

## Describing a solution<sup>1</sup>

### Example 1: Integrated Care Model with Case Management for Neurodivergent Children

**Name of the solution:** Integrated Care Model with Case Management for Neurodivergent Children

**Purpose of the solution:** The purpose of the solution is to provide an interconnected support system for neurodivergent children by integrating educational, healthcare, and social services. This integration prevents care fragmentation, promotes smooth transitions across life stages, and empowers families with streamlined access to services through case management. The model emphasizes collaboration among stakeholders to ensure sustainability and inclusive practices.

**Target group / population of the solution:** The solution targets neurodivergent children, including those with conditions such as autism spectrum disorder (ASD) and ADHD. Secondary beneficiaries include parents and families, who gain access to coordinated resources and reduced service burdens. The tertiary audience comprises professionals such as educators, healthcare providers, and policymakers, all of whom play critical roles in implementing the solution effectively.

**Solution as a practice:** The implementation of the Integrated Care Model with Case Management for Neurodivergent Children is grounded in a systemic, relational approach that views success as emerging from the coordinated interaction between all actors—both human and non-human—involved in the care ecosystem. The underlying theory of change assumes that meaningful, sustainable improvement occurs when these actors align around shared objectives, practices, and tools.

The process begins with a comprehensive needs assessment, where neurodivergent children, their families, educators, healthcare providers, and social workers collaboratively identify goals rooted in the lived experiences of the children themselves. Standardized diagnostic tools, communication platforms, and assessment protocols are used to support this process, enabling consistent identification of needs and progress tracking. This phase fosters mutual understanding and aligns participants toward reducing care fragmentation and delivering inclusive, equitable support.

Following this, case management becomes the linchpin of the model. Case managers serve as the primary coordinators, connecting families with relevant services across educational, healthcare, and social domains. Their efforts are supported by interoperable digital platforms that enable real-time data sharing and communication between sectors. These technologies not only streamline service delivery but also help avoid duplication and gaps in care. The case manager thus functions as a critical connector within the network, guiding families through complex systems with clarity and consistency.

The capacity-building phase focuses on equipping professionals—educators, healthcare providers, and social workers—with the knowledge and tools needed to adopt neurodiversity-informed practices. This includes training on inclusive pedagogy, the use of assistive technologies, and the creation of sensory-friendly environments. These learning opportunities are designed to strengthen human-to-human connections across sectors while embedding systemic support for neurodiversity into daily practices. Success in this phase depends on the meaningful integration of new knowledge and tools into institutional routines.

Cross-sector collaboration is further enabled by shared digital infrastructure and clearly defined protocols, which bring coherence, accountability, and transparency to interdisciplinary work. These systems support information flow and informed decision-making, allowing professionals to respond swiftly and effectively

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<sup>1</sup> The examples were created using ChatGPT and Copilot AI tools.

to evolving needs.

Integral to the model is a robust feedback loop that supports continuous learning and adaptation. Families and professionals contribute qualitative insights through regular reviews and engagement forums, while data dashboards and performance reports provide quantitative feedback. Together, these mechanisms enable the network to adjust in real time, reinforcing its responsiveness and effectiveness.

This approach to practice is built on the belief that sustainable change results from a resilient, well-aligned network of actors. When professionals, families, and digital tools operate in harmony, the system not only meets immediate needs—such as developing individualized support plans and reducing fragmentation—but also builds toward long-term transformation. The ultimate goal is the creation of lifelong, seamless support pathways that adapt to each child's changing circumstances.

Success, therefore, depends not only on the efforts of individual people but also on the strength of their relationships, the consistency of their practices, and the interoperability of their tools. The integrated care model thrives when this ecosystem is continuously reinforced and adapted, allowing it to respond to diverse settings and evolving challenges with flexibility and inclusivity.

**Organisational requirements of the solution:** Effective implementation depends on strong organizational support, including funding to establish case manager roles and technical infrastructure for shared digital platforms. Additionally, inter-organizational collaboration protocols need to be clearly defined to facilitate integrated workflows. Investing in professional development and partnerships between schools and healthcare providers further supports system-wide efficacy.

