor-made care trajectory ; Provide polyvalent carers for night care services at home; Intake of users; Participation in interdisciplinary meetings and follow-up; Role of (trajectory) counselor; Signal function, report psychosocial observations made
- (6) Volunteer organisations. Their tasks are: Promotion of the project; Activities in the tailor-made care plan; Provide volunteers to support home care; Expansion of the telephone center
- (7) Informal caregiver organisations. Their tasks are: Provide information, advice, education and peer contact to informal caregivers; Organize a threshold lowering education initiative in the nursing home
- (8) Sitting services. Their tasks are: Sitting services by volunteers; Night care by volunteers

The participants of the project are a geriatrician and 6 GP/*coordinating and counselling physicians (CRA)*. The geriatrician has the role of expert, advisor. The GP's are key persons in the interdisciplinary meetings because they know the users best.

"Elke partner heeft zijn eigen kennis en ervaring. Daar hebben ze op ingespeeld om de verschillen tussen de residentiële zorg en de thuiszorg te ontdekken en die te proberen overbruggen. Het samenbrengen van die verschillende know-how was verrijkend." (Int2013)

The coordination of the partnership (strategic coordination).

The project coordinator is responsible for submitting the project plan, RIZIV contacts, administration, follow-up of the project, financial redistribution between partners, organisation of the steering committee.

The project plans to have 6-weekly meetings of 2 hours with the steering committee. All 8 partner organisations have a representative in this committee. The goal of this steering committee is to monitor the project's aims and progress reports and to adjust the project plan.

The project asks a budget for 0.08FTE for these steering committee meetings (0.01FTE/member).

THE PLANNED SKILL-MIX

Nursing staff, consisting of 2.57FTE nursing bachelors + 3.40 FTE licensed nurses and 2.13 FTE nursing aids; Physiotherapist: 1.28 FTE; Social worker: 4.76 FTE; Occupational therapist: 2.90 FTE and GP: 0.26 FTE

Training of the staff. The project plans to have 3 education modules ; BelRAI education: 2 nurses attending 8hours (1 day) and 'train the trainer' about the use of BelRAI: 8hours (1 day)

Information session for all key persons in the involved organisations: 4 hours

COST OF THE PROJECT

The budget asked from RIZIV is high according to the jury's comments.

The project will not ask the user for a contribution for interdisciplinary meetings, follow-up and screening. However, for the regular home care services that will be included in the tailor-made care plan, the project will follow the legal regulations (user contribution is determined based on the financial strength and the degree of care needs of the FOP).

For the innovative services in the tailor-made care plan, the project plans to ask a fair remuneration, determined based on the financial strength and the degree of care needs of the FOP. The will use already existing scales and instruments to determine what is fair.

Comment of the jury : the project is an added value in cases where the existing care coordination is insufficient. However, the financing asked for is too expensive.

3. THE PROJECT AS IMPLEMENTED

The project held information sessions and published articles in magazines to recruit potential partners. (FB2011)

THE INTERVENTION

When there is a demand from a FOP, an ICG or a professional, the case manager checks if selection criteria are met; if the person is eligible, she meets the FOP at home and explains the intervention to the FOP. If he or she consents to be included, the nurse case manager fills in the BelRAI questionnaire. If needed, an outpatient occupational therapy and/or physiotherapy screening by the occupation therapist and/or physiotherapist of the nursing home is performed.

An interdisciplinary team meeting is then organized by the home care coordinator: results from initial screenings (BelRAI, occupational and or physiotherapy) are discussed. The following people are invited and involved: Frail older person; Informal caregiver; General practitioner; Social worker of the nursing home; Home care nurse; Occupational therapist (and other care providers if already present in FOP's home care or needed). During this team meeting it is decided who will be the FOP's care trajectory counselor (case manager). A tailor-made care trajectory is composed based on what care is already provided and what is needed. The care trajectory counselor makes a report of the tailor-made care plan and sends it to all people involved. The care trajectory counselor is responsible for further follow-up.

Every 6 weeks the home care coordinator and all care trajectory counselors have a meeting to discuss and adjust if needed all care trajectories. Every quarter of a year the nurse assesses the users (BelRAI + other instruments) to evaluate progress. For every user they plan a yearly follow-up interdisciplinary team meeting as described in point 6.

THE COORDINATION OF THE INTERVENTION (MEETINGS & TOOLS)

The project made clear agreements between all partners about how to introduce the project to the potential users. Interdisciplinary meetings take place with partners, which allow the expertise of the various sectors be put together. The home care coordinator is facilitator of the interdisciplinary meetings. He monitors the goals of the meetings and writes the minutes of the meeting including working agreements. The care trajectory counselor monitors the agreements made within a care trajectory.

The BelRAI and the occupational therapy screening (COPM) form the base for the tailor-made care trajectories. As the sharing of information is important to the project, for an efficient and high quality care and services, the project wants to investigate how they can develop e-health record that can be used by all partners.

The project changed some aspects of the intervention since the start, because the time between the first contact and the first multidisciplinary meeting, needed before the care planning, was too long (three to four

weeks). Now, they start the planning at once. The intensity of the intervention varies between 10-20 hours. Their self-evaluation showed that the planned 10 hours on average of trajectory counseling was not enough. They actually provide 15 hours on average, with 10 hours as a minimum. For the future they plan to work with a 'basic' trajectory of 10 hours and an 'intensive' trajectory of 20 hours. The case managers work proactively, in order to avoid crisis situations (int 2013).

Follow-up team meetings: The first team meeting at inclusion stays unchanged. For the follow-up team they make a distinction according to the users situation: (a) For 50% of the users a 'big' follow-up team meeting is enough where the trajectory counselor discusses the client during the transdisciplinary meeting; (b) For 15% of the users they have a separate formal team meeting with the care providers and (c) For 35% of the users they provide a full follow-up team meeting.

BelRAI screening is carried out every 6 months: the first assessment is done by a nurse or already multidisciplinary if partner organisations are already part of the clients home care. Every following screening is multidisciplinary coordinated.

BelRAI screening + occupational therapy screening: The goal is to make a care plan proposal in preparation of the multidisciplinary team meeting or client consultation by comparing the 2 assessments. One of the observed results of the project is an intensive cooperation between nurse assistants and paramedics.

Not every client needs the organisation of a complete team meeting (i.e. 10 professionals). This is needed at the start of the process, but not during follow-up. When the situation is stable, a smaller team meeting might be enough, or even a phone contact between healthcare providers (int 2013).

The primary care physician of the client is asked to participate in the meetings; to fill out his part in the BelRAI and is, of course contacted in case of problems. But the medical part is not central to this project, the medical part is part of the regular care.

DAY-TO-DAY ORGANISATION OF THE PROJECT

The planning of the interventions is time-consuming, as it is difficult to gather the teams: the primary care physician, the case manager, the client and his caregiver.

The project organizes intervision meetings for the staff by the means of (a) quarterly intervisions for trajectory counselors and consultation coordinators; 6 monthly intervisions for occupational therapists and ad hoc provincial intervision for trajectory counselors and occupational therapists. During the project process, the occupational therapist and the family aid had to learn to respect each others' role, which was not an easy task, because for the same intervention, an occupational therapist would say that he was trained to do this and the family aid said the same because she knew the client better. This asks for coordination.

One nurse coordinates the BelRAI completion for the four East-Flemish projects, which is considered an important added value.

IMPACT ON THE LOCAL HEALTHCARE SYSTEM

After three years of functioning, the project observes that the waiting list of nursing home decrease. (Int2013)

Evaluation and follow-up of the care plan is done continuously through trajectory counseling, 6-weekly through client consultation, through transdisciplinary follow-up team meeting if necessary. The trajectory counselor is responsible for the follow-up and evaluation. They use a tool for follow-up. The care plan is available for every care provider involved in sharepoint.

They use new multidisciplinary protocols, specially made for P3. The start-up budget was used to make the protocol.

There was initially a huge resistance against the use of the BelRAI-tool but the main coordinator did not stop promoting the use of this tool. After two years, the use of BelRAI was integrated into the daily routine.

“One of the people who were very much against the use of BelRAI at the start of the project claimed now (after two years of use), that it was very important that all professionals filled out the tool in real multidisciplinary” (main coordinator, interview 2013).

The use of the BelRAI and COPM tool is considered as an added value. The use of it was extended to the residents of the nursing homes. They use the CAPs of the BelRAI and out of the COPM, they determine with the client which are his or her priorities. They started to see the added value of the BelRAI when they saw what they could do with the results. Out of this, they made a manual around the CAPs, in order to coordinate the way care is provided by which professional.

THE TARGET POPULATION

Recruitment: the FOPS are referred by home care services (49.5%*) and by nursing homes (50.5%).

* home care services of mutuality (12%), family care services (12.5%) and home care nurse organisations (25%). (WQ2012)

“De inclusies kwamen niet vanzelf, in het begin hebben ze daar inspanningen voor moeten doen. In het begin werden er ook mensen geïncludeerd waar enkel afstemming van de bestaande zorg genoeg was en die geen zorgvernieuwing nodig hadden. Die moesten ze terug kunnen excluderen. Maar zolang ze nog niet aan de vooropgestelde caseload zaten aarzelden ze om terug te excluderen om hun cijfers te kunnen halen. Nu zijn ze veel selectiever bij de inclusies. Er wordt eerst gezien of er effectief iets kan aangeboden worden dat buiten het reguliere valt.” (Int2013)

The caseload was reduced from 144 to 130 clients. At the start of the project, due to pressure to achieve the ‘expected caseload’, clients were included for whom it appeared that the ‘innovative care services’ were not useful. The extensive assessments (questionnaires) scared off clients so that they dropped out. Clients and informal caregivers expect some ready-made solutions which the project cannot meet. (WQ2012)

THE SKILL-MIX

The project had to decrease the number of FTE, especially in the case of the nursing staff, as it overestimated the number needed of nurses and underestimated the number for family care. That is the reason why they asked in 2012 for a change in the convention, based on their own monitoring of the project.

The case managers are mainly social workers, and one nurse (of a home nursing organisation). All professionals hired by the projects are people with a solid professional experience. This means that, at the onset of the project, they experienced some resistance to change because of the fact that they had to change their working environment. Nevertheless, no one quit the project for this reason. The turnover rate within the project is very low. Only one social nurse quit, to be able to work nearer her home. All staff members have a contract of indefinite duration.

Training of the staff is done by the means of (a) intervision moments; (b) newly hired staff members receive a basic training in their employing partner organisation; (c) education package for trajectory counselors; (d) education for nurse assistants of the home care services given by paramedics of the nursing home (about the role of the nurse assistant in the paramedic care trajectory); (e) use of the output of the BelRAI

INTERACTION WITH THE ENVIRONMENT

They had no changes in the composition of the partnership. The essential partners and their tasks are: (a) Home care nurse organisation: Wit-Gele Kruis Oost-Vlaanderen (Intake; **Nurses** for filling in BelRAI + coordination BelRAI; Participation at meetings; Implementation of innovative nursing services; Acquire expertise in trajectory counselling) (b) Sickness fund (Intake; Coordination of consultations; **Social workers** for care trajectories; Trajectory counselling; Participation in meetings; Project coordination; Multidisciplinary filling in of BelRAI); (c) Family care services (Intake; Implementation of innovative nurse assistant services; **Nurse assistant** support in paramedic care trajectories; Multidisciplinary filling in of BelRAI; Participation in meetings); Nursing homes (Intake; Implementation of innovative **paramedic** services at home and in the nursing home; Participation in meetings; Trajectory counselling; Project coordination; Project administration) (WQ2012)

It was very important to them, during the implementation process, to build upon the existing structures and processes, in order not to double the number of meetings unnecessarily. For instance, the (social) home care sector had already a specific type of multidisciplinary coordination, which model they used for the project.

Coordination of the partnership. It was not easy to get all 9 partner organisations aligned. This requires a thorough project structure (provincial core group, provincial strategic steering committee, project core group, operational project steering committee, strategic project steering committee, several peer intervention groups, training, provision of tools, monitoring, customized software).

The bottom-up and top-down implementation is not easy.

ORGANISATION OF THE STRATEGIC COORDINATION OF THE PROJECT

There are three main types of meetings to discuss on the strategic organisation of the project: (a) Strategic steering committee (8-weekly, with the project coordinator, representatives of all partner organisations); (b) Operational steering committee (6-weekly; Project coordinator, members of the core group, representatives of all partner organisations); (c) Core group meeting (If needed, to prepare steering committee; Delegates of the operational steering committee). Additionally, they organize ad hoc working groups (for example to prepare an education afternoon). There are also provincial steering committees and core groups (East Flanders). The most important tool for strategic coordination of the project are: a report module, intervention moments with staff, evaluations of staff. (WQ2012). The project coordinator observes a high turnover rate of the directors of the partner organisation (three out of the five nursing home directors). Fortunately, the level of engagement in the project of the new directors is very high.

In the beginning of the project, the strategic steering committee was very important; afterwards, it was the case of the operational steering committee. Because of the high workload linked to the steering committee of the project, a core committee was constituted, with mandates from partner organisations. In this group, two partners were champions and this allowed them to develop tools, such as a communication platform; to organise trainings, interventions and supervisions.

Actually the strategic steering committee is more concerned with questions around the future of the project, whereas the operational steering committee is committed to search solutions for every day issues, such as communication problems.

4. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

	<u>Expected objectives of the intervention</u> <i>resources & activities</i>	<u>Expected effects (Mechanisms)</u>	<u>Expected outcomes</u>
TARGET 1	Support of self care. - <i>check eligibility</i> - <i>BelRAI+COPM assessment</i> - <i>Multidisciplinary care planning</i> - <i>Education</i> - <i>Home visits</i>	Tailor-made care programs allow the specific needs of the FOP to be met Education improves medication adherence Identification of risks can allow the anticipation of crisis situation higher sense of safety leads the FOPs and the ICGs to envisage the possibility to remain at home	Remain at home ↘ social hospital admissions ↘ hospital admissions because of ↘ exacerbations ↗ QoL
TARGET 2	Social activation. - <i>FOP in daycare</i> - <i>provision of sources, based on social needs</i> - <i>home visits</i>	Contact with other people Anticipate moments of risk of loneliness	↘ loneliness ↘ social hospital admissions ↗ QoL
TARGET 3	Empower ICG. - <i>information to ICG</i> - <i>help to access resources</i> - <i>FOP in daycare, respite</i> - <i>Education</i> - <i>Home visits</i>	Increase of coping abilities of ICGs Respite of ICGs Substitution of care usually provided by ICG	↘ burden ICG ↗ adequate care ↗ ADL, IADL
TARGET 4	Seamless care. - <i>single entry point</i> - <i>sharepoint</i> - <i>check eligibility</i> - <i>BelRAI+ COPM assessment</i> - <i>provide nursing acts that are not reimbursed</i> - <i>care plan</i>	Better collaboration between different sectors and professionals Better information flow. Preventive actions (e.g. pressure ulcer prevention and better medication adherence)	↗QoL ↗ADL ↘pressure ulcers, falls, ...
TARGET 5	<i>Impact on the HC system</i> - <i>provincial coordination of BelRAI</i> - <i>MD completion of BelRAI</i> - <i>MD meetings</i> - <i>transorganisational meetings</i> - <i>coaching of other care providers</i>	Shared values Promotion of BelRAI for HC Better info flow about FOP, resources Better knowledge on best practices	Better tailored care Better knowledge about each roles
 Contextual factors and barriers + : the engagement of the main coordinator, who is part of partner organisations (healthcare and social organisations)			

Figure 14. Programme theory of project CMR190

5. KEY POINTS LEARNED FROM THIS PROJECT

- a. The project relies heavily on the self-made interprofessional protocol, which took the totality of the starting sum (15% of yearly budget of the first year). This tool made each role in the project very clear, especially the role of the case manager. This protocol was made together with the other Protocol 3 projects in the same region.
- b. The engagement of the administrative coordinator at different levels of government was an important added value for the project.
- c. The project was very well prepared, especially to collaborate with professionals from the home care sector.
- d. Flexibility of the intensity of the intervention is key because the situation of the FOPs is fluctuating. Interventions and meetings have to be organised accordingly.
- e. The hiring of experienced professionals is a must, as they have to know the care needs of this population very well, along with the local social and healthcare organisations.
- f. The implementation of the BelRAI was difficult at the onset and needed time. When the added value of the tool is observed, it is accepted.
- g. The project used existing structures and processes to build their own processes upon.

3.1.3.10 CASE STUDY 5 (CMR185)

This project was part of the case study since the start of the evaluation and was included from 2010-2013 in the multiple case-study design

1. CONTEXT OF IMPLEMENTATION

This project was located in one of the main cities in the Flemish region. The project was created because of the existing lack of coherence between the support services and health care services, especially during the evening, nights and weekends. This gap in continuity may lead to unnecessary institutionalization, as the FOPs need care and support 24/7. This was especially a problem during the nights and during meals, because it was the experience of the project conceivers that this could lead to unwanted institutionalizations.

2. PROJECT AS PLANNED

This is not the first experience of the project's conceivers to write out a project.

THE INTERVENTION

CASE MANAGEMENT

According to the project, the **epicentre of the project is the case manager** « *zorgcoach* » (care coach). The most important service is, subsequently, case management. In this project, the case manager is a dedicated professional, which functions as a reference for the FOP, her/his informal caregiver (ICG) and all (health) care providers.

This case manager is responsible for following tasks:

- Determination of care needs of FOP and ICG ;
- Translation of care needs of the FOP and mobilisation of ICG ;
- Assessing home care resources during transitions (e.g. hospital discharge) ;
- Home visits at FOP and ICG ;
- Management of FOP record ;
- Organisation of patient-centred care, in coordination with (health) care providers : nurse, GP, physiotherapist, nursing assistant, occupational therapy AND with FOP and ICG ;
- Coordination of filling out of CGA (BelRAI), as a preparation for multidisciplinary meeting (multidisciplinary meetings) ;
- Organisation and making of minutes of multidisciplinary meetings ;
- Support of FOP & ICG during the whole process ;
- Facilitation of the collaboration between formal and informal care provision, with a special focus on the coping capacities of the ICG ;
- Monitoring and regular evaluation and adjustment of care process.

Delivery of case management is performed by (a) a central patient record and (b) centralized shared file. This software enables the sharing of minutes of multidisciplinary meetings. (c) for night surveillance; there is an extra paper file, containing an extra patient file and notebook. Every day, the case manager has access to these records and, if needed, the patient record. (d) Additionally, 90% of the FOP have an extra record at home, where care providers can exchange information. The information flow is easier between the professionals belonging to the same umbrella organisation than with professionals across organisations. The project believes this is because of the sharing of the professional culture within the umbrella organisation, which is used to work in multidisciplinary.

Additionally, multidisciplinary meetings with health care providers are initiated by the case manager, who invites them. They all receive the minutes of the meetings afterwards.

As a result of the needs assessments of the FOP, an individualized set of services is proposed to the FOP. The unit of activity is a set of individualized services, expressed in number of hours and based on the needs and preference assessment.

Following services can be offered:

NIGHT SURVEILLANCE

This service is delivered for FOP needing surveillance or night care between 10 :00 p.m. and 06 :00 a.m. This allows continuity of care during hours presently not covered by nurses or nursing assistants.

PROFESSIONAL ALARM

If needed, FOP can use the professional alarm system. When it is activated, a nurse or nursing assistant can go and check for the FOP. In every case, the case manager is informed about the alarm situation and the intervention needed.

FAMILY SUPPORT OUTSIDE OFFICE HOURS AND DURING WEEKENDS

If the case manager notes that familial support is required outside office hours or during weekends, nursing assistants and volunteers can be supplied (e.g. during two or three hours, or before 08 :00 a.m. or after 05 :30 p.m.).

DAY CARE DURING ADAPTED HOURS

The current time schedule of the centre for day care (08:00 a.m. to 05:00 p.m.). FOP can attend the centre for day care from 07:00 a.m. till 08:00 p.m. For FOP coming at 07:00 a.m., breakfast can be provided and an evening meal is served to FOP staying after 05:00 p.m.

SCREENING BY AN OCCUPATIONAL THERAPIST

Based on the assessment made by the case manager, it is possible to plan a visit at home by an occupational therapist, in order to enhance the comfort and training for the FOP. This professional will then, after careful assessment of the home environment, make some suggestions about possible or desirable interventions: equipment, training and coaching of the FOP, (some) adaptations of the home. The occupational therapist contacts the case management and the report of his intervention is part of the FOP record.

CRISIS ACCOMMODATION

One bed is provided in a nursing home, in order to accommodate a FOP in a crisis situation. This might be the case when the ICG is suddenly ill. The case manager seeks a rapid alternative solution, in order that the FOP does not stay more than one week in the crisis accommodation.

TARGET POPULATION

The inclusion criteria relate to frail older persons (60+) and their informal caregivers in a complex care situation. Exclusion criteria relate to FOP with severe dementia or psychiatric problems. Two third of the FOP in their project do not have an informal caregiver.

The expected caseload is hundred FOP/year and they think that they can handle up to 70 clients simultaneously for two case managers. Theoretically, it should be possible to care managers to care for 50 FOP each but, because of the flexibility needed in other services, they currently handle only 30. Not every FOP needs intensive case management at any time.

SKILL-MIX

Case manager

The case manager is an important person in the project. Her role consists of coordination and adjusting, if needed. She knows the situation well and can react quickly. The project planned two case managers at the onset, but the project started effectively with only one (an experienced social nurse). The second case manager was hired when the caseload was achieved (March 2011). The new case manager is also an experienced social nurse. In order to introduce the second case manager with ancient FOP, first visits were made together. After this introduction, two geographical zones were separated. This second case manager was asked to have a specific focus on blind spots in the area. This second case manager has to leave and the project is looking for a replacement.

Nursing assistant

The project had no problem to recruit nursing assistants, even for night work. There are currently two younger nursing assistants, and a more experienced one. If needed, it should be possible to expand this staff. There has already been a turnover with nursing assistants. Currently, there are five people working half-time for the night surveillance at home.

Training

The nursing assistants conducting night surveillance attend vocational training on a yearly basis. Themes include collaboration in primary care, prevention of low back pain, etc., as well as information sessions in collaboration with a ICG organisation.

INTERACTION WITH THE ENVIRONMENT

There are not many partners and they were known beforehand. Their main role goes further than only promotion and FOP referral. They highlight the fact that close collaboration between partners and input of their expertise from primary, second- and third line care is really an added value for maintaining FOP at home. The main partner is a Coordination centre ; other partners are shown in table below, along with their expected task

Table 14. Partners of project CMR185

Type of partner	Expected task
Nursing home and day care centre	Day care during extended hours
	Crisis accommodation
	Information about possible care offer
	Referral of FOP who are on a waiting list of a nursing home and need help in between
	Personal alarm device proposal and maintaining
	Member of steering committee
Hospital ward/social service in teaching hospital	First screening of FOP
	Information about and referral to the project
	Attend multidisciplinary meetings, if needed
	Collaboration with case manager (social service) by discharge
	Expertise about discharge and dementia
	Member of steering committee
Public Centre for Social Action-1	Information about occupational therapy
	Occupational therapy delivery
	Attend multidisciplinary meetings by occupational therapist, if needed
	Referral of FOP to project
	Member of steering committee
Public Centre for Social Action-2	Input of night care, in collaboration with nursing care centre
	Member of steering committee
Centre for home care	Input of nursing assistants : family support outside office hours and with irregular duration of service, when needed
	Input of volunteers, if desirable
	Member of steering committee
Circle of GP	Dissemination of information towards GPs
	Feedback of results towards GPs
	Member of steering committee
Coordination centre (SEL)	Is main partner
	Provision of overview of existing projects (i.e. besides P3), in order to make collaboration possible, if desirable services for the FOP can be offered
	Member of steering committee

The inclusion of new FOP is not continuous, e.g. there is a trough in summer time, because of personal shortage.

COST OF THE PROJECT

The project seeks to work independently of NIHDl, with own financing or via other means.

Cost for the FOP:

- Alarm system: the FOP pays 20€ monthly (+ intervention costs) for the alarm system
- In the project, the FOP pays when the set of services is not free (transport, meals on wheels, household support...).

3. PROJECT AS IMPLEMENTED

At the start of the project, advertising was done through hospitals, GP circles. Now, it is merely done by mouth-to-mouth and via flyers distributed by the case manager during multidisciplinary meetings.

Initially, people were not eager to collaborate but with the satisfaction of the FOP, the professionals who were expected to do the referrals are more enthusiastic. For instance, GP who already have a FOP in the project will refer more easily the next time.

It seems difficult to find a balance between promoting and not-promoting. When there is active promotion, people are referred. If, for any reason, the project has to say that inclusion is impossible, this leaves a bad impression.

THE INTERVENTION

After almost two years of project activity, the most popular services are family care, night surveillance and occupational therapy. If they should start the project over again, the project should consider the delivery of the same services, except for day care centre. Currently, there is only transport provided for the day centre during office hours. They should consider offering transport possibilities during the extensive opening hours also.

In the early stage of the project, when a FOP was admitted in a hospital, the case manager had to call the ward. Now she gets a call from the hospital, in order to know which care the FOP already received.

COORDINATION OF THE PROJECT

The decisions about the strategic organisation of the project are made by the coordinators of the different partners, based on the information provided by the frontline workers: case managers, nurses, family support, FOP and ICG). The steering committee meets every six months, with partners. The aim is to discuss the state of the art of the project, regarding inclusion and discharge of FOP and service delivery.

At an operational level, every case manager organizes her own care delivery.

Because the transport needs to be more flexible (all day long), they would organize the day care in a different way if they had to submit a new project design all over again.

Evaluation of the project

The project planned to evaluate the clinical path and indicators, but they seem not to do this formally. They believe their project to be successful.

THE TARGET POPULATION

Starting of the project took some time as, in the beginning, the referrers: GPs, hospitals, etc. were not convinced that the project would be helpful. When first FOP were included, it became clear that the project really brought an added value in the care system and referrers addressed FOP to the project.

THE SKILL MIX

Because of the starting phase, they hired a second case manager only when the number of FOP was sufficient for two.

Number of FOP/case manager. They expected each case manager could handle 50 clients, but because of the flexibility needed in the other services, 50 is not possible. Actually, they handle: 30/case manager.

4. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

	<u>Expected objectives of the intervention</u> <i>resources & activities</i>	<u>Expected effects (Mechanisms)</u>	<u>Expected outcomes</u>
TARGET 1	Improve continuity of care <i>Extension of existing daycare hours</i> <i>Provision of night care</i> <i>Coordination of services</i> <i>Case management by a case manager</i>	Improve sense of security Improved sense of continuity of care Improved adequacy of the care	Longer time at home ↗ QoL ↘ burden ICG
TARGET 2	Improve interdisciplinary collaboration <i>Meetings</i> <i>Manual for the professional</i>	Avoiding gaps and overlaps in services provision.	↗ adequate care
TARGET 3	Intensive support of FOP <i>home visits by case manager</i> <i>providing info about possible ressources</i> <i>management of patient record & BelRAI</i>	Identification of needs, preferences, demands and offer services and healthcare accordingly	↘ instit. ↗ ADL, IADL ↗ QoL, ↗ satisfaction
TARGET 4	Improve comfort and wellbeing at home <i>advice by OT</i> <i>adaptation of the home</i> <i>provision of adapted equipment</i>	FOP can live in a well-adapted home	↗ ADL, IADL ↗ QOL
TARGET 5	Improve collaboration between professionals <i>regular MD meetings</i> <i>sharing of info about FOP, resources</i> <i>management of patient record</i> <i>feedback about BelRAI to GP</i> <i>supervision of night tour</i>	Improving communication and information flow about patient Confront values Better knowledge about each other's roles allows more adequate care	↗ adequate care
TARGET 6	Impact on the HC system <i>interorganisational meetings, agreements</i> <i>transmural communication (discharge planning)</i>	Improve knowledge of professionals about local resources	Satisfaction of both FOPs and care providers
			
Contextual factors and barriers + : support of umbrella organisation			

Figure 15. Programme theory of project CMR185

5. KEY SUCCESS FACTORS

- The project finds that a major key success factor is related to the fact that they are heavily supported by the umbrella organisation.
- Due to the different services they provide, they can offer support and care in many need situations.
- A third point is the central role of the case manager in this project. This point should be developed in the next wave of interviews.

3.1.3.11 KEY POINTS OF CASE MANAGEMENT PROJECTS WITH NIGHT AND/OR RESIDENTIAL CARE

- The specificity of this group is that case management is organized out from a residential setting, even if the visits are done at home. This allows the offering of an impressive set of extra services (up to five additional services).
- Case management can be done by nurses, a group of nurses, or a MD group of professionals. It was very hard, to isolate this function amongst other functions, in other words to determine who does what in the project; case managers also provided direct care.
- All projects, except one, were well-embedded in the local network. The only one who was not, was linked to a revalidation centre. The others were housed by a nursing home as umbrella organisations.
- Four projects are supervised by a provincial core group, which allowed simultaneous training, joint making of tools (interdisciplinary protocols) and interventions.

3.1.4 PROJECTS PROVIDING CASE MANAGEMENT IN COMBINATION WITH PSYCHOLOGICAL OR PSYCHOSOCIAL SUPPORT

Five projects are in this category, two are part of the case study design. Out of the six projects, two are in the Flemish Region, two in Brussels and two in the Walloon Region.

3.1.4.1 THE INTERVENTION

Description of the services provided

The projects included in this subcategory offer case management, together with psychological or psychosocial support, sometimes combined with occupational therapy and, in one case, with nutritional support. The details are provided in Table NN and a concise description per project follows hereafter.

Project CMPS183 presented itself as a spin-off of a geronto-psychiatric expertise centre and offers a way of supporting frontline care providers caring for FOPs with psychological support, including counselling, coordination meetings, diagnosis and trainings for frontline workers. Before the project, these services were already offered by the centres for mental health at home using individualised care pathway.

Project CMPS198 offers a 'generic set of support and help for the FOPs, ICGs and professional caregiver, including professional support of the FOP, by means of a specific way of coordination. Its intervention is situated at the level of the frontline network support, by means of a multidisciplinary cell, and its intervention is done 'where the request comes from'. The project defines its intervention as a way of '*coordinating the network by coordination meetings*'. The project is described further as case study.

Project CMPS144 is situated in a structure of alternative housing for isolated persons, who rely on the help of a Public Centre for Social Support. They coordinate the global offer of services for an individual (her/his network), with a special focus on communication between the health care providers, by means of a care plan or adapted support, which is regularly evaluated and adapted, if needed.

Project CMPS186 wishes to offer the services, normally provided in a geriatric one day hospital unit, at home, in order to support the existing services at home and, through this, allow the FOP to remain at home. Central in their approach is the comprehensive geriatric assessment (BelRAI) and the systematic provision of psychological support of FOPs and ICGs once per month. Occupational therapy and nutritional support are offered if needed. This project is unsure about its status as a case management project because, if coordination is needed, they relay this coordination to the coordination centre of the home nursing organisation, to which they belong. As this project is also part of the second case study in this group, this will be developed further.

Project CMPS175 offers a light form of case management, which they wish to develop further as, for now, they are not able to provide in a satisfactory way, regarding the complex needs of the target population. Besides this, they provide psychological support to the FOP and his ICG. While the former have difficulties to cope with loss of autonomy, living with chronic diseases and accepting professional help, the latter express frequently feelings of guilt. They also offer the services of an occupational therapist, who can offer to adapt the home environment to improve the safety and improve communication with FOP with cognitive problems. This project also added a social dimension in their package of interventions, because of their experience of recurrent loneliness of most of their target population. They put a focus on social reactivation, by the means of intensive information about social meaningful activities for the FOP in the local network.

Table 20. Objectives, activities and professionals delivering case management with psychological support

Criterion	CMPS183	CMPS198	CMPS144	CMPS186	CMPS175
Objectives of the intervention	Support for FOPs, ICGs and PCGs.	Support for FOPs via ICGs and PCGs	Coordination of psychosocial and sociocultural activities by the means of CM	Support of FOPs and ICGs by the means of a care package	Support of FOPs and ICGs; psychological support and OT support
Description of services provided	Nurse : CM and psychosocial support; OT: BelRAI assessment contribution; Psychologist : Psychological support consultations for FOP and-or ICG	OT: CM; Psychologist: CM; Social worker : CM	SW: CM ; Psychologist : CM & Psychological consultations with FOP or ICG for PS support	Nurse: CM; OT: ADL assessment and counselling of FOP by OT at home; Psychologist: Psychological consultations with FOP or ICG for PS support; Dietician : Nutritional educations	Nurse: CM; OT: Counselling about the home adaptation by OT; Psychologist: Psychological consultations with FOP or ICG for PS support

Organisation & coordination of interventions

Organisation and coordination of interventions at the FOP level

The meetings described here concern the organisation of interventions around an individual FOP. They may include the FOP, her/his ICG, case manager and other care providers. These meetings are mainly organized at the FOP's home and are different than visits at home for usual care.

Table 21. Meetings organised around an individual FOP in case management projects providing psychological support

	CMPS183	CMPS198	CMPS144	CMPS186	CMPS175
Name of the meeting	Multidisciplinary meeting	Consultation meeting	Psychosocial follow-up meeting	Consultation meeting	Coordination meeting
Frequency	On demand of FOP or ICG	On demand, on average/ 3 month	On demand, from 2x/ month to 2x/ year	2x/ year	On demand
Duration	+/- 1,5 h	+/- 45'	1h	1-1,5h	1 h
Presence of FOP or ICG?	Yes	Only ICG	Yes	Yes	Yes
Invitation to of FOPs' GP?	No	Yes	No	Yes	Yes

Tools

Comprehensive geriatric assessment. The BelRAI is filled out by multiple professionals in four out of five projects and in one project by a single professional (nurse). In one this completion is even done across settings (i.e. by professionals outside the project, the project of the case study). None of the projects use the results of this comprehensive assessment to make the care plan and the rationale for not using the results of the BelRAI are very diverse/creative, according to the projects, going from the fact that BelRAI-HC is not suited for home care to the filling out in paper version and the CAPs not being available in real time for care planning.

Table 22. Tools and use of BelRAI

	CMPS183	CMPS198	CMPS144	CMPS186	CMPS175
Professionals filling out of the BelRAI	OTs, nurses, psychologists from different organisations	Nurse, GP, social worker, OT	Social worker, psychologist	Nurses	OT, social worker or psychologist
Professionals responsible for the BelRAI and making of the care plan	Coordinator P3 project does not use the results of BelRAI	OT, social worker of P3	SW, do not use results for care planning	Nurses, do not use the results of BelRAI	OT, social worker or psychologist do not use the results of BelRAI
Use of shared electronic patient file	Yes	Yes	Yes	Yes	Yes
Care plan	Weekly adjusted	"Service" plan ; they did not want to use the	Monthly adjusted	Yes , adjusted every 6 month	Yes , adjusted every 6 month

		word « care plan »			
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3.1.4.2 THE TARGET POPULATION

The projects from this type aim to reach FOP with cognitive and mental health problems and, for three of them, their ICGs. Two projects (CMPS183 and CMPS175 included indeed a high proportion of FOP with cognitive problems). One project has a high proportion of FOP without cognitive and functional problems; we can make the assumption that they are probably more socially isolated.

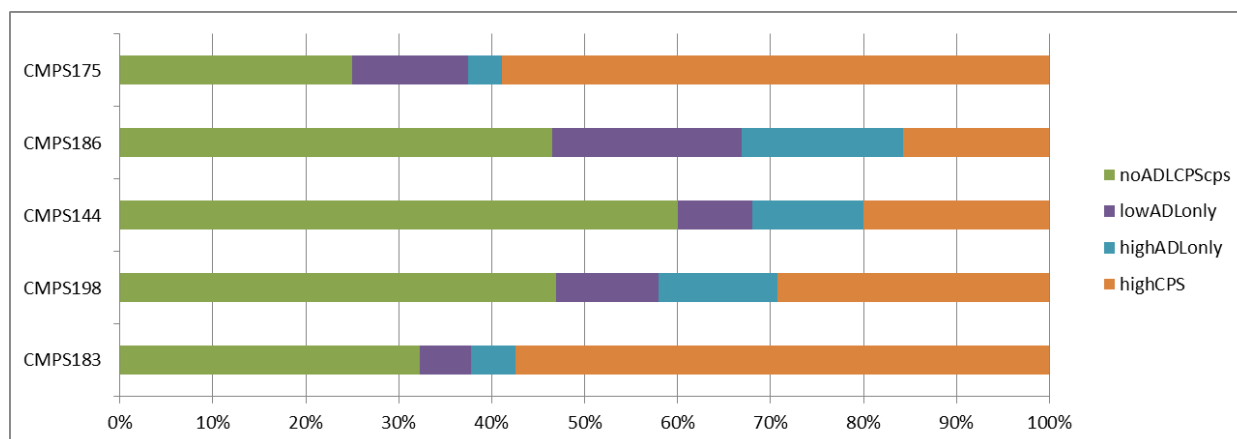


Figure 16. Profile of FOPs at inclusion in projects providing case management with psychological support

Only one project had problems to achieve their caseload and asked to change their convention accordingly (from 65 to 60 FOP).

Table 23. Expected and recruited population

	CMPS183	CMPS198	CMPS144	CMPS186	CMPS175
Profile of <i>expected</i> target population	FOPs with dementia or psy problems and ICGs	FOPs with mental health problems	FOPs with mental and physical problems	(1) Isolated FOP (2) FOP with specific psy demand (depression, mourning, loss of autonomy) (3) Support of ICGs of demented	FOPs with cognitive problems and ICGs
Expected caseload	50	99	15	60	26
Achievement of the caseload	Yes (and exceeded)	Yes (and exceeded)	Yes (and exceeded)	No (see case study)	Yes
Recruitment means	HC services	Hospitals & HC services	Hospitals & HC services	Hospitals & HC services	Hospitals & HC services

3.1.4.3 THE SKILL-MIX

The skill-mix in the teams is shown below.

Out of these five projects, two use a dyad of professionals, social worker/nursing assistant, social worker/nurse for case management; three hired nurses. The ratio FOP per full time equivalent varied highly, from one for 13 FOPs (the lowest) to one for 37 FOPs. The project with the highest FTE CM to FOP ratio was the project with the lowest proportion of FOP with cognitive problems, as defined by the percentage of FOP with a CPS>3.

Table 24. Profile of the case manager and of the professional delivering psychological support

	CMPS183	CMPS198	CMPS144	CMPS186	CMPS175
Profile of the CM	Nurse	OT + Psy + SW	Psy + SW	Nurse	Nurse
Total FTE involved in case management	3	5	1	1,64	2
Ratio FTE CM:FOPs	1: 17	1:19,8	1:15	1:37	1:13
Description of services provided by the psychologist	Psychological support consultations for FOP and-or ICG	Case management	CM & Psychological consultations with FOP or ICG for PS support	Psychological consultations with FOP or ICG for PS support; Dietician : Nutritional educations	Psychological consultations with FOP or ICG for PS support

3.1.4.4 THE COST OF THE PROJECTS

The yearly project costs per patient in this subcategory ranged from 1052€ to 3019€ and we verified if this could be related with the FOP to FTE case manager ratio in this category, as the cost of the project could be linked to this ratio (the higher the ratio, the lower the cost). This was not verified, as the most costly project of this category did not have the lowest FTE FOP to case manager ratio (CMPS198).

3.1.4.5 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

The five projects had an organisation for home nursing care as umbrella organisation. Except for project CMPS175, all projects had structural relationships with a coordination centre and three projects had a structural link with a mental health centre, which was considered important for the psychologists of the project, because of the expertise provided in this area.

	CMPS183	CMPS198	CMPS144	CMPS186	CMPS175
Partnership with coordination service (SISD/SEL/GDT or CCSSD)	Yes	Yes	Yes	Yes	No
Partnership with community organisations	Yes	No	Yes	No	Yes
Partnership	Yes	Yes	No	Yes	No

with mental health centre					
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3.1.4.6 ADAPTIVE BEHAVIOURS

- These project adapted frequently their exclusion criteria, in order to be able to care and support FOPs who are most likely to benefit from their intervention (e.g. FOPs with severe psychiatric disorders or homeless FOPs) but also changing of inclusion criteria for the same reason (e.g. including FOPs who did not receive a nursing lump sum (because they did not needed nursing care) but however needed care of this type of project);
- Strategies to reach their caseload in terms of number of FOPs with data in BelRAI included the adaptation of their discourse by making the information look less threatening and expanding of the catchment area, in order to be able to reach the caseload (one project);
- Changes in the partnership: mostly, the agreements between partners had to be refined: inclusion of an expertise centre for dementia, in order to support the working of the steering committee of the project (one project); for one project, the initial number of partners was very high and five of them left the project because they did not collaborate as expected (i.e. no professionals put at the project's disposal); for another project, the services were not needed (e.g. cultural services offered by a nursing home were not acceptable for the FOPs)
- Changes in the internal organization, in order to be able to work more in-depth:
 - o consultation with the FOPs occur with dyads of professionals of the project (one project);
 - o recruitment of an extra psychologist for one project, because the workload was so high with one psychologist that the waiting times for the FOPs were unacceptably long;
- Changes in the type of service delivered, in order to match the needs they perceive: one project decided to add activities to support the socialization process of the FOP (by the means of a community nurse).

3.1.4.7 EXPECTED EFFECT ON THE OUTCOMES AS A RESULT OF THE NORMATIVE ANALYSIS

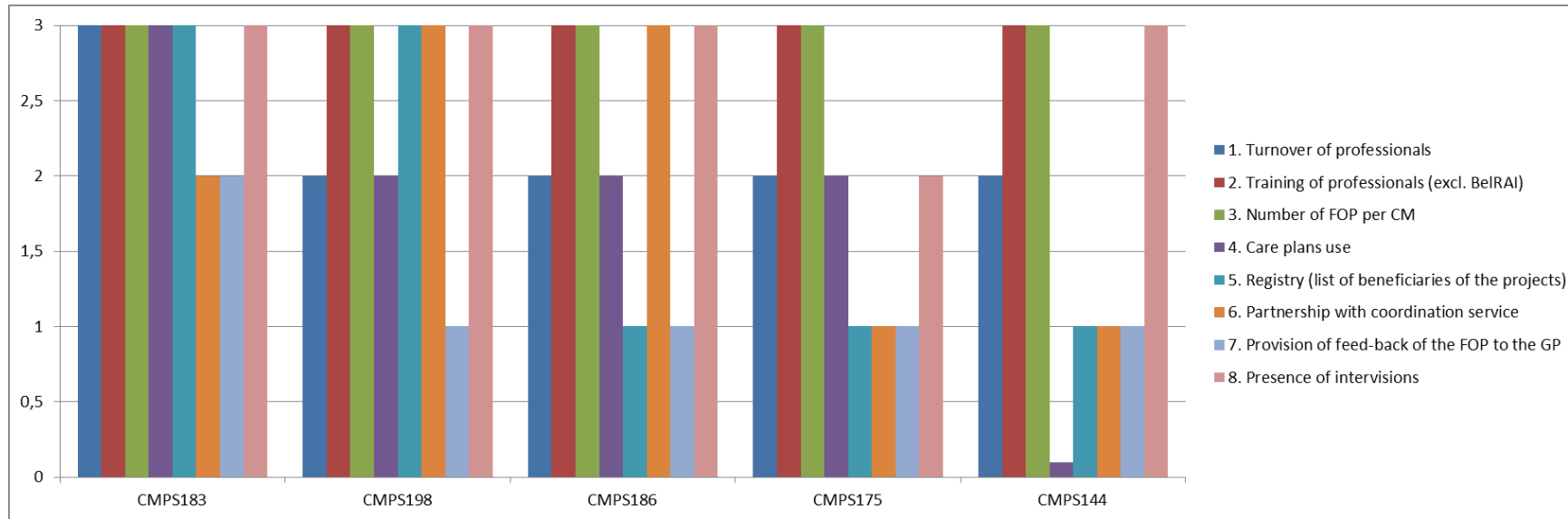


Figure 17. Normative analysis of the projects providing case management with psychological or psychosocial support: view per project

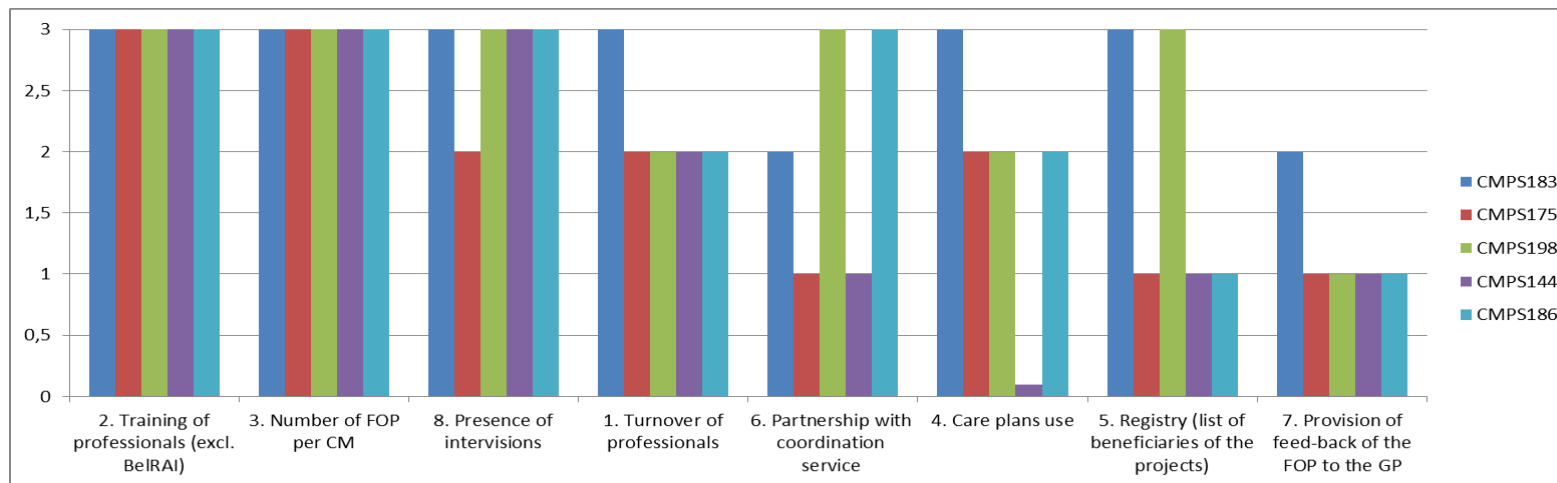


Figure 18. Normative analysis of the projects providing case management with psychological or psychosocial support: view per item

All the projects of this category reported that they organised a specific training for the case managers by an external teacher.

The caseload per FTE case manager was below 40 for all projects. This ratio might indicate an adequate workload and thus probably sufficient resources to provide high-intensity case management.

In all but one project, interventions were organised and included a supervisor and one project reported the presence of a geriatrician or physician during those interventions.

Except for project CMPS183, all projects reported at least one turnover of their case manager(s).

The partnership with coordination services, supporting the continuity of care with other agencies organising home care, was also inconsistent, as only two projects had formal and operational partnerships with home (health) care agencies. The level of interaction with GPs appears to be rather low for this subgroup of projects. This is also the project with the lowest reported turnover rate.

3.1.4.8 SYNTHETIC TABLE OF THE PROJECTS' DATA

Table 25. Synthetic table of the features of projects providing case management with psychosocial or psychological support

Criterion	CMPS183	CMPS198	CMPS144	CMPS186	CMPS175
Objectives of the intervention	Support for FOPs, ICGs and PCGs.	Support for FOPs via ICGs and PCGs	Coordination of psychosocial and sociocultural activities by the means of CM	Support of FOPs and ICGs by the means of a care package	Support of FOPs and ICGs; psychological support and OT support
Description of services provided	Nurse : CM and psychosocial support; OT: BelRAI assessment contribution; Psychologist : Psychological support consultations for FOP and- or ICG	OT: CM; Psychologist: CM; Social worker : CM	SW: CM ; Psychologist : CM & Psychological consultations with FOP or ICG for PS support	Nurse: CM; OT: ADL assessment and counselling of FOP by OT at home; Psychologist: Psychological consultations with FOP or ICG for PS support; Dietician : Nutritional educations	Nurse: CM; OT: Counselling about the home adaptation by OT; Psychologist: Psychological consultations with FOP or ICG for PS support
Profile of the CM	Nurse	OT + Psy + SW	Psy + SW	Nurse	Nurse
Total FTE involved in case management	3	5	1	1,64	2
Ratio CM:FOPs	1: 17	1:19,8	1:15	1:37	1:13
Profile of <i>expected</i> target population	FOPs with dementia or psy problems and ICGs	FOPs with mental health problems	FOPs with mental and physical problems	(1) Isolated FOP (2) FOP with specific psy demand (depression, mourning, loss of autonomy) (3) Support of ICGs of demented	FOPs with cognitive problems and ICGs
Expected caseload	50	99	15	60	26
Achievement of the caseload	Yes (and exceeded)	Yes (and exceeded)	Yes (and exceeded)	No	Yes
Recruitment means	HC services	Hospitals & HC services	Hospitals & HC services	Hospitals & HC services	Hospitals & HC services

Criterion	CMPS183	CMPS198	CMPS144	CMPS186	CMPS175
Partnership with coordination service (SISD/SEL/GDT or CCSSD)	Yes	Yes	Yes	Yes	No
Partnership with community organisations	Yes	No	Yes	No	Yes
Partnership with mental health centre	Yes	Yes	No	Yes	No
Incentives for GP participation	No	Paid by project	No	Paid by project	Paid by project
Provision of feed-back about FOPs to the GP	Yes	Yes	Yes	Yes, at each new inclusion, the CM visits the GP in his surgery	Yes, when possible
Presence of interventions/planned supervisions and MD group meetings	Yes, and include a supervisor	Yes, and include a supervisor	Yes, and include a supervisor	Yes, and include a supervisor	Yes
Care/service plans use	3,0	2,0	0,0	2	2,0
Use of BelRAI results	No	No	No	No	No
ICT Tool for clinical coordination	EHR + for project management	EHR + for project management	No	EHR	No
Duration of the intervention	permanent	Permanent	permanent	274 days	6 months
Umbrella organisation	HC	HC	HC	HC	HC
Missing elements for the project?	Need for more experimentation	No	High turnover of SW	Need for better definition of the role of CM	More coordination around the FOP
Unit of activity	1 care-hour	1 care-hour	1 care-hour	care package	care package
Nb of Units/FOP (Sept 13)	0,98	82,82	94,2	0,94	0,8
Annual cost per FOP	€ 1.902	€ 3.019	No data	€ 1.052	€ 1.896

Two projects of this type are part of the case studies, the first since the start of the scientific evaluation (2010-2014) and the second, from 2012 on.

