DOCTORAL DISSERTATION

Prof.(FH) Ing. Mag. Peter J. Mayer, MAS MSc MBA

University of Sopron
Sopron
2022

University of Sopron

Alexander Lámfalussy Faculty of Economics

István Széchenyi Management and Organization Studies Doctoral School

Joint Cross-Border PhD Program

INTERPROFESSIONAL COLLABORATION IN INTEGRATED HEALTH CARE

Doctoral (PhD) Dissertation

Written by:

Peter J. Mayer

Supervisor:

Prof. Dr. Dr. h.c. Csaba Székely, DSc

Sopron

2022

INTERPROFESSIONAL COLLABORATION IN INTEGRATED HEALTH CARE

Dissertation to obtain a PhD degree Written by:

Peter J. Mayer

Prepared by the University of Sopron

István Széchenyi Management and Organization Studies Doctoral School

within the framework of the

International Economy and Management Programme

Supervisor(s): Prof. Dr. Dr. h.c. Csaba Székely, DSc

Dr. ______________________________

The supervisor(s) has recommended the evaluation of the dissertation be accepted:

yes / no

____

supervisor signature

Date of the comprehensive exam: 20_____ year ___________________ month ______ day

Result of the comprehensive exam __________ %

The evaluation has been recommended for approval by the reviewers (yes/no)

1. opponent: Dr. ____________________________ igen / nem ______________________

(signature)

2. opponent: Dr. ____________________________igen / nem ______________________

(signature)

Result of the public dissertation defence: ____________ %

Sopron, 20____ year __________________ month _____ day

____

Chairperson of the Judging Committee

Qualification of the PhD degree: _______________________

____

UDHC Chairperson

Best Point of Service

means "curative care at the right time in the right place
with optimal medical and nursing quality
as cost-effectively to the economy as a whole."

Integrated health care

means "patient-oriented, continuous, cross-sectoral,
interdisciplinary and/or multi-professional health care."

(Both according to Article 3 of the
Austrian Health Targets Steering Act, according to the Act's definitions.)

It is the patients

"…who are the reason hospitals are operated;
It’s their reason we work there."

(Eugen Hauke, former General Director of the Vienna Health Association)

TABLE OF CONTENTS

1. INTRODUCTION 1

2. RESEARCH QUESTION AND HYPOTHESIS 2

2.1 RESEARCH QUESTION 2

2.2 HYPOTHESIS 2

2.3 METHODOLOGY 3

2.3.1 Literature Review 4

2.3.2 Quantitative Research 5

2.3.3 Qualitative Research 7

3. LITERATURE ANALYSIS 9

3.1 HEALTH CARE SYSTEMS 9

3.1.1 Definition Health Care System 9

3.1.2 Basic Models of Health Care Systems 10

3.1.3 The Austrian Health Care System 12

3.1.4 Health Care Sectors and Service Providers 16

3.2 HEALTH CARE ORGANIZATIONS 16

3.2.1 Organizations in a Metaphorical View 18

3.2.2 Health Care Organizations as Expert Organizations 20

3.2.3 Characteristics of the Austrian Health Care Organizations 22

3.2.4 The Role of the Patients 24

3.3 ORGANIZATIONAL CULTURE 24

3.3.1 Mission Statement 25

3.3.2 Cultural Values and Cultural Work 26

3.3.3 Cultural Work in the Health Care Facilities of the Sisters of Mercy 32

3.4 LEADERSHIP AND MANAGEMENT 40

3.4.1 Management Structures in Health Care Organizations 42

3.4.2 Leadership Requirements 43

3.5 HEALTH PROFESSIONALS 44

3.5.1 Profession and Professionality 44

3.5.2 Interprofessional Collaboration 50

3.6 INTEGRATED HEALTH CARE 51

3.6.1 Definition Integrated Health Care 52

3.6.2 Integrated Health Care Management 55

3.6.3 Best Point of Service 56
3.6.4 Integrated Health Care Region „Healthy Kinzigtal" 59
3.6.5 Quality in the Context of Integrated Health Care 62
3.7 THE FUTURE OF HEALTH CARE SYSTEMS 63
3.7.1 The Importance of Public Health 64
3.7.2 Digitization in Health Care 66
3.7.3 Health Literacy 66
3.7.4 The Future of Health Care 68
3.8 SUMMARY OF LITERATURE ANALYSIS 70

4. EMPIRICAL STUDIES / OWN RESEARCH ……………….........…………..78
4.1 DEMOGRAPHICS 78
4.2 STATISTICAL ANALYSIS 78
4.3 CONTENT ANALYSIS 108
4.3.1 Analysis of the Expert Survey 108
4.3.2 Analysis of the open-ended Questions of the quantitative Survey 117
4.4 LIMITATIONS 120

5. RESULTS AND FINDINGS ...………………......……………………………….....123
5.1 RESULTS OF THE QUANTITATIVE RESEARCH 123
5.2 RESULTS OF THE QUALITATIVE RESEARCH 127
5.3 OVERALL RESULT OF THE QUANTITATIVE AND QUALITATIVE RESEARCH 134
5.4 OVERALL RESULT SUMMARIZED 136

6. NEW SCIENTIFIC STATEMENT (THESIS) **……………………….....………....137**
6.1 ANSWERING THE RESEARCH QUESTION 137
6.2 SCIENTIFIC ADDED VALUE FOR HEALTH SERVICES RESEARCH 139
6.3 ADDED VALUE FOR HEALTH CARE PRACTICE AND EDUCATION 141

7. CONCLUSION ………………………........…………………………………..…..144

8. REFERENCES ……………………………..……………………………….....148

9. ANNEX ………………………………………………………..……...……..…..170
ANNEX A - LIST OF LEGAL NORMS (USED NORMS) …………...…........…..…..169
ANNEX B - HOSPITAL QUESTIONNAIRE (QUANTITATIVE SURVEY) ……….......170

ANNEX C - NURSING HOME QUESTIONNAIRE (QUANTITATIVE SURVEY) ……....177
ANNEX D - SUM SCORES (QUANTITATIVE SURVEY) ………..………………..…..181
ANNEX E - VARIABLES OF THE QUANTITATIVE SURVEY INTEGRATION OF HEALTH CARE (HO PERSPECTIVE VS. NH PERSPECTIVE) ..187
ANNEX F - STATISTICAL ANALYSIS DATA (QUANTITATIVE SURVEY: HO PERSPECTIVE VS. NH PERSPECTIVE) ……….…………..…...188
ANNEX G - OPEN QUESTIONS (QUANTITATIVE SURVEY: TRANSCRIPTIONS) …….192
ANNEX H - QUESTIONNAIRE OF THE EXPERT INTERVIEW ….....………......200
ANNEX I - RESULTS OF THE EXPERT SURVEY …….…………………..………..201

ABOUT THE AUTHOR …………………………………………………….…………229

INFORMATION ON THE FORMER SUPERSVISOR ………………………………..230

ABOUT THE SUPERSVISOR ……………………………………………..…………..231

ACKNOWLEDGMENT ………………………………………………………….....232

DECLARATION OF ACADEMIC HONESTY …...…….…………………….……..233

ABSTRACT

Health care systems originated in earlier epochs as responses to the needs of the time and currently present themselves as evolved systems that in many respects no longer meet the requirements of the present day. The Austrian health care system is based on the social insurance model of Otto von Bismarck, the former Chancellor of the Prussian Empire (1815-1898).

Although continuously developed, health care providers, as well as patients, are confronted with evolved structures that have to be overcome by mostly costly compensation services. Patients who are becoming more self-determined as well as upcoming generations of health professionals are demanding more and more meaningfully designed treatment processes.

Integrated care, in both forms population-based and indication-based form, guarantees good coordination of the care pathways. The prerequisite for this is, in addition to the approach to the "best points of service" along the health care pathways, good interprofessional cooperation between health professionals within care institutions and across institutions.

The results of this research show that, in addition to the creation of suitable health policy framework conditions, the culture of interprofessional cooperation across institutional and sectoral boundaries is of decisive importance. Strategies based on shared guiding principles and responsibility by leadership and management for the entire care pathway, are among the most influential factors for a contemporary design of the health care system.

KURZFASSUNG

Gesundheitsversorgungssysteme finden Ihren Ursprung in früheren Epochen als Antworten auf die Nöte der damaligen Zeit und stellen sich gegenwärtig als gewachsene Systeme dar, die den Anforderungen der heutigen Zeit in vielerlei Hinsicht nicht mehr entsprechen. Das österreichische Versorgungssystem beruht auf dem Sozialversicherungsmodel von Otto von Bismarck, dem ehemaligen preußischen Reichskanzler (1815-1898).

Obwohl laufend weiterentwickelt, sehen sich Gesundheitsdienstleistende sowie auch Patienten gewachsenen Strukturen gegenüber, die es durch meist aufwändige Kompensationsleistungen zu überwinden gilt. Nicht zuletzt selbstbestimmter werdende Patienten fordern ebenso wie nachkommende Generation in Gesundheitsberufen sinngebende und sinnverstehende Aufgabenbereiche und Versorgungsablaufe.

Integrierte Versorgung gewährleistet sowohl dabei als populationsbezogenes als auch indikationsbezogene Versorgungsform eine gute Abstimmung der Versorgungswege. Als Voraussetzung hierfür gilt freilich neben der Annäherung an die "Best Points of Service" entlang der Versorgungswege, ein gutes interprofessionelles Miteinander der Gesundheitsberufe sowohl innerhalb der Versorgungsinstitutionen als auch institutionenübergreifend.

Die Ergebnisse der vorliegenden Forschung zeigen, dass neben der Schaffung geeigneter gesundheitspolitischer Rahmenbedingungen, der Kultur des interprofessionellen Miteinanders über Institutions- und Sektorengrenzen hinweg maßgebliche Bedeutung zukommt. Auf gemeinsamen Leitsätzen basierende Strategien, gefolgt von der die gesamten Versorgungswege mitverantwortenden Führung und Management, zählen zu den einflussreichsten Faktoren einer zeitgemäßen Gestaltung des Gesundheitsversorgungswesens.

LIST OF FIGURES

Figure 1 Structure of the Thesis, own illustration 4
Figure 2 Organizational Structure of the Vincent Group, Vinzenz Gruppe (2020d) 34
Figure 3 Health and Education Systems, WHO (2010) 47
Figure 4 Competence Atlas, according to Heyse and Erpenbeck (2004) 49
Figure 5 Components of dHealth, Johner Institut (2018) 69
Figure 6 Decision Tree for Test Selection, own illustration based on Keller (2021) 82
Figure 7 Age Distribution of the Survey Participants (HOs vs. NHs), own illustration 83
Figure 8 Education Level of the Survey Participants (HOs vs. NHs), own illustration 83
Figure 9 Type of Health care institutions (HOs vs. NHs), own illustration 84
Figure 10 Primary Profession of the Participants (HOs vs. NHs), own illustration 85
Figure 11 Management Experience of the participants (HOs vs. NHs), own illustration 85
Figure 12 Professional Experience of the Participants (HOs vs. NHs), own illustration 86
Figure 13 Interprofessional Cooperation (HOs vs. NHs), own illustration 87
Figure 14 Interinstitutional Improvement Coordination, Cooperation and Communication, own illustration 89
Figure 15 Intrainstitutional Improvement Coordination, Cooperation and Communication, own illustration 90
Figure 16 Best Point of Service, own illustration 91
Figure 17 Importance of the Culture of Togetherness, own illustration 92
Figure 18 Status quo of the Culture of Togetherness, own illustration 93
Figure 19 Characteristics of Lived Culture, own illustration 94
Figure 20 Resource Optimization through Cooperation, own illustration 95
Figure 21 Potential Savings – histogram (0 to 30%), own illustration 96
Figure 22 Different Professionals - Different Leadership Expectations, own illustration 97
Figure 23 Age Group over 40 Years, own illustration 97
Figure 24 Education and Training, own illustration 99
Figure 25 Different Generations - Different Mindsets (HOs vs. NHs), own illustration 99
Figure 26 Actuality of the Leadership (HOs vs. NHs), own illustration 100
Figure 27 Ethical Responsibility (HOs vs. NHs), own illustration with 101
Figure 28 Mission Statement Effects (HOs vs. NHs), own illustration 102
Figure 29 Functionality of Mission Statements (HOs vs. NHs), own illustration 104
Figure 30 Culture Manageability (HOs vs. NHs), own illustration 105

Figure 31 Culture Effects (HOs vs. NHs), own illustration ……….…………….……………..……105
Figure 32 Effects of Integrated HC on Patients (HOs vs. NHs), own illustration …………….106
Figure 33 Responsibilities and Competencies, own illustration …………..………….………107

LIST OF TABLES

Table 1 Age Distribution of the Participants (HOs vs. NHs), own illustration ……………….…..82
Table 2 Education Level of Participants (HOs vs. NHs), own illustration ………………….……83
Table 3 Type of Health Care Institution (HOs vs. NHs), own illustration ……………..….……84
Table 4 Primary Profession of the Participants (HO vs. NH), own illustration ………..….……84
Table 5 Management Experience of the Participants, own illustration …………………....…85
Table 6 Professional Experience of the Participants, own illustration...…………………….…..…86
Table 7 Interprofessional Cooperation (HOs vs. NHs) - own illustration ……………………..86
Table 8 Interprofessional Cooperation - test statistic, own illustration ……………….………87
Table 9 Interinstitutional Improvement in Coordination, Cooperation, Communication, own illustration …………………………..…………………………………..…88
Table 10 Intrainstitutional Improvement in Coordination, Cooperation, Communication, own illustration ……………………………………..………………………..89
Table 11 Best Point of Service, own illustration …………...……………………….…………90
Table 12 Best Point of Service - test statistics, own illustration ……..………………………..91
Table 13 Importance of the Culture of Togetherness - test statistics, own illustration ………92
Table 14 Valuation of the Status quo of the Culture of Togetherness - test statistics, own illustration ……………………………………………………………….…92
Table 15 Culture of Togetherness - test statistics, own illustration ………………...………93
Table 16 Characteristics of Lived Culture - test statistics, own illustration ….…………..….…93
Table 17 Variables and Sum Variables (HOs vs. NHs) - simultaneous tests, own illustration ……………………………………………..…………………94
Table 18 Resource Optimization through Cooperation, own illustration ..…………….……95
Table 19 Potential Savings - cross table (0 to 30%), own illustration with...………………….……96
Table 20 Different Professionals - Different Leadership Expectations – statistics, own illustration ……….…………………….………………………………..…96
Table 21 Age Group over 40 Years - statistics, own illustration...…………………….………..97
Table 22 Age Group over 40 Years - statistics, own illustration …..……………….……......….98
Table 23 Response Age Group over 40 - test statistics, own illustration ………………..….98
Table 24 Education and Training - test statistics, own illustration …..………………………98
Table 25 Different Generations - Different Mindsets (HOs vs. NHs), own illustration ………99
Table 26 Actuality of the Leadership (HOs vs. NHs), own illustration ..…………..………..100

Table 27 Other Variables and Other Sum Variables (HOs vs. NHs) - simultaneous tests, own illustration ……..…………………………………………………..……101
Table 28 Ethical Responsibility (HOs vs. NHs), own illustration ………..................………..101
Table 29 Mission Statement Effects (HOs vs. NHs), own illustration ………..………..…....102
Table 30 Functionality of Mission Statements (HOs vs. NHs), own illustration …………..…103
Table 31 Culture Manageability (HOs vs. NHs), own illustration …….…………………..…….104
Table 32 Culture Effects (HOs vs. NHs), own illustration ……....…………………….……..….105
Table 33 Effects of Integrated HC on Patients (HOs vs. NHs), own illustration ….…………106
Table 34 Responsibilities and Competencies, own illustration ………………………..……107
Table 35 Hypothesis testing results summarized ……………………………………………126
Table 36 Findings and Recommendations for Health Care Practice, own illustration ………143

LIST OF ABBREVIATIONS

ABGB	Allgemeines bürgerliches Gesetzbuch (General Civil Code)
AHA	American Hospital Association
ahd.	althochdeutsch (old high German)
AI	Artificial Intelligence
α	significance level
ÄrzteG	Ärztegesetz (Austrian Professional Act for Doctors)
asymp.	asymptotic
AOK	Allgemeine Ortskrankenkasse/Gesundheitskasse (Federal Association of Statutory Health Insurance in Germany)
APP	application
ASVG	Allgemeines Sozialversicherungsgesetz (Austrian Social Insurance Act)
BBR	Barmherzige Brüder (Brothers of Mercy)
BHS	Barmherzige Schwestern (Sisters of Mercy)
BMSGPK	Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz (Federal Ministry of Social Affairs, Health, Care and Consumer Protection in Austria)
BPoS	Best Point of Service
BUKO	Bundeskonferenz der Krankenhausmanager Österreichs
B-VG	Bundesverfassungsgesetz, Österreichisches (Federal Constitutional Act)
BW	Baden-Würtenberg
CCIV	Competence Center for Integrated Care
CDS	Clinical Decision Support Tool
COPE	coaching and process evaluation
COVID-19	coronavirus disease 2019
CPD	continuing professional development
doi	Digital Object Identifier
DVFA	Deutsche Vereinigung für Finanzanalyse und Asset Management (German Association for Financial Analysis and Asset Management)
GDA	Gesundheitsdiensteanbieter (health service providers)
GDP	Gross Domestic Product
GP	General Practitioner
HKP	Hauskrankenpflege (home nursing)

EIT	European Institute of Innovation and Technology
EKIV	Evaluationskoordinierungsstelle Integrierte Versorgung (coordination unit IV)
etc.	et cetera (and the rest of the things)
et seq.	et quentes
EU	Europaen Union
EUR	EURO (European currency)
e.V.	eingetragener Verein (registered association)
GeKiM	Gesundes Kinzigtal Mitgliederbefragung (Healthy Kinzigtal Member Survey)
GmbH	Geselschaft mit beschränkter Haftung (Ltd., limited company)
GOe	Global Observatory for eHealth
GÖG	Gesundheit Österreich GesellschaftmbH (Health Austria Ltd.)
GQG	Gesundheitsqualitätsgesetz (Austrian Health Quality Act)
G-ZG	Gesundheits-Zielsteuerungsgesetz (Austrian Health Targets Steering Act)
H, h	hypothesis
$h_{0.n}$	null hypothesis (n = 1 to 10)
$h_{1.n}$	alternate hypothesis (n = 1 to 10)
HC	health care
HMO	health maintenance organizations
HO	hospital
HVB-SV	Hauptverband der Sozialversicherungsträger
IBM	International Business Machines (Corporation)
ICT	information and communication technologies
i.d.g.F.	in der geltenden Fassung (in the current version)
i.e.	id est (lat.)
ISBN	International Standard Book Number
ISSN	International Standard Serial Number
IT	Informationstechnologie
IVGK	Integrierte Versorgung Gesundes Kinzigtal (Integrated care Healthy Kinzigtal)
KAKuG	Kranken- und Kuranstaltengesetz (Austrian Hospital Act, principle law)
lat.	lateinisch (Latin)
Ltd.	Limited (limited company)
LKK	landwirtschaftliche Krankenkassen (Agricultural Health Insurance in

	Germany)
MAXQDA	MAX stands for the German sociologist Max Weber, QDA for Qualitative Data Analysis (brand name of the analysis tool)
MQNK	Medizinisches Qualitätsnetz – Ärzteinitiative Kinzigtal (Medical Quality Network - Doctors' Initiative Kinzigtal)
MVZ	Medizinisches Versorgungszentrum (Medical Care Center)
n. No.	no number
NH	nursing home
NHS	National Health Service (in Great Britain and Northern Ireland)
NHST	null hypothesis significance testing
OECD	Organization for Economic Co-operation and Development
ÖÄK	Österreichische Ärztekammer (Austrian Medical Association)
OGH	Oberster Gerichtshof (Austrian Supreme Court)
ÖGK	Österreichische Gesundheitskasse (Austrian Health Insurance)
ÖGPH	Österreichische Gesellschaft für Public Health
p	probability
p., pp.	page, pages
para.	paragraph
PDA	personal digital assistant
PIV	populationsbezogene integrierte Versorgung (population-based integrated care)
Q, q	question
SARS-CoV-2	**s**evere **a**cute **r**espiratory **s**yndrome ***co****rona****vi****rus* type **2**
SDM	Shared-Decision-Making
sig.	significance
sic	sīc erat scriptum (so it was written)
SPSS	Statistical Package for the Social Sciences (brand name of the analysis tool)
Subpara.	subparagraph
SVR	Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheits-wesen (expert council for the assessment of the development in the health care system)
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization

US	United States
USA	United States of America
vs.	versus
WGKK	Wiener Gebietskrankenkasse
WHO	World Health Organization
y.	year

1. INTRODUCTION

In many ways, integrative health care is a form that has long been urgently needed. Coordinated care pathways do not only allow the optimization of health resources, they also create conditions for putting patients at the center of attention - as can be found in almost all mission statements of health care institutions - and treating patients at the right time in the right place according to their care needs. Interprofessional cooperation across institutions is a conditio sine qua non of integrated care. The research interest of this thesis is based, first on the author's many years of professional experience in various leadership functions in the Austrian health care system, both at the operational and strategic level, second is justified by his constant scientific examination of health care deficits. An analysis of the health care system to identify and develop optimization potentials would fall short without orientation towards health professionals and their interaction.

Joint coordination between health care sectors in the sense of integrated health care is becoming a fundamental challenge. Interprofessional cooperation is gaining essential importance in this context. The recent scientific discussion speaks of best points of services in health care and has already been taken up by health policy so that care is being provided in the best possible and also economically justifiable form for the health care systems. Besides objective care needs the focus of this thesis is on the far-reaching approximation to subjective needs of patients. The indention of this work is to promote further scientific debate and, gain knowledge for a continued discourse in health care sciences and provide guidance for all levels of the health care system as to which measures are suitable to promote interprofessional cooperation as an essential basis for integrated health care or, in some places, to make it possible in the first place.

The thesis is assigned to the health sciences and in particular to health services research in the scientific field of Public Health. Following Acheson (1988), the WHO describes Public Health as "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society". The European Commission, referring to Don Nutbeam (1998), adds, "Public health can be understood as the structures and processes by which the health of the population is understood, protected and promoted through the organized efforts of society" (WHO, 2011b).

2. RESEARCH QUESTION AND HYPOTHESIS

2.1 RESEARCH QUESTION

The research question, based on the current state of research, should express the research interest of the present thesis. Research questions usually indicate a "neutral interest in knowledge" and are intended to contribute to further research into the subject matter. Building on the theoretical analysis of the following part of this thesis (see section 3), hypotheses are generated to determine the "existence, direction and strength" of certain effects (Braunecker, 2016; Döring & Bortz, 2016).

The main question of this thesis is dealing with the development and implementation of sustainable, humanistic organizational cultures in integrated health care:

How can integrated health care management, based on well-founded values concepts, be developed sustainably?

The sub-research questions ask about their controllability, the management of value-based organizational cultures, and their influence on interprofessional cooperation in care:

How can organizational culture be managed across the boundaries of health care institutions?

and

How can values-based organizational culture improve interprofessional collaboration across organizations?

2.2 HYPOTHESIS

In the following, the hypotheses of the thesis are listed:

Interprofessional cooperation (q1 + q2)

H_1: There is a difference between HOs and NHs regarding the view of interprofessional collaboration.

Best point of service (q7)

H_2: From the organizational point of view of HOs, the realization of BPoSs is evaluated significantly higher than from the point of view of NHs.

Culture of togetherness (q8)

H_3: In highly developed socio-technical systems like HOs, the culture of togetherness is more highly assessed than in NHs.

Optimizing potential through cooperation (q14)

H_4: In highly developed socio-technical systems like HOs, the assessment of savings (optimization) potential is significantly lower than the assessment in long-term care, as NHs.

Different leadership approaches (q15)

H_5: There is a difference between HOs and NHs regarding the view that different health professions need different leadership approaches.

Different mindsets (q18 + q19)

H_6: There is a difference in the view of HOs and NHs that upcoming generations have changed leadership expectations due to a different mindset.

Mission statements performance (q24 to q26)

H_7: There is a difference between HOs and NHs regarding the view of the importance of mission statements for the organization.

Mission statements' functionality (q27 to q32)

H_8: There is a difference regarding trust in guiding principles between HOs and NHs in general.

Impact of cultural work (q36 to q39)

H_9: There is a difference regarding the importance of cultural work between HOs and NHs in general.

Confidence in the effects of integrated HC (q40)

H_{10}: There is a difference regarding the confidence in the effects of integrated HC on patients between HOs and NHs.

In the course of the statistical analysis (see chapter 4.2), the hypotheses are presented in the form of $h_{0.1}$ to $h_{0.10}$ (null hypotheses) and $h_{1.1}$ to $h_{1.10}$ (alternate hypotheses).

2.3 METHODOLOGY

Following the methodological considerations, it is necessary to develop a precise and appropriate research design that leads to meaningful results regarding the research problem (Döring & Bortz, 2016). In the following, the empirical research design on which the thesis is based will

be presented. The design explains in particular why certain methods are used. An essential criterion is that the chosen methods are suitable to adequately examine the research subject (Hug & Poscheschnik, 2015).
The following chapter provides information about the methodology and used methods. It describes particulary the systematic approach that leads to the answer of the research question. An extensive literature review provides a reflection on the current state of research following the research question. A series of research hypotheses will serve to specify this more precisely.

Using a quantitative research approach, "theoretically derived research hypotheses are tested on many research units using structured data collection methods" (Döring & Bortz, 2016). This thesis is intended to be an application-oriented study. The findings are aimed at solving practical problems in health care, especially for interprofessional collaboration in integrated care through appropriate interventions. A mixed method research design was chosen. On the basis of research hypotheses derived from the theoretical background interrelationships of the object of study as well as already researched facts regarding health care integration are to be investigated and statistically evaluated. The results are completed by a qualitative investigation among designated experts from the health care system.

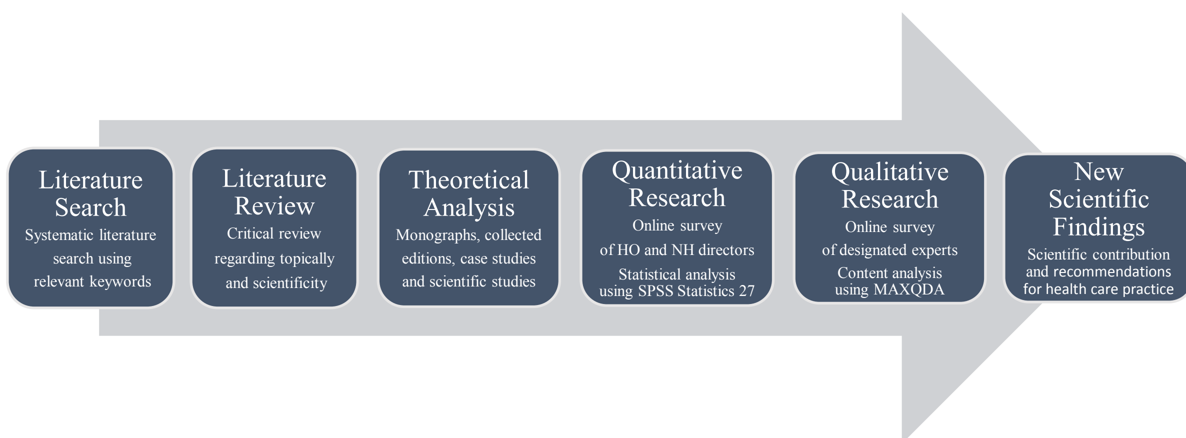


Figure 1 Structure of the Thesis, own illustration

2.3.1 Literature Review

A systematic approach and use of relevant literature is recommended, and search terms should first be defined. On this basis scientific databases are systematically searched (Döring & Bortz, 2016). Hannah Snyder (2019) pleads for literature review as a research methodology. Questions about the quality and trustworthiness of findable sources can be asked quickly, and a good selection can be made. The certainty that the selection of literature is based on great accuracy

makes it easier to refine research questions and formulate hypotheses precisely (Döring & Bortz, 2016).

Search terms are thematic key words which are used to find relevant sources. In the present thesis, the main search criteria were "interprofessional", "interprofessional cooperation", "health care", "health care provision" and "integrated care". The thesis is based almost exclusively on scientific sources that could be found in the form of subject-specific and subject-related monographs, contributions from collective works and specialist journals. The sources were subsequently reviewed and structured. Databases and internet research were used in the search, as well as sources from local university and college libraries and specialist literature from the library's own holdings. To facilitate electronic searches, search terms with Boolean operators such as *and* (conjunction) were used. *or* (disjunction) and *not* (negation) were combined. After checking for suitability, including the research background of the author(s), the full text of the sources was searched for and the acquisition of the literature sources was organized, partly also in electronic form. The selection of specialist literature was largely based on newer, i.e., current literature from the last five years. Wherever it was possible to produce the literature in accordance with the current state of research, literature older than five years has also been used.

2.3.2 Quantitative Research

The choice of methods suitable for empirical research requires precise preparation. In line with the quantitative research approach, the process step of "operationalization" (Döring & Bortz, 2016) involves defining a specification of all "relevant features of empirical reality" within the framework of the hypotheses to be tested. And obtaining meaningful data requires defining measurement criteria in relation to the characteristic values. Therefore the scale level of the variables needs to be defined to ultimately achieve the greatest possible descriptive content of the data and to make a suitable choice regarding the statistical evaluation methods (Döring & Bortz, 2016).

The collection of data is based on a systematic survey using a sampling approach. On the one hand, top-level managers of hospitals (HOs) and, on the other hand, managers of nursing homes (NHs) are to be surveyed. However, the aim is to obtain a "miniature image of the population"

(Döring & Bortz, 2016), so that the characteristics and effects of the population ("sample representativeness") can be reflected as accurately as possible.

The survey is based on a fully standardized questionnaire. Standardized questionnaires mainly consist mainly of closed questions. In addition, context-dependent statements with answer specifications are provided. The structure of standardized questionnaires usually consists of six parts, the title of the questionnaire, instructions for filling it in, the content of the question blocks, statistical information, a feedback option, and a word of thanks. A logical sequence of the content blocks is recommended as well as a structure separated by subheadings. The content blocks contain items that are used to operationalize the variables of interest according to the research hypotheses. Questionnaire items can consist of a question plus answers, a statement plus answers, or invitations plus answers. The statistical part of the questionnaire provides space for socio-demographic information. For this section of the questionnaire, partly closed (e.g. education) and partly quasi-closed factual questions (e.g. years of work experience) are being used. At the end of the content section an open qualitative question provides space for individual comments (Döring & Bortz, 2016).