**Requirements for the broader context of the solution:** Broader societal support is essential for the success of this model. Advocacy and public awareness campaigns are required to build acceptance for neurodiversity and foster community buy-in. Policymakers need to enforce regulations for data-sharing and integrated care while providing financial backing for sustainable implementation. Cultural, social, and linguistic considerations must also be addressed to ensure inclusivity across diverse demographics and regions.

This comprehensive framework lays the foundation for building a supportive, inclusive ecosystem that adapts to the unique needs of neurodivergent individuals, empowering them and their families while fostering systemic reform.

**Background material:** This model is inspired by practices documented in the EU Best Practices Portal for integrated care approaches and existing evidence-based frameworks for supporting neurodivergent populations. Relevant material includes WHO guidelines on inclusive education, healthcare coordination, and multi-professional team practices.

## Example 2: Integrated Rural Healthcare Access Model (IRHAM)

**Name of the solution:** Integrated Rural Healthcare Access Model (IRHAM)

**Purpose of the solution:** The IRHAM model aims to improve access to primary healthcare services in rural areas, reduce healthcare disparities between urban and rural communities, increase the recruitment and retention of healthcare professionals in rural settings, strengthen preventive care and early intervention to lower the burden of chronic diseases, and foster health literacy and self-care behaviours within rural populations.

**Target group:** This solution is designed for rural and underserved communities requiring accessible healthcare, healthcare providers such as doctors, nurses, and community health workers working in rural settings, local governments and policymakers responsible for healthcare infrastructure, and community organizations and NGOs involved in healthcare education and service delivery.

**Solution as a practice:** The implementation of the Integrated Rural Healthcare Access Model (IRHAM) is guided by the understanding that meaningful healthcare reform in rural areas depends on the dynamic interaction of both human and non-human actors. The model's theory of change asserts that aligning these actors into a coordinated and goal-oriented network is key to addressing systemic healthcare disparities.

The process begins with a comprehensive needs assessment, which is carried out through collaborative engagement between rural residents, healthcare providers, local governments, NGOs, and policymakers. This collective effort uses surveys, focus groups, and diagnostic tools—supported by communication platforms—to standardize the collection of data and evaluation of healthcare gaps. These shared tools help define common goals, ensuring that all stakeholders are united in their commitment to improving healthcare access and equity.

Following this, infrastructure development becomes a central focus. Mobile health clinics and expanded telemedicine capabilities are introduced to bridge the geographic and logistical barriers that typically limit rural healthcare access. These technologies act as critical non-human actors, bringing specialized care directly to remote communities while reducing inefficiencies and duplication. The effectiveness of this phase lies in the seamless coordination between these tools and the human actors who operate, support, and rely on them.

To ensure long-term impact, the model emphasizes the recruitment, training, and retention of healthcare professionals in rural areas. This includes implementing incentive structures such as scholarships, loan forgiveness programs, and rural residency placements. Ongoing professional development opportunities, tailored to rural healthcare contexts, help integrate new tools and evidence-based practices into daily workflows. These educational initiatives not only enhance the capacity of rural health workers but also foster cross-sector collaboration and knowledge exchange.

Policy alignment and financial investment are critical enablers of the IRHAM model. Government support—both legislative and fiscal—is required to sustain mobile health services, telehealth infrastructure, and training programs. Shared digital platforms and formalized coordination protocols ensure that data flows securely and consistently between providers, local officials, and NGOs. These systems enhance decision-making, reduce response times, and improve care continuity.

A strong emphasis is also placed on community education and outreach. Programs focused on preventive care—covering areas like nutrition, maternal health, vaccination, and chronic disease management—are delivered through trained community health workers. These workers serve as trusted liaisons, providing culturally responsive education and basic healthcare services. This grassroots engagement helps to foster health literacy and encourages self-care behaviors, which are essential for sustainable impact.

Continuous improvement is embedded through a feedback loop that captures both qualitative and quantitative data. Community members and frontline professionals provide firsthand insights through interviews and participatory reviews, while digital dashboards and performance metrics track trends and outcomes. This combination of perspectives enables ongoing refinement of strategies, making the model adaptive to evolving needs and emerging challenges.