3.1.4.9 CASE STUDY 6

(CMPS198) This project proposes to support the existing network (either professional or informal) around the community-dwelling FOP. The aim is to (re)mobilise the resources and skills of this network which, in turn, allows the (re)mobilisation of the FOPs' resources.

The most important tools for this project are consultation meetings, based on listening to the voice of the different professionals and the FOP and the creation of a "qualitative meeting and caring space", thanks to the specific consultation work. This is done by the means of a mobile multidisciplinary team, which intervenes where needed, facilitates the accesses to adequate services and monitors each situation following a specific process. Even if it shows some features of a case management process, the project does not define itself as a case management process because it situates itself in second, even in third line of the care process. However, they define themselves as reference person for the FOP or as case managers in second line (cf. amendment of the convention, February 2011) but do more than case management, because of the consultation part, which coordinates the network around a single FOP. In this sense, they declare having a similar counterpart in Brussels (Dutch project).

1. CONTEXT OF IMPLEMENTATION

Firstly, this project took part in the previous "therapeutic projects" of mental health, of which it retained its partners, some tools, such as the consultation meetings and support of the network.

The administrative coordinator of the project is also part of the coordination centre (SISD) in Brussels, to which all French-speaking selected Protocol3- projects belong. This centre played a central role in the preparation of the projects and saw to their complementarity. Despite this, the different projects do not interact together closely, as only six FOPs share more than one project.

The project is located in a main city, characterised by a highly heterogeneous population in terms of economic and cultural status, which allows the project to use the setting as an urban laboratory.

2. THE PROJECT AS PLANNED

The preparation and writing of the submission file, including the analysis of the current situation, took almost two years. This allowed the project coordinator to seek how to articulate the future project with the existing ones. The proposal was written by a mental health centre, but was submitted by a coordination centre. This was possible because the same person is CEO of both.

THE INTERVENTION

Objectives of the project

(a) Patient objectives

- a. Empowerment of the professional and informal care provider and of the FOPs and improve the well-being and quality of life of them;
- b. Support the maintaining at home of the FOPs while improving his quality of life;
- c. Reduce the number of nursing home and hospital admissions for social reasons, when the FOPs is not willing to do this;
- d. Support social insertion, if needed.

(b) Clinical objectives

- a. Support the accessibility to adequate care by the means of the mobile team and create trans sectorial practices;

- b. Improve familial and social integration, taking into account the different social statuses;
- c. Listening to needs; identify and respond to expressed worries about somatic and cognitive decline;
- d. Value the resources of each FOP;
- e. Respond to mental health needs (30% of the 60+) via an adapted care supply.

(c) Innovative objectives

- a. Promotion of the project via a mental health service, which enables the development of gerontopsychiatry; willingness to contribute to mental healthcare for older persons; taking into account the preoccupation of the FOPs around the nearness of death;
- b. Creation of a meeting point, enabling FOPs to stay at the center of the care provided; creation of intersectorial clinical practices by the means of the co-construction of a care plan (which takes into account the needs and resources of all involved stakeholders) and which is political, community and philosophically neutral...;
- c. Creation of a institutional memory space, enabling a qualitative listening of caregivers (formal or informal), to prevent burnout; a proposal of tailored care for the FOP and, in the continuity, reinforce primary care by financing their participation to consultation meetings.

Through these explicit objectives, the project wishes also to have a systemic impact, by changing the clinical practices.

The operational steps of the intervention

First step: identification of the demand and, if relevant, intake during a first interview by the means of the mobile team (two or three members), in presence of the professional demander or, in some cases, in the FOP's home. During this first meeting, a first plan can be proposed, as well as two key reference persons for the FOP, the first being responsible for the CRM or BelRAI, the second being responsible for the consultation and care plan.

Second step : organisation of a consultation meeting (« type A »), where all stakeholders are present, excepted for the FOP and his ICG. This consultation meeting allows the building of a trustful and secure space between all professionals and aims to clarify each one's role (who does what and when?) and to plan the future consultation meetings.

Third step : organisation of other meetings, according to the care plan and evaluation of the care.

End of the case management process: admission in nursing home or hospital; the project transmits the needed information to the setting where the FOP is admitted.

An important tool for these meetings is an ad hoc ICT, allowing to share FOP's information among care providers, including the minutes of consultation and case manager's meetings.

TARGET POPULATION AND RECRUITMENT

- (1) FOPs 60+
- (2) His/her formal and informal network

FOPs had to be recruited by the partners of the SISD, which are all potential catchers of targeted FOPs. The expected caseload was 99 persons, which should represent a total workload of 89h/year/FOPs

SKILL-MIX

The project planned to recruit 9,5 FTE to man the mobile team and take care of the administrative coordination. The composition of the team will be detailed below, when comparing the skill-mix as planned, with the skill-mix as implemented.

Interaction with the environment

Organisational partnership

The partnership is impressive, as it comprehends partners of the previous mental health project and new ones: one SISD, two mental health centres, the scientific society of general practice, two nursing homes, two organisations providing nursing care at home, a non-profit organisation for social integration, two coordination centres for home care and services, independent nurses, etc.

3. THE PROJECT AS IMPLEMENTED

PROJECT PROMOTION

Project promotion was done by the means of flyers send to a hundred institutions and their website, along with the promotion of the other Protocol3 projects the coordination centre supported. Partners took part in the promotion process by sending the flyers to their own network. During this advertising period, they received a lot of demands, including for children.

INTERVENTION

The intervention was carried out as planned.

TARGET POPULATION

Achievement of the caseload

The project could start, as expected, in April 2010. 96% of their caseload was achieved after eight months of functioning.

Change of inclusion and exclusion criteria

With time, they experienced that their intervention did not seem effective for FOPs with premature aging and psychotic disorders, so FOPs with this profile were not included, along with FOPs with a physical impairment or a chronic disease.

At the same time, the project extended its zone of catchment area and, as a consequence, had to include new partners and plan longer travel times.

SKILL-MIX

The staff was different than planned because the partners could not delegate a social nurse as expected, because of nursing shortages. This resulted in the recruitment of external professionals with different profiles, a social worker and a psychologist. A computer specialist was also hired.

One professional left the project because he disagreed with the way informed consent was obtained¹⁴.

Table 26 below shows the shift in professionals since the start of the project. Currently, 14 professionals work for the project. Case management is carried out by the social workers, psychologists and occupational therapists. If occupational therapy is recommended for a FOP, the project hires an occupational therapist of a partner organisation.

Table 26. Change in skill-mix since the start of the project

Profile of professionals	Submission file (FTE)	December 2012 (FTE)
Administrative worker	1,5	1,5
Social worker	3	3
Psychologist	3	3

¹⁴ At the start of the project, only 30% of the informed consents were signed by the FOPs. This is the reason why the project changed its strategies and presented the informed consent as “a way to allow the project to be evaluated”. As a result, the percentage of informed consents rose to 90%, but one of the professionals left because of this, in his view, unethical strategy.

Nurse	0,75	
Master physical education	0,75	
Primary care physician	0,5	0,5
Computer specialist		0,17
CEO mental health centre		0,25
Occupational therapist		0,5
Psychiatrist		0,25
TOTAL	9,5	9,22

Coordination of the interventions

The project uses two ad hoc tools for the coordination of the interventions

- (1) For partners and participants: to plan and organise the consultation meetings (registry of presences, agenda, proof for payment of travel expenses etc.)
- (2) Electronic record with FOP meeting data: exchanges between the two reference persons of the FOP, results of FOP scales, etc.

To engage the primary care physician to fill out his part of the BelRAI, they finance his input (23€, the price of a consultation meeting). This way of working causes, of course, delays in the computation of CAPs and scales, which explains why the project is not able to use them for the care planning. At the other hand and maybe because of this, they never had problems to engage primary care physicians in consultation meetings. Overall, their perception of collaboration with this professional group is considered satisfactory. The project developed also standardized letters, to be sent to the different healthcare providers, who perceive a financing for the time spent in consultation meetings.

4. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

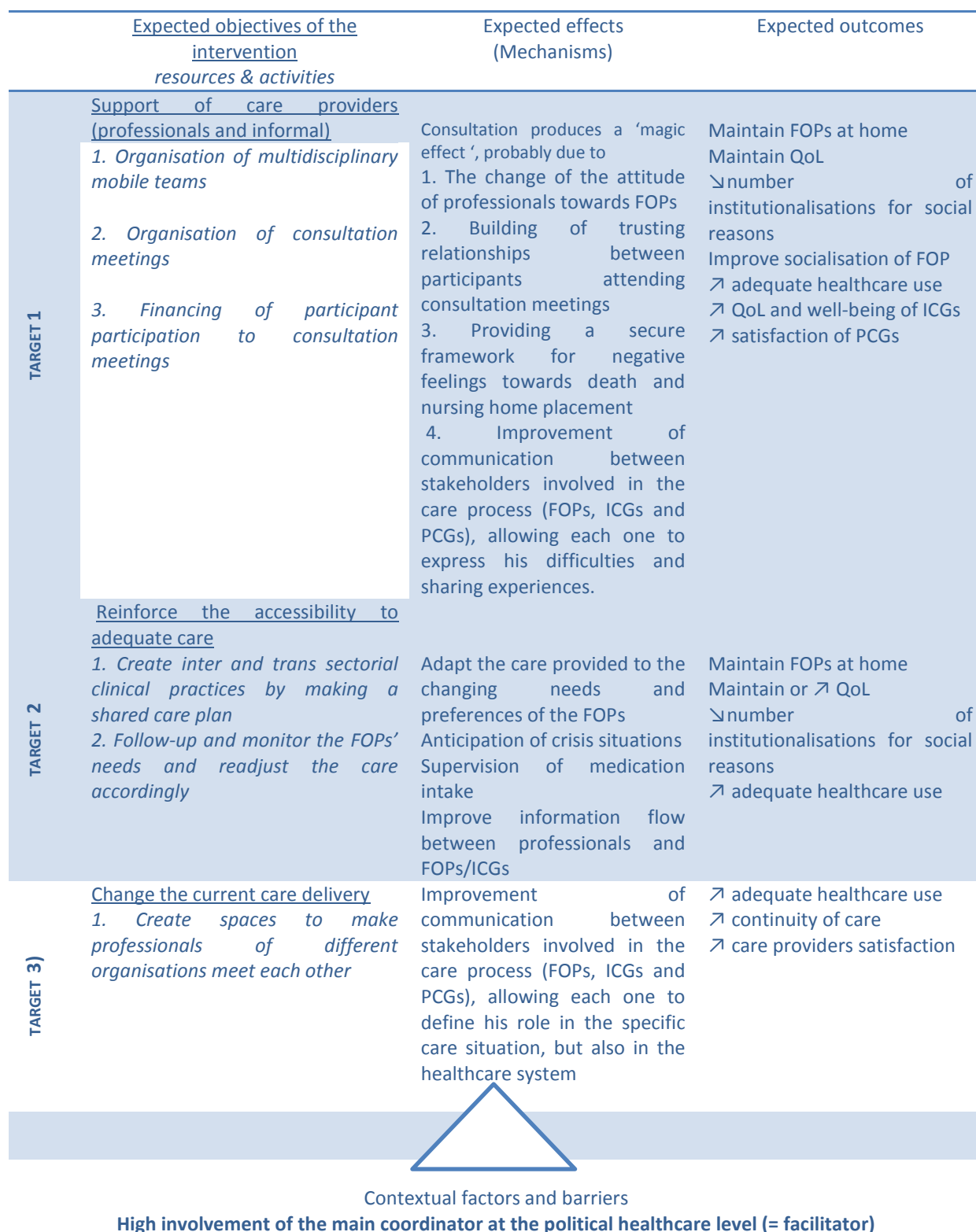


Figure 19. Programme theory of project CMPS198

5. KEY FACTORS FOR THIS PROJECT

Among the elements explaining the ease of the project to achieve its caseload, the fact that it was carefully planned is certainly a major point, along with the main coordinator's professional engagement in the political horizon of the city. However, the project is the most expensive of its category, mainly due to the high number of professionals participating in each consultation meeting. Indeed, it is not one professional who manages each but a multidisciplinary mobile team, supervised by a team of highly qualified professionals.

3.1.4.10 CASE STUDY 7 (CMPS186)

This case management project is about supporting FOPs and their ICGs at home, as well as their professional care providers. Like the previous case study, it aims at reinforcing the existing network around the FOPs. It was included in the case study approach from 2013 on.

1. CONTEXT OF IMPLEMENTATION

The project was proposed by an organisation of home nursing care. In this region, there are three coordination centres of home care, which the main coordinator of the project is part of. Before this project, they already had an experience with a psychiatric outreaching project, which is still ongoing and with which they share the same roof and values (Int2013).

The conceivers were willing to extend the existing healthcare in the region, by the means of hospitalisation at home. The preparation took 4 to 5 months, representing about 50 hours meetings with the potential partners and writing.

2. THE PROJECT AS PLANNED

THE INTERVENTION AND SKILL-MIX

The objectives of the project were

- FOPs' objectives
 - Multidisciplinary assessment of the skills of the FOP and the ICG in maintaining the FOP at home in optimal conditions (security and quality) ;
 - Maintain and stimulate the capacities of the FOP to be as autonomous as possible. Professionals have to be aware « to do with », instead of « in the place of » ;
 - Reinforcement of QoL at home, by taking into account all the risk factors (falls, medication intake, home adaptation, nutrition, etc.):
 - Support the FOPs by the means of supporting his ICGs, for instance by proposing him diverse respite forms (short stay in nursing home, hospitalisation for complete assessment, home attendants, ...), which in turn may prevent difficult situations which can lead to elderly abuse.
- Objectives related to innovation
 - Innovative : implementation of a new concept of geriatric care at home, to support the work of GPs and their patients, specifically aimed at frail older persons. This concept is based on the making of a care plan and consultation meetings ;
 - Alternative : previously, those multidisciplinary assessments are carried out in hospitals (geriatric wards or geriatric one-day clinics).Complementary : Extension of existing services (intra-extra muros).
- Organisational objectives
 - The project aims to guarantee continuity of care by the means of optimal communication amongst the involved care providers in care for an individual FOP;
 - Consultation meetings with the FOP's GP, the other healthcare providers, formal and informal caregivers and the FOP are organised on a regular basis (at the launching of the care plan, after four months, after eight months and after termination of the care pathway, i.e. twelve months);
 - A support for communication, a communication notebook is left at home to centralise the messages of the different care providers ;
 - The BelRAI evaluation tool is used for optimal communication amongst primary care providers and institutional care providers (short stay, rehabilitation) and hospital;
 - Trainings are proposed to care providers to increase the adequate use of these communication tools. (Convention)

The means by which they plan to achieve these objectives consisted of the implementation of a 12-month care pathway for every FOP, by the means of the following interventions

- Evaluation of needs at home via the use of the BelRAI;

- Making of a care plan;
- Psychological support of the FOP and/or his ICG every month ;
- Support by occupational therapist or dietician;
- Monitoring, evaluation and readjustment if needed, in collaboration with coordination centres and all involved stakeholders.

The care plan is validated during a consultation meeting in presence of the FOP, his ICG, his GP and professionals involved. During this meeting, a reference person is chosen (either an ICG or a PCG), who is the “warden of the good implementation of the care plan”.

Planned consultation meetings are held at home to evaluate this care plan.

The intensity of the intervention is supposed to vary according to each FOP’s situation. Typically, a care pathway will be carried out as follows:

1. Nurse of the project and partners identify a FOP for which the project could be beneficial (0,5h/FOP) – information and formalisation with the candidates (0,5h/FOP).
2. Nurse of the project (with the collaboration of the FOP’s GP) : coordination of a multidisciplinary assessment (2h/FOP) – making of a care plan (1h/FOP).
3. Occupational therapist : assessment and proposal of home adaptation (2h/FOP).
4. Dietician : (2h/FOP).
5. All care providers involved in a FOP’s care : formalisation of a care plan and identification of a reference person (3h/FOP) – consultation meetings (9h/FOP → 3 care providers x 1h x 3 meetings).
6. Nurse of the project: support of reference person (12 interventions of one hour/FOP/an).
7. Psychologist of the project and of the mental health centre : psychological support of the FOP and his ICG (12 visits of one hour/FOP/year).
8. Nurse of the project: possible organisation of short stay, respite, (3h/FOP).

The project does not plan to ask any financial contribution to the FOP for the case management or psychological support. However, some recommended healthcare services are to be paid, which could be a barrier for some of their target population (e.g. for respite care).

THE TARGET POPULATION

The planned target population have the following characteristics, besides the NIHDI criteria

- Attend a day care centre, without perspective of a nursing home admission ; OR
- Be on a waiting list for nursing home admission; OR
- Benefit from reimbursed nursing care; OR
- Be recently discharged from an institution.

The planned caseload was 65 FOPs .

INTERACTION WITH THE CONTEXT

Two coordination centres were included as partners (SISD and CCSSD), along with a mental health centre, a hospital, a nursing home, a rehabilitation centre and an association of GPs.

3. THE PROJECT AS IMPLEMENTED

PROMOTION OF THE PROJECT

The senior council, one of the project’s participants, was charged with the diffusion of the information about the project.

THE INTERVENTION

The intervention of the project consists of a care package of 12 interventions that are systematically proposed to the FOP but not systematically carried out, with the exception of the psychological support, which means that, if the psychological support is not needed, the FOP is not included in the project. However, if the FOP needs psychological support, but does want to be included, they refer the FOP to a mental health centre.

If the content of the services provided did not change since the start, the rhythm of the pathway was adapted. For instance, the psychological support was offered once per month and currently, it is offered 12 times per year, but the rhythm is adapted to the individual situation.

TARGET POPULATION

Recruitment

To achieve its caseload, the project changed its inclusion criteria by the means of an amendment of the convention: The FOPs can be included based

1. on the Edmonton score alone (and not, as previously, by the means of the Edmonton plus the Katz scores A, B or C;
2. on a diagnosis of dementia, even if they are younger than 60 years.

The caseload fluctuates between 55 and 62-63 patients. The project uses waiting lists.

The « typical » beneficiary is:

- A lonely person, expressing a need to talk, especially to counter this loneliness. These FOP are especially in demand for a psychologist ;
« Among the 30 beneficiaries I have currently in my caseload, when I think of those who have no one as informal caregiver [...] I have seven or eight out of 30 who have no one [...] We have a lot of isolated people. » (Psychologist during interview)
- A patient with a specific therapeutic support demand (depression, bereavement, acceptance of loss of autonomy, etc.)
- Patient living difficult experiences (illness, relational difficulties, worsening of the general health status, etc.)
- People with dementia, for whom the support is especially needed for their ICGs

The intervention ends with the definitive admission in an institution or when the FOP deceases or when, during the evaluation it appears that the project does not add any plus to the FOP. They made a decision tree to assess, during an evaluation, if the project is still needed or not. If the project is stopped, the psychologist mentions that they still can call them in case of need.

Patients are mainly referred by coordination centres, hospitals and, occasionally, by primary care physicians. One of the important referrers is the geriatric ward of the hospitals, who sees the added value of the project in making the FOPs accept family aids at home when they are discharged, because these aids add to the FOP's and ICG's sense of security:

SKILL-MIX AND DURATION OF THE INTERVENTION

Table 27. Professionals of the projects and their average intensity of intervention

professional	Content of the intervention	Duration	Frequency	Location
Nurses (bachelors and licensed nurses)	Evaluation of FOP's needs Making of a care plan If needed, transmission to coordination centre	1h to 1h30	At intake, at 6 months, 12 months	At home
Psychologists	Psychological support of FOP and/or ICG	1 hour (strictly)	On average, once monthly	At home
Occupational therapist	Assessment of autonomy and home environment		If needed, on average two times	At home
Dietician	Nutritional assessment and counseling		If needed, on average, two times	At home

The most important mechanism through which the project expects to delay institutionalisation is by the means of the sense of security provided by the fact of being included in the project and having a reference person

« A lot of FOPs feel lonely and insecure. If we arrive at home, to offer a framework providing a sense of security ... to know that there are care providers around, who interact with the GP, having regular visits of the psychologist to have an update about what goes on and what doesn't work out so well, this can provide a sense of security to the person, because she is able to say ; "Yes, I am still able to remain in my home".

The coordination of the intervention

This was difficult to organise, because of the confusion between the role of the existing coordination provided by the coordination centre. Clarification of the different roles was an important step to make the project accepted by the other nurses. For the moment, a weekly coordination meeting with the coordination nurses allow to discuss the cases of the FOP and allow the case allocation between professionals.

Another difficulty arose because of the part-time working in the project, making agenda planning difficult. For instance, the nurses provided direct care in the mornings and working as case managers in the afternoon, which was difficult because working with different logics. Now, they chose to work some days as case managers and the other days, provide direct care, which seems easier.

Four consultation meetings are also organised by the SISD, if the required professionals can be gathered (i.e.the GP, the home care nurse and a member of the SISD).

Evaluation of the intervention

They planned to make a satisfaction survey but, with the experience of the project, the psychologists found it too delicate to carry out because of their role as patient's support, not compatible, in their view, with evaluation of the project.

Coordination of the project

The day-to-day coordination of the project is carried out by a nurse. In the steering committee of the project are members of the coordination centre of the home nursing organisation. They meet every two months. Beside this (small) steering committee, there is also an extended version, three times per year. All representatives of the partner organisations participate in these meetings.

INTERACTION WITH THE CONTEXT

The project has seven partners, of which three are considered essential (1) the coordination centre of the home nursing association, which is an important referrer; (2) the geriatric liaison of a local hospital; (3) the local association of GPs.

The collaboration with the hospital improved significantly in 2013, when a new head nurse was recruited in the geriatric ward, because the identification of the FOPs needing the intervention most was much better and her participation in the steering group meetings

The four other partners are (1) a rehabilitation centre, who refers FOPs and (2) a nursing home. Those two partners can refer FOPs to the project. (3) The coordination centre (SISD, which provides administrative and logistical support for consultation meetings and payment of attendance fees for these meetings. (4) A mental health centre, with which they collaborate intensively.

4. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

	Expected objectives of the intervention <i>resources & activities</i>	Expected effects (Mechanisms)	Expected outcomes
TARGET 1	<u>Coordination of the interventions of the project with the interventions of the existing coordination centre</u> 1. <i>Presentation of the project to the FOP by nurse CM</i> 2. <i>Assessment by the means of BelRAI by nurse CM</i> 3. <i>Care pathway of 12 months</i> 4. <i>Designation of a reference person (CM)</i> 5. <i>Relay between the project and the coordinators of the home nursing organisation by nurse CM</i> 6. <i>Coordination of the interventions of the OT and the dietician by nurse CM</i>	The adequate services are provided to the FOP Anticipation of crisis situation Provide sense of security because of the designation of a key referent Better communication flow between care providers and FOPs Monitoring of medication adherence	↗ adequate healthcare ↗ functional status ↗ satisfaction with care ↗ QoL and well-being ↘ crisis situations
TARGET 2	<u>Improve psychological support of FOPs and ICGs</u> 1. <i>Home visits by psychologists</i> 2. <i>The focus of the session is on communication between FOPs, ICGs and PCGs</i> 3. <i>24/7 availability, if needed (mobile phone)</i>	Enhance sense of security and empowerment Increase coping abilities and sense of control	↗ satisfaction with care ↗ QoL and well-being ↘ crisis situations and social admissions
TARGET 3	<u>Dietary support</u> 1. <i>Nutritional screening</i> 2. <i>If needed, nutritional education and support</i> 3. <i>Evaluation of the intervention and adjustment, if needed</i>	Adequate nutritional support and advice is provided	↗ nutritional status ↘ risk of falls
TARGET 4	<u>Support of occupational therapist</u> 1. <i>Assessment of the home environment</i> 2. <i>Assessment of the functional status</i> 3. <i>Education and proposal of home adaptation, if needed</i>	The home is better adapted to the needs and preferences of the FOPs	↘ risk of falls ↘ risk of institutionalisation ↗ autonomy ↗ IADL
 Contextual factors and barriers Resistance of the FOPs to the psychological support (= barrier)			

Figure 20. Programme theory of project CMPS186

5. KEY POINTS FOR THIS PROJECT

(a) Changing recognition of the occupational therapists

When the project started in 2010, these professionals came rarely at home. Today, OT interventions are paid by the region, which makes the project reconsider the supply of OT by the project.

(b) Acceptance of the psychologist

Overall, the acceptance of the psychologist is not easy for the target population. The project adapted their functioning by presenting the psychologist in an indirect way.

« Mais alors, je dis maintenant : " J'ai ma formation de psychologue " ce qui fait que le côté psychologue passe un peu plus loin ». (Interview)

They observe that the patient accept more easily familial aids, for instance, when the psychological support is in place.

(c) Lack of training

Nothing was planned for the training of the professionals for their new roles and, with the project progressing, they feel they need extra training.

(d) Importance to collaborate closely with the FOP's GP

They see the role of the case manager as a relay of the GP and the specialist, especially in coordinating and monitoring the care plan.

« Comment est-ce que vous voyez le rôle de l'infirmière ? » « Comme le relais à domicile des spécialistes et des MG. C'est vraiment la coordination du suivi. Le plan de soins, c'est les dossiers et le package qu'on propose... la coordination de l'information médicale et paramédicale... la rencontre d'un médecin généraliste en début (...) et ce doublon infirmière et médecin généraliste, c'est quelque chose de spécifique ». (Interview)

(e) Maintaining FOP at home is not always the desired outcome; the added value of the project can also be to provide support, so that the transition to nursing home can be done in good conditions.

« Ce que M. G. n'appréciait peut-être pas parce que, l'objectif c'est le maintien à domicile... mais dans certains cas, on se rend compte que le maintien à domicile ce n'est pas la meilleure chose pour la personne et c'est peut-être travailler, finalement, l'idée d'un placement en maison de repos et c'est aussi notre boulot. » (Interview)

(f) Importance of defining clearly the role of the nurse case manager, as opposed to the coordinator of the home nursing organisation. For instance, at the start of the project, the role of the nurse manager was unclear towards the role of the coordinator already in place in the coordination centre for home nursing care, which went along a certain resistance to collaborate with the case manager.

« Une suspicion de vol de travail ? » « Oui (...) Voilà l'information, que chacun respecte ses plates-bandes. » (Interview)

Facilitating factors

A GP association was already part of the partners but, to increase his input, case managers visit now patient's GP systematically and to present a care plan. Beforehand, a letter was sent to the GP to ask him to fill out the medical part of the BelRAI but they were never returned. This was because, after one year of functioning, the project was still unknown to local GPs.

Adaptations of the project

The project hired an extra psychologist, in order to be able to perform monthly visits to the patient, when they reached their caseload and observed that the travel time was very long in this region..

3.1.4.11 KEY POINTS OF CASE MANAGEMENT PROJECTS IN COMBINATION OF PSYCHOLOGICAL OR PSYCHOSOCIAL SUPPORT

In this type of project, the added value of having a psychological/psychosocial component in the project design aimed at the provision of a sense of security to the FOP and his ICG, allowing him to remain at home. Crucial to this type of project is to mobilise the FOPs' own resources and enhance thus his coping skills.

3.1.5 KEY RESULTS OF CASE MANAGEMENT PROJECTS

Out of the 22 projects of case management, five were part of the case studies. Data could be extracted and analysed for project components out of the submission files and yearly questionnaires of almost all projects, the exception being those of which, despite recalls by email and phone, data were not available.

These data allowed the identification and description of structure and process-related components that, according to the actors of the projects, were likely to explain the success or not of their project in achieving their objectives. The case studies allowed to describe further, as the data was more extensive, the links between the components and the success of the projects, to come up with new insights and to clarify grey zones. Moreover, only the case studies allowed the analysis of the implementation level of the project (were all elements implemented as expected? If so, How (with which means, including adaptation strategies)? When? With what outcomes? If this introduction is similar to the key results of all types of projects, case management projects were different in different ways, of which the most important maybe was the high level of complexity.

Indeed, case management projects are complex projects, if complexity is to be defined as in complexity science, or theory of complex adaptive systems (CAS). CAS are characterised by qualities such as embeddedness, nonlinearity, unpredictability, self-organisation, diversity, fuzzy boundaries and emergent behaviour (Plsek and Greenhalgh, 2001). Chaos theory is a subset of complexity science; its central tenet is that order underlies and emerges from apparent disorder. This was certainly the case in the case management projects we evaluated

EMBEDDEDNESS

The projects existed within larger systems: local, regional, provincial, etc., of which they were part and that influenced them. More than other projects, case management projects relied on exchanges and interactions with the different types of (health) care professionals. For instance, for the organisation of care around an individual they needed, on the one hand, information about the situation of the FOP, which the care providers have to share. On the other hand, they needed information about the local health care system in which the FOP and their project were embedded.

One example of the challenge encountered in this topic was related to the collection of medical data about patients. When the GP was not formally involved as a partner in the project, there seemed to be a reluctance to share data. On the other hand, GP's who were well-informed about the objectives of the project were willing to share the needed data.

A proposition was that the quality of these exchanges might be improved by the use of ICT for information transfer and exchange. The common claim of most of the projects that they missed a tool to share the information flow, hints in this direction. Every project has, at least, developed and adapted an ad hoc tool, even *a minima*, such as a shared Excel file.

NONLINEARITY AND UNPREDICTABILITY

This refers to the fact that the direction of dynamic change in a project is unpredictable; a small action by an actor might produce a large change in the project and vice versa. This is because the patterning in interaction is continuous and often non predictable. This could be seen, for instance, in the effects of some projects on the local healthcare system. When all the actions of some projects tended to achieve desired outcomes at the FOP's level (e.g. delay of institutionalisation), this had also an effect on the length of the waiting lists in a given area, where shorter waiting times before (desired) nursing home admission were observed, potentially leading to more concurrence between nursing homes and as a consequence, maybe more hostility towards the nursing home hosting the case management project.

SELF-ORGANISATION

This refers to the ability of the projects to influence their structure and processes by creating new patterns through interaction with other systems. This was particularly apparent as the projects continuously adapted to the challenges they met.

The main challenges observed were those at the level of the recruitment and clear definition of the target population, the recruitment and retention of adequate professionals, the organisation of data collection for the scientific evaluation, the development of a new role (case manager). Some main points are described below.

- target population. The majority of the projects declared they did not have problems to achieve their caseload. When the caseload set in the submission file seemed unachievable, they promptly demanded for a reduction of the caseload to the NIHDI. On the other hand, some case management projects did not seem to be beneficial to certain patient profiles. This might be linked to the specificity of the profile of the professionals in the project. For instance, a case management project that only supports the network around a single FOP did not have the resources to provide case management to FOP with chronic diseases or psychosis and changed their inclusion criteria accordingly.
- profile of professionals. Some projects had difficulties to recruit professionals with the needed expertise. Indeed, data from the case studies showed that an in-depth knowledge of the local health and care network was essential to be able to work as case managers. Literature shows that a level of leadership might be needed to work efficiently as case managers. This was also visible in the present case management projects, where the role of case manager could be seen as intrusive with regard to the role of GPs or other health care professionals. In this case, it is important to be able to clearly define the respective roles expected by different professionals, in an assertive and respectful way.
- Organisational modalities. As the amount of information to gather is very important, adaptation strategies in this category of projects focused on the **formalization of collection and sharing** of information about FOP. This formalization process seems to serve different purposes, among which (1) the possible substitution of the case manager in case of problems, and ensure continuity of the case management process (2) the building of the formalization process itself is a learning opportunity to delineate the roles and function of the case manager(s) in the care delivery process, along with the other care providers.
- Intensity of the intervention around a single FOP. Very often, **projects adapted their intervention and the intensity** of the intervention to the needs of the FOP. Home visits were replaced by phone calls when the coordination of care was stabilized. When the coordination worsened, the intensity of the case management increased. This adaptation could also occur when the caseload (i.e. number of FOP/ case manager was too high).
- **Allocation to case managers** could occur following diverse criteria. The most frequently cited was by geographic location, as this allowed the fine-tuning of the knowledge about a given local network. Another criterion was according to the profile of the FOP and the know-how of case managers.

DIVERSITY

The case managers, projects' organisational modalities, geographic location, type of case management provided (as described above) varied highly and was unique. These differences might be critical for their impact on FOPs', ICGs' and systems' outcomes and have to be acknowledged when evaluating the projects.

FUZZY BOUNDARIES

The boundaries of the projects were not very tight, permitting continuous interaction with other systems, as is shown by the fact that the umbrella organisation interacted continuously, on different levels, with the case management project, by the means of visible or invisible input, e.g. providing extra financing by the means of

human resources for professionals who were not financed through NIHDI financing, putting rooms at disposal for multidisciplinary meetings, influencing the organisational culture of the project internal organisation, etc.

EMERGENT BEHAVIOUR

This refers to the creative and innovative change of a project, which occurs most often at the edge of the project. We observed that some projects were innovative in their changes than others and this was, according to the persons we interviewed, directly linked to the freedom they perceived they owned, towards NIHDI's control framework and regulations. It was also more frequently present in projects where (1) the position of the main coordinator was strongly sustained by the umbrella organisation and (2) where the project benefited by previous experience of pilot experiments. Examples of this emergent behaviour are the fact that, in three projects, the starting sum (15% of the annual financing) was allocated to the making of an interdisciplinary agreed protocol, which took months to achieve but was considered crucial to the success of the project. Another example is the organisation of group sessions of physical therapy, to support their interventions to counter social isolation in FOPs with dementia and their ICGs.

ADEQUACY OF THE CASE MANAGEMENT INTERVENTION: SOME KEY POINTS

ROLE DEFINITION OF CASE MANAGERS

Besides the characteristics of complex adaptive systems which have to be acknowledged, case management projects share also specificities, as they rely heavily on a recognized function of a *case manager*. This reference person – or persons- is often, but not always, clearly identified as the key reference person for the FOP. He or she is responsible for the needs assessment, the making and formalization of a care plan, the coordination of services needed around a given FOP, monitoring and follow-up of the coordination, as well as the evaluation of the adequacy of the case management. In this case, case management might be seen as a care delivery, and not only an administrative coordination task.

A point that came out recurrently, was the fact that the project coordinators were very careful to try to hire an experienced professional, with either an expertise in geriatric care or in specific knowledge about the local resources. Whenever this professional was on sick leave and had to be temporarily replaced, projects favoured experience over a specific profile. Overall, the preference expressed was for a community nurse, who is supposed to (1) be trained to be able to care for the FOPs in a holistic perspective and (2) have a good knowledge of the resources of the local system, including a clear view on the roles of other (health) care providers .

CORE FUNCTIONS OF THE CASE MANAGERS

Whether the case managers were nurses, social workers, occupational therapists or psychologists, we were not able to make a clear distinction between the functions they carried out and their initial training. One of the most specific task performed by the case managers of the protocol3 projects, namely the use of the results of the BelRAI for the making of the care plan, were not more frequently carried out by nurses or case management teams including nurses. If this is considered a positive outcome, this means that the case managers do not have to be carried out by a specific professional (e.g. nurses) and that they can be interchangeable. On the negative side, this could also mean that the level of case management was suboptimal, as it cannot be expected that professionals, which are not trained to have a holistic approach and do not have access to the whole BelRAI data, such as social workers, occupational therapists or psychologists, are more likely to carry out a suboptimal way of case management.

An important function of case manager was found to be the monitoring of the situation. This means that the case manager, during the follow-up of its intervention, monitors the situation in function of the wishes of the FOP/ICG dyad, but also in function of the lability of the situation. This careful monitoring allowed the case manager to observe subtle signs of deterioration, anticipating crisis situations or helping the FOP/ICG to cope

with this crisis situation (e.g. providing information about whom to call in case of falls). This is particularly important because of the profile of the frail older persons, whose health status is likely to deteriorate rapidly.

This monitoring should also occur in other domains, such as monitoring of vital or clinical parameters (e.g. weight gain in kidney failure, glucose levels in diabetes), medication intake (e.g. chronic heart failure), depression symptoms, etc. It has to be stressed that the aforementioned monitoring cannot take place without the close involvement of the FOP's primary care physician, to agree what has to be monitored and when, in order to be able to link this function of case management adequately with the other functions of case management. This means that the engagement of the primary care physician goes far beyond what was reported by most of the case management projects described in this report.

a. Organisational requirements to function adequately as case managers

- Adequate resource to handle information flow (about an individual beneficiary, about the human resources available inside and outside the project (i.e. recommended services and care);
- Planned interventions to exchange expertise about the managed situations;
- Financial independence to be able to sort out the most adequate care to recommend to each individual situation, as opposed to prevalent organisational-centred logics, i.e. risk that the care recommended is the care provided by the umbrella organisation.

b. Case management-sensitive outcomes.

The realist approach undertaken in this evaluation allowed the identification of "soft" outcomes, besides the "hard" outcomes asked for by the NIHDI. Amongst these, the projects identified the following desired outcomes of case management

- increasing sense of security,
- satisfaction with care,
- detection and anticipation of crisis situations,
- lower threshold for help-seeking behaviours,
- (health)care providers and FOPs' access to the relevant information,
- Decreasing of social isolation,
- FOP's sense of belonging to a community,
- healthcare literacy (including about the project's functioning),
- Improving QoL,
- Increasing coping abilities and sense of control

3.1.6 STRATEGIES CARRIED OUT BY CASE MANAGEMENT PROJECTS TO ENGAGE BENEFICIARIES' GENERAL PRACTITIONER IN INTERPROFESSIONAL COLLABORATION

As the projects reported difficult relationships with the beneficiaries' GPs, regarding the required input of BelRAI data (diagnosis and medication regimen), we performed a secondary data analysis about the strategies carried out by these projects to engage GPs to collaborate with the professionals in the projects.

The underlying assumption is that, more than other projects of the first call of projects, case management projects, relied on the willingness of GPs to collaborate, not only because of their required input in the BelRAI, but also (1) to co-construct the care plan, in collaboration with the FOP and his ICG, and (2) to facilitate the FOP's adherence to the care plan. In general, GPs have an important role to sustain the FOPs/ICGs' willingness to collaborate (Bernabei, 1998 ; Counsell, 2006-2007-2009 ; Landi, 2001 ; Moore, 2012).

Data collection was based on the same resources as mentioned before. For the analysis, we used D'Amour's structuration model of inter-organisational collaboration (2008). This model is based on the concept of collective action in organisational sociology, specifically in strategic analysis as developed by Crozier and Friedberg (1977) and in Friedberg organisational approach (1993). In this approach, collaboration is the central problem in any active undertaking. It is based on the premise that professionals want to work together to provide better care. At the same time, they have their own interests and want to retain a degree of autonomy and independence. The main instrument for negotiating such autonomy is power. The model takes issues of structure into account and focuses on relationships between individuals and the interaction between the relationships and the organisational dimensions. The model suggests that collective action can be analysed in terms of four dimensions, operationalised by 10 indicators. They are reported in Annex 2.

The results of the analysis, including the strategies used by the projects per domain, are listed by those dimensions and indicators

GOVERNANCE:

- **Centrality** : the projects reported a poor level of involvement of central authority (Federal, Regional) to provide direction towards collaboration. Even if there is a trend to move towards interprofessional collaboration, by the means of providing tools (e.g. BelRAI) to support the information flow among professionals, this was merely seen as an imposition linked to the scientific evaluation and a threat to the workload than a clear and explicit direction meant to guide action towards collaboration. However, as the projects were going on, most projects reported the usefulness of the BelRAI for the planning of care, even if this was not done in collaboration with the beneficiaries' GPs. Other means supporting GPs' participation in this aspect would include a specific NIHDI nomenclature code or SIT/GDT/SEL/SISD financing for primary care participation in multidisciplinary meetings.
 - Strategies used by the projects: some (4/22 projects) indicated to the GP the existence of an existing reimbursement status (i.e. nomenclature number for participating in multidisciplinary coordination meetings).
- **Leadership** is divided between different partners
 - Strategies used by the projects: No strategies were identified to share the leadership amongst organisations. Only one project provided a legal framework including all the partners and participants in the same region. This (non-for profit organization) allowed shared leadership. The role of the GPs was to share the decision making for the organisation of care and healthcare in this region.
- **Support** for innovation: because collaboration leads to new activities, it entails new clinical practices and the sharing of responsibilities. Collaboration cannot occur without learning opportunities

supporting those new practices. However, in Belgium, the training of different stakeholders is not oriented towards collaborative practices. Therefore, strategies planned by the projects involved other incentives to support these innovative practices:

- Strategies used by the projects: Projects provided extra financing by the project to participate in multidisciplinary meetings and make the care plan (30€-134€) : 10/22 projects. Projects providing an extra financing planned more often interprofessional meetings including GPs.
- **Connectivity** : opportunities to meet between GPs and case management projects make possible rapid and continuous adjustments in response to coordination problems.
 - Strategies used by the projects: meetings with GPs occurred in 15/22 projects

FORMALISATION

- **Formalisation tools** are important to clarify how the responsibilities are shared. Literature shows that collaboration is less influenced by the tools (e.g. for sharing information) than by the consensus emerging around the formalisation mechanisms and the rules that are implemented.
 - Strategies used by the projects: agreements with GP's circles occurred in 13/22 projects but no information is provided about how this formalisation was the expression of the frontline workers' consensus;
 - Projects reported that the GP was included as reference person in the care plan in 18/22 projects.
- **Information exchange**
 - Strategies used by the projects to provide feedback of the results of their interventions to the beneficiary's GP:. In general, little feedback was provided as listed below:

Type of feedback provided from the case management projects (N=22) to the GPs	N	%
About the results of the BelRAI	11	50
Only in case of exacerbation	5	22
Only when leaving the project	2	11
In real-time	2	11

- Strategies to get information from GP for diagnosis and medication regimen¹⁵:
 - Printing, sending forms with pre-addressed envelope with stamps;
 - Meeting with PCPs in their surgery to collect the data on paper;
 - “creative” bargains with GPs (patients whose data were collected for the BelRAI could hire hospital beds without to have to pay a deposit ...
 - These strategies were reported as time-consuming, but effective.

SHARED GOALS AND VISION

Goals: common goals were not made explicit between GPs and projects; projects reported to provide information about their goals to GP's circles but we do not have information about whether the vision was a shared one.

Client-centered orientation. This needs mutual adjustments between the projects and the GPs, to express the interests of each of the parties and, if needed, readjusted. No negotiated processes were expressed by the projects.

INTERNALISATION

¹⁵ Due to the secondary data analysis, we do not have occurrences for these strategies

Mutual acquaintanceship: conditions were not provoked to foster collaboration and projects relied heavily on the information provided by flyers and other media;

Trust: we have no data from GPs in this part of the evaluation.

Other co-occurring project components were examined and some correlations were found by comparing means between groups. Projects succeeding more often in organising meetings with GPs and paid more often GPs to participate in multidisciplinary meetings when they included FOPs with a higher level of dependence and were « bigger » projects (with a higher number of FTE involved in case management). No such associations were found for the other variables. Due to the small sample of projects, statistical significance was not sought.

D'Amour's indicators of interprofessional collaboration proved useful to inform the data collection and analysis and identify the domains aimed at by the projects' strategies. The data showed, on average, a low level of collaboration with GPs in the making of the care plans and participation in multidisciplinary meetings. We assumed that the conception, design and implementation of projects was organisation-centered, rather than patient-centered. To underpin this statement, we saw that rarely associated at the conception phase of most of the Protocol 3 projects. Moreover, the information flow was mainly mono-directional, from project to the GPs, a sign that the projects expected the input of the GPs would follow automatically. Findings of D'Amour's model helped to stress that projects that ~~the projects~~ used strategies essentially aimed at the organisational setting and not so much interpersonal relationships.

We recommend that projects develop strategies to engage GPs to collaborate. To get them on board and allowing thus to fir more to the Chronic Care Model, we suggest:

- To include GPs in the design of the projects and share the leadership more explicitly;
- Offer decent payment for their participation;
- Provide adequate feedback about the intervention to the beneficiaries, including the evaluation of the intervention;
- Simplify administrative proceedings. For instance, we propose to integrate the BelRAI application into the regular software of GPs.

Also, developing a relationship of trust (as defined by the perception of the competence of others) is likely to be another big challenge. Furthermore, literature shows that local leaders should be supported to promote collaboration (are the best placed to eliminate the barriers to collaboration) (Murray et al., 2010). These leaders should be identified by the projects and strategies should aim at supporting their adhesion to a shared vision.

The limits of the current analysis include (1) the fact that the analysis was done on secondary project data and (2) contextual elements were not taken into account (beneficiaries, informal caregivers, other primary care providers, including social care), modulating the interprofessional collaboration between case management projects and PCPs.

Building on these findings, the interview guide for the evaluation of the projects of the second call will be adapted and new informants (GPs, beneficiaries, informal caregivers and other primary care providers, including social care) will be included in the analysis.

3.2 PROJECTS PROVIDING NIGHT CARE (N = 11)

By definition, the 'night care projects' represent a category of projects whose interventions occur at night, between on average 10 pm to 5 am. They mainly offer nursing care at night or surveillance for FOP with clinical or psychological needs during the night.

Eleven projects have been classified in this category that is divided in three sub-types according to the intervention delivered: 'night hostel only', 'night care at home' and 'night care by one professional per FOP'. In the first part of this section, we present the descriptive and comparative features of this type of projects. In the second one, we present the four projects being part of the case studies. The Key results of the implementation analysis are listed and summarized at the end of this chapter.

Descriptive and comparative features of night care projects

According to the main service(s) they provide, night care projects have been classified in three groups.

1. Night care at home. Nurse and/or nurse assistant visit patients at home during the night. They usually provide surveillance and/or technical acts like monitoring parameters, bed and/or toilet support and pressure ulcer prevention;
2. Night hostel. The FOP is admitted in nursing home to spend one or several nights a week. Professionals provide surveillance and nursing home interventions;
3. Night care one professional per FOP. It is usually volunteers that spend the night at FOP's home. They are not paid by Protocol3 (see below) and their main activity is surveillance and support to the FOP.

3.2.1 THE INTERVENTION

The main goals of night care projects designers is to provide care that is usually given in hospital but in the home setting at night.

Table 28. Synthetic table of the interventions provided by night care projects

Type of night care	Project code	Objectives of the intervention	Description of services provided in terms of 'care'
Night care at home	NC166	Giving care by night	Night surveillance at home
	NC201	Delay premature NH placement; focus on care during the night	Planned night nursing care at home; Night surveillance at home; Emergency interventions
	NC156	Warrant a 24h/24h service (care continuity)	ADL-support at home during the night; Night surveillance at home or nursing home (respite ICG); Unplanned nurse visits at home by nurses or nurse assistant; Parameter control by nurses at home
	NC157	Surveillance and care at home	Surveillance at home during day and night; Pressure ulcer prevention during night, Monitoring of devices during night; Bed and/or toilet support; Fall prevention

	NC167	Warrant a 24h/24h service (care continuity)	ADL-support at home during night; Monitoring of devices during night; Parameter control by nurses at home; Planned night nursing care at home; Pressure ulcer prevention during night; Bed and/or toilet support; Fall prevention; Medication support/delivery
Night hostel only	NC162	Helping of FOP and ICG	Nursing care in night hostel; Medication delivery; Parameter control by nurse; ICG support
	NC150	Helping of FOP and ICG	ADL-support in day care; ADL-support by nurses or nurse assistants in day care; Pressure ulcer prevention in night hostel; Surveillance in night hostel; Medication delivery
	NC153	Helping high impaired FOP with burdened ICG	ADL-support in day care; Surveillance in night hostel; Nursing care in night hostel; Information and emotional support for ICG in day care centre; Information and advice at intake in night hostel; Medication delivery
Night care one professional per FOP	NC195	Helping ICG during the night	Night nursing care at home; Night surveillance at home; Night surveillance by nurses in an institution
	NC182	Helping of FOP and ICG	ADL-support at home during night; Household activities (nurse assistant); Night visits at home for Psychosocial support by nurse assistants; Psychosocial support to FOP and respite to ICG at home at night; Surveillance at home during day and night; Surveillance in night hostel
	NC192	Helping of FOP and ICG	ADL-support at home during night; Household activities (nurse assistant); Night surveillance at home; Night visits at home for Psychosocial support by nurse assistants; Psychosocial support to FOP and respite to ICG at home at night; Surveillance at home during day and night; Nursing care in night hostel; Psychological support for health care professionals

Services provided: projects providing 'night care' generally offer night observation, psychological support during the night, coordination of services and respite care between 10 pm to 5 am. The 'intervention', whatever the services provided, can take place at home or in a 'night hostel'.