The survey process is seen as an essential part of the empirical study. Standardized questionnaires are used, systematically distributed, processed and returned electronically. The questionnaire is accessible via web link. The addresses are contacted with the help of the central mail distribution list of the Federal Conference of Austrian Hospital Managers (BUKO, Bundeskonferenz der Krankenhaus-Manager Österreichs) on the one hand and with the help of the distribution list of the Federal Association of Old People's and Nursing Homes in Austria (Lebenswelt Heim – Bundesverband) on the other hand. Therefore only persons with expertise in the researched field will be interviewed. The survey is to be preceded by a pre-test in which paper-pencil questionnaires are distributed to the investigators and collected immediately after the survey has been completed. In order to avoid "trial leader effects" (Döring & Bortz, 2016) in this face-to-face group situation, attention is paid to accurate standardization in the oral communication (e.g. about the concerns and purpose of the investigation). In order to further exclude "pre-test effects" (such as the so-called "test exercise") (Döring & Bortz, 2016) a group of people who are separate from the survey but who come from the same world of experience as the target groups is being interviewed. The pre-test particulary serves to evaluate the understanding of the questionnaire and to improve the questionnaire instrument if necessary. The evaluation of the survey data of the two groups (setting hospital and setting nursing home) is

carried out according to scientific criteria for quantitative analysis methods by means of software-supported data analysis. The analysis tool used is "IBM SPSS Statistics 27" (Statistical Package for the Social Sciences), published by the IT company "International Business Machines Corporation" (IBM, 2020).

The hypotheses (see point 2.2) can be formulated which serve for a closer analysis of the research field. For each research hypothesis (or alternative hypothesis), a complementary null hypothesis can be defined which negates the postulated effect. The alternative and null hypotheses form the basis of the significance test (NHST: null hypothesis significance testing). In the presentation of the hypotheses in scientific papers only research hypotheses are mentioned (Döring & Bortz, 2016).

2.3.3 Qualitative Research

In the qualitative research section, experts from different areas of Austrian health care have been interviewed. The experts are working in health care planning, in the field of health economics or in strategic and operational health care areas. In addition experts from health care consulting and representatives of patient organizations will also have their say. The survey results are subjected to qualitative content analysis. Hussy, Schreier & Echterhoff (2013) describe the procedure of content analysis as a systematic and data-reducing method for the "comparative analysis of material containing meaning". In this process individual segments (parts of the material) are assigned to a previously determined "content-analytical category system" and subsequently evaluated. In the following, the main and subcategories of the qualitative survey are presented (see chapter 4.3):

category **Integrated Health Care**

subcategories: Interprofessional Cooperation
Interfaces Management
Covid-Impact

category **Culture of Cooperation**

subcategories: Culture of Togetherness
Attaining a Living Organizational Culture
Optimizing Potential through Cooperation

category **Leadership in an Interprofessional Context**

subcategories: Education and Training
Different Mindsets
Style of Leadership

category **Shared Cultural Understanding**

subcategories: Culture Manageability
Mission Statements Performance
Mission Statements' Functionality

category **Impact of Integrated Health Care**

subcategories: Transferability of Integrated Health Care Models
Integrated Health Care Interface Optimization
The Individual's Influence on Health Care Integration

3. LITERATURE ANALYSIS

The work is preceded by a comprehensive systematic literature review on the topic. Relevant studies were consulted as well as current scientific literature. Following the theoretical discourse, hypotheses are generated whose validity is subjected to statistical tests. The literature section is divided into seven subchapters. At the beginning, an attempt is made to describe the complexity of health care systems in general and the Austrian health care system in particular in a comprehensible way. Afterward, health care organizations are being systematically analyzed and in particular the phenomenon of organizational culture, its development as well as the chmaintenance of claimed cultural values are examined. The theoretical part continues with the challenges for leadership and management functions in health care organizations and the interprofessional cooperation of different health professionals. This section concludes with a discussion of the concept of integrated health care and an outlook on the organizational future of further developed health care systems.

3.1 Health Care Systems

Health systems consist of “all the people and actions whose primary purpose is to improve health. They may be integrated and centrally directed, but often they are not" (WHO, 2000). The question "Why do Health Systems matter?" and the introductory quotation of the literary review of this work introduces the first chapter of the WHO Health Report 2000, which has set itself the goal of developing the potential of health systems and enabling comparisons. - "Why do health systems matter?" is also the central guiding question, which is to be given a framework at this point.

3.1.1 Definition Health Care System

Different definitions of the term „Health Care System“ can be found in the relevant literature. A WHO definition was created at the European Ministerial Conference on Health Systems: "Health Systems for Health and Wealth" in Tallinn (Estonia, June 25-27, 2008). As stated in the Tallinn Charter "Health Systems for Health and Wealth" in item 2 of the preamble, health care systems are described as follows: „Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and

resources mandated to improve, maintain and restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health“ (WHO, 2008a).

There is no uniform definition of the term "health care system" in the specialist publications on health sciences, particularly in the literature on health services research. According to a conceptual version of the World Health Organization (WHO) referring to "The world health report 2000" by WHO, a health system is defined as "all the activities whose primary purpose is to promote, restore and/or maintain health; the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health."

The Allgemeine Ortskrankenkasse/Gesundheitskasse in Germany (AOK) defines a health care system as a system that „includes all facilities that maintain, promote and restore the health of the population and prevent disease“ (translated into English) (AOK, 2016). Similarly, on the health portal of the Austrian Ministry of Health: "The health system ensures that sick people get well again, and healthy people stay healthy: it includes health care, health promotion, and prevention" (translated into English) (Gesundheit.gv.at, 2020). It is also stated that the health and guarantee of health care is a public concern: the federal government, the states, the municipalities, social insurance, and legal interest groups are responsible for various health care tasks. However, health services are provided by public, privately organized non-profit organizations and private institutions (BMSGPK, 2020a). Almost all health care systems have one thing in common: their complex design. Health systems have a large number of institutions and actors, which are diverse and interrelated. Not least, this is also due to the fact that health systems consist of grown structures, in a part-dependent historical development.

3.1.2 Basic Models of Health Care Systems

In traditional typologies, health care systems are usually assigned to the Bismarck Model, the Beveridge Model, or the Market-based Model. In addition, the so-called "Semashko Model", a state health service of Soviet character, existed in Central and Eastern European countries until the beginning of the 1990s. It should be noted that the reality of today's national health care

systems is no longer reflected in its pure form in any of the types. The health systems are generally more complex than the typology suggests (Mayer, S., 2016; Schölkopf & Pressel, 2017).

The Bismarck's model, which is based on the social security principle, goes back to the German Chancellor Otto von Bismarck (1815-1898). Social rights are acquired in the sense of insurance through contributions from wage income. In accordance with the principle of needs-based justice, the insured person receives the necessary medical benefits, regardless of the amount of the contributions paid. The state is responsible for shaping the legal framework. The concrete control takes place in the form of self-administration by the health insurance funds and service providers, especially doctors and hospitals (Mayer, S., 2016; Schölkopf & Pressel, 2017).

Beveridge's model, which goes back to the British economist and politician Lord William Henry Beveridge (1879-1963), provides for universal basic security, which makes the necessary medical care available to every citizen in accordance with the health care principle. It is not financed by contributions from the insured, but by tax revenues. The state has a central role to play in its responsibility for both the planning and the provision of medical care in the form of benefits in kind (Mayer, S., 2016; Schölkopf & Pressel, 2017).

And last but not least the market model: The market economy principle prevails in countries with a low grade of social security and public health provisions. Basic health care is based on economic principles and is therefore controlled by market processes. Demanders for health services have a freedom of choice. There is high competition between the various providers of health services. The risk, therefore, remains with the citizens themselves. It is up to them to decide whether to take out private health insurance (Mayer, S., 2016).

The social finance experts Martin Schölkopf & Holger Pressel (2017) tried to capture the reality of the different health care systems more closely by means of "alternative systematization". Their country-by-country division into five categories is intended to illustrate the results as follows:

Category 1: Health care is based on national, centrally administered health services. In addition to Great Britain, where the system originated, this category includes Ireland and Portugal. Local health care facilities are therefore part of the central public administration. Greece offers a mixed form. In addition to the national health services, a social security system exists there, which is assigned to the case of illness.

Category 2: Health care is based on national but regionally administered health services. The provision and management of health care is the responsibility of the regions or provinces. This category includes Italy, Spain, but also Australia, New Zealand and Canada.

Category 3: Health care is also based on national health services, which are managed by individual counties, cities, and municipalities. This category includes the Scandinavian countries Denmark, Norway, Sweden, and Finland.

Category 4: Health care is based on the social security principle. Apart from Austria, this category includes Germany, France, Belgium, Luxembourg, and Japan. Services are provided by local authorities, private non-profit, or private service providers. In the Netherlands and Switzerland, the health care systems are based on the social security principle, but contributions are not dependent on wages but in the form of per capita flat rates.

Category 5: Health care follows a market economy orientation in which there is neither compulsory health insurance for all inhabitants nor a public health service. The health care system of the USA is assigned to this category. The responsibility of the state is limited to public health services for old and vulnerable population groups.

3.1.3 The Austrian Health Care System

The health experts at the Austrian Public Health Institute „Gesundheit Österreich GmbH" (GÖG) and at the European Observatory on Health Systems and Policies emphasize in their analysis of the Austrian health system good access to services of the Austrian health care system. According to Austria Health System Review from 2018 (WHO, 2018), the Austrian consumers of health care services have the lowest levels of unmet medical needs across the EU. Almost the entire Austrian population is socially insured. Nevertheless, the Austrian health system is relatively expensive. The focus remains on inpatient hospital care. This creates imbalances in the allocation of resources between inpatient and outpatient care. Ongoing reforms are aimed at expanding primary health care. In Austria, the focus is on health care. Measures to maintain health (health promotion) and to avoid illness (prevention) are becoming increasingly important (BMSGPK, 2020a).

The Austrian health care system is complex and fragmented. Austria is a democratic republic in the center of Europe with an area of about 83,879 km². As a federal-state Austria consists of

nine provinces. The responsibilities are shared between the state of Austria and the provinces. Many responsibilities have been delegated to self-governing bodies (social insurance and professional bodies of health service providers); and health care financing is mixed, with the state (federal and *Länder* level) and social insurance funds contributing to the budget (Pöttler, 2020; WHO, 2018). Austria has been a member of the United Nations (UN) since 1955 and joined the European Union (EU) in 1995. The gross domestic product (GDP) was about EUR 42.060 per capita in the year 2019. In comparison, the average gross domestic product of the member states of the European Union in 2019 was EUR 31.080 per capita (Statista, 2020a). At the beginning of 2020, there were about 8.9 million people living in Austria. This represents a 0.5 percent increase in the number of inhabitants compared to the previous year. The average life expectancy of men born in 2019 in Austria is about 79.5 years and about 84.2 years for women. In addition to the difference between men and women, which can also be observed in an international comparison, there are also relevant differences between the individual Austrian provinces. According to this, life expectancy for both women and men in Vienna is about one year lower (Statista, 2020b). Measured by the fertility rate, a woman living in Austria had an average of 1.46 children in her lifetime in 2019 (Statista, 2020c). At the beginning of 2020, the proportion of under-twenty-year-olds was 19.3 percent. 61.6 percent of the Austrian population were between 20 and 64 years of age, 19 percent were 65 years and older. A long-term comparison thus shows both a steady decline in the younger population and an increase in the older population (Statista, 2020d). The main causes of death in the Austrian population include cardiovascular diseases, strokes, heart attacks and cancer, which are responsible for about two thirds of all deaths in Austria (Bachner et al., 2019).

Expenditure on Austrian health care amounted to around EUR 28.59 billion in 2018. Around EUR 13.2 billion (46.3%) was spent on inpatient care, around EUR 9.9 billion (34.8%) on outpatient care, EUR 4.24 billion (14.8%) on continued payment in case of illness and only EUR 1.16 billion (4.1%) on health care services and prevention (Statista, 2020e). In 2018, a total of 60,575 nurses were employed in Austrian hospitals, about 51,126 of whom were women. The medical-technical professions had 16,080 employees, about 13,360 of whom were female (Statistik Austria, 2020a). In 2018, a total of 60,575 nurses were employed in Austrian hospitals, about 51,126 of whom were women. The medical-technical professions had 16,080 employees, about 13,360 of whom were female. In the same year, medical personnel, doctors and physicians combined, accounted for about 25,079 persons, of which about 7,987 were in training. 14,773 were specialists, 2,319 doctors were general practitioners (Statistik Austria, 2020b). The age structure of physicians shows that especially among younger physicians, an increasing

number of women are to be found. The Austrian Medical Association (ÖÄK) sees the high proportion of over fifty-year-olds in particular as a major challenge facing the health care system (ÖÄK, 2020).

In the Austrian health care system, in 2017, the population had a total of 271 hospitals with about 64,800 beds at their disposal. Of these, 45,600 beds were allocated to 121 non-profit acute-care hospitals. Accordingly, 7.4 beds per 1,000 inhabitants were available, based on all hospitals, and 5.2 beds per 1,000 inhabitants, based on non-profit hospitals. A fundamental principle of Austrian health care is „to ensure access to high-quality health care which is provided equally – regardless of the inhabitants' age, gender, origin, social status or income – in a way which is suited to the target group, and barrier-free". The Austrian Social Security Act is based on the principle of compulsory insurance, which gives insured persons a legal right to benefits financed on a solidarity basis. Austrian social insurance is mainly financed by insurance contributions and follows the principles of solidarity and self-administration (BMASGK, 2019b).

The scientist and clinical psychologist Herbert Janig & the three physicians Rudolf Likar, chair of palliative medicine, Georg Pinter, clinical geriatrics, & Ferdinand Waldenberger (2020), heart surgeon and chair of health economics and organizational ethics, criticize the Austrian health care system fundamentally: "Institutions obstruct each other. Arguments are more likely to be found why changes are not feasible instead of jointly looking for solution models". Likar et al. (2020) call for a holistic view, to draw on elaborated solutions from other scientific disciplines, "such as philosophy, sociology and psychology", and to learn from past mistakes. A "common vision" is needed that meets the requirements. The interaction of medicine and other areas of health care, as well as their "mutual dependence" must be made conscious in order to create new solutions that aim at communication and cooperation within and between care institutions. Likar et al. (2020) also advocate improved intra- and interprofessional cooperation and communication in care teams. According to the authors, "efficient and effective cooperation" leads to more time for patients: "A functioning team-patient relationship is needed". The "excessive administrative workload" also costs time, which is missing in the relationship work. Likar et al. (2020) speak of "documentary medicine". They generally see the doctor-patient relationship in crisis and therefore demand that the focus should be "back on care medicine".

The health manager and former director of several provincial hospitals Max Laimböck (2008) speaks in a critical review of "disintegrated care" in the Austrian health care system. According to Laimböck, the insufficiently coordinated care provided by health care institutions such as

doctors' surgeries, hospitals, rehabilitation clinics, etc. leads to considerable additional costs due to duplicate examinations and "due to a lack of coordination of treatments" to possible medical disadvantages for patients. According to Laimböck, the integration of the supply routes would lead to both an improvement in the quality of care and to greater efficiency of care (Laimböck, 2008).

The physicians Likar, Pinter, Waldenberger & the psychologist Janig (2020) encourage the establishment of new structures and demand a rethink, both among health policy decision-makers and patients. "Emergency admissions are bursting at the seams", "wards are overcrowded", due to the lack of structures in the primary care sector (especially at weekends and at off-peak times), the hospital is becoming a point of contact. The former Viennese health politician Ingrid Korosec & the health economist Ernest Pichlbauer (2007) even speak of a "displacement of patients to the hospital" due to a lack of suitable care structures. The high number of avoidable hospital treatments, however, requires a strengthening of the primary care sector, which is one of the main goals of the health reform package 2017 (OECD, 2017). The team of authors Likar et al. (2009), like Laimböck, calls for better coordination between intramural (inpatient) and extramural (outpatient) care: "The family doctor is the patient's guide". For this, according to the experts, he must be given time for the patients' concerns: "Only then can he arrange for the correct referral to a specialist or to hospital", otherwise "under-, over- or misdiagnosis" could occur. Apart from adverse consequences for the patient, there would be a disproportionate use of care institutions (OECD, 2017). The Austrian physician and publicist Günther Loewit (2019) also advocates strengthening the family doctor system: "No one in the health care system is better networked with the patient and his social environment than the family doctor". As a long-standing country doctor, he considers the inclusion of the social/family environment to be indispensable, especially since, in his view, the family sphere exerts a decisive influence on "the development and cure of the most common diseases". Loewit therefore believes that it is no coincidence that "the family doctor in English usage is called family doctor". Like Likar, Pinter, Waldenberger & Janig, Loewit advocates "care and humanity towards patients: Touch, care and nursing sensitivity are of enormous importance for seriously ill people. A doctor who has time to sit at the bedside and discuss the course of diagnostics and therapy with his patient will contribute more to the quality of the health care system than countless new prescriptions and quality criteria" (Loewit, 2019).

3.1.4 Health Care Sectors and Service Providers

Basically, the professional health care system is divided into an outpatient or extramural sector and an inpatient or intramural care sector. In addition, health care is divided into three levels of care: primary, tertiary, and secondary. In the current definition of primary care (2014), which was suggested by the European Commission based on the WHO Declaration of Alma-Ata (1978), in which primary health care was given high priority, there is a detailed line of implementation of the primary care level (Dorner, 2016). According to this, primary care is presented as a level of care that provides "generally accessible, integrated, person-centered and comprehensive as well as family-oriented and population-based services" of health care (ÖGPH, 2016). The secondary level of care is defined as medical care provided by specialists, regardless of whether the health care services are provided in the extra-mural or intramural care sector. The primary care level should always be the first point of contact, and the specialist level should only be consulted if medical care cannot be provided adequately. At the tertiary level, care is provided in specialty and university hospitals or special care centers (Dorner, 2016).

In the Austrian health care system, the utilization of secondary and tertiary care is many times higher than in other countries (Pichelhöfer & Maier, 2015). In order to relieve the secondary care sector in particular, the Austrian health reform of 2017 created the legal basis for an expansion of primary health care. In order to realize "multi-professional and interdisciplinary primary care close to home", so-called primary care units (PVE) based on the model of primary health care centers (PHC) were to be established throughout Austria by 2021 (Pöttler, 2020), which only took place to a very limited extent due to the covid pandemic.

3.2 Health Care Organizations

The US-American economic philosopher and management coach Frederic Laloux sees our current organizational models as reaching their limits. Laloux renounces our "structural faith" in organizational design and calls for an epochal paradigm shift: "Even activities in which people follow a vocation are not immune to disillusionment with organizational structures" (Laloux 2015). Laloux quotes in his work, first published in English in 2014, in his book "Reinventing Organizations", a number of renowned masterminds, such as the pioneer of modern management theory Peter F. Drucker (1909-2005): "The greatest danger in times of upheaval is not the upheaval itself, it is acting with yesterday's logic" or American philosopher and visionary Richard

Buckminster Fuller (1895-1983): "We do not change things by fighting against the existing reality. In order to change things, we have to develop a new model that makes the old model superfluous". His statements and findings still seem to be valid today. Laloux compares organizations, especially hospitals, to "soulless" machines in which pretended procedures have to be followed: "We have turned hospitals into cold, bureaucratic institutions, depriving doctors and nurses of their ability to care for people from their hearts (Laloux, 2015).

Laloux describes the stages in the development of organizational models from a "tribal" organization, to the "traditional" or "conformist" organization, with strongly formalized roles and rigid hierarchical structures to "modern, performance-oriented" organization, characterized by competition and expansion, and finally to the "post-modern, pluralistic" organization, with a focus on "culture and empowerment", in order to open up the potentials of the members of the organization in particular (Laloux, 2015). Grave change requires one thing: courage! A contemporary mastermind, who has been committed for many years to the design of health care facilities that are compatible with the times, is Heinz Lohmann, former chairman of the board of German state hospitals and now the organizer of large-scale health care industry congresses in Austria and Germany. In "Mut zum Wandel", a collection of field reports by renowned authors from the health care industry, the former president of the umbrella organization of German hospitals, Wolfgang Pföhler, states right at the beginning, in his foreword, that there is a lack of scientifically sound solutions and political plans "for the area of conflict between entrepreneurial action, medical possibilities and welfare state care" (Lohmann, 2004). In the year 2022 it is not much different.

The question that now arises is, when will it be until the next stage can be reached? Or vice versa, who will stick to the existing organizational view, or better: world view? Laloux (2015) describes the change from one level to the next one as a "great undertaking in cognitive, psychological and moral terms". And "it requires courage". Of course, it is an advantage if the entire organization has reached a level of maturity that favors change when the members of the organization already see the world from a "more complex perspective". On the other hand, the insistence on the status quo is justified on the normative level. Consciously or unconsciously, according to Laloux (2015), "leaders consciously or unconsciously provide those structures, practices and cultures" that "seem to make sense to them and correspond with their approach to the world". Laloux examined twelve organizations of different sizes and from different sectors, including three companies from the health and social services sector: a profit-oriented clinic group in Germany with 600 employees, a non-profit ambulatory care organization in the Netherlands with 7,000 employees and a non-

profit social organization in the USA for the care of people with disabilities, illnesses and homelessness with around 4,000 employees. Coming his "postmodern pluralist perspective" Laloux (2015) worked out three characteristics for evolutionary organizations: "Self-management", the control of the internal organization is done through collegial relationships, "wholeness", the development of the entire potential of a person, and "evolutionary sense", the adaptive abilities of the organization. For Laloux measures to secure the existence of post-modern organizations are "empowerment" of the organization members, the maintenance of a "value-oriented culture" and "plurality", the integration of different interests. Laloux believes that a "strong common culture" will ensure that they donot fall apart. "Culture always triumphs over strategy," is another quote from Peter F. Drucker. Organizational members orient themselves at common values instead of a plethora of "rule descriptions and agreements", says Laloux. In contrast to modern, performance-oriented organizations, where "strategy and execution" are at the forefront, in postmodern organizations "culture" is at the heart of the organization (Laloux, 2015).

3.2.1 Organizations in a Metaphorical View

The term metaphor is described in the etymological dictionary of Kluge (2002) as "a figure of speech". The term itself comes from the Greek, borrowed from 'metaphora', which can be translated as "transmission". According to Gareth Morgan, a classic of management literature, "Images of Organization" come to mind. Images determine our thinking about organizations and thus also influence our actions. Long recognized by management consultants from all industries and strategy developers, metaphors serve to symbolize mission statements: "The metaphor is based on the 'collective subconscious' (Carl Gustav Jung), whereby all actors in the company, but also the external stakeholders, develop a similar understanding of the task and values of the company (Häfelinger & Von Trotha, 2020).

A hospital is a complex system in itself. Different professional groups with high expertise work together in multi-professional teams. In addition, there are always new technologies that need to be understood and applied. For patients it is usually difficult to find their way around in a world of experts as a quasi "loan". "Patient-orientation" and "patient-centeredness" have become the guiding principles of health care organizations but are often neglected in everyday care because they are not anchored in the organizational culture. However, it is not to be expected that the complexity of hospitals in particular will stagnate or even decrease. The opposite is the case. The world is becoming increasingly complex. In the introduction to "Images of

Organization", the organization theorist Gareth Morgan (2006) refers to this phenomenon by denying credibility to a general understanding of complex interrelationships: "We often tell ourselves that everything is much simpler than it really is, and deal with complex interrelationships as if they did not actually exist. The real challenge, Morgan says, is "to learn how to deal with that complexity". In order to understand the "multi-layered dynamics" of organizations, the doyen of pictorial organizational analysis, Gareth Morgan, recommends using metaphors (Morgan, 2006).

Morgan (2006) begins his analysis with the "mechanistic organizational approach", which, according to the author, limits rather than mobilizes human capabilities. The analysis continues with the help of the "organism metaphor", which is based on nature. In contrast to the mechanistic organizational picture, the organization attaches great importance to environmental relations, which is of course important for a hospital that is in competition with other service providers. Another strength of this metaphor lies in the "emphasis on needs", (Morgan, 2006) both internally and externally. In order to come close to a "desired" organizational culture, the hospital world must give the greatest possible scope to the design of interacting processes. Using the "metaphor of a human brain" as a kind of self-organization, Morgan draws pictures of the organization as an information-processing brain. This form of observation focuses on the further development of the organization, its "learning and self-organization ability". Admittedly an "openness", which is found in (still) hierarchical systems such as those found in hospitals, is at its limits. It will depend on the degree of organizational maturity whether those in "power" can deal constructively with the autonomy inherent in this form of organization (Morgan, 2006). The next metaphor refers to the "cultural context" of organizations: "Organization as a cultural phenomenon". Metaphorically, Morgan links his presentation to the notion of "cultivation", the process of "cultivating and tilling land". This approach comes closest to the cultural understanding of mostly private-profit, non-profit, denominational hospitals in the Austrian hospital landscape, which are committed to active "value management" ("cultural work"). In their organizations, they successfully strive for a common system of meaning ("common interpretation scheme") to guide organizational actions, especially on the social level. "Organization as a political system", is the next metaphor that Morgan addresses in his work. One is almost inclined to recognize institutions, especially hospitals, in the public health care system, whose political influence, from outside, is considerable due to the ownership constellation, which usually leads to supply policy and, as a further consequence, economic distortions. "Power" plays an important role in these organizations in order to ultimately "get others to do things that are beneficial to their own interests" (Morgan, 2006).

3.2.2 Health Care Organizations as Expert Organizations

According to Rasche & Von Reinersdorff (2016), hospitals can be understood as expert organizations in a broader sense. Experts are professionals who usually undergo a long period of training and whose expert status is expressed through certificates, accreditations, supplementary designations, etc. Another characteristic feature is that experts and professionals "are in permanent competition for competence and qualifications. In the opinion of Rasche & Von Reinersdorff (2016), an expert organization is a "complex structure of relationships with internal and external stakeholders". Hospital organizations are also characterized by the fact that for members of the health professionals, particularly for the medical profession and for the higher services from the nursing and medical-technical professions, academic training is a mandatory requirement for the respective occupational field. This means that almost all occupational groups represented in the hospital sector have undergone a longer "training and human refinement process". Hospital organizations are classified as "High-Reliability Organizations", i.e., organizations that require highly reliable expert professionalism. Critically, Rasche & Von Reinersdorff (2016) argue that hospitals often lack "the professionalism of integrated total service provision". On the one hand, according to the authors, "operative service islands and functional specialist silos dominate the clinical value-added system" and, on the other hand, despite the permanent demand for "patient centricity" throughout the entire care sector, a "pronounced expert centricity" is evident, especially in hospitals (Rasche & Von Reinersdorff, 2016). This is a finding that could be extrapolated to the entire care system in the current Austrian health care system across institutional boundaries.

The management of expert organizations is a challenge, especially for hospital organizations. Experts, who are equipped with a pronounced sense of personal responsibility, especially among members of health professionals in hospitals, are usually characterized by a high degree of "autonomy" and "judgement self-sufficiency", or, as the authors describe it, are "intent on achieving luminary status". Ultimately, the "striving for fields of activity that are not bound by instructions" of the individual actors makes integrated, cross-institutional and cross-interface service provision more difficult. In most cases, however, ways are found, such as project or case management, which bypass structures and can still design processes in a cooperative and coordinated manner (Rasche & Von Reinersdorff, 2016). Starting with negatively exaggerated self-centeredness an often experienced phenomenon can be described according to which the patient is reduced to a mere object, a "case of care". Patient-centered care constellations, on the other hand, are characterized by a humanly "equal" cooperation, a consideration of the wishes

and needs of the patient in order to be able to meet him personally and individually, in his "vulnerability" due to his illness.

According to Grossmann, Pellert & Gottwald (1997), experts are characterized by "high qualifications" and in particular they orientate themselves "on the professional development of the specific professional community" to which they belong. Experts see themselves more as representatives of a particular subject (in terms of health care, e.g. surgery or physiotherapy) than as an employee of a particular health care institution (e.g. hospital). Experts, therefore, identify less with the organization in which they work but more with the profession they belong to (Rasche, & Von Reinersdorff, 2016).

Rasche & Von Reinersdorff (2016) see hospitals as expert organizations in a broader sense. In particular, this is due to the "collegial management structures based on partnership" that exist especially in hospitals, made up of managers from the relevant specialist areas, but also to "the complex relationships with internal and external stakeholders" that are inherent in expert organizations. Rasche & Von Reinersdorff emphasize the importance of all stakeholders exerting a beneficial influence, which in the authors' view has a decisive impact on the value creation performance of an expert organization. In addition to a high degree of regulation of the hospital organizations themselves, which appears justified in view of the client/patient care provided, professional and ethical rights also assume a quality assurance function. In Austria, the exercise of health professionals in particular is subject to general reservations, in addition to special provisions resulting from the rights of appointment. The general reservations include a "reservation of activity or exercise of a profession", the "reservation of professional titles" and a "reservation of training". Based on the legal basis of the "Competence Factor Health Care" (Art. 10 para. 1 subpara. 12 B-VG) anchored in the Austrian Federal Constitution ("Bundesverfassungsgesetz", in short: B-VG), a health professional is understood to be a specialised "whose occupational profile includes the implementation of measures to care for the general state of health of the population". These are primarily activities within the framework of health care which "serve people for the purpose of promoting, maintaining, restoring or improving health in a holistic sense and in all phases of life". In the brochure on the health professionals in Austria written by the Austrian Federal Ministry of Labor, Social Affairs, Health and Consumer Protection (BMASGK), explicit reference is made to the protection of well-being and health of the people/patients entrusted to the health professionals "in compliance with the applicable regulations and professional obligations and in accordance with the professional and scientific knowledge and experience". The authors additionally state that the activity "must be carried out

conscientiously without distinction of any kind". It is expressly stated that the training must be "patient-oriented" and be carried out under "legally defined framework conditions" and professional supervision. Another measure to ensure and maintain quality in the exercise of their activities is the statutory obligation of the health professionals to provide continuing professional development (CPD). Members of the health professionals are required to undergo regular training on the "latest developments and findings in occupationally relevant sciences" (translated into English). Particularly since the European Educational Convention (Lisbon 1997) on the mutual recognition of qualifications in higher education, the "continuous adaptation of skills to new medical and scientific findings and to changes in society" have also become significantly more important (BMASGK, 2019c).

3.2.3 Characteristics of the Austrian Health Care Organizations

Numerous experts of the Austrian health care system, such as the health policy expert Ingrid Korosec & the health economist and physician Ernest Pichlbauer (2007), the health scientists of "Gesundheit Österreich GmbH" (GÖG) Florian Bachner et al. (2019) as well as the co-authors Wilm Quentin and Juliane Winkelmann from the European Observatory on Health Systems and Policies, and also the former head of Health and Care of the European Center for Social Welfare, Policy and Research in Vienna, Maria Hofmarcher-Holzhacker (2013) as well as numerous other scientists and health experts see the Austrian health system as a complex and fragmented system in which responsibilities and funding are distributed among the federal government, the provinces and the social insurance system, and numerous tasks are assigned to self-governing bodies (such as the social insurance system). According to Korosec & Pichlbauer (2007), "complex systems" tend to "disintegrate into sub-systems", which of course prevents the integration of care.

However, not only the level of organization and financing of the overall system shows a high degree of complexity, but also the care institution itself poses challenges for the leadership due to its internal, organizational and external complexity regarding environmental relations. Hospitals in particular are regarded as highly developed socio-technical systems. For the hospital manager and physician Heinz Brock (2018) the hospital represents a "leading organization" in the health care system. Brock sees the expert organization hospital as a "highly developed" organizational entity whose "structure, functionality and tasks" are "extremely complex", especially since the courses of action of the individual actors are "interwoven and interrelated".