At the heart of IRHAM is the belief that sustainable rural healthcare systems emerge from the alignment and active engagement of all involved actors. When community members, healthcare workers, technologies, and institutions work in synergy, the model delivers tangible short-term improvements—such as enhanced service delivery and provider availability—as well as long-term outcomes, including reduced health disparities and increased system resilience.

Ultimately, the IRHAM model's strength lies in its ability to create a dynamic, responsive, and inclusive network. Its success depends not only on infrastructure and technology but also on the relationships, trust, and shared commitment among all actors. By maintaining this ecosystem over time, the model ensures its adaptability and effectiveness in addressing the unique healthcare challenges of rural communities.



The IRHAM model provides an integrated and sustainable approach to addressing rural healthcare disparities. By leveraging technology, workforce development, policy advocacy, and community engagement, IRHAM ensures long-term improvements in healthcare accessibility, affordability, and overall health outcomes in rural communities.

**Organizational requirements:** For effective implementation, the IRHAM model requires technical infrastructure, including stable internet connectivity, medical equipment for mobile units, and robust data management systems. Human resources must include adequate staffing of physicians, nurses, and community health workers. Financial support must be secured through sustainable funding from government budgets, grants, and private sector investments. Operational workflows should establish clear processes for service delivery, healthcare worker recruitment, and telehealth consultations. Quality and safety standards must be maintained through adherence to evidence-based medical protocols and regulatory guidelines.

**Broader contextual requirements:** For IRHAM to be successful, cultural and social adaptation must be considered by tailoring programs to local beliefs and customs to ensure community acceptance. Supportive policies for telehealth reimbursement, mobile healthcare licensing, and rural healthcare incentives are necessary. Geographical and logistical factors such as efficient transportation strategies for mobile clinics and robust supply chain management for medical resources must also be addressed. Public awareness and community engagement initiatives should be implemented to build trust, raise awareness, and encourage participation in healthcare programs.

**Background material:** This model integrates practices from the EU Best Practices Portal and World Health Organization (WHO) guidelines. Adaptations from successful rural healthcare initiatives worldwide—such as mobile healthcare units, community-based healthcare programs, and telemedicine—have informed the IRHAM framework.

### **Example 3: Community-Based Obesity Prevention and Lifestyle Promotion Initiative (COPLPI)**

**Name of the Solution:** Community-Based Obesity Prevention and Lifestyle Promotion Initiative (COPLPI)

**Purpose of the Solution:** The COPLPI aims to reduce obesity prevalence and encourage healthier lifestyles within communities. The objectives include raising awareness about the importance of nutritious eating and regular physical activity, improving access to affordable healthy food options and fitness programs, and fostering an environment conducive to long-term, sustainable lifestyle changes.

**Target Group / Population of the Solution:** The initiative targets several groups, including individuals at higher risk of obesity, particularly in underserved or rural areas, parents and families striving to improve household-level health habits, healthcare providers addressing obesity management, school-aged children and their educators, as well as policymakers and community leaders invested in public health progress.

**Solution as a Practice:** The Community-Based Obesity Prevention and Lifestyle Promotion Initiative (COPLPI) is underpinned by a clear theory of change that recognizes the multifaceted nature of obesity and its prevention. The initiative posits that meaningful and sustainable reductions in obesity prevalence can only occur through a coordinated, multi-sectoral approach that addresses individual behaviours, family dynamics, community resources, and systemic barriers. By fostering collaboration among key stakeholders, COPLPI aims to create an enabling environment that supports and sustains healthy behaviours across different levels of society.

The process of the solution unfolds through a series of interrelated phases, each designed to achieve specific milestones that contribute to the overall goal of reducing obesity:



Phase 1: Stakeholder Engagement and Goal Alignment. This phase establishes the foundation for the initiative by bringing together healthcare providers, educators, policymakers, community organizations, and individuals affected by obesity. These stakeholders negotiate and translate their needs into shared objectives, aligning their resources and strategies around common metrics. This collaborative effort ensures that the initiative is both inclusive and contextually relevant. A shared vision is formalized, focusing on awareness, access to resources, and behavior change.