The intensity of night interventions offered by projects varies from systematically visits at night to interventions in case of emergency.

The night care intervention mainly consists of providing three kind of services night surveillance, psychological support, coordination of (day and night) services and respite. The intensity of the intervention varies between projects.

3.2.2 THE TARGET POPULATION

The night care projects seem to be designed for FOP aged 60 years and above needing surveillance and/or care during the night (change of incontinence material, support for going to bed). About the population profile included into the projects, it appears that in general night projects target an impaired population in loss of independence and/or a cognitive decline.

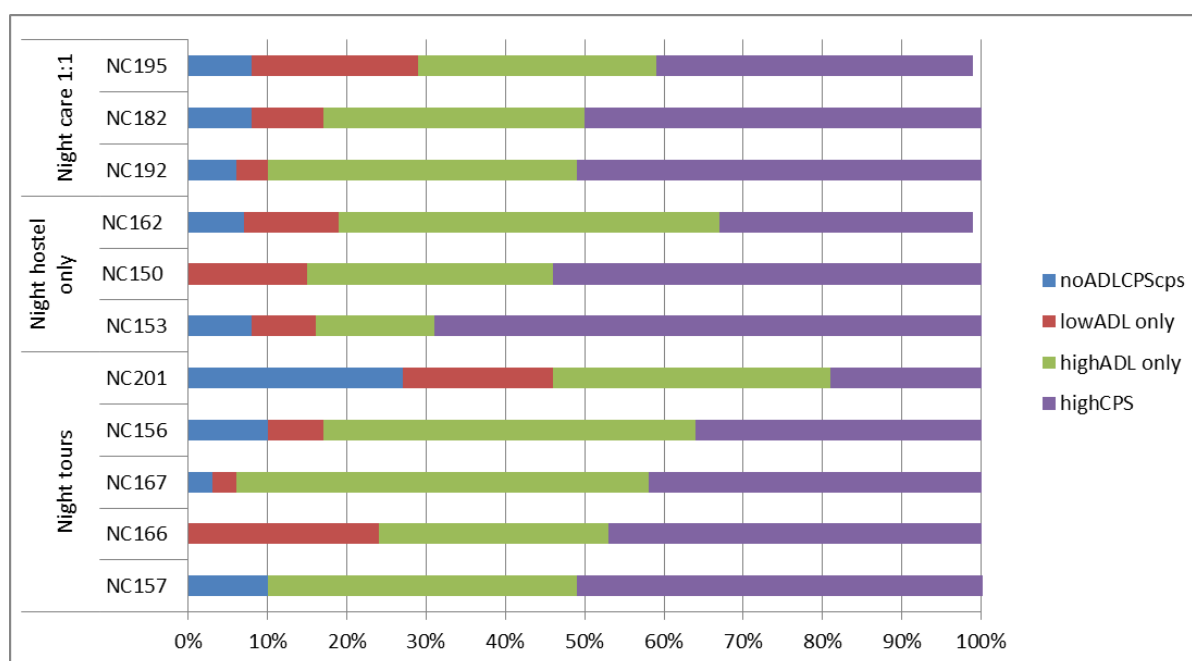


Figure 21. Profile of patients in night care projects, per subcategory

3.2.3 THE SKILL-MIX

Unsurprisingly, people engaged by the projects to be involved in care are nurses and nurse assistants. The number of FTE involved in care in this category of projects is meanwhile very diverse since it varies from 0.35 to 7 FTE. In fact, what is more surprising is that two projects really similar into the conception have no care professional paid by Protocol 3. In another way the majority of the administrative tasks are also done by nurse and nursing assistants. Some projects employ secretaries or social workers for the administration tasks. The annual cost per FOP is like the number of FTE very diversified: the cheapest is around 800 € while the most expensive approaches 9.800 €!

The role of the night care project professionals is mainly care and technical acts and coordination of nurse/nurse assistant's teams.

This observation may raise a question: why is there no psychologist implicated into projects? This kind of project combined with a psychologist day project could be a good initiative and a pragmatic continuity of 'care'. A psychologist might be useful to prepare some beneficiaries to leave their own home to go to another structure even for few nights or to welcome unknown care providers at home for night surveillance.

The caseload and data are quite amazing: they not only diverse in function of projects (from 2 to 200 persons) but also the size of the caseload does not seem to depend on the number of FTE engaged for care. For instance, in the same sub-category, a project that has 4,98 FTE nurses and nurse assistants, has a caseload of 24 patients while another project that benefits from 2 FTE nurses, has included 200 patients. So the size of the team does not seem having an influence on the size of the caseload.

- **The professionals who are included in the team of the night care projects are mainly composed by nurses and nursing assistants.**
- **The size of the caseload does not seem to depend on the number of FTE engaged for care.**

TOOLS USED TO COORDINATE THE NIGHT INTERVENTION WITH THE DAY CARE

In order to maintain the continuity of care during the night, it is essential that night care projects have links with day care structures. Three night care projects say using BelRAI as a tool for therapeutic decisions and also declare using it as a tool for care coordination. But the case studies reveal contradictions between the information gathered by interviews and the answers in several electronic surveys. One is using BelRAI only as a tool for care coordination.

Other tools used are meetings, patient's files, phone calls or emails. At the difference with the other category's projects, seven night care projects say having good interactions with general practitioners.

- **Some night care projects declare to use BelRAI for the therapeutic decision and for coordination, but the data collected show contradictions about this topic.**
- **Contrary with other kind of projects, the majority of these projects declare having good interactions with GPs.**

3.2.4 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

Table 29. Links with organisations likely to enhance continuity during day care

		Umbrella organisation	Extra link to ensure day/night care continuity
Night care at home	NC166	NH	external with HC network
	NC201	HC	internal
	NC156	NH	formal with HC network
	NC157	HC	internal
	NC167	HC	internal
Night hostel only	NC162	HC	internal
	NC150	NH	external with HC network
	NC153	NH	external with other NH
Night care 1:1	NC195	HC	internal
	NC182	HC	internal
	NC192	HC	internal

The projects from this category are exclusively associated with a day care centre or a home care coordination centre. This observation seems to be quite logical because these two types of umbrella organisation can offer either a package of care or a bed for the night hostel. In fact, the need when a home care service proposes a night hostel intervention is having one or several nursing home(s) as partners and when a nursing home provides care at home is having either a home care service or independent care professionals or both as partners.

3.2.5 ADAPTATIONS AND CONVENTION CHANGES

Six night care projects introduced changes in their convention files with the NIHDI. Project one extended its inclusion criteria to FOP pertaining to A Katz's category. Project two asked for changes in the financial table in terms of funds allocated to raise salary rates.

New partners join two projects. Nursing homes beds were provided for projects organizing night hostels and an organisation of family care service in another project provides nursing assistants for night care and is active in the accompanying committee.

Another project reduced the emergency interventions distance to maximum 10 km from the nursing home, limits the intervention to two visits a night maximum (for the same client).

Finally, a project halved the number of nursing assistants because of an overestimation of the demand.

Two projects providing night care at home had to stop in November 2013 (projects NC167 and NC157), one of them wishing to continue despite the willingness of NIHDI to stop the convention (see case studies).

The main changes and adaptations introduced by night care projects are related to inclusion criteria, partnership, staff and deliverance of interventions.

3.2.6 EXPECTED EFFECT ON THE OUTCOMES AS A RESULT OF THE NORMATIVE ANALYSIS

Night care projects were analysed according 6 specific items:

- Collaboration with professionals and organizations responsible of day care. Night care projects think the continuity of care is the most important thing. To ensure continuity of care during the night, collaboration with day care organization is needed;
- Adequacy of the type of night care provided to the needs of the target population;
- Surveillance and security. Some projects have only an eye on older people. Security with specific devices;
- Access of patients to night care project;
- The financial accessibility. Do the patients pay for care or other services? Is the night care project free?
- The cost paid by the patient.

Except for one project, patients do not experience difficulties in accessing night care projects. The majority of night care projects implement a collaboration link with organizations that follow patients during the day. What strikes the reader is the fact that no project is free for the patient. The patients always pay for night care interventions (Financial accessibility) and in two cases it goes over 100€ a month.

a. *Night care projects 1:1*

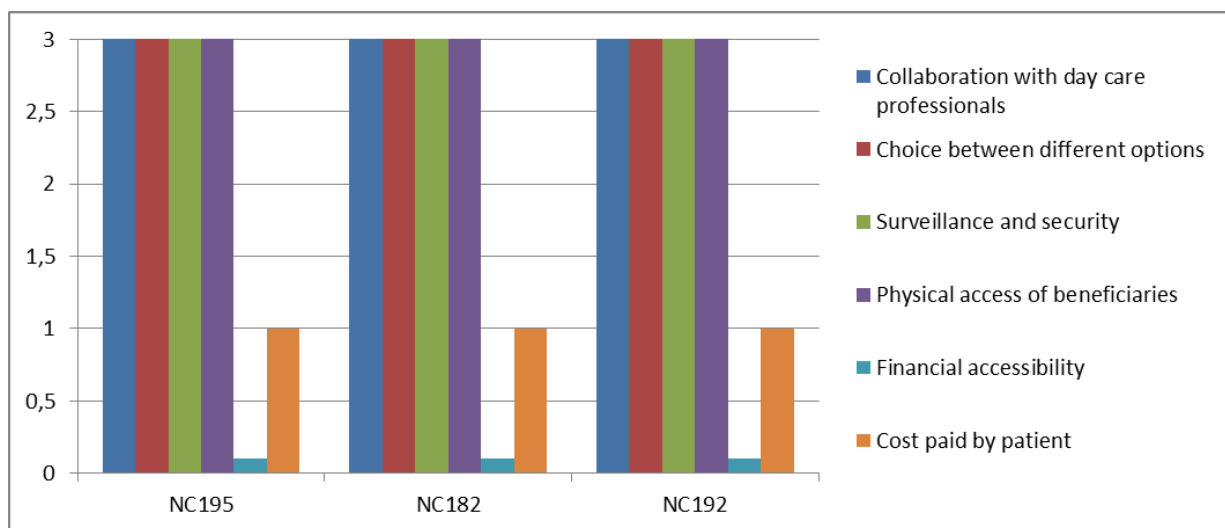


Figure 22. Normative analysis of night care projects 1:1

Night care projects presented in the graph above are tailored according a same pattern. They do have collaboration with organizations and professionals to ensure the continuity of care. They seem to answer patients' needs. Their accessibility is easy but patients do pay much a month for the intervention.

b. Night hostel only

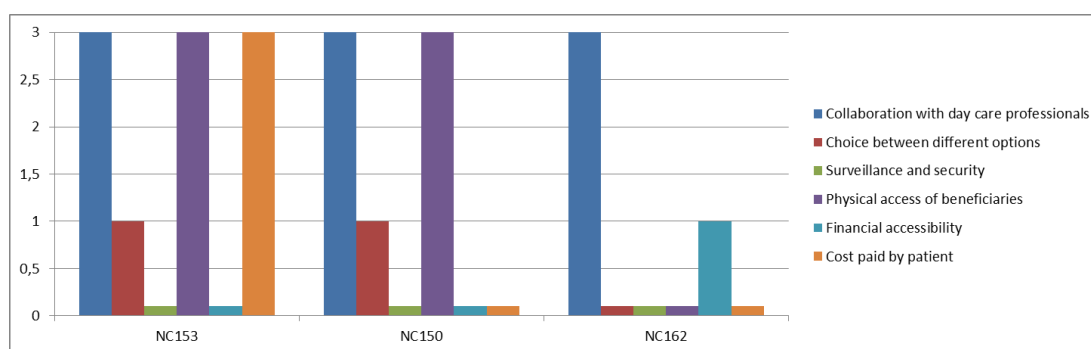


Figure 23. Normative analysis of night care projects for those that provide night hostel only

Night care projects offering night hostel interventions do have collaborations with other day professionals or organizations. They do not seem having an answer to the target population's needs: there is only one type of intervention which is going to a nursing home to spend the night. That also explain why those projects score badly on the item surveillance and security. None of night hostel projects is free and one is considered as cheap.

c. Night care at home or with night hostel

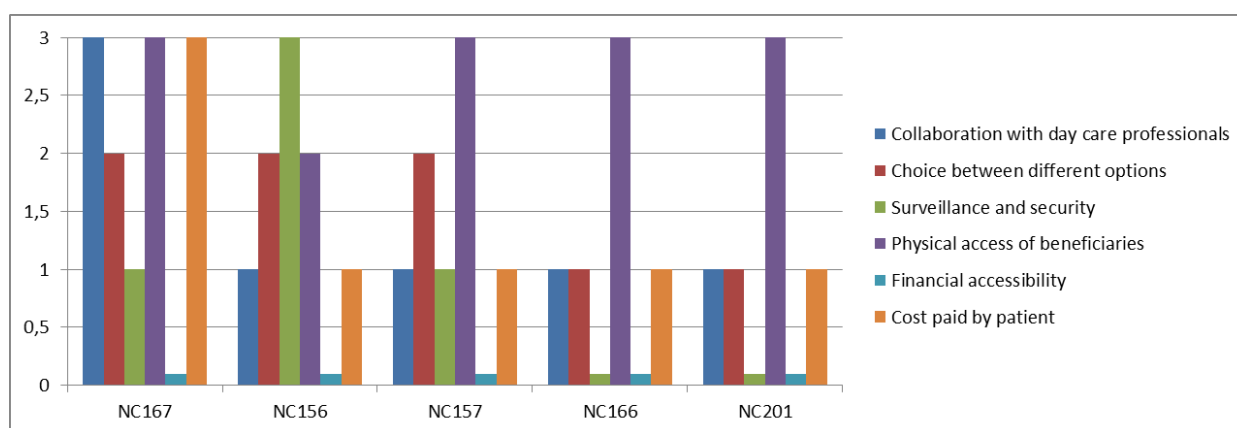


Figure 24. Normative analysis of night care projects for those that provide night care at home

Except for one night care at home project, the collaboration with other organizations or day professionals is not implemented. Patients do benefit from great accessibility to the projects. This type of projects is mainly adequate to the needs of their target population. One project is considered as very cheap in comparison with the other projects.

3.2.7 SYNTHETIC TABLE OF THE PROJECTS' DATA

Table 30. Synthetic table of the features of projects providing night care

	Night care at home					Night hostel only			Night care one professional per FOP		
	NC166	NC201	NC156	NC157	NC167	NC162	NC150	NC153	NC195	NC182	NC192
Profile of professionals involved in care financed by the project	Nurse assistant	Nurse	Nurse assistant	Nurse and Nurse assistant	Nurse	Nurse and Nurse assistant	Nurse and Nurse assistant	Nurse, Nurse assistant and Social worker	No professional involved in care and financed by the project	No professional involved in care and financed by the project	Nurse, Social worker, and Psychologist
Total FTE involved in care financed by the project	2,6	2	2,25	4,98	7	2,09	0,38	0,3	0	0	2
Profile of expected target population	Isolated FOPs	Overall FOPs	Overall FOPs	Isolated FOPs	FOPs with dementia	FOPs with dementia	FOPs with dementia and risk of fall	Overall FOPs and ICG	Overall FOPs with dementia	Overall FOPs with dementia	Overall FOPs with dementia
Caseload	21	200	40	24	45	13	2	6	57	24	42
FTE carer to FOP ratio	1 :8,1	1 :100	1 :17,8	1 :4,8	1 :6,4	1 :6,2	1 :5,3	1 :20,0	/	/	1 :21,0
Annual cost per FOP	€ 5.651	€ 800	€ 8.190	€ 9.808	€ 7.021	€ 4.077	€ 3.137	€ 1.232	€ 6.237	€ 5.386	€ 6.158

Four 'night care' projects have been part of the case studies.

3.2.8 CASE STUDY 8 (NC156)

This first night care project is designed for frail people of 60 year old and more, and who wants to stay at home. It involves a nursing home and several home care services.

1. CONTEXT OF IMPLEMENTATION

The project is implemented in a rural area, where it collaborates to all HCS. Before starting the night project, an opinion pool was organized in the nursing home in order to evaluate the need for such a kind of service. The conclusion was that there was a real need in night care to maintain as long as possible old patients with high care needs and therefore providing the continuity of health care.

2. PROJECT AS PLANNED

TARGET POPULATION

The project targets old people of 60 and above who needs care or support during the night. The patients often have an informal caregiver and are already receiving day care services. The project will also include patients with dementia.

OBJECTIVES

The project aims to prevent institutionalisation or prepare the return of the FOP at home after a stay in hospital, to manage for a longer stay at home with the help of night care. With the guarantee of continuity of care, the project will also support the informal caregiver. Proposing night care or night support to dement patients and their caregivers will be considered as an added value to what already exists in the area of activity of the project.

INTERVENTIONS

The project will offer three types of services: a night hostel, an emergency service and a night intervention at home. Care is given by the home care services during the day and the nursing home takes it over during the night. The social service of the nursing home will take contact with the patients. It also meets all the care professionals, writes all the information in the nursing file and finally is responsible for the fulfilling of all the instruments.

As far as the night hostel is concerned, the patient will stay from 9pm to 7am and will leave after breakfast. Concerning night interventions, patients will be visited one or two times a night (it may consist of toilet help, medications or psychological support). Each visit will last 15 to 30 minutes. Finally, the nursing home will also be responsible for emergency interventions like falls.

For each intervention, a home visit takes place in order to define what type of care the patient needs.

The project will have its own evaluation files.

PARTNERSHIP

The project has three main partners: a nursing home, an association dealing with speech problems and the local social help services. The communication about the daily functioning of the project runs quite well, mostly by phone. Other home care services of the area will also collaborate with the project but they will not meet systematically.

STAFF

The social workers of the nursing home manage for the administrative tasks of the coordination. The project employs three nursing assistants and one bachelor in social work. The nursing home director is the coordinator

of the project. If a caregiver from the project is absent, then a caregiver from the nursing home takes over. As the nursing assistants work during the night, the nurse does the supervision tasks during the day.

3. THE IMPLEMENTATION PROCESS, INCLUDING CHANGES AND ADAPTATION

TARGET POPULATION AND CASELOAD

The target population is aged 60+ and has a known demand or need for night care (physical or psychosocial) and/or a known risk. Patients know that someone will be available within 10 minutes.

The project is also accessible to people under 60 with a known demand or risk but are not included in the BelRAI nor in NIHDI data.

The caseload was changed after demand of NIHDI, which did not accept the caseload based on a 'passive' list. In other terms, only FOP receiving home visits during the night would be considered in the caseload. As the project reached its caseload, they do not promote the project any more.

OBJECTIVES

The objectives of the project did not have to be changed. They observe that the care they provide was not delivered before, e.g. changing of position for pressure ulcer prevention, support for going to the toilet, control of wandering, etc. This is especially the case for people in an early stage of dementia, who are physically too good to be in a nursing home, but whom reinsurance is needed during the night.

INTERVENTION

- 1) **Night hostel**, the FOP stays in the nursing home between 06 p.m. & 10 a.m., receives the planned care by the staff of the nursing home and goes back home after breakfast. The bus of the day care centre can pick the FOP up.
- 2) **Planned night intervention** at home; the client remains at home and receives up to two visits during the night. A home visit last up to 30 minutes.
- 3) **Unplanned night intervention**. Between 09 pm and 07 am, in 'crisis' situations.

Care in night hostel is provided by the staff already present in the nursing home. The nurse of the nursing home receives all calls during the night and dispatches the demands to the nurse assistant during the night, if needed. During the day, the social worker of the nursing home, working half time for the project, receives the calls. There is no waiting list for this project, thanks to the flexibility of the system, allowing building up the number of the visits gradually:

- 1) The FOP, ICG or partner of the project can contact the social worker;
- 2) The social worker contacts all care providers and makes a home visit and assesses the precise needs and demands of the FOP and ICG, along with the existing resources;
- 3) The FOP file is made, with all administrative, social and medical data. Agreements are made with the FOP and ICG about how the night care is to be organized;
- 4) If needed, the social worker contacts the other health care partners to obtain data to fill out the questionnaires and scales.

For care at home, the nurse assistant comes with a fully equipped car, provided by a home care organization.

PARTNERSHIP

The main partners are a nursing home, a home care nursing organization and a PCSW. All of them contribute to a good knowledge of the local home care situation. The essential partners are all home care organizations (for referral and continuity of care between day and night care), GPs and hospitals supporting the project.

The project is by the way well known among the general practitioners.

The other partners (coordination center, circle of GP, two home services organizations, another home care nursing organization, an expertise center for dementia, a palliative network are described as 'home care

partners', with which the project does not want to concur and who have a very good expertise in home care. Even if there are often contacts with those other partners, meetings aren't structurally planned, because it is difficult to bring everyone together at the same time.

The role of the partners is mainly promotion of the project and referring potential clients or, in the case of the expertise center or palliative network, to provide advice.

The project is well-imbedded in the local health and social sector but feels uncertain about the future. They view their night care service as essential to maintain FOP at home. The demand is so high that they do not know what would happen to the FOP if the project had to be stopped.

STAFF AND SKILL MIX

The project has four nurse assistants and one social worker. It is considered important to be able to rely on different persons (there is only one nurse assistant needed per night), in order to manage both sick leaves and vacations. Recruitment of the staff was not easy from the start, because the project had to start very quickly. The profile of the nurse assistant working autonomously at night is specific, because they are on their own and do not have to fear during the night. They tried to recruit among their staff in the nursing home but those people did not want to drive during the night. They were of course, not forced to do so and this explains why the caseload was build up gradually, they started with a very small team. The turnover rate is very low. This is, according to the project, also related to the fact that they do not feel alone during the night, as they can rely often on the manpower and skills of the nursing home.

Nurse assistants work 3-4 days in a row and have then 4 days off; there are nurse assistants and one night nurse, working in the nursing home, which can jump in if needed.

The problem is that nurse assistants have to work independently, but under the supervision of a nurse. The latter comes at home during the day and, moreover, they can always phone a nurse of the nursing home.

Training of the staff is not specific to the project: all nurse assistants are trained 10h/year on palliative care, nutrition, dementia, etc. There seems to be no demand for a specific training.

4. KEY SUCCESS FACTORS

The service delivery has been very well thought practically because of the **previous consultation by all partners** involved. In doing so, they benefited from the expertise of the professionals regarding the possible barriers and/or incentives for the patients to access the service. Practical barriers, such as transport or safe home access, were carefully addressed. The enthusiasm of the GPs to address patients and the satisfaction of the beneficiaries are some of the indicators of the success of this project. The service delivery is **highly flexible** (intensity, speed and type of night care). There are indirect signs of **high concerns for the safety and working conditions** of the professionals (first home visit is mandatory, careful description of surroundings, police was involved, only volunteers do this job, ...), allowing for the staff willing to remain in the project.

The key success factors of this project are:

- A good knowledge of the needs of the target population (by a previous needs analysis)
- The provision of three different types of services : residential night care, night care at home and emergency outreach
- Flexible input of the service (contact during the day → service delivered the same night)
- Two types of intensities of included patients : active versus passive list
- Thorough support of the nursing assistants : permanent back-up by nurses because the high level of connectedness with the umbrella organization is perceived as very helpful for logistical problems security
- Good interlinking in the local health and care system (GP and other care professionals and organisation)
- A high level of practical knowledge about the possible barriers of the target population

- Support of a nursing home (night nurse, transport of patients, coordination)
- Carefully planned care pathway : previous visit by social worker at home
- Interchangeability of the two coordinators.

5. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES



Figure 25. Programme theory of project NC156

The service delivery has benefited of the experience and expertise of all the project's partners. So, the potential barriers and/or incentives for the patients to access the services were carefully addressed. Surprisingly, this project does not use a systematic geriatric assessment tool, what may raise problems in the sharing of information between night and day caregivers.

3.2.9 CASE STUDY 9

(NC157)

1. CONTEXT OF IMPLEMENTATION

The project is developed by a home care coordination centre in a large city in the centre of Belgium where another night care project was accepted by NIHDI. Even if the coordination centre had a surveillance service on call, the designers wanted to fill a gap in the care organisation in order to create a 24/24 service. The project was presented in the social services of several hospitals. The idea was to create night tours at home, coupled with the installation of a remote monitoring system. Professionals would come at night to for example give medications to patients or to make an intervention after a fall.

2. PROJECT AS PLANNED

TARGET POPULATION

The project targeted the 65 years old patients and above scoring A, B or C on the Katz Scale. Patients had to be referred by all health institutions, hospitals, nursing homes and home care services present in the area of activity of the project.

INTERVENTION

The two main objectives of the project were to be able to offer care 24/24 due to a remote monitoring system like in hospital or nursing home and to keep an eye on frail elderly people at night with the visit of a mobile team composed by nurses and nursing assistants.

Theoretically, an intervention would take 20 minutes travel included. A caregiver can then visit 24 patients a night. A visit costs five Euros per patient, several visits will cost accordingly which may represent a weakness for the project.

The project hopes that informal caregivers will take benefit from the services offered to old people and the quality of life of old people will be improved by coordination and continuity in care. Each patient is assessed every six months by the RAI HC and the Katz instruments.

Amongst what the project provides as services the surveillance is most represented. Cares at night are not the most common interventions but when they are delivered it's mainly helping the FOP going to bed.

PARTNERSHIP

The project had six partners on paper having each a specific task in the project, but the promoter of the project admits that it is entirely managed by his own organisation.

STAFF OF PROFESSIONALS

At the beginning of the project, the staff was composed by two nurses and four nursing assistants, organised in two mobile teams. A coordinator is responsible for the calls at night and a nurse coordinator is responsible for emergency calls.

The team will work 8 hour a night during seven days and a week off. The first visit at home is always done by a nurse. The others are done by nursing assistants under the supervision of a nurse.

COORDINATION BETWEEN DAY AND NIGHT CAREGIVERS

Every week, day coordinators and night coordinators meet together for one hour. They are nurse and their work consists of the care management and care organisation. The call centre and the night coordinator organise the intervention. Moreover, the day coordinator is also responsible for the communication and management between the field worker and the manager.

3. THE PROJECT AS IMPLEMENTED, INCLUDING CHANGES AND ADAPTATIONS

PROMOTION OF THE PROJECT

Some local papers, general practitioners, hospitals and nursing homes have promoted the project.

INTERVENTION

The nurse does the first evaluation of FOP's needs and sees if the nurse assistant can take over in the other visits. When the patient is included in the project, there is a systematic visit to control if all is running well. According to the coordinator, the project does more surveillance than caring. Care interventions consists of pressure ulcer prevention, monitoring of devices, bed and/or toilet support and fall prevention.

The interventions are adapted to the beneficiaries needs and depend on caregivers demands. It's only in some rare emergency cases that the team goes more than once a night at beneficiaries' home.

The organisation has its own cars and the caregivers do use this transportation because it is easy to driver in the city at night.

The project has underestimated the time needed for the administrative work (collection of information, registration of data in the BelRAI web application and the completion of the questionnaires for the scientific evaluation). Those tasks are completed by the coordinator himself and he was overworked. Moreover, the project encountered financial difficulties due to a financial misunderstanding with the NIDHI about the cost of the whole project.

TARGET POPULATION

According to the project coordinator, the target population may be divided in two groups. One group consists of people where the team visits them on family demand to check if everything is all right. They are mostly asleep. The other group consists of isolated old people with physical and cognitive impairments. The intervention is also provided to people not targeted by Protocol 3. Those people aren't included in the BelRAI web application.

But against all expectations, it didn't succeed to reach its expected caseload because, according to the coordinator of the HCCC, 'we have neglected that people sleep at night', what should explain why the demand of care or support during the night is not really so important. Another consequence of the low caseload is that the project's manager reduced its staff. After a very slow start, the project included 70 patients after two years of activity.

Apparently, the intervention as proposed is not easily accepted by all the FOPs. In fact, some patients left the project because they found the intervention too invasive, and didn't want the team at night any more.

SKILL-MIX

Because of the difficulties to reach the caseload, the two project teams are composed by one nurse and one nurse assistant. Initially the project would implement two teams with one nurse and two nurse assistants. The team works one week and then has a week off. Each team works from 10 pm to 6 or 8 am. As the first visit at patient's home is always done by a nurse, other visits are done by nurse assistant under the supervision of the nurse.

ORGANISATIONAL FEATURES

Most of the project beneficiaries come from other services proposed by the project organization. According to the project coordinator, the project would be less efficient for fragile old patients coming from other home care organizations because those people are not known by the services (own pillar).

3. CHANGES AND ADAPTATIONS

The intervention offered today is nearly the same as planned. However, it's only in case of emergency that the mobile team would visit the patient more than one time a night. All patients included in the project receive an alarm device. In most cases, this gives security to old patients so that they do not call the project. That's also the reason why the project has to reduce its staff because of the difficulty to get patients included.

The project faced difficulties with the completion of administrative tasks which delayed the registration of data in the BelRAI web application. Those administrative tasks were not initially evaluated and should be completed by the coordinator himself.

Some difficulties in accountancy appeared because it's not easy for the project to distinguish acts funded by the nomenclature and those paid by the mobile teams of Protocol 3. (Day) care provided by nurse and/or nurse assistant is already in the nomenclature and the project would avoid NIHDI to pay twice for a night intervention.

Finally, NIHDI threatened to stop this project because the project did not respect their convention (the non-completion of questionnaires and files and the misunderstanding about the budget).

4. THE KEY SUCCESS FACTORS OF THIS PROJECT ARE:

- Support of the home care coordination centre (transportation, coordination, logistic means and alarm devices)
- Clients from the home care coordination centre to reach the caseload
- The new service is integrated into a set of other services. It's a continuity of care/service provided
- Good knowledge of the local area and local/regional politics
- No difficulty to find new staff members, specially nurses.
- The financial accessibility for the target population

5. THE RISK FACTORS FOR THIS PROJECT ARE:

- The underestimation of the barriers towards night care at home, from the beneficiaries' point of view
- Competition with another night care project sharing the same intervention area
- Administrative tasks including the BelRAI completion
- No collaboration with the 'paper' partners as the promoter manages the entire project on its own

6. KEY RESULTS

This night care project can be viewed as a new service offered by the coordination of home care centre, allowing 24/7 interventions. The advantage of this project is that it is well integrated into a set of other services, which guarantees the continuity between day and night care. On the other side, the project is poorly embedded in the local care system. The partners don't play any role in the project, which has already been mentioned by the project selection committee.

The case study points out that, for this project, the night intervention is more keeping an eye on old people at night or support rather than offering care.

Case studies points out that the night intervention is giving a help to FOP going to bed and keeping an eye on the FOP.

7. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

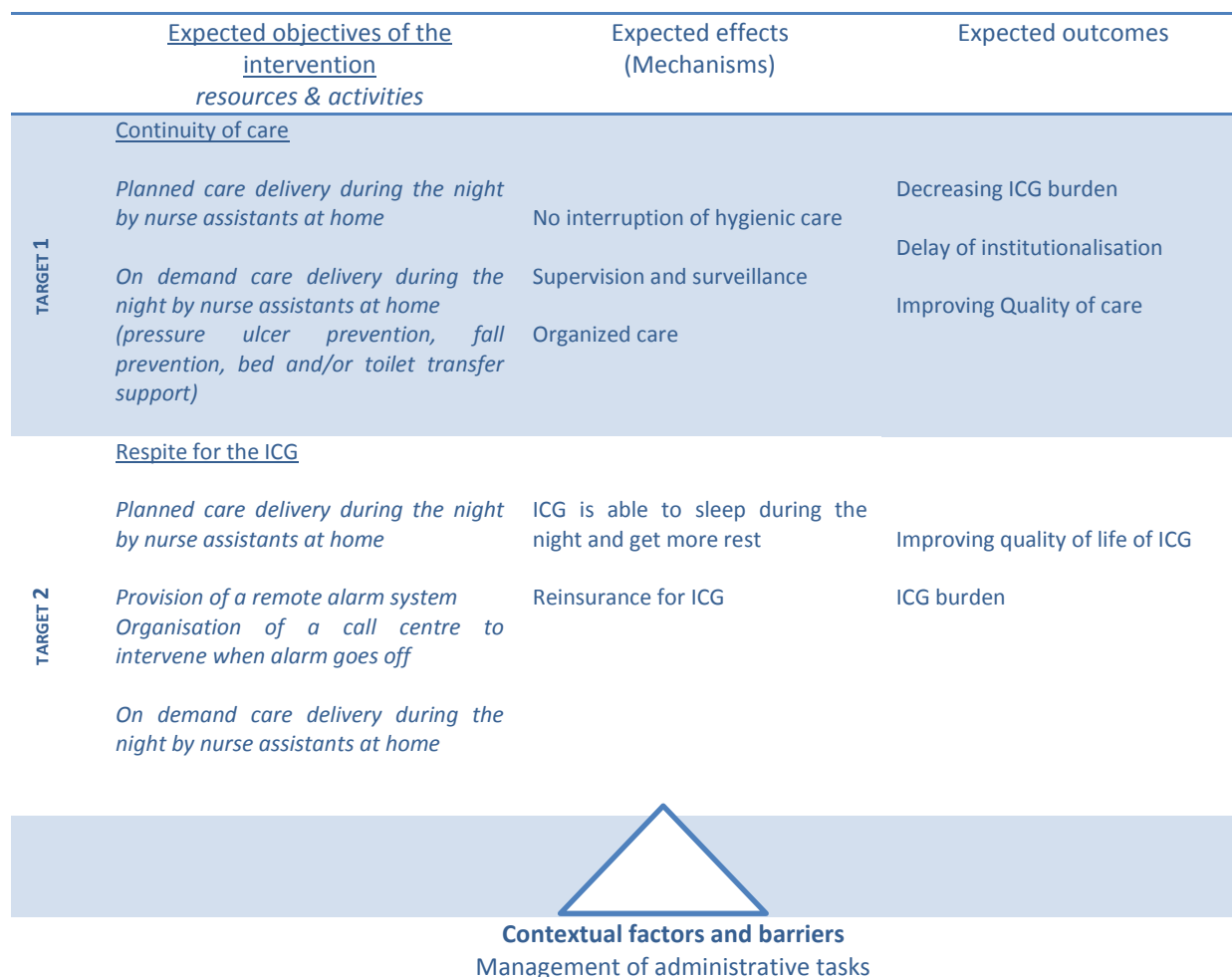


Figure 26. Programme theory of project NC157

3.2.10 CASE STUDY 10

(NC167)

1. CONTEXT OF IMPLEMENTATION

The project is developed by a home care coordination centre in a large city in the centre of Belgium. The project is the result of the merge of two projects which was accepted to be financed by Protocol 3 but did not start because of potential financial difficulties. The budget has it was thought and accepted by NIHDI was underestimated.

The designers wanted to fill a gap in the care organisation in order to create a 24/24 service. To prevent any problems inherent to urban areas mainly security matters, the night tours are organised in pairs, one driver and one nurse. It is presented as the main innovative feature of the project. Another particularity of this project that comes from circumstances, in which it has been created, is the presence of two nursing care organisations that belong to two different philosophical communities: one working with independent nurses (private) and the other is public.

2. PROJECT AS PLANNED

TARGET POPULATION

To benefit from the project, the patient must be in loss of autonomy and present some decline cognitive signs (beginning of dementia). They must also be as much as possible followed by care teams during the day.

INTERVENTION

The main objective is to propose a continuity of care in terms of nurses care at home by filling the gap of this kind of service during the night. The inclusion time in the project depends on FOP needs.

In terms of delivered services, the main are: replacement of incontinence material or putting on towels, support for bed transfer, change of position, engineering controls such as checking the dialysis equipment, etc., and finally, monitoring visits.

PARTNERSHIP

As the project is the result of the fusion of two projects, his partnership is a mixed of the initial partnerships that never changed since the beginning. The project has several partners:

Home care services;

a PCSW;

a coordination centre;

a hospital geriatric department

STAFF OF PROFESSIONALS

To ensure cares, the project wants to recruit some experienced nurses who know well the home care sector, the work at night and the work with fragile old patients. In addition to the care providers, drivers will be enrolled for the project and they will be paid by the umbrella organisation. The only aim of the drivers is to accompany the care professional and ensure their security. A nurse will be responsible of the project and another one responsible of the night team in particular.

COORDINATION BETWEEN DAY AND NIGHT CAREGIVERS

Organisation of tours and the coordination between night and day teams will mainly be ensured by the nurse responsible of the project who will use different coordination tools: an internal patient file and an external patient file that stays at home. Concretely, the responsible nurse will organise the tours in function of patient needs in targeting travels optimization. A daily roadmap team will be established and adapted if needed. The roadmap will be completed by nurses and will be considered as tour report.

3. THE PROJECT AS IMPLEMENTED, INCLUDING CHANGES AND ADAPTATIONS

During the implementation process, the project added an ICG goal to enhance the security and the quality of life at home by accessing the home being discreet to not disturb the FOP and ICG sleep. According the project, the rest provided to the ICG thanks to a professional surveillance allow him to have better contact during the day with the FOP and prevents abuse risks.

TARGET POPULATION

The included patients are people needing a medical support, are isolated and if not, are living with a burdened ICG. Because the project had great trouble in reaching its caseload, some adaptations concerning the inclusion criteria were asked and in some cases accepted by NIHDI (people under 60, with dementia or Alzheimer).

PARTNERSHIP

There is no adaptation or modification in the partnership. The collaboration with GP has known some difficulties because of tensions existing between the GP federation and one of the project partners. GP federation did not see which benefit it would get with night care projects because of financial issues.

SKILL MIX

The project wanted to recruit five half-time experienced nurses. It finally recruited four $\frac{3}{4}$ time caregivers. The salary is more or less equal to a full time because of the time frame and night work. This is considered attractive for professionals. The project also recruited one nurse for the coordination and one responsible for the management.

Some professionals of the project left because of the very specific time frame but also because of the short term contract (based on the duration of the financed project) and the ignorance about the existence or not of the project after the scientific evaluation.

INTERVENTION

Interventions on call for emergency situations, one of the project's intervention defined in the convention, could not be implemented because the NIHDI did not accept that these beneficiaries could not be part of the caseload, on which base the financing of the project was determined and the inclusion time in the project is less than 6 months. It was decided to refer them to the other night care project.

Each care team has eleven beneficiaries to visit by night from 10 pm to 4 am during around 25 minutes. This is a problem because they wish to start earlier. Previously, when nursing care services were done in split shifts, the patients who needed help to go to bed could have a visit from a nurse till 8 pm. Now, because these split shifts were suppressed, there are less and less nurses who accept to come to the patients' homes till 8 pm. The home access by professionals has never known problems.

Most acts consist of changing incontinent devices, support in bed and toilet transfer, fall prevention.

The project has modified the inclusion time of beneficiaries. Instead of a stop after 6 months, the patient can be re-integrated immediately after the 6 months without waiting 1 month as previously planned.

The project does not use BelRAI results for the care plan. Home visits and coordination meetings are enough to organize patient's care.

The collaboration with independent nurses is considered as an added value because those caregivers see in night care projects the importance of the continuity of care during the night (patients' quality of life).

4. KEY RESULTS

The project has known some difficulties to achieve its caseload. Some professionals left the project and therefore it has to stop. Some patients sent letters to NIHDI declaring that this night care project had a very

positive impact on them and it takes time before patients and professionals can build up a confidence relationship and therefore allowing 'strangers' coming at night.

The reason why this project experienced difficulties to achieve its caseload was, according to the nurse coordinator, because of the time frame in which the NIHDI asked them to work. At the one hand, the demand for care was very high in the beginning of the night (from 20:00-24:00) and, at the other hand, they were not allowed to start before 22:00. The demands in this time frame were for helping the FOP to go to bed and provide nursing care (support for going to the toilet, etc.) Much less demand was asked for later hours of the night.

Other difficulties for the project are the presence of another night care project sharing the same territory, the competition with mobile teams from hospitals and the lack of promotion, the project is not enough known in structures that could refer patients.

The experience of many projects shows that it takes some time before a new service is well integrated within the other services of the same umbrella organization. Working with independent nurses may cause a feeling of being controlled by the authority.

One of the challenges of night care projects is the articulation and coordination of their activities with the day care. A priori, this coordination is more easily achieved when the night and day services are in the same organization because it asks less time and money. Competition may exist between teams, as refers to the project manager.

From an organisational point of view the night and day cares coordination has to be ensured by a set of tools that allow teams to communicate well. To exchange information about the patient in order to ensure the continuity of care between day/night shift, nurses use their formal documents and files. They also ask patient's GP's.

5. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

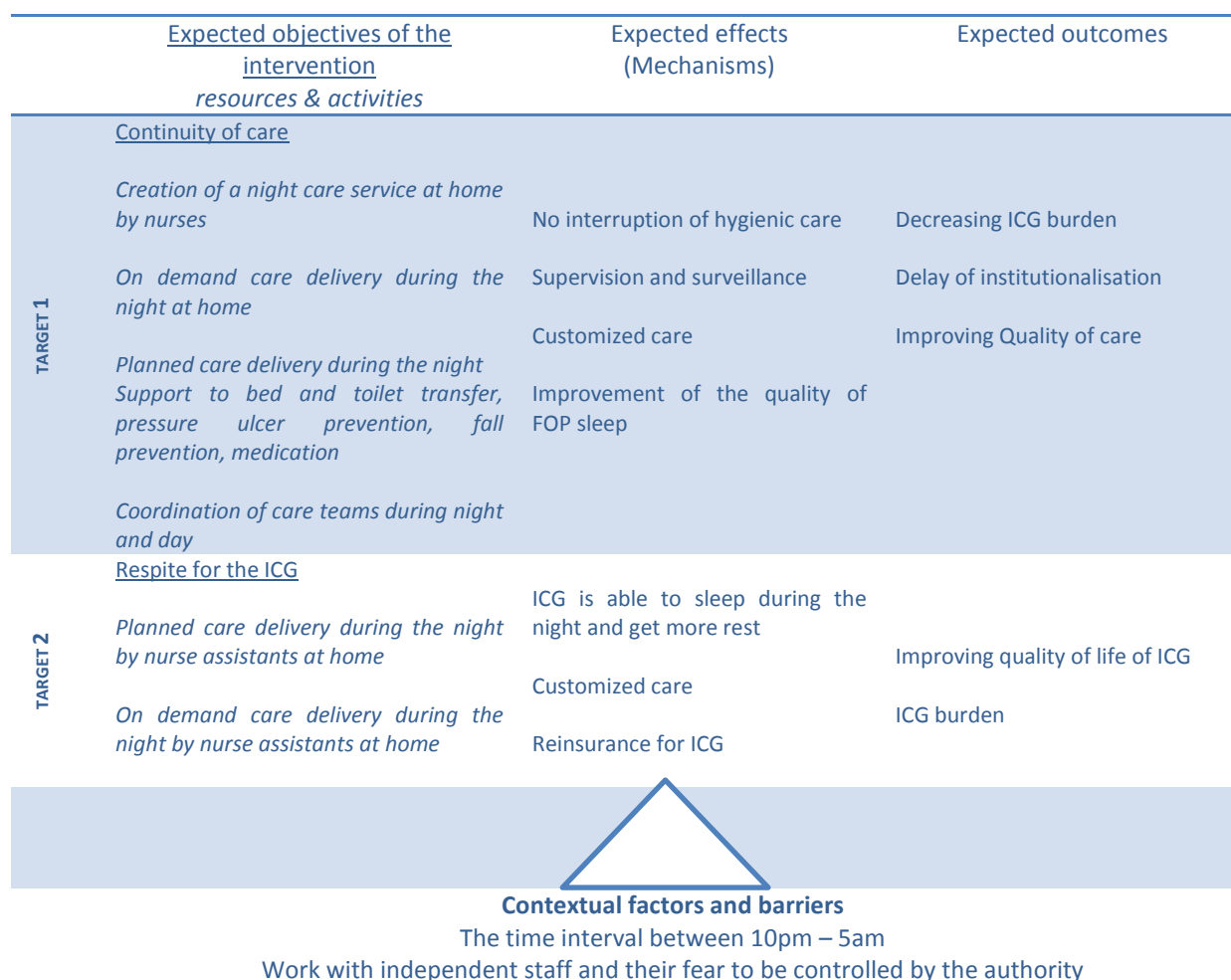


Figure 27. Programme theory of project NC167

3.2.11 CASE STUDY 11 (NC192)

1. CONTEXT OF IMPLEMENTATION

The project unfolds in a big area where all partners belong to the 'arrondissement'. There is no similar project in this region.

2. PROJECT AS PLANNED

TARGET POPULATION

The population targeted is frail, old, lives in the area of the project AND needs night care. Operationally, besides the inclusion criteria of NIHD, the specific FOP needs complex or long-term care or has dementia. This might also include patients in need of palliative care.

INTERVENTION

The main objective is the continuity of care (during the night), while the FOP remains at home. Three types of night care can be supplied (1) night care at home by a nursing aid; (2) night care at home by a volunteer or (3) night hostel in a residential setting.

The care is provided in the FOP's own home or, in the case of night hostel, in the direct vicinity of the FOP (max. 15 km). This is made possible by the means of the extension of the locations of the nursing homes. If transportation is required, one of the partners of the project can handle this.

The project aims at coordinating the existing network, in order to provide continuity of care; they assume that the pooling of the resources of the different partners will allow the organization of the continuity of care, which would not have been possible by each of the partners alone.

The coordinator makes an evaluation of FOP's needs and proposes care between three types of night care according to those needs. This night care is expected to be temporary, i.e. max three nights per week.

Exception to this rule may apply in the following situations:

- Terminal illness patients,
- Patients who are recently discharged from hospital
- When the ICG is temporarily absent

Activities done during the night by the nursing aid or volunteer: in most cases, they start at 10:00 p.m. by helping the FOP to go to bed, even if some of them are already in bed. Medication at bedtime is then delivered. During the night, the most usual care is help to go to the toilets, change of incontinence protection or bed sheets, supervision of wandering behaviour of FOP with dementia. In very rare cases, they help people to dress themselves in the morning but most often this is done by the nurses of the home nursing organizations. When there is a crisis situation during the night, the volunteers and nurse assistants know that they had to notify the ICG, of which they have the phone number. When a FOP deceases, which happens quite often, they know they have to notify the GP. In other situations, they notify the project coordinator. There is also a permanence system which has a call centre in case of emergency. The last person in the cascade system to be informed is the administrative coordinator.

A fixed financial contribution is asked (25€), which is the same for each type of night care. This is considered as relatively low because of the profile of expected FOP, who has already to pay a lot for day care. Additional costs for transportation are not included here and are supported by the FOP.

PARTNERSHIP

The partnership is essentially present to provide professionals (nurse assistants and house attendants) and beds for night hostel at disposal of the project.

SKILL MIX

The night care can be provided by three sorts of care providers:

- Volunteers can only handle non-complex, non-medical situations ; their work has to be expanded to be able to care for FOP;
- Nurse assistants, under direct supervision of GP, can also provide hygiene care, assistance during meals, drug administration, support the ICG and make an overall observation of FOP;
- Night hostel can be offered to FOP with behavioural disorders. This can provide respite for the ICG (« the most ideal way of supporting the ICG »).

This night care is very flexible, as the FOP can choose between several means of night care, location or type of care needed. Moreover, the night care may be organized very quickly and stopped very quickly as well.

This coordination function is also expressed by a single entry point. One night coordinator organizes and coordinates the project among the partners.

External coordination is also possible by the means of GDT meetings. Indeed, GDT is the umbrella organization.

3. THE PROJECT AS IMPLEMENTED, INCLUDING CHANGES AND ADAPTATIONS

TARGET POPULATION

The recruitment of FOP occurs through different referrers (most important first)

- FOP or ICG
- Services for family support
- Social services of hospitals
- Palliative network
- Nurses working at home
- GPs
- Social services of mutuality's
- Nursing homes

The project seems most adequate for palliative situations; the second most relevant target population is FOP with dementia, then the FOP with chronic illnesses, such as Parkinson's, and ALS patients.

CASELOAD

The caseload was easily reached. 42 FOP can be included simultaneously in the project. NIHDl does not allow the project to grow further which is bad considered because the demands are high.

SKILL-MIX

The profile of the staff changed, in comparison with the submission file and conventions. A psychologist was hired, instead of a second social worker. The added value of having a psychologist as coordinator of the interventions is clear for her, because, when there is a demand, the ICG is already overburdened. At that moment, they need a professional with good listening skills, for which a psychologist is supposed to be an expert.

At this point, they think it can be an added value to have a nurse as coordinator, because the profile of the patients, needing complex interventions. This can be evaluated more precisely by a nurse, as it is the case for the sister project in Brussels. At the other hand, a social worker can be more efficient to handle conflictual situations or where an updated knowledge of the social geography is needed.

Profile of the volunteers is very diverse, as some of them are nursing students. Those do not stay in the project very long, because of their increasing workload. But most of the volunteers are widowers of 60 years and older, whose motivations are altruistic and socially concerned. They go very well along with the FOP.