With reference to studies by Grossmann (1995 and 1997), Pelikan (1993) and Pelikan and Wolff (1999), the organization theorist Ralph Grossmann & the social scientist Klaus Scala (2002) point out organizational contradictions of the hospital organization, which may of course also apply to other care institutions. According to Grossmann & Scala (2002) four central contradictions can be identified, which are relevant to clarify the complexity and everyday practice of the hospital: the contradiction between a "professional system" on the one hand and "organizational events" on the other; the contradiction between "expert culture" and the requirement for "measurable patient orientation"; the contradiction between "increasing specialization" and "cooperation across professional groups"; and finally the contradiction between "autonomy of the departments" and the need for integration into the overall organization". In the context of integrated care, this list can of course be supplemented by the contradiction between "increasing competition" between the care institutions "integration and joint control of the care paths".

Grossmann & Scala (2002) see health care institutions in general as being subject to a "decisive organizational change". According to the authors the "restructuring" as well as the rethinking inside the organizations are necessary in order to maintain "or increase" the efficiency of these increasingly complex systems and thus to ensure an "effective, socially responsible use of public resources". Grossmann & Scala argue for the promotion of accountability. They also see the "long-needed" cultural change in "investing in interprofessional teams" and in "strengthening coordination mechanisms". According to the authors interprofessional teams are considered "promoters of quality" and ultimately form the basis for "motivation and job satisfaction".

In the Austrian health care system a distinction is made between "intramural" and "extramural" in the field of curative care ("diagnosis and therapy"). The term "intra" comes from Latin (lat. 'intra') and means "within", while "mural" (ahd. 'intra') can also refer to German roots and means "wall" (Kluge, 2002). B-VG Curative treatments are either "outpatient" or "inpatient". Treatment in hospitals is referred to as intramural ('within the hospital walls'), in contrast to extramural, in-patient care. However, "outpatient" is not the same as "extramural", especially since in the "intramural sector" outpatient services are also provided (in hospital outpatient departments as well as in the day-care sector), (Korosec & Pichlbauer, 2007).

3.2.4 The Role of the Patients

Particularly in health care facilities the correct handling of the basic values of the organization, and the permeability of the "claimed values" from the normative level to the operative level is of undisputed importance. Not least because the client/patient, as a subject, plays an increasingly important role. The patient gradually becomes an "equal partner" in the care process. At the beginning of the 21st century, the patient's self-image changed from a rather passive role to that of a "competent patient". From the mostly "patronized patients" of the 1960s the patient gained in maturity ("mature patient" of the 1980s), especially through increasing information ("informed patient" of the 1970s), up to the "autonomous patient" of the 1990s (Mayer, 2012). Regarding the increasing patient autonomy, the author of this thesis already pointed out in a scientific contribution on the patient perspective in 2012 that every patient is in a state of emergency in his or her illness and must therefore be perceived in his or her "vulnerability", which of course requires special care (Mayer, 2012). The social scientist, theologian, and philosopher Clemens Sedmak gives in his impressive work "Mensch bleiben im Krankenhaus: Zwischen Alltag und Ausnahmesituation" (People Stay in Hospital: Between Everyday Life and Exceptional Situation) food for thought by asking questions about the deep structures of a hospital. Sedmak describes the hospital as a "microcosm in which the whole range of human life is shown" and asks in the foreword of his work very specifically what it feels like "to work in a hospital or to stay there as a patient". Sedmak operates at the "interface between health science and ethics" and focuses his interest primarily on the question of how the hospital shapes the human being. He refers to the organizational culture of the hospital, whose "moral face" is expressed. Accordingly patients and staff have legitimate expectations regarding moral standards (Sedmak, 2013).

3.3 Organizational culture

For the economic philosopher Frederic Laloux (2015), who can also draw on his experience as an Associate Partner at McKinsey, the "meaning and context of an organization" are determining factors for its culture. According to Laloux traditional norms such as following orders are losing their importance in postmodern organizations.

In his work, Laloux (2015) refers to three aspects inherent in cultures of "progressive organizations", some of which are to be taken out and presented: Aspects of "self-management", which

are based above all on trust in the organization and between its members, transparency in the actions of the management and individual responsibility for the organization, aspects of "wholeness", which emphasize the equality of each member and their relationships with one another, describe a safe and caring working environment and emphasize the learning character of the organization, and aspects which provide answers to "questions of meaning". The collective sense that gives the organization "a sense of its own" and "a soul", the individual sense that brings "vocation" to the task, and the commitment that "sense and profit" are not contradictory.

Laloux (2015) asks crucial questions about how organizational culture is being created and what makes one culture more effective than the other. He sees the organization as a "living organism" that needs its own culture: "Everyone should be invited to perceive the culture that best fits the context and meaning of the organization". Laloux points out three paths of further developing the culture that can be taken simultaneously. These are developing support structures and processes, the role model effect that is given to managers (or individual "moral authorities"), the possibility of reflection and the extent to which personal convictions are compatible with this culture. Laloux also advocates the implementation of regular practices (in the sense of actions) to help members develop and perceive the organizational culture. As example he cites a culture of gratitude and appreciation. Actions that be taken here could be, for example, is a "day of gratitude". Such a days' lasting effect could be to develop a culrure in which people feel "that it is natural to praise someone and to thank them spontaneously". Laloux refers to the practice of a Japanese company that had succeeded in developing a culture of gratitude in a sustainable way through such an action. He draws a philosophical conclusion that four dimensions ("culture", "system", "ways of thinking" and "behavior") must be given meaning in organizations in order not to play off one against the other, such as "hard aspects" against "soft" or vice versa. Only in this way, Laloux continues, all factors can be "strengthened in service to the meaning of the organization" (Laloux, 2015).

3.3.1 Mission Statement

Helmut Siller (2011) prefaces his discussion of normative controlling with a quote from ARGE proEthik, a voluntary association of members of the Austrian Chamber of Commerce who are committed to "modern principles" of ethical behavior: "Intelligent corporate management begins with ethical principles". In the mission of an enterprise Siller sees the outwardly expressed self-conception of the enterprise. In addition to the business purpose of the company, its "raison

d'être" also becomes clear in the mission, which, according to Lombriser & Abplanalp (2018), should be consistent with the values and expectations of the most important stakeholders. Accordingly, mission can be described as that corporate philosophy through which the company's vision is concretized, as well as the company's business purpose and the limits of its business activity and, consequently, its raison d'être are circumscribed. The mission statement makes statements about the corporate identity and fundamental values. Accordingly, the mission statement represents the "instrument of management for the purpose of shaping the corporate culture in the direction of the corporate philosophy and vision" (Siller, 2011). Siller attributes normative effect to the mission statement, provided it is suitable to serve as a means of communicating vision and mission to the company's stakeholders.

3.3.2 Cultural Values and Cultural Work

The author of this paper has already dealt in an earlier contribution with the question of how cultural values can be implemented in health care institutions in such a way that they can be perceived by staff and clients alike and sustainably anchored in the organization. As an example of successful management of cultural values, he draws on the experiences of the Vincent Group, a private, non-profit Austrian operator of several hospitals and care facilities, and describes the "value management" practized by the Vincent Group as "culture work" (Mayer, 2016a).

Before going into more detail about organizational cultures in health care institutions, the phenomenon of culture is to be explained in its general meaning. From an etymological point of view, the culture of an organization can be understood as a latent or manifest consensus of values that is expressed in an organization. The term "culture" comes from the Latin (lat. 'cultura') and is related to "to cultivate" (lat. 'colere'), which subsequently also means "to care for someone or something" (Kluge, 2012; Kirchner, 2007). According to the British sociologist Anthony Giddens (2004), "corporate culture" in pure management theory terms means an attempt "to increase productivity and competitiveness by creating a unique organizational culture". Various measures of social interaction can serve to actively shape the organizational culture, especially to promote loyalty and cooperation among employees (Giddens, 2004). Innovative approaches to shaping organizational culture are particularly evident in business practice. In a German company, for example, instead of a works council, a "cultural council" was set up to institutionalize value-oriented structures. In addition to general tasks of staff representation, the cultural council deals with questions on topics such as "appreciation", "work organization",

"company health" or "social benefits" (Vranken & Attallah, 2016). Just like the economic philosopher Frederic Laloux (2015), the ethicist Michael Lischka (2016) calls for the establishment of organizational structures that allow employees to "reflect ethically". US-American and Bristish examples show the effectiveness of such supporting measures. In the Anglo-American region, for example, it has become common practice to appoint so-called "ethics officers" who serve as direct contact persons for ethical questions.

So how can the "claimed culture" of a health care institution (e.g. in a hospital) be made tangible? How can the permeability of values defined at the normative level be guaranteed? An open corporate culture that is directed towards the people in the hospital organization also has a positive effect externally and can increase the perception of the health care institution, especially among those who demand health care services among patients who need care. A positive self-image of a hospital is reflected by the population in the hospital's catchment area and thus causes the hospital to acquire a visible identity and to stand out from its competitors (Grass & Hille, 2017). The design of the normative management level is of essential importance in this context. The normative level serves the long-term safeguarding of the principles, norms and rules that determine the "viability and development capability" of the hospital (Bleicher, 1994; Rüegg-Stürm, 2002). The vision (lat. 'viso' = imagination, idea) represents the foundation, the basis of the enterprise (Kluge, 2012). It defines the basic orientation and formulates fundamental goals and basic principles. The task of management is to ensure that "vision and basic principles are lived" (Eschenbach et al., 2007). The formulation of the normative goals is reserved for the owner of the company and therefore, in hospitals, for the hospital owner. Normative goals create the basis for the strategic orientation. The operative work should subsequently be oriented to following these. The economist and business ethicist Siller (2011) sees normative goals as a "source of inspiration" for the tasks to be performed as well as a possibility to ensure "realization of meaning". According to Siller, the company should be legitimized by "professional, morally impeccable management". Standards for "ethically impeccable conduct" should guide employees. The entire management of a company, and even of a hospital, is differentiated into three levels: "normative management", "strategic management" and "operative management" (Rüegg-Stürm, 2002). In "operative management" everyday business is mastered. This is where the treatment processes take place and patients are cared for. The focus is on the provision of services by the company and, of course, on the economical use of available resources. "Strategic management", on the other hand, refers to a long-term perspective, such as setting priorities in care. Strategic management is characterized by a high level of responsiveness to environmental changes and generally aims to preserve the company's substance. "Normative management", on

the other hand, serves as ethical legitimation and as the basis for all management activities, thus providing the company, the hospital, with a framework at the strategic and operational level (Rüegg-Stürm, 2002; Mayer, 2016a). The German economist and founder of the St. Gallen Management Model Knut Bleicher (1994) considers normative management in the mid-1990s in a more comprehensive system context, in which he includes both management dimensions and all other corporate components. In his integrated management model, Bleicher argues for a "paradigmatic guiding idea", a philosophy according to which normative, strategic and operational levels should be aligned. In his management philosophy, the underlying human image forms the basis of the company and the value system based on it (Bleicher & Abegglen, 2017). How does one succeed in making the values underlying the company perceptible to all employees and customers/patients? The experienced former top manager Jürgen Dormann approaches this question in the foreword to the "Handbuch Wertemanagement" (Value Management Handbook) published by the German business ethicist Josef Wieland by arguing in favor of clear messages regarding values: "A company needs clearly documented statements and instructions on value management which employees and managers can use as a guide and which customers, business partners and investors can rely on" (translation into English) (Wieland, 2007; Mayer, 2016a).

What distinguishes health care facilities from other service providers? It is quite difficult to look at health care facilities from a conceptual point of view. The term "health care facility" is not uniformly defined in the technical literature. Essentially it is possible to differentiate health care facilities into inpatient, day-care, and outpatient care areas, although there are some overlaps. In general, health care facilities are characterized by diversity and high complexity. In simple terms it can be said that they are places that offer health care services (Mayer, 2016a). For example, hospital treatment in Austria can be provided in public, private non-profit or private hospitals. The majority of hospitals have specialist or special outpatient clinics that provide emergency care around the clock. Day clinic services are usually services that require an inpatient hospital stay, but admission and discharge take place on the same day. In-patient stays of more than one day are therefore carried out if this appears medically indicated (ÖGK, 2020). The care system can generally be divided into primary, secondary, and tertiary care. The primary care sector offers deliberately low-threshold, outpatient care ("primary care"), which is provided primarily by general practitioners (e.g. family doctors). The secondary care area represents "specialist primary care", which is mainly provided by general practitioners. The tertiary care sector includes "extended specialist care" (e.g. through clinics), (Pfaff, 2003; Hagenbichler, 2005). A more precise differentiation of the areas of care is, however, provided by the team

of authors of the Austrian Institute for Advanced Studies. According to Czypionka, Riedel, Kraus & Sigl (2012), primary care includes not only general practitioners but also other providers of outpatient services (e.g. outpatient clinics). The health policy planning principles of the Austrian Health Care Structure Plan (ÖSG 2017, adapted in 2020) are designed in particular to "strengthen the outpatient sector" through the rapid development of primary care structures and "specialist outpatient care structures" (BMASGK, 2020). According to health scientists Czypionka et al. secondary care includes specialized outpatient care as well as inpatient health care provided by specialists and hospitals. Tertiary health care only includes Austrian university hospitals such as Vienna, Innsbruck, Graz and Salzburg. According to Austrian Hospital Act, hospitals are divided into general hospitals (no restrictions on care), special hospitals (for certain diseases, certain age groups or certain care purposes), homes for convalescents (with medical and nursing care), nursing homes for the chronically ill (with medical care), maternity and delivery homes, sanatoriums (private, profit-oriented hospitals) and independent outpatient clinics (hospitals that do not, however, have beds). A distinction is made between standard hospitals (basic care), specialty hospitals and central hospitals (usually organized as university hospitals), (BMSGPK, 2020c). At the end of 2018, in the last reporting year, there were 264 hospitals in Austria. In total, 67,000 systemized beds (approved by the sanitary authorities) were available in the hospitals, compared to 64,285 beds that were actually set up. About two thirds (63.2%) of the installed hospital beds were in general hospitals, 26.3% in special hospitals and convalescent homes, 3.7% in sanatoriums and 6.8% in nursing homes for the chronically ill (Statistik Austria, 2020c). 10,136 (15.8%) of the beds that were actually set up are attributable to denominational carriers (spiritual orders) (BMSGPK, 2020d). This corresponds to a real number of beds of 726 per 100,000 inhabitants for all hospitals in total. Since the beginning of the 1980s, the number of beds has tended to decline. 110 of all hospitals (41.7%) have a right of public access (one of the prerequisites for this is non-profit status), (Statistik Austria, 2020c).

The complexity of health care facilities is mostly evident in hospitals. Hospitals can be public, private non-profit or purely private, as mentioned above. In the Austrian hospital landscape, public and private-non-profit hospitals are usually organized as non-profit enterprises, whereas private non-profit hospitals usually have a denominational sponsor. Non-profit, denominational hospitals, however, often have the same characteristics as other privately run non-profit organizations. Organization-related, but usually also individually shaped mission statements as well as a socially dominated basic attitude and high commitment (informal processes often gain too much importance) come more to the fore than in other organizations. In addition, there is a high level of emotionalization, which of course can also lead to a more frequent tendency to conflict.

The contradictions inherent in the system, i.e., healing versus economic efficiency, are also more strongly supported. Furthermore, the measurement of outcomes, especially when it comes to the demand for needs-based care, is usually multi-layered and occasionally reaches its limits (Simsa & Patak, 2008).

Günther Brenzel (2013), expert for strategy consulting and organizational development in health care facilities, speaks of the "emergence of increasingly efficient organizations with high complexity" and increasing workloads. Hospitals are exposed to rising case numbers, shorter lengths of stay and constantly advancing technology. In addition, they are subject to considerable "economic and competitive pressure" as well as ever new legal regulations and requirements. Günther Brenzel (2013), Georg Marckmann & Jens Maschmann (2014) see the increasing commercialization of hospitals as a threat to the preservation of values, especially "patient orientation" and "appreciation of employees". Nevertheless, in the authors' view it seems important to combine ethics and economics in a kind of "rigorous value management" and to integrate normative guidelines into everyday life. This requires the creation of suitable conditions, an appropriate design of the "conditions for action" (Marckmann & Maschmann, 2014) as well as resources that can be gained by exploiting existing potential. Ethical guidelines should be anchored in the operative hospital everyday life and thus become an "integral part" (Marckmann & Maschmann, 2014) of thinking and acting. However, ethics must not become the "antagonist" of economic considerations; moreover, ethics must be lived in organizations (Mayer, 2016). The health economist Hagen Kühn of the Berlin Social Science Research Center (Wissenschaftszentrum für Sozialforschung) is of the opinion that increasing commercialization leads to conflicts of interest in institutions, especially among health professionals (Kühn, 2003). Profitability and competitive pressure as well as the resulting "risks of misconduct" raise questions that can be attributed to "structural ethics" (Kühn, 2011). For Karl Homann (1994), the ethicist of organization, one of the central tasks of management is to create "conditions for action" that prevent the erosion of morals in competition through systematic misdirected incentives.

What prevents the individual care sectors, especially the actors in the sectors, from cooperating with each other? In order to create space for the optimization of corresponding structural conditions, strategic considerations with new approaches are necessary, considerations that enable extended thinking and action (Brenzel, 2013), especially regarding the "integration of health care" within and between the health care institutions. Brenzel uses a pointed language, speaks of "functional silos" in which members of the individual health professions carry out their single tasks. Similarly, Mayer (2016b) calls for a "move away from pure functionalism" in health care

institutions and a "return to an inherently ethical behavior". Like Brenzel, he sees the integration of care as the answer to many questions that are currently being asked in the health care system. The triad of terms "cooperation", "coordination" and "communication", which Mayer (2016a) describes as one of the foundations for organizational processes within health care institutions and along the supply routes, is essential in this context. Decisive here are both the individual willingness to cooperate as well as the willingness to cooperate and communicate in the collective culture, expressed both externally and internally against the background of these favorable organizational structures. "Structural capital" belongs to the intangible assets of care institutions, holds the potential for performance activities and forms the basis for the development and use of other intangible assets such as "human capital" and "relational capital" (Stoi, 2003; Bode, 2015). In order to be able to meet future challenges in the health care system in the best possible way, Bode (2015) pleads to add "development and renewal capital" to these three categories. This refers to the ability of health care companies not only to participate in change by observing it, but also to analyse and exploit the opportunities it offers. Of course, it is not only the structural prerequisites that are decisive, but also the willingness and ability of the members of the organization to react to changes accordingly.

What is the relationship between "culture and leadership" of health organizations? In his essay "The Spiritual Foundations of Leadership" the philosopher and theologian Baldur Kirchner (2007) examines the leadership behavior of Benedict of Nursia, the founder of the Benedictine Order, and sees in it a "worthy synthesis" of "culture" and "leading people". Kirchner expresses this clearly in relation to the person of the leader by emphasizing the exemplary character of the leader. Leadership culture, according to Kirchner, means the "making visible of norms and attitudes in the hierarchical relationship with those being led. For this reason, leadership culture must be tested by the practical interaction with the partners in action. The US American Christine Kane-Urrabazo comes to a similar conclusion. She examined the role of management in the course of developing and maintaining organizational cultures and came to the conclusion that attitudes, values and, as a consequence, behavior in institutions are dependent on leadership (Kane-Urrabazo, 2006). In her study of the relationship between organizational culture, leadership behavior and job satisfaction, health researcher Yafang Tsai (2011) once again emphasizes the importance of organizational culture. She concludes that "good interaction" between leaders and subordinates, such as good communication, encouragement in fulfilling tasks, etc., is conducive to the achievement of objectives and subsequently leads to an increase in job satisfaction. When leaders create a vision of the organization in an appropriate way, this can lead to a change of attitudes and an improvement in work behavior. The social and economic scientists

Ruth Simsa & Michael Patak (2008) speak in their early work on Leadership in Nonprofit Organizations" of the need for "professionalization of leadership". They also see leadership "as a service to the organization", which must be actively shaped. In terms of values, they demand a "reflected approach".

How important is the correct handling of corporate values? A company needs clear statements and instructions on how to deal with its values, a value management system that gives employees and all other stakeholders of the company clarity and orientation. Value management ("cultural work") thus requires the "visualization" of a value attitude intended by the owner, anchored in normative management and perceptible both at the strategic level and in day-to-day business.

Regarding the term "cultural work": The term culture was explained above, but what does "culture" mean in connection with "cultural work"? What is meant by "cultural work"? The term "work" can be seen positively in connection with "cultural work". Etymologically, this term can be traced back to the Old High German word 'urchin', which means "to work", "to do", "to create". It is also related to the Old High German word 'wircan' which means "to work". This has led to a broader explanation of cultural work: "Cultural work" is understood as constant effort to develop culture based on established values, to build structures and implement concrete measures that serve to continue existing and lived values" (Vinzenz Gruppe, n.y.)

3.3.3 Cultural Work in the Health Care Facilities of the Sisters of Mercy

"Value management" in general: According to the German business ethicist and founder of the so-called "governance ethics" Josef Wieland, value management systems can be described as "company-specific instruments" which aim to "define the moral constitution of teams or an organization as well as its guiding values and to fill them with life in daily practice". According to Wieland (2007), basic values of a company contribute to the formation of identity and to general structural decisions. Members of organizations, cooperation partners, clients can have "reliable expectations" regarding entrepreneurial and organizational action. Wieland distinguishes four value categories: Performance values (e.g. competencies, benefits, quality), communication values (e.g. openness, transparency, and honesty), cooperation values (e.g. willingness to cooperate, team orientation, communication orientation) and moral values (e.g. integrity, fairness, truthfulness) (Wieland, 2007).

"Cultural work" using the example of the Vincent Group: Organized as a non-profit strategic holding company, the Vincent Group forms a network of Austrian hospitals and nursing homes run by various religious orders. With 8,454 employees (end of 2019), the Vincent Group is one of the most important private non-profit health care providers in Austria (Vinzenz Gruppe, 2020a). The Vincent Group comprises five hospitals in Vienna and two hospitals in the province of Upper Austria with a total of 2,680 systemized beds (end of 2019). The Vienna hospitals include the "Krankenhaus der Barmherzigen Schwestern", which also houses the headquarters of the holding company, the "Orthopädisches Spital Speising", the "St. Josef-Krankenhaus", the "Krankenhaus Göttlicher Heiland" and the "Herz-Jesu Krankenhaus". The hospitals in Upper Austria include the main hospital in Ried, "Krankenhaus der Barmherzigen Schwestern Ried" and the "Ordensklinikum Linz", a joint venture of the Barmherzige Schwestern and the Community of the Elisabethinen. The Vincent Group also owns two nursing homes, the "St. Katharina" nursing home in Vienna and the "St. Louise" nursing home in the province of Lower Austria with a total of 196 nursing places (end of 2019), an assisted living facility and a hospice. In order to strengthen health care facilities orders in the spirit of their spiritual orders despite a decrease in the number of members, the non-profit St. Vincent Foundation, "St. Vincent gemeinnützige Privatstiftung der Barmherzigen Schwestern" (St. Vincent Non-profit Private Foundation of the Community of the Sisters of Mercy) was established in 2009. In "St. Vincent" the "Vinzenz Gruppe Krankenhausbeteiligungs- und Management GmbH" and the "Vinzenz Gruppe Service GmbH" (meal supply, technical services etc.) have subsequently be incorporated. Early on, the establishment of a so-called „Wertemanagement“ (translated: “Value Management System”) had been develoed to ensure the "continued existence of the non-profit health care companies on the basis of Christian values", according to the Vincent Group's motto "Medicine with quality and soul" (Vinzenz Gruppe, 2020b; Vinzenz Gruppe, 2020c).

The following diagram (see next page) provides a clear overview of all the Vincent Group's facilities (Vinzenz Gruppe, 2020d).

Corporate structure Vinzenz Gruppe Krankenhausbeteiligungs- und Management GmbH and Vinzenz Gruppe Service Ltd.

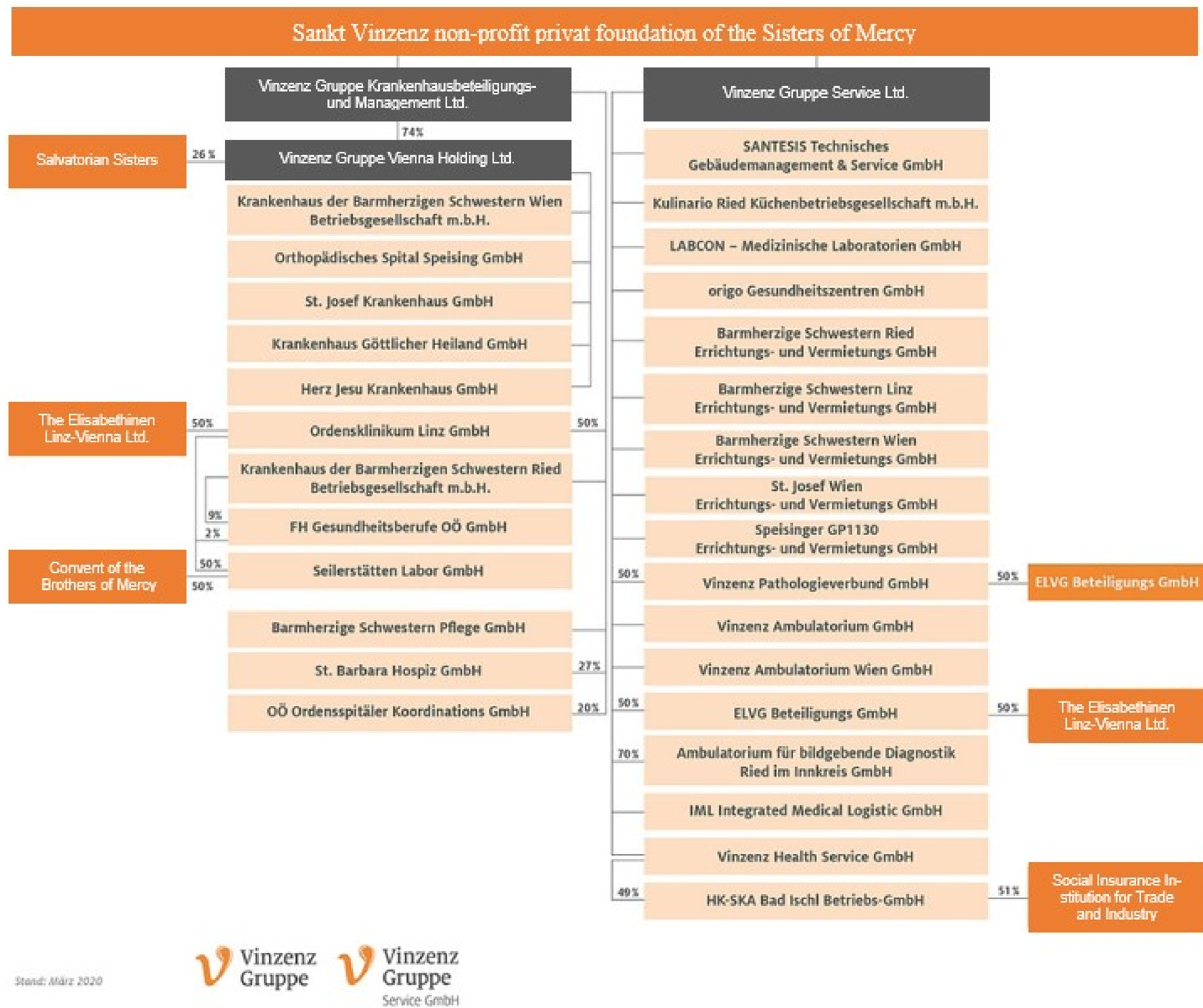


Figure 2 Organizational Structure of the Vincent Group, Vinzenz Gruppe (2020d)

The origins of the Vincent Group's value management can be traced back to an ethnographic field study by a doctoral student who was looking for a company where she could conduct her research. At the invitation of the director of the "Hospital of the Sisters of Mercy" in Vienna, she began her research work in 1995, the year in which the first association of several religious hospitals, an early form of the Vincent Group, was founded (Szabo, 1998). In order to gain insights into the life and daily routine of the hospital's organizational members and into their culture-dependent values, Szabo undertook an initial analysis of documentation available in the hospital. According to Szabo (1998) organizational documents reflect the "construction of social reality by the members of the organization". This was followed by ethnographic interviews with selected members of the organization and observations of everyday life. Since the universal set was still unclear, a "theoretical sampling" following the methodology of Glaser & Strauss (1998) was carried out. Subsequently 29 ethnographic problem-centered interviews were conducted with 19 different organizational members of the hospital (Szabo, 1998). The recording

of observations primarily brought knowledge regarding the interaction between the members of the organization: "Who spoke when, with whom, in what way, who exercised control in a particular situation? The analysis of the data focused mainly on four questions that particularly concerned organizational groupings ("social categories" based on common characteristics as well as "cultural areas"). A key question was thus: "Who was in control of a particular situation?", "Which groups exist in the organization? (Szabo, 1998). Szabo (1998) sees organizational groupings as "part of the social construction of reality by the members of the organization". The second question is: "How have the individual groups developed in the sequence?" According to Szabo (1998) the development of a group is influenced on one hand by the history of the hospital and on the other hand by the internal as well as external environment of the organization. The following questions focus on the issues these groups deal with and the way interactions within and between the groups are designed (Szabo, 1998). Apart from the applied taxonomy, Szabo distinguishes between "in-groups", to which the members of the organization feel they belong, and "out-groups". It also graphically illustrates the relationships between the individual categories (Szabo, 1998). In the interviews the affiliation to certain social categories ("in-group") as well as regarding the common language (e.g. through "we-statements") was reflected (Szabo, 1998). It is noticeable that almost all members of the organization define the hospital organization itself as an in-group, which indicates a high existing identification with the religious hospital. Szabo's study from 1995, which, as explicitly stated, is an analysis of an individual case, empirically refutes the idea that organizational culture can easily be shaped. It also refers to the homogeneity of organizational culture (Szabo, 1998), which it describes as an umbrella term for the "thinking, feeling and acting of the members of the organization", resulting in different, partly overlapping cultural fields ("cultural groupings"). The coexistence of the different cultural fields and their joint efforts create a dynamic that affects interdisciplinary and multi-professional cooperation in the hospital (Szabo, 1998).

What are the effects of active value management in health care facilities? "Values appeal to people themselves, they fascinate people, touch and move them, trigger enthusiasm and rational insights. Nobody can prescribe values. You cannot manage values, but you can create spaces where positions based on values can (but do not have to) grow and develop" (original text in German: "Werte sprechen von sich aus eine Person an, ziehen sie in ihren Bann, berühren und bewegen sie, lösen in ihr Begeisterung und vernunftmäßige Einsichten aus. Werte kann man niemandem verordnen. Werte selbst kann man nicht managen, aber man kann Räume schaffen, in denen Wertehaltungen wachsen und sich entwickeln können (nicht müssen)" (Vinzenz

Gruppe, n.y.). The implementation of this philosophy undoubtedly requires effort, as demonstrated by all the measures taken by the Vincent Group in recent years. Thus, the Vincent Group has developed a cross-institutional approach that focuses on both patients and potential demanders of health services. According to the Vincent Group's equally long-standing and proven experience in value management, the focus seems to be less on actively influencing behavior and more on building appropriate relationships. Relationships that enable the development of the desired culture (Mayer, 2016a).