Phase 2: Awareness and Capacity Building. In this phase, the focus shifts to empowering individuals and communities with knowledge and skills. Community workshops are conducted to educate participants on nutrition, cooking techniques, and the benefits of physical activity. Simultaneously, healthcare professionals and educators receive specialized training on obesity prevention and management. The theory of change emphasizes that enhanced knowledge and capacity will drive early adoption of healthier practices, setting the stage for broader community uptake.

Phase 3: Implementation of Interventions and Support Systems. The third phase operationalizes the initiative through targeted interventions. These include subsidized access to fitness programs, family-oriented physical activity initiatives, and healthier school meal plans. Policy advocacy is also intensified, aiming to introduce structural changes such as subsidies for fresh produce in underserved areas and urban planning initiatives that encourage physical activity. By providing these resources and interventions, the initiative removes financial and logistical barriers that hinder the adoption of healthier behaviors.

Phase 4: Monitoring, Feedback, and Iterative Adaptation. To ensure effectiveness, the initiative incorporates continuous monitoring of both processes and outcomes. Real-time data collection mechanisms track participation rates, feedback from stakeholders, and progress against short-term and long-term metrics. Insights from this data are used to refine activities and address emerging challenges. For instance, if certain interventions exhibit low uptake, they are reassessed and adapted based on community feedback. This iterative approach aligns with the theory of change by ensuring that the initiative remains responsive and contextually appropriate.

Phase 5: Sustaining and Scaling the Solution. The final phase focuses on embedding the initiative into the community's fabric and exploring opportunities for scalability. Partnerships with local organizations and schools are formalized to ensure continuity, while long-term funding opportunities are pursued. Success stories and best practices from pilot regions are documented to guide replication in other areas. The underlying assumption of the theory of change is that sustained stakeholder collaboration and community engagement will institutionalize the behaviours and practices promoted by the initiative.

The core features of the solution—stakeholder collaboration, contextual adaptation, and a structured process for engagement, implementation, and monitoring—serve as essential pillars for achieving the expected outcomes. The process reflects the theory of change by addressing root causes, leveraging community assets, and building systemic resilience against obesity.

**Organisational requirements of the solution:** To implement COPLPI effectively, the organization will require a team of skilled professionals including dietitians, fitness experts, educators, and community organizers. Technical infrastructure will be needed to develop online platforms for resource sharing and tracking program participation. Adequate funding must be allocated for subsidized programs, educational materials, and stakeholder training sessions. Facilities such as accessible spaces for workshops, fitness activities, and community gatherings will also be essential.

**Requirements for the broader context of the solution:** The broader context must provide cultural sensitivity to accommodate diverse dietary practices and physical activity norms. Social and political support will be necessary to introduce and enforce policies that encourage healthy environments. Healthcare information systems must be compatible with the program's data collection and privacy protocols. Geographic accessibility will be critical, particularly in rural areas, to ensure transportation and infrastructure support program activities.

**Background Material:** This solution is adapted as an example using A! from the "Community Action Framework for Obesity Prevention," which has been successfully implemented in rural and underserved areas across several EU countries. The original framework focuses on multi-sectoral efforts, community engagement, and stakeholder collaboration. Detailed methodologies and background information are available through the EU Best Practices Portal: EU Obesity Prevention Framework. The original framework was designed for urban settings and emphasized public transportation and digital engagement. COPLPI has been adapted for rural regions, incorporating mobile workshops and pop-up fresh produce markets. Partnerships with local schools and churches have been established to broaden the initiative's reach. Additionally, the digital tools of the program have been simplified to address the limited internet access that may exist in certain areas.