The nurses do not stay in the project, they leave for 'more interesting' initiatives.

PARTNERSHIP

The partners play their role as planned through the submission file. However, they added an extra partner, an additional service for family support of a PCSW, in order to be able to provide more nurse assistants during the nights. Additionally, this partner refers also FOP and takes active part in the steering group.

INTERVENTION

During the night, different types of services may be provided **by the nurse assistant**, several times per night, aiming at (1) direct physical FOP care (2) providing a sense of security to the FOP and/or his ICG, providing also some respite for the ICG, (3) preventive actions (supervision of drug intake, mobilization to prevent pressure ulcers, etc.), (4) household support (warming of and assistance with meals, in order to prevent dehydration). This care is delivered at home and the care providers stay at home during the whole night. Nurse assistants may also provide support and care during the night. The access to the home is in most cases provided by an ICG, sometimes there is a key in safe boxes, rarely is the key passed to a professional of the project. During the first night, it is essential that the ICG can introduce the professional of the project or the volunteer in the house and show the way and routines.

The maximum frequency is three nights/week, except for crisis situations (e.g. terminally ill FOP, or just after hospital discharge). But this frequency never exceed seven nights a week. In very busy periods, everybody is asked to lower the number of nights/week, as to benefit to more FOP.

The maximum of three nights is perceived as too low to the FOP. Despite this, the project does not want to accept more than three nights, because 'it has to remain home care'; when the amount of care needed during night and day is too high, this is not an acceptable alternative for nursing home admission.

COORDINATION BETWEEN DAY AND NIGHT CAREGIVERS

The **psychologist** and **social worker** of the project perform the home visits at inclusion, assess the health care needs and make a care plan. They also provide information to the FOP, makes the planning of care and task allocation between nurse assistants, volunteers, along with the administrative tasks related to this planning, such as the billing.

For the coordination of the care around an individual, the most important tool is the visit at home. They use the minutes of meetings, a notebook at the FOP's home, an electronic and paper patient record. They use the BelRAI, contrary to what was planned. This has to be nuanced by the fact that this project uses the short version of the BelRAI, which is unable to provide CAPs. Moreover, the input of the GP in the BelRAI is very low, so they have few data. Each professional who comes during the night is expected to leave a note in the notebook. This notebook is to be used by the night care only but, in very complex situations, there is a small book, which is used by different disciplines, and not only night care providers

The **psychologist** and **social worker** of the project function as project coordinator and do not provide direct patient care. They make every other week a planning for all the collaborators in the project. They have to supervise the work of both nurse assistants and volunteers. They can easily supervise the work of nurse assistants, because the latter are fully detached from their former organization. This is not the case of the volunteers, who are working under the supervision of their own supervisor and this is viewed as a weakness in the system. For instance, they are not 100% reliable if they are needed on a given date. Fortunately, volunteers take care of FOP requiring light care and this care might be postponed if there is no volunteer available at the moment. But the management of 50 volunteers would not have been possible with the resources of the current project.

4. KEY RESULTS

One of the difficulties they mention is related to the information about the availability of the nursing home beds for the 'night hostel' intervention.

The project seems most adequate for palliative situations.

The intervention costs 25€/night for the beneficiary and this very costly for some FOP, who have to reduce the number of nights. Especially because night care is the last care they receive: they already get household support, nursing care, meals on wheels, etc. 25€ is at the same time cheap (for 9 hours' care, i.e. 2.77€/h) and very expensive, if you need it 12 nights per month (300€).

The maximum of three nights is perceived as too low to the FOP. Despite this, the project does not want to accept more than three nights, because « it has to remain home care; when the amount of care needed during night and day is too high, this is not an acceptable alternative for nursing home admission. In addition, the night hostel option is rarely used by the FOP who prefers to stay at home, by all means.

5. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

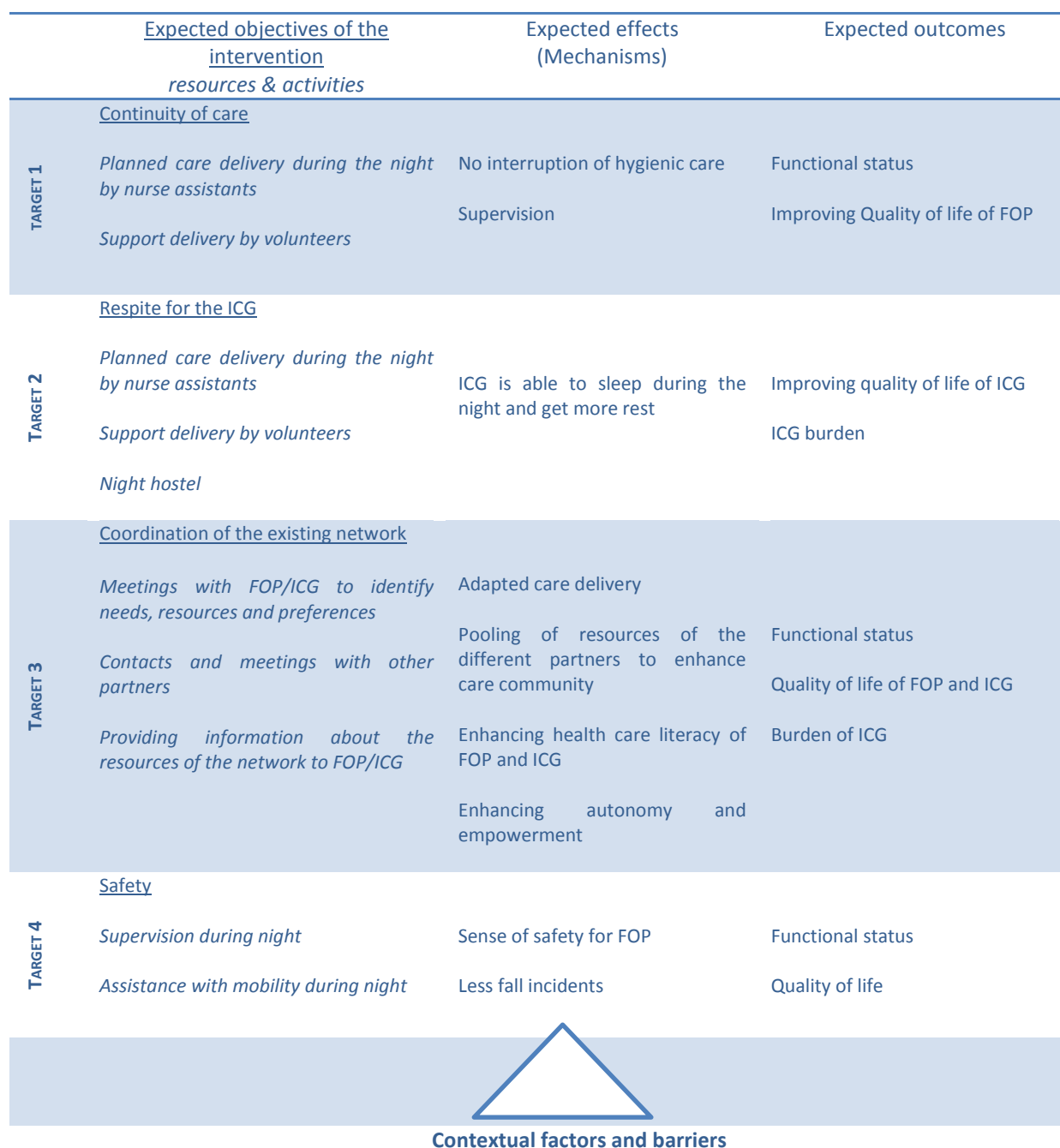


Figure 28. Programme theory of project NC192

3.2.12 KEY RESULTS OF NIGHT CARE PROJECTS

Night care projects are an important link in the chain of care continuity for frail older persons. Results show that this continuity has to be carried out in collaboration with professionals and organisations providing day care. Results of the case study show that this has to be seen in light of the fact that the FOPs benefiting from night care already benefit from professional (day) healthcare.

Two of the night projects delivering night care at home, delivered by nurses, had to stop because of difficulties to reach their target population.

Other key findings are related to

- The flexibility of the supply, as to respond to the needs and preferences of the target population; in this aspect, projects which are able to deliver different types of night care (night hostel in combination with night tours and crisis accommodation) are more likely to reach the FOPs who need their care in an adequate way (timely). Indeed, the objectives of night care may differ according to the type of service they deliver. For instance, for FOP with a cognitive decline, night care at home aims to check if the FOP is indeed sleeping and thus, providing respite for his ICG. Respite is also provided in the case of FOP with ADL impairment, when the healthcare professional can change incontinence material or support the FOP going to the bathroom. Besides these healthcare services delivered at home, specific nursing care is also provided (position change to prevent pressure ulcers or, in case of technical dependent FOP (home dialysis or respiratory assistance), specific nursing care).
- An important barrier is the cost of night care for the FOP, as the FOP has to pay this care in addition to existing healthcare delivery.
- The professionals delivering night care. Most projects work with nurse and nurse assistants. Due to the legal framework, nurse assistants have to work under the supervision of nurses and be part of umbrella organisations having at least seven nurses to be able to hire nurse assistants. Moreover, those nurses and nurse assistants have to be able to work (1) autonomously and (2) have a previous experience of working with this population.
- The supply of the umbrella organizations is a key success factor in providing logistic support (car maintenance, etc.) and emotional support (e.g. when FOP dies during the shift).
- Partnership: collaboration partnership with a nursing home, home care services and GP organizations, in order to be able to organise the continuity of care between day and night at a meso-level. Other roles of partners include referring potential beneficiaries or, in the case of the expertise center or palliative network, to provide advice.

3.3 PROJECTS PROVIDING DAY CARE (N = 9)

Among all Protocol 3 projects, nine projects can be grouped into the category 'day care projects', and of which the majority (eight) are situated in Flanders, the remaining being in Wallonia. Since the change in the regulation of the insurance on the day care centres, patients with profile A dementia were eligible for funding within the F package from 1st December 2012 on. Furthermore, Article 3 of the Royal Decree of 2 July 2009 prohibits Protocol3 funding when NIHDI structurally financing exists. As a consequence, the scientific evaluation stopped for five projects at this date. Nevertheless, the data collected till then were included in the scientific evaluation.

All day care centres have a nursing home as umbrella organisation.

Descriptive and comparative features of day care projects

3.3.1 THE INTERVENTION

OBJECTIVES OF DAY CARE PROJECTS

These nine day care projects had in common to aim at maintaining the frail elderly at home by offering varied services during the day (outside the home of the FOP). By doing so, most of the projects also wanted to provide some respite to the informal caregivers. Other objectives that most projects covered included: improvement of autonomy and quality of life, by the means of maintaining or improving the cognitive skills, reactivation and social reintegration, providing psychosocial support, supervision of medication delivery and hence, improve FOPs' adherence to treatments. Most of the project also aimed at providing specific guidance of eating habits (preparation and meals), in order to improve the nutritional status but also as an opportunity for socialising.

Some day care projects had some very specific aims,

- (1) One day care project including patients with a psychiatric profile aimed at improving the self-image of their patients, who frequently suffer from a low self-esteem and image because of self-neglect during the frequent hospitalisations. They wished to enhance this self-esteem by the means of providing activities of stimulation of self-care (hygiene, shaving, make-up, etc.) but also by the means of offering meaningful activities, two means that also could lead to better socialisation and hence, less isolation and time for negative thoughts.
- (2) Two day care projects started a comprehensive geriatric assessment (BelRAI) and provided the results to the regular home and healthcare agencies, already in place for the FOPs.

The majority of those projects provided goal-oriented care, as they described in the yearly questionnaire that the services they provided were carefully tailored to meet the goals, negotiated with the beneficiary and his/her informal caregiver. Two projects did however not mention such an approach (DC161 and DC158).

SERVICES PROVIDED

Most projects described their services as customized care, customized assistance, differentiated care, etc. The emphasis was on the individual counselling of clients according to their individual needs and preferences. Activities were organized to improve the independence of the elderly. Older people often also got psychological support. In addition, group activities were organized in order to encourage social contact. Most projects also provided information and/or support to informal caregivers. Nevertheless, it was unclear how the individual daily programme of an older person was determined and adapted.

Crucial for the accessibility of the day care centre for this target population was the organisation of the transport of the frail older person to the day care centre. This was organised by all but two projects, the latter failed to report any information about this item, either in the submission files or in the yearly questionnaires. The cost of this transportation was fixed in all but one project and varied between 2,5 € and 9 € per day (return

cost). One project modulated to cost related to the distance between the home of the person and the day care centre. Data from the case study show that the drivers of these adapted vehicles were often specifically trained to manage their job, including how to transport safely this population and interact adequately with them.

3.3.2 THE TARGET POPULATION

Out of the nine projects, there were five that focused exclusively on the elderly with dementia.

This is confirmed by the high percentage of FOP with a CPS score ≥ 3 at inclusion in those projects, as displayed in Figure NN. Surprisingly, one of those projects, which reported to include exclusively FOP with dementia, had only 18% of their population with a CPS score ≥ 3 at inclusion (DC146).

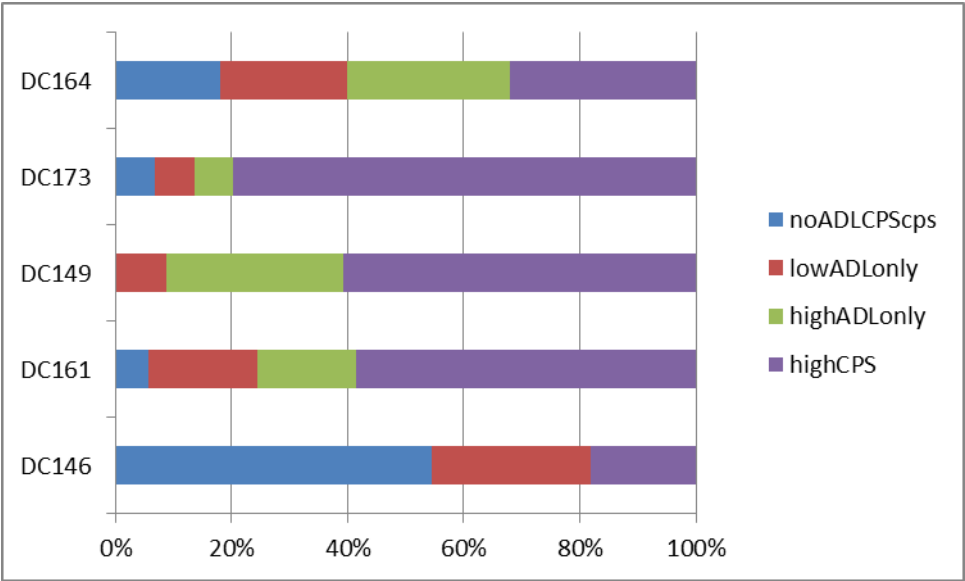


Figure 29. Profile of FOP included in day care projects targeting FOP with dementia

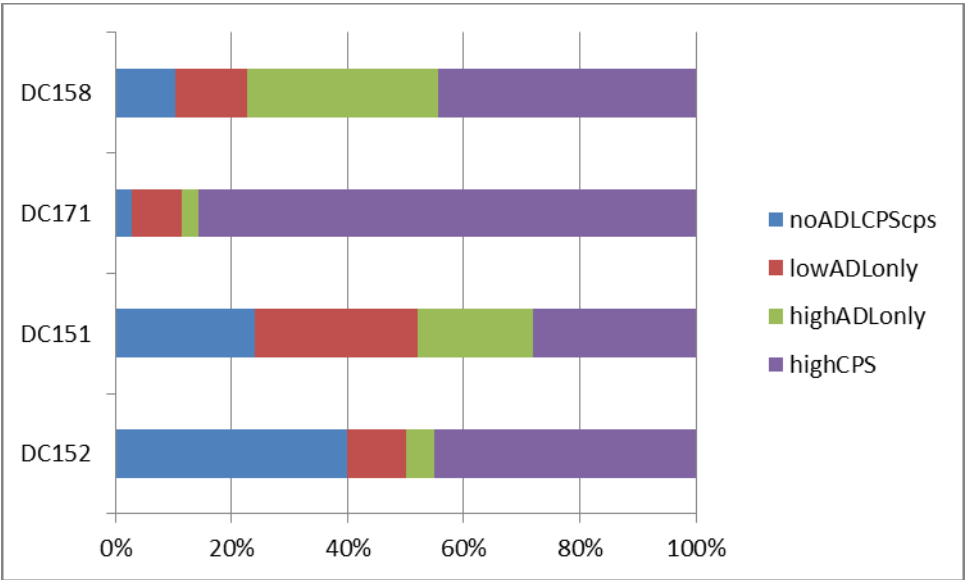


Figure 30. Profile of population included in the projects at inclusion

Among those, one project focused on younger people with dementia, for which the project had received a special agreement from NIHDI (DC171). Another project focused exclusively on the elderly with psychiatric problems (DC158).

The average cognitive status of the included FOPs in this category differed significantly from other category of projects, as was expressed by the mean higher % of FOPs having a CPS score higher than 3. (50,3 % versus 36%).

The caseload per project varied between eight and 70 (median = 15) and was easily achieved for seven projects; two reported difficulties achieving their caseload, one of them reported the reason for this was the changing of the project's location.

3.3.3 THE SKILL-MIX

The intervention itself was usually done by nurses, nursing assistants and occupational therapists. Two projects have a social worker employed for the intervention. Other professions (physiotherapist, speech therapist, educator and psychologist) were less common.

All projects have personnel to perform administrative tasks. In four of the eight projects, an accountant was involved for maximum 5% FTE. Furthermore, the administration was done by different people.

Table 24. Profile of the professionals' staff and their role in the project

	DC152	DC151	DC173	DC164	DC161	DC149	DC171	DC158	DC146
Description of healthcare services provided	Nurse : ADL-support; CGA & Follow-up of care plan Psychologist: group sessions; Psychological support consultations for FOP and-or ICG; Psychological support for health care professionals Nurse : ADL-support; CGA & Follow-up of care plan Psychologist: group sessions; Psychological support consultations for FOP and-or ICG; Psychological support for health care professionals	Nurse & nurse assistants : Medication delivery & ADL-support OT: ADL-training by Orthopedagogist :ADL-training	Nurse :CGA ; information and emotional support for ICG in day care centre; Organization of meaningful activities in day care centre, Unplanned nurse visits at home by nurses or nurse assistants OT: ADL-training, Group sessions – relaxation, Memory training SW: Orientation in the health and care system	Nurse: Organization of meaningful activities OT: Group sessions -FOP Entertainment Nurse assistant: ADL-support	OT: ADL-screening ; Group sessions -FOP Entertainment Nurse or nurse assistant: ADL-support ; Monitoring of vital signs in day care	Nurse :Liaison function OT: Counselling about the home adaptation ; Psychosocial support Physiotherapist: Falls prevention Nurse or nurse assistant: ADL-support by nurses or nurse assistants; ADL-support ; Bathing; Mictional training ; Support during meals	Nurse : Organization of meaningful activities Orthopedagogist: Organization of meaningful activities Psychologist: emotional support consultation	Nurse: ADL-support ; Monitoring of the care plan Social worker: CGA ; Making of a psychosocial care plan; PS support Nurse or nurse assistant: ADL-support ; Preventive mobilisation	OT: Group sessions -FOP Entertainment or relaxation; Memory training & Revalidation activities Speech therapist: Multisensory stimulation & Relaxation session (group or individual)
Total FTE for P3	1,62	1,9	5,43	5,6	2,9	1,5	3,13	2,15	No data

The intervention was usually done by nurses, nursing assistants and occupational therapists.
In each project at least three different professional groups were represented.
The project coordination was usually done by a manager working for one of the partner institutions.
Administrative tasks were done by both administrative clerks and persons with a care profile.

3.3.4 EMBEDDEDNESS OF THE PROJECT IN THE ENVIRONMENT

Nursing homes were the umbrella organisations of all the day care projects; this is the reason why we tried to assess the level of embeddedness by the means of interactions with entities providing healthcare and services at home (structural agreements or planned meetings). Indeed, for this type of intervention, it is expected that continuity of care is to be structurally organised by formal agreements between the project and other primary care providers.

The results are summarised in Table 32 and show that seven of those day care projects had formal agreements and/or regular, planned meetings with services that provided or coordinated healthcare at home. Amongst those, four had also the same level of collaboration with community organisations (OCMW/CPAS). Of special interest for this group of projects is the interaction with expertise centres having a specific knowledge in mental health, reported for five projects. These are the same projects providing day care for frail older persons with dementia.

Interaction with the primary care providers, who were also providing care to the population benefiting from day care projects was also investigated through the feedback those services provided to the FOPs' GPs and other care providers. Four projects reported that the GPs came in the day care centre on a regular basis to care for their patients and that informal, face-to-face contact enabled fluent information flow. Those same projects reported also providing feedback to other primary care providers on a regular basis. Two projects reported that they only had interaction with the FOPs' GPs in case of problem, one project only interacted with the GP of the patient in case of medication problems and one project did not answer to this question.

As to the question about the element they missed most to interact with other care providers (i.e. outside their project), four projects answered spontaneously that they missed a shared ICT tool to allow fluent and secure information flow.

3.3.5 ADAPTIVE BEHAVIOUR

One project ~~they~~ refined their objective, because they observed that their project had an impact on the stability of the situation of psychiatric patients, who experienced less 'up and downs', thanks to their intervention. No other project of this category changed their objectives.

Inclusion criteria

One project requested to decrease the inclusion age, because they had several demands. After the new regulation about the structural day care projects for patients with A dementia, the projects who wanted to continue and had a mixed target population excluded this population. One project added persistent aggressive behaviour from the beneficiary as an extra exclusion criteria.

Two projects (DC151 and DC173) had to cope with a large turnover of nurses (resp. four and two nurses in each project). Another project had a turnover of coordinators. Data from the case studies show that a high turnover rate affects the implementation process, as during the time needed for the new professional to take on her/his new role, all processes take more time (networking, etc., because of the novelty of the project). One project's location was changed and this was, according to the project, the reason for the difficulty to achieve its caseload.

Changing of content of the partnership was observed only in one project, which experienced difficulties in filling out the electronic version of the BelRAI in multidisciplinary and asked for one person to encode the data, while the others provided paper versions of their assessment. This can be seen as a drawback in comparison to the expected use of the BelRAI.

3.3.6 EXPECTED EFFECT ON THE OUTCOMES AS A RESULT OF THE NORMATIVE ANALYSIS

For the normative analysis of day care project, we chose to select different criteria than the other group of projects, which could explain the success of the project to achieve desired outcomes in the frail older persons they cared for.

The four salient components of the projects, as viewed by the projects' collaborators, were the following:

- The **achievement of the caseload**, as this was viewed as an adequate proxy of the ability of the project to catch the beneficiaries as expected, the adequacy of the project design to the expectations of the target population and the adequacy of the financing by the NIHDI, as the financing of the professionals depended on the achievement of the caseload ;
- The **formal and operational partnership with the coordination services** in the local area. As described above, the day care centres were organised by nursing home facilities and, to ensure continuity of care, needed to interact closely with home care and home nursing care agencies.
- To ensure the continuity of medical care, the day care project needed to interact closely with the frail older person's **primary care physicians**.
- The **shared use of the results of the comprehensive geriatric assessment**, the BelRAI, whose results were introduced into a shared patient record, preferably electronically, to be accessible to at least any professional in the project, was viewed as an important tool to share the adequate information timely to the adequate professional. This was viewed as a prerequisite to be able to provide patient-centred, tailored care.

The results provided in the two tables below are presented per target population of the projects: the first figure shows the projects which targeted a mixed population of frail older persons with psychiatric problems, with neurological disorders or young patients with dementia problems. The second figure shows results of the projects which targeted only frail older persons with dementia. Those projects were structurally financed from December 2012 on.

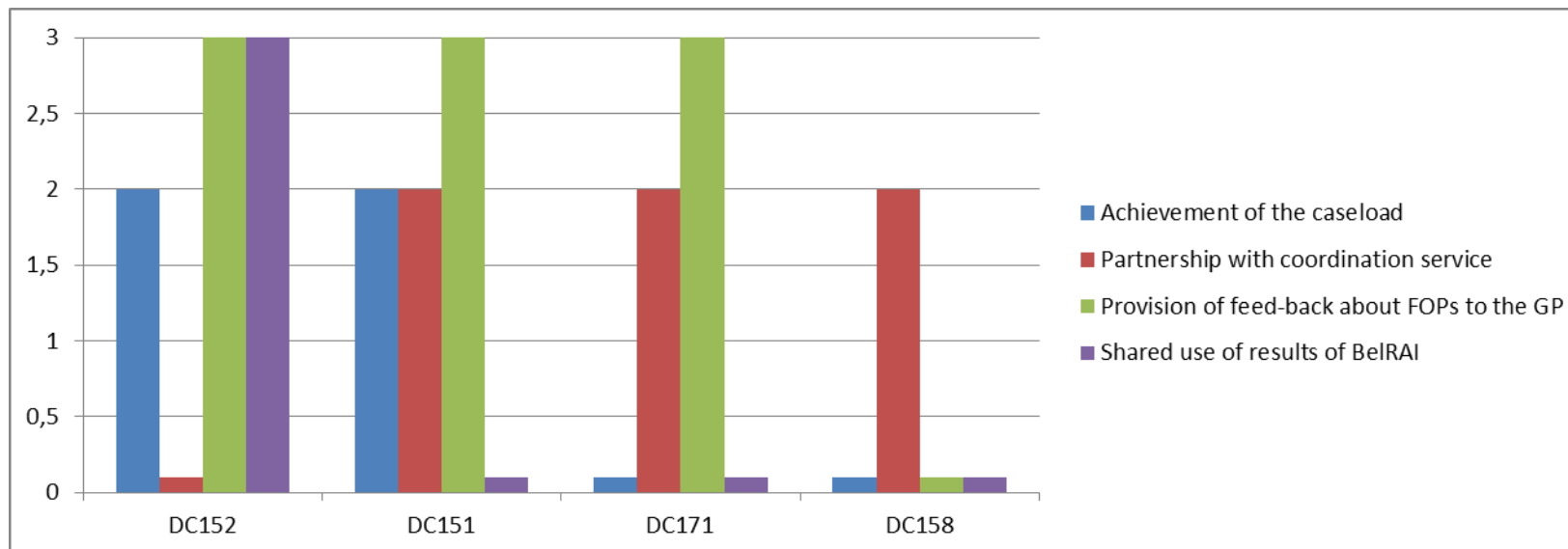


Figure 31. Normative analysis of day care projects targeting a mixed population of frail older persons

Every project in this subgroup had problems in managing their caseload, as two projects exceeded their caseload and two did not reach it. From a beneficiary's point of view, the two configurations are problematic as, when the caseload was exceeded, some beneficiaries had to be put on a waiting list, which was very negatively viewed as in most cases, this could not wait because of the respite needed for the informal caregiver. Because the financing of the project depends on the caseload, this means that when the caseload was not achieved, the professionals were not paid and, thus provided, leading to a risk of insufficient staff in these projects.

The level of collaboration with coordination services was lower in this subgroup than in the subgroup targeting FOPs with dementia but the provision of feedback about the FOPs was, on average, better than in the projects targeting FOPs with dementia. The latter is surprising, because of the high level of frailty expected from people with dementia, demanding a higher level of interprofessional collaboration to provide care continuity.

Only one project in this subcategory used the results of the BelRAI in a shared electronic patient record.

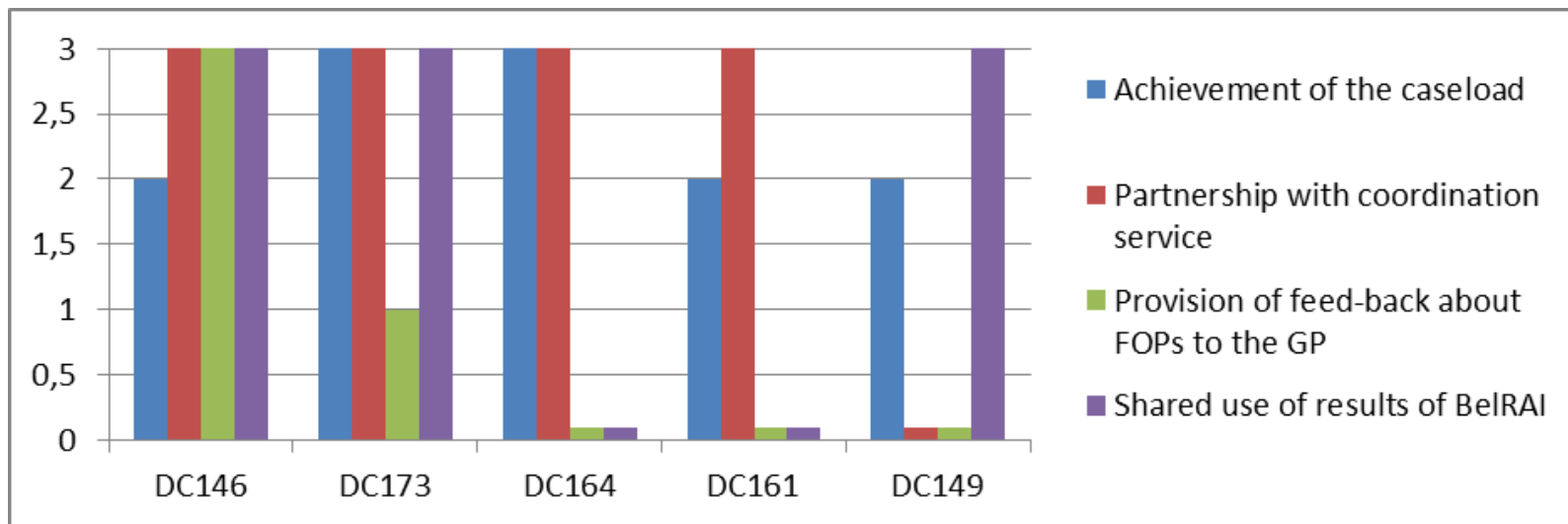


Figure 32. Normative analysis of day care projects targeting frail older persons with dementia

In this subgroup, two projects managed to keep their caseload as expected. Only one project did not have formal agreements with partners likely to provide nursing care or other care at home for their population. Overall, the collaboration with the beneficiaries' GPs seemed rather low, except for one project. This is also the project which shared the data about their beneficiaries in an electronic patient record, including the results of the BelRAI. Because of those three last components, i.e. the partnership with coordination services, provision of feedback to the GP and shared results of the results of the CGA, the level of interprofessional and interorganisational collaboration of this project will also be more important than in the other projects.

3.3.7 SYNTHETIC TABLE OF THE PROJECTS' DATA

Table 31. Synthetic table of the features of projects providing day care

	DC152	DC151	DC173	DC164	DC161	DC149	DC171	DC158	DC146
Objectives of the intervention	Integration in existing care and respite for ICGs	Day care for FOPs with psychiatric problems; social reactivation of FOPs living in an assisted housing	Integration in existing care and respite for ICGs	Day care and activities for FOPs with dementia; respite for ICGs	Integration in existing care and respite for ICGs	Integrated day care for FOPs with dementia; memory activation, orientation and social skills are enhanced	Day care for young people with dementia; specialised care, support and discussion groups	Stimulation of autonomy with support of ICGs	Day care and 2 nd line support; nursing activities (monitoring, patient education), home adaptation, support for ICGs
Description of services provided	Nurse : ADL-support; CGA & Follow-up of care plan Psychologist: group sessions; Psychological support consultations for FOP and-or ICG; Psychologic support for health care professionals	Nurse & nurse assistants : Medication delivery & ADL-support OT: ADL-training by Orthopedagogue :ADL-training	Nurse :CGA ; information and emotional support for ICG in day care centre; Organization of meaningful activities in day care centre, Unplanned nurse visits at home by nurses or nurse assistants OT: ADL-	Nurse: Organization of meaningful activities OT: Group sessions -FOP Entertainment Nurse assistant: ADL-support	OT: ADL-screening ; Group sessions -FOP Entertainment Nurse or nurse assistant: ADL-support ; Monitoring of vital signs in day care	Nurse :Liaison function OT: Counselling about the home adaptation ; Psychosocial support Physiotherapist: Falls prevention Nurse or nurse assistant: ADL-support by nurses or nurse assistants; ADL-support ; Bathing;	Nurse : Organization of meaningful activities Orthopedagogue: Organization of meaningful activities Psychologist: emotional support consultation	Nurse: ADL-support ; Monitoring of the care plan Social worker: CGA ; Making of a psychosocial care plan; PS support Nurse or nurse assistant:ADL-support ;Preventive mobilisation	OT: Group sessions -FOP Entertainment or relaxation; Memory training & Revalidation activities Speech therapist: Multisensory stimulation & Relaxation session (group or individual)

	DC152	DC151	DC173	DC164	DC161	DC149	DC171	DC158	DC146
	Nurse : ADL-support; CGA & Follow-up of care plan Psychologist: group sessions; Psychological support consultations for FOP and-or ICG; Psychologic support for health care professionals		training, Group sessions – relaxation, Memory training SW:Orientation in the health and care system			Mictional training ; Support during meals			
Is transport organised?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	NR
Transportation cost (return)	€ 6,0	€ 5,0	€ 7,1	€ 7,5	€ 2,5	€ 9,0	€ 5,0	NR	NR
Total FTE	1,62	1,9	5,43	5,6	2,9	1,5	3,13	2,15	No data
Ratio FTE professionals : FOPs	1: 6,2	1: 4,2	1: 5,8	1: 12,5	1: 5,2	1: 5,3	1: 12,8	1: 9,3	No data

	DC152	DC151	DC173	DC164	DC161	DC149	DC171	DC158	DC146
Profile of expected target population	FOPs with stabilised psychologic or psychiatric need (no AD); some of them with behavioral problems, refused by existing services	FOPs discharged of psychiatric hospital; social isolation +++; high motivation of the FOP is required	Persons with dementia	Persons with dementia	Persons with beginning dementia	Persons with beginning or light dementia	Young persons with dementia	FOPs with neurologic disorders	FOP
Asking diagnosis of dementia?	No	No data	Yes	No	Yes	Yes	Yes	No	Yes
Expected caseload	10	8	32	70	15	8	40	20	15
Achievement of the caseload	Yes (exceeded)	Yes (exceeded)	Yes	Yes	Yes (exceeded)	Yes (exceeded)	No	No	Yes (exceeded)
Recruitment means	Hosp, Mut & OCMW	Hosp & assisted living	Hosp, OCMW, GPs & HC services	Hosp, OCMW, GPs & mutuality	ICGs, GPs & hosp	GPs, HC services	Hosp & ICGs	Revalidation centre	HC services, GPs, hosp
Partnership with coordination service (SISD/SEL/GDT or CCSSD)	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Partnership with community	No	NR	Yes	Yes	Yes	No	No	No	Yes

	DC152	DC151	DC173	DC164	DC161	DC149	DC171	DC158	DC146
organizations									
Partnership with centres for mental health	Yes	No, but with psychiatric hospital	NR	NR	NR	Yes	Yes	No	Yes
Incentives for GP participation	No	No	No	No	No	No	No	Paid by the project	No
Provision of feed-back about FOPs to the GP	Yes	Yes	Only in specific situations	No	No	No	Yes	No	Yes
Care/service plans use	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Use of BeIRAI results	Yes	No	Yes	No	No	Yes	No	No	Yes
ICT Tool for clinical coordination	EHR	No	EHR	No	No	EHR	No	No	EHR
Duration of the intervention	Permanently	Permanently	NR	Permanently	Permanently	NR	Permanently	240 days	318
Umbrella organisation	NH	NH	NH	NH	NH	NH	NH	NH	NH
Missing elements for the project?	Cooperation of GPs	EHR and electronic care plan	EHR, compatible with BeIRAI	NR	NR	NR	Shared care plan with external PCGs	Shared care plan with external PCGs	NR
Unit of activity	Care day	Care hour	No data	No data	No data	No data	2 diff types	Care day	No data

	DC152	DC151	DC173	DC164	DC161	DC149	DC171	DC158	DC146
Nb of Units/FOP (Sept 13)	175	364	No data	No data	No data	No data	38,75	112,32	No data
Annual cost per FOP	5 188 €	7 933 €	4 271 €	5 337 €	4 325 €	8 152 €	2 864 €	4 492 €	No data

Two projects of this category were part of the case studies since the start but were not included in the last interview round in 2013, because they were structurally financed by the NIHDl since 2012 and did not participate formally in the scientific evaluation any more.

3.3.8 CASE STUDY 12

Project DC173

1. CONTEXT OF IMPLEMENTATION

When the call came, the directors of four nursing homes in the same geographic area came together, as to examine whether there existed care gaps in their region. The result of their discussion was the proposal of four different projects, of which only one – the current project – was submitted because this was deemed the one with the highest priority. It is important to report that two years before this P3 project, the conceivers promoted the concept of their day care centre in the area.

2. THE PROJECT AS PLANNED

INTERVENTION: A DAY IN THE DAY CENTRE

The project proposed the development of a new day care centre unit for older people with dementia, in addition to the already existing day care centre unit for older people with physical care needs. Besides the expansion of the capacity of the day care centre, the project wanted to offer differentiated activities for people with dementia, while the FOPs did not have to choose in advance for a specialised (stigmatising) day care centre but might participate in collective activities whenever meaningful and possible and, at other times, benefit from individualised care and services.

The different aims of the project were to delay institutionalization, by strengthening the older persons' autonomy, giving structure in their lives, increasing their quality of life, giving meaningful daytime activities and supporting the informal caregiver.

A typical day will start with picking up the older person at their home. Then, differentiated activities in the day care centre will be offered, including lunch. The day will finish with taking the older person back home. The emphasis of the intervention was the individualization of the activities based on the older person's individual needs. The project will offer creative activities and ADL/IADL training.

COST OF THE INTERVENTION

Day care users have to pay 13,60 € per day. This fee includes infrastructure, accommodation, maintenance, meals, and animation materials. People who want to use transportation services have to pay an additional 7,10 € per day.

TARGET POPULATION

The intended target population is people with dementia, attested by a psychiatrist, neurologist or geriatrician, and their informal caregiver. They will have a caseload of 32, which represent 15 places in their day care centre, as the majority of their beneficiaries do not come five days a week.

SKILL-MIX

The project planned to hire 1 FTE nurse bachelor, 2 FTE nurse assistants, 0,8 FTE occupational therapist and 0,2 FTE social worker.

EMBEDDEDNESS

In the same area of activity, there was another P3 project offering night care. Those two projects signed a collaboration agreement. The day care project also planned to collaborate with a similar day care project in the same province. They expected to have an exchange of experiences and also exchanges of staff. The partners of the project were a nursing home.

There was a structural link between the project and the 3 different PCSWs in the area of activity. They signed a collaboration agreement, thereby avoiding competition. The 3 PCSWs were expected to be the main referrers of older people for the project.

3. THE PROJECT AS IMPLEMENTED

INTERVENTION

Before inclusion of a new client, a meeting takes place between the project coordinator and the informal caregiver(s). A professional from the project goes on a home visit or organizes a visit by the client and the caregiver to the day care centre. Before the start of the actual intervention a care record, a care plan and a contract were drawn up, based on the results of the BelRAI. The domains chosen to work with in the care planning are based on a common decision of all stakeholders and take into account the domains where there is the most room for improvement. The final decision to start with the day care intervention is made by the responsible of the day care centre in consultation with the home care coordinator, the caregiver and (if cognitively capable) the older person.

During the process of their project, they moved on to provide more support to the informal caregiver of the FOP, during sessions delivered in the day care centre, or by the means of 1:1 training sessions when the FOP was attending day care (e.g. for an ICG who could not manage the change of incontinence materials for his spouse). This is considered crucial in building trusting relationships with the ICG.

COORDINATION OF THE INTERVENTION

Each day a short meeting (± 15 min) takes place between the responsible of the day care centre, the occupational therapists, nurses, nursing assistants and the animator. Every week there was a meeting (30min) between the responsible of the day care centre, the occupational therapist and the nurse. In this meeting key concerns of the individual visitors were being discussed. Monthly team meetings (2 hours) between the responsible of the day care centre, the occupational therapists, nurses, nursing assistants, administrative assistant and the animator were about the individual approach of the clients.

Three to four times a year they organize a steering committee with representatives of the project (head of the nursing home, responsible of the day care centre) and representatives of several partners, but not all. There were a lot of partners and participants but the composition of the partnership did not change during the implementation period so far. Originally the project intended to offer activities in two separate groups where people with dementia would be separated from people without dementia. However, after one year and a half this division did not seem to be relevant anymore and they now offer more individualized activities based on the needs and preferences of each older person, regardless of the day care unit they were in.

TARGET POPULATION

Results of the BelRAI show that this project included a population of FOPs with a higher proportion of cognitive decline (79,7% of their population has a CPS score ≥ 3) than in other projects in its category (mean CPS score $\geq 3 = 50,3\%$), which shows that they indeed reached the population they targeted. They do not have a waiting list, as they adapt the frequency of attending to the demand.

This population comes often one or two days a week, for a shorter period and this was different than the profile of the older people outside the P3 project (with a non-dementia profile), who attend the day care centre for a longer period. This means that the turnover of the people attending the day care centre is higher, along with the administrative workload. This also means that they are able to help more people.

NIHDI approved a request (March 2011) from the project to adapt the inclusion criteria in the convention, allowing inclusion of people from 56 to 60 years with dementia in the project, as long as their share was no more than 5% of the total caseload. However, this type of demand was not expressed frequently as it only

happened once and is maybe not desirable, as the beneficiary considered him/herself too young to be participating in activities with and by surrounded by “older” people.

A difficulty of the project was that they needed a diagnosis of dementia to be able to include the FOP and that some FOP had not such a diagnosis, for two main reasons. The first reason was, that GPs are often reluctant to consider this diagnosis, because of the risk of stigmatisation and the second, closely linked to the first, that they fear that the condition of the FOP will worsen because of the tests needed for the diagnosis. Moreover, if a dementia is suspected, they are reluctant to refer the FOP to a geriatric one day hospital for diagnosis, since the diagnosis is certainly not the main demand of the FOP.

They observe that the FOPs’ social network is shrinking very quickly when dementia begins. This is partly linked to the fact that the FOP does not want/dares go outside the house.

SKILL-MIX

The project views the diversity of the skill-mix as highly important, as is shown by the fact that they use interchangeably the nurse bachelors, assistants, occupational therapists etc. to take part in the animation activities, along with the fact that they wanted to hire a mix of experienced and non-experienced collaborators.

Table 32. Evolution of the skill-mix

	Submission file (2009)	2011	2012
Nurse bachelor	1	1	1
Nurse assistant	2	2	2
OT	0,8	0,8	0,8
Social worker	0,2	0,4	0,2
Administrative worker		0,23	0,23
Driver		1	0,9
Cleaning staff		0,3	0,3
TOTAL	4	5,73	5,43

This project had the opportunity to hire a bachelor nurse, since the day care centre did not yet have one before the P3 financing. However, the recruitment of a bachelor nurse was difficult. During the first 2 years, 2 newly graduated nurses dropped out during their trial period because of more attractive working conditions elsewhere (i.e. not in nursing home-related units). In September 2011 the third nurse (also newly graduated) started to work for the project.

Due to the high turnover of (bachelor) nurses, some parts of the project were not sufficiently developed, as the support to the informal caregiver, the use of BelRAI results for care planning and the development of a shared electronic patient record.

The staff can enter in internal and external training activities. Training of all collaborators is viewed as highly important, as is shown by the fact that the day care centre closes a couple of days per year, as to allow their collaborators to attend specific training about supporting dementia care. For instance, the driver, who is considered a key link in the chain of care because he is, in everyday life, the one who has the most contact with the home situation, is specifically trained to cope with difficult situations linked to the departure to the day care centre when the FOP is very confused.

EMBEDDEDNESS

There are a lot of other day care centres in the same area.

The collaboration with all partners is better than expected. For instance, the collaboration with the similar day care project in the province, after a difficult start-up due to turnover problems of the project coordinators in

this other project, goes well after two years. They are now able to share experiences about their respective pilot project. The collaboration with other care providers of the primary care sector is also viewed as very good. They have a good feedback from the FOPs' primary care physicians, who provide easily information about the medical condition and requirements of the FOPs. They explain this success by the fact that they were able to promote their project by the means of GP's circles and because a lot of local GPs regularly attend coordination meetings (SIT). Collaboration with other primary care providers is also viewed as very good.

4. LESSONS LEARNED

When asked what the key success factors of the project are, the conceiver responded that the size of the project was important, as a day care centre with sufficient FOPs allow a higher skill-mix and a more diversified proposal of activities, along with an economy of scale. Moreover, the fact that the day care centre is very well known to the average population makes that the threshold to the centre was made very low. The actors of the project also mention that it is important to be attractive for the professionals, for instance by the means of providing them immediately a contract of indeterminate duration, without a probation period (as opposed to projects who hire professionals for the duration of the pilot experiment).

They observe that, as an effect of the presence in the day care centre, FOPs are often capable of better functioning than at home, because their environment is highly structured.

Key to the access of the FOP to the intervention is the provision of transport as 95% of their FOPs are brought by the bus of the day care centre. This bus is completely paid by the umbrella organisation.

5. KEY RESULTS

This project could not exist without the financial and logistical support of the nursing home. The project benefits from the already existing day care centre, with which it shares the rooms, human resources and logistics.

Transport to and from the day care centre by means of busses was organized and paid for by PCSW, but the older people still have to pay 7,10 € per day for it on top of the 13,60 € per day they pay for the intervention. By consequence, this project was not accessible for poor older people, if the PCSW was not willing to support them financially.

The project was flexible in including older people. Any older person in need of the intervention can immediately come to the day care centre, even if it was only one day per 2 weeks to start with. They were not put on a waiting list.

Project tries to organize meaningful daytime activities for the older persons. The activities in the day care centre were tailored to the demands of the elderly using among other methods the CAP's from BelRAI. The use of the BelRAI (including the filling out of the data) was performed by one person only. Consequently, concerns may rise if this person was absent or quits the project.

The project cooperates maximally with the other care providers and sends the results of the scales and CAPs to GPs and other care providers to make them aware of the specific needs and risks of the elderly.

6. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

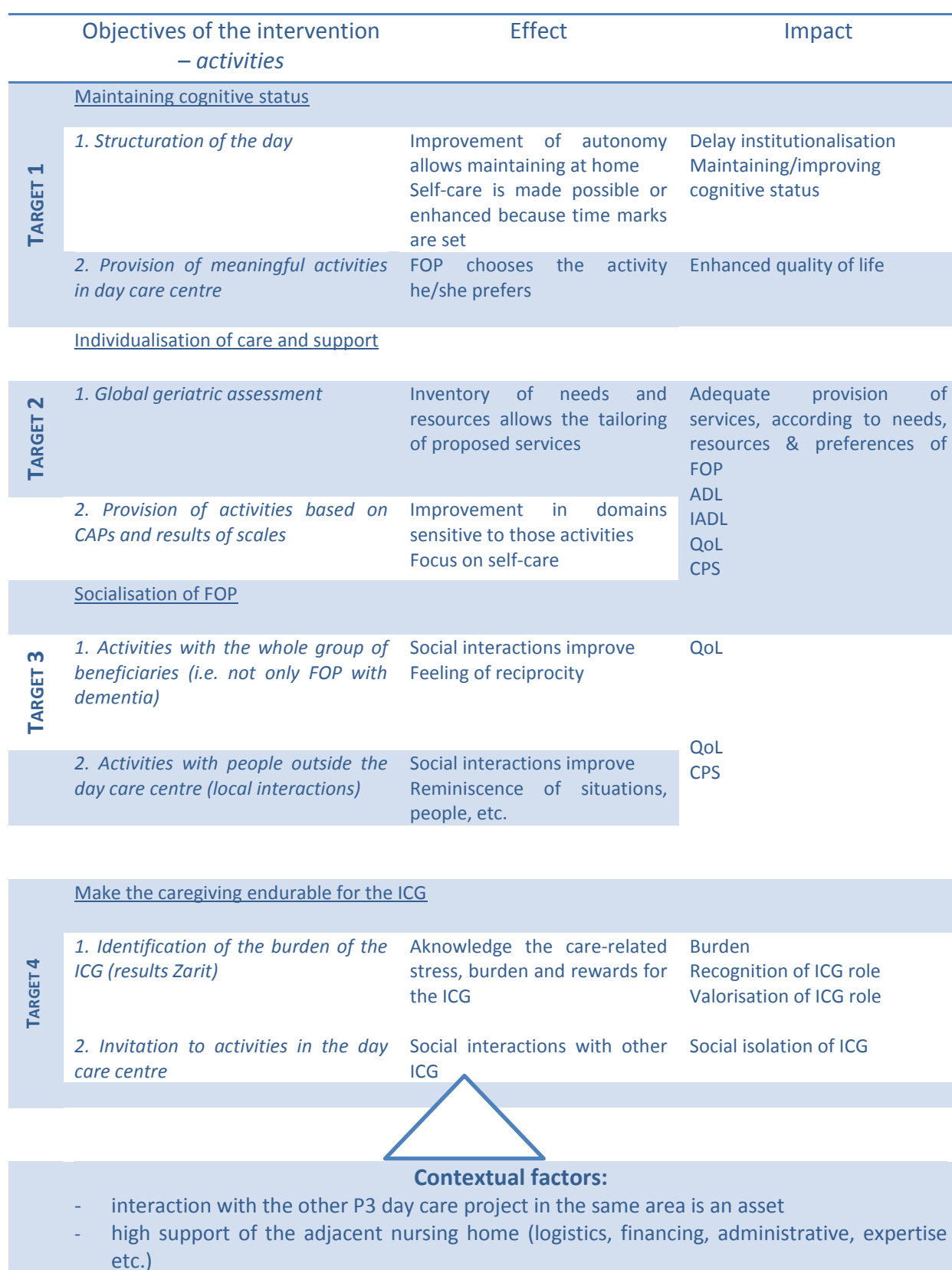


Figure 33. Programme theory of project DC173

3.3.9 CASE STUDY 13

Project DC164

1. THE CONTEXT OF IMPLEMENTATION

The P3 project gave them the opportunity to expand their already existing day care facility. The day care centre already had five years of experience with the specific target group of demented elderly and elderly with mental health needs.