Practiced value management undoubtedly brings a number of advantages. In addition to the orientation towards the basic values of the company, this system justifies decisions, actions and dealings with the outside world. It can be understood as a sign of stability and correctness in the cooperation within the hospital and within the Vincent Group as well as with other institutions. Furthermore, values can also have a financial aspect, which increases the reputation and value of a company and reduces costs. In this way, better results can ultimately be achieved (Bertelsmann Foundation, 2008).

The question that does arise, of course, is how the outcome of value management can be measured. An interesting, but little evidence-based approach to measuring culture relates to the so-called "inner quality" of health care facilities, which is seen as a critical success factor for a company (Rechkemmer, 2012). According to the Austrian Health Quality Act, "quality" is understood as the "degree of conformity with the characteristics of a patient-oriented, transparent, effective and efficient provision of health care services". The founder of this approach to intrinsic quality primarily understands it as implementation of values by fulfilling "practices" that are measured, controlled and analyzed by means of "micro-controlling" (Rechkemmer, 2012; Brenzel, 2013). The internal quality and the degree of fulfilment of the measurement parameters used are determined on the basis of regular employee surveys, the results of which are translated into meaningful indicators. In the event of deviations, measures of correction are developed as part of "integrated planning" (Rechkemmer, 2012). The focus is on an "inspiring" sense of community that is perceptible to the patients (Rechkemmer, 2012; Rechkemmer, 2013). Rechkemmer (2013) defines inner quality as the "fourth dimension" of the quality model of health care according to Avedis Donabedian ("structural, process, outcome quality"), whereby, in Rechkemmer's view, individual partial qualities are always connected with inner quality. Like structure, process, and result quality, internal quality is also subject to a process of continuous improvement. On the other hand, Rechkemmer (2012) sees a change in values, depending on the constellation of these changes, as a possible early indicator for organizational developments.

Without providing evidence-based proof, Rechkemmer associates "good internal quality" with "efficiency and competitiveness" and "optimum motivation and job satisfaction". Siller (2011) also advocates meaningful indicators. In his work on "Normative Controlling", he also addresses the question of the measurability of values and, with reference to Krystek & Müller-Stewens (1993) he lists five criteria that indicators must meet: "clarity" (precise description), "unambiguity" (comprehensible and reliable), "completeness" (valid for the entire area of observation), "cost-effectiveness" (economically justifiable) and "acceptance" (acceptable in the context of intersubjective evaluation).

As described above by Daniela Bode (2015), human, structural and relational capital, supplemented by development and renewal capital, are among the intangible assets of utilities. Siller (2011) defines "human capital" as "professional competence, employee motivation, and social competence and leadership skills"; in his view, "structural capital" contains "cooperation and knowledge transfer", "product and process knowledge", or even "the corporate culture". The author classifies "relationship capital" as "customer and supplier relationships" (in the hospital, of course, "patient relationships" or relationships "with referring institutions and doctors"), "cooperative relationships" (in the sense of integrated care: "with all stakeholders and care partners") and also "public relations". According to Siller (2011), in order to achieve measurability of the indicators, the question must now be asked whether the quantity and quality of the influencing factor is sufficient to achieve the strategic goals. Furthermore, whether "the influencing factor is systematically maintained and developed". In studies of the "German Association for Financial Analysis and Asset Management (DVFA, 2010) the following key metrics were identified: "Employee commitment" (human capital), "Customer satisfaction" (in the hospital: "patient satisfaction", relationship capital), "Public perception of partnerships in the process flow" (in the hospital: "treatment process", cross-institutional: "integrated care process", human, structural and relational capital as well as development and renewal capital), "waste management" (in the hospital: in particular hazardous waste disposal, environment-related structural competence), "product development" (human, structural and renewal competence, but also, regarding the care integration, relational competence) and finally "ethical integrity", "composition of management" (corporate governance: "principles of corporate management"). According to Siller (2011) the final step is to consider suitable key figures, such as "degree of patient satisfaction", "contact rate of patient advocacy", or even "extent of employee absenteeism". As a supplement to conventional controlling instruments, "normative controlling" can serve to open up potential for success, such as "integrated, sustainable corporate governance", as well as helping to create identity and a sense of community and ultimately contribute to making the

values represented by employees and patients and their relatives (e.g. in hospitals) (Vinzenz Gruppe, 2020e).

So where are the limits of dealing with values, the limits of "cultural work"? The psychologist and economist Reinhard Sprenger (2015) warns against a desire for admiration. He forcefully describes institutionalized admiration addiction as an evil that results high transaction costs and blocks self-determination, self-initiatives as well as innovative and entrepreneurial action. In his work with the catchy title "The Reputable Company" (original title: „Das anständige Unternehmen“), he puts forward the thesis that there is an excess of "institutional intrusiveness" in modern companies. Borders are crossed, free spaces are abolished, and the resulting lack of distance is disguised as "good intentions", "caring" and "support". Sprenger speaks of the "total involvement of the hand, heart and brain" of the complete monopolization of the working population by the world of work. With reference to the theologian Dietrich Bonhoeffer (1906-1945) he pleads for a "culture of distance" (Sprenger, 2015). For example, in Bonhoeffer's work entitled "Cultivating Distance" (original title: "Kultivierung der Distanz") he claims: "If we do not have the courage to re-establish a genuine feeling for human distances and to fight for it personally, we will perish in an anarchy of human values (in German: "Wenn wir nicht den Mut haben, wieder ein echtes Gefühl für menschliche Distanzen aufzurichten und darum persönlich kämpfen, dann kommen wir in einer Anarchie menschlicher Werte um“). According to Sprenger distance is about "living together with respect" ("in respektvoller Distanz"), which avoids conformity and allows individuality (Sprenger, 2015). The employee is an individual and a person in whom we must trust, and we must give space for individuality to become strength.

The Vincent Group is an excellent example of how "sustainable cultural work" can be implemented in health care facilities. The success as well as the development of transfer concepts is, due to its exemplary effect, of great importance for the entire health system. Best practices can be transferable models from which the health care system can learn. In fact, however, a certain degree of maturity is required for transfer and sustainable implementation. It is important that the prerequisites and framework conditions for a culture based on values exist or can be created. As stated above, values must be anchored at the normative level of management. They serve the strategic orientation of the company and must be brought back down to the ground, to the operational level (Mayer, 2016a). "Spaces" must be created in which the claimed values can be lived, and transfer and learning are possible: "Being a role model is indispensable, but it is not

enough. It also requires management competence and a strategic commitment of the management" (Vinzenz Gruppe, n.y.).

A fundamental ethical argument for the establishment of value management systems is the absolute necessity to get away from the objectification of the human being ("the patient", "the doctor" and "the employee") that is usually common in health care practice. In this way, value management contributes to a higher quality of social interaction. But it is also about maintaining a balance in terms of closeness and distance to the individual, a balance that enables the creation and use of (open) spaces. This is the only way to create value management that can achieve the desired sustainable effect and make the values represented by the organization perceptible to employees and, especially in hospitals, to patients (Mayer, 2016a).

The Vinzenz Group's experience regarding long-term "cultural work" has shown that success can be achieved when ethical values and virtues are handled carefully, and this is reflected in all facilities: "Our value management system helps us to make our values perceptible to our employees, our patients and the residents of our nursing homes. Values create that sense of identity and community that we need in order to master the challenges in the health system together" (in the original: "Unser Wertemanagement unterstützt uns dabei, die Werte unseren Mitarbeiterinnen und Mitarbeitern, unseren Patientinnen und Patienten sowie Bewohnerinnen und Bewohnern erlebbar zu machen. Werte schaffen jene Identität und Gemeinschaft, die wir benötigen, um miteinander die Herausforderungen im Gesundheitswesen bewältigen zu können.") (Vinzenz Gruppe, 2020e). For private non-profit health care facilities this also means a competitive advantage over public hospitals, which focus on higher occupancy rates and higher numbers. Values are ultimately also reflected in higher quality features. It could be shown that "cultural work" in health care facilities does not only refer to behavior, but that organizational conditions have to be created that enable or facilitate the desired behavior. The establishment of a value management system that refers to the individual (in the hospital: "employee", "patient") requires a deep encounter with the person, but also with the embedding organization and the community as a whole. Interdisciplinary and multi-professional cooperation is thus encouraged, which, in the hospital, ultimately benefits the patient (Mayer, 2016a).

Worldwide, there are countless best practice examples that can be transferred to one's own institution, but also to coherent, inter-institutional, mutually cooperating care systems. Once the prerequisites for this are in place (Mayer, 2016a).

3.4 Leadership and Management

The renowned American economist and founder of modern management theory of Austrian origin, Peter F. Drucker, sees leadership as doing the right things, while management, in Drucker's view, aims to get things done right and fast, hence efficiently. Without a doubt, Drucker places people at the center of action and in doing so addresses a basic essence of the work at hand: "The task of management is to enable people to perform together" (Drucker, 2002). Drucker describes people who have followers as "leaders" in the preface of "The Leader of the Future", a publication of the Drucker Foundation, and points to the behavior of effective leaders: "An effective leader is not someone who is loved or admired. He or she is someone whose followers do the right things. Popularity is not leadership. Results are." Drucker continues in his list of criteria for effective leadership: "Leaders are highly visible. They, therefore, set examples." And concludes with the demand for awareness of taking responsibility: "Leadership is not rank, privileges, titles, or money. It is responsibility" (Drucker, 1997).

There are many different definitions of the term "management" in the management literature, but what they have in common is the general separation into "management in the institutional sense" and "management in the functional sense" (Staehle et al., 1999; Steinmann et al., 2013; Schreyögg & Koch, 2020). While management in the institutional sense describes a group of people who are responsible for carrying out management tasks, management in the functional sense defines functions such as planning, organization, personnel management, and control, which as cross-sectional functions are in a complementary relationship to the factual corporate functions (Busse & Schreyögg, 2010). Key competencies mentioned in the literature are "technical competences", which are aimed at the ability to apply knowledge, methods, and techniques to concrete situations, "conceptual competences", which require a quick structuring of complex situations, and "social competences", which are aimed in particular at the willingness and the ability to cooperate (Busse & Schreyögg, 2010; Steinmann et al., 2013; Schreyögg & Koch, 2020). According to Busse & Schreyögg (2010), the scientific classification of management in the health care sector differs from classical management theory primarily in that, technical competence is highly pronounced.

The functional management perspective is directed towards the tasks of a purpose-oriented organization, which are to be fulfilled for the efficient and effective control of the processes within the organization (Schreyögg & Koch, 2020). Particularly in health care, where the service processes relate directly to the treatment of patients, the organization is increasingly also jointly

responsible for upstream and downstream care processes. Not least in order to smoothly organize takeovers from primary care areas and transfers to follow-up care areas. In general, health care institutions are still characterized by pronounced hierarchical structures. This form of control hierarchy is intended to serve an effective fulfilment of management functions. According to Schreyögg & Koch (2020), management represents a complex of control tasks that must be performed in the provision of services and, above all, their quality assurance based on the division of labor. Schreyögg & Koch follow on from the classic management functions that go back to the organization theorist Harald Koontz and the management consultant of large American corporations Cyril O'Donnell from 1955. The two were the first to describe the so-called classical canon of five management functions, which has become the standard of management theory and practice to this day and describes the essential tasks of management: 'planning', 'organizing', 'staffing', 'directing' and 'controlling'. However, Schreyögg & Koch point out that the five functions should always be seen as part of an integrated process, which is described in management literature as the classic management process (Staehle et al., 1999; Schreyögg & Koch, 2020).

What characterizes effective management? The management scientist and renowned expert on the management of complex systems Fredmund Malik sees it as one of the most important tasks of "effective management" to ensure a goal-oriented orientation of the company. Malik places the onus on the individual manager, who is responsible for understanding the goals at the respective company level and subsequently for achieving them. Malik considers manageability to be the basic rule for managing with goals: *„Wenige Ziele, dafür aber große – solche, die ins Gewicht fallen, die etwas bedeuten, wenn sie erreicht werden"* (translated into English: "Few goals, but big ones - ones that matter, that mean something if they are achieved.") (Malik, 2014) Accordingly, Malik advocates the quantification of goals, i.e., their measurability, as well as a personal addressing of goals. He describes the implementation of decisions as another essential task of management. According to Malik, making decisions as a management task is widely accepted, but the implementation of decisions is often lacking. Malik sees the inclusion of realization in the decision-making process as an essential feature of effective leadership. To achieve the broadest possible acceptance among employees, it is advisable to involve employees in a co-responsible decision-making process at an early stage. The management consultant Reinhard K. Sprenger (2018) advocates a „Mitsprachepflicht" (engl.: "a duty to have a say") in companies. Cooperation as a component of a living culture leads on the one hand to greater identification with the company and on the other hand to greater sensitivity towards clients and

their needs. According to Malik (2014) effective management is primarily reflected in sense-making.

In his work "Leadership: Theory and Practice", the American communication scientist Peter G. Northouse draws a distinction between leadership and management and points out both the common features and the differences: "Leadership and management are different concepts that overlap". While leadership focuses on the classic areas of responsibility such as planning, organization, staffing and controlling, management aims to exert a general influence on performance processes. As described in some management literature, management deals with creating order and stabilizing measures of organizational events, while leadership aims at ongoing adjustments to necessary changes as well as constructive change. In his differentiation, Northouse also refers to the person, the type of manager or leader, with reference to literary sources. Accordingly, managers are assigned a more active and less emotional role, while leaders are ascribed more proactivity and emotional involvement. Northouse sees overlaps in the exertion of influence on individuals or groups while achieving organizational goals (Northouse, 2018). In order to lead health systems and especially health organizations into the future, managers with communication, cooperation, and coordination skills are needed who are capable of adopting a patient-oriented and cross-institutional perspective, as well as visionary leaders who can recognize the signs of the times and lead the care sectors into coordinated integrated care with best points of service in each case.

3.4.1 Management Structures in Health Care Organizations

Hospitals and increasingly also nursing homes are characterized by a complex organization. They are facilities for medical health care and nursing, at the same time places of work for mostly highly specialized professional groups and, in some cases, teaching facilities for training and further education of health professionals. At the same time health care facilities are also places where patients stay, especially in acute care areas, and living environments for home residents in long-term care. In addition there are rarely such diverse interest groups, from politics, health administration and sanitary authorities, scientific communities, as well as consumers of care services and their relatives. The aging of society increasingly requires a link between medical-therapeutic interventions and care actions (Grossmann & Lobnig, 2013).

While Austrian Hospital Act provides for a collegial management body ("Die Kollegiale Führung") consisting of medical, nursing and administrative management, nursing home management, with the exception of geriatric centers (nursing homes for the chronically ill), is the responsibility of the nursing home director, to whom the nursing service management is usually subordinate. Only private nursing homes, which are usually organized as limited liability companies under Organizational Act, have a management board. In private non-profit hospitals, this is usually the administrative director in a personal union. The tripartite management body in the acute care sector usually does not do sufficient justice to the complexity and the manifold-specific situational requirements of hospitals. The highly hierarchical hospital system with a concentration of many decisions at the management level shows clear weaknesses and, according to Salfeld, Hehner & Wichels (2009), creates barriers where flexible action would be necessary, especially when it comes to cross-interface cooperation or cross-institutional communication requirements necessary for the integration of care. Decision-making authority in accordance with the requirements of the care process, especially at the interfaces, would increase the speed of action in the overall process, including at the transitions, and thus lend efficiency and ultimately effectiveness to treatment processes.

3.4.2 Leadership Requirements

According to the Leadership Report of the German Future Institute (2016), an established research and consulting institution committed to trend and future research, leadership work in the future will be much more related to navigating than to controlling. "Enabling" and "making possible" will be of central importance. "Enabling," according to the authors, means "opening spaces" and "offering support" so that employees can empower themselves and largely assume responsibility. If co-responsibility of all participants for the success of cross-institutional health care processes is to be realized, the assumption of responsibility by everyone is required. Not only the social level, the multi-professional cooperation, will require increased participation of the individual, but also on the technical level there will be further demands on health care institutions and especially on leadership. Increasing digitization, including artificial intelligence (AI), requires the development of digital ethics, especially since the responsibility for their use cannot be attributed solely to the intelligent machines themselves, but ultimately lies with the leader and, in the future, increasingly with each individual employee.

3.5 Health Professionals

In Austria, health professionals are defined as professions regulated by law on the basis of the competence element of health care according to Art. 10 Para. 1 No. 12 B-VG, whose job description includes "the implementation of measures for the care of the general state of health of the population". Health professionals are authorized by special professional rights to perform activities within the framework of health care which are provided "directly or indirectly for human beings for the purpose of promoting, maintaining, restoring or improving health in a holistic sense and in all phases of life". Health professionals are characterized by three reservations in the Austrian health care system: the training reservation, the professional practice reservation, and the professional designation reservation. Health professionals perform their activities in the intra- and extramural care sector, in areas of prevention, diagnostics, therapies, rehabilitation as well as nursing. They are obliged to carry out their activities in accordance with professional and scientific knowledge and to continue their education in accordance with the latest scientific findings. The ongoing adaptation of competences to scientific findings as well as to social changes is based on the international convention on the recognition of qualifications in higher education (Lisbon 1997), in which the need for "lifelong learning", especially for health professionals, was given great importance (BMSGPK, 2020e).

3.5.1 Profession and Professionality

The term "profession", coming from the French ('profession', lat. 'professio') stood in its original meaning, not far from its current attributions, for "occupation", "trade" as well as "vocation" (Pfeiffer, 1993). According to this, "professionalism" can be described as "being professional", having the prerequisites for the exercise of the profession, combined with job-related skills such as autonomy and independence (Bibliographical Institute, 2020; Mieg, 2018). According to Schroeder (2010), professional action is based on an "objective, scientifically legitimated competence-base, on which "rationally justified and not traditionally legitimated action" is based. The social scientist Gudrun Ehlert (2019) describes professionalism as a "skillful professionalism", to which a "normative as well as an action-theoretical dimension with a perspective related to concrete situations" is immanent. Mahler, Gutmann, Karstens & Joos (2014) describe professionalism as a "service occupation relevant to society" that applies "highly specialized knowledge acquired over a long period of training in a relatively autonomous and collectivity-

oriented manner". A profession, according to the further explanation, is based "on the action science knowledge of the associated discipline". Ehlert (2019) focuses less on "high-level specialization" and more on "professionalism related to the vocational training" and its practitioners, and relates professionalization to the "individual ability of the individual skilled worker and to the process of qualification, but also to collective processes of professional development of occupational fields".

In sociology, for a long time, there were divergent approaches to the characteristics of a profession and in particular which professions have a claim to professionalization (Kälble, 2005; Gerlach, 2008). Around 1930 a closer examination of professionalism and professionalization began for the first time in the Anglo-American world. Especially the activities of the medical profession, judges and clergy were recognized as professions. The decisive factors were scientific training, the existence of professions, and the degree of self-control and external control (Veit, 2004). To this day, no definitive version of the concept of professionalization can be found in the scientific literature. The sociologist Hans Albrecht Hesse (1968) described professionalization as a process leading to the emergence of a profession. He characterizes professionalization as a dynamic process and not as a fixed quantity. For Hartmann (1972), a sociologist of the early seventies, a professional must have a social orientation to be considered as such. Thus, in addition to the steadily increasing professionalization, the orientation of a profession towards the common good is also important. The Encyclopedia of Sociology describes the term "professionalization" as the specialization and scientificication of a profession, due to the increasing demands on the necessary expertise (Fuchs-Heinritz et al., 2011). Mieg (2018) clearly distinguishes the term "profession" from the term "expert" and sees the professions as having a sovereign right of interpretation over expertise as a central feature: "Professions create standards of performance assessment and monitor them", which also expresses the constantly evolving process of professionalization.

What makes a Profession a Health Profession? The German social psychologist and expert for organizational and competence development Volker Heyse sees the future society as a competence society rather than a knowledge society. Health care systems in particular are affected to a large extent. Increases in knowledge in the health sciences, especially regarding the medical care, have made it necessary to question existing structures and to change treatment methods as a result of technological progress. In order to cope with this development, further education and training are required to adapt to the changing circumstances (Heyse, 2014). New demands require the recognition of fundamental key competencies in health professionals, accompanied

by increasing personal responsibility for the "entrusted human, economic and technical resources". Heyse considers a new professional self-image, combined with "comprehensive personal responsibility", especially in the "advanced health care systems" (he refers here to the USA, Canada, Australia, as well as Western European countries) to be indispensable. Equal cooperation between physicians, nursing staff and other health care providers characterizes this development and requires a fundamental change in the health care system (Heyse & Schircks, 2012).

Hauke, Holzer & Offermanns (2012) complain that in Austria in particular, unlike in other Western European countries, previous health care reforms have "hardly taken place at all" and that in the Austrian health care system economic interests and the "interests of individuals" are the main focus. In the opinion of health experts, who can draw on many years of scientific activity and care practice, the Austrian health care system is also dominated by individual professional groups (Hauke et al., 2012). All the more a paradigm shift is needed, a view of the health care system from the patient's perspective. According to Heyse (2014), new forms of cooperation and competencies are "not primarily" oriented to the viewpoint of the individual professional groups, but "result primarily from the patient perspective".

Interprofessionality in health care systems received special attention through the report of the German Council of Economic Experts on the Assessment of Developments in the Health Care System (SVR, 2007). In its report "Cooperation and Responsibility - Prerequisites for Goal-Oriented Health Care" from 2007, the focus was not only on the cooperation of the health professionals but also on integrated care. "Instead of the previously favored focus on the individual interests of the respective occupational group", it is sobering to read in the report, an "expansion of cooperation" should take place, which can prove to be "far more beneficial" for all those involved, especially for the patients themselves. As a prerequisite for this, the experts cite a change in the self-image of the health professionals and organizational changes such as flattening and networking in team structures (SVR, 2007). The experts also state the objectives that should guide the development. For example, the redistribution of tasks should be preceded by a comprehensive analysis, the occupational groups should be oriented to the current deficits in health care provision and economic aspects ("optimization of the use of resources") should be of decisive importance from the outset. In addition, an adjustment to the respective care needs is demanded: "The changed roles of the health professionals must be designed flexibly, appropriately to local conditions and capable of development in order to be able to react optimally to future, not always foreseeable care needs (SVR, 2007). Shortly afterwards, in 2010, the Robert

Bosch Foundation's memorandum on "Cooperation between the health professionals" gained attention in science and practice. Like the experts of the German Council of Economic Experts, renowned experts take up the status quo of health care practice in a critical discourse and offer a series of solutions that usually hardly differ from the topics known from literature. Nevertheless, individual aspects are accentuated, and their mention enables a critical follow-up. Thus, it is interesting to read that the evil of "superficial cooperation" is seen primarily in economic pressure (Rudolf Bosch Stiftung, 2010). The experts of both studies agree that the "establishment of sustainable forms of integrated and cooperative health care" requires the creation of conditions that give it the necessary space. Reference is also made to the professional self-image of the individual occupational groups. Thus, the need for a "new culture of cooperation" is emphasized, a culture that pushes "professional thinking" into the background. The World Health Organization (WHO) also addressed the topic at almost the same time. In its "Framework for Action on Interprofessional Education and Collaborative Practice", published in 2010, an attempt was made to take a global view of the current state of interprofessional collaboration and interprofessional education and to identify mechanisms that shape successful teamwork and to make the results available to local decision-makers in the health care worlds (Figure 3) (WHO, 2010).

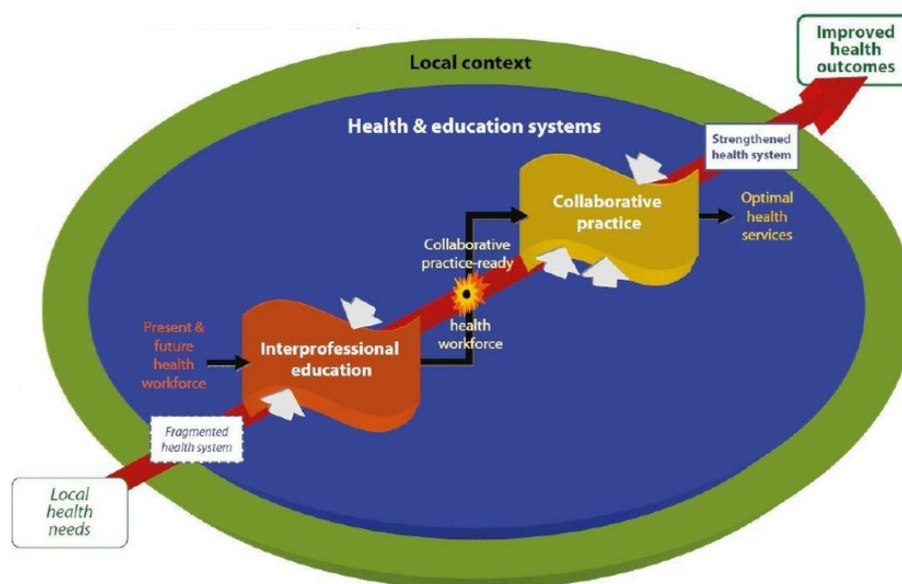


Figure 3 Health and Education Systems, WHO (2010)

This is why there exists an undisputed consensus on the need for a broad orientation towards actual needs, which at the same time guarantees high-quality care. In addition to changed structures, this requires that healthy occupations are also prepared for this in their initial, further, and continuing training (Hauke et al., 2014). The Lancet Report, a report by the Swiss Careum

Foundation published in 2010, contains strategic considerations on training for health professionals with a view to greater compatibility of needs. The report, entitled "A new global initiative to reform the training of health professionals", once again points out the urgency of adapting vocational training to the needs of care and to the changing needs and expectations of patients. To improve the performance of systems, the authors of the Lancet Report propose a reorientation of educational concepts based on "competency-driven approaches". Interprofessional and cross-professional learning should help to overcome job-specific thought patterns and promote hierarchical teamwork (Lancet Commission, 2010). Demand-oriented health care is understood here in accordance with the needs of the individual patient for "high-quality health care in accordance with his or her [sic!] self-determination" (SVR, 2018) and with the "need of all insured persons for long-term availability of such health care". A need which "subject to change over time". According to the Council of Experts (SVR, 2018) a distinction must be made between the subjective need, which corresponds to the individual needs of the patients, a latent need, and the self-determination of the patients. In its clear statement, the Council of Experts sees the success of health care that corresponds to the individual needs and largely takes into account the needs of patients in an effective and efficient use of existing human, structural and financial resources as well as in the exploitation of technical possibilities. In a realistic view, the SVR also emphasizes the existence of "control deficits", which manifest themselves in overuse, underuse, and misuse of health care, and therefore advocates "more targeted control" (SVR, 2018).

How can the concept of competence and especially key competencies be described in relation to health professionals? Heyse et al. (2010) see competencies as the essential "prerequisites for self-organization" and describes them as complex, partly hidden human potentials that include "implicit experiences" as well as "knowledge, abilities, skills, values, and potentials". Building on the four pillars of the UNESCO educational model: "learning to be" ("personal competence"), "learning to do" ("action competence"), "learning to know" ("technical and methodological competence") and "learning to live together" ("social-communicative competence"), emerging from the report "Learning: The Treasure Within" (1996), prepared under the direction of Jacques Delors (former President of the European Commission, 1985-1995). Volker Heyse & John Erpenbeck (2004) developed the "extended" competence atlas, which presents 64 key competences.

Figure 4 Competence Atlas, according to Heyse & Erpenbeck (2004)

Heyse & Schircks (2012) refer to various studies carried out in 2009 in Switzerland and Germany "key competencies that will be important in the future" (Heyse, 2014) are summarized in an overview. The "personal competencies" can thus be assigned to the key competencies "normative-ethical attitudes", "personal responsibility", "self-management", "willingness to learn" and "employee development". The basic competence "competence to act" should be supplemented by "result-oriented action" and "decision-making ability". Seen from the perspective of the integration of care, of course, "coordination ability" is also significant. "Specialist and methodological competence" require "ability to judge" and "interdisciplinary knowledge", and "social-communicative competence" will in future be expressed more strongly by "ability to communicate", "ability to cooperate", "ability to advise", skills in "relationship management" and "ability to work in a team". In addition Hauke, Mayer, Holzer & Offermanns (2014) place the interdisciplinary aspect in the foreground and thus also demand that "interdisciplinary knowledge be incorporated" and add to the list of key competencies "problem-solving ability", the ability "to successfully solve problems with others", "awareness of consequences", the "ability to foresee the consequences of decisions" and "result-/evidence-oriented action", "to act based on results and the success of treatment".

3.5.2 Interprofessional Collaboration

In publications relating to cooperation between health professionals, in German-language specialist literature as well as in the English-speaking world (McCallin, 2001; Chamberlain-Salaun et al., 2013; Mahler et al., 2014), terms relevant for cooperation can be found in many different forms. For example, terms such as "interdisciplinary", "interprofessional", "multi-professional" and "intraprofessional" are used for cooperation in health care facilities, whereby the terms "interdisciplinary cooperation" and "interprofessional cooperation" are usually used synonymously (Mahler et al., 2014). Clarification of the terms "cooperation between health professionals" is not only indispensable for the present thesis, but also necessary for further research, training of the health professionals and for practice, especially since cooperation between the health professionals is one of the basic building blocks for integrated care concepts.

Axel Kuehn (2004) and Mahler et al. (2014) see the prefixes "multi" "inter" and "trans" not only as a distinction of the type but also as a clear indication for the intensity of cooperation. According to their model "multi-professional cooperation" is probably done in cooperation, but largely by independent actors. Whereas "interprofessional cooperation" according to the authors overlapping competencies between different professions require, which is also expressed in the fact that the scientific disciplines overlap. "Intraprofessional cooperation" means cooperation within the occupational groups and "transprofessional cooperation" ultimately leads to a far-reaching dissolution of occupational boundaries (Mahler et al., 2014). The sociologist Karl Kälble (2004) sees interprofessional cooperation between health professions as cooperation of different "occupational groups with different specializations, professional self-perceptions and perceptions of others, areas of competence, fields of activity and different status in the sense of complementary, high-quality, patient-oriented care, so that the specific competences of each individual profession can be made available to the patient". A definition that can undoubtedly be useful for the present thesis especially since the process of interprofessional understanding is of essential importance in the context of the integration of care. The social scientist Beat Sottas (2013) has a similar interpretation, framing interprofessionality as a "key concept for the health care system". For Sottas "cooperation competence" stay in the foreground, which he describes with skills and knowledge such as "principles of teamwork, organization of the division of labor, interface management, appreciation, group dynamics and power, interprofessional conflict ability, transfer of practice, process moderation, cooperative management principles".