## **Example 4: Integrated Care Model for Multi-Professional Teamwork in Chronic Disease Management**

**Name of the solution:** Integrated Care Model for Multi-Professional Teamwork in Chronic Disease Management

**Purpose of the solution:** The primary aim of this model is to enhance health outcomes and care coordination for individuals with chronic conditions by fostering structured multi-professional teamwork. The approach focuses on preventing disease progression, reducing hospital readmissions, improving patient self-management, and minimizing care fragmentation through enhanced communication among healthcare providers.

**Target group / population of the solution:** This model serves patients with chronic diseases such as diabetes, cardiovascular conditions, COPD, and mental health disorders, with special attention to elderly patients with multimorbidity requiring integrated care. Additionally, the model supports healthcare professionals, including general practitioners, specialists, nurses, pharmacists, social workers, and psychologists, by providing a structured framework for interdisciplinary collaboration.

**Solution as a practice:** The Integrated Care Model follows a structured process designed to ensure collaboration, patient-centred care, and system-wide efficiency across healthcare settings.

The model operates on the principle that by systematically fostering interdisciplinary collaboration, integrating digital tools, prioritizing shared decision-making, and embedding proactive care strategies, healthcare systems can enhance patient outcomes and optimize resource utilization. The theory of change suggests that if healthcare teams work in a coordinated and structured manner, leveraging technology and data-driven approaches, patient engagement and health outcomes will improve, leading to a more efficient and cost-effective healthcare system.

Through digital integration, shared care planning, and a focus on preventive interventions, the model ensures that patients receive continuous, well-coordinated care. By aligning financial incentives with patient-centred outcomes, healthcare systems can reinforce collaborative practices and long-term sustainability.

### Client process

**Patient Identification and Inclusion:** Patients are identified using electronic health records (EHRs) and risk stratification tools to recognize individuals with complex needs. Primary care providers engage patients, explaining the benefits of the model and guiding them into coordinated care pathways.

**Assignment to a Multi-Professional Team:** Each patient is assigned to a dedicated multi-professional team, including physicians, nurses, social workers, and other specialists. A designated care coordinator ensures alignment, continuity, and effective communication among team members.

**Comprehensive Assessment and Care Plan Development:** A personalized care plan is co-designed by the multi-professional team, incorporating medical, psychological, and social factors. The patient and their family actively participate to ensure a holistic, patient-driven approach.

**Ongoing Care Coordination and Real-Time Adjustments:** Regular interdisciplinary meetings review patient progress and adapt treatment plans. Digital tools, such as shared EHRs and telemedicine, facilitate real-time updates and seamless coordination.

**Proactive and Preventive Care Implementation:** Screening tools, predictive analytics, and early intervention programs help shift the focus from reactive treatment to prevention, reducing hospitalizations and long-term complications.

**Financial Alignment and Resource Optimization:** Value-based payment models incentivize high-quality, coordinated care, ensuring sustainable funding for digital infrastructure, workforce training, and community partnerships.

**Outcome Tracking and Continuous Improvement:** Data analytics assess patient progress, refine workflows, and inform intervention strategies. Patient and provider feedback loops ensure the model remains responsive to emerging healthcare challenges.

By integrating multi-professional collaboration, shared decision-making, digital tools, proactive care, and financial sustainability, the Integrated Care Model provides a scalable and adaptable framework for optimizing chronic disease management.

**Organizational requirements of the solution:** Successful implementation requires a robust digital infrastructure supporting interoperable EHRs and secure communication platforms for care teams. Training programs equip professionals with skills for interdisciplinary teamwork. Financial sustainability is ensured through reimbursement models aligned with value-based care, while structured protocols guide care coordination, referrals, and case discussions.

**Requirements for the broader context of the solution:** A supportive policy and regulatory environment is essential for enabling data sharing while ensuring privacy compliance. Culturally tailored patient engagement strategies enhance participation and effectiveness. Professional education fosters acceptance of collaborative care models, and digital infrastructure must facilitate seamless data exchange across care settings.

**Background material:** This solution builds on established integrated care models, including the Patient-Centred Medical Home (PCMH), the Accountable Care Organization (ACO) framework, and the WHO Integrated Care for Chronic Diseases model. Additional insights are drawn from OECD Health Policy Studies and the European Best Practices Portal.