2. THE PROJECT AS PLANNED

OBJECTIVE OF THE PROJECT

The project wanted to provide an answer to the large and growing demand for day care in the area. The overall objective of the project was to ensure that older people with dementia or mental health needs could keep on living in their home environment and therefore to delay institutionalization. The project also aimed at improving the mental, physical and social (re)integration of the older person. By separating the older persons into two day care units (demented and non-demented elderly) they wanted to create a greater wellbeing for all older persons. In addition they wanted to give respite to the informal caregivers while the older person was in the day care centre. Both units, separated geographically, should interact with each other on a daily basis.

THE INTERVENTION

It was planned that, after referral by the general practitioner, social service of the hospital or other referrer, a nurse or occupational therapist from the project would make a home visit to the older person and, if applicable, the informal caregiver. The project will then be explained and the older person assessed on eligibility for the project. Based on the intake it would be decided in which of the 2 day care units the older person would fit best. The final decision whether or not to include the older person in the project should be made by the responsible of the day care centre in consultation with the social worker of the social service of the PCSW. It was considered important to split the populations of FOPs into two separate units, because they felt that FOP with dementia problems would not fit with FOP with mental health problems, because of communication issues (e.g. a person with aphasia as a result of a stroke will not be able to interact with a person with an Alzheimer dementia).

A day in the day care centre includes transportation from and to the day care centre, meaningful activities, lunch and snacks. Additional services can be provided like taking a bath, pedicure, and hairdresser. Clients pay 10 € per day. If they want transportation service, they pay an additional 7,50 €.

TARGET POPULATION

Besides the NIHDI-criteria, they set additional criteria, as the diagnosis of dementia or other mental illness had to be attested by a medical specialist.

THE SKILL-MIX

The professionals of the projects will be working in two different day care units.

They planned to hire professionals who already worked for the day care centre or the PCSW. The staff consisted of 1,50 FTE nurses, 3,25 FTE nursing assistants and 1 FTE occupational therapist.

3. THE PROJECT AS IMPLEMENTED, INCLUDING CHANGES AND ADAPTATIONS

THE INTERVENTION

The intervention is delivered in two different locations, which have its own specificities regarding target population (size and profile). In the first location, there is room for 15 frail older persons with dementia problems and in the second location, 29 frail older persons with mental health problems. There were no

changes in the intervention during the implementation process. Regarding the activities provided, they are mostly provided in subgroups of 6,7 people but they plan to offer more individualised, differentiated care in the future, as the results of the BelRAI will be used (see below).

THE COORDINATION OF CARE AND PROJECT PROCESS

The coordination of care in the day care centre was done by an occupational therapist and a social nurse. They focus on the involvement of the older person and his informal caregiver. By doing so, they want to ensure the continuity of the care services offered to each person included. Communication flow among care providers occur mainly by the means of a notebook, which follows the frail older person at home and which can be used by care providers outside the project, along with the FOP's caregiver.

There was a monthly team meeting where beneficiaries were discussed and planning was made. Next to these meetings, there were also monthly meetings with the social services. Client information was kept in an electronic care record.

Four times a year a meeting takes place between the coordinator and the geriatrician-psychiatrist who was a partner of the project. This doctor gives advices and if necessary contacts the older persons' general practitioners. In addition to these four meetings, the doctor can always be reached by phone to answer specific questions. Twice a year a peer supervision meeting was organized together with the dementia expertise centre. Several times a year the province organizes a meeting between all coordinators of the different day care centres in the province. During these meetings the participants exchange information and receive training. These supervisions/intervisions are seen as essential for the ongoing training of the collaborators.

THE TARGET POPULATION

Most of the population included are already on a waiting list of a nursing home. As planned, the target population is FOP with dementia problems in the first unit and FOP with stabilised psychiatric disorders or mental health problems in the second unit. There are no waiting lists for the first unit, and 10 FOPs in the second. This is a problem because, when the help is needed, an immediate answer is asked. It happens often, when they contact people on the waiting list, that they are already institutionalised. Most of the FOP come two or three times a week, a minority five times. The typical profile is a FOP who needs supervision at home and a sense of security. They first try to be helped by the means of family aids, nurses, and day care comes eventually, when the other care and services are insufficient.

The FOP have to pay for day care (10€/day), and an additional 7,5€/day for transport. The majority of their population attends the day care centre two or three days per week. Some FOPs only come once or twice a week, even if they should need to come more often because of their health status. They cannot afford it, because it is not acceptable for them because of economic reasons.

THE SKILL-MIX

After two years of functioning, the coordinator of the first unit (15 FOP with dementia) is an occupational therapist, who is the third coordinator of the project. In the other unit, the coordinator is a social nurse, who went two times into maternity leave since the start of the project (29 FOP with mental health problems). The hiring of the present coordinator was not on a voluntary basis but seemed to be imposed by circumstances. She had the impression to have to do it besides her current tasks, which resulted in extra out-of-hours work.

Due to the very high turnover rate of the coordinator, the filling out of the BelRAI was left behind and the present coordinator had to catch up a huge amount of work. In this, she was supported by the social service of the PCSW, who provided timely extra workforce (social workers) to fill out the scales at home. This resulted in the availability of extra data about the FOPs included, which decided the coordinators to try to use these results to work in a more differentiated way (i.e. more individualised, targeted interventions during day care). Regarding the turnover of professionals, they were obliged to recruit new collaborators and were able to be

present during the solicitation interviews, which was viewed as very positive, since they could assess whether their views were compatible with the views of the new collaborators. They feared that the new collaborators were motivated by attractive working hours (no night, nor weekends work), rather by the motivation of caring for frail older persons in a pilot project.

The staff can attend training programmes organized by the PCSW or, along with the other Protocol 3 project with day care, training sessions with the local expertise centre of dementia (see below).

EMBEDDEDNESS

The project was initiated by the PCSW and got therefore more referrals from the PCSW hospital than from the other hospital in the region. They observe that the FOP coming from the private hospital are referred to private day care centres and FOP discharged from a public hospital are referred to public day care centres; There were different day care centres in the area of activity of the project. Although they do not see each other as competition, they do not work together structurally either. Every year, the provincial authorities organise an intervision among all day care projects, where projects can interact with each other and attend training sessions about a specific theme (e.g. about dementia, organised by a local expertise centre about dementia).

Collaboration with the FOP's GP is not perceived as a problem, as most of the FOPs have their own GP coming over to visit them in the day care centre. However, when investigating further, they agree that they have difficulties to obtain medical data to put them into the BelRAI application and intend to perform more proactive strategies (information campaigns) to sensitise them. Moreover, they do not provide systematic feedback to the GP about the observations they make during the activities in their centre or results of CAPs and scales.

4. ADAPTATION STRATEGIES

The project requested a sum of money from NIHDI for investments in technical aids such as a patient lift, a high-low bed, a bath, 15 geriatric relax seats and 2 mini buses. The mini buses were not accepted by NIHDI. However they were an important resource for the project. Now the buses were funded by the PCSW. The project was strongly dependent on the financial and logistical support they receive from PCSW. Without this support the project would not manage.

They also made a request to NIHDI to change the name of the project because it does not correspond completely with the target population. The name of the project suggests that they only include demented elderly while they also include older people with mental health needs.

In February 2011 the project relocated to a new building, close to the hospital and next to a nursing home. This move was already planned before the start of the P3 project. All of the existing clients stayed in the project after the relocation. Since the relocation of the day care centre, a geriatrician who was affiliated to the neighbouring nursing home visits regularly. The nursing home became a new partner of the project and replaced another nursing home that was now closed for renovation.

Originally, collaboration with another P3 day care project was planned. But because of the changes in administrative coordination, this collaboration was not as structured as planned.

5. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

	<u>Expected objectives of the intervention</u> <i>resources & activities</i>	<u>Expected effects (Mechanisms)</u>	<u>Expected outcomes</u>
TARGET 1	<u>Improving functional status</u>		
	<i>Individual or group sessions of physical activities</i>	FOPs engaging in those sessions will be able to maintain or improve their physical abilities in a secure (architecture and supervision) environment.	ADL IADL Reduce risk of falls
TARGET 2	<u>Improving overall well-being</u>		
	<i>Provision of aesthetic care: hairdresser in day care centre, relaxation sessions (including relaxation baths)</i>	By the means of improving the self-image of the FOP, allowing him to feel better in a secure environment.	DRS QoL Delay institutionalisation Reduce physical and chemical restraints
TARGET 3	<u>Provide a secure environment</u>		
	<i>Provision of a set of meaningful, tailored activities by dedicated professionals. Working in a differentiated way</i>	The set of activities proposed will provide the FOP the possibility to choose the ones that are the best adapted to his preferences and capabilities (tailored, and goal-oriented care), improving his willingness to participate and, if satisfactorily completed, increasing his self-esteem.	ADL/IADL Increase social contacts DRS CPS QoL
TARGET 4	<u>Providing respite to the ICG</u>		
	<i>Planned day care in adapted environment by adequate professionals. Transportation to and from the day care centre.</i>	Because the ICG trusts the environment and the professionals to care adequately for the FOP, the ICG can be offered some respite in his 24/7 care for the FOP during the times that the FOP is in the day care centre.	ICG burden, QoL and overall health

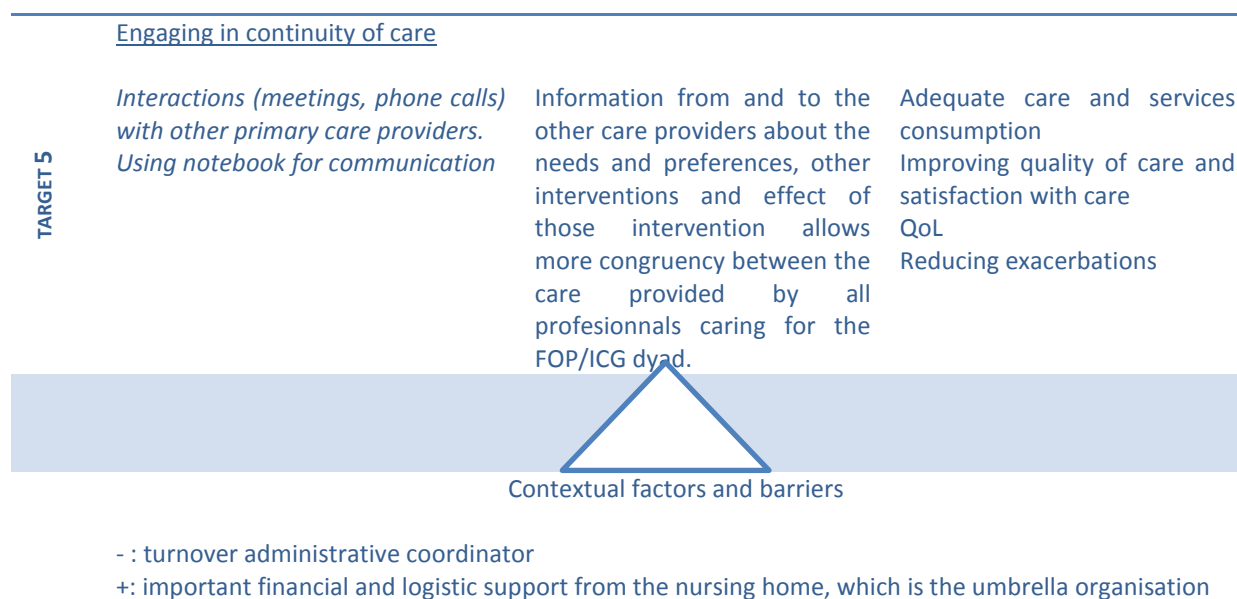


Figure 34. Programme theory of project DC164

3.3.10 KEY RESULTS OF DAY CARE PROJECTS

- The main objectives of day care projects are
 - To provide meaningful activities for frail older persons;
 - To improve their functional status by stimulate their capacities by providing group sessions of physical activities or, if relevant and possible, through individual activities. The latter is very important to be able to provide tailored, goal-oriented care;
 - To improve their overall well-being by providing them aesthetic care (hairdresser etc.), relaxation sessions (including relaxation baths);
 - To improve their memory by reminiscence sessions, embedded in leisure activities;
 - To improve their social well-being by offering room for contact with other persons;
 - To support their IADL capacities by providing them education and information about everyday devices (cooking plate, microwave oven, etc.).
 - To provide respite and social contacts to their informal care providers
- Data from the case studies suggest that these projects were highly dependent on the financial and logistical support they receive from their umbrella organization, e.g. for financing of drivers and buses for transport; provision of extra help when needed (e.g. to keep up with the requirements of the scientific evaluation regarding BelRAI).
- Transportation services were indispensable when offering day care services. The majority of the target population unable to come to the day care centre by themselves.
- Despite of the support from the umbrella organization and the NIHDI budget, clients still need to pay a considerable sum, especially when they need transportation services, which can be a barrier to access services.
- Staff turnover problems slowed down the implementation process of the projects of the two case study projects.
- Staff in this type of project (experimental and working with a vulnerable population) requires the hiring of professionals who could (1) deal to work in uncertain working conditions: short-term contracts, fuzzy boundaries of working time and role/function definition; (2) be able to work with vulnerable persons. The workload can be very high, especially during periods of high turnover, when out-of-hours' work is common.
- For those same projects of the case studies, even if there was a reluctance towards using the BelRAI and they only filled out the assessment because it was required by convention, whenever possible (i.e. after stabilisation of the implementation process), they started to use the results of the assessment after a couple of months.
- The partnership of daycare projects with day centres ("dagverzorgingscentra") was considered an important issue; those day centres are frequent in the Flemish region but scarce in the French-speaking part of Belgium

3.4 PROJECTS PROVIDING OCCUPATIONAL THERAPY (N = 7)

According to the World Federation of Occupational Therapist, « **Occupational therapy** is a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement » [1]. In Belgium, the Belgian Association of Occupational Therapist defines the occupational therapist as a « paramedical who assists patients suffering from a physical, psychic and/or social disability, in order to allow them to acquire, recover or maintain an optimum ability for performing functions required in their daily life, their professional occupations or their sphere of leisure, by using concrete related activities and taking into account the patients potentialities as well as the constraints of their environment ».

Occupational therapy is a relatively new health profession in Belgium which meets a great interest among people. In fact, few people, even other health professionals know well what an occupational therapist really does. It's not uncommon to see an occupational therapist working in a hospital or into a long term care setting, but working at home into the everyday live environment is unusual. However, this profession integrated to client's environment seems to be effective. According to an Australian study, home assessments conducted by occupational therapists generally protect patients from falling in the first month after their discharge from hospital [2]. Home assessments of this study were based on features reported in other research: (1) evaluation of hazard identification and priority setting (including personal risk and environmental audit with a standard assessment tool), (2) evaluation of the functional capacity of the person within the context of their environment, (3) follow-up and support for adaptations/modifications. On the other hand, an American article shows benefits from an occupational therapist intervention using control-oriented strategies (including use of environmental modifications and behavioural and cognitive strategies) at home about mortality risk for elderly patient [3].

Very recently some coordination centres offer occupational therapy but one of the first positive things coming from the creation of Protocole 3 is that it has allowed developing this discipline at home. In 2010 occupational therapists benefit from a NIHDI number which allows reimbursement under specific conditions (see Royal Decree December 2010).

3.4.1 THE INTERVENTION

Within the whole set of 63 projects, 7 (11%) have been classified under the category of « occupational therapy at home » because their main intervention was occupational therapy. Among these, 3 have been more in-depth investigated through a case study.

DESCRIPTION OF INTERVENTIONS

In terms of objectives, occupational therapists from these projects work on the capacity of elderly to be less dependent. They try to improve their independence and also prevent falls by advices and home adaptation so that elderly can stay longer and safer at home. The detailed description of the services provided by these projects, based on what they declared, gives an overall picture of the intervention proposed.

Table 33. Detailed description of interventions of occupational therapy projects

Description of provided services	OT174	OT181	OT187	OT180	OT176	OT163	OT177
Activities directly linked to OT intervention							
Counselling about the home adaptation	X	X	X	X	X	X	X
ADL assessment		X		X	X	X	
Falls prevention						X	X
Living environment assessment					X	X	
Giving advice to other professionals						X	X
Improvement of working conditions					X	X	X
ADL training		X	X				
Follow-up after intervention		X		X	X		
Revalidation activities		X	X				
Pressure ulcer prevention							X
Other activities							
Promotion of the project	X						
Psychosocial support					X		X

All the projects from this category declare that their main intervention consists to provide counselling about the adaptation of the FOP's home in order to:

- 1) Make the patient's living environment more adapted to their current conditions;
- 2) Offer better work conditions to home professional caregivers.

Home modifications are adaptations to the living environment intended to increase ease of use, safety, security, and independence. Modifications can include:

- 1) Changes or additions to the structure (e.g., widening doorways, adding a first floor bathroom or a ramp);
- 2) Installing special equipment (e.g., grab bars and handrails);

3) Adjusting the location of items (e.g., moving furniture).

Home modifications overlap considerably with assistive devices (e.g., bath benches, walkers) which tend to be more mobile in nature and not attached to the structure of the house. In addition, home modifications are often accompanied by repairs (e.g., fixing worn-out stairs) to insure their usefulness.

Two projects also offer another type of intervention that could be more developed in the future that is rehabilitation. This type of activity is comparable to what an occupational therapist is used to perform in revalidation service in a hospital (e.g., patient education in case of hip prosthesis, strengthening of the upper and lower limbs, advice to prevent falls, rehabilitation in activities of daily living, etc.). Combined with a home modification, the rehabilitation might give better results in terms of independence, safety and home maintaining.

Still among what projects declare to offer, the ADL assessment of FOP seems to be important (4 out of 7 projects declare doing it). Of course the evaluation of the functional capacity of the person within his environment is an essential step to warrant adequacy between home modifications and FOP's needs what makes us say that the other 3 ones do it as well but didn't explicitly declare. Another point as important as ADL assessment is the follow-up that is also probably under-reported (3 out of 7) because this is the final step that shows how adaptations answer to FOP's difficulties and improve functional status.

- The main occupational therapy interventions offered by OT projects consist of an adaptation of FOP's home after home visits and ADL assessment.

ORGANISATION AND COORDINATION OF THE INTERVENTIONS

All occupational therapy projects state organise management meetings where the coordinator, the occupational therapists and some partners evaluate the functioning of the project, and care meetings where the occupational therapists meet the care team. The frequency of those meetings is not regular. Their objective is mainly sharing care and coordination information among caregivers. Minutes of those meetings are mainly sent to caregivers. Four projects collect information in a specific patient file with the same objective of information sharing. Other tools mainly used are phone calls, emails or communication papers.

3.4.2 COST OF THE PROJECTS

In general, costs per FOP are relatively low in opposite to other projects as case management and night care projects. However, they are mostly little projects as reflected by the total FTE and the caseload. Five out of seven projects had difficulties to reach the caseload. Reasons are: (1) lack of FOP's knowledge about what an occupational therapist is and (2) FOP's resistance to change. There is no certain fact that could explain that for a project with 1 FTE a caseload of 40 persons per year cannot be reached but a hypothesis might be the relative poverty of the population where the project works.

3.4.3 THE SKILL-MIX

Table 34. Profile of the professionals in the ot projects, including FTE

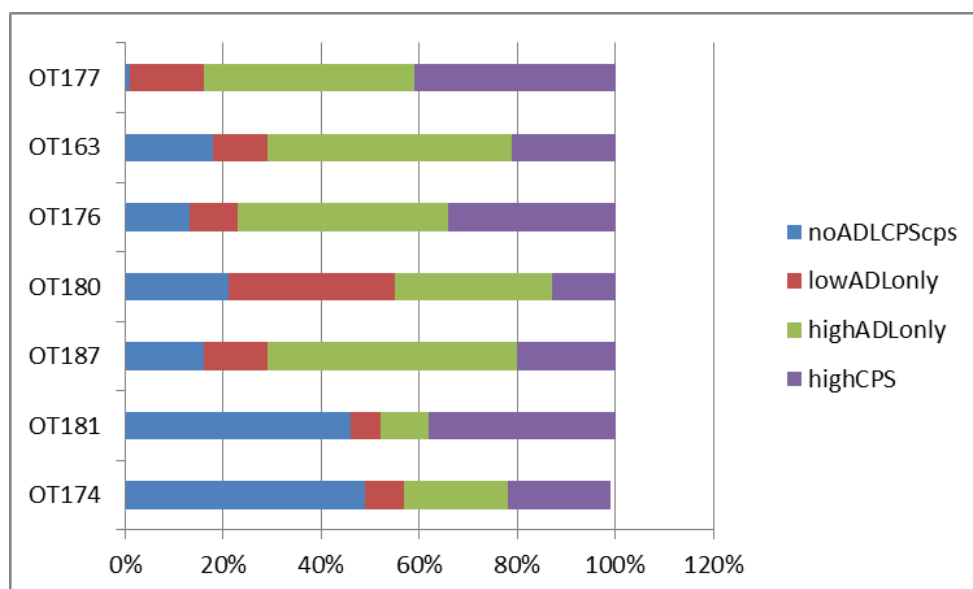
	OT174	OT181	OT187	OT180	OT176	OT163	OT177
Profile of professionals in the project	OT	OT	OT	OT + experience with FOP	OT + experience with FOP	OT + experience with FOP	OT + experience with FOP
Total FTE of OT involved in the project	0,84	1,5	1,5	1	0,5	0,5	0,75
Ratio FTE OT: FOPs	1 :7	1 :17	1 :40	1 :10	1 :50	No data	1 :75

It is firstly noticeable that the number of FTE of professionals varies from one project to another, from 0.5 to 1.5 FTE. Moreover, projects having the highest number of interventions usually have the lowest number of FTE (see table 34). The ratio of frail older persons per FTE occupational therapy varied from 1:7 to 1:75, which is likely to impact the intensity (number of hours per FOP) spend in care.

The occupational therapist is really the kingpin of these projects. No occupational therapist has a specific experience directly linked with home care, which reflects the novelty of this professional and his intervention **at home**.

3.4.4 THE TARGET POPULATION

Table 35. Target population and achievement of the caseload



Most of these projects seem to have difficulties to reach a caseload higher than 45-50. A possible explanation may come from a contextual factor at least for projects from the French speaking part. Few times after the projects starting, the regional authority of the French speaking projects has created a platform allowing a free occupational therapy visit for elderly what may has played a kind of competition and made the reaching of the caseload more difficult.

Surprisingly, two of these seven projects have almost 50 % of beneficiaries who have no adl and cps problem. This observation seems to show that some adaptations are not only performed to improve functional status but as a prevention approach. Objectives of home modifications are of course to improve functional status but also to maintain independence. Thus, home modifications can be used both as “treatment” to improve the functional status and as prevention to prevent for instance any decline or fall.

Generally, occupational therapy projects do not use a comprehensive evaluation tools with the exception of one which declare doing a special OT screening and two others declare using BelRAI as a CGA.

3.4.5 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

Table 36. Proxies of the projects' embeddedness

	OT174	OT181	OT187	OT180	OT176	OT163	OT177
Umbrella organization	PCSW	NH	PCSW	PCSW	HC	HC	HC
Partnership with coordination service (SISD/SEL/GDT or CCSSD)	Yes	No	Yes	Yes	Yes	Yes	Yes
Involvement of GP	GP are poorly involved, despite the financing provided by the project	GP are not involved	GP are not involved	GP are well involved and financed by the project	GP are poorly involved, despite the financing provided by the project	GP are well involved but seems to run out of time	GP are well involved and financed by the project
Collaboration with other care providers	Relevant information for their own functioning	No feedback given spontaneously	Feedback given by an agenda at home or in face to face	Report upon request essentially by phone	Feedback about care plan is given with more or less details according to the type of professional	Feedback given by phone or e-mail	Report is sent to all professionals working around the FOP

Most of the occupational therapists, especially for French speaking projects, work under coordination centre authority which is implemented in the local area for years and so facilitates the implementation into the local health system. In the same way, two projects, from the north of the country, declare having a cross-sectorial collaboration with the local coordination centre. Of course, if an occupational therapy project is organised by a home care services coordination centre, interactions between this one and the occupational therapist occur.

Three projects say that GP are well involved in their functioning essentially by giving a feedback about the patient condition while two others have a poor collaboration with GP despite the financial incentive provided. For the others, GP are not involved at all.

Except for one project, all the other ones declare exchanging some information with other professionals working around the FOP essentially by giving a call. The only project that does not exchange information is the one that has a little effective caseload in comparison to the number of FTE. GP and other professionals with which this project has poor or no collaboration are some potentials client providers, important thing for a new project that has to make itself know.

3.4.6 ADAPTIVE BEHAVIOURS

Table 37. Adaptation of the conventions

	Conventions modification
OT174	Decreasing of FTE: from 1 to 0.84 FTE
OT181	Decreasing of caseload : from 307 to 209 persons per year
OT187	No changes
OT180	No relevant changes
OT176	Widening of target population about Katz scale
OT163	Decreasing of caseload : from 100 to 65 persons per year
OT177	Increasing of FTE (from 0.64 to 0.75) and travel costs to meet needs of target population

Among the seven occupational therapy projects, five of them made modifications of their convention. Two have modified their caseload in decreasing it while 2 others have changed their FTE number (increase for one and decrease for the other). The fifth one has expanded its target population in order to reach easier its caseload. We can notice that one project has really overestimated its caseload to the extent that even in reducing it this was still too high to reach in comparison to the other projects.

3.4.7 EXPECTED EFFECT ON THE OUTCOMES AS A RESULT OF THE NORMATIVE ANALYSIS

First, it's worth to note here that projects OT181 and OT163 stopped before the official end of Protocol 3 program.

The following figures show the comparison on specific items that have been chosen as relevant for a well-functioning of an OT project. Projects have been classified in two categories one about those delivering only home modifications and the other that declares offer home modifications and a specific revalidation.

- (“Interprofessional collaboration”) Collaboration and coordination with other care providers, including GPs: it is preferable that all caregivers around the FOP be informed of home modifications especially for nursing care that can be facilitated by new helps in using them. Home modifications may make nursing care useless in improving *ADL* abilities. GP is also an important agent to collaborate with because as a care prescriber he can support the home modification project or even propose it.
- (“Partnership with distributor of home use devices”) Having a distributor of home use devices as partner seems to be relevant in terms of financial accessibility. A project that works with such professionals that have so a near monopoly, benefits from prices reductions that are also enjoyed by patients.
- (“Follow-up”) Planned follow-up of intervention: this step of an OT intervention in a home modifications purpose is crucial because it allows the occupational therapist to check the work done and mainly to test them with the FOP.
- (“Education”) Education component: this component is linked to the previous item and is mainly employed in case of home modifications when the occupational therapist shows and teaches FOP to correctly use the new materials.

- (“Shared decision-making”) Shared decision with patient and his caregiver: to be accepted, used and correctly used home modifications require the agreement, will and participation of FOP and his caregiver if there is one.
- Rehabilitation activities: this item has been analyzed only for the two projects declaring doing revalidation at home like ‘ADL training’ in addition to home modifications.

Home modifications only

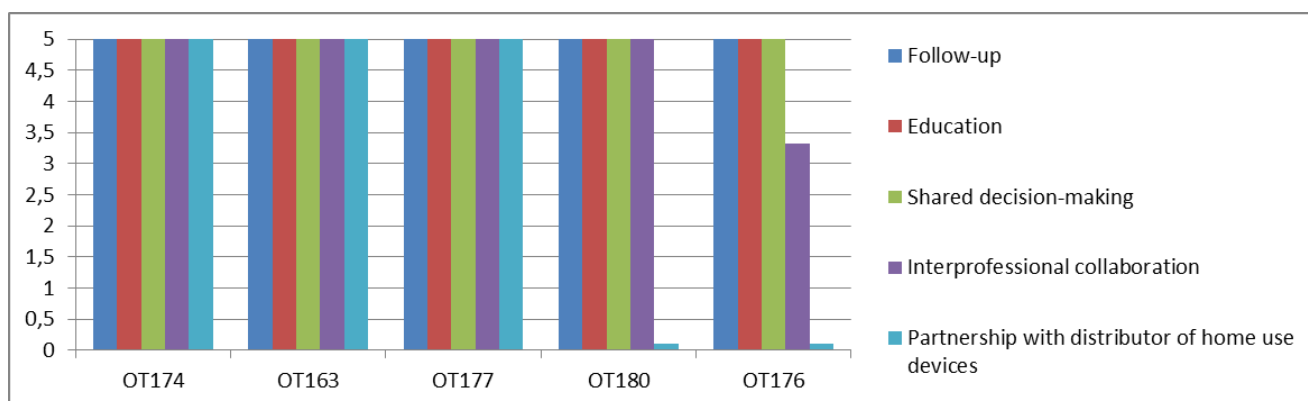


Figure 35. Normative analysis of ot projects related to home modifications

Based on what they declared three out of five projects have the maximum points for the five items. The worst item for two projects is the presence of a distributor of home use devices as partner that could be involved in their difficulty to reach the caseload. As we previously said, a distributor of home use devices, in supposing he benefits from a kind of monopoly for one institution will practice a price reduction that could attract some new clients. However if this element has played a role in the difficulty to reach the caseload, it's probably minimal because even if costs of home modifications may be a barrier to this intervention they are some non-cost options like environmental management. In term of procedures the five projects show consistency in respecting some elements that could be defined as crucial for the well-functioning of this type of project that is: shared decision, planned follow-up and education component.

Rehabilitation activities in addition to home modifications

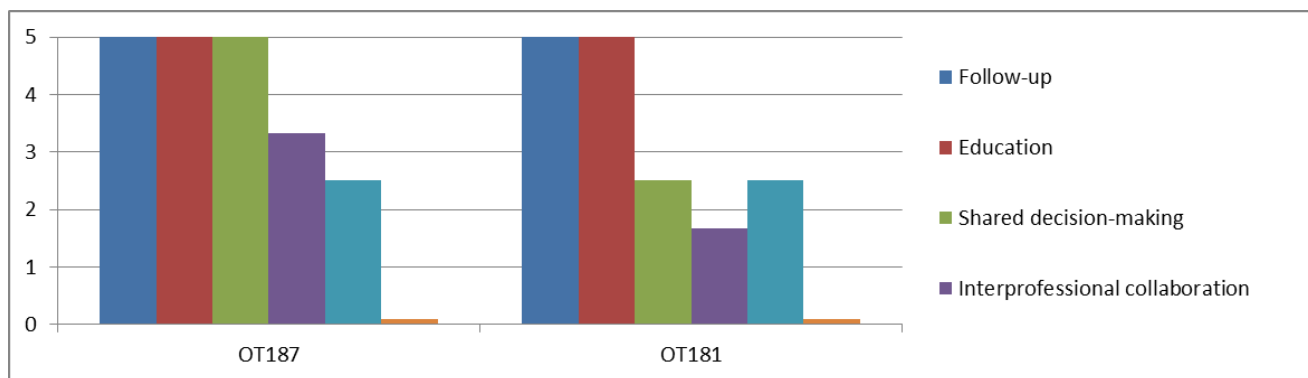


Figure 36. Normative analysis of OT projects related to additional revalidation activities

For this sub-group the worst item is also the absence of a distributor of home use devices as partner, which is followed by the 'collaboration and coordination with other care providers'. The project that has the worst notation for these two items is also the one that had the biggest difficulty to reach his caseload. The two projects proposed rehabilitation activities as ADL-training. However this kind of activities takes more time than home modifications and needs much more sessions and more closed than what they proposed to do (in addition to home modifications): one project spends on average 8 hours per patient without indication on their repartition by day while the other offers a six session intervention distributed over 4 weeks. That's why 'revalidation activities' as these two projects propose them are probably performed after home modifications in using the new 'material' which is of course a right way to show to FOP benefits he can retire from new helps as the other OT projects also do but maybe without saying it.

3.4.8 SYNTHETIC TABLE OF THE PROJECTS' DATA

Table 38. Synthetic table of the features of projects occupational therapy

	OT174	OT181	OT187	OT180	OT176	OT163	OT177
Type of intervention	Home adaptation	Home adaptation and rehabilitation	Home adaptation and rehabilitation	Home adaptation	Home adaptation	Home adaptation	Home adaptation and rehabilitation
Description of services provided	Counselling about the home adaptation	ADL assessment of FOP; ADL-training; Counselling about the home adaptation; Follow-up after intervention; Revalidation activities	ADL-training; Counselling about the home adaptation; Revalidation activities	ADL assessment of FOP; Counselling about the home adaptation; Follow-up after intervention	ADL assessment of FOP; Counselling about the home adaptation; Follow-up after intervention; Living environment assessment; Psychosocial support	ADL assessment of FOP; Counselling about the home adaptation; Falls prevention; Living environment assessment; Handling advice to other professionals; Improvement of working conditions	Counselling about the home adaptation; Falls prevention; Pressure ulcer prevention; Psychosocial support; Revalidation activities; Handling advice to other professionals; Improvement of working conditions
Profile of professionals in the project	OT	OT	OT	OT + experience with FOP	OT + experience with FOP	OT + experience with FOP	OT + experience with FOP
Total FTE of OT involved in the project	1	1,5	1,5	1	0,5	0,5	0,6
Ratio FTE OT: FOPs	1 :7	1 :17	1 :40	1 :10	1 :50	No data	1 :75
Profile of expected target population	FOPs + home adaptation needs	60 years or more + ADL impaired	Overall FOPs	Overall FOPs	Overall FOPs	60 years or more + ADL impaired	Overall FOPs
Caseload	7	25	60	10	25	No data	45
Achievement of the caseload	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Recruitment means	Day care center or ICG	HC and Care centre (« Dienstencentrum)	Partnership and PCSW	PCSW and Hospital	HC	HC	HC
Partnership with coordination service (SISD/SEL/GDT or CCSSD)	Yes	No	Yes	Yes	Yes	Yes	Yes

	OT174	OT181	OT187	OT180	OT176	OT163	OT177
Partnership with community organizations	No	No	No	Yes	Yes	Yes	No
Incentives for GP participation	Yes	No	No	Yes	Yes	Yes	Yes
Provision of feed-back about FOPs to the GP	If needed	No	If needed	Yes	If needed	If needed	Yes
Reevaluation and follow-up of intervention	Yes	No	No	Yes	Yes	Yes	Yes
Use of BelRAI results	No	No	No	No	No	No	No
Duration of the intervention	40	40	180	61	180	65	270
Umbrella organisation	PCSW *	NH	PCSW	PCSW	HC	HC	HC
Unit of activity	1 prestation	Care package	3,8h or half day	Care package	1 prestation	No data	Care Package
Nb of Units/FOP (Sept 13)	1	1	13,27	1,07	5	No data	1
Annual cost per FOP	1.070 €	1.197 €	894 €	855 €	296 €	761 €	386 €

As mentioned here above, three occupational therapy projects, one Dutch-speaking and two French-speaking ones were part of the case studies and are described here.

3.4.9 CASE STUDY 14

OT181

This project has been included in the case studies from 2011 to 2013.

1. CONTEXT OF IMPLEMENTATION

This project comes from a large nursing home care institution, largely involved in the innovation in health care to frail older people in the north of country. This project was seen as an opportunity to offer occupational therapy to elderly people to prevent and fight frailty. The preparation of the project required intense work at the partnership level in order to adapt the already existing service to the Protocol 3 programme. A social worker, a nurse and an occupational therapist collaborated for the preparation of the project.

2. THE PROJECT AS PLANNED

OBJECTIVES

The occupational therapists were supposed to advise the informal caregiver because their support is a key element on helping old people at home. The project will also provide custom-made care.

TARGET POPULATION

The project was designed for people older than 60, living in a limited area of the city and needing complex care or not (with a score of A-B-C on the Katz home scale or a score of B-C-Cd on the Katz residential scale). The project was also designed for people sitting on a waiting list for institutionalization in a nursing home or home care services. Those people may have very different profiles, but have as common characteristic to be still at home.

PARTNERSHIP

The partners of this project are institutions (12) that were already collaborating with each other before the project submission. Those institutions are mainly nursing homes, home care services, an Integrated Services Home Care (SIT/GDT) and mutualities. The role of the partners is mainly to refer clients to the project.

SKILL MIX

The project intends to offer services of six occupational therapists for a total amount of 1.53 FTE. Two occupational therapists will be directly involved in the project, the others will come from the health insurance companies (mutualities).

PROJECT PROMOTION

In order to promote the project, information sessions with PowerPoint presentations and occupational therapy material will be organised in long-term care institutions. Risks of falls will be including into the presentation. To promote the project, the social worker from the main nursing home could be a good help because has been trained to provide clients to the project.

INTERVENTION AND COORDINATION

The project is mainly based on the occupational therapist intervention whose the objective by the means of home modifications, FOP's and ICG's advices is to delay institutionalization at least for one year that is the period during which the FOP can call the OT. FOPs enter the project either by their own or by the occupational therapists who contact FOPs on a waiting list or in the files of partners by phone. The first contact is so mainly by phone and conducts to the FOP admission or not. Then, before talking about home modifications the first home visit is over all to create a confidence relationship. The other ones allow getting the informed consent

signature, passing assessment scales and above all talking about the concrete intervention (home adaptation, FOP's and ICG's advices). According to the project an intervention lasts on average 7 hours per FOP and each may ask 3 over a year that's why the project aims to delay the institutionalization for one year at least.

THE COORDINATION OF THE PROJECT

The coordinator manages a weekly meeting between occupational therapists belonging to different partners. Moreover a monthly meeting was organized to provide information about the project.

3. THE PROJECT AS ADAPTED

CHALLENGES MET

The project met some difficulties throughout its implementation.

After a while the social worker, the nurse and the occupational therapist who collaborated to the writing of project did not work anymore in the project and the coordinator has changed many times because of internal troubles.

The staff has never been as it was planned: from the start to the end of the project there was only one occupational therapist who did everything and the collaboration with occupational therapists from mutualities has never worked. The fact that there was only 1 OT doing everything was probably the main problem of this project because the first one left and the replacement got a burn-out.

As 'challenges', the project met some difficulties because occupational therapy is still little known by the targeted population. In the beginning, the project experienced difficulties with the inclusion of patients. The inclusion criteria and the tools used to select inclusion candidate produced the unexpected effect that they could not reach their caseload.

Initially addressed to the FOP living in a limited area of the city, the project has asked to increase its area of activity to the whole city in order to reach their caseload. At the beginning, the project only included patients having a B or C score on the Katz instrument. Most of patients on a waiting list for institutionalization were scoring lower than B or C. The project asked for an adaptation of its convention file with the NIHDI. The project now includes patients only on the basis of the Edmonton Scale. As far as occupational therapy advice is concerned, the minimum age for possible inclusion is 65 instead of 60 because every patient under 65 may ask support and home adaptation from a regional association for disabled people.

Once a week, the occupational therapist and the coordinator of the project meet together. At the start of the project, the coordinator organised a general meeting to collect information for the inclusion of future clients. Every three months, the coordinator organises an evaluation meeting where the number of contacted people, included patients, and interventions are discussed. If necessary, the coordinator can organise a special meeting depending on the agenda.

The occupational therapist discusses the different home adaptations with the patient and his informal caregiver. He puts all this information in an Access database and in BelRAI. He also puts this information in the nursing file, if there is one. The project points out the difficulties with the general practitioner and the physiotherapist in the sharing of information.

4. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

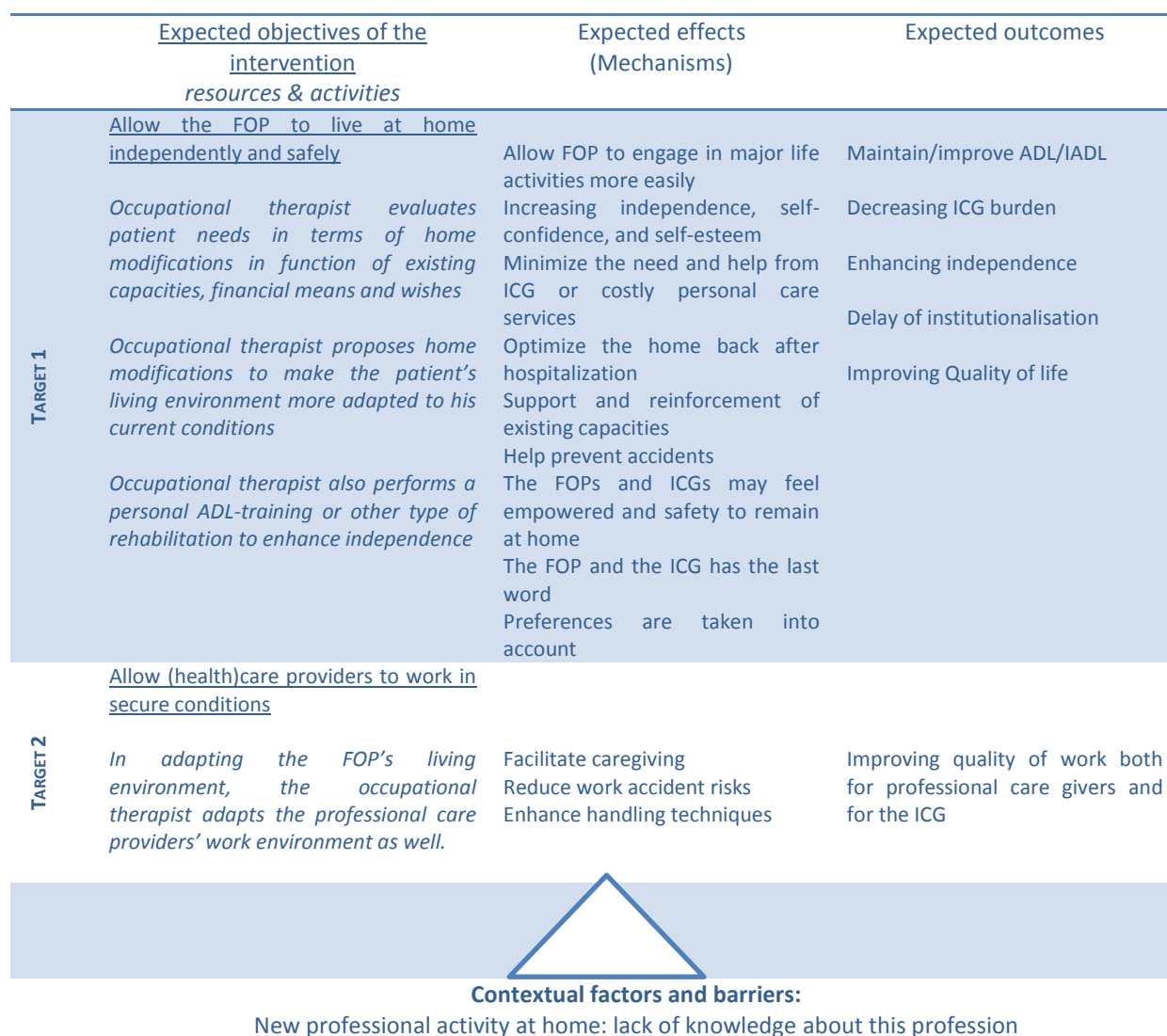


Figure 37. Programme theory of project OT181

3.4.10 CASE STUDY 15

OT180

This project has been included in the case studies from the beginning in 2010 to 2012.

1. CONTEXT OF IMPLEMENTATION

This second project, coming from the Public Municipal Social Service Department (PCSW) of a great city in Wallonia has been created by the occupational therapist with the head of the PCSW's help. The occupational therapist, who is also the coordinator of the project, is the main person involved. The project is implemented in a former steel factory area, which explains that most homes are 'workers houses' often outdated and not adapted to the living conditions of the frail elderly. This project seems to have benefited of the previous experience of another project of occupational therapy.

2. THE PROJECT AS PLANNED

MOTIVATIONS TO SUBMIT A PROJECT

The origins of the project are based on the desire to develop, by the mean of an occupational therapist activity at home, the home adaptation for the frail elderly, to improve the working conditions of the other professionals, and to adapt the house according to the patient's needs.

In fact, the specific purposes of the project, besides the home maintaining, would aim to decrease the risk of work accidents and handling troubles of the nursing staff of the Public Municipal Social Service Department when working at patient's home. Other **objectives** are the optimization of the house after an institution stay, the evaluation of patient's performances into his living environment and the transmission of that information to the professional caregivers.

THE TARGET POPULATION

The target population of this project is people of 65 years old or more, living in the area of activity of the project, a large city, but the most of included beneficiaries come from a more limited area: only two clients living out of the periphery of the city have been included. The project also excludes people who can't express themselves (because project need them to be able to answer to the questions of the occupational therapist) and/or are opposed to an adaptation or change of their living environment.

The project is addressed to elderly who present signs of frailty on the Edmonton or Katz home scale.

The population concerned is, for a great part of it, socially and economically disadvantaged. The patients are included into the project by the PCSW, the social workers of the revalidation or clinical centres, the 'mouth to ear', the town coordination centre and the local Home Care Services.

COORDINATION MEANS, TOOLS AND PROCESS

The occupational therapist coordinates at the same time the interventions and the project in its day to day functioning that is, here, reduced to the minimum. The project tries to organize some regular meetings (every two month) with his several partners.

PARTNERSHIP

The partnership of the project include 7 partners forming a 'large family', according to the project's coordinator, including the Home Nursing Service of the PCSW, a Nursing Home of the PCSW, the local Integrated Services Home Care, the Coordination Centre of the town and other social services closely associated to the PCSW.

As other 'occupational therapy' projects, the project has not involved as 'partners' a company of 'social economy' that can install new home materials when necessary, and a bandagist that can provide adaptation materials, that are yet essentials to the day to day functioning of the project.

THE INTERVENTION

In this project, the intervention is conceived as a 'unit of 40 hours', including a set of two to six visits and taking into account the first contact, the informed consent, the screening / assessment of the beneficiary (by the use of AESOP and MHAVIE scales), the filling of the tools inherent in the scientific evaluation (BelRAI), the choice of the adaptations and the evaluation of the intervention.

Concerning the cost of the intervention, the home adaptation advices are free but the intervention (implementation of adaptations) and the equipment are paid by the patient. According to the occupational therapist, the average amount that a client is ready to pay for his living environment adaptation is about 150 euros. That's why the occupational therapist prefers the environment reorganisation (simply moving furniture) which is cheaper than the installation of new equipment. Nevertheless, in this case, to provide to the patient a better price, the occupational therapist makes a market survey with the companies with which he collaborates.

SKILL MIX

The project has also engaged a quart-time secretary to record the assessment tools. She is responsible for the registration in BelRAI of the several tools filled out by the occupational therapist, but on paper version.

3. THE PROJECT AS ADAPTED

PROMOTION OF THE PROJECT

To promote his project, the occupational therapist has participated to a fair like "salon des seniors" in distributing some folders talking about his job and project. This initiative came in the wake of difficulties to reach the caseload.

CHALLENGES MET

Several weaknesses have been identified during the project's implementation. First of all, occupational therapy is a new discipline, not really integrated into the practice. This results in a lack of recognition from client and GP. Moreover, the fact that the population is economically disadvantaged makes the client hesitate or refuse to pay something for home improvement. According to the occupational therapist, it represents about 60% of interventions. This is a financial limit. Finally, some clients don't want to change their living environment whereas the work is based on the client involvement. Another difficulty is linked to the persons that the project cannot contact for the follow-up and evaluations.

Despite of a federation of GP as partner the collection of information about data patient is not always good even if the collaboration is. It's the same situation for other professionals who do not work into the PCSW.

CHANGES AND ADAPTATIONS

At the beginning of the project, the secretary had a half-time job which is now reduced to a quarter time. The occupational therapist is fulltime employed.

The project tried to organize some regular meetings (every two month) with his several partners. However, because it's not easy to have all the partners in the same time at the same meeting, the project sometimes has to organise some shifted meetings.

MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

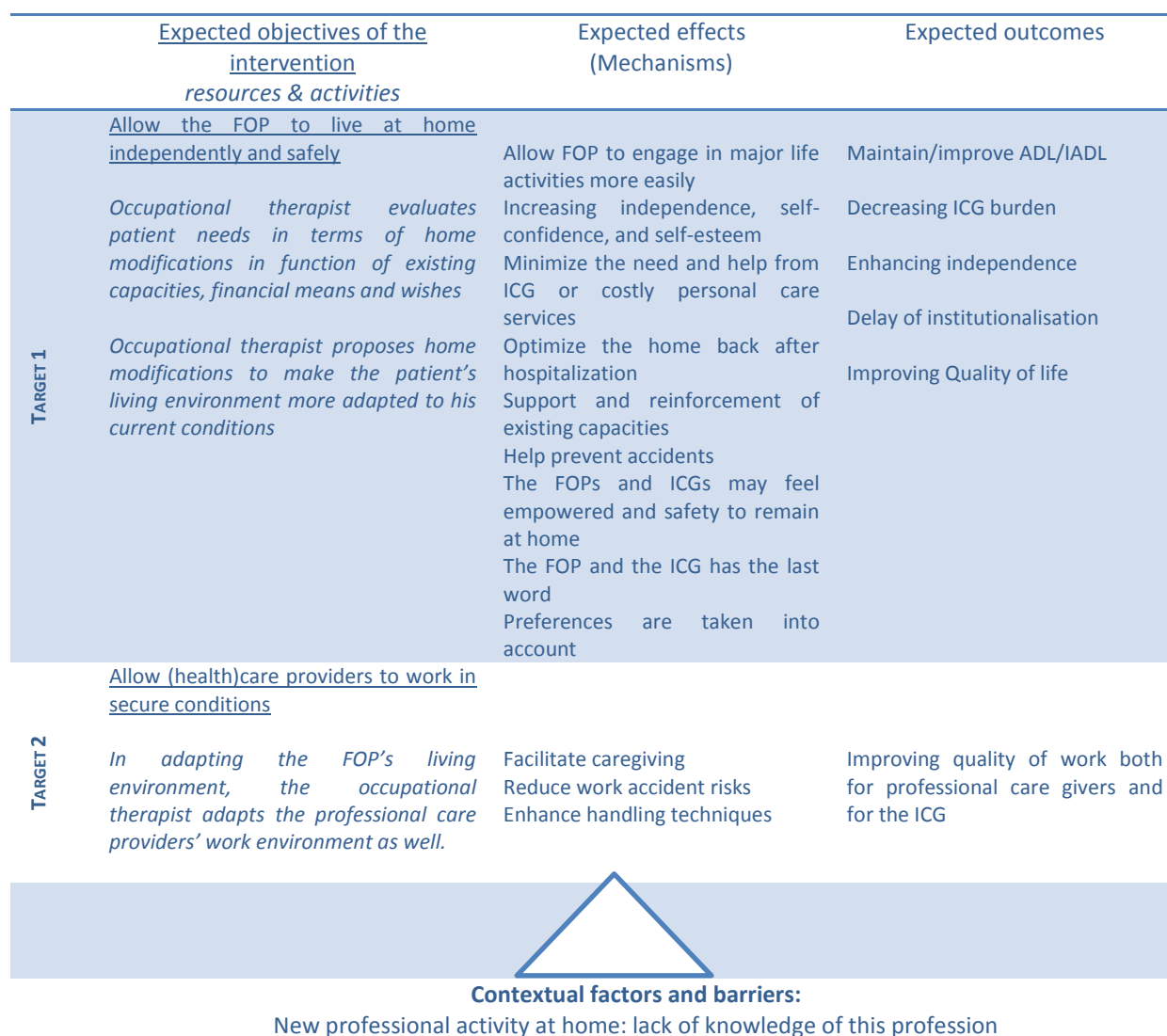


Figure 38. Programme theory of project OT180

3.4.11 CASE STUDY 16

OT163

This project has been included in the case studies throughout the duration of this study i.e. from 2010 to 2013.

1. CONTEXT OF IMPLEMENTATION

This third project was elaborated by one responsible of a Home Care Coordination Centre (HCC) who had the feeling they were not sufficiently helping people living at home and wanted to promote an occupational therapist as a new service amongst those already offered by its organization. The area of activity of the project is the same than these of the HCC itself and of the local ISHC.

2. THE PROJECT AS PLANNED

The project was written by the director and an accountant of the HCC. The project has three objectives: the adaptation of the house to the needs of the patient, the improvement of work conditions of professional caregivers in patient's room and the adaptation of the house when the patient comes back home after a stay in nursing home or hospital.

THE PARTNERSHIP

The six partners of the project are all members of the 'socialist' local family and should helping to catch beneficiaries, amongst them: a Home Service Coordination Centre, two patients associations, the local ISHC, a Nursing Home.

Each month, the coordinator of the project (the HCC's director) leads a meeting with the different home care professionals (mainly caregivers working in nursing homes).

THE PROMOTION OF THE PROJECT

The promotion of the project is made by the folder of the local health insurance company.

THE TARGET POPULATION

The project targets elderly aged of 60 or more, presenting some signs of independent loss. People with dementia (physically well but cognitively disturbed), as well as people 'resistant to any change in their living environment' are excluded. The majority of people in this region is economically deprived and some are isolated.

THE STAFF

The project just employs a half time occupational therapist to provide services, doing evaluations and making the trainings for other care providers.

THE INTERVENTION

The intervention can be decomposed in three axes. The first axis concerns the patient and consists of 3 or 4 home visits (contact with client, material delivery, adaptations and evaluation). The second axis aims to train other professionals and to promote the project. Finally, the third axis deals with the registration of the different assessment instruments.

The occupational therapist makes use of a kit of material to show the different solutions to the patient before home modifications. This kit is provided by the 2 bandagists (companies providing home adaptation materials) who work with the project but not as partners (no signed convention). These ones bring to the project an advantage: the 2 bandagists have an almost monopoly and have a big institution as client; they reduce so their prices whose FOPs benefit from what may increase the rate of inclusion in rising the financial accessibility. However as other OT projects, advices are free but the patient pay any adaptation or material.

3. THE PROJECT AS ADAPTED

CHALLENGES MET

The project only employed a half time occupational therapist to do everything. After a while he left the project out for a more secure job and has been replaced.

The project rapidly realized that number of home visits, three, was too low and needed, to be effective, to give a 4 or 5 home visits intervention because of an important confidence relationship to obtain before the home modifications process itself.

Trainings given by occupational therapists took time because it was not only the training in itself but also the preparation of it. Of course, after a while this training has taken much less time because preparation was done and just needed sometimes an update and was only given to professionals newly engaged.

Administrative tasks have been underestimated. The project didn't expect such kind of administrative tasks. GPs are often unavailable despite solicitations from the occupational therapist by phone or in face to face. It seems to be a lack of time from GPs.

People who benefit from specific allocations take up a huge time because they need collaboration with another organization that also has to manage a client file. Thus the occupational therapist had to adapt himself to the rate procedure of this organization.

CHANGES AND ADAPTATIONS

In the beginning, the project wanted to include 100 patients, but after some months, asked the NIHD to reduce this number to 65 patients, because it represents too much work for a half-time job (overestimated caseload). The occupational therapist left and has been replaced because she found a job more secure (long-term contract).

At the start of the project, the partnership helped the project to catch beneficiaries. Now, they are coming from home care services, hospital social service and local social services. After few months of functioning, two companies providing home adaptation materials (bandagist) have been associated to the project, because they have been considered as essential partners.

MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

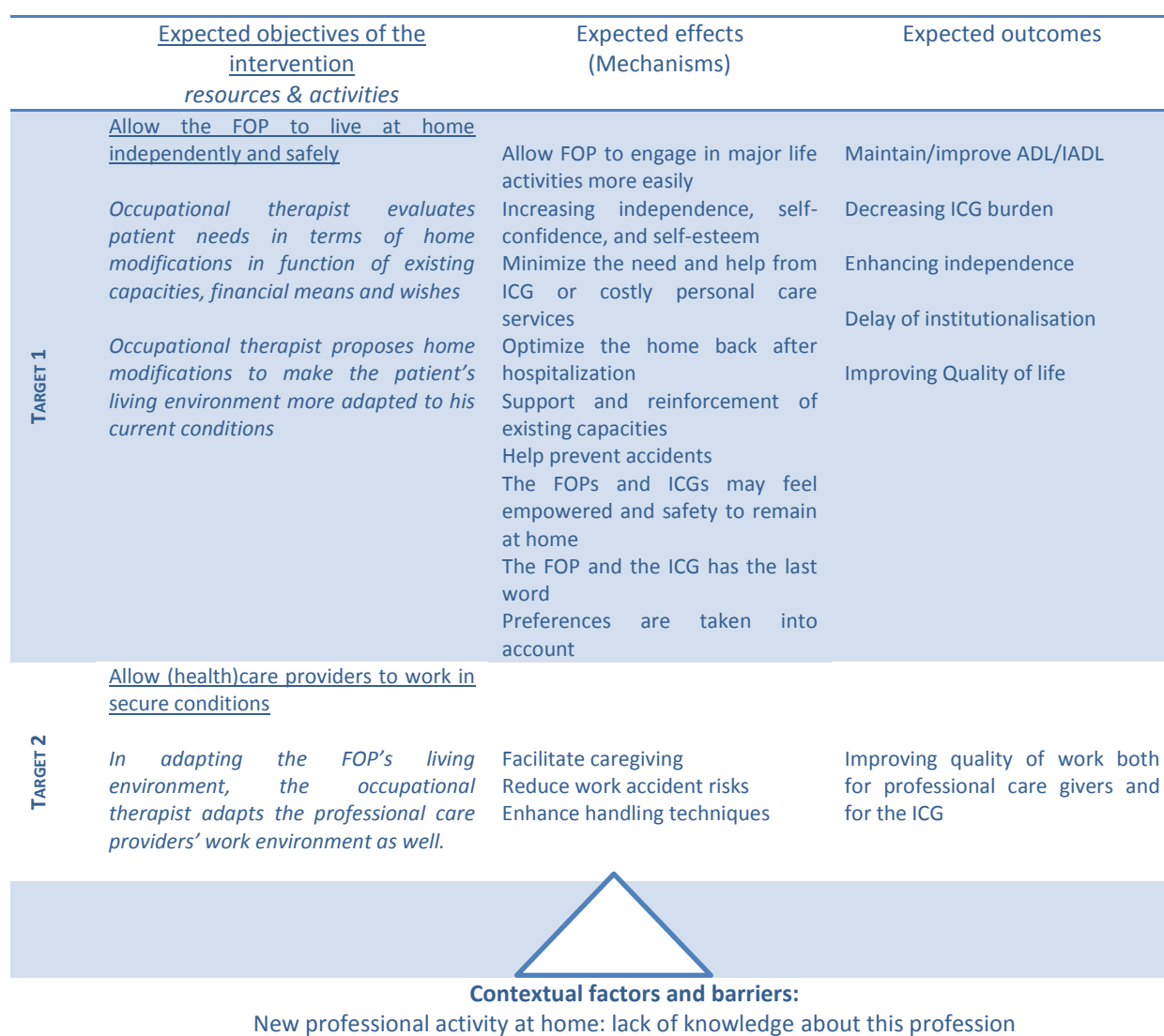


Figure 39. Programme theory of project OT163

3.4.12 KEY RESULTS OF COMPARED 'OCCUPATIONAL THERAPY' PROJECTS

In this section, we summarize some of the observations the implementation analysis allowed us to make on the category of occupational therapy. These results have been gathered under three titles: the descriptive organisational features, the challenges met and the adaptations introduced by projects from this category in order to overcome these challenges.

MAIN DESCRIPTIVE FEATURES OF THE FUNCTIONING OF SUCH PROJECTS

First, except for one project that has a nursing home as umbrella organization, all the others have been implemented by a large umbrella organisation, particularly active in the home care services (a PCSW or a HCC), and to which they are closely associated. It seems that this type of umbrella organisation provides some useful resources that makes this kind of projects viable (for example, in providing the project in beneficiaries). By consequences, those projects appear more like new services offered by the umbrella organisation to its affiliated people, than as a neutral service in the local health system.

In fact, the projects share the same main **objective**: allow the FOP to live at home independently and safely in adapting the FOP's home to fit his or her current conditions and creating the appropriate conditions of living at home after a stay in residential care institution. However, they differ from each other by their "secondary" goals: some target the working conditions of the first line of home care professional to avoid accident while others prevent falls or pressure ulcer. Activities provided to reach objectives don't vary a lot from a project to another: the podium is completed by (1) counselling about home adaptation, (2) ADL assessment and equally (3) revalidation activities and follow-up after intervention.

Thirdly, the **partners** of such projects are often members of the same local 'family' of organisations (in term of ideological and political affiliation), but don't really play another role than providing the project in beneficiaries. In the facts, the projects examined are entirely managed by the occupational therapist, as an employee of the umbrella organisation, not as independent entities. It is also noticeable that almost all projects are mainly supported and managed by a limited staff, mainly a same and lonely person. Consequently, this may be a threat when this person leaves the project, when it rests entirely on the shoulders of one person. For this type of project, a positive thing is that there is no occupational therapist shortage but a negative point is that an occupational therapist trained in home modifications is rare due to the novelty of this activity at home.

Fourthly, these 'occupational therapy projects' have, less or more, defined the same **inclusion and exclusion criteria**, although the tools used to assess the level of autonomy of the candidates are different. The Katz scale seems to have raised some problems, because it excludes some people who should benefit from an occupational therapy support.

In terms of **target population**, the home modifications target more people presenting a physical deterioration than people with dementia, for example, who are physically in good conditions but cognitively limited. Comparatively, an 'occupational therapy intervention' as proposed by the three case studies presents the characteristics of a 'package', including 3 to 6 home visits, during which the different stages of the intervention are performed: contact, assessment and evaluation of the situation, proposition of adaptation, adaptation, post-adaptation evaluation. This relative homogeneity of the intervention means that such an intervention can easily be standardized. Intervention of every occupational therapy project was free but the modifications that they could generate were borne by the patients (for those who beneficiate of any financial help) what may have an impact on the accessibility of this type of service.

What makes the difference between projects is the great difference in the time allocated to an intervention conceived as a 'package' with the approximately same content. In a first project, for instance, an intervention is said to take between 8 to 10 work hours, while in a second project, it is said to take more than 40 hours. In the same trend, the FTE occupational therapist to patient ratio varies from 1:7 to 1:75. These discrepancies explain

that the workload of the occupational therapist varies a lot from a project to another, but also the number of hours of care the beneficiary receives. The workload that underlies the FTE number and thus the cost might also explain differences between projects about costs. Reasons that could explain a certain level of turnover within these projects are so the workload but also the lack of professional security (fixed-term contract) inherent to a pilot project.

From the point of view of the 'local system of care', occupational therapy projects play an important role in the continuity of care, because they may facilitate the return of the elderly after a stay in a revalidation centre or after a hospitalisation. In this sense, they answer to a need from the residential care institutions, which often can't 'go outside of their walls'.

MAIN CHALLENGES

Two of the three projects being part of the case studies have expressed some initial difficulties to reach their expected caseload. They seem to have overestimated the number of potential candidates to the inclusion:

- (1) Firstly, in a general way, occupational therapy is a relatively new profession in the Belgian care sector, in a recognition process, but largely unknown by the target population of these projects, what explains that some projects encountered difficulties to take off. For this reason, the promotion of this relatively 'new function' represents a first challenge to its implementation.
- (2) Secondly, several projects have explicitly expressed as a threat of the implementation of the occupational therapist function the 'resistance' of some elderly to change something in its living environment. Some situations of psychological resistance to changes have been mentioned during the interviews. The task of the occupational therapist may also been complicated by the fact that the FOPs are in a process of denial of their vulnerabilities, and by the financial cost of some interventions, especially for people with economic deprivation.

Finally, projects have expressed difficulties with the management of the administrative tasks represented by the registration of patient data in the BelRAI web application that were clearly underestimated by these projects. Only one project, where these administrative tasks are allocated to another professional seems to have less difficulty with it, but the collection of medical information with GP remains in general a problem for these projects.

MAIN ADAPTATIONS

Mainly confronted to the difficulties to reach their caseload, occupational therapy projects concerned by have introduced some changes in their inclusion criteria: reduction of their expected caseload, change of the assessment tool used to evaluate the level of autonomy of potential candidates, extension of its area of activity, etc.

After one year, one project has raised the number of hours theoretically allocated to one intervention in the submission file, because the experience has shown that home visits were longer than expected and that more visits were needed to establish a confidence relationship between the occupational therapist and the FOP.

Finally, in order to find a solution to the underestimated administrative tasks, one project has specifically recruited a part-time secretary to register the needed data in the different tools. Such a distribution of tasks between the professionals in the project seems to be beneficial for the project.

3.5 PROJECTS PROVIDING PSYCHOLOGICAL OR PSYCHOSOCIAL SUPPORT OR THERAPY (N = 8)

In this project category the projects delivering psychological, psychosocial support or psychotherapy at home by a trained psychologist or psychotherapist were grouped. These projects share the aim to maintain frail older people in their homes by providing psychological support to the older people and their informal caregivers. The way they concretise psychological support often differs between projects. Out of the 8 projects 5 are situated in *Flanders*, 2 in Wallonia and 1 in Brussels.

Objectives of the psychological projects

All projects have the main objective to **delay institutionalization**. Besides this shared objective, projects formulate several more specific objectives. They can be grouped into objectives for the FOP, objectives for the ICG and objectives for the care.

- FOP objectives: Four projects mention that they aim to improve the FOP's **autonomy**, also 4 projects (not necessarily the same) aim to improve the FOP's **quality of life**. Other objectives are to achieve less hospital admissions, less psychological complaints, better functional and cognitive status and strengthen the FOP's identity.
- ICG objectives: Four projects have the objective to support the ICG, improve their **coping ability** and/or **quality of life**.
- Care objectives: Sensitise and prevent crisis situations by early interventions, fill in the gaps in the existing health care system, ensure continuity of care, lower the threshold to psychological services and provide support and psychological expertise to other first line health care workers.

3.5.1 THE INTERVENTION

All projects offer **individual psychological interventions** to the FOP (and/or their informal caregiver) in their homes. The content of these interventions vary from real psychological support like psychological consultations, psychotherapy, writing life review and psycho-education to sometimes more psychosocial or just social support like giving information about existing health care and social services and practical advice. Two projects report to stimulate the FOP to have more social contacts. Only one project organises **psycho-education in group** that facilitates the FOP to exchange experiences with peers. When advisable and with permission of the FOP, others like ICG's or family members can be invited to the individual psychological consultations. For example to resolve a conflict or strengthen the family ties. All but one project support the ICG directly or indirectly. Three projects mention to **support directly the informal caregiver** by offering consultations to them.

There is a link between the proposed intervention and the type of population that is targeted by the projects. Three projects (PS168, PS194, PS165) stated in their inclusion criteria that the FOP had to be able (cognitively and verbally) to have a (therapeutic) conversation with the psychologist or other professional. In these three projects the percentage of FOP with a high CPS score is the lowest. The 2 projects that have the highest proportion of 'high-CPS'-FOP (PS155, PS172) are the projects that target especially FOP with dementia and their ICG. The intervention in these 2 projects is more targeted towards supporting the ICG.

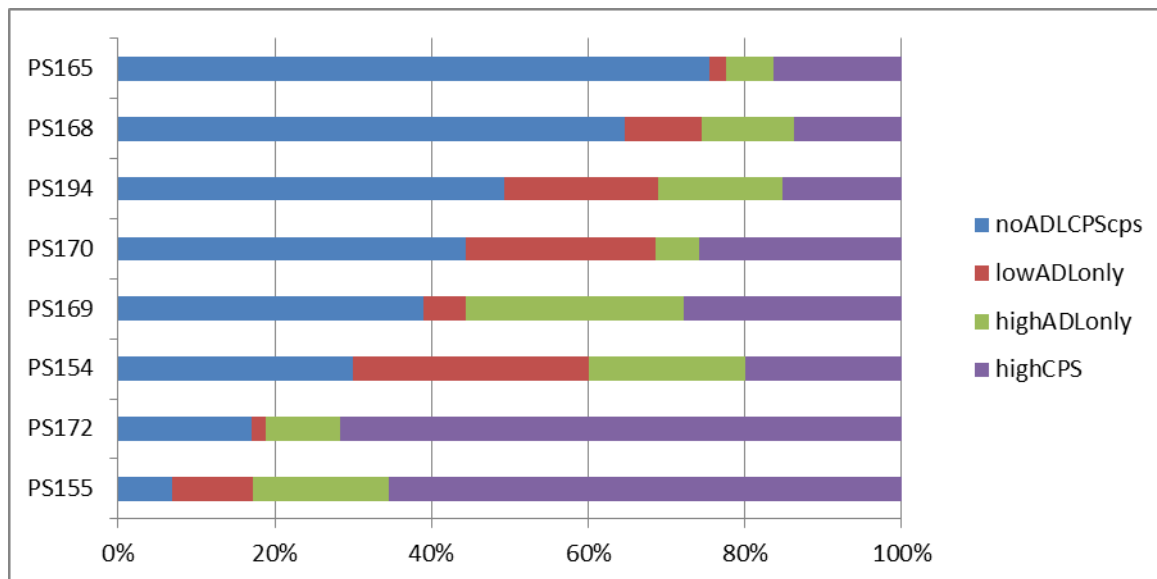


Figure 40. Profile of fop included in psychological project

ACCESSIBILITY OF THE INTERVENTIONS

All projects acknowledge the difficulty of FOP to cross the threshold of getting psychological support. There is still a taboo. The psychological intervention has to be accessible in terms of location, finances and culture. All projects offer interventions at home. Four projects offer their intervention for free (PS154, PS155, PS168, and PS194). The other projects have prices that vary from on average 45 euro to 400 euro per year. One project (PS170) states that they deliberately ask a contribution because according to them FOP have more respect for the intervention if they have to pay for it.

From a case study project (PS168) we learned that despite the fact that they are situated in a very multicultural neighbourhood they get no or few applications from immigrants.

ORGANISATION OF THE INTERVENTIONS

Meetings

Meetings on the organization of services for the client

Most projects organize mono- or multidisciplinary team meetings, both internally with the project staff, as well as with external professionals or organizations. During these meetings, individual clients are discussed and the existing care and necessary care is coordinated. One project indicates that, although it is a large time investment, this type of meeting is very useful and necessary for proper functioning of the project. The frequency of client meetings is very variable between projects. In most of them, meetings where individual clients are discussed happen monthly or more frequently. Meetings about one individual client take mainly place at the project office or at the client's home.

Almost all projects indicate that they most frequently use **telephone calls, e-mail and reports of meetings** as a tool to share information and coordinate the care for the clients on an individual base. Remarkably, only 3 projects indicate to use a **patient record** (on paper) as a central tool in the coordination. One project uses a shared ICT tool (SharePoint) to share information between staff members. Only 2 projects mention **BelRAI** as a coordination tool and only one project reports to use the BelRAI results but not in a multidisciplinary way.

DURATION AND INTENSITY OF THE INTERVENTIONS

Most projects did not plan a limited duration of the intervention. FOPs stay in the project as long as necessary. Three projects have set a limit of 6 months. The three case studies, all adapted their planned number of sessions per client based on their experiences.

- One project originally planned fifteen 1.5 to 2 hour sessions per client every two weeks. In reality it appears that for some clients 15 sessions were not enough, and that for others it is too much. They added the opportunity to prolong the intervention once with another 15 sessions. There was more need for shorter (one hour) weekly sessions for a longer period in time. In comparison with younger adults, FOP need more time (in weeks) to build a relationship of trust with the therapist. On average the FOP receive 10 weekly one hour sessions.
- Another case study project also indicates that not every client needs an equally amount of sessions. They started with the idea of having weekly two hour sessions with no maximum in time. Experience teaches them that 20 sessions is the maximum number of sessions needed by the FOP with a mean of 10. The originally proposed rhythm of two hours per session is now reduced to 0.5 to 1 hour per session.
- The third case study planned to have weekly two hour sessions with a maximum of 40 sessions per client and a limit in time of 6 months, eventually extendable once with another 6 months. Now they mainly deliver weekly or 2-weekly sessions of one hour, depending on the situation of the FOP

Clients that need more psychological support after the maximum of sessions or have too acute or severe psychological needs are being referred to a mental health centre in all 3 case studies.

3.5.2 THE TARGET POPULATION

These psychological projects target FOP who are 60+ and suffering from non-complex psychosocial problems and their ICG. The most common complaints are early stage of dementia, depression, mourning, loneliness and fear. FOPs are frail in terms of psychosocial factors but they need to have some good level of independence and in some projects be verbally and cognitively able to have a conversation with the therapist. It is important that the FOP is motivated, that he has a positive attitude towards psychosocial support and that he has disease awareness. Many FOPs in these projects have a very small or no social network.

Three projects did not reach their estimated caseload. One other project encountered some problems to achieve the estimated caseload due to staff problems, but overcame those problems. Four projects had no problems reaching their caseload; in fact 3 of them exceeded their estimated caseload.

3.5.3 THE SKILL-MIX

In most projects, the intervention itself, "psychological support" is done by one or more psychologists. One project works with a duo of professionals including a bachelor in applied psychology and a pastoral worker. Another project works with three psychologists and two masters on orthopedagogy that were trained as psychotherapists. This project emphasized during an interview that for them it is more important to have psychotherapists with some practice experience in the project than hiring a master in psychology who never did any field work. One project works with a bachelor in rehabilitation sciences and a master in orthopedagogy. They call themselves "levensverhaalschrijvers" (biography writers).

In most projects the project coordination is done by different people, often by a manager of a nursing home. In two projects no one has an explicit administrative function. These are the two projects in this category that have the lowest total FTE. In each of these 2 projects, only a part-time psychologist (60% and 50%) and a manager (2% and 5%) are employed.

The total FTE in the project varies from 0.50FTE to 3.4FTE. There is a link between the psychologist/FOP ratio and the cost of the project. The project (PS169) with the lowest FTE Psy/FOP ratio (1/09) has the highest annual cost per FOP (3029 euro/year). The project with the highest FTE Psy/FOP ratio (1/45) has the lowest annual cost per FOP (743 euro/year).

3.5.4 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

In 4 of the 8 projects the umbrella organisation is a nursing home (PS172, PS154, PS155, and PS168). Two projects have a GDT/SISD (PS194, PS165) as an umbrella organisation; the other two projects are projects from a SSD of the CPAS (PS170) and from a home nursing organisation (PS169).

All but one project have a coordination service as a partner of the project. Four projects have a mental health centre as a partner. One other project has a psychiatric hospital as a partner. Three projects do not mention a mental health service, psychiatric hospital, psychiatrist or psychologist as a partner. All projects have partners that can refer FOP to the projects.

In many projects, the daily functioning and organization of the project itself is discussed during both internal meetings and external meetings with partners. The meetings usually take place in the project office or at a partner organisation. The meetings with external partners happen less frequently than internal meetings. One project has no meetings with partners specified.

Most of 'psychological' projects have little structural interaction with the environment because of the fact that many FOPs in these projects do not yet have a lot of health care providers. In most cases just the GP. This carries a risk to work too fragmented. One coordinator in a case study project emphasises during the interview that one of his goals is to bring first line and second line closer together in order to avoid fragmentation of the care. It seems important that psychological support is provided to FOP at home by psychologists or psychotherapists that are working in a multidisciplinary team in order not to lose the global view on a patient.

3.5.5 ADAPTIVE BEHAVIOURS

INTERVENTION

Projects did not fundamentally change their objectives. However some projects planned to support the ICG as well but noticed that the percentage of FOP with an ICG is lower than expected. All three case studies adapted the intensity/duration of their intervention based on their experiences. They came to a more realistic number of sessions per FOP. One project implemented an ICT tool for coordination of the work between all therapists in the project (a SharePoint application). Although not yet implemented, four projects mention that multidisciplinary electronic patient files for communication and coordination of care could be very useful in the future.

WORK AREA

One project has expanded its work area to be able to reach more FOPs. Another project initially struggled with a work area that was too large. The psychologists had to travel long distances to do the home visits. They have not reduced or split the area, but they allocate new clients to a psychologist who is close by.

STAFF

One project employed a nurse who works for (and is paid by) one of the partners to enter the client data into BelRAI. This was necessary at the start of the project, because the other project staff members did not have the proper qualifications to have access to the web application. But even when the other staff could enter BelRAI, the help from the nurse stayed important and increased even in terms of working hours (from 4 hours/week to 8 hours/week).

3.5.6 EXPECTED EFFECT ON THE OUTCOMES AS A RESULT OF THE NORMATIVE ANALYSIS

Each project was scored on 7 components that were found important for psychological interventions.

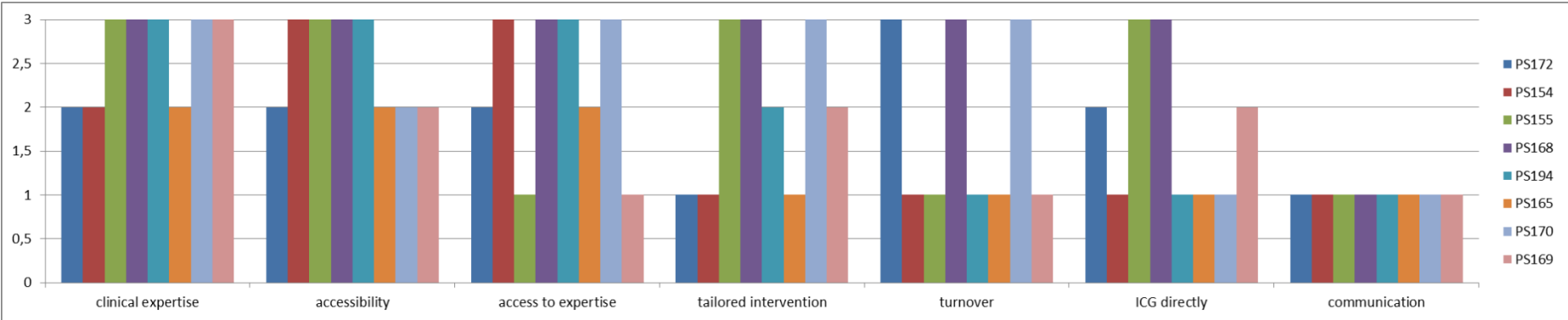


Figure 41. Scores per item of projects providing psychological support

1. CLINICAL EXPERTISE

Clinical expertise of the staff and experience in working with an older target population are important factors that will determine the success of a project. Five projects work exclusively with (clinical) psychologists or licensed psychotherapists. These are the projects that offer more standardized psychological therapies (cognitive-behavioural therapy, psychotherapy). In the other 3 projects, which offer non-standardized interventions like psychosocial and emotional support or reminiscence therapy, also social workers (and other professionals) are employed. Pre-existing clinical expertise about FOP and an interest in working with older people is necessary. This target population demands a different approach than people under 60 years old. Projects that employ adequate and experienced staff are more likely to be successful.

2. ACCESSIBILITY

A project delivering psychological interventions has to be accessible to FOP/ICG financially, geographically and culturally. There still rests a taboo on all that is 'psycho' in society. All or most projects were aware of this possible threshold. All projects offer interventions at home. Four projects offer their intervention for free, the others ask for a contribution that varies from 45 euro/year to 400 euro/year. The proportion of immigrant FOP in the projects is very low compared to their proportion in the environment of the projects. This is something projects should be aware of and try to find a way to reach this specific population.

3. ACCESS TO EXPERTISE

It is important that psychologists and other professionals working in the project have access to expertise from specialized mental health organizations (Centres for mental health care, psychiatric hospitals, psychiatrists,...). Psychological or psychiatric problems can be or become very complex. It is important that the psychologist in the project can discuss cases with specialists or other psychologists. All projects have partners that could provide expertise. In 4 projects expertise is exchanged on a regular basis. In 2 other projects expertise is shared on demand. In the remaining 2 projects there is no indication that expertise is shared.

4. TAILORED INTERVENTION

The FOP and his ICG have a central position in the intervention. The FOP has to be motivated and willing to be treated. Tailored interventions that are based on the FOP's actual needs, remaining capacity, preferences are more likely to be successful. Three projects offer tailored interventions including standardized psychological therapy and social reactivation. Two other projects offer standardized psychological therapy (cognitive-behavioural, psychotherapy) but no social component. The other 3 projects offer non-standardized interventions (support, psycho-education).

5. TURNOVER

Turnover of therapists has a negative effect on the success of the project. People do not like to tell their psychological problems to a stranger. It takes time to build a relationship of trust between the FOP and the therapist. Continuity is very important; a FOP should be having only 1 therapist during the entire period of treatment. Four projects experienced turnover of a therapist due to pregnancy leave. In two of these projects it had a clear impact on reaching the estimated caseload.

6. ICG DIRECTLY

Despite the fact NIHDI did not allow the projects to exclusively target informal caregivers, some projects did target informal caregivers directly in addition to their interventions targeting FOP. Especially projects targeting FOP with dementia will be more likely to have success if they do target the ICG directly. Four projects only invite the ICG to join a session together with the FOP if it is relevant for the FOP's therapy; for example to resolve a conflict between the FOP and the ICG. The other 4 projects offer the opportunity to the ICG to have sessions of their own. These sessions can be standardized therapeutic interventions or just non-standardized support or advice. Decreasing stress or burden in the ICG will have an indirect effect on the FOP.

7. COMMUNICATION

Communication is the component that is scored the lowest. All projects mention having problems to communicate with other healthcare providers. For projects providing psychological interventions the most important other healthcare provider to communicate with is the GP (treatment with antidepressants, general health status). Often it is even the only other health care provider in the FOP's network because the projects mention that their population does not yet need the support of other care providers.

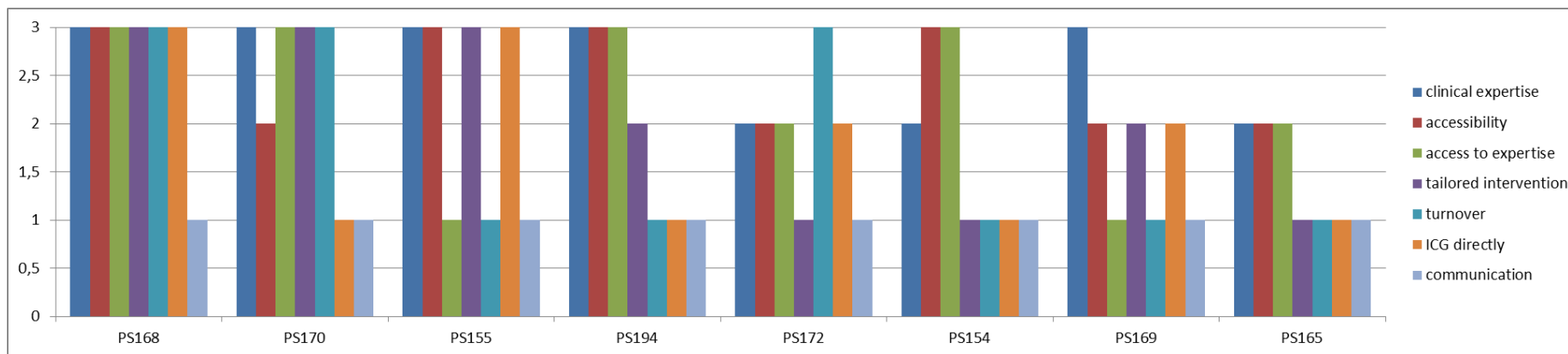


Figure 42. Scores of projects providing psychological support

The graphs of the normative analysis of the projects show the expected effect of each project on the outcomes. The higher the combined scores, the more likely the projects will be successful.

3.5.7 SYNTHETIC TABLE OF THE PSY PROJECT DATA

Table 39. Synthetic table of the features of projects providing psychotherapy or psychological support

	PS172	PS154	PS155	PS168	PS194	PS165	PS170	PS169
Objectives of the intervention	Low-threshold contact point. Early intervention (preventive). Sensibilisation.	Delay institutionalisation or hospital admission. Achieve more and longer stability in home care situation.	Better quality of life for FOP and ICG, higher coping ability for ICG, more autonomy, less hospital admissions, delay institutionalisation.	Provision of new care service in addition to existing services (filling a gap). Support for FOP and ICG.	Decrease psychological complaints, increase quality of life, stay independent at home longer. Support for FOP, ICG and other care providers.	Strengthen the identity of the FOP, increase psychological well-being and self-worth.	Delay institutionalisation. Increase autonomy, functional and cognitive status, psychosocial support, quality of life and well-being. Coordination and continuity of care. Prevention of crisis situations.	Psychological support of FOP, ICG and other care providers. Delay of institutionalisation, Better preparation of institutionalisation.
Description of services provided	psycho-education, advise, information psychosocial and emotional support Stimulation of peer-contact.	Psycho-education information Psycho-education in group	Education, information, practical advice	Psychological guidance	Individual psychotherapeutic conversations.	Life review (writing a biography)	Psychological consultations.	Psychological conversations
Total FTE	2,15	0,74	0,75	0,55	3,4	2,24	1,6	2,43
Ratio FTE psy/FOPs	1:23	1:13	1:16	1:45	1:17	1:21	1:12	1:09
Profile of expected target population	65+, early stage of dementia, partner and/or social network available, no psychiatric or neurological illness, disease awareness, positive attitude towards help.	Service flat habitants, 60+, sufficient level of independence. Frailty in terms of psycho-social factors.	ICG of FOP with early stage of dementia, FOP attends DVC of organization.	People with psychological problems (mourning, depression, dementia). Especially those with small or no social network.	FOPs with simple psychosocial problem (mourning, depression...), motivated FOP, cognitive and verbal capable to communicate with a psychotherapist.	FOP with depression or early stage of dementia, FOP with frailty in terms of physical, social and/or psychological factors.	Isolated FOP, low or no social network, feelings of loneliness, depression, and fear. FOP with dementia. FOP and ICG.	FOP with physical problem and/or dementia and ICG partner with burden as a result of the FOP's problem. FOP with no or small social network who faces his problems alone.
Expected caseload	50	10	12	25	60	49	20	23
Achievement of the caseload	yes	yes, and over	yes, problems (solved)	yes, and over	yes, and over	no (difficulties)	no	no
Recruitment means	Home care coordinators, social services, geriatrician from hospital, some GP's, hospital psychologists, home care services, reference nurse	Service flats of own umbrella organization. Referral through home care services (nurse, cleaning) and DVC (own org), family.	Through own DVC.	Occupational therapist and social worker of care zone (woonzorgzone), GP's, hospitals in the region, district health care centre (wijkgezondheidscentra)	25% through FOP or family (direct application), 43% primary care service (OCMW, GP, social worker, home care), 28% hospitals.	Local service centres, other P3-projects, CGG (umbrella org), FOP or ICG (direct).	Professionals that already provide care to FOP (home care, nurse,...), coordination centre, CPAS, CSD, ASD, ACDI, hospitals in the region (general	ASD (nurse, family care, coordination centre.

	PS172	PS154	PS155	PS168	PS194	PS165	PS170	PS169
	dementia in nursing home.			trum), local service centre.			and psychiatric)	
Partnership with coordination service	yes	yes	no	yes	yes	yes	yes	yes
Partnership with community organizations	yes	yes	yes	yes	yes	no	yes	no
Partnership with mental health centre	CGG is mentioned as partner but no indication that there are meetings	no (yes, psychiatric hospital, but only for exchange of expertise)	no	no	yes	yes (umbrella org)	no	CGG is mentioned as partner but no indication that there are meetings
Provision of feedback about FOPs to the GP	information of the FOP being in the project	information of the FOP being in the project	information of the FOP being in the project	information of the FOP being in the project	information of the FOP being in the project	information of the FOP being in the project	information of the FOP being in the project	information of the FOP being in the project
Intervisions/planned supervisions and MD group meetings to enhance the knowledge of psychologists	partners that actually provide expertise, but not structured	interview, organized exchange of expertise	partners that could provide expertise, but no indication that they do (e.g. CGG)	interview, organized exchange of expertise (external, with psychologists of the region)	interview, organized exchange of expertise	partners that actually provide expertise, but not structured	interview, organized exchange of expertise	partners that could provide expertise, but no indication that they do (e.g. CGG)
Care/service plans use	are achieved through a standardized approach (NA=1)	are achieved through a standardized approach (NA=1)	no	are achieved through a standardized approach (NA=1)	are achieved through a standardized approach (NA=1)	are achieved through a standardized approach (NA=1)	are achieved through a standardized approach (NA=1)	no
Use of BelRAI result	no	no	no	yes (but not MD!)	no	no	no	no
ICT Tool for clinical coordination	no	no	no	no	yes (SharePoint)	no	no	no
Duration of the intervention	permanent	permanent	permanent	permanent	permanent	6 months	6 months	6 months
Umbrella organisation	Nursing home	Nursing home	Day care centre	Nursing home	Coordination centre	Mental health centre	Public Centre for Social Welfare	Coordination centre
Missing elements for the project?	Faster referral in region, feedback from other providers, shared use of BelRAI or other MD- electronic file.	electronic patient files	involvement of GPs	electronic patient files for communication with GP's	More FTE because of the high number of applications (expansion of the project). User friendly electronic care plan.	no	more sensibilisation of all actors in the region	More regular contact with other care providers. Availability and adequate financing of all actors for coordination meetings.
Annual cost per FOP (euro)	2 939	2 480	2 210	743	1 448	2 962	1 700	3 029

3.5.8 CASE STUDY 17

(PS194)

1. THE CONTEXT OF IMPLEMENTATION

In the working area of the project, there is only one other psychiatric home care service for clients aged of 65 years or more. However, this service only works in the municipality and just beyond. Before the start of this P3 project, older people living in other municipalities of the district and in need of psychiatric home care had no place to go. The work area of the project is relatively large.

2. THE PROJECT AS PLANNED

OBJECTIVES

The project's objective is to preserve the home care. More concretely, the project aims at maintaining or improving the self-sufficiency and autonomy of the older people and the coping ability of the caregiver. This project wants to reach people who would otherwise never be reached because they do not dare to take the first step towards therapy or, literally, cannot take that step because they are not mobile. The project wants the quality of life and psychological well-being of this group to increase and it aims at the reactivation and the social integration of the target group. It also wants to lower the threshold to make use of psychological aid.

INTERVENTION

The project gets referrals from the social workers of the mutuality, the hospital, general practitioners or family assistance. It also happens that the client or their informal caregiver contacts the project directly. After the referral, the project coordinator contacts the potential client by telephone. She asks if the client is aware of the referral and asks if she can come over for an intake. After the inclusion, the project coordinator tells the client that a therapist will contact him for a first therapeutic session. The client receives a total of 15 interview sessions, usually once a week. Clients do not have to pay anything for the intervention. The main partner the local ISHC (GDT) sponsors the budget that is needed for meetings and coordination of the project.

The project coordinator and the different therapists all work on different locations. It is not obvious to come together at the same time. The communication about the intervention is usually done via email and phone. Monthly there is a meeting between the psychotherapists and the project coordinator. During these meetings, individual clients and practical issues related to the care are discussed.

TARGET POPULATION

The target population of the project is the frail older people living at home and their informal caregivers. To be included in the project, clients must have a psychological or emotional problem that may be due to a physical problem. Only in case of dementia, a diagnosis has to be attested by a doctor.

SKILL-MIX

The staff of the project consists of a project coordinator and 2FTE psychotherapists. Initially it was intended that the project would work with 2 fulltime working psychotherapists. But already before the start the 2FTE was filled in otherwise. There are 2 psychotherapists who work 80% each for the project. A third therapist works 20% for the project, what corresponds to 4 or 5 clients. There are also 2 therapists who each work 10% for the project. The reason for the change in FTE allocation is that before the start of the project, the psychotherapists already worked for a mental health service (CGG) partner. If they would work 100% for the project, they could not be deployed by their CGG's anymore. In the project there is a mix of young therapists with little experience and others more experienced. Next to the project coordinator and the psychotherapist, there is also a nurse working in the project.

COORDINATION OF THE PROJECT

Much time went into getting together the many partners and convincing the nursing homes to participate. At first sight, the large amount of partners is seen as an advantage because all partners can refer potential clients. But a disadvantage is that it is difficult to get all noses in the same direction. In the daily functioning of the project only 3 partners are involved: an ISHC (GDT) who supplies the administrative coordinator, the mutuality who provides workspace for the project coordinator and a home nursing organization who delivers a nurse to encode the data into the BelRAI application. The administrative coordinator of this project is also the coordinator of another P3 project providing night care, but there is no structural links between the two projects.

3. THE PROJECT AS IMPLEMENTED

The professionals of the project state that their working area is too large. In the beginning they did not take into account the distance between therapist and client resulting into too much lost hours in the car. If possible, the project coordinator tries to allocate new clients to a nearby therapist, avoiding unnecessary long work trips for the therapists.

The project is thinking about installing an upper limit for inclusion of clients (not implemented yet). In that case, clients with a psychological problem that is already too advanced will not be included anymore but referred to other mental health services. Half of the older people in the project have an informal caregiver. Many are alone.

Since the start, the project has had several changes of project coordinator, due to pregnancy leave of the first coordinator, but moreover due to the fact that the umbrella organization (mutuality) only works with fixed contracts for short periods.

A partner provided a nurse to encode data in the BelRAI. Originally, a nurse was not foreseen in the project, but none of the staff members had access to the BelRAI web application. In the course of the project, they even increased her work time from 4 to 8 hours a week. Her task is mainly to manage the BelRAI application. The project did not yet organize trainings for the staff. The therapists coach each other during intervention moments. The staff can also attend external trainings, but until now they did it not.

In the beginning, each therapist kept his own patient records in separate Excel files. These files were then sent to the project coordinator monthly, who then merged them into its own Excel file. Now they use a secure internet domain where the most important documents are stored and which holds one Excel file where all therapists put their data. The system is not quite on point, but the project coordinator wants to develop it further.

They planned to do regular home care meetings, but in practice they have not done many (or any at all). Because they have to be with 3 home care providers: P3 therapist and GP are involved but most of the time there is no 3th.

4. KEY RESULTS

The project manages to offer a free service to its clients. The included older people do not have to pay for the intervention, what is important because the threshold to use the project's psychological support service should be as low as possible. The main partner (GDT) gives financial support on top of the RIZIV budget, but that extra support goes to coordination of the project.

This project only organizes psychological support; other potential needs of the client are not being addressed. There is not a structural collaboration between the project and other home health care providers or general practitioners.

The different psychotherapists work very independently from each other. The project coordinator makes efforts to bring them closer together. She tries to implement a shared space for documents, but it is not very successful. The therapists do not like to share information on their clients.

5. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

	Objectives of the project <i>Activities</i>	Mechanisms	Expected impact
TARGET 1	<u>Improve autonomy of FOP</u> <i>Psychotherapeutic sessions at home by psychologist experienced in care for older persons</i>	Empowering FOP, Activating FOP, Stimulating to use own capacities	Improve ADL/IADL Improve QoL Delay/avoid institutionalisation
TARGET 2	<u>Improve/stabilize ICG coping ability</u> <i>Psychotherapeutic sessions at home by psychologist experienced in care for older persons</i>	Teaching situational and emotional strategies will enhance the coping skills of the ICG	Decrease ICG burden Improve QoL ICG Increase in the use of 'respite' care (e.g. day care centre for FOP, night care etc.)
TARGET 3	<u>Reach FOP who would otherwise never be reached</u> • <i>Actions to lower threshold: sensibilisation, house visits, screening</i> • <i>Contacting other care provides</i>	FOP and other care providers know about existence of psychological interventions. FOP do not fear to talk about their psychological problems	Improve use of services (health care and social care) Improved health literacy Increased self-efficacy
TARGET 4	<u>Improve quality of life and psychological well-being</u> <i>Psychotherapy</i>	FOP learns to deal with his psychological problems	Improve QoL, DRS, CPS
TARGET 5	<u>Reactivation and social integration</u> <i>Psychotherapy</i>	FOP joins in social activities	Less isolation of FOP
TARGET 6	<u>Guarantee continuity of care</u> • <i>Organising coordination meetings</i> • <i>Participating in md-meetings</i> • <i>Referring if needed</i>	Adjusting the needs and preferences of the frail older person to the service and healthcare supply	Adequate, timely care
 Contextual factors and barriers + : The administrative coordinator has a large network The filter-function of the psychotherapist-coordinator is important The psychotherapists are in the steering committee to really have a voice - : Often only a small network of professionals involved in the care for the FOP (often only GP): difficult to organise a MD-meeting			

Figure 43. Programme theory of project PS194

3.5.9 CASE STUDY 18

(PS168)

1. THE CONTEXT OF IMPLEMENTATION

This second 'psy care project' is embedded in a nursing home. It provides psychosocial support to older people with dementia and their informal caregivers through the intervention of a psychologist. The psychologist works half time for the project. The aim of this project is delaying institutionalization, reactivation and social integration. The informal caregivers are involved in the psychological counselling. There is also continuity of care on a psychological level intended. The project is focused only on the psychological health. There is little multidisciplinary approach. The cooperation between colleagues in the care area was an important positive point in the beginning. They all knew each other really well.

2. THE PROJECT AS PLANNED

The project resulted from the awareness of a social worker and an occupational therapist that made home visits in a limited care area. They were not successful in referring older persons to a mental health service (CGG) because the threshold was too high for the older people. The project wants to lower the threshold to enter the project by delivering the intervention at home and not asking for a financial contribution from the clients.

OBJECTIVES

The aim of the project is delaying institutionalization by providing psychosocial support to the older people and their caregiver through reactivation (for example: participation in activities at a local service) and social integration (for example: maintaining family ties). The informal caregivers and the frail older people are involved in psychological counselling. The project also aims the continuity of care at a psychological level.