Mere "interdisciplinarity" or "interdisciplinary cooperation" would therefore be inadequate. Nevertheless, especially in the context of cooperation in health care facilities, attributions such as "interdisciplinary" and "interprofessional" are usually used synonymously. Interdisciplinarity is more likely to be attributed to the scientific discussion (Jungert, 2013). Schroeder (2010) sees interdisciplinary cooperation as collaboration between individual disciplines, such as the social sciences and economics. Interprofessional cooperation, on the other hand, is ascribed to the cooperation of members of different professional groups, which are characterized by different areas of competence and activity, specializations, status, and professional self-perceptions and images of others (Kälble, 2004; Schroeder, 2010; Stock & Radaélli, 2019).

In health care, different professional groups come together, depending on the form of care and the need for care. For example, as described above, the concept of primary care units (PVE) provides for an interdisciplinary and multi-professional team around the family doctor. According to this concept, the core team of these facilities consists of several health professionals from medicine, nursing, and therapies, supported by technical and administrative staff. Depending on regional care needs, members of social professions should also be available (BMG, 2014b). Care facilities organized as PVEs represent an exemplary form of health care integration. They are primary points of contact for medical care and act as links to facilities for inpatient and outpatient acute care as well as to outpatient and inpatient nursing care.

In all models and concepts of integrated care, the "3 Cs of health care", cooperation, coordination, and communication, can be found. In her comparison of integrated care between Germany, Austria, and Switzerland Britta Schumm (2016) emphasizes the need for coordination, especially the interdisciplinary nature of cooperation and communication: "When defining the treatment processes, it is important to include all the professional groups and care institutions involved". Schumm advocates a "reorientation from a functional view of health professionals to a process-oriented and patient-centered view." In her view, the organization must develop from a "hierarchical, occupational group-based structure to a process-oriented structure" in order to "create the necessary framework conditions for communication and cooperation between the occupational groups".

3.6 INTEGRATED HEALTH CARE

The term "integration" can be traced back to the Latin verb integrāre (in the sense of "to complement") (Kluge, 2002), whereby the verb "to integrate" can be understood as the bringing

together of elements that were previously separated (Kodner & Spreeuwenberg, 2002). By linking "integration" and "care" the pair of terms is given system theoretical meaning (Mayer, 2017). The components are assigned complementary roles to correspond to the common objective, the integration of health care (Kodner & Spreeuwenberg, 2002).

The harmonization of the areas of care in national health care systems towards modern processes and structures is a primary health policy goal at the national level as well as at the international level, guided and driven by the World Health Organization (WHO).

3.6.1 Definition Integrated Health Care

"Integrated care" is becoming increasingly important in national health care systems (Kodner & Spreeuwenberg, 2002). Different interpretations of terms require the creation of a common understanding. If one looks for the roots of the term, one comes across different interpretations depending on the professional perspective. In most cases, the degree of integration of the health care system in the respective country is reflected in the understanding of the term (Mayer, 2017). In their analysis presented in the International Journal of Integrated Care in 2002, Dennis L. Kodner and Cor Spreeuwenberg attempted to get to the bottom of the term "integrated care". Starting from the etymological meaning of "integration", Kodner and Spreeuwenberg attempt to grasp the logic behind the concept of integrated care with the aim of creating a solid basis for the political and health science discussion as well as for care practice (Kodner & Spreeuwenberg, 2002). A scientific article published by the International Journal of Integrated Care in 2009 already referred to more than 175 partly overlapping definitions of integrated care. Armitage et al. (2009) listed several conceptual features that can be found in numerous definitions. "Coordination of care" can be found as well as "cooperation", "continuity", "user-centeredness", "cross-sectoral care", etc., but also care concepts such as "disease management", "case management" and "managed care".

The first broader debate among Austrian experts on integrated care goes back to the founding of the "Competence Center for Integrated Care" (CCIV) of the Austrian social insurance system (WGKK, 2006; Mayer, 2017). Subsequently, Eger & Sandholzer (2007) presented a first survey of existing forms of integrated care in Austria. Disease management programs, such as "Therapy active diabetes under control" for patients with diabetes mellitus type 2 diseases were men-

tioned as well as forms of interface management at the transitions between the health care sectors, such as the so-called "discharge management", which is intended to support the transition from hospital to home or to another health care sector. While in the neighboring German-speaking countries it was already possible to relate to empirical knowledge (e.g. MVZ, medical care center) in Germany, or experience with "Health Maintenance Organizations" (HMOs) in Switzerland (Güntert, 2007), in Austria there was still talk of "ambitious projects", whose "medical and economic evaluation" would have to wait (Eger & Sandholzer, 2007). Other obstacles were unclarified political responsibilities, the still heterogeneous Austrian financing systems and barriers that are to be found in the corporate structures and also in the organizational cultures (Güntert, 2007). Nevertheless, the advantages of integrated health care have always been discussed, and the CCIV acclaimed "patient-oriented, continuous, cross-sectoral and/or interdisciplinary care based on a standardized treatment concept" (Becka, & Schauppenlehner, 2011; HVB-SV, 2012) as the main benefit aspects of integrated care. To ensure a comprehensive and holistic approach to the subject the CCIV developed the concept of "population-based integrated care" (PIV), which differs from special integrated care models (such as disease management programs). Here the "structural or procedural organization of the form of care is comprehensive (not specific to any particular indication), quality-oriented, cooperative/networking, effective and efficient and timely". Indication-related integrated forms of care (such as disease management programs) can be embedded in this (HVB-SV, 2012). An outstanding network for the further development of integrated care is the "Austrian Forum Primary Care", which sees itself as an "Alliance for the Promotion of Primary Care in Austria". At a "Future Conference" held in Graz in April 2016 on the topic of "Innovative Models in Primary Care", the Institute of General Medicine and Evidence-Based Care Research at the Medical University of Graz laid the foundation for this innovative initiative, which is known beyond the borders of the provinces. The forum, which brings together well-known players in the Austrian health care system at regular events, has set itself the goal of continuously reviewing the possibilities and benefits of expanding primary care in Austria, promoting pilot projects, promoting the networking of Austrian health care experts, and contributing to training opportunities and the quality of training for health professionals (Medizinische Universität Graz, 2016). In Article 3 No. 7 (definitions) of the consolidated version of the “Austrian Health Targets Steering Act" (G-ZG), **Integrated health care** *is defined as*

"Patient-oriented, continuous, cross-sectoral, interdisciplinary and/or multi-professional care oriented according to standardized care concepts".

(note: Integrated health care comprises both process and organizational integration).

In operational target 6 (contained in Article 6 "Catalogue of Targets and Measures" of the Austrian agreement on the management of objectives "Objectives and Measures for Health 2017-2021"), which deals with "measures to improve integrated care" (derived from the strategic goal of the agreement "Ensuring the satisfaction of the population by optimizing care and treatment processes"), individual objectives are reported, which include measures at the federal level (e.g. definition of uniform nationwide quality standards for certain illnesses and creation of framework conditions for their implementation) as well as measures at the state level (implementation of uniform nationwide quality standards).

Integrated care in Austria is to be promoted by the establishment of a part-national target management system. In 2013, the Austrian system partners - the federal government, the provinces and the social security system - committed themselves for the first time to a "contractually supported organization of health care" based on cooperation and coordination. With the target management agreement 2017-2021, the original agreement has now been extended and further developed until 2021. In order to ensure the "best possible quality" of health care, combined with secure provision, the preamble to the agreement sets out guiding principles for its implementation, such as "impact orientation, responsibility, accountability, openness, transparency and fairness" (BMSGPK, 2020b).

Nevertheless, up to now only isolated measures for specific to indications of diseases have been implemented in Austria. For the renowned British health scientist and public health expert Ellen Nolte (2016) the evidence for integrated care models is "still insufficient". However, Nolte also points out that patients who participate in integrated care models usually have a better health status. Nolte sees the successful implementation of integrated care models above all in the early and comprehensive involvement of all health professionals and a high degree of political support.

According to the World Health Organization (WHO) integrated care is "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money (WHO 2008b). Through networking within and between the sectors of health and social services and through improved cooperation between the various professions, integrated care can offer solutions to the fragmentation that currently still prevails in most health systems. Especially in the care of elderly and multimorbid people, integrated care represents a promising solution concept, since disease-centered care is made more difficult if several diseases are present (Czypionka, et al., 2016).

3.6.2 Integrated Health Care Management

Integration of care from a management perspective essentially comprises four dimensions: The integrative treatment process - integration; the multi-professional togetherness regarding the treatment goals - cooperation; the exchange on a social level required for this regarding the diagnostics and therapy - communication; and finally the transfer of information, which becomes necessary due to increasing networking. Two areas can be distinguished. The medical area, which includes medical, nursing and therapeutic care, and the organizational area, which relates to responsibilities, timing, and inter-institutional or inter-sectoral transfer management. A distinction can be made between horizontal and vertical integration of care. Horizontal integration is seen as the coordination of the treatment pathway between different health care providers at the same level of care. Vertical integration, on the other hand, means the integration of care across different levels of care (e.g. general practitioner, hospital, rehabilitation) (Busse & Schreyögg, 2010).

The management theorist and communication scientist Peter G. Northouse describes leadership as a process "whereby an individual influences a group of individuals to achieve a common goal". According to Northouse, leadership is a communicative event between the leader and the group he or she leads, which is influenced by the leader and geared toward common goals. More clearly in the contribution of Siller (2011), who, following Lombriser and Abplanalp (2004), emphasizes the visionary side of leaders, according to which leaders "develop a vision and explain the strategies to achieve this vision" and guide the led towards goals through enthusiasm and motivation. The question that arises is the distinction between management and leadership, especially since leading is included in both functions. Tarigan (2012) elaborates the difference between management and leadership in his argument: "A leader must face risks (risk taker) and then lives the tensions of the unpredictable future (future builder) and a leader tries to transform the possibility of the future into the certainty of the present (agent of change), on the other hand, a leader must have the courage to make a responsible decision (decision maker)." For him, leadership means empowerment of those led, as already explained above by futurologist Kühmayer (2016): "A true leader isn't someone who makes the others dependent on him/her, but energizes them to help themselves." This is a quality that is particularly important in the development of the integration of health care and especially in interprofessional collaboration.

If one follows the understanding of management according to the managerial functions approach and describes management in the classic form as organizational processes and functions such as "planning, organization, leadership and control" (Staehle et al., 1999), then this would only partially meet the requirements of integrating health care. The important management theorist Peter Drucker (2002), however, also placed people at the center of management: "People are at the center of management. The task of management is to enable people to perform together. In addition to a wide range of management solutions, the implementation of integrated care also requires leadership of the highest quality. Leadership that takes up innovative approaches to solutions, is capable of transforming vision into strategies and ultimately persuades people to see common goals in the overall context and to implement them in the interests of the people to be cared for.

3.6.3 Best Point of Service

In the collective awareness of the health care system beneficiaries the patient is not only at the center of the professional discourse attributable to the health care sciences, but increasingly also in the health policy discussion among experts and representatives of health care practice. In an "Expertenletter" published in 2003 by the Lower Austrian patient advocacy office, the health scientist and renowned health care author Eugen Hauke appeals to the point: "It is the patients who are the reason why hospitals are operated; it is their reason we work there" (Hauke, 2003). During the Health Talks at the "European Forum Alpbach 2019" on the topic of "The Liberated Patient: From Digitization to Individualization", Michael Heinisch, Chief Executive Officer of the Austrian Vinzenz Group, a group of several denominational, private non-profit hospitals, was convinced that new technologies and digitization would enable patients "to have even more self-determination than before". According to Heinisch patients will gain more freedom. Patients will "determine the place and time at which they consume their health care services." Heinisch is equally convinced that there will only be one "Best Point of Service" "and that it will be directly with the patient". "Those who recognize the potential of digital change in the health care sector and use it properly will do a lot for a health care system that will be able to take more account of people in the future than ever before," the health care expert appealed to the representatives from science and practice present at the forum (Heinisch, 2019).

In the political discussion, however, clarification of the term "Best Point of Service" looks a little more differentiated and has not yet been completed. At a health policy discussion forum held in Vienna in 2019, Josef Smolle, a politician and physician, pointed out that the question of a conceptual interpretation of the best point of service would require further "education, advice and information" regarding the implementation, and knowledge of how health care facilities can be supported in this respect (Smolle, 2019). For Stefan Gara (2019), who also comes from a political background, the declaration for Best Point of Service contained in the Austrian Health Targets Steering Act is too short. In the course of the discussion, Gara noted that the legal form could only be applied to the curative area, the treatment level and that the term "Best Point of Service" should be extended. In his view, the meaning of the term should be expanded to include health information (also in the sense of health promotion and prevention) and also extended to the nursing sector. However, he explicitly points out that this would raise further questions about financing (Gara, 2019). The Viennese nursing and patient advocate Sigrid Pilz adds to the discussion by referring to basic patient rights. Pilz points out that patients have a right to transparent and high-quality information, especially regarding the regional care provision. In the opinion of the patient advocate, Internet applications should also serve for this (Pilz, 2019). Gabriele Eichhorn, who comes from the Austrian social insurance sector, emphasized in her contribution to the discussion in the forum the structural optimizations already achieved in health care, such as the construction of outpatient clinics as low-threshold care facilities upstream of the hospital or the increased expansion of primary care through group practices in urban areas (Eichhorn, 2019). The "Best Point of Service" was already at the center of the health policy discussion in Austria in 2015. In a parliamentary inquiry from 2015 to Health Minister Sabine Oberhauser the "Best Point of Service" was the focus of interest. The sequence of the detailed questions is also interesting, which will also be briefly described below. Starting with the questions about clarification of the definition and whether the "Best Point of Service" applies to the different areas of care, and if so, in what form, the interest was directed towards a clear localization of the Best Point of Service in the different areas of care, possible contact persons in these areas and the question of a "quasi-success assessment" ("quality control"), how and by whom the achievement of the "Best Point of Service" can be ensured (Austrian Parliament, 2015). The reason for the request was, on the one hand, that already in the course of the preparations for the Austrian health reform in 2013, Health Minister Alois Stöger mentioned a "Best Point of Service" as a kind of "contact point" ("without further details") and, on the other hand, that the term was also used in the Executive Summary of the Austrian National Action Plan for Rare Diseases (BMG, 2015) as follows: "Patient safety and health competence should

be strictly limited by objective, quality assured and target group-specific information, thereby indirectly facilitating the access to the best point of service.

Already the inner-Austrian State Treaty on Health Target Steering between the Federal Government and the Länder (agreement according to Art. 15a B-VG Target-based Health Steering) contains in the definitions of Art. 3 (identical to Article 3 G-ZG Definitions, the consolidated version of the Austrian Health Target Steering Act) a definition of the "Best Point of Service", which is, however, limited to curative care: "curative care is to be provided at the right time and in the right place with optimal medical and nursing quality at the lowest possible cost to the economy as a whole". In the preamble of this agreement, explicit reference is made to the basic principles of "cooperation" and "coordination" as well as to the general goal of overcoming "organizational and financial particular interests of the system partners". Furthermore, it explicitly emphasizes "to ensure low-threshold access to needs-based health care and its high quality in the long term" and the will to extend this. In the systematics of this agreement, this is of course to be understood in the context of "integrated care", care that refers to "patient-oriented joint and coordinated cross-sectoral health care including related areas (acute inpatient care, outpatient care, rehabilitation, interfaces with the nursing sector)" and, according to Article 3, para. 5 of this Article 15a of the Federal Constitution, includes both process and organizational integration. In the answer to the parliamentary question of 05.05.2015, the "Best Point of Service" is described as a vision of the future, which is to be approached in alternating sequence, depending on the phase of the individual care requirement and the available care offer.

The scientific team from the University of Applied Sciences Burgenland around and with the author of the present thesis, Michael Mut & Alexandra Weghofer, dedicated their contribution on the topic of "Network formation in integrated care" to networking, which must be considered a prerequisite for the creation of a "best point of service" in the Austrian health system. They critically note in their contribution that the "Best Point of Service", which is becoming increasingly important in the health policy discussion not only for the consideration of the needs of care but also of the requirements, is usually "interpreted differently, often also distorted". In its holistic "Active Assisted Living" approach to the care of elderly people in assisted living facilities, which is also geared to individual care needs, a model for economic control based on key figures is presented, especially since one of the main arguments for integrated care is usually based on cost control and financial feasibility (Mayer et al., 2018).

The chairman of the Austrian Medical Association (ÖÄK) Lukas Stärker, admittedly from the perspective of purely medical care, raises a number of questions in the online edition of the

Ärztezeitung of 25.02.2014, which in his opinion could be solved on the basis of a multi-stage implementation concept. His questions relate to the services themselves, where questions of justified distances of service providers also play a role, and to the type of financing, which reflects the well-known dilemma of responsibilities. Similar to Heinisch (see above), he also considers it a prerequisite for the "best point of service" that patients "know where to turn for optimal treatment in each case". In Stärker's view, the "Best Point of Service" can be determined by several steps. After creating a common basis for discussion (stage 1: clarification of all open questions), a definition of when and where (in which care sector) treatment should take place based on the clinical picture and diagnosis (stage 2). Based on this, the treatment steps in the respective care region can be specified (stage 3) (Stärker, 2014). However, it should be borne in mind that the definition of the term contained in the consolidated provisions of the Austrian Health Objectives Management Act explicitly refers to optimal medical "and nursing quality", which should be "at the right time in the right place" and, from a macroeconomic perspective, "as cost-effective as possible".

3.6.4 Integrated Health Care Region „Healthy Kinzigtal"

The model region "Healthy Kinzigtal" ("Integrierte Versorgung Gesundes Kinzigtal", herein-after IVGK), for example, is considered the leading reference model for integrated care in the German health care system. According to the basic principle of integrated care, the IVGK aims to improve the health status of the insured in the region and to reduce the overall costs of health care in the region. The Healthy Kinzigtal Model Region dates back to 2005. The specially founded "Gesundes Kinzigtal GmbH", consisting of the "Medizinisches Qualitätsnetz - Ärztei-nitiative Kinzigtal e.V." (MQNK) and OptiMedis AG, which sees itself as a "health science-oriented management and investment company" (OptiMedis, 2016) concluded a contract with the German so-called "Allgemeine Ortskrankenkasse" (AOK, 2016; now: "AOK Gesund-heitskasse") in the state of Baden-Wurttemberg (AOK BW) for the integrated care of the Kinzigtal care region. Subsequently, the "Landwirtschaftliche Krankenkassen" (LKK BW) joined the care concept and an opening for further health insurance companies followed. The minimum term of the contracts was initially nine years, but was extended due to the success.

The health care company OptiMedis AG, which was founded in 2003, was concerned from the outset with the development of "regional multi-professional health care networks, in which pharmacies, fitness studios, clubs, schools, businesses and the local authorities are involved in

addition to doctors, therapists and hospitals" (OptiMedis, 2020). In its mission statement, the company criticises the German health care system in an unusually clear manner: "Health care in Germany does not meet current and future requirements" and sees itself as a provider of prospects "for ensuring high-quality care close to home". Health insurance companies, as well as medical and non-medical providers of health services, act as partners of the health care company. With the involvement of political decision-makers, the quality of the German health care system is to be adapted to regional needs, both in terms of patient orientation and economic efficiency. One focus is the establishment of care networks, the cooperative association of several service providers who are committed to the joint provision of population-based integrated health care (Hildebrandt et al., n.y.; OptiMedis, 2020). OptiMedis (2020) is committed to evidence-based solutions. The primary goal is to improve the health status of the population in the Region and thus to achieve a collective health benefit. The success is undisputed; above all, the improved intersectoral and interdisciplinary cooperation of service providers represents a significant factor in the success of Healthy Kinzigtal" (Hildebrandt et al., n.y.).

Scientific evaluation is of great importance in the operation of the "Healthy Kinzigtal". A coordination office established at the German University of Freiburg serves for regular evaluation of integrated care. Scientific evidence of improvements in disease patterns is evident (e.g. osteoporosis, high blood pressure, etc.) (OptiMedis, 2016). The economic concept is designed to reward the insured for maintaining good health. Benefits are paid after a health status has been established which is at least as good or better and the costs of care are also lower than the German average for all insured persons with similar demographic characteristics. The result proves both health and economic success (OptiMedis, 2016). In a survey carried out by the University of Freiburg as part of a trend study ("GeKiM Study 2015“, a sample is drawn from the population at regular intervals), the "registered members" of the model region "Healthy Kinzigtal" were asked about their satisfaction with the health care system and in particular about the doctor they trust (the first survey took place in 2012/13). The results of the first and second survey were subsequently compared. In the second survey, from January to May 2015, additional questions were also asked about the increase in knowledge regarding "possibilities of maintaining one's own health, changes in one's own health behavior and health-related quality of life". Patient attitudes were also surveyed according to the paradigm "active"/ "activated" patient. Satisfaction with the physician of trust or with the medical practice was evaluated on the basis of summarizing, comparable indicators according to three evaluation categories, "practice and staff", "physician-patient communication" and "treatment" as such. By means of multiple regression, it was then analyzed which variables are suitable for the representation of

"overall satisfaction" ("IVGK readiness to recommend further treatment"). This led to the conclusion that the willingness to recommend the IVGK to others depends on the degree of subjective "health care perception" and, secondarily, on the self-assessed "increase in knowledge" regarding health maintenance. In addition, the "overall impression of the doctor of trust" is also decisive. Furthermore, the study (in the course of the second survey) showed that "the more 'active' or 'activated' a patient is, the more he or she recommends IVGK membership" (Siegel et al., 2015).

The guiding principle of the concept "Gesundes Kinzigtal" ("Healthy Kinzigtal") is compatible to the Triple Aim approach of the US-Americans Donald M. Berwick, Thomas W. Nolan & John Whittington (2008). They are envisaging a strengthened health care system, an improvement in the health of the population, and a reduction in per-capita costs in health care. According to former Deputy Managing Director Alexander Pimperl (2008) measures are appropriate if they generate a "health benefit" and improve health care in three respects: In order to be able to implement these goals, an organization (a so-called "Integrator") and registered members who commit themselves to universality in the use of care are required. According to Berwick et al. (2008) the "integrator" should focus on the members' health management and be able to coordinate health care services accordingly. Striving for the Triple Aim requires that the members of the organization are continuously better informed about determinants of their own health status and about the advantages and disadvantages of individual health practices. Accordingly, the integrator's skills should relate to building and maintaining a culture of transparency, health literacy, communication, and collaborative, joint decision-making with patients and the community at large. According to Pimperl (2008), there are three paths that lead to Triple Aim: The evidence-based path, "health services research", continuous renewal, "innovation promotion" and, of course, cross-sectoral, patient-centered, interdisciplinary care, "integrated care". In health services research, care and health data are analyzed, outcome measurements are taken and, as a result, learning impulses are set for the health network as well as for further research and stakeholders (health insurance companies, hospitals, doctors' networks, municipalities). Innovations (health apps, tele-interventions etc.) are subject to regular benefit and acceptance tests. Within the framework of integrated care, health institutions and health service providers (hospitals, doctors etc.) work together in a coordinated and cooperative manner with the aim of "making people healthier through health promotion, activation and care management" (Pimperl, 2008).

3.6.5 Quality in the Context of Integrated Health Care

Regarding the quality of health care, Mayer (2019) is guided by the Austrian Health Quality Act (GQG) of 2006, which defines quality as the "degree of fulfillment of the characteristics of patient-oriented, transparent, effective, and efficient service provision in the health care system" and adds Donabedian's sub-qualities of "structural quality", "process quality", and "outcome quality" as the conditio sine qua non of care optimization in his paper (Mayer, 2019; BMASGK, 2019a). Mayer (2019) refers to the often described "fragmentation" and "insufficient coordination" of the Austrian health care system, which can be found in almost all expert contributions to the Austrian health care system (such as Hofmarcher-Holzhacker 2013; Bachner et al., 2019) and raises the question "to what extent quality in the sense of improved coordination of the health care sectors can be realized in health care systems in general in the foreseeable future" (Mayer, 2019). At the same time Mayer (2019) gives the answer that conditions must first be created that allow "state-of-the-art care structures". The author calls for the creation of suitable conditions in the required quality as prerequisite for an improvement in the design of the supply routes. In his contribution on "Quality in the context of integrated care", Mayer describes the approach that is frequently observed in Austria; instead of establishing or adapting structures according to the processes necessary for care, care structures that have grown over time are usually simply adapted to processes.

Mayer (2019) points to permanent change, to changes in disease patterns as well as to the necessary adaptation of care processes. Mayer also makes us think that the needs of patients are also subject to change, although not every individual need for care can be met in a fully comprehensive manner, nor can the subjective need be met. Modern care requires extensive personalization in both the medical and personal area (Mayer, 2012; Mayer, 2019) In view of the rather hesitant development of the Austrian health care system, Mayer (2019) does not spare criticism of health managers in decision-making functions and of health policy decision-makers: "Every responsible entrepreneur would focus on the individual needs and requirements of his or her employees. Every responsible entrepreneur would directly focus on the individual needs and requirements of his or her clients and align all processes, even if they are cross-divisional, to these needs and requirements" and quotes the German health entrepreneur Heinz Lohmann who very clearly expresses the root of the problem in a blog post from 4.12.2018: "Many managers in health care companies have recognized the challenges of the hour and are investing in the 'what', but unfortunately not in the 'how'". According to Peter J. Mayer (2019), the sole purpose of structures is "to support these processes in the best possible way". In his

appeal to the responsible actors in the health care system Mayer also largely coincides with Lohmann's recurring statements ("Mut zum Wandel" 2004; "Zukunft braucht Mut" 2020). With the same persistence, Mayer calls for "the courage to really orientate oneself to the patients' clinical pictures and their care needs and then to model coordinated care processes that enable continuity of care, even across different areas of care, and, because all processes are checked for meaningful and comprehensibly meaningful areas of responsibility, enable interdisciplinarity and multi-professional cooperation in care. Structures have only one purpose: to ensure a high degree of fulfilment of the characteristics of "patient-oriented, transparent, effective and efficient health care services" (according to the Austrian GQG).

In his contribution, Mayer (2019) draws the bow back to quality and concludes with a thesis that is well known in business circles: "Investing in quality, and especially in the core areas of the systems, always keeping the patient perspective in focus, usually leads to quality improvements as well as to cost optimization". The author cites the German reference project for integrated care, the model region "Gesundes Kinzital" (IVGK), as a successful care model, which will be discussed below (Siegel, Achim & Niebling, 2018).

3.7 The future of health care systems

What would be the point of model projects that (demonstrably) serve to improve health care if they were not imitated? A major goal of this thesis is also to raise awareness on this issue and to shed light on one or two aspects.

In order to convince all stakeholders and in particular political decision-makers of the feasibility, and in particular of the economic viability, of new care concepts, it is recommended to consider evaluation measures (effectiveness and efficiency measurements) from the very beginning. Systematic and results-oriented evaluation is increasingly becoming the central criterion for health policy decisions. This is especially true when it comes to transferring new care model projects into the regular operation of the health care system. Outcome evaluation (effectiveness) and economic evaluations (efficiency) as well as process evaluation as accompanying measurement should serve health economic analyses (GÖG, 2020). The model region for integrated care "Healthy Kinzigtal" (IVGK) is considered an excellent example of ongoing evaluation. IVGK is one of the few health care concepts that offers cross-indication and cross-sectoral medical care. The evaluation according to the so-called triple approach

according to Berwick, Nolan and Whittington (GÖG, 2020) serves in particular to legitimise the system as a responsible care system vis-à-vis health policy, the health insurance funds financing the system, the participating patients and ultimately society as a whole. According to Berwick et al. (2008), the following basic requirements should be met in a responsible and sustainable care system: 1st Improvement of the health status of the participating population, 2nd Consideration of individual care needs perceived as such by patients and 3rd Proof of sustainably achieved resource allocation (Hildebrandt et al., 2015).

The aim of the evaluation is to assess the effects of IVGK on the triple-aim dimensions (improvement in health status, individual experience of improved care and cost-effectiveness). Since its implementation in the year 2005, the evaluation of the model region Integrated Care Healthy Kinzigtal has been carried out both internally and externally, comprehensively and continuously by the operating organizations OptiMedis AG, the shareholders of Gesundes Kinzigtal GmbH and the contractual partner health insurance funds AOK Baden-Württemberg (AOK BW) and LKK Baden-Württemberg (LKK BW). An Evaluation Coordination Unit (EKIV) was set up at the University of Freiburg, Department of Medical Sociology, for external evaluation. Among other things, possible overuse, underuse or misuse should be identified at an early stage. Other evaluation modalities deal with concepts such as "Shared-Decision-Making" (SDM) as well as "coaching" of functionaries and "process evaluation" (COPE) from the perspective of health care providers (Hildebrandt et al., 2015). First results of the evaluation showed relevant effects in all three dimensions as well as a positive development. Hildebrandt et al. (2015), however, emphasise the need for long-term studies that can evaluate results from cross-sectional measurements. According to the authors, detailed analyses should provide information on the influences of partial aspects of the overall intervention. In the analysis of the care experience of the participating patients, 92.1% stated that they "definitely" or "probably" recommended IVGK, 24% said they had "lived healthier" since participating in IVGK, and even 45.4% in the case of participants who had agreed health objectives with their doctor. And last but not least, the costs of the two health insurance companies show a positive result compared to a reference population.

3.7.1 The Importance of Public health

The chairman of the Austrian Society for Public Health (ÖGPH), the social physician and re-nowned public health expert Thomas E. Dorner, describes public health in his 2016 publication

as an examination of the "physical, psychological and social conditions of health in a society with the aim of providing the best possible health care for the population" (Dorner, 2016). In an international context, especially relevant in times of the pandemic events of Covid-19, the World Health Organization WHO describes Public Health with reference to Detels et al. (2002) as "the process of mobilizing and engaging local, state, national, and international resources to assure the conditions in which people can be healthy". WHO health experts criticize that public health is usually seen merely as a third pillar of the health system, "operating in parallel and in cooperation with the fields of outpatient and inpatient care" (WHO, 2011b). Accordingly, public health is concerned with the state of health of the population and, beyond that, with the state of the health care system as a whole. Public health implies in its scientific as well as in its practical view system design in the health care system. In addition to questions of the effectiveness of health-promoting measures, process design and measure effectiveness of prevention, curation, rehabilitation, as well as care and palliation, there are also questions of equity (Dorner, 2016). It is undisputed that the creation of conditions that promote the effectiveness of measures requires a cross-sectoral view of health care, interdisciplinary and multi-professional actor alliances in the health care system and in particular the health professionals working in the patient-centered care areas (WHO, 2011b).

The concept of public health is based on the integration of health care. The health care system is to be seen as an overall system that serves the health of the population and is also oriented to the supra-regional and international health events. In the regional areas, integrated care can create the conditions that are necessary for the implementation of Public Health. Integrated Care focuses on the individual and ideally considers both medical and therapeutic as well as social care needs. This requires the coordination of care, information and communication processes that encompass all areas of medical and nursing care, including health promotion and prevention (Dorner, 2016). Economic aspects in particular are also gaining importance. Multimorbid chronically ill patients in particular require comprehensive care, the effectiveness of which as a result of good coordination, communication and cooperation is reflected not only in the allocation of resources but also in a reduction in follow-up costs.