INTERVENTION

An initial screening is done, on gut feeling, by the social worker or the occupational therapist. No measurement scales are used. During the home visit by the psychologist, she checks if the older person really needs an intervention. After that, the necessary assessments are done but the results are not directly used in the intervention. The psychologist makes sure that the referrer and the general practitioner of the client receive written feedback.

An intervention takes between 30 and 60 minutes. Initially, 2 hours per session was planned. The frequency of the intervention varies according to the condition of the older person. The duration of 1 session depends on the pace of speech and cognitive functioning, emotional openness and on the client being already used to the sessions or not.

Meetings, reports of meetings, phone calls, e-mails and a patient record on paper are the main resources for the organization of the care.

TARGET POPULATION

The target population is older people aged 60 years or older living in the work area. Referrals come from the social worker, occupational therapist, home care nurses and general practitioners in the care area.

THE SKILL-MIX

The staff consists of a half time psychologist. She also works halftime in the nursing home that is the main partner. Three times a year she meets other psychologists of the region to discuss their work and learn from each other.

COORDINATION OF THE PROJECT

The partnership of the project consists of a nursing home (main partner), the local PCSW, 4 hospitals, a GDT, a GP circle, a community health care centre, a service centre and a senior counsel. All partners are member of the steering committee of the project.

The administrative coordinator has also another P3 project of night care, but there is no structural collaboration between the 2 projects.

3. THE PROJECT AS IMPLEMENTED

The project requested an expansion of their work area. The reason was that initially they did not reach their estimated caseload of 40 older persons. Now they have a high caseload (60 instead of 40), resulting in a high workload. They do not know what they should do if applications keep coming at this pace. They do not want to work with a waiting list because the older person's care needs cannot be put on hold.

The vast majority of the clients deal with depression or grief. The project also supports people with dementia. Less than half of the clients (44%) have an informal caregiver. Despite of the high presence of ethnic minorities in the work area, they do not have clients from foreign origin. Apparently, the threshold to seek psychological help is even larger in this population.

4. KEY RESULTS

In the work area of the project there is a strong collaboration between health care professionals. The project benefits from the existence of that care area.

The project is embedded in a nursing home. The psychologist works as well for the project as for the residents of the nursing home (main partner). This has as an advantage that, especially in the beginning, she could be flexible in working more or less percentage for the project according to the caseload.

The project is monodisciplinary and they only address the psychological needs of the older people.

The threshold to seek psychological help is high for a lot of older people. The project wants to keep the threshold to enter the project low by delivering the intervention at home and not asking for a financial contribution from the clients.

5. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

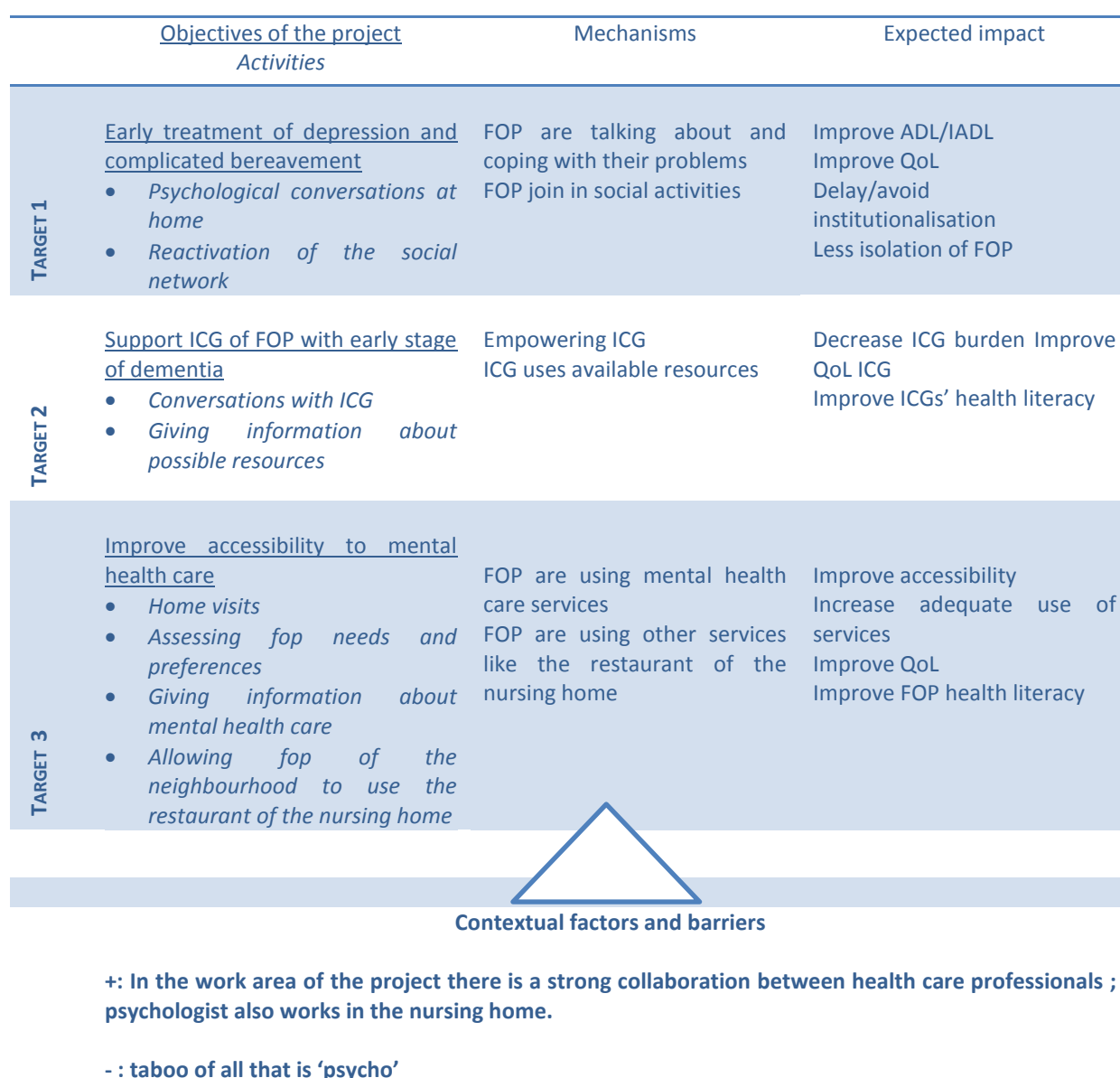


Figure 44. Programme theory of project PS168

3.5.10 CASE STUDY 19 (PS170)

1. THE CONTEXT OF IMPLEMENTATION

The project is introduced by the *Public Welfare Centre* of a big city in the South of Belgium. The idea of the project is part of the identification of a missing service in the current offer of the *Public Welfare Centre*, namely a service offering home visits by a psychologist. Its main intervention consists of home visits which are a novelty in the current service delivery. The project works in a very communal context. Despite a dense network of mental health services in the territory of the city, the services are not available and not accessible to the older population without a psychiatric profile. The idea of the project was to provide "psychological" support without being a substitute for the mental health services

2. THE PROJECT AS PLANNED

OBJECTIVES

Overall, the project aims to:

- Provide psychological support to FOP in their everyday issues to avoid placement in a nursing home (for reasons which are not bound to their status: conflicts, etc.)
- Assist other healthcare providers to improve their provider-patient relationship which would tend to deteriorate for some reason or misperceived by the practitioner
- (When nursing home placement is inevitable) prepare the older people and caregivers
- Accompany returns to home, where possible.

INTERVENTION

The main intervention of the project consists of counselling (individual or in group) at home by a psychologist. The intervention may respond to different types of situations, the project mentions following different "services":

- Service 1: psychological and psychosocial support to prevent a crisis situation.
- Service 2: communicational support between the client and / or his informal caregivers to prevent a crisis situation and/or to improve the psychosocial and psychological well-being of the FOP and ICG
- Service 3 : preparation of (inevitable) institutionalization to guarantee continuity of care and/or to improve the psychosocial and psychological well-being

The psychologist judges on the appropriateness of the intervention in regard of the individual situation. The intervention can consist of:

- Psychological interviews at the home of the FOP (individual or if relevant with spouse, another family member, neighbour, friend)
- Accompaniment (escort) of the FOP and ICG : The psychologist accompanies the older people and caregivers in different possible situations (finding housing or nursing homes , social service , ...)

The unit of activity is the intervention by a psychologist (max 2 hours/intervention). They estimate to provide 720 interventions/year. A FOP is included in the project for six months, renewable once.

Each service will be billed to the patient at the end of the month. The FOP's financial contribution varies according to their income: € 5 or € 10 per intervention.

Coordination meetings will be organized by the coordinating centre. The psychologist attends these meetings to provide a more psychological view of the person. They plan to have 40 consultation meetings/ year). FOP and ICG will be kept informed by mail or orally.

TARGET POPULATION

The project is intended primarily for frail and/or demented older people (65 and older) whether or not requiring complex care. They address both the older people living alone, married or in an intergenerational situation. The project's area of activity is the territory of the city. The caseload as planned was 18 FOP.

Beneficiaries are referred to the project by professionals who already come to the FOP's home, for example, a housekeeper or a nurse. Referrals are also done by care coordination centres in the city. The mutuality also refers clients to the project. Finally the hospitals in the region (whether general hospitals, psycho geriatric or psychiatric hospitals) refer FOP to the project.

SKILL-MIX

In total, the project involves a total of 1.5 FTE distributed as follows: 1 FTE for a psychologist (0.85 for psychological intervention + 0.15 administrations) and a 0.5 FTE for an "administrative" position (secretary).

COORDINATION OF THE PROJECT

The project has **3 key partners** (without which the project would not work):

- A nursing home placement service of the Public Welfare Centre.
- Residences of a consortium of nursing home and day care facilities.
- The *coordination centre of the local area*.

The **other** partners are:

- All homecare and social services of the *Public Welfare Centre*.
- Medical homes.
- Geriatric and psycho -geriatric clinics of the consortium.
- Nursing homes of the consortium.

The project is coordinated internally by a director of the *Public Welfare Centre* and an expert committee. Two times a year the expert committee meets to evaluate and adapt the project according to the last evaluation. This committee consists of representatives of the medical homes, psychologists and a sociologist. Also two times a year all partners have a meeting to receive information about the project.

3. THE PROJECT AS IMPLEMENTED

After initial difficulties (access to BelRAI) and many adjustments during the implementation period, the project finally found its place in the local supply of services, next to the coordination centre. However, it took some time and a lot of internal and external promotion before interprofessional tensions, caused by the fear of competition from a new care provider, diminished.

The jury noted that the risk with this type of intervention would be to offer a form of occupational support instead of psychological counselling. This risk seems to be avoided. The psychologist sets boundaries and does not accept it when the FOP expects him/her to be 'a companion lady'.

In terms of inclusion criteria the project indicates that some younger people (<60) could also benefit from the project because there is currently nothing to support them in the area. The project is now working with a population aged 60 years and older. The average age of recipients is 79 years. Regarding the profile of people included in the project the project states in the annual survey (2012): A typical FOP in this project is a single person with few or no social contacts, complaining of loneliness, suffering from depressive feelings or anxiety. Another type of FOP in this project is people with dementia. It is not uncommon that these two types are intimately related.

In terms of caseload, the project has asked RIZIV to increase its caseload from 18 to 41 FOP per year, with 20 FOP on an active list at a rate of 12 intervention sessions/FOP/year. With respect to the intensity (frequency) of interventions, the project has adapted:

Table 40. Evolution of the skill-mix since start

	Project as planned (submission file)	Project as implemented (questionnaire)
Caseload	18 FOP /year on active list	41 FOP/year
FOP on active list	18 (idem)	20
Frequency of interventions	1 intervention (2h max) / week / FOP	2 interventions /month / FOP
Units (consultations) /FOP / year	40	12
Total units of intervention / year	720	492

The composition of the partnership has changed somewhat since the beginning, but mainly for administrative reasons. The project reports that the current partnership is not the perfect partnership. They could benefit from having a medical home as a partner and a coordination centre.

Currently (2013), the project has no steering committee anymore. If a problem arises, the project turned to the researchers of the consortium for the scientific evaluation.

The project relies heavily on a psychologist hired in the internal reserve of the umbrella organization, without special experience with FOP. There is no formation organized by the project for the staff. During the first months of the project, the psychologist was formed "on the job". During the years, the psychologist regularly participates in seminars.

Currently (2013) the unit of activity is one home visit, which lasts an hour (plus transport). The average frequency is 2 interventions per month for 6 months but may be adapted, depending on the FOP's situation. In terms of intervention units per year, the project introduced an amendment in June 2012 to reduce this number (initially 720) to 492 units. (48 home visits / month; 20 patients / month)

Initially it was expected that the FOPs should be included in the project for 6 months to 1 year maximum starting from manifesting FOP support needs. Once the "crisis" passed, that the FOP should be reoriented to a mental health if psychological problems persisted. In practice, the project realized that it was not so easy to "step down" to the mental health centre because they target a different population.

4. KEY RESULTS

In terms of affordability, the contribution requested from the older people (between 5 and 10 euro per intervention) limits the access of the population to the service. To what extent is unknown, but the psychologist mentions repeatedly that the asking price is a barrier for the target population. Thus, some FOP have decided to leave the project for financial reasons. According to the psychologist of the project, some beneficiaries will deprive meal to benefit from the consultation.

Besides financial reasons (FOPs contribution), the factors that have limited the implementation of the intervention at achieving its caseload are the same as those faced by other projects of psychological support. At the level of the intervention as proposed, we can mention the resistance of the FOP with regard to all that is "psy ". Another difficulty encountered by the project was to be known and accepted by other professionals within the CPAS or in the FOP network. As in many projects, collaboration with GP is problematic.

5. MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

	Objectives of the intervention – <i>Resources & activities</i>	Mechanisms	Expected impact (results)
TARGET 1	<u>Provide support to FOP (psychological support and other) for their everyday problems in order to avoid placement in a nursing home.</u> 1. <i>Implement the function of psychologists in the home care service of the CPAS</i> 2. <i>Promote the service within the system</i> 3. <i>Individual or group therapy</i> 4. <i>Improve communication between the FOP, its ICG and health care providers ("make the connection")</i> <u>Helping other health care providers</u>	1. FOPs are doing what they still can still do themselves; 2. FOP are requesting information on the services they can benefit from 3. FOP are regaining control (dressing ...) 5. FOP are aware of their limitations	Avoid hasty and unnecessary institutionalizations: 1. Avoiding relationships between providers and the FOP to degrade (conflict management); 2. Adapting the home (the psychologist who said do some occupational therapy). 3. Enhance the autonomy of the FOP 4. Improve the well-being of FOP
TARGET 2	1. <i>Participate in consultation meetings and provide psychological insight</i> 2. <i>Organize consultation meetings (when no coordination)</i>	Better collaboration between healthcare providers	
TARGET 3	<u>Accompany returns to home</u> 1. <i>Visit the health care team when the person is hospitalized</i>	Transition between hospital and home is well organized	
TARGET 4	<u>(When nursing home placement is inevitable) Prepare the older people and caregivers to the change of place of living.</u> 1. <i>Making contact with the institutions</i> 2. <i>Accompanying the FOP and its ICG.</i> 3. <i>Organisation of consultation meetings</i>	Transition from home to nursing home is well prepared	
 - Implementation of new services: fear of competition, interprofessional tensions ...; - limited offer of services (mental health), saturation of the system; - Resistance of the FOP with respect to the "psy" function; - Financial limits ... Contextual factors and barriers			

Figure 45. Programme theory of project PS170

3.5.11 KEY RESULTS OF PROJECTS PROVIDING PSYCHOLOGICAL SUPPORT

All projects in this subgroup offer psychological support to frail older people living at home. The objectives of the projects are similar. They aim at delaying institutionalization, improve reactivation and social integration and they want to lower the threshold that exists for seeking psychological help. In the projects only half of the clients or less has an informal caregiver. This is low, comparing with other types of projects. The projects involve the informal caregiver, if applicable, in the intervention.

The projects have a monodisciplinary approach, focusing only on the older person's psychological needs. There is little multidisciplinary collaboration. However, the second case study project (PS168) claims to benefit from the existing strong collaborating between different health care providers in the care area. Probably the collaboration stays mainly on the level of referral.

In the first case study project (PS194), most referrals come from social workers of the mutuality, the hospital, general practitioners and family assistance. In the second case study project (PS168), referrals come from social workers and occupational therapists working in the care area, home care nurses and general practitioners. In the third case study project (PS170), most referrals come from the home care services of the CPAS. The differences are linked to the partnerships of the projects. In the first case study project, the mutuality is a main partner. In the second one, there is no mutuality in the partnership, but the care area is a main partner, in the third project the CPAS is the main partner. In the other 5 non-case study projects in this subgroup the partners are the main referrers of FOP.

In the first case study project, the initial contact with the FOP is made by the project coordinator. She makes a phone call followed by a home visit to assess (using scales) if the client is eligible to be included in the project. In the second case study project, a social worker or occupational therapist makes a first assessment (gut feeling). Based on the assessment, the psychologist decides if the client is eligible for inclusion. In the third case study project the psychologist makes the first assessment. The main difference between the ways of performing assessments in all 8 projects in this subgroup is the level of evidence based practice. In relation to the therapeutic sessions, all 3 case study projects are flexible in the intensity of these sessions according to the older person's condition or needs.

The composition of the project's staff differs between projects. Where the first case study project has 5 psychotherapists working 20% to 80% with a total of 2FTE plus a part time nurse, the second case study project employs 1 half time psychologist and the third case study employs 1,5FTE.

In order to keep the threshold as low as possible the projects deliver the intervention at the client's home. Four projects deliberately do not charge the client anything to maintain the threshold as low as possible. One project asks for a contribution depending on the FOPs income. The other 3 projects ask a fixed contribution. One project mentions that they ask for a contribution because they have the opinion that FOP will have more respect for the intervention if they have to pay for it.

The threshold for seeking psychological help is high. Possibly even higher in some subgroups of society like ethnic minorities. Actions to lower that threshold are delivering the care in the older person's home and offering free services.

Cooperation with other healthcare providers in the same work area is very important. Especially since the projects can only offer partial support, namely psychological.

3.6 PROJECTS PROVIDING 'OTHER' SERVICES (N = 5)

3.6.1 PROJECT PROVIDING AGENDA MANAGEMENT (N=1) (O188)

This project was part of the case studies, but was visited only once during the first interview round. It was replaced by another (more complex) project for the following interview rounds because this project was seen as not very complex.

The general objectives of this project are to improve the quality of life and the autonomy of the FOP and to avoid or delay institutionalisation. By helping the FOP from a distance to give structure to their day planning and remind them of things, they aim at unburdening the informal caregiver who usually is the one who has to remind the FOP to take medication, go to an appointment, etc. The project aims at improving the FOP's social integration by reminding them of socio-cultural activities in the neighbourhood. Another aim is to be able to manage a more efficient staff deployment and avoid unnecessary house visits.

3.6.1.1 INTERVENTION

The project offers telephone care. The ICG or the FOP himself remains the manager of the FOP's agenda and makes the necessary appointments. In the beginning, every month and in case of changes the ICG or FOP communicates the agenda to the project by mail or phone. The project takes care of calling the FOP to remind him of his appointments.

After the application, mostly through 1 of the partners, one of the staff members of the project contacts the ICG and/or the FOP. They always make sure that the FOP is motivated to collaborate. If that is the case, the intake is done, preferably with both ICG and FOP present. After the intake, the agenda is made up for a first time together and they agree on a date to start sending the reminders. The agenda is then communicated to the dispatchers of the call centre who enter the agenda in a software program. When a FOP needs to get reminded of an appointment, the dispatcher gets a notification on his screen and calls the FOP.

3.6.1.2 TARGET POPULATION

The target population is FOP with an early stage of dementia, depression or a psychiatric problem. They are disoriented in time and need help to structure their day-to-day life. Most referrals come from the PCSW, social workers, hospitals and family help services. The expected caseload is 90FOP/year.

3.6.1.3 SKILL-MIX

The project coordinator (0.3FTE), a communication specialist, has experience in project management. She does not have direct contact with the FOP. The project employs a psychiatric nurse and a speech therapist. They are responsible for the intakes and Belrai. There is a team of 16 call centre dispatchers. They are a mix of nurses and administrative employees. If necessary the administrative employees can call a nurse on duty 24/7 with their questions. The dispatchers not only work for Protocol 3. The selection procedure is thorough and all new dispatchers have to take a course in the first few weeks to get to know the job.

3.6.1.4 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

The work area of the project covers 5 neighbouring municipalities. The project uses the same work area as the 2 of their partners (a local service centre and a nursing home). The intervention is new and the project did not notice any counteraction from care providers in the work area. The umbrella organisation is a large well known home nursing organisation. The administrative coordinator is also coordinator of another Protocol 3 project (O160). For now, there is no collaboration between these two projects because they operate in different work areas. In the future however they want to integrate the 2 interventions.

3.6.1.5 ADAPTIVE BEHAVIOURS

In the beginning they promoted the project to their partner organisations but they noticed that they did not reach people that were close enough to the FOP. They changed their promotion strategy and went straight to those care providers who had direct contact with the FOP like home nurses and family aids. This adaptation had a positive effect on the number of applications.

Originally the target population was only FOP with an early stage of dementia. They opened up to FOP with psychiatric problems because of an existing need in the community.

They planned to focus their intervention to health related agenda items only (medication reminders, doctor's appointments, etc.). Gradually they added more items (reminder of social activity in local service centre, hairdresser appointment, etc.) with the objective to unburden the informal caregiver.

3.6.1.6 KEY RESULTS

- No turnover problem of staff because of the thorough selection procedure and on the job training of new employees.
- Answering to an existing need showed that FOP with psychiatric problems can also benefit from agenda management to structure their days.
- In promoting a project it is important to reach those people who are directly in contact with FOP.

3.6.1.6 MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

	Concrete objectives of the intervention – <i>activities</i>	Mechanisms	Expected impact (results)
TARGET 1	Structuring the day • reminder calls from a dispatcher • agenda management	FOP does not forget to take medication, to go to appointments. FOP has a normal day-night rhythm.	Improve quality of life Improve autonomy
TARGET 2	Unburden the informal caregiver • help with agenda management • take over task to remind FOP	ICG is less stressed ICG feels less responsible if FOP forgets an appointment	Improve QoL of ICG Decrease burden
TARGET 3	More efficient employment of professionals • (video)phone calls by professional • Care from a distance	Less time spent travelling between patients	More efficient care
TARGET 4	Social integration of FOP • reminders of social activities • stimulating FOP to go outside and join in activities	FOP takes part in social activities	Improve QoL Decrease loneliness
			
Contextual factors and barriers			

Figure 46. Programme theory of project O188

3.6.2 PROJECT OF MEDICATION MANAGEMENT (N=1)

O160

During the first year of the project it was difficult to get the needed information for the evaluation from the project because of difficult communication with the project coordinators. Therefore what is known about the project is not very in-depth information.

The objective of the project is to guide the FOP towards a more efficient medication use and to avoid institutionalisation by improving adherence to chronic medication intake. They want to come to a better collaboration between nurses, general practitioners, pharmacists, informal caregivers and FOP.

3.6.2.1 INTERVENTION

The project offers 3 interventions.

1. Medication care by a nurse: A nurse will ensure that the medication is picked up at the pharmacy and helps the FOP to properly take the medication. The nurse consults the FOP's medication schedule in the healthcare portal 'zorgportaal' or keeps his own medication schedule if the healthcare portal can not be used. The nurse consults with the doctor and pharmacist in case of problems and deletes or adds medication when modifications are made.

2. Delivery of medication by dose in the pharmacy based on the medication schedule in the healthcare portal: The pharmacist drafts the medication schedule, follows up changes and gives access to the care providers involved, the FOP and the ICG. The pharmacist visits the doctor and the patient and makes an inventory of the medication present at the FOP's house.

3. Telemonitoring : When the FOP uses this system it will record that the FOP takes medication from the dispenser. When it does not happen an alarm is generated in the call centre and the dispatcher contacts the FOP or ICG.

3.6.2.2. TARGET POPULATION

The target population is FOPs who still have a certain level of autonomy and are physically capable of taking their medication on their own, but struggle with manipulating the medication, keeping the overview, forgetting to take the medication.

3.6.2.3 SKILL-MIX

They employ 1,5 FTE nurses to provide the services. A nurse is hired for 0,3FTE to be the project coordinator and for 0,2 FTE to be a developer of project information.

The pharmacists and the dispatchers in the call centre are indispensable for the project but are not paid by P3-budget.

3.6.2.4 PROJECT'S EMBEDDEDNESS IN THE LOCAL SYSTEM

The umbrella organisation is a large well known home nursing organisation. The administrative coordinator is also coordinator of another Protocol 3 project (O188). For now, there is no collaboration between these two projects because they operate in different work areas. In the future however they want to integrate the 2 interventions.

3.6.2.5 ADAPTIVE BEHAVIOURS

The project encountered problems to reach the estimated caseload. They mention that they needed more time as estimated to convey general practitioners. They underestimated the workload linked to including FOP, especially mapping the FOP's medication situation. In 2013 they received a red alert from RIZIV with regards to the caseload.

3.6.2.6 KEY RESULTS

- It takes time (more than usually estimated by projects) to get the collaboration of the general practitioners.

3.6.2.7 MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

	Concrete objectives of the intervention – <i>activities</i>	Mechanisms	Expected impact
TARGET 1	<u>Guide FOP towards a more efficient medication use</u> • <i>Medication care by a nurse: update FOP's medication schedule, pick up medication at pharmacy, help FOP to take medication</i> • <i>Telemonitoring</i>	FOP taking the correct medication at the correct time.	Improve medication adherence Avoid medication-related problems/complications Improve QoL Improve independence
TARGET 2	<u>Collaboration between different care providers</u> • <i>Pharmacist visits GP and FOP to update medication schedule</i> • <i>Nurse consults with the doctor and pharmacist in case of problems</i>	Medication schedule is up to date and available to all care providers through the healthcare portal	Better MD collaboration Avoid misunderstandings about medication intake



Contextual factors and barriers

Figure 47. Programme theory of project O160

3.6.3 PROJECTS PROVIDING ALTERNATIVE HOUSING (N = 2)

The two projects included within this category provide an alternative housing to the nursing home. This is somehow halfway between a private home and a nursing home because of the proximity of cohabitation of seniors and some cares can be delivered. One specific aspect of these housings is that they are addressed to a limited group of people who have to share some common rooms. To rise the “at home”-feeling, the housing is mostly a house instead of a building.

3.6.3.1 DESCRIPTIVE AND COMPARATIVE ANALYSIS OF ALTERNATIVE HOUSING PROJECTS

Amongst these two projects, one is a French speaking project and the other is a Dutch speaking project.

The first one that regroups two different housings has been created and is actually supported by a PCSW from a big city of Belgium. These collective dwellings are intergenerational and each welcome four 60 aged or more persons and a single-parent family with two children maximum. According to the project, this type of housing is really interesting for lonely people or feeling unsafe in their own homes and who a daily framing becomes useful. In this project each senior has a privative bedroom. A bathroom is shared by two persons. The living room, dining room, kitchen, terrace and garden are common to all the inhabitants of the house. A lift has been placed in order to facilitate access to the floors. The rent is quite cheap and turns around 260 euros per month in adding charges. The single parent family has two bedrooms with mezzanine, a privative bathroom and toilet. She has also access to the common rooms and pays about 100 euros per month to cover charges. A social worker coordinates the two housings and is available to manage or implement a possible home care network in working with the elderly.

The second project has also a PCSW as umbrella organization. It proposes an alternative housing to cognitive impaired patients. To avoid (re)admission in psychiatric hospital, the project offers the possibility to those patients to be admitted in an adapted structure. The objective of this structure is to create a home situation and to provide stability and safety to cognitive impaired people. The links with psychiatric caregivers are very important. This house is made for five residents. A multidisciplinary team visits them regularly. Their main activity is psychosocial support.

3.6.3.2 DESCRIPTION OF INTERVENTIONS

Table 41. Interventions provided in different types of alternative housing

	Type of intervention	Description of services provided
O147	Alternative housing for cognitive impaired FOP	Household activities; ADL-support by nurses or nurse assistants at home; Psychosocial support by social worker; Participation in MD meetings
O148	Intergenerational housing	Care coordination between different care providers; Social support

These two projects propose an alternative housing to the retirement home but provide some different types of interventions and services. One focuses on cognitive impairments with more care services while the other insists on the intergenerational link. The first one is such as a little nursing home outside the structure: a partner of the project is a nursing home settled close to the house where the five FOPs live. The principle of this project approaches the one of ‘cantou’. A ‘cantou’ in Belgium is a place of community life, small size, especially dedicated to patients with dementia in which shares and communication are promoted in order to

maintain them into a stimulating environment. The second one puts more emphasis on the support that is provided by the single-parent family as an informal care giver may do and finally recreates what we used to see few years ago when cohabited within the same family several generations. The social worker engaged by the project is not here to provide care but to manage some potential care providers and plays a case manager role.

3.6.3.3 SKILL-MIX, TARGET POPULATION AND CASELOAD

Table 42. Target population and skill mix of projects of alternative housing

	O147	O148
Profile of professionals in the project	Nurse assistant; Nurse; Rehabilitation science undergraduate	Social worker
Total FTE involved and paid by the project	1,11	1 FTE of which 0,3 paid by the project
Profile of expected target population	FOPs with cognitive troubles	Isolated FOPs socially impaired
Caseload	5	8
Achievement of the caseload	Yes	The caseload has not been reached or with difficulties
Partnership with coordination service (SISD/SEL/GDT or CCSSD)	Yes	Yes
noADLCPScps	13%	67%
lowADLonly	13%	17%
highADLonly	13%	0%
highCPS	63%	17%
Monthly cost per FOP	615 euros (participation to care)	Rent of 260 euros + charges

We can easily see the concordance between the profile of their expected target population and the profile of their effective beneficiaries: 63% of FOPs from the project that targets cognitive impaired persons have a bad score to the cognitive performance scale. People from the second project have generally no impairment or other than physical or cognitive (67%). An important wish of this project was to target and 'give a chance' to socially and economically disadvantaged elderlies.

Profile of professionals engaged under Protocol 3 is different according to the project and reflects well the way they want to follow and people they want to target. The Dutch speaking project is more into the cares and has engaged providers for this while the French speaking one chose a professional who is not involved in care but rather in their managing.

Whatever the project, the caseloads are quite small but also logical according to number of places by house and the residence time: one project has one house with five places and the other has two houses with four

places each. In parallel, the budget paid by P3 per year is not huge compared to other projects: 52.288,82 € for the Dutch speaking project and 49.711,33 € for the French speaking one.

The cost per patient really differs from one to the other project. For the first one, the each FOP's rent is paid by Protocol 3 budget while the cares are funded by patients. For the second, the rent and the potential care are already financed by the beneficiary himself while Protocol 3 is used to pay a part of the social worker's time. This one has maybe a more long-term thought than the other because the Protocol 3 budget has no incidence on what the patient benefits from (except for a part of social workers' time) whereas within the other project, the FOP's rent is paid by Protocol 3 which means that if it stops beneficiaries will have to pay more than now (with P3 budget).

3.6.3.4 ORGANISATION AND COORDINATION OF THE INTERVENTIONS

For the French speaking project the social worker organizes his entire job, manages his own interventions and those of other care providers. He's responsible of the coordination of all interventions. The project coordination is administered by the umbrella organization, the director of the nursing home partner and the social worker.

For the Dutch speaking project this is the coordinator who manages the professional's schedule. The same coordinator participates with the nursing home direction (director and director assistant) to the project coordination.

3.6.3.5 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

Table 43. Proxies of projects' embeddedness in the local system

	O147	O148
Partnership with community organizations	No	No
Involvement of GP	No GP are not involved	Yes GP are well involved
Provision of feed-back about FOPs to the GP	Yes	Yes
Provision of feed-back about FOPs to the other professionals	Yes, when it's asked	Yes, systematically
Umbrella organization	PCSW	PCSW

As the table shows us above, the French speaking project had no problem with the GPs involvement. However, this same project declares that one difficulty was that several elderlies had no GP what was an important obstacle to organize the potential cares around them and to fill in the BelRAI instrument correctly. As for the GPs the two projects send feed-back to the other professionals working around the FOPs, when it's asked for the first and systematically for the second.

3.6.3.6 CHANGES AND ADAPTATIONS INTRODUCED IN THE ALTERNATIVE HOUSING PROJECTS

The Dutch speaking project has not known any changes while the French speaking one has adapted its convention in amending the budget down (less than 1.000 euros per year). It let us think the two projects were well thought before their start.

3.6.3.7 DIFFICULTIES REPORTED

The French speaking project reported several difficulties:

- As explained above, the absence of GP for some FOPs that is an obstacle to care organizations and the filling of BelRAI instrument.
- The community life that can be a favourable support has raised some reluctance from potential beneficiaries even if they were really isolated what made caseload's reaching difficult. According to the project, if necessary an elderly plans going to a nursing home rather than an alternative housing.

3.6.4 PROJECT PROVIDING RESPITE CARE (N=1) (O159)

Amongst the 'other' projects being part of the case studies, one project offers 'respite care' to the FOP and its informal caregiver. This project was followed during three years and offers an intervention consisting in a combination of : 1) a provision of care (including psychological care) and a supervision at home to the FOP by a multidisciplinary team during three consecutive days and two nights and 2) a monitoring period of six months.

The project was conceived and written by the director of the local Home Care Coordination Centre (HCCC). The design of the intervention was inspired from the *Baluchon Alzheimer's* service, but is provided in a slightly different way: the 'respite' period is shorter and prepared by the means of home meetings by a psychologist, who is also the coordinator of the project.

To benefit of a respite intervention, the demand has to come from the informal caregiver (often the husband) and to be expressed to one home caregiver. The caregiver has to transmit the demand to the coordinator (the psychologist) of the project. It was initially planned that a same person could ask one intervention a year.

The project started end 2010 because they were not ready to start earlier (difficulty to catch clients, as described below).

The intervention as provided had a double objective: first, to support the ICG by allowing him/her to leave the home during three days; second, to offer a multidisciplinary support and follow-up to the FOP, allowing a better assessment of its needs.

3.6.4.1 THE INTERVENTION

A 'respite intervention' includes the psychological preparation, the day and night respite intervention itself, and the follow-up of the situation, six months after the respite package. The respite intervention itself is delivered by a family help, an educator and a volunteer who stays during the night. During the intervention, it is asked to the informal care giver to leave the home. The intention is to help him to change his mind.

The coordination of the whole intervention is entirely taken up by the coordinator (psychologist) who works full-time in the project. The information about each beneficiary is gathered into a patient record which is shared between all the partners / participants, and which provides the basis for the coding of the data in the BelRAI.

One of the particularities of the project is the central role of volunteers as a key element of the intervention that was clearly identified as a challenge by some partners of the project.

3.6.4.2 THE TARGET POPULATION

The target population was initially defined as 'frail elderly people who need complex care, including patients with dementia, and having a C reimbursement status. Those people were estimated at 600 in the area of activity of the project (that is the same than the one of the HCC), and the demand of such a 'respite care intervention' was estimated at 100 per year. The project expected initially to provide 90 interventions a year.

3.6.4.3 SKILL-MIX

Initially, it was planned to recruit 1,48 FTE psychologist, 1,37 FTE educator and 12h family help per respite intervention. Because of the difficulties of the project to catch beneficiaries, the project recruited a 1 FTE psychologist and FTE educator (0,5 FTE each).

3.6.4.4 PROJECTS' EMBEDDEDNESS IN THE LOCAL SYSTEM

This 'respite' project is implemented in a rural area in the south of Belgium, characterized by long distances between providers and beneficiaries. Some healthcare services (e.g. day care centres) are lacking.

During the preparation phase, the project has been presented to all the potential partners. Because some of them had suspicions regarding the 'neutrality' of the project and the use of its public funding, this 'problem', typical of the political and ideological partitioning of the healthcare system in Belgium, was resolved by the representation of the independent nurse profession in the steering committee of the project.

The main 'strategic' partners of the project are a panel of organisations involved in the home care sector to deliver care to FOP, and are supposed to be able to refer some beneficiaries to the project: a nursing home organisation, a coordination centre, two home care services, a geriatric hospital service and the GP. Furthermore, the project has some 'operational' partners that are a volunteer association, a hotline service and a respite service for people with Alzheimer. The participation of the volunteers in the project was clearly facilitated by the privileged links between the promoter of the project and the volunteer association and most of the volunteers are former nurses of the umbrella organisation.

Implicit tensions were present in the partnership. For example, besides the suspicious partners, the 'Baluchon Alzheimer' partner, which inspired the design of the interventions, was a potential concurrent of the project.

The partnership was coordinated by a steering committee including a seat for each partner. This committee played a strategic and evaluation role in the management of the project. Each included situation was examined and discussed during the steering committee meetings that were planned on a monthly basis.

3.6.4.5 IMPLEMENTATION ISSUES

The project started at the end of 2010. But despite an important promotional work made by the coordinator to promote it by encouraging the home professionals (nurses) working for the umbrella organization to propose the intervention to the couples of FOP and their ICG they visit, the project faced difficulties to recruit beneficiaries and to reach its caseload. In fact, in a first time, very few demands arrived to the coordinator. In December 2011, after 13 months, the project organized 19 respites intervention, instead of the 50 expected (and 45 after two years). Because of this, the total FTE of the professionals recruited in the project is less than planned.

The project faced an unexpected but important hindering factor: the targeted population seems not to be attracted to the respite care as provided. The intervention as proposed seemed acceptable only for some type of ICG. Spouses ICG, in fact, seem reluctant to accept the intervention because they had to leave the home, contrarily to the children ICG, who accept more easily the intervention.

Other reasons of this 'resistance' from a part of the targeted population vary from the different professionals' point of view. According to the manager of the project, the intervention require that the FOP and his/her ICG 'make the step' to ask it, but they are often close related, closely dependent from each other, and the threshold is too high for some couples. The 'resistance' to the 'respite package' is thus explained by the typical psychological dynamics of the 'fusional dyad'. According to the coordinator, the respite concept may induce feelings of culpability of the ICG. According to another professional, the intervention as proposed implies a kind of home invasion by a set of professionals, what older people do not appreciate.

3.6.4.6 ADAPTIVE BEHAVIOURS

In order to overcome this important hindering factor, some adaptations have been introduced in the inclusion criteria and in the way the intervention was offered : 1) an extension of the target population to people with A and B reimbursement status and to people with dementia; 2) the provision (if asked) of a second respite within a year ; 3) a decrease of the caseload from 90 intervention a year to 50 ; 4) an extension of its catchment area; 5) an extension of its partnership, in order to include another potential referrer ; 6) a better preparation of the respite, by a psychological support. In July 2012, the target population was re-defined as : 'people aged of 60 or more and presenting either a A,B or C score on the Katz scale, or suffering from dementia'. But even so, the caseload was difficult to be reached.

3.6.4.7 KEY RESULTS

The results from this case study are interesting for the future, because they allow us to learn a lot about the real needs and values of some dyads composed by the FOP and his/her ICG and, subsequently, of the acceptability of this type of project. In fact, there was a 'gap', in the conception of the project, between the expected and the real needs of the target population. By consequence, the project benefitted only to a part of the initially targeted population. A defined population is generally not so homogeneous than it is expected at first sight, what may have as a result that the intervention is inappropriate for a part of these population. What is acceptable for some dyads might be unacceptable for the majority. Moreover, the project is rather rigid in its design: one package of three days/two nights, once, maximum twice a year and prepared by a psychological intervention. Informal contacts with partners of this project showed that the need for respite has to be more flexible and the response time more short, in order to be able to offer respite in emergency situations.

The difficulties met by this project during its implementation process show that the success of an innovative service depends not only on the abilities of professionals to deliver the service provided, but that values, social and psychological characteristics have also to be taken into account and addressed appropriately.

Besides the issue of the complexity of the targeted population, the intervention as proposed is more based on intuition than on theory or evidences. The scientific literature, for example, illustrates well that FOP rarely easily accept respite care. Furthermore, it is not clear through which mechanism the intervention as proposed may have an impact on the risk of FOP institutionalization over time. Eventually, it is evident that the 'respite package' as provided is only relevant for some dyads, and under some conditions.

- **Despite an important promotional work, the demands for respite care were lower than expected because of the gap between the values and preferences of part of the target population and the way intervention aiming to cover their needs were designed.**
- **The experience of the project has shed a light on the necessity to make a distinction between the ICG as spouse/husband of the FOP or as descendant in order to assess adequately their respective needs and values.**
- **The target population was seduced by the respite 'package' as proposed, because it is not so easy for the some ICG to leave its frail spouse during three days and two nights, and because it is too short for others.**
- **Others type of respite (e.g. more responsive and/or more flexible) may be more attractive for the targeted dyads.**
- **The respite concept seems to induce culpability feeling that is not easily manageable. In order to face this resistance, some changes have since been introduced in the design of the project.**

3.6.4.8 MECHANISMS THROUGH WHICH THE PROJECT EXPECTS TO ACHIEVE POSITIVE OUTCOMES

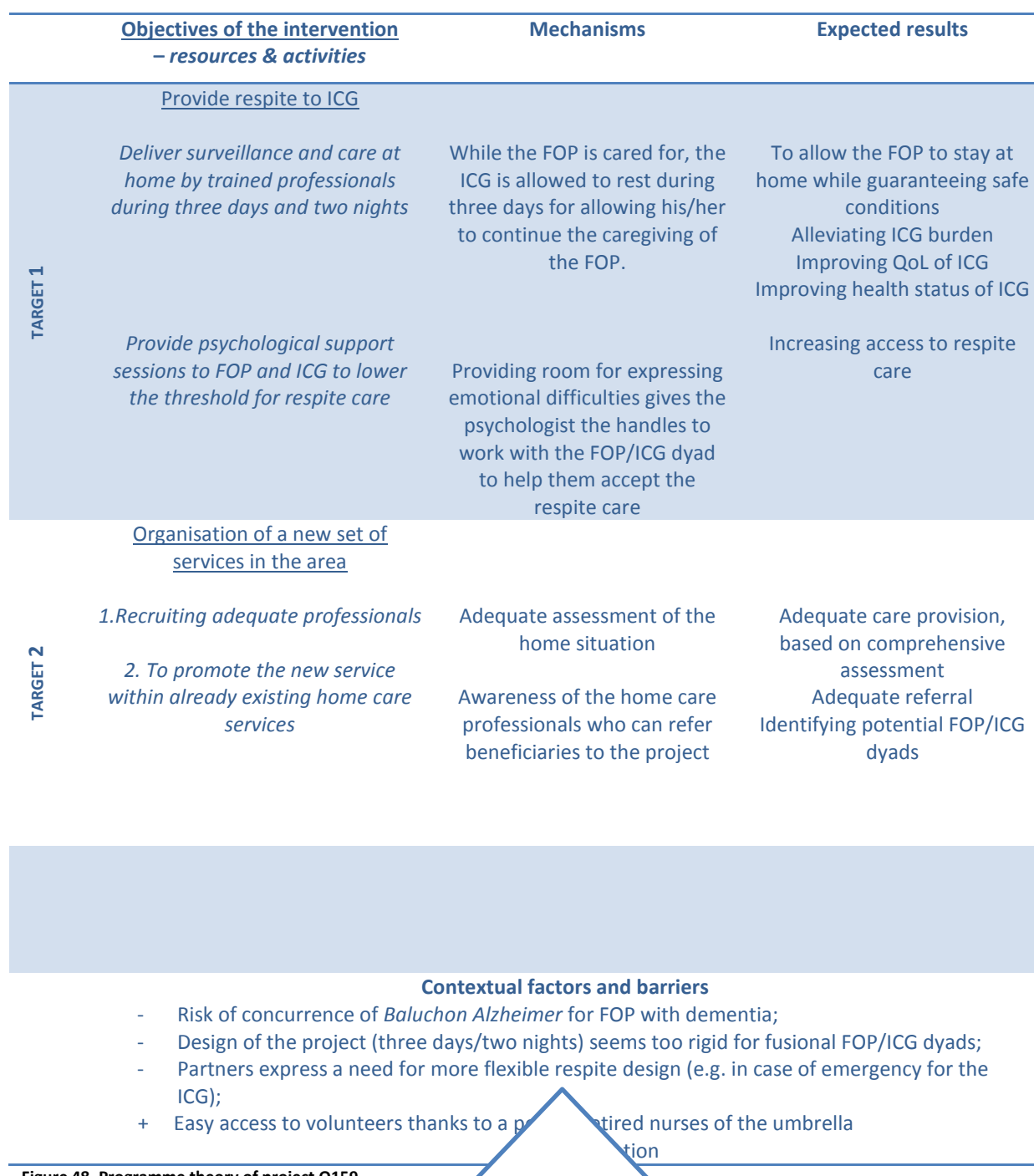


Figure 48. Programme theory of project O159

4 RESULTS FROM VALIDATION GROUPS

As mentioned in the methodology section, four validation groups were held in September 2012. During these meetings, preliminary emerging results from the case studies were presented and discussed with project coordinators and frontline professionals working in projects which were not part of the case studies.

This allowed gathering of more extended qualitative data from 40/63 projects, which is, of course, very helpful to have a more in-depth understanding of the implementation processes, as projects unfold. All previous findings regarding the implementation processes were confirmed by these validation groups and the methodology allowed the emerging of new findings regarding 24 projects' experiences. The discussions were held in separate moments, in order to enable discussions in homogeneous groups, regarding language and decision level in the projects. We were unable to gather sufficient large groups with professionals coming from similar types of projects, e.g. gathering only professionals from projects providing case management, etc. However, the rhythm of the discussion, along with the findings from the focus groups showed that, even if the projects were dissimilar in service provision, they shared more or less common experiences regarding implementation processes, contextual challenges and adaptation processes. The key results of these validation groups are presented below, gathered by theme.

4.1 COORDINATION.

Overall, projects confirmed that the time, money and energy dedicated to coordination at the frail older person's level was grossly underestimated. Moreover, some projects stressed the need for a certain degree of formalization of the coordination of information and healthcare around a single FOP. Those were projects taking into account the global needs and preferences for healthcare of the FOP and were case management projects. They highlighted the fact that, when multiple care providers deliver care to the FOP and because the FOP is reluctant to have to deal with ever-changing people, this formalization of shared information is crucial. Those projects stressed the fact that their project would merely benefit from a software allowing to share information with care providers outside their project, e.g. with GPs. One project had also conceived an interprofessional care protocol, in order to be able to deal with the CAPs of the BelRAI, per discipline, which helped to define the roles of each professional in their project.

At the other hand, other projects, mainly projects providing occupational therapy and psychosocial or psychological support, used much more informal exchange or, in some cases, used a notebook, remaining at the FOP's home, where each professional wrote remarks about the FOP situation, in a non-structured way.

Projects also highlighted some problems linked to the use of tools for sharing information:

- When only a notebook exists to formalize the information needed among professionals, this is really a problem, as concerns about the confidentiality of the data rise within projects providing psychological support for instance.
- One project reported the situation of FOP having five notebooks at home at the same time.
- Non-interoperability of software between organizations, i.e. in the case of existing electronic patient records of partner organizations.
- Ignorance or indifference for the need for information of care providers from other disciplines, e.g. an occupational therapist having difficulties in obtaining information from a nurse from another organization, or from GPs.

Projects also stressed some adaptation processes, in order to overcome the abovementioned limitations :

- Use of a single interdisciplinary notebook, remaining either at the FOP's home or in the coordination center.

- For the case management projects, this notebook is filled out by every professional, except for the psychologist, for which the communication channel remains informal (phone and e-mail).

4.2 INTERACTION WITH PARTNERS OR UMBRELLA ORGANIZATIONS.

Projects agreed that they were very (inter)dependent from their umbrella organization (nursing home or coordination centres, such as SISD/GDT or ASD-WGK/CSD), and would not be able to function without this close collaboration, because these umbrella organizations brought some key resources (administrative, logistical, financial, HR...) to the project.

But the downside of the coin was that, in return, the projects had to deal with the 'mammoth bureaucracy' coming along with this interdependency, especially with an umbrella organization linked to the Public Centre for Social Welfare (PCSW).

Some projects located in a major urban area complained about the unavoidability of a specific coordination centre, impeding every innovative initiative in which the latter did not agree.

4.3 TARGET POPULATION

In the validation groups, the project corroborated the fact that, to be effective, they have had to fine-tune their intervention to the needs and preferences of the target population throughout the implementation process.

As a result, they had to either change the inclusion criteria for the inclusion, or modify their intervention. This will be presented in the intervention paragraph below.

4.4 STAFF : SKILL-MIX AND TRAINING

Small projects including one single professional (mainly occupational therapists) did not have to modify the structuration of their staff. Multiprofessional projects did it, for different reasons, such as the unexpected results of the interactions between the different professionals. For instance, the working of occupational therapist in the home setting is relatively new in the Belgian system and, when implemented, their role had a positive effect on the capacities of their colleagues, who are not occupational therapists, such as nurses and, especially, nurse assistants. Because of their increased capacities, nurse assistants worked more effectively with dependent patients and project coordinators could hire them instead of nurses.