3.7.2 Digitization in Health Care

"Digitization and integrated care are mutually dependent," is how Stefan G. Spitzer (2020), physician and Chairman of the Board of the Deutsche Gesellschaft für Integrierte Versorgung im Gesundheitswesen (DGIV), sums it up in his article "Overcoming Sectoral Barriers with Integrated Care". Digitization in health care is generally seen as a driver of system design. On the other hand, the realization of digitization effects requires not only a willingness to innovate but also a high degree of integrated networking, both in terms of the transfer of health-related data and the diagnostic and therapeutic process as well as cooperation and communication at the personal level. The goal of using eHealth applications to improve the effectiveness and efficiency of health care is a high priority both in Austria and at the European level (Mayer & Leyrer, 2013).

The electronic health insurance card (eCard), which was introduced in 2005, and the electronic health record, which was adopted in 2012, are of key importance for the digital development of the Austrian health care system and have led to administrative simplifications. In general, eHealth offers opportunities for information and communication technology networking, which is only just beginning, with the aim of advancing the integration of health care and consequently improving it for the population (BMSGPK, 2021). Mutual knowledge exchange should drive developments and promote mutual learning. Accordingly, Austria is a member of an association for eHealth services at the European level, the eHealth Portal of the European Union. The aim is to make information, expertise and best practices available to policymakers and health care stakeholders alike (European Commission, 2021).

3.7.3 Health Literacy

In a comparative study on health literacy conducted among eight EU member states as Bulgaria, Germany, Greece, Spain, Ireland, the Netherlands, Poland and Austria (2012), it was shown that the Austrian population, after Bulgaria and Spain with 56.4% (inadequate to problematic health literacy), had low health literacy compared to the overall average of 47.6% and significantly lower than in the Netherlands (with 28.7% best value). However, different levels are evident depending on the region. A comparison of the federal states carried out following the EU study "Bundesländerstudie" (2012) pointed to a clear west-east divide. While only 36% of the population in the westernmost province of Vorarlberg had insufficient health literacy, this

figure was around 63% in Styria. According to the study, this was mainly due to social determinants such as income, age and gender (Kickbusch et al., 2016).

The consortium of authors around the German political scientist Ilona Kickbusch, who is known from several functions in health programs of the World Health Organization, defines health literacy in the publication "Health Literacy, The Solid Facts", which was first published by the WHO Regional Office for Europe in 2013, as being linked to education and encompassing the knowledge of "the motivation and competencies of people regarding the finding, understanding, assessing and applying relevant health information in different forms". Empowerment to make decisions relates to health promotion as well as prevention and management of disease (Kickbusch et al., 2016).

Regarding the health care sector, the importance of communication is once again brought to the fore. Health professionals should be encouraged through appropriate training and continuing education measures to develop and expand their communication skills and, regarding the health care of people with a migration background, to develop cultural sensitivity (Kickbusch et al., 2016). This is a development of competence that can ultimately also serve to deal with patients without a migration background, but who are impaired due to age or illness. Whereby another conclusion is also obvious: the improvement of communication skills and cultural competence can ultimately also have an effect on intra- and interinstitutional cooperation in the sense of an integration of care.

Patient participation in health care delivery is becoming increasingly important. Patient participation is explicitly mentioned in target 3 of the Austrian Framework Health Targets from 2012 as an area of action to strengthen the health literacy of the population. International agreements of the World Health Organization such as the Alma-Ata Declaration (1978) or the World Health Report (2008) as well as the Social Covenant of the United Nations (ratified in 1978) point to the necessity of patient participation in the design of the health care system. As far as the involvement of self-help organizations is concerned, Austria lags a bit behind in international comparison. Only the so-called patient advocates are found in individual federal and state bodies as state-institutionalized representatives of patients' rights.

3.7.4 The Future of Health Care

In a joint study on the promising topic of "Transforming Health care with AI: The impact on the workforce and Organizations" by the established management consultant McKinsey and the "European Institute of Innovation and Technology" (EIT) founded by the EU in 2015, the impact of automation on the European health care system was subjected to an in-depth investigation. Existing studies on the future of the workplace were compared with the experiences of health care managers with "digital health" or Artificial Intelligence (AI) and with stakeholders from the innovation and application sectors. The main finding was that the integration of AI into everyday clinical practice is already well underway. The following areas were identified as the ones that will be most affected by increasing automation, and in some cases already are, (Meyer, 2020): care in general, the management of chronic diseases, clinical decision paths, diagnosis, as well as questions of health competence, prevention, and health promotion. In the first phase, there is to be considerable relief in administrative and documentation matters, areas that primarily concern the work of nurses and doctors. In a second phase, the authors of the study are expected to develop telemedical applications such as the transmission of vital parameters. Above all, a significant part of integrated care, the transition from inpatient care to care at home, should be facilitated by this. The third phase is equated with "optimization and efficiency increase in clinical practice" (Meyer, 2020). Physicians in particular are to be provided with a so-called "CDS-tool" ("Clinical Decision Support Tool") on the basis of large amounts of data. For health personnel, this means the earliest possible acquisition of digital skills. The National Health Service (NHS: public health system in Great Britain and Northern Ireland) predicts that within two decades, digital skills will be essential for 90% of health professionals (Meyer, 2020). However, increasing automation is also meeting the growing demand for health workers. The author of the article refers to the American Hospital Association (AHA), whose findings ("similar to the authors of the study", Meyer, 2020) assume a substitution of AI for clinical staff tasks of 33%, and 40% in non-medical health professionals. The authors cite "more time for patient care", "improved accuracy of diagnoses", "rapid availability of knowledge" and "greater independence of patients" as qualitative effects of the use of AI (Meyer, 2020). Another effect that should not be underestimated is the upgrading of the non-physician health professionals, which is very beneficial to interprofessional cooperation, especially at the interfaces to upstream and downstream care areas. The co-responsibility of the transitions ("interfaces between the care sectors") in socio-technical terms is becoming more and more an unavoidable necessity for all those working in the care sector. Mayer (2017) in particular advocates the

acquisition of "additional competence" ("Zusatzkompetenz") from the field of integrated care. He sees this as a complementary competence that promotes joint cooperation and thus "cooperation", "communication" and "coordination", combined with a high degree of orientation towards the needs and requirements of the patients, and makes them a matter of course.

Manuela Schweiger (2020) dealt in her thesis very extensively with new technologies used in health care. She was particularly interested in the extent to which stakeholder awareness for new technologies is already pronounced in Austria and which measures might be needed to use new technologies. Schweiger focused her investigation on mobile applications in the health sector ("mHealth" applications). According to the Global Observatory for eHealth (GOe), an initiative of the WHO to investigate the development and effects on the health of eHealth in the context of international studies, "mHealth" is understood to mean "medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices" (WHO, 2011a). Mobile or mHealth applications (usually abbreviated as "apps") are seen as a sub-area of eHealth. The World Health Organization (2020) defines eHealth ("digital health") as "the use of information and communication technologies (ICT) for health". Accordingly, the focus is very broad. With the aim of optimizing health care to a large extent through digitization, all areas of life are to be subjected to interdisciplinary networking (Bhavnani, Narula & Sengupta, 2016). The following figure illustrates the spectrum of dHealth:

Figure 5 Components of dHealth, Johner Institut (2018)

Regarding the current state of implementation of mHealth applications in Austria, Schweiger (2020) was able to identify some successful implementations, such as "telemonitoring for heart failure or diabetes, a wound management app, preoperative applications, and programs for telerehabilitation". Nevertheless, the experts from the Austrian health care system pointed out the "enormous development potential" through possible mHealth applications and see Austria in a European comparison "at best in the middle field, or even far below". Interest would be there at any rate. All experts clearly committed themselves to mHealth applications and emphasized

the advantages (such as "quality of treatment" and "quality of life" as well as "empowerment of patients"), which, in the opinion of the experts, far outweigh possible disadvantages (such as the danger of a possible "uncontrolled proliferation of mobile applications") and risks (such as in the area of "data quality"). Further advantages were seen as the "conservation of human resources in view of the imminent shortage of health professionals", but also "possible cost efficiency". Schweiger (2020) sees measures that have to be taken in Austria to promote mHealth technologies, above all, as measures regarding the compensation by the social insurance institutions, the creation of legal framework conditions (the Austrian Medical Act, "Ärztegesetz", contains a so-called remote treatment ban, "Fernbehandlungsverbot"), solutions to the interface problems of the technical systems as well as infrastructural measures such as "regional availability of broadband Internet" and "provision of digital end devices" as a further social measure.

3.8 Summary of Literature Analysis

Interprofessional cooperation within and between health care institutions is an essential prerequisite for the success of integrated health care (Amelung et al., 2017). An analysis of the health care system to identify and develop optimization potentials would fall short without an orientation towards the health professionals and their interaction. The current scientific discussion speaks of "best points of services" in health care. The thesis is intended to provide orientation at all levels of the health care system as to which prerequisites can be created and which measures can be taken to promote interprofessional cooperation as an essential basis of integrated care.

The thesis is preceded by a comprehensive systematic literature review. Relevant studies were consulted as well as current scientific literature. Following the theoretical discourse, hypotheses were generated whose validity was to be statistically tested. The literature section is divided into seven subchapters. In the beginning, an attempt is made to make the complexity of health care systems in general and the Austrian health care system in particular understandable. Afterward, health care organizations are dealt with and in particular, the phenomenon of organizational culture, its development as well as the maintenance of asserted cultural values are examined. The theoretical part continues with the demands on leadership and management functions in health care organizations and the interprofessional cooperation of different health professionals and concludes with a discussion of the concept of integrated care and the outlook on further development in relation to health care systems.

How can a health system now be described? Different definitions of "health system" can be found in the relevant literature. A comprehensive WHO definition was already presented at the European Ministerial Conference in Tallinn (2008). According to a very simple description on the health portal of the Austrian Ministry of Social Affairs, it is the task of the health system to ensure that "sick people become healthy and healthy people stay healthy". The essential areas are "health care, health promotion and prevention" (Gesundheit.gv.at, 2020). The Austrian health care system is based on the social insurance principle, which goes back to the Bismarck model. According to WHO (2018), Austrian health care recipients have the lowest unmet medical need in the EU. Nevertheless, numerous deficits are evident in the Austrian health care system. Experts from health practice (2020) propose the establishment of new structures and call for a rethink, both among health policy-makers and patients: "Emergency rooms are bursting at the seams, wards are overcrowded" because, according to health experts, primary care structures are lacking. Especially at weekends and at off-peak times, the hospital becomes the first port of call. However, the high number of avoidable hospital treatments requires a strengthening of the primary care sector. There is a need for coordinated care between intramural and extramural care according to the principle of "GP as pilot" through the health care system. Moreover, according to OECD (2017), there is a disproportionate use of care facilities in Austria. Better coordination of the care sectors is expected to set resources for care free as well as more time for human interaction with patients. Attention and nursing empathy are of enormous importance, especially for seriously ill people. "A doctor who spends time at the bedside to discuss the course of diagnostics and therapy with his patient contributes more to the quality of the health care system than countless prescriptions and quality criteria," is how physicians sum it up in a joint publication from everyday practice.

The question arises whether the current design of organizations in the health care system offers conditions that enable optimization of service provision? (see chapter 3.2) Philosophers, management and organizational theorists have their say on this. Peter Drucker, for example, says: "The greatest danger in times of upheaval is not the upheaval itself, but acting with yesterday's logic." But how can improvements now be made? What conditions are necessary to adapt care systems? A hospital is in itself a complex system. Different professional groups with a high level of expertise work together in multi-professional teams. In addition, there are always new technologies that need to be understood and applied. For patients, it is usually difficult to find their way in a world of experts. Patient orientation as well as patient-centered have become guiding principles of health organizations. However, they are usually neglected in everyday care because they are not or not sustainably enough anchored in the organizational culture.

Managing expert organizations is a challenge, especially for managers. Professional groups acting strongly on their own responsibility, especially health professionals in hospitals, are usually characterized by a high degree of autonomy and sovereignty of judgement as well as by striving for luminary status. The Austrian health system does not differ from other health systems in this respect. It is also a complex and fragmented system in which responsibilities and financing are distributed among the federal government, the provinces and the social insurance system, and numerous tasks have been transferred to self-governing bodies. Internal, organizational and external complexity in terms of environmental relations also pose major challenges for the management of health care institutions. Hospitals in particular are considered highly developed socio-technical systems. However, long-term care facilities are also becoming increasingly complex.

What role do patients or people in need of care now play in care systems? Especially in health care institutions, the correct handling of the basic values of the organization, the permeability of the claimed values, from the normative level to the operational level, is of undisputed importance. Not least because patients or those in need of care are playing an increasingly important role as subjects. The patient, the person in need of care, is gradually becoming an "equal partner" in the care process. Health care facilities are becoming "microcosms in which the entire spectrum of human life is represented", according to the ethicist Sedmak (2023), who sees his field of activity at the "interface between health science and ethics". The culture of a health care institution rather expresses its "moral face". Patients, residents as well as health professionals have legitimate expectations of moral standards. Philosopher Laloux (2015) sees organizations as "living organisms" that need their own culture: "Everyone should be invited to perceive the culture that best fits the context and meaning of the organization".

How can the "aspirational culture" of a health facility be made tangible, how can the permeability of the values be defined and the normative level be ensured? (see chapter 3.3). An open, people-oriented corporate culture in health care organizations also has a positive external effect and can increase the perception of the health care facility, especially among the demanders of health care services, patients, and service recipients in need of care. A positive self-image of a health facility is reflected in the minds of the population and leads to the facility acquiring a visible identity, thereby setting it apart from its competitors. The formulation of normative goals is the responsibility of the health facility's management. Dealing with them concerns everyone. Normative goals create the basis for strategic orientation. Operational work should be guided by them. A health facility needs clear statements and instructions on how to deal with its values.

Value management gives clarity and orientation to the staff and all other stakeholders of the organization. Value management ("culture work") thus requires the "visualization" of a value attitude that is desired by the owner, anchored in the normative management, and can be felt and experienced both at the strategic level and in day-to-day business. What can active value management in health care institutions achieve? The Vincent Group, a denominational Austrian group of private non-profit hospitals, describes it very aptly: "Values speak to people themselves, they fascinate people, touch and move them, trigger enthusiasm and rational insights. No one can prescribe values. You cannot manage values, but you can create spaces in which value-based positions can (but do not have to) grow and develop.

In a separate chapter, the central concepts of "leadership" and "management" were briefly discussed theoretically (see chapter 3.4). The management theorist Drucker (2002) sees leadership as doing the right things, while management, in Drucker's view, aims at doing things right and fast, i.e., efficiently. He places people at the center of the action and thus addresses a basic core of work: "The task of management is to enable people to accomplish things together". Echoing the behavior occasionally observed in expert organizations such as health care facilities, Drucker brought a certain pragmatism to the table: "An effective leader is not someone who is loved or admired. He or she is someone whose followers do the right things. Popularity is not leadership. It's results." As far as the concept of management is concerned, different definitions can be found in the management literature. Common to all definitions, however, is the general division into "management in the institutional sense" and "management in the functional sense". So what characterizes effective management? The management scientist and expert on the management of complex systems Malik (2014) sees it as one of the most important tasks of "effective management" to ensure a goal-oriented focus. While in Austrian hospitals an institutionalized collegial management body, consisting of medical, nursing and administrative management, holds the management responsibility, this function in nursing homes is at the level of the administrative home management, to which the nursing service management is usually subordinate. According to Kühmayer (2016), leadership work in the future will have much more to do with navigating than with controlling. "Enabling" will be of central importance. Enabling, according to the institute, means "opening spaces" and "offering support" so that employees can empower themselves and largely take on responsibility. To lead health systems and especially health organizations into the future, managers are needed who are capable of adopting a patient-oriented and cross-institutional perspective, as well as visionary leaders who can lead the care sectors into coordinated integrated care.

Health professionals and interprofessional collaboration (see chapter 3.5) are the topics that lead to the penultimate chapter of the theoretical analysis on health care integration (chapter 3.6). What makes a profession a health professional? Health professionals in Austria are characterized by three caveats: the training caveat, the professional practice caveat and the professional designation caveat. Health professionals exercise their activities in the intra- and extramural care sector, in areas of health promotion, prevention, diagnostics, therapy, rehabilitation as well as nursing. The social psychologist Heyse (2014) sees future societies more as a competence society than a knowledge society. Health systems are highly affected by this. Increases in knowledge in the health sciences, especially in the medical field, make it necessary to question existing structures and treatment processes. In order to do justice to the development, education, further education and training curricula in particular must be adapted to the changed circumstances. As far as the health sector in general is concerned, a paradigm shift is necessary. The health sector must be viewed from the patient's perspective, whereby forms of cooperation and the coordination of care sectors must be oriented towards patients, their care needs and increasingly also individual needs. New forms of cooperation and competencies are needed. According to Heyse (2014), cooperation must "not primarily" be oriented towards the perspective of the individual occupational groups, but "primarily result from the patient's perspective". The prefixes "multi", "inter" and "trans" in relation to professional cooperation are seen in the literature not only as a distinction of the form of cooperation, but also as a clear indication of the intensity of cooperation. According to this, in "multi-professional cooperation", work is probably done in cooperation, but largely independently of each other. Mahler et al. (2014) assume in interprofessional cooperation that competences of the different professions overlap, which is also reflected in the fact that scientific disciplines overlap. Kälble (2004) sees in interprofessional cooperation of the health professionals a cooperation of different "occupational groups with different specializations, professional self-images and images of others, areas of competence, fields of activity and different statuses in the sense of complementary, high-quality and patient-oriented care, so that specific competences of each individual profession can be made useful for the patient". In addition to "interprofessional cooperation", "coordination" and "communication" are also found in all models and concepts of integrated care, which have gained importance as "the 3 Cs" in care.

Integrated health care (see chapter 3.6) is becoming increasingly important in health care systems. The first, broader debate among Austrian experts on integrated care dates back to the foundation of the "Competence Centre for Integrated Care" (CCIV) of the Austrian social in-

surance system. According to this, integrated care is understood as "patient-oriented, continuous, cross-sectoral and/or interdisciplinary care based on standardized treatment concepts". In general, a distinction is made between a "population-based approach" and an "indication-based approach" such as disease management programs. In the definitions of the Austrian Heath Target Steering Act, "Integrated health care" is defined as "patient-oriented joint and coordinated cross-sectoral health care involving adjacent areas (acute inpatient care, outpatient care, rehabilitation, interfaces with the care sector)". It is explicitly pointed out that integrated care includes both process and organizational integration. The integration of care from a management perspective essentially comprises five dimensions: The integrative treatment process - integration; the interprofessional togetherness regarding the treatment goals - cooperation; the exchange necessary for this on a social level regarding the diagnostics and therapy - communication; and finally, the information transfer that becomes necessary due to increasing networking - information exchange. Two areas can be distinguished. The medical domain, which includes medical, nursing, and therapeutic care, and the organizational domain, which refers to responsibilities, scheduling, and interinstitutional or cross-sectoral transition management. Following Busse & Schreyögg (2010), a distinction can be made between horizontal and vertical integration of care. Horizontal integration refers to the coordination of the care pathway between different health care providers at the same level of care. Vertical integration, on the other hand, refers to the integration of care across different levels of care, e.g. primary care physician, hospital, rehabilitation. One of the biggest challenges in integrating health care is ensuring the best locations of care at the best time. Mayer et al. (2018) see networking as an essential prerequisite for defining "best points of service" in the Austrian health care system. Best points of service are becoming increasingly important in health policy discussions. The definition of "best point of service" according to the Austrian health goals explicitly focuses on "optimal medical and nursing quality", which should be "at the right place at the right time" and from an economic point of view "as cost-efficient as possible". In order to convince all stakeholders and, above all, political decision-makers of the feasibility and, above all, the cost-effectiveness of integrated care concepts, it is advisable to establish evaluation measures to measure effectiveness and efficiency. Multimorbid chronically ill patients in particular require comprehensive care, the effectiveness of which is reflected not only in the distribution of resources but also in a reduction in follow-up costs through good coordination, communication and cooperation. In particular, also from a public health perspective, it is undisputed, according to WHO (2011), that creating conditions that promote the effectiveness of interventions requires a cross-sectoral

perspective, interdisciplinary and multi-professional action by the actors involved, and patient-centered action by the health professionals working in the care settings.

Similarly, building health literacy among patients seeking health care services helps improve communication skills and interaction, which ultimately impacts intra- and interinstitutional collaboration for care integration. Patient participation in health care is becoming increasingly important. Patient participation is also explicitly mentioned in the action plan for the Austrian health goals. International agreements of the WHO, such as the Alma-Ata Declaration (1978), the World Health Report (2008) or the United Nations Social Covenant (ratified in 1978), have long pointed to the need for patient participation in the design of health care. As far as the participation of self-help organizations in optimization processes is concerned, Austria admittedly still lags behind in international comparison.

According to Mayer and Leyrer (2013), digitization in health care is seen as a driver for system developments. However, the realization of digitization effects requires not only a willingness to innovate, but also a high degree of integral networking, both in terms of the transfer of health-related data and in terms of cooperation and communication at the personal level. The goal of improving the effectiveness and efficiency of health care through eHealth applications is a high priority both in Austria and at the European level. The proven use of eHealth during the pandemic by Covid-19 (e.g. eMedication) has advanced digitization in health care. Of course, digitization and artificial intelligence will also contribute to the development of health care systems. In their various manifestations, health care facilities can already be seen as sociotechnical systems. In a study conducted by McKinsey together with the European Institute of Innovation and Technology (2015) on the topic of "Transforming Health care with AI: The impact on the workforce and Organizations", it was shown that the integration of AI into clinical practice is already well advanced. In particular, technological development thrusts can be expected in the area of telemedicine applications, such as the transmission of vital signs. In particular, the transition from inpatient care to home care, an essential component of integrated care, is expected to be facilitated by the use of innovative technologies. As a further consequence, according to Meyer (2020), optimizations and increases in efficiency are to be expected in everyday hospital care. For health care staff, this means the need to acquire digital skills as early as possible.

In his article "Integrated care as an additional competence in the health professions" (in the original: "Integrierte Versorgung als Zusatzkompetenz in den Gesundheitsberufen"), the author of this thesis sees the development of decision-making and action competence specifically for integrated care as indispensable for the performance of tasks in management and leadership

functions of health systems. Especially in management and leadership functions, the understanding of integrated care is essential. The author sees in this the need for a kind of complementary competence that is suitable for promoting cross-interface cooperation and thus "collaboration", "communication" and "coordination", combined with a high degree of orientation towards the care needs and personal needs of patients and their empowerment (Mayer, 2017). For the success of integrated, cross-sectoral care, the theoretical analysis shows that it makes sense to scrutinize all areas and levels of care and to look for optimization potential in and between the care institutions at the behavioral level and in the area of framework conditions and to initiate a continuous process to improve and maintain high-quality, coordinated health care.

4. EMPIRICAL STUDIES / OWN RESEARCH

4.1 DEMOGRAPHICS

In the quantitative survey board members of health care facilities in different health care sectors, intra- and extramural, were interviewed.

The demographic characteristics of the interviewees show a differentiated picture. In terms of age distribution, the group of 51 to 60-year-olds is the largest group, especially among the respondents of acute care facilities, with 17 persons; in long-term care facilities, the group of 30 to 40-year-olds represents the largest number of participants, with 13 persons out of a total of 29. Regarding the level of education, two thirds of the respondents have a diploma or master's degree; in the long-term care facilities this is the case for about half of the respondents.

Regarding the type of institution, the picture is almost uniform. Around two thirds of the respondents are from public institutions, five institutions are run by religious denominations and belong to the private non-profit sector, and three institutions are purely private health care facilities.

When asked about primary profession, half of the participants in the acute care setting responded that they were from nursing. In the long-term care sector, this was three-quarters of the participants. The other half came from administrative or management areas. Around two-thirds of the participants from the acute care sector and just over half from the long-term care sector have five or more years of management experience. About 90% of the interviewees have more than ten years of professional experience.

4.2 STATISTICAL ANALYSIS

The statistical evaluation of the data aims to postulate as comprehensive a picture as possible of the existence, direction, and strength of certain effects using descriptive and interference statistical methods (see also point 2.3.2). In descriptive-statistical procedures, data are illustrated in the form of figures and tables based on "sample characteristics" (location and disper-

sion behavior), while interference-statistical methods are used to draw conclusions about population relationships from sample data, in particular to test hypotheses on relationships between variables in the basic population (Döring & Bortz, 2016).

In the following, the content of the questionnaire will be discussed. In particular, the content of the questionnaire will be presented with reference to the hypotheses underlying the thesis (see also point 2.2), to the research question (see point 2.1), and to other aspects of the problem context of the study (see chapter 3.3 "Organizational Culture" and point 3.6.3 "Best Point of Service"). The question blocks of the content section of the questionnaire are arranged in a logical sequence. Starting with general references to the "Austrian health care system", the parts on "interprofessional cooperation" and "integrated health care" follow, which are guided by the interest in knowledge. This is followed by questions on the importance of "organizational cultures" in health care areas and, in the last part of the sequence of contents, on the "best point of service" in health care. In order to do justice to the statements made in the hypotheses and to enable a meaningful analysis in the course of the hypothesis testing, a series of sociographic data are queried in the "statistical part" of the questionnaire, which serve to operationalize the variables of interest according to the research hypotheses.

Different scale levels are intended to reflect empirical facts as accurately as possible and to ensure a high information content. For example, for the sociographic data (statistical part) a nominal scale was used for the variables "gender" and "occupational group" and an ordinal scale for the variable "education". Nominal scales only express "equality or inequality". Ordinal scales, on the other hand, in addition to equality and inequality, form a ranking between the individual variable values (Raab-Steiner & Benesch, 2010). The "Likert scales" were predominantly used in the content blocks of questions. Likert scales consist of several statements that "measure" the same characteristic and, as so-called "rating scales" (more than two answer categories), express an assessment of "the degree of agreement". Depending on the requirements for measurement accuracy, 5 to 7-level rating scales were used in the course of questionnaire construction. Two questions (question block 2, question 1, and question block 3, question 1) with 10 gradations were chosen. The scale values flow into the analysis as average scores of the individual ratings (Döring & Bortz, 2016; Raab-Steiner & Benesch, 2010). Depending on the requirements and desired significance, sum scores are also formed. More recent as yet little-noticed aspects are also of interest, the questionnaire also includes open questions (question blocks 4 and 5 on "organizational culture" and "best point of service").

Before use, the questionnaire (for the draft questionnaire see Annex I) is to be subjected to a pre-test, in which "usability and quality" (Raab-Steiner & Benesch, 2010) are examined on the basis of a small sample. In particular, the comprehensibility of the question formulation is examined, whether all answer categories can also be assigned, whether the duration of the processing was correctly assessed, and, last but not least, whether the intended hypothesis testing can be successfully carried out with the questions at hand (Raab-Steiner & Benesch, 2010).

The content of the questionnaire is based on the results of the theoretical analysis in the present paper, and, on the other hand, on a number of other sources. Accordingly, questions 1 to 10 in the first block of questions on the "assessment of the Austrian health care system" were developed, based on contributions by Marckmann (2018) and Pimperl (2018) among others. Question 1 of the second block of questions on "interprofessional cooperation" is based on research hypotheses 1 to 4 (for hypotheses see point 2.2), question 2 of the second block of questions to Hüster et al. (2016) and question 3 requires the interviewee to give a personal assessment in form of a percentage rating. The question in the third block of questions on "integrated care" (this is only one question), relates solely to research hypotheses 5 to 8 (point 2.2). The questions in the fourth block of questions, "organizational cultures", were based on Hüster et al (2016), questions 1 to 10, and on a contribution from the Vincent Group (Vinzenz Gruppe, n.y.), questions 11 to 20. The fourth block concludes with an open-ended question that is derived from hypothesis 9 (point 2.2) and the research questions of the present thesis (see point 2.1). The fifth and final block of questions refers to the "Best point of Service". The first question in this block was constructed on the basis of Hildebrandt et al. (n.y.) and SVR (2007), the second question was derived from the theoretical discussion of the present thesis and the third question is also created as an open question. The section with the content of the draft questionnaire and the statistical part (sociographic part) can be found in the appendix.

Research hypotheses are statements derived from "established theories and/or well-founded empirical findings" (Döring & Bortz, 2016). Hatzinger and Nagel (2013) describe the process of hypothesis testing in their very practical and application-oriented work as a statistical task to achieve a basis for decision-making that produces "a rather 'yes' or rather 'no'" as the correct answer, especially since, according to the authors, "it can never be 100% certain whether a hypothesis is correct". Regarding the nature of the expected effects, both "difference hypotheses" and "correlation hypotheses" are used in the present thesis, in which differences between groups, e.g. differences in the explanatory reality between the group of hospital managers and the group of nursing home managers, and correlations between variables exist.

The following is a brief presentation of the reasoned choice of methods used and the results of descriptive statistical and interference statistical analysis using the IBM SPSS Statistics Analysis tool.

Since many methods require normal distribution, especially for interval-scale variables, hypothesis testing is preceded by checking all variables for normal distribution. In addition to the obvious test in a graphical representation of the distribution, the use of the Kolmogorov-Smirnov test is recommended in the relevant literature (e.g. Backhaus, Erichson, Plinke & Weiber, 2011; Hatzinger & Nagel, 2013; Bühl, 2014; Braunecker, 2016). The t-test (comparison of two independent samples) is cited as a classic example of tests that assume a normal distribution. A t-test is always used when the mean values of two groups are to be compared, assuming a normal distribution of the respective dependent variables. It is to be examined whether both groups come from the same population. A preceding level test (analysis of variance) can be used to check the homogeneity of the sample variances. The variance represents the "sum of the deviation squares, relativized by the size of the sample" (Hussy et al., 2013). Based on an F-distribution, it is to be examined whether there are differences in the variances between the groups or whether there is variance equality. The null hypothesis describes that there are no differences in the variances, the alternative hypothesis that there are.

If there is no normal distribution, i.e., if there are no conditions for a normal distribution in the samples for a t-test, the significance test is carried out using Mann-Whitney or U-test procedures. The Mann-Whitney or U-test for independent samples checks whether the central tendencies of two independent samples are different. A prerequisite for the Mann-Whitney U-test, however, is an ordinal scaling of the dependent variables (Hatzinger & Nagel, 2013).

In the first part of the empirical survey (quantitative part), administrative and nursing directors of acute hospitals - who are usually responsible for the transition of care to follow-up care - were interviewed using an online questionnaire tool (32 data sets of 75 addressed to hospital directors were returned, 3 remained unanswered) and directors of nursing homes (28 data sets of 57 addressed were returned, the data set of a geriatric center was added). Thus, under the premise of random selection, both parts of the survey yielded exactly 29 data sets that could be evaluated comparatively.

The selection of the statistical test method based on the available data is illustrated by the decision tree shown below:

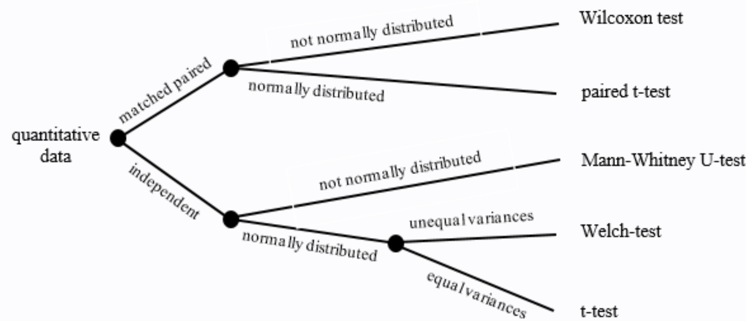


Figure 6 Decision Tree for Test Selection, own illustration based on Keller (2021)

All variables are not normally distributed according to the results of the Kolmogorov-Smirnov test. Therefore, non-parametric tests such as the Mann-Whitney U test are applied. A t-test would be incorrect here, as parametric tests assume the underlying statistical distributions in the data. A t-test for two independent samples would only be reliable if each sample follows a normal distribution and the sample variations are homogeneous. Nonparametric tests do not rely on any distribution and therefore can be used even if the parametric validity conditions are not met. However, the advantage of parametric tests is that they have greater statistical power: The probability that a parametric test leads to the rejection of H_0 is greater. The p-value is usually lower than the p-value of a non-parametric test performed on the same data.

Z indicates the direction of the difference between the groups. A negative sign indicates that the second group has significantly higher values, a positive sign that the first group has significantly higher values. The difference between the two groups is more pronounced the further the Z-value is from zero.

Beginning with the demographic characteristics of the survey participants and a brief presentation of their professional backgrounds, such as institutional affiliation, original occupation, professional and management experience, the results from the hypothesis testing are presented.

		HC sector		
		HO	**NH**	total
age	up to 30 years	1	2	3
	30 to 40 years	4	8	12
	41 to 50 years	5	13	18
	51 to 60 years	17	6	23
	60 years and more	2	0	2
total		29	29	58

Table 1 Age Distribution of the Participants (HOs vs. NHs) - cross table, own illustration (using SPSS)

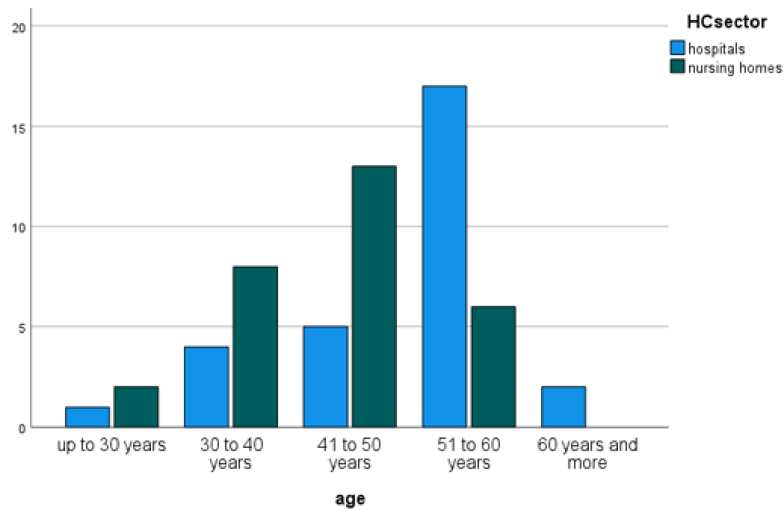


Figure 7 Age Distribution of the Survey Participants (HOs vs. NHs) – histogram, own illustration (using SPSS)

A **comparison of the two groups** (HO & NH) shows a significantly higher proportion of **over 50-year-olds** among hospital directors: about two thirds. Among the home directors, the picture is reversed: about 80 % of the respondents are younger or equal to 50 years.

		HO	NH	total
education	basic vocational training	2	3	5
	secondary school degree	3	3	6
	academy/bachelor´s degree	3	6	9
	diploma/master´s degree	20	14	34
	doctorate/equivalent	1	3	4
total		29	29	58

Table 2 Education Level of Participants (HOs vs. NHs) - cross table, own illustration (using SPSS)

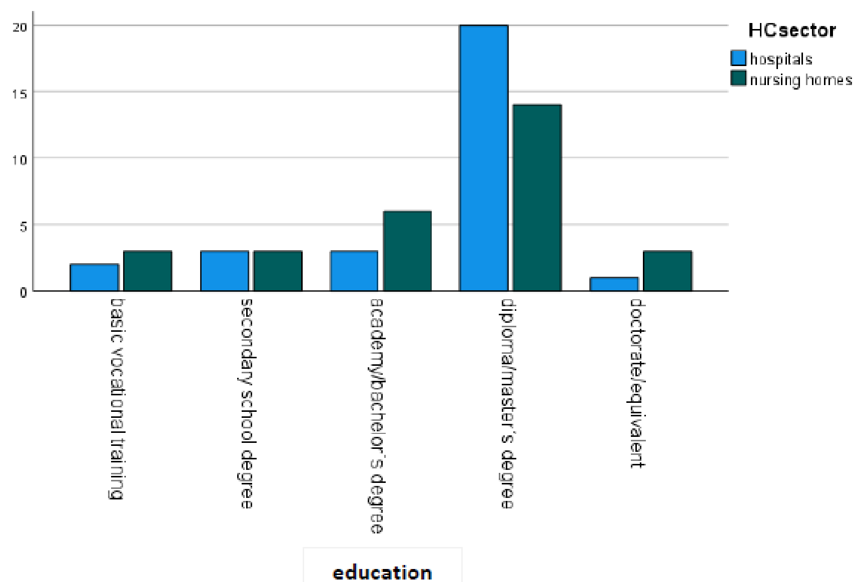


Figure 8 Education Level of the Survey Participants (HOs vs. NHs) – histogram, own illustration (using SPSS)

There are only minor differences in the **level of education**. Two thirds of the hospital directors and around half of the nursing home directors have a diploma or master's degree, one person from the group of hospital directors has a doctorate, while two of the nursing home directors have a doctorate.

		HO	NH	total
HC institution	*no indic.*	2	0	2
	public	20	18	38
	privat np denominational	5	4	9
	privat np	0	3	3
	privat fp	2	3	5
	no indication	0	1	1
total		29	29	58

Table 3 Type of Health Care Institution (HOs vs. NHs) - cross table, own illustration (using SPSS)

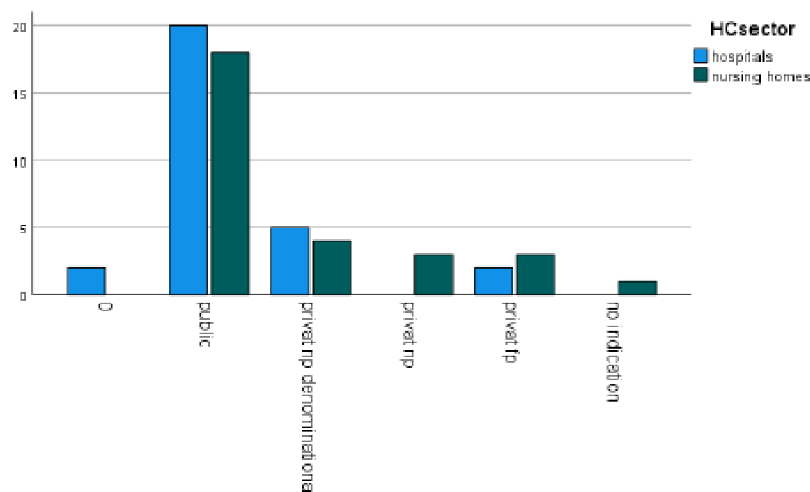


Figure 9 Type of Health care institutions (HOs vs. NHs) – histogram, own illustration (using SPSS)

The share of **public facilities** is about two thirds in both samples. In addition, five hospitals and four nursing homes are run by **denominational organizations**. The remaining homes are privately owned.

		HO	NH	total
primary profession	administration	14	7	21
	nursing	14	21	35
	other (e.g. eng., IT)	1	1	2
total		29	29	58

Table 4 Primary Profession of the Participants (HO vs. NH) – cross table, own illustration (using SPSS)

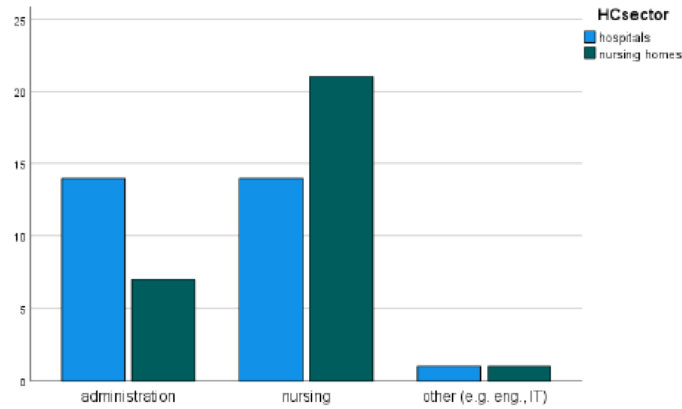


Figure 10 Primary Profession of the Participants (HOs vs. NHs) – histogram, own illustration (using SPSS)

Of the survey participants from hospitals, about half have a **nursing background**, while the other half come from **administrative or management field**s; of the survey participants from nursing homes, about two thirds have a nursing background, while one third come from administrative professional fields.

		HO	NH	total
management experience	*no indic.*	1	0	1
	less than 5 years	5	10	15
	5 to 10 years	10	3	13
	more than 10 years	13	14	27
	no indication	0	2	2
total		29	29	58

Table 5 Management Experience of the Participants – cross table, own illustration (using SPSS)

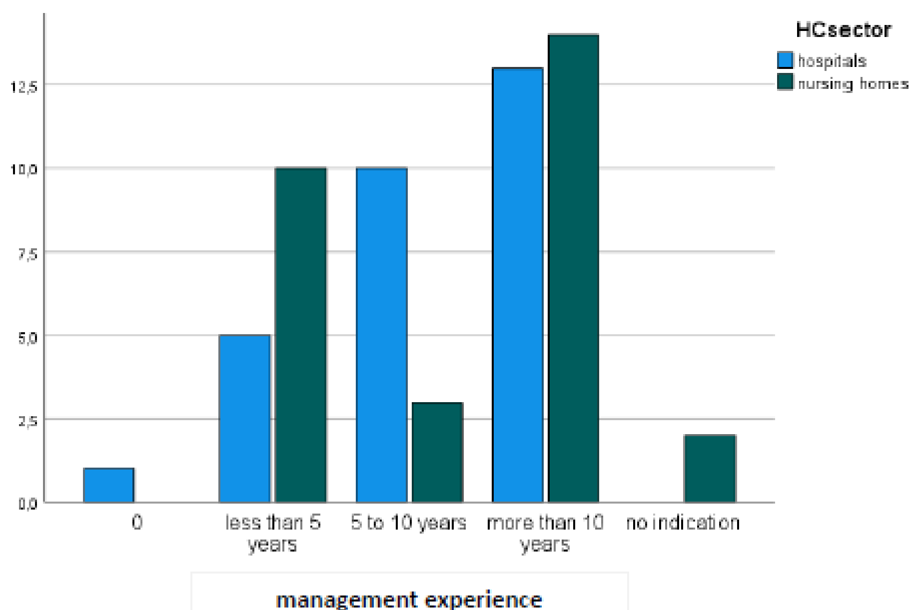


Figure 11 Management Experience of the participants (HOs vs. NHs) – histogram, own illustration (using SPSS)

Among hospital board members, only five survey respondents have less than five years of **management experience**, compared with twice as many among nursing home directors.

		HO	NH	total
professional experience	less than 10 years	2	3	5
	10 to 20 years	6	10	16
	more than 20 years	21	16	37
total		29	29	58

Table 6 Professional Experience of the Participants – cross table, own illustration (using SPSS)

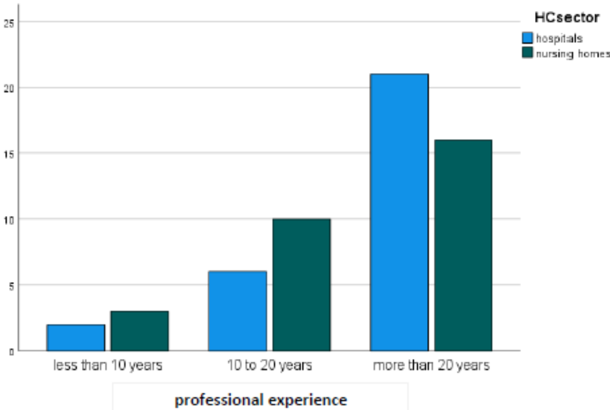


Figure 12 Professional Experience of the Participants (HOs vs. NHs) – histogram, own illustration (using SPSS)

As far as the **professional experience** of the survey participants is concerned, both groups (HO + NH) show an almost similar picture (see table 6 as well as figure 12).

to **Interprofessional Cooperation** (q1 + q2)

sum variable		HC sector HO	NH	total
q1 + q2	2	1	0	1
	3	3	3	6
	4	7	8	15
	5	9	8	17
	6	7	5	12
	7	1	3	4
	8	1	0	1
	9	0	1	1
	10	0	1	1
total		29	29	58

Table 7 Interprofessional Cooperation (HOs vs. NHs) - cross table, own illustration using SPSS)
(intrasectoral [q1] + intersectoral [q2])

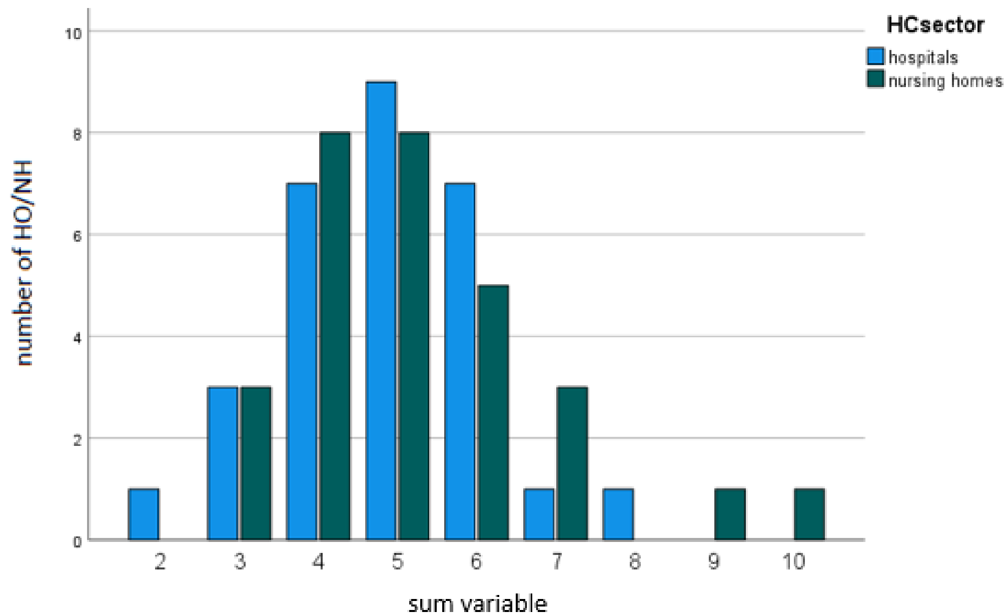


Figure 13 Interprofessional Cooperation (HOs vs. NHs) – histogram, own illustration (using SPSS)

When asked about **Interprofessional Cooperation** within health care facilities (HOs or NHs), also between health care facilities (HOs + NHs), distributions of the data without statistically significant differences were found using the statistical test procedure ($h_{0.1}/h_{1.1}$: q1 + q2), (see the table below, table 8). The hypothesis was as follows ($h_{0.1}/h_{1.1}$): There is no/a difference between HOs and NHs regarding the view of interprofessional collaboration.

sum variable	**q1 + q2**
Mann-Whitney-U-test	391,500
Wilcoxon-W	826,500
Z	-,463
asymp. sig. (2-sided)	,643

group variable: HC sector (HOs vs. NHs)

Table 8 Interprofessional cooperation - test statistics, own illustration (using SPSS)

-> Result of testing: p-value is **0.643** (greater than 0.05). Both institutions (HOs vs. NHs) share the same view of **Interprofessional Collaboration**. There were no statistically significant differences between the two groups in the assessment of interprofessional cooperation, both intra- and intersectoral. It is interesting, however, that the survey participants almost exclusively answered with satisfactory to good. Only two of the respondents from the intramural sector answered "sufficient" once each and another two from the long-term care sector answered "insufficient" once each.

The next questions refer to the respondents' assessments of **Interface Management** in general and of the possible influences and **Effects of Covid-19**. On the one hand, the questions are formulated openly (see also Annex G: q3 + q4) and on the other hand, they can be answered in percentages (q5 + q6). All answers are included in the further discourse in the final chapter of the thesis. The following tables show the evaluation of a possible improvement of coordination, cooperation and communication in and between health care facilities through Covid-19 (see table 9 and figure 14 as well as table 10 and figure 15).

		HC sector		
	(0% to 100%)	**HO**	**NH**	total
q5	1%	1	1	2
	3%	0	1	1
	5%	2	1	3
	10%	2	5	7
	13%	1	0	1
	16%	0	1	1
	20%	3	1	4
	25%	1	0	1
	30%	2	2	4
	31%	0	2	2
	45%	1	0	1
	50%	3	1	4
	60%	1	1	2
	64%	0	1	1
	65%	1	0	1
	70%	2	2	4
	75%	1	1	2
	80%	0	2	2
	89%	1	0	1
total		22	22	44

Table 9 Interinstitutional Improvement in Coordination, Cooperation, Communication – cross table, own illustration (using SPSS)

When answering the question of whether Covid-19 has led to a sustainable improvement in cooperation and communication between the health care sectors (see table 9 and figure 14), all but four respondents were optimistic. - When asked about a sustainable improvement in coordination, cooperation, and communication within their own institution, it is noticeable that the board members of the intramural sector (HOs) answered more confidently (table 10, figure 15).

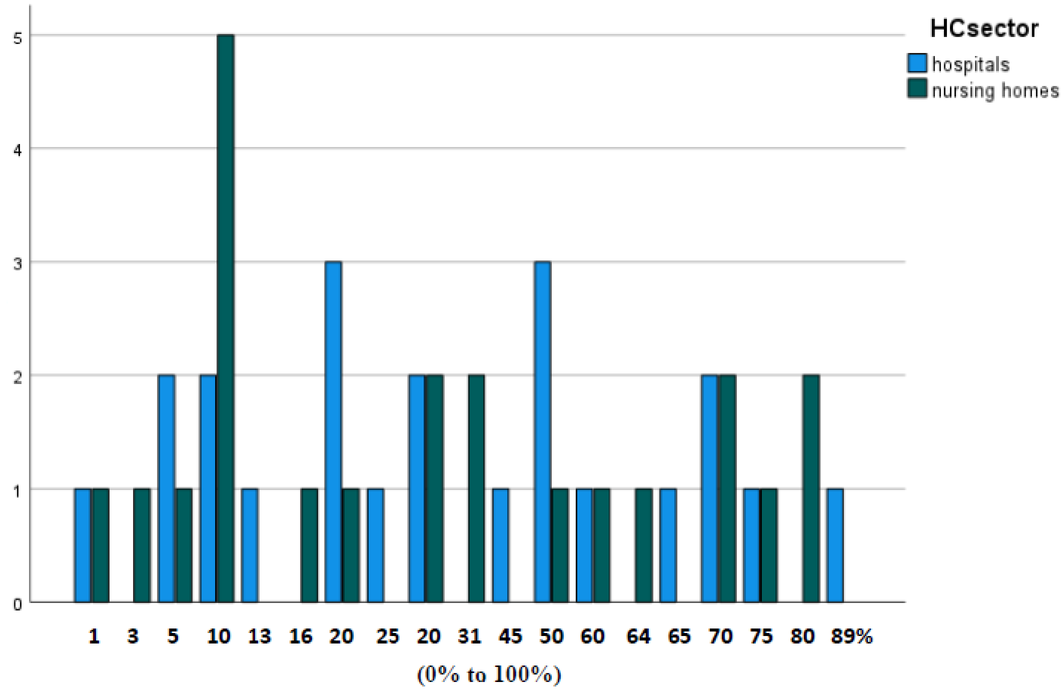


Figure 14 Interinstitutional Improvement in Coordination, Cooperation, Communication – histogram, own illustration (using SPSS)

		HC sector		
	(0% to 100%)	**HO**	**NH**	total
q6	3%	0	1	1
	10%	3	1	4
	12%	1	0	1
	16%	1	0	1
	19%	0	1	1
	20%	3	4	7
	21%	1	0	1
	25%	1	0	1
	30%	0	3	3
	31%	0	1	1
	40%	3	1	4
	49%	0	1	1
	50%	3	5	8
	51%	1	0	1
	54%	1	1	2
	60%	2	2	4
	65%	0	1	1
	70%	1	1	2
	80%	2	1	3
	81%	0	1	1
	90%	3	1	4
	99%	1	0	1
total		27	26	53

Table 10 Intrainstitutional Improvement in Coordination, Cooperation, Communication – cross table, own illustration (using SPSS)

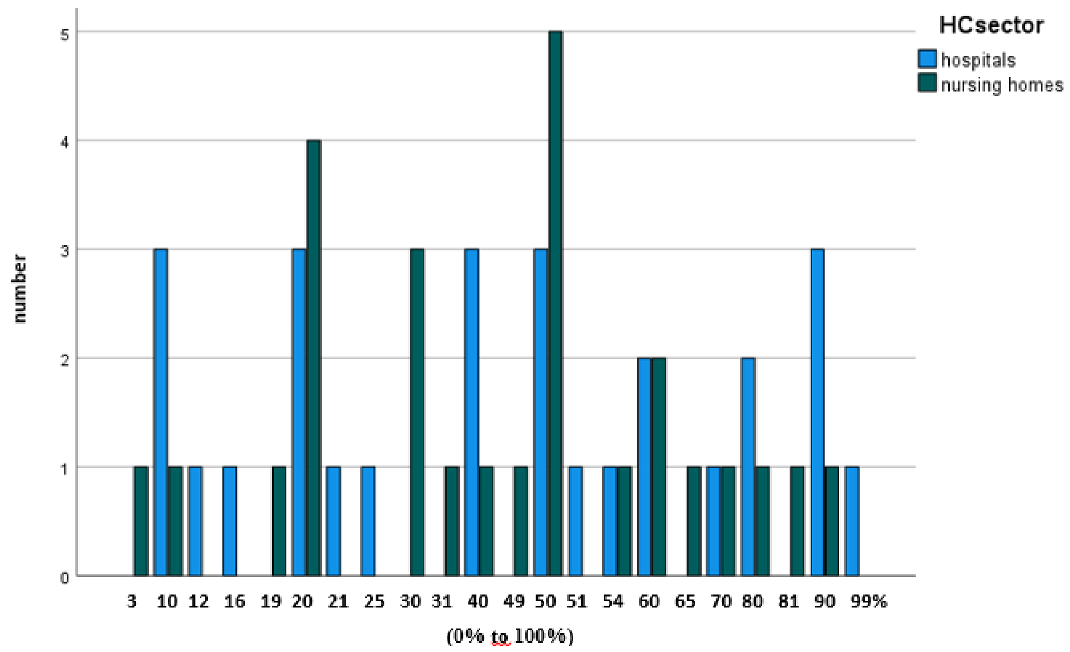


Figure 15 Intrainstitutional Improvement in Coordination, Cooperation, Communication – histogram, own illustration (using SPSS)

to **Best Point of Service** (q7)

		HC sector		
		HO	**NH**	total
q7	1	1	0	1
	6	0	1	1
	10	3	7	10
	15	0	1	1
	20	6	2	8
	23	1	0	1
	25	0	1	1
	30	1	2	3
	31	0	3	3
	33	1	2	3
	35	0	1	1
	36	0	1	1
	40	4	1	5
	41	0	1	1
	50	2	3	5
	55	0	1	1
	60	2	1	3
	65	1	0	1
	70	3	0	3
	73	1	0	1
	78	0	1	1
	80	2	0	2
	100	1	0	1
total		29	29	58

Table 11 Best Point of Service – cross table, own illustration (using SPSS)

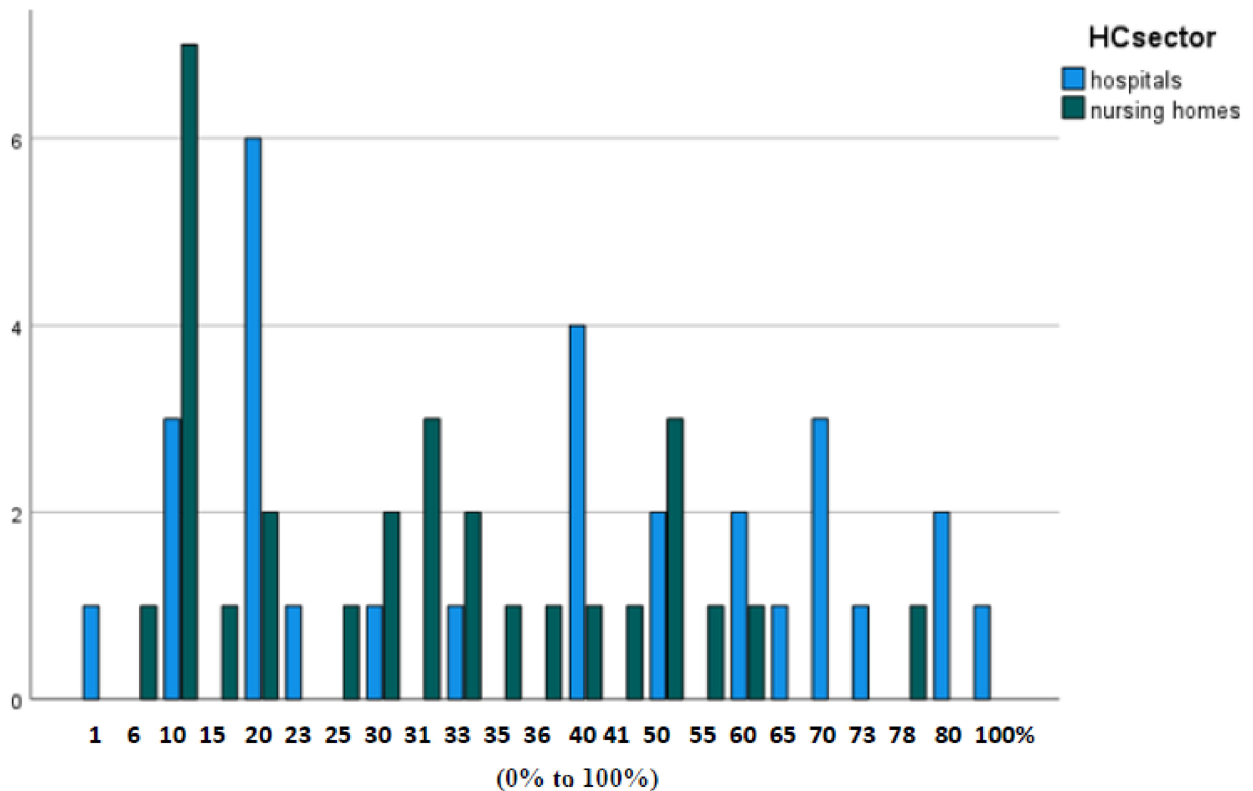


Figure 16 Best Point of Service – histogram, own illustration (using SPSS)

variable	q7
Mann-Whitney-U-test	308,500
Wilcoxon-W	743,500
Z	-1,750
asymp. sig. (2-sided)	,080

group variable: HC sector (HO vs. NH)

Table 12 Best Point of Service - test statistics, own illustration (using SPSS)

-> Result of testing: p-value is **0.08** (greater than 0.05). The results of the question about the status quo of the **"Best Point of Service"** (BPoS) in the Austrian health care landscape regarding the degree of achievement ($h_{0.2}/h_{1.2}$: q7) did not show a statistically significantly different picture.

Regarding the feasibility of best points of service in the Austrian care landscape, the statements of the participants from the **Acute Health Care Sector** were mostly in the higher percentage ranges than the statements from the **Long-term Care Sector**. Nevertheless, overall, there was no statistically significant difference between the two care sectors.

The following question (q8) aims at the importance attributed to a **"Culture of Togetherness"**. It also asks about the status quo regarding the culture (q9) of cross-sectoral, interprofessional collaboration in the Austrian health care system.

to **Culture of Togetherness** (q8 + q9)

		HC sector		
		HO	**NH**	total
q8	0	1	0	1
	1	13	17	30
	2	11	7	18
	3	1	1	2
	4	3	4	7
total		29	29	58

Table 13 Importance of the Culture of Togetherness – cross table test statistics, own illustration (using SPSS)

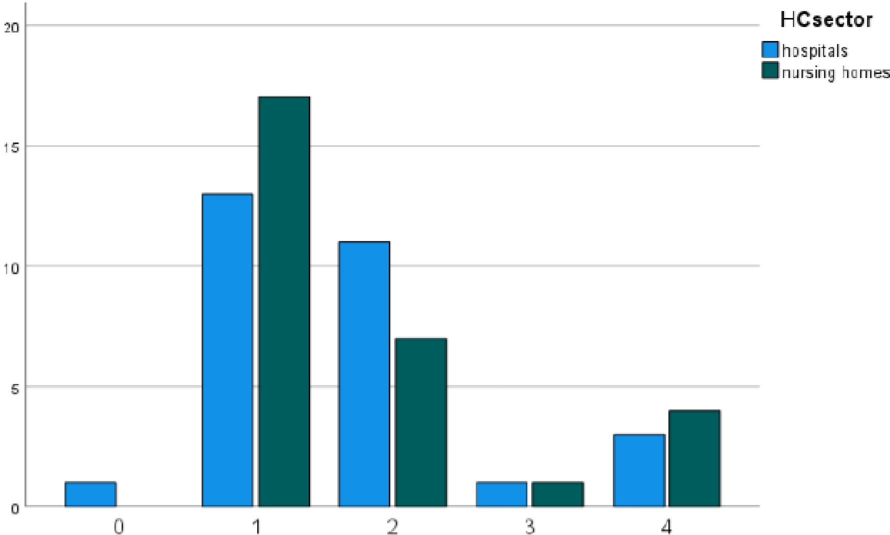


Figure 17 Importance of the Culture of Togetherness – histogram, own illustration (using SPSS)

		HC sector		
		HO	**NH**	total
q9	0	1	0	1
	2	7	7	14
	3	10	6	16
	4	11	16	27
total		29	29	58

Table 14 Valuation of the Status quo of the Culture of Togetherness - test statistics, own illustration (using SPSS)

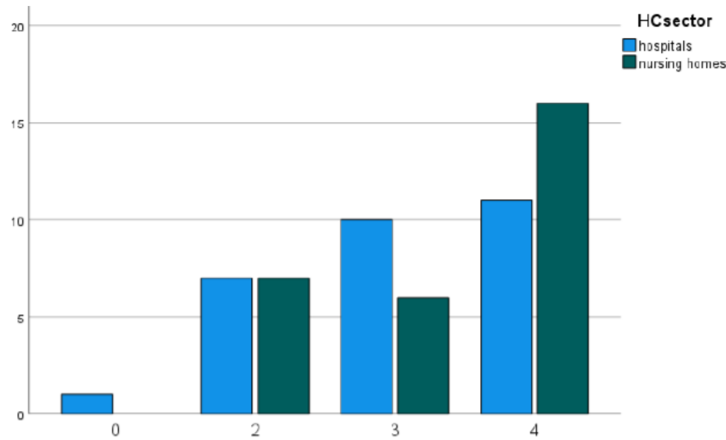


Figure 18 Status quo of the Culture of Togetherness – histogram, own illustration (using SPSS)

variables	q8	q9
Mann-Whitney-U-test	399,500	355,500
Wilcoxon-W	834,500	790,500
Z	-,358	-1,087
asymp. sig. (2-sided)	,720	,277

group variable: HC sector (HO vs. NH)

Table 15 Culture of Togetherness - test statistics, own illustration (using SPSS)

-> Result of testing: no statistical significance, p is **0.720** respectively **0.277**. Similarly, the results to the questions (sum variable: q8 + q9) about the **Culture of Togetherness** in the Austrian health care system ($h_{0.3}/h_{1.3}$) did not show a statistically significantly different picture.