Financial difficulties could have had an impact on the skill-mix. This was the case in some projects, where more senior professionals, having a good knowledge of the existing network, were hired. These professionals were too expensive to hire over time, because experience over ten years was not financed by NIHD. After the project was running, their administrative coordinators sought to recruit less experienced staff, to replace the experienced, more costly care providers. As a consequence, the working of the project was slightly halted, because of this turnover.

Projects agreed that there was a current lack of specific training for the case management function in Belgium. They also highlighted the need for training and support for professionals delivering care to FOP with dementia, because of the inevitably declining of the capacities of the FOP. They stressed the fact that care providers had a rough time dealing with their own emotional health in these situations.

Finally, projects highly appreciated the added-value of both innovation flexibility and multidisciplinary.

4.5 INTERVENTION INTENSITY

In agreement with the findings of the case studies, most of the projects had to adapt the intensity of their intervention, in order to be more adequately based on the needs of the patients or as a consequence of the high workload. These projects had two files of FOP, one being an 'active file' (i.e. with an intensity as expected) and a 'passive file', with a lower intensity of intervention. FOP could switch rapidly from the passive to the active file, as their needs or preferences increased.

A new finding was expressed, related to the demand for psychosocial support, as some projects found that the FOP having already nursing care provided by nurses or nurse assistant refused more often the psychosocial support of the projects, because they felt they did not need it. Conversely, FOP having only family aids or occupational therapists was more open to this type of health care service.

4.6 PARTNERSHIP

A main trend among the projects was the fact that the Protocol3 project had significantly enhanced the quality of inter-organizational collaboration, because of NIHDI's constraint of formalization. In the four validation groups, the formal partnership had not changed since the start of the projects, but the role of the partners had. This was most often mentioned in the case of referrals, where some partners did not refer as they were expected to do, and others referred, when it was not expected.

Another main trend was the difficult collaboration of the GPs. Not only was this clearly visible when it came to information needed to fill out the BelRAI. The sole case where a project mentioned there was no problem, was a project depending on a nursing home, where all these GPs already had a personal contact with professionals of the project. But projects mentioned cases where GPs did not refer FOP to the projects, out of fear to have to collaborate to the BelRAI.

Projects provided some tips and tricks to obtain medical information, such as asking the medical record to the social service of a nursing home, where the FOP was previously admitted, or mentioning the existing nomenclature for the reimbursement of the time spent in 'coordination activities', adapting their time schedule to the GPs availabilities, etc.

4.7 INFORMAL CAREGIVER INVOLVEMENT

When present, informal caregivers (ICG) were highly involved and considered as full partners in care provision. The care providers need them in terms of information required for professional care and also, to ensure continuity of care. The projects provided them extra attention, such as in the cases of providing specific psychosocial support when there was a suspicion of risk of burn-out. In other cases, projects organized group activities for ICG (day care projects), from which they said they were highly appreciated in terms of social support and recognition.

7. DISCUSSION

This mixed-method study addresses important issues regarding the projects in protocol 3 from 2010 until 2014. The most important findings will be discussed here. We end up with some methodological considerations.

Some relevant issues are emerging

These results offer plenty of indications on **relevant issues** with regard to the implementation of the P3 projects. These findings stimulate to raise questions, formulate comments and develop reflexions for the next steps of this research.

Amongst the main observations related to the factors having played a facilitating or hindering role in this process, we can highlight that:

- Some projects are small scale projects;
- A majority of projects offer case management in some form, often combined with other services;
- Management is sometimes strong and often volatile. This hampers a rapid start of a project;
- Many projects feel they suffer a high administrative burden and this was especially so for the collection of data for the BelRAI. Some project had underestimated this work at the beginning of the project. ;
- The caseload is very hard to define exactly. The time patient spent in the projects is often long and sometimes short;
- Building on existing projects seems successful;
- Umbrella organisations may help if needed. It was for them hard to attract extra money from NIHD's budget.

Even if the need for a shared communication tool was explicitly stated, hindering mechanisms impeding the actual use of these tools were very much present. Personal, cultural, contextual, logistical, financial, political... barriers prevented the use of a shared tool and will have to be addressed simultaneously by both the care providers, project coordinators and policy makers. Being complex because of the multilevel barriers of the different persons involved, dealing with this issue will certainly take time and energy exceeding largely the scope of this project.

However, and in the meanwhile, coordination is also about role definition and projects stressed the fact that there was a lack of recognition of the need for information of care providers from other disciplines and other organizations. Initiatives clarifying and valorising the role, by the means of need for information to enhance coordinated care at the FOP's level, need more attention. This was done by case management projects, which gathered their efforts with other projects, under the umbrella of a provincial organization, to make a list of inter-professional protocols, adapted to a list of CAPs from the BelRAI, as to describe the tasks to be done by each professional group. This common information was perceived as very helpful for enhanced care coordination.

Overall, the projects were highly interdependent with umbrella organizations. In some cases, this was seen as very positive, as those organizations provided extra resources or referred potential FOP. Overall, these projects were embedded into networks of organizations sharing similar political objectives and worked mainly in (concurrent) silos: private versus public, mental health versus general health, etc.

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9. ANNEXES

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ANNEX 1. CRITERIA AND SCORES OF THE NORMATIVE ANALYSES OF THE PROJECTS

1. NORMATIVE ANALYSIS OF PROJECTS PROVIDING CASE MANAGEMENT

The first table includes the long version (26 items) and the second, the short version (8 items). The first version follows Wagner's Chronic Care Model dimensions, the second focuses on three requirements of the CCM : appropriateness of the workforce, embeddedness and clinical information tools. The criteria are provided per subscore, along with the sources used for data collection.

TABLE 44. 26-ITEM VERSION OF THE NORMATIVE ANALYSIS OF PROJECTS PROVIDING CASE MANAGEMENT

Criterion	Source	Evaluation
a. Appropriate workforce		
1. Recruitment of adequate professionals by projects	WordQs Dec 2012 + LimeSurvey	0 = could not recruit professionals
		1 = professionals with lower skills (training, expertise) were recruited
		2 = professionals with lower expertise were recruited
		3 = professionals with expected training and expertise were recruited
2. Skills of professionals	LimeSurvey	0 = no professional to provide this service
		1 = diploma of professional is not related to the service delivered
		2 = diploma of professional is related to the service delivered
		3 = diploma is related to the service delivered and this professional is experienced in this field
3. Turnover of professionals	LimeSurvey	0 = turnover of frontline worker and coordinator > once
		1 = turnover of frontline worker and coordinator = once
		2 = only frontline worker turnover
		3 = no turnover of professionals since start
4. Training of professionals (excl. BelRAI)	WordQs Dec 2012 (10)	0 = no training planned
		1 = training planned, but could not organize it
		2 = internal training, not specific
		3 = internal training, specific
		4 = external training, specific
b. Tailored service design and organisation		
5. Achievement of the caseload	WordQs Dec 2012 (3.4); BelRAI - P3 app & submission files	0 = achievement of <30% of the caseload
		1 = achievement of 31-50% of the caseload
		2 = achievement of 51-75% of the caseload
		3 = achievement of >75% of the caseload
6. (Beneficiary view) physical access	LimeSurvey Dec 2012	0 = the intervention is outside the beneficiaries' home and nothing is organized for transportation

Criterion	Source	Evaluation
		1 = the intervention is outside the beneficiaries' home and they have to pay for transportation
		3 = the intervention is delivered at home or transportation is provided freely by the project
7. Adequacy of the inclusion/exclusion criteria	WordQs Dec 2012 (3.2) and P3 app & submission files	0 = inclusion/exclusion criteria are not adequate and the project did not change them
		1 = inclusion/exclusion criteria were not adequate, the project changed them, but they are still inadequate
		3 = inclusion/exclusion criteria are adequate or were inadequate, but were adapted and are now adequate
8. Shared decision process	WordQs Dec2012 (6.1 -> 6.3)	0 = no meetings including all the professionals of the project
		2 = professionals of the project attend meetings but do not share decision making/do not attend meetings of the steering group or do not receive minutes of those meetings
		3 = professionals of the project attend meetings and share decision making
9. Coordination and communication mechanisms	WordQs Dec2012 (6.4; 7.2)	0 = are not available
		1 = use of monodisciplinary protocols
		2 = use of existing MD protocols
		3 = interprofessional protocols were specifically designed for the P3P
c. Self-management and support		
10. Addressing concerns of beneficiaries and ICG	Economic questionnaire BelRAI export	0 = is not consistently done
		1 = percentage of ICG OR FOP attending a MD meeting during last 3 months is LESS than median than this subgroup
		2 = percentage of ICG OR FOP attending a MD meeting during last 3 months is MORE than median than this subgroup
		3 = percentage of ICG AND FOP attending a MD meeting during last 3 months is MORE than median than this subgroup
d. Community linkages		
11. Existence of a structural link with organizations that can refer beneficiaries	WordQs Dec 2012 (3.5. & 4)	0 = no link
		1 = convention signed, but no referral from beneficiaries
		2 = convention signed, referral less than expected
		3 = convention signed and referral as expected

Criterion	Source	Evaluation
12. Partnership with coordination service (SISD/SEL/GDT or CCSSD)	WordQs Dec 2012 (4)	0 = no link
		1 = ad hoc meetings, on initiative of project
		2 = ad hoc meetings, on initiative of coordination center
		3 = are reported through planned project meetings
13. Partnership with community organizations	Submission files and WordQs Dec 2012 (4)	0 = do not exist
		1 = are being considered, but not implemented
		2 = are part of the partnership
		3 = take part at project meetings
14. Partnership with organizations from another pillar	Submission files and WordQs Dec 2012 (4.1)	1 = only partners from own pillar and primary care
		2 = pillars are from own pillar and include secondary care
		3 = pillars are from other pillar and secondary care
e. The appropriate financial incentives		
15. (Beneficiary view) financial access	BelRAI 2013 and conventions	0 = the beneficiary had to renounce services because of cost
		1= the beneficiary has to pay more than 10€/d for the service
		2 = the Protocol 3 intervention is free, but beneficiaries have to pay for the recommended services
		3 = the intervention is completely free for the beneficiary
16. Adequacy of the financing of the project	LimeSurvey	0 = the project intends to stop because it is not viable
		1 = the projects reports some financial difficulties and did not ask for extra financing from the NIHDI, or the financing was refused
		2 = the projects reports some financial difficulties and asked for extra financing from the NIHDI or FOP, which was accepted
		3 = the project did not report any difficulties related to financing
17. Incentives for GP participation	WordQs 2012 (6.7)	0 = GP are not involved and there are no indications that the project thought of it
		1 = GP are not involved, the project suggested the GP to use of the nomenclature number related to MD coordination, with no result
		2 = GP are poorly involved, despite the financing provided by the project
		3 = GP are well involved and financed by the

Criterion	Source	Evaluation
		project
f. Processes in support of quality of care		
18. Use of quality or performance indicators	Submission file and WordQs Dec 2012 (8.4.)	0 = quality indicators are not mentioned
		1 = quality indicators are mentioned in submission files
		2 = monitoring of quality indicators is part of the discussion in steering committees meetings
		3 = results of quality indicators are provided
19. Monitoring of the care plan	WordQs 2012 (6.6)	0 = no individualized care plan
		1 = care plan only made once (e.g. at intake)
		3 = use and follow-up of care plan
20. Provision of feed-back of the FOP to the GP	WordQs 2012 (6.7.3.)	0 = no feedback provided
		1 = information of the FOP being in the project
		3 = feed-back provided about the results of the BelRAI
g. Knowledge management and decision support		
21. Use of results of research	Submission file	0 = the rationale on how the intervention will impact the FOP outcomes is not mentioned or unclear
		1 = the rationale on how the intervention will impact the FOP outcomes is based on projects' conceptors' perception
		2 = the rationale on how the intervention will impact the FOP outcomes is based on results of research OR pilot study
		3 = the rationale on how the intervention will impact the FOP outcomes is based on results of research AND pilot study
22. Use of evidence-based protocols or guidelines	Submission files & WordQs Dec2012 (6.4; 7.2)	0 = protocols or guidelines are not mentioned/not used
		1 = protocols or guidelines are mentioned in the submission files, but not later
		2 = protocols were made and/or used by the project and there is no information about their being linked to EB literature
		3 = MD protocols were made and used by the project and they rely on EB literature
23. Presence of interventions/planned supervisions and MD group meetings to enhance the knowledge of case managers	WordQS Dec2012 (9.1; 9.2 & 10)	0 = no such meetings are planned
		2 = meetings are planned and do not include a supervisor (physician or senior clinician)
		3=meetings are planned and include a supervisor
h. Clinical information tools		

Criterion	Source	Evaluation
24. Registry (list of beneficiaries of the projects)	WordQs Dec2012 (7.4.)	0 = is not available
		1 = includes name, diagnosis, contact information and date of last contact either on paper or in a computer database
		2 = allows queries to sort beneficiaries by priorities
		3 = provides prompts and reminders about needed services
25. Reminders to providers	WordQs Dec2012 (7.5.)	0 = are not available
		1 = include general notification of presence in the project, but do not describe needed service
		3 = include specific information for the team about the results of the BelRAI
26. Care plans use	WordQs Dec2012 (6.4 ; 6.6)	0 = are not expected
		1 = are achieved through a standardized approach
		2 = is achieved but not really used in the organization of care
		3 = are established collaboratively and include the results of the BelRAI

TABLE 45. 8-ITEM VERSION OF THE NORMATIVE ANALYSIS OF PROJECTS PROVIDING CASE MANAGEMENT

Criterion	Source	Evaluation
1. Turnover of professionals	LimeSurvey	0 = turnover of frontline worker and coordinator > once
		1 = turnover of frontline worker and coordinator = once
		2 = only frontline worker turnover
		3 = no turnover of professionals since start
2. Training of professionals (excl. BelRAI)	WordQs Dec 2012 (10)	0 = no training planned
		1 = training planned, but could not organize it
		2 = internal training, not geriatric
		3 = internal training, specific to geriatric care
3. Number of FOP per CM		0 = > 70/FTE CM
		1 = 51-70/ FTE CM
		2 = 41-50/FTE CM
		3 = ≤ 40/FTE CM
4. Care plans use	WordQs Dec2012 (6.4 ; 6.6)	0 = are not expected
		1 = are achieved through a standardized approach
		2 = is achieved but not really used in the

		organization of care
		3 = are established collaboratively and include the results of the BelRAI
5. Registry (list of beneficiaries of the projects)	WordQs Dec2012 (7.4.)	0 = is not available
		1 = includes name, diagnosis, contact information and date of last contact either on paper or in a computer database
		2 = allows queries to sort beneficiaries by priorities
		3 = provides prompts and reminders about needed services
6. Partnership with coordination service (SISD/SEL/GDT or CCSSD)	WordQs Dec 2012 (4)	0 = no link
		1 = ad hoc meetings, on initiative of project
		2 = ad hoc meetings, on initiative of coordination center
		3 = are reported through planned project meetings
7. Provision of feed-back of the FOP to the GP	WordQs 2012 (6.7.3.)	0 = no feedback provided
		1 = information of the FOP being in the project
		2 = feed-back provided, non structured
		3 = feed-back provided about the results of the BelRAI
8. Presence of interventions/planned supervisions and MD group meetings to enhance the knowledge of case managers	WordQS Dec2012 (9.1; 9.2 & 10)	0 = no such meetings are planned
		2 = meetings are planned and do not include a supervisor (physician or senior clinician)
		3 = meetings are planned and include a supervisor

2. NORMATIVE ANALYSIS OF PROJECTS PROVIDING NIGHT CARE

TABLE 46.25-ITEM VERSION OF THE NORMATIVE ANALYSIS OF PROJECTS PROVIDING NIGHT CARE

Criterion	Source	Evaluation
a. Appropriate workforce		
1. Recruitment of adequate professionals by projects	WordQs Dec 2012 + LimeSurvey	0 = could not recruit professionals
		1 = professionals with lower skills (training, expertise) were recruited
		2 = professionals with lower expertise were recruited
		3 = professionals with expected training and expertise were recruited
2. Skills of professionals	LimeSurvey	0 = no professional to provide this service
		1 = diploma of professional is not related to the service delivered
		2 = diploma of professional is related to the service delivered
		3 = diploma is related to the service delivered and this professional is experienced with FOP
3. Turnover of professionals	LimeSurvey	0 = turnover of frontline worker and coordinator > once
		1 = turnover of frontline worker and coordinator = once
		2 = only frontline worker turnover
		3 = no turnover of professionals since start
4. Training of professionals (excl. BelRAI)	WordQs Dec 2012 (10)	0 = no training planned
		1 = training planned, but could not organize it
		2 = internal training, not specific
		3 = internal training, specific
		4 = external training, specific
b. Tailored service design and organisation		
5. Achievement of the caseload	WordQs Dec 2012 (3.4); BelRAI - P3 app & submission files	0 = achievement of <30% of the caseload
		1 = achievement of 31-50% of the caseload
		2 = achievement of 51-75% of the caseload
		3 = achievement of >75% of the caseload
6. (Beneficiary view) physical access	LimeSurvey Dec 2012	0 = the intervention is outside the beneficiaries' home and nothing is organized for transportation
		1 = the intervention is outside the beneficiaries' home and they have to pay for transportation
		3 = the intervention is delivered at home or transportation is provided freely by the project
7. Adequacy of the inclusion/exclusion criteria	WordQs Dec 2012 (3.2) and P3 app & submission files	0 = inclusion/exclusion criteria are not adequate and the project did not change them
		1 = inclusion/exclusion criteria were not adequate, the project changed them, but they are still inadequate
		3 = inclusion/exclusion criteria are adequate or were inadequate, but were adapted and are now adequate

Criterion	Source	Evaluation
8. Shared decision process	WordQs Dec2012 (6.1 -> 6.3)	0 = no meetings including all the professionals of the project
		2 = professionals of the project attend meetings but do not share decision making/do not attend meetings of the steering group or do not receive minutes of those meetings
		3 = professionals of the project attend meetings and share decision making
9. Coordination and communication mechanisms	WordQs Dec2012 (6.4; 7.2)	0 = are not available
		1 = use of monodisciplinary protocols
		2 = use of existing MD protocols
		3 = interprofessional protocols were specifically designed for the P3P
c. Self-management and support		
10. Addressing concerns of beneficiaries and ICG	Economic questionnaire BelRAI export	0 = is not consistently done
		1 = percentage of ICG OR FOP attending a MD meeting during last 3 months is LESS than median than this subgroup
		2 = percentage of ICG OR FOP attending a MD meeting during last 3 months is MORE than median than this subgroup
		3 = percentage of ICG AND FOP attending a MD meeting during last 3 months is MORE than median than this subgroup
d. Community linkages		
11. Existence of a structural link with organizations that can refer beneficiaries	WordQs Dec 2012 (3.5. & 4)	0 = no link
		1 = convention signed, but no referral from beneficiaries
		2 = convention signed, referral less than expected
		3 = convention signed and referral as expected
12. Partnership with coordination service	WordQs Dec 2012 (4)	0 = no link
		1 = ad hoc meetings, on initiative of project
		2 = ad hoc meetings, on initiative of coordination center
		3 = are reported through planned project meetings
13. Partnership with community organizations	Submission files and	0 = do not exist
	WordQs Dec 2012 (4)	1 = are being considered, but not implemented
		2 = are part of the partnership
		3 = take part at project meetings
14. Partnership with organizations from another pillar	Submission files and	1 = only partners from own pillar and primary care
	WordQs Dec 2012 (4.1)	2 = pillars are from own pillar and include secondary care
		3 = pillars are from other pillar and secondary care
e. The appropriate financial incentives		
15. (Beneficiary view) financial access	BelRAI 2013 and conventions	0 = the beneficiary had to renounce services because of cost

Criterion	Source	Evaluation
		1= the beneficiary has to pay more than 10€/d for the service
		2 = the Protocol 3 intervention is free, but beneficiaries have to pay for the recommended services
		3 = the intervention is completely free for the beneficiary
16. Adequacy of the financing of the project	LimeSurvey	0 = the project intends to stop because it is not viable
		1 = the projects reports some financial difficulties and did not ask for extra financing from the NIHDI, or the financing was refused
		2 = the projects reports some financial difficulties and asked for extra financing from the NIHDI or FOP, which was accepted
		3 = the project did not report any difficulties related to financing
17. Incentives for GP participation	WordQs 2012 (6.7)	0 = GP are not involved and there are no indications that the project thought of it
		1 = GP are not involved, the project suggested the GP to use of the nomenclature number related to MD coordination, with no result
		2 = GP are poorly involved, despite the financing provided by the project
		3 = GP are well involved and financed by the project
f. Processes in support of quality of care		
18. Use of quality or performance indicators	Submission file and WordQs Dec 2012 (8.4.)	0 = quality indicators are not mentioned
		1 = quality indicators are mentioned in submission files
		2 = monitoring of quality indicators is part of the discussion in steering committees meetings
		3 = results of quality indicators are provided
19. Monitoring of the care plan	WordQs 2012 (6.6)	0 = no individualized care plan
		1 = care plan only made once (e.g. at intake)
		3 = use and follow-up of care plan
20. Provision of feed-back of the FOP to the GP	WordQs 2012 (6.7.3.)	0 = no feedback provided
		1 = information of the FOP being in the project
		3 = feed-back provided about the results of the BelRAI
g. Knowledge management and decision support		
21. Use of results of research	Submission file	0 = the rationale on how the intervention will impact the FOP outcomes is not mentioned or unclear
		1 = the rationale on how the intervention will impact the FOP outcomes is based on projects' conceptors' perception
		2 = the rationale on how the intervention will impact the FOP outcomes is based on results of research OR pilot study

Criterion	Source	Evaluation
		3 = the rationale on how the intervention will impact the FOP outcomes is based on results of research AND pilot study
22. Use of evidence-based protocols or guidelines	Submission files & WordQs Dec2012 (6.4; 7.2)	0 = protocols or guidelines are not mentioned/not used
		1 = protocols or guidelines are mentioned in the submission files, but not later
		2 = protocols were made and/or used by the project and there is no information about their being linked to EB literature
		3 = MD protocols were made and used by the project and they rely on EB literature
h. Clinical information tools		
23. Registry (list of beneficiaries of the projects)	WordQs Dec2012 (7.4.)	0 = is not available
		1 = includes name, diagnosis, contact information and date of last contact either on paper or in a computer database
		2 = allows queries to sort beneficiaries by priorities
		3 = provides prompts and reminders about needed services
24. Reminders to providers	WordQs Dec2012 (7.5.)	0 = are not available
		1 = include general notification of presence in the project, but do not describe needed service
		3 = include specific information for the team about the results of the BelRAI
25. Care plans use	WordQs Dec2012 (6.4 ; 6.6)	0 = are not expected
		1 = are achieved through a standardized approach
		2 = is achieved but not really used in the organization of care
		3 = are established collaboratively and include the results of the BelRAI

TABLE 47. 6-ITEM VERSION OF THE NORMATIVE ANALYSIS OF PROJECTS PROVIDING NIGHT CARE

Criterion	Evaluation
1. Collaboration with professionals and organisations responsible of day care for a beneficiary	0 = no collaboration
	1 = collaboration if needed
	3 = collaboration with professionals and day care organizations
2. Adequacy of the type of night care provided to the needs of the target population (flexibility or choice between different interventions)	1 = one service
	2 = two services
	3 = night hostel + emergency + nursing tour

3. Surveillance and security	0 = no surveillance nor security (TBV)
	1 = surveillance or security
	3 = surveillance and security
4. Access of patients to night care project	0 = waiting list
	2 = passive list
	3 = no passive nor waiting list
5. Financial accessibility	0 = FOP pays for care and other costs
	1 = FOP pays transportation and other costs but not for care
	3 = The project is free
6. Cost paid by patient (on a maximum price)	0 = FOP pays more than 75€ a month
	1 = FOP pays between 30 and 75€ a month
	3 = FOP pays up to 30€ a month

3. NORMATIVE EVALUATION OF PROJECTS PROVIDING DAY CARE

TABLE 48. 5-ITEM VERSION OF THE NORMATIVE ANALYSIS OF PROJECTS PROVIDING DAY CARE

Criterion	Source	Evaluation
1. Achievement of the caseload	WordQs Dec 2012 (3.4); BelRAI - P3 app & submission files	0=not reached
		2=exceeded
		3=achieved
2. Partnership with coordination service	WordQs Dec 2012 (3.5. & 4)	0= no partnership with either coordination service nor community organisation
		1=only partnership with community organisation
		2=only partnership with coordination service
		3=coordination with both
3. Provision of feed-back about FOPs to the GP	WordQs 2012 (6.7.3.)	0=no feedback
		1=only in crisis situations
		3=systematically
4. Shared use of results of BelRAI	WordQs Dec2012 (6.4 ; 6.6)	0=no use of BelRAI nor EHR for clinical coordination
		1 = BelRAI completed and used by only one discipline
		3= use of BelRAI and EHR for clinical coordination
5. (for day care centres targeting FOP with dementia) Partnership with centres for mental health	Submission files and WordQs Dec 2012 (4)	0=Yes
		3=No

4. NORMATIVE EVALUATION OF PROJECTS PROVIDING OCCUPATIONAL THERAPY

TABLE 49. 25-ITEM VERSION OF THE NORMATIVE ANALYSIS OF PROJECTS PROVIDING OCCUPATIONAL THERAPY

Criterion	Source	Evaluation
a. Appropriate workforce		
1. Recruitment of adequate professionals by projects	WordQs Dec 2012 + LimeSurvey	0 = could not recruit professionals
		1 = professionals with lower skills (training, expertise) were recruited
		2 = professionals with lower expertise were recruited
		3 = professionals with expected training and expertise were recruited
2. Skills of professionals	LimeSurvey	0 = no professional to provide this service
		1 = diploma of professional is not related to the service delivered
		2 = diploma of professional is related to the service delivered
		3 = diploma is related to the service delivered and this professional is experienced with FOP
3. Turnover of professionals	LimeSurvey	0 = turnover of frontline worker and coordinator > once
		1 = turnover of frontline worker and coordinator = once
		2 = only frontline worker turnover
		3 = no turnover of professionals since start
4. Training of professionals (excl. BelRAI)	WordQs Dec 2012 (10)	0 = no training planned
		1 = training planned, but could not organize it
		2 = internal training, not specific
		3 = internal training, specific
		4 = external training, specific
b. Tailored service design and organisation		
5. Achievement of the caseload	WordQs Dec 2012 (3.4); BelRAI - P3 app & submission files	0 = achievement of <30% of the caseload
		1 = achievement of 31-50% of the caseload
		2 = achievement of 51-75% of the caseload
		3 = achievement of >75% of the caseload
6. (Beneficiary view) physical access	LimeSurvey Dec 2012	0 = the intervention is outside the beneficiaries' home and nothing is organized for transportation
		1 = the intervention is outside the beneficiaries' home and they have to pay for transportation
		3 = the intervention is delivered at home or transportation is provided freely by the project
7. Adequacy of the inclusion/exclusion criteria	WordQs Dec 2012 (3.2) and P3 app & submission files	0 = inclusion/exclusion criteria are not adequate and the project did not change them
		1 = inclusion/exclusion criteria were not adequate, the project changed them, but they are still inadequate
		3 = inclusion/exclusion criteria are adequate or were inadequate, but were adapted and are now adequate

Criterion	Source	Evaluation
8. Shared decision process	WordQs Dec2012 (6.1 -> 6.3)	0 = no meetings including all the professionals of the project
		2 = professionals of the project attend meetings but do not share decision making/do not attend meetings of the steering group or do not receive minutes of those meetings
		3 = professionals of the project attend meetings and share decision making
9. Coordination and communication mechanisms	WordQs Dec2012 (6.4; 7.2)	0 = are not available
		1 = use of monodisciplinary protocols
		2 = use of existing MD protocols
		3 = interprofessional protocols were specifically designed for the P3P
c. Self-management and support		
10. Addressing concerns of beneficiaries and ICG	Economic questionnaire BelRAI export	0 = is not consistently done
		1 = percentage of ICG OR FOP attending a MD meeting during last 3 months is LESS than median than this subgroup
		2 = percentage of ICG OR FOP attending a MD meeting during last 3 months is MORE than median than this subgroup
		3 = percentage of ICG AND FOP attending a MD meeting during last 3 months is MORE than median than this subgroup
d. Community linkages		
11. Existence of a structural link with organizations that can refer beneficiaries	WordQs Dec 2012 (3.5. & 4)	0 = no link mentioned
		1 = convention signed, but no referral from beneficiaries
		2 = convention signed, referral less than expected
		3 = convention signed and referral as expected
12. Partnership with coordination service (SISD/SEL/GDT or CCSSD)	WordQs Dec 2012 (4)	0 = no link mentioned
		1 = ad hoc meetings, on initiative of project
		2 = ad hoc meetings, on initiative of coordination center
		3 = are reported through planned project meetings
13. Partnership with community organizations	Submission files and	0 = not reported
	WordQs Dec 2012 (4)	1 = are being considered, but not implemented
		2 = are part of the partnership
		3 = take part at project meetings
14. Partnership with organizations from another pillar	Submission files and	1 = only partners from own pillar and primary care
	WordQs Dec 2012 (4.1)	2 = pillars are from own pillar and include secondary care
		3 = pillars are from other pillar and secondary care
e. The appropriate financial incentives		
15. (Beneficiary view) financial access	BelRAI 2013 and conventions	0 = the beneficiary had to renounce services because of cost

Criterion	Source	Evaluation
		1= the beneficiary has to pay more than 10€/d for the service
		2 = the Protocol 3 intervention is free, but beneficiaries have to pay for the recommended services
		3 = the intervention is completely free for the beneficiary
16. Collaboration with orthopedic technicians company	Conventions	0 = no orthopedic technician as partner
		1 = one orthopedic technician as partner
		2 = more than one
		3 = one or more with reduced prices
16. Adequacy of the financing of the project	LimeSurvey	0 = the project intends to stop because it is not viable
		1 = the projects reports some financial difficulties and did not ask for extra financing from the NIHDI, or the financing was refused
		2 = the projects reports some financial difficulties and asked for extra financing from the NIHDI or FOP, which was accepted
		3 = the project did not report any difficulties related to financing
17. Incentives for GP participation	WordQs 2012 (6.7)	0 = GP are not involved and there are no indications that the project thought of it
		1 = GP are not involved, the project suggested the GP to use of the nomenclature number related to MD coordination, with no result
		2 = GP are poorly involved, despite the financing provided by the project
		3 = GP are well involved and financed by the project
f. Processes in support of quality of care		
18. Use of quality or performance indicators	Submission file and WordQs Dec 2012 (8.4.)	0 = quality indicators are not mentioned
		1 = quality indicators are mentioned in submission files
		2 = monitoring of quality indicators is part of the discussion in steering committees meetings
		3 = results of quality indicators are provided
19. Monitoring of the care plan	WordQs 2012 (6.6)	0 = no individualized care plan
		1 = care plan only made once (e.g. at intake)
		3 = use and follow-up of care plan
20. Provision of feed-back of the FOP to the GP	WordQs 2012 (6.7.3.)	0 = no feedback provided
		1 = information of the FOP being in the project
		3 = feed-back provided about the results of the BelRAI
g. Knowledge management and decision support		
21. Use of results of research	Submission file	0 = the rationale on how the intervention will impact the FOP outcomes is not mentioned or unclear
		1 = the rationale on how the intervention will impact the FOP outcomes is based on projects' conceptors'

Criterion	Source	Evaluation
		perception
		2 = the rationale on how the intervention will impact the FOP outcomes is based on results of research OR pilot study
		3 = the rationale on how the intervention will impact the FOP outcomes is based on results of research AND pilot study
22. Use of evidence-based protocols or guidelines	Submission files & WordQs Dec2012 (6.4; 7.2)	0 = protocols or guidelines are not mentioned/not used
		1 = protocols or guidelines are mentioned in the submission files, but not later
		2 = protocols were made and/or used by the project and there is no information about their being linked to EB literature
		3 = MD protocols were made and used by the project and they rely on EB literature
h. Clinical information tools		
23. Registry (list of beneficiaries of the projects)	WordQs Dec2012 (7.4.)	0 = is not available
		1 = includes name, diagnosis, contact information and date of last contact either on paper or in a computer database
		2 = allows queries to sort beneficiaries by priorities
		3 = provides prompts and reminders about needed services
24. Reminders to providers	WordQs Dec2012 (7.5.)	0 = are not available
		1 = include general notification of presence in the project, but do not describe needed service
		3 = include specific information for the team about the results of the BelRAI
25. Care plans use	WordQs Dec2012 (6.4 ; 6.6)	0 = are not expected
		1 = are achieved through a standardized approach
		2 = is achieved but not really used in the organization of care
		3 = are established collaboratively and include the results of the BelRAI

TABLE 50. 5-ITEM VERSION OF THE NORMATIVE ANALYSIS OF PROJECTS PROVIDING OCCUPATIONAL THERAPY

Criterion	Evaluation
1. Collaboration and coordination with other care providers, including GPs	0 = no collaboration
	1 = collaboration "on request", not systematic
	2 = systematic collaboration with GP or other care providers
	3 = systematic collaboration with GP and other care providers
2. Distributor of home use devices as partner to make FOP's financial access easier	0 = no systematic financial aid or costs reduction for FOP or no indication about this
	1 = collaboration with a distributor for home use devices or another organism that systematically provides financial help or cost reduction
3. Planned follow-up of intervention (home modifications)	0 = no follow-up of home modifications
	1 = follow-up but not systematically
	2 = a systematic follow-up
4. Education component in the occupational therapist's intervention	0 = no indication
	1 = yes but not systematic
	2 = yes, systematically
5. Shared decision with patient and his caregiver	0 = decision is made exclusively by the OT
	1 = decision is made by OT after discussion with FOP and ICG (when there is one)
	2 = decision is made by the FOP and the ICG when there is one

5. NORMATIVE ANALYSIS OF PROJECTS PROVIDING PSYCHOLOGICAL SUPPORT OR PSYCHOTHERAPY AT HOME

TABLE 51. 28-ITEM VERSION OF THE NORMATIVE ANALYSIS OF PROJECTS PROVIDING PSYCHOLOGICAL SUPPORT OR PSYCHOTHERAPY AT HOME

Criterion	Source	Evaluation
a. Appropriate workforce		
1. Recruitment of adequate professionals by projects	WordQs Dec 2012 + LimeSurvey	0 = could not recruit professionals
		1 = professionals with lower skills (training, expertise) were recruited
		2 = professionals with lower expertise were recruited
		3 = professionals with expected training and expertise were recruited
2. Skills of professionals	LimeSurvey	0 = no professional to provide this service
		1 = diploma of professional is not related to the service delivered
		2 = diploma of professional is related to the service delivered
		3 = diploma is related to the service delivered and this professional is experienced in geriatric mental healthcare
3. Turnover of professionals	LimeSurvey	0 = turnover of frontline worker and coordinator > once
		1 = turnover of frontline worker and coordinator = once
		2 = only frontline worker turnover
		3 = no turnover of professionals since start
4. Training of professionals (excl. BelRAI)	WordQs Dec 2012 (10)	0 = no training planned
		1 = training planned, but could not organize it
		2 = internal training, not specific
		3 = internal training, specific
		4 = external training, specific
b. Tailored service design and organisation		
5. Achievement of the caseload	WordQs Dec 2012 (3.4); BelRAI - P3 app & submission files	0 = achievement of <30% of the caseload
		1 = achievement of 31-50% of the caseload
		2 = achievement of 51-75% of the caseload
		3 = achievement of >75% of the caseload
6. (Beneficiary view) physical access	LimeSurvey Dec 2012	0 = the intervention is outside the beneficiaries' home and nothing is organized for transportation
		1 = the intervention is outside the beneficiaries' home and they have to pay for transportation
		3 = the intervention is delivered at home or transportation is provided freely by the project
7. Adequacy of the inclusion/exclusion criteria	WordQs Dec 2012 (3.2) and P3 app & submission files	0 = inclusion/exclusion criteria are not adequate and the project did not change them
		1 = inclusion/exclusion criteria were not adequate, the project changed them, but they are still inadequate

Criterion	Source	Evaluation
		3 = inclusion/exclusion criteria are adequate or were inadequate, but were adapted and are now adequate
8. Shared decision process	WordQs Dec2012 (6.1 -> 6.3)	0 = no meetings including all the professionals of the project
		2 = professionals of the project attend meetings but do not share decision making/do not attend meetings of the steering group or do not receive minutes of those meetings
		3 = professionals of the project attend meetings and share decision making
9. Coordination and communication (sharing results in the project)	WordQs Dec2012 (6.4; 7.2)	0 = no communication/coordination between professionals in the project
		1 = oral and/or written feedback to each other (not structured)
		2 = meetings between professionals to discuss results of interventions
		3 = (ICT) tools to facilitate communication/coordination between professionals in the project (shared files,...)
10. Tailored intervention	LimeSurvey Dec2012	0= group therapy only
		1= non-standardized therapies (reminiscence, support...)
		2= standardized therapies (cognitive-behavioural, problem-solving, IP psychotherapy,...)
		3= Tailored interventions for elderly individuals (psychosocial + rehabilitation,...)
c. Self-management and support		
11. Addressing concerns of beneficiaries and ICG	Economic questionnaire BelRAI export	0 = is not consistently done
		1 = percentage of ICG OR FOP attending a MD meeting during last 3 months is LESS than median than this subgroup
		2 = percentage of ICG OR FOP attending a MD meeting during last 3 months is MORE than median than this subgroup
		3 = percentage of ICG AND FOP attending a MD meeting during last 3 months is MORE than median than this subgroup
d. Community linkages		
12. Existence of a structural link with organizations that can refer beneficiaries	WordQs Dec 2012 (3.5. & 4)	0 = no link
		1 = convention signed, but no referral from beneficiaries
		2 = convention signed, referral less than expected
		3 = convention signed and referral as expected
13. Partnership with coordination service (SISD/SEL/GDT or CCSSD)	WordQs Dec 2012 (4)	0 = no link
		1 = ad hoc meetings, on initiative of project
		2 = ad hoc meetings, on initiative of coordination center
		3 = are reported through planned project meetings
14. Partnership with community	Submission files and WordQs Dec 2012 (4)	0 = do not exist
		1 = are being considered, but not implemented

Criterion	Source	Evaluation
organizations		2 = are part of the partnership
		3 = take part at project meetings
15. Partnership with organizations from another pillar	Submission files and WordQs Dec 2012 (4.1)	1 = only partners from own pillar and primary care
		2 = pillars are from own pillar and include secondary care
		3 = pillars are from other pillar and secondary care
16. Partnership with Centre for mental healthcare (mental health centre)	Submission files and WordQs Dec 2012 (4)	0 = no link mentioned
		1 = mental health centre is mentioned as partner but no indication that there are meetings
		2 = ad hoc meetings between project and mental health centre
		3 = are reported through planned project meetings
e. The appropriate financial incentives		
17. (Beneficiary view) financial access	BelRAI 2013 and conventions	0 = the beneficiary had to renounce services because of cost
		1= the beneficiary has to pay more than 10€/d for the service
		2 = the Protocol 3 intervention is free, but beneficiaries have to pay for the recommended services
		3 = the intervention is completely free for the beneficiary
18. Adequacy of the financing of the project	LimeSurvey	0 = the project intends to stop because it is not viable
		1 = the projects reports some financial difficulties and did not ask for extra financing from the NIHDI, or the financing was refused
		2 = the projects reports some financial difficulties and asked for extra financing from the NIHDI or FOP, which was accepted
		3 = the project did not report any difficulties related to financing
19. Incentives for GP participation	WordQs 2012 (6.7)	0 = GP are not involved and there are no indications that the project thought of it
		1 = GP are not involved, the project suggested the GP to use of the nomenclature number related to MD coordination, with no result
		2 = GP are poorly involved, despite the financing provided by the project
		3 = GP are well involved and financed by the project
f. Processes in support of quality of care		
20. Use of quality or performance indicators	Submission file and WordQs Dec 2012 (8.4.)	0 = quality indicators are not mentioned
		1 = quality indicators are mentioned in submission files
		2 = monitoring of quality indicators is part of the discussion in steering committees meetings
		3 = results of quality indicators are provided
21. Monitoring of the care plan	WordQs 2012 (6.6)	0 = no individualized care plan
		1 = care plan only made once (e.g. at intake)

Criterion	Source	Evaluation
		3 = use and follow-up of care plan
22. Provision of feed-back of the FOP to the GP	WordQs 2012 (6.7.3.)	0 = no feedback provided
		1 = information of the FOP being in the project
		3 = feed-back provided about the results of the BelRAI
g. Knowledge management and decision support		
23. Use of results of research	Submission file	0 = the rationale on how the intervention will impact the FOP outcomes is not mentioned or unclear
		1 = the rationale on how the intervention will impact the FOP outcomes is based on projects' conceptors' perception
		2 = the rationale on how the intervention will impact the FOP outcomes is based on results of research OR pilot study
		3 = the rationale on how the intervention will impact the FOP outcomes is based on results of research AND pilot study
24. Use of evidence-based protocols or guidelines	Submission files & WordQs Dec2012 (6.4; 7.2)	0 = protocols or guidelines are not mentioned/not used
		1 = protocols or guidelines are mentioned in the submission files, but not later
		2 = protocols were made and/or used by the project and there is no information about their being linked to EB literature
		3 = MD protocols were made and used by the project and they rely on EB literature
25. Expertise sharing, intervention	Submission file (partners); WQ2012 (partners, meetings)	0= no indication that expertise is shared
		1= partners that could provide expertise, but no indication that they do (fe. mental health centre)
		2= partners that actually provide expertise, but not structured
		3= intervention, organised exchange of expertise
h. Clinical information tools		
26. Registry (list of beneficiaries of the projects)	WordQs Dec2012 (7.4.)	0 = is not available
		1 = includes name, diagnosis, contact information and date of last contact either on paper or in a computer database
		2 = allows queries to sort beneficiaries by priorities
		3 = provides prompts and reminders about needed services
27. Reminders to providers	WordQs Dec2012 (7.5.)	0 = are not available
		1 = include general notification of presence in the project, but do not describe needed service
		3 = include specific information for the team about the results of the BelRAI
28. Care plans use	WordQs Dec2012 (6.4 ; 6.6)	0 = are not expected
		1 = are achieved through a standardized approach
		2 = is achieved and used in the organization of care

Criterion	Source	Evaluation
		3 = are established collaboratively and include the results of the BelRAI

TABLE 52. 7-ITEM VERSION OF THE NORMATIVE ANALYSIS OF PROJECTS PROVIDING PSYCHOLOGICAL SUPPORT OR PSYCHOTHERAPY AT HOME

Criteria	Evaluation scores
1. Pre-intervention clinical expertise of the psychologist about FOP (clinical psychologist or psychotherapist; experience with FOP)	0 = no professional to provide this service
	1 = diploma of professional(s) is not related to the service delivered
	2 = diploma of professional(s) is related to the service delivered or experience with geriatric mental healthcare
	3 = only clinical psychologists and this professional is experienced in geriatric mental healthcare
2. No turnover of psychologists (for building relationship of trust, continuity of the therapy)	0 = turnover of frontline worker > once
	1 = turnover of frontline worker = once
	2 = only coordinator turnover
	3 = no turnover of professionals since start
3. Communication with other professionals (most important the GP) (GP for treatment with antidepressants, anxiolytics,...)	0 = no communication with other professionals
	1 = only (oneway) information about the FOP being in the project
	2 = communication (back and forth) about the care for the FOP
	3 = communication (back and forth) about the care for the FOP using Belrai results
4. Targeting also the ICG (directly) (burden, coping, indirect effect on FOP)	0 = ICG not targeted
	1 = ICG targeted only with FOP ('group' therapy, for f.e. conflicts)
	2 = non-standardized intervention directly targeting ICG (emotional support,...)
	3 = standardized intervention directly targeting ICG (cognitive-behavioral,...)
5. Tailored intervention (based on FOP/ICG's needs, capacity, preferences; including choice of therapist)	0 = group therapy only
	1 = nonstandardized therapies (reminiscence, support...)
	2 = standardized therapies (cognitive-behavioural, problem-solving, IP psychotherapy,...)
	3 = tailored interventions for elderly individuals (psychosocial + rehabilitation,...)
6. Financial and geographical accessibility of the psychological intervention (avoid thresholds: financial, mobility, cultural)	0 = the beneficiary had to renounce services because of accessibility
	1 = the beneficiary has to pay more than 10€/session for the P3 intervention
	2 = the P3 intervention is free or less than 10€/session, but beneficiaries have to pay for recommended services
	3 = the intervention is completely free for the beneficiary

7. Psychologist's access to the expertise of a mental health centre (interview, discuss cases, sharing expertise; link 1st and 2nd line)	0 = no indication that expertise is shared
	1 = partners that could provide expertise (mental health centres, but no indication that they do
	2 = partners that actually provide expertise, but not structured
	3 = interview, organised exchange of expertise

ANNEX 2. D'AMOUR'S DIMENSIONS OF INTERPROFESSIONAL COLLABORATION

TABLE 53. INDICATORS OF COLLABORATION

Indicators of collaboration			
	Indicators		Description
SHARED GOALS AND VISION	Goals		This indicator is related to professional values in the form of common goals, with particular reference to the consensual and comprehensive nature of the goals. Identifying and sharing common goals is an essential point of departure for a collaborative undertaking. The data suggest that the goal most likely to rally stakeholders is that of promoting patient-centred care. Providing a response to clients' needs thus becomes a central objective on which everyone can agree. The problem is that this goal entails a radical transformation of values and practices; its achievement would truly be an innovation.
	Client-centred orientation vs. other allegiances		There generally exists a complex structure of interests involving a variety of different types of allegiance: to the clientele, to the profession, to the organization, to private interests, etc. The result is thus an asymmetry of interests among partners or a partial convergence of interests. Mutual adjustments are required, making the need to negotiate all the more important. In some cases, negotiation is possible. In others, interests are left largely unexpressed, and there is no negotiating process. When shared goals are not negotiated, the risk is that private interests will emerge, resulting in opportunistic behaviour and a concomitant loss of focus on client-centred collaboration.
INTERNALIZATION	Mutual acquaintanceship		The data show that professionals must know each other personally and professionally if they are to develop a sense of belonging to a group and succeed in setting common objectives. Knowing each other personally means knowing each other's values and level of competence. Knowing each other professionally means knowing each other's disciplinary frame of reference, approach to care and scope of practice. The familiarization process occurs at social occasions, training activities and formal and informal information-exchange events. It is necessary to create the social conditions that will foster collaboration, particularly through social interaction.
	Trust		According to the professionals, collaboration is possible only when they have trust in each other's competencies and ability to assume responsibilities (that is, when goodwill exists). Trust reduces uncertainty. Professionals acknowledge that they do not know each other well, and so must constantly gauge risks and allow themselves to be placed in a vulnerable position. When there is too much uncertainty, the data show, health professionals hold on to responsibility for their clients as long as possible to avoid collaborating. Such actions run counter to the goal of constructing networks. Professionals use the results of collaboration to evaluate each other and build trust.
GOVERNANCE	Centrality		Centrality refers to the existence of clear and explicit direction that is meant to guide action, in this case, towards collaboration. The data reveal the importance of the involvement of some central authorities in providing clear direction and playing a strategic and political role to further the implementation of collaborative processes and structures. Senior managers can exert significant influence on interorganizational collaboration, particularly through agreements they reach with the managers of other facilities to make the collaboration official.
	Leadership		Local leadership is necessary for the development of interprofessional and interorganizational collaboration. Leadership may take a variety of forms and can be categorized as either emergent or as related to a position. With respect to collaboration, leadership can be exercised either by managers who have been mandated to do so or by professionals who take the initiative themselves. In the latter case, leadership is shared by the different partners and is subject to wide agreement. When leadership is related to a position, power should not be concentrated in the hands of a single partner; all partners must be able to have their opinions heard and to participate in decision making.
	Support for innovation		Because collaboration leads to new activities or because it involves dividing responsibilities differently between professionals and between institutions, it necessarily entails changes in clinical practices and in the sharing of responsibilities between partners. These changes represent real innovations that must be developed and implemented. Collaboration cannot take hold without a complementary learning process and without the organization involved drawing on internal or external expertise to support this learning process.
	Connectivity		Connectivity refers to the fact that individuals and organizations are interconnected, that there are places for discussion and for constructing bonds between them. Connectivity is the opposite of being cut off, isolated, separate. It solves

coordination problems and makes it possible to make adjustments to practices. Connectivity allows for rapid and continuous adjustments in response to problems of coordination. It takes the form of information and feedback systems, committees, etc.

FORMALIZATION	<i>Formalization tools</i>	Formalization is an important means of clarifying the various partners' responsibilities and negotiating how responsibilities are shared. There are many types of formalized tools: interorganizational agreements, protocols, information systems, etc. For professionals, it is important to know what is expected of them and what they can expect of others. Earlier findings suggest that collaboration is influenced less by the degree of formalization than by the consensus that emerges around formalization mechanisms and the specific rules that are implemented.
	<i>Information exchange</i>	The exchange of information refers to the existence and appropriate use of an information infrastructure to allow for rapid and complete exchanges of information between professionals. The findings suggest that professionals use information systems to reduce uncertainty in their relationships with partners they do not know well. Feedback provides professionals with the information they need to follow up with patients as well as to evaluate their partners on the basis of the quality of the written exchanges and feedback. This is an important aspect of establishing relationships of trust.

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