The results of questions q10 to q12 presented in the following refer to the views of groups on **"Lived Value-based Organizational Culture"** as well as **"Appreciative Cooperation"** and its effects on cooperation. The results serve for further discussion and are therefore included in the scientific discourse.

		HC sector		
		HO	**NH**	total
q10 to q12	2	1	0	1
	3	11	8	19
	4	10	12	22
	5	0	4	4
	6	5	4	9
	8	2	0	2
	9	0	1	1
total		29	29	58

Table 16 Characteristics of Lived Culture - test statistics, own illustration (using SPSS)

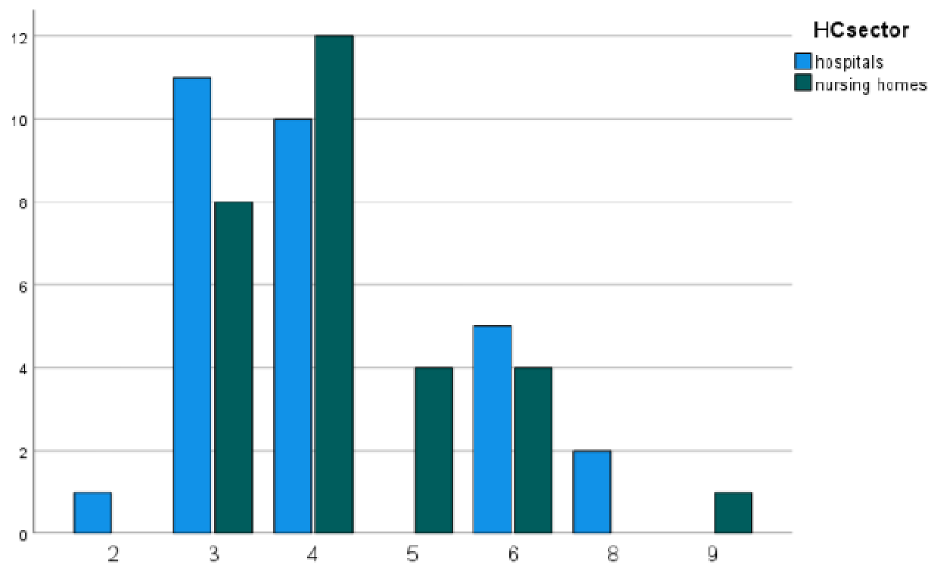


Figure 19 Characteristics of Lived Culture – histogram, own illustration (using SPSS)

In the following, the results of the hypotheses $h_{0.4}/h_{1.4}$ to $h_{0.6}/h_{1.6}$ and other variables (carried out in simultaneous tests, see table 17) are presented, which once again focus on questions such as **Culture of Togetherness:** Is this associated with potential for optimization? **Optimizing Potential through Cooperation** ($h_{0.4}/h_{1.4}$: q13 + q14), **Leadership in the interprofessional Context:** Do different professional groups need **Different Leadership Approaches**? (q15) and do future generations think differently? **Different Mindsets** ($h_{0.6}/h_{1.6}$: q18 + q19).

Responses to survey questions q16 and q17 - **Education and Training** - and questions q20 (see Annex G: q20) and q21 - **Institutional Leadership** and **Leadership Style** - are also included in the concluding discourse of this paper.

variables and sum variables	q13	q14	q15	q16 + q17	q18 + q19	q20 + q21
Mann-Whitney-U-test	404,000	290,000	263,000	366,000	415,000	418,500
Wilcoxon-W	839,000	668,000	698,000	801,000	850,000	853,500
Z	-,409	-1,497	-2,650	-,956	-,088	-,036
asymp. sig. (2-sided)	,683	,134	,008	,339	,930	,971

Table 17 Variables and Sum Variables (HOs vs. NHs) - simultaneous tests, own illustration (using SPSS)

-> The result marked in red are statistically significant, p = **0.008** (less than 0.05)

to **Optimizing Potential through Cooperation** (q13 + q14)

The majority of respondents see good interprofessional cooperation as optimizing resources (see table 18, figure 20); when estimating the savings potential in a range of 0 to 30%, the nursing home managers show a higher degree (see table 19, figure 21, also $h_{0.4}/h_{1.4}$: q13 + q14).

		HC sector		
		HO	NH	total
q13	(1)	24	25	49
	(2)	4	4	8
	(3)	1	0	1
	total	29	29	58

Table 18 Resource Optimization through Cooperation - cross table, own illustration (using SPSS)
agree completely (1) tend to agree (2) neither nor (3) tend to disagree (4) disagree at all (5)

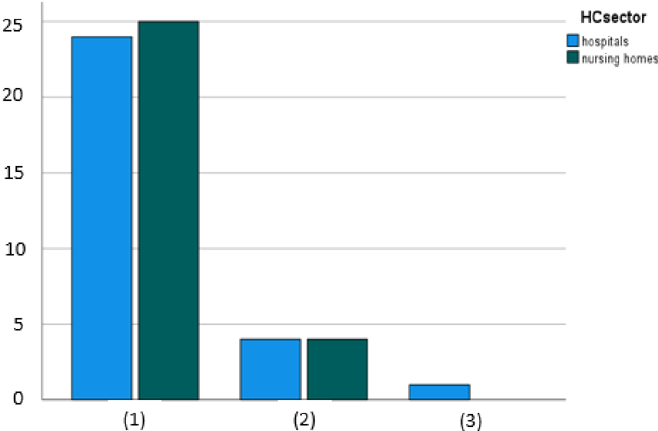


Figure 20 Resource Optimization through Cooperation - cross table, own illustration (using SPSS)
agree completely (1) tend to agree (2) neither nor (3) tend to disagree (4) disagree at all (5)

A central question in health care practice is usually not the question of quality improvement, but the strongly limited view from a business management perspective, of whether costs are caused. Accordingly, in the survey of practitioners, the question was also asked about a **Possible Savings Potential** (q14) with improved framework conditions, measured in terms of their daily working time. Estimates could be given in a range from 0 to 30%. The following table (table 19) and the subsequent distribution (figure 21) show a clear picture. Overall, it can be seen that nursing home management sees a significantly higher degree of optimization potential in the current care landscape.

	(0% to 30%)	HC sector HO	NH	total
q14	2%	1	0	1
	5%	1	2	3
	6%	0	1	1
	7%	1	0	1
	8%	1	1	2
	10%	5	4	9
	12%	2	0	2
	15%	4	2	6
	20%	5	7	12
	21%	1	0	1
	22%	1	0	1
	23%	1	0	1
	25%	3	4	7
	28%	0	1	1
	30%	1	6	7
	total	27	28	55

Table 19 Potential Savings – cross table (0 to 30%), own illustration (using SPSS)

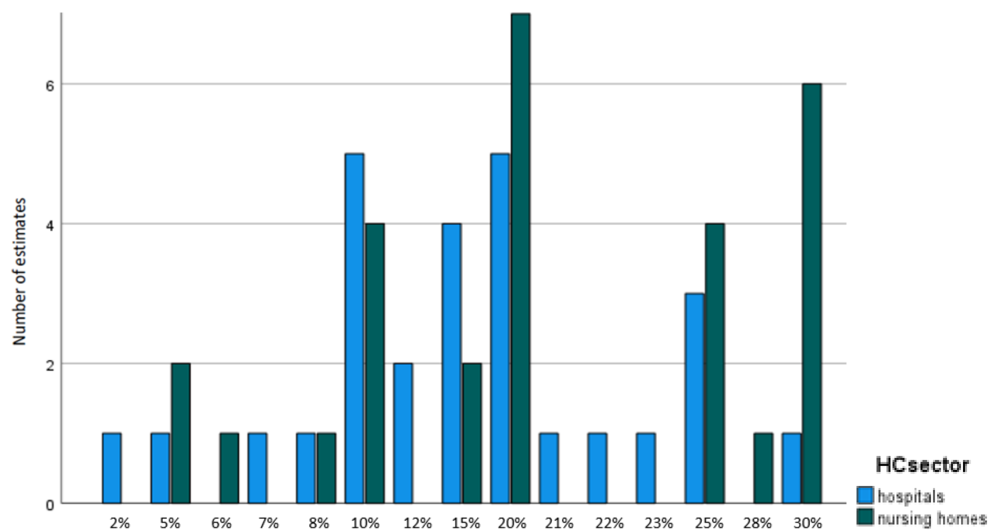


Figure 21 Potential Savings – histogram (0 to 30%), own illustration (using SPSS)

to **Different Leadership Approaches** (q15)

		HC sector HO	NH	total
q15	1	16	6	22
	2	10	16	26
	3	1	2	3
	4	2	4	6
	5	0	1	1
total		29	29	58

Table 20 Different Professionals - Different Leadership Expectations – cross table statistics,

own illustration (using SPSS)

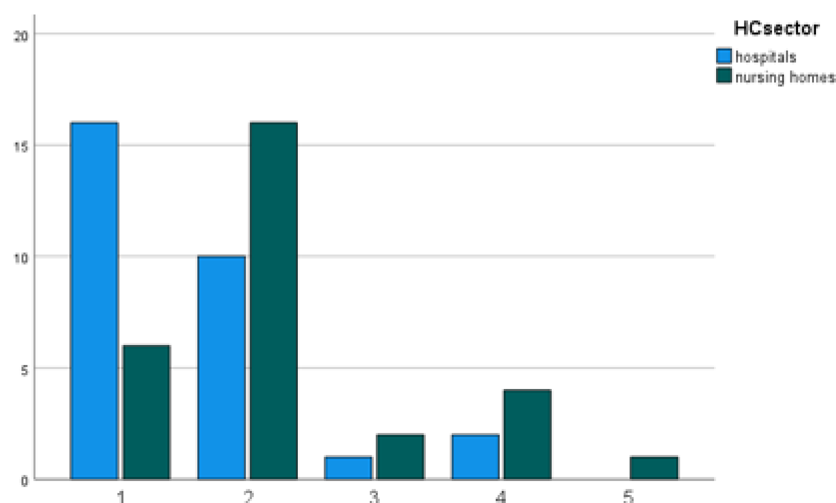


Figure 22 Different Professionals - Different Leadership Expectations – histogram, own illustration (using SPSS)

On the question of whether **Different Occupational Groups bring different Leadership Expectations with them** (q15), differences were evident.

In order to get to the bottom of the question of possible **differences in the leadership approach**, a specification **by generations** followed by means of the hypothesis that over 40-year-olds agree/disagree to a significantly higher extent that different health professionals require a different leadership approach ($h_{0.5}/h_{1.5}$):

		HC sector		
		HO	NH	total
Age cat. < 40	1,00	5	10	15
40 and > 40	2,00	24	19	43
total		29	29	58

Table 21 Age Group over 40 Years – cross table statistics, own illustration (using SPSS)

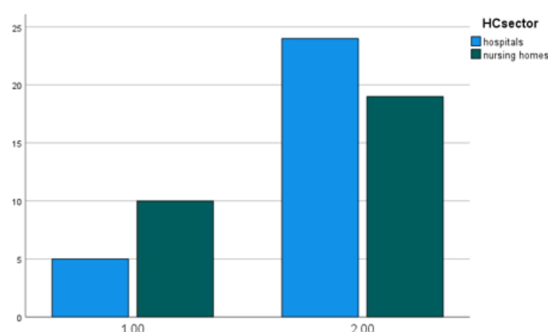


Figure 23 Age Group over 40 Years – histogram, own illustration (using SPSS)

	frequency	percent	valid percentages	accumulated percentages
HO	15	25,9	25,9	25,9
NH	43	74,1	74,1	100,0
total	58	100,0	100,0	

Table 22 Age Group over 40 – cross table statistics, own illustration (using SPSS)

	q15
Mann-Whitney-U-Test	256,500
Wilcoxon-W	1202,500
Z	-1,268
asymp. sig. (2-sided)	,205
group variable: Age group > 40 years	

Table 23 Response Age Group over 40 - test statistics, own illustration (using SPSS)

-> Result of testing: The result marked (HOs vs. NHs) in red in the table above (see table 17) is statistically significant, p = **0.008** (less than 0.05), ($h_{0.5}/h_{1.5}$: q15) - it shows a statistically significant difference in hospital boards compared to nursing home boards in the view that **Different Leadership Approaches** are needed for different health professionals. But the response of all those over 40 years of age (see table 21 to table 23) shows no difference between the generations, p is **0,205** (greater than 0.05).

to **Education and Training** (q16 + q17)

The question category education and training refers to the necessity of **interprofessionality in education and training** of health professionals, in particular to the aspect of whether **a common basic module** for all health professionals would be beneficial for interprofessional cooperation in health care practice (q16 + q17).

		HC sector		
		HO	**NH**	total
q16 + q17	2	19	14	33
	3	6	12	18
	4	2	3	5
	5	1	0	1
	6	1	0	1
total		29	29	58

Table 24 Education and Training – cross table test statistics, own illustration (using SPSS)

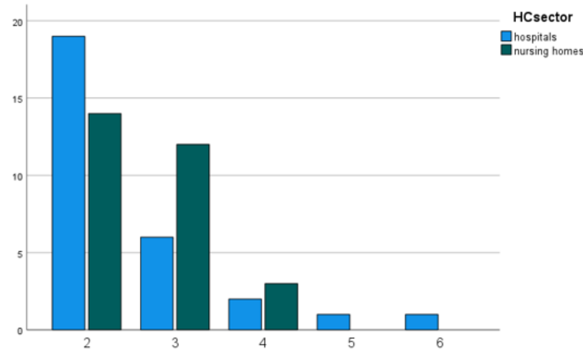


Figure 24 Education and Training – histogram, own illustration (using SPSS)

The result shows no significant difference between hospital boards and nursing home managers (see table 17): p is **0.339** (greater than 0.05).

to **Different Mindsets** (q18 + q19)

The question about differences in the mindset of future generations refers to the associated changes in leadership expectations, i.e., whether a new understanding of leadership will be necessary. The associated hypothesis is: There is a/no difference in the view of HOs and NHs that upcoming generations have changed leadership expectations due to a different mindset ($h_{0.6}/h_{1.6}$):

		HC sector		
		HO	**NH**	total
q18 + q19	2	3	4	7
	3	8	7	15
	4	8	8	16
	5	7	7	14
	6	2	2	4
	7	1	1	2
total		29	29	58

Table 25: "Different Generations - Different Mindsets" (HOs vs. NHs), own illustration (using SPSS)

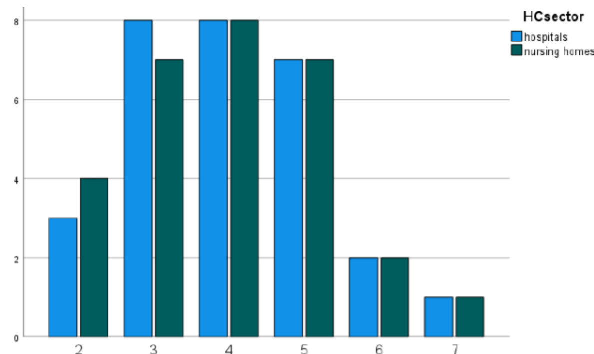


Figure 25 Different Generations - Different Mindsets (HOs vs. NHs) – histogram, own illustration (using SPSS)

to **Institutional Leadership** and **Leadership Style** (q20 + q21)

This category of questions focuses on the question of whether **current leadership models still** seem **up to date**. The first part (q20) refers specifically to this and was scaled on the one hand using a Lickert scale (*agree completely, tend to agree, neither nor, tend to disagree, disagree at all*) and on the other hand as an open question part (see point 4.3.2 as well as ANNEX G). The second part (q21, also scaled on 5 levels) refers to the **co-responsibility of upstream and downstream care sectors**.

		HC sector		
		HO	**NH**	total
q20 + q21	0	1	0	1
	1	4	6	10
	2	19	17	36
	3	3	4	7
	4	2	2	4
total		29	29	58

Table 26 Actuality of the Leadership (HOs vs. NHs), own illustration (using SPSS)

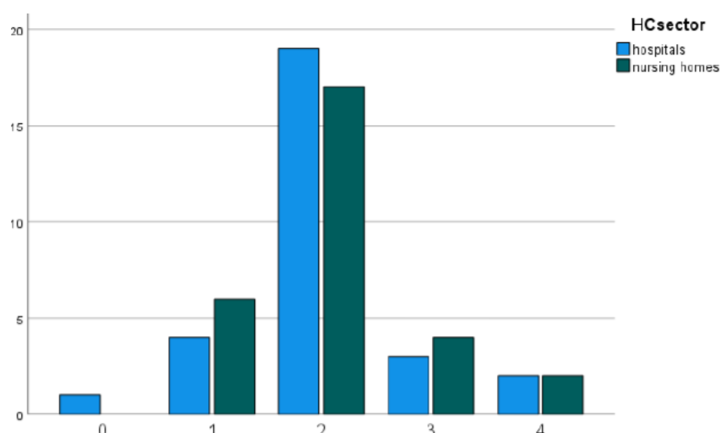


Figure 26 Actuality of the Leadership (HOs vs. NHs) – histogram, own illustration (using SPSS)

The analysis shows no significant differences in the views of the two samples, p is **0.971** (greater than 0.05). A detailed analysis of the open questions can be found in the results section of the paper. In particular, the answers are correlated with the expert opinions on this question from the qualitative survey (see section 5 as well as chapter 4.3.1).

In the now following part, the results of the hypotheses $h_{0.7}/h_{1.7}$ to $h_{0.10}/h_{1.10}$ (variables are carried out in simultaneous tests, see table 27) are presented, **Mission Statements Performance:** Is this assessed differently by HOs and NHs? ($h_{0.7}/h_{1.7}$: q24 + q26), the **Mission Statements'**

Functionality: Does trust in mission statements differ between HOs and NHs? ($h_{0.8}/h_{1.8}$: q27 to q32), **Common Cultural Understanding:** Are there differences between denominational and public institutions? ($h_{0.9}/h_{1.9}$: q36 to q39) and **Confidence in the Effects of Integrated HC on Patients**: Are there differences between HOs and PHs? ($h_{0.10}/h_{1.10}$: q40). The results of the sum variable q22 + q23, which is also aimed at **Performance of Mission Statements**, and the sum variable q33 to q35, related to the **Common Understanding of Culture**, will be discussed later in the discourse.

sum variables and variable q40	q22 + q23	**q24 to q26**	**q27 to q32**	q33 to q35	**q36 to q39**	**q40**
Mann-Whitney-U-test	386,500	245,000	303,500	313,000	364,500	302,500
Wilcoxon-W	821,500	680,000	738,500	748,000	799,500	737,500
Z	-,649	-2,763	-1,825	-1,691	-,886	-1,896
asymp. sig. (2-sided)	,517	**,006**	,068	,091	,376	,058

Table 27 Other Variables and Other Sum Variables (HOs vs. NHs) - simultaneous tests, own illustration (using SPSS)

-> The result marked in red is statistically significant, p = **0.006** (less than 0.05, see below).

to **Mission Statements Performance** (q22 + q23 and q24 to q26)

"**Basic ethical attitude** must be an integral part of leadership and management function" (q22) was the subject of the first part of the question category **Mission Statement** and "ethics is not opposed to economics, a better understanding would be to speak of **'ethically responsible business'**" (q23) was the subject of the second part (see table 28 + figure 27).

		HC sector		
		HO	**NH**	total
q22 + q23	2	21	19	40
	3	5	5	10
	4	3	5	8
total		29	29	58

Table 28 Ethical Responsibility (HOs vs. NHs) – cross table, own illustration (using SPSS)

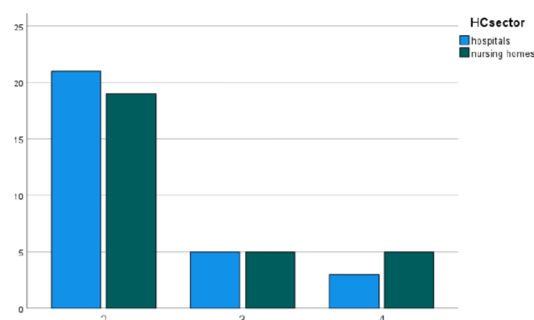


Figure 27 Ethical Responsibility (HOs vs. NHs) – histogram, own illustration (using SPSS)

-> The result indicates a high level of awareness regarding the ethical management and ethically responsible economics, but no differences between hospitals and nursing home: p is **0.517**.

Regarding the **performance of mission statements** in the second part, the answer to three questions was decisive: "**Mission statements touch on one's own attitude** and provide orientation for everyday life" (q24); "**Mission statements promote interprofessional collaboration**, especially across care settings (hospital/nursing home/outpatient services, etc.)" (q25) and "**'If you can't measure it, you can't manage it!**', also applies to mission statements?" (q26).

		HC sector		
		HO	**NH**	total
q24 to q26	3	0	2	2
	4	0	2	2
	5	4	7	11
	6	7	7	14
	7	2	4	6
	8	4	1	5
	9	1	1	2
	10	2	4	6
	11	4	1	5
	12	3	0	3
	13	1	0	1
	14	1	0	1
total		29	29	58

Table 29 Mission Statement Effects (HOs vs. NHs) – cross table, own illustration (using SPSS)

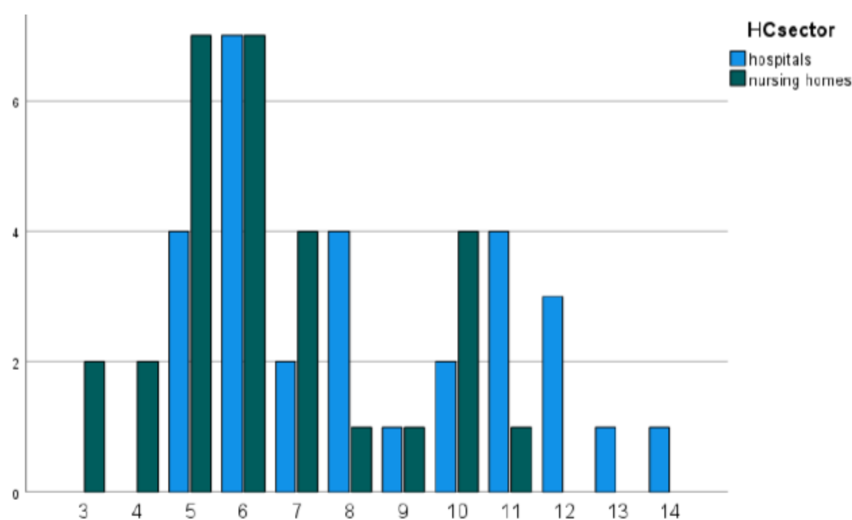


Figure 28 Mission Statement Effects (HOs vs. NHs) – histogram, own illustration (using SPSS)

-> The result regarding the attributed meaning of the **Mission Statements Performance** (see above, table 27) shows a **statistically significant difference** (p = **0.006,** less than 0.05) between

HOs and NHs ($h_{0.7}$/$h_{1.7}$: q24 to q26). Accordingly, statistically significant are differences between HOs and NHs regarding the view of the importance of mission statements for the organization. The result shows that the confidence of nursing home managers in the performance and importance of mission statements is significantly higher than that of hospital directors.

to **Mission Statements' Functionality** (q27 to q32)

		HC sector		
		HO	NH	total
q27 to q32	6	0	1	1
	7	3	2	5
	8	3	2	5
	9	1	0	1
	10	4	0	4
	11	4	2	6
	12	3	1	4
	13	1	4	5
	14	1	4	5
	15	3	2	5
	16	2	0	2
	17	1	3	4
	18	0	4	4
	19	1	1	2
	20	0	1	1
	21	0	2	2
	22	1	0	1
	24	1	0	1
total		29	29	58

Table 30 Functionality of Mission Statements (HOs vs. NHs) – cross table, own illustration (using SPSS)

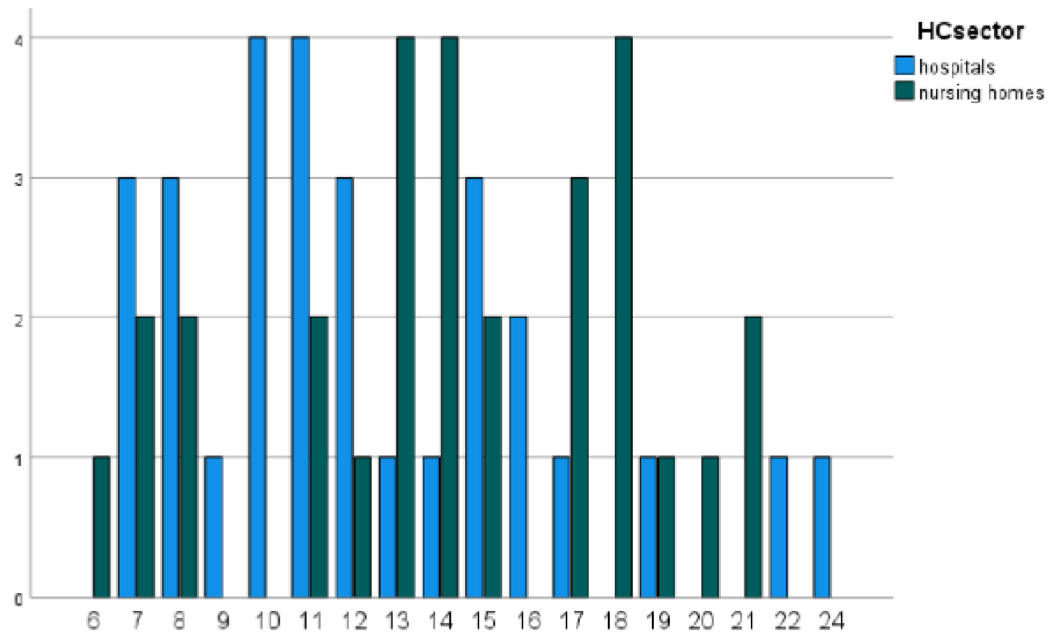


Figure 29 Functionality of Mission Statements (HOs vs. NHs) – histogram, own illustration (using SPSS)

-> The result regarding the trust in the **Mission Statements' Functionality** (see also table 27) shows no difference (p = **0.068**, greater than 0.05) between HOs and NHs ($h_{0.8}/h_{1.8}$: q27 to q32). The associated hypothesis $h_{0.8}/h_{1.8}$ is: There is no/a difference regarding the trust in guiding principles between HOs and NHs in general.

to **Common Cultural Understanding** (q33 to q39)

		HC sector		
		HO	**NH**	total
q33 to q35	3	5	3	8
	4	7	2	9
	5	5	4	9
	6	3	7	10
	7	4	7	11
	8	3	2	5
	9	1	2	3
	10	0	2	2
	11	1	0	1
total		29	29	58

Table 31 Culture Manageability (HOs vs. NHs) – cross table, own illustration (using SPSS)

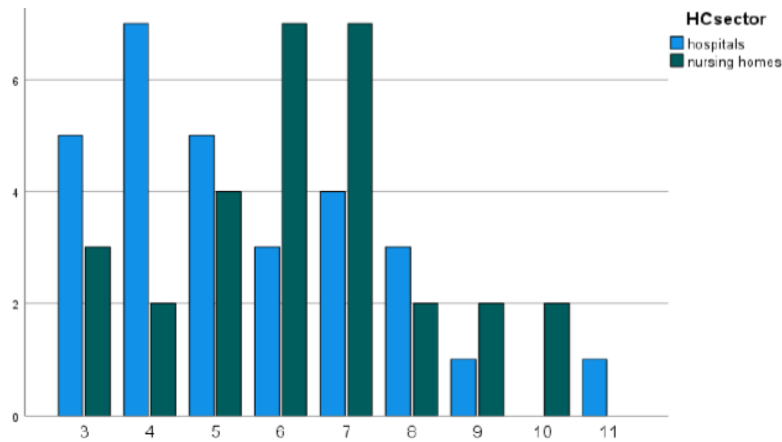


Figure 30 Culture Manageability (HOs vs. NHs) – histogram, own illustration (using SPSS)

-> The result regarding the **common cultural understanding** (see also table 27) shows no statistical difference (p = **0.091**, greater than 0.05) between HOs and NHs.

		HC sector		
		HO	**NH**	total
q36 to q39	4	6	3	9
	5	6	5	11
	6	5	8	13
	7	7	5	12
	8	2	7	9
	9	2	0	2
	10	1	0	1
	12	0	1	1
total		29	29	58

Table 32 Culture Effects (HOs vs. NHs) – cross table, own illustration (using SPSS)

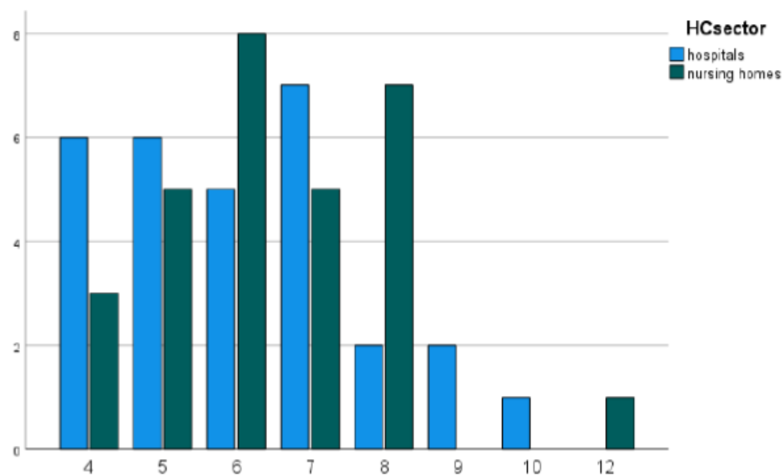


Figure 31 Culture Effects (HOs vs. NHs) – histogram, own illustration (using SPSS)

-> The result regarding the **Impact of Cultural Work** (see also above, table 27) shows no statistical difference (p = **0.376**, greater than 0.05) between HOs and NHs ($h_{0.9}/h_{1.9}$: q36 to q39). Associated hypothesis $h_{0.9}/h_{1.9}$: There is no/a difference regarding the importance of cultural work between HOs and NHs in general.

to **Confidence in the Effects of Integrated HC** (q40)

		HC sector		
		HO	**NH**	total
q40	3	0	2	2
	4	3	4	7
	5	5	7	12
	6	4	5	9
	7	3	4	7
	8	14	7	21
total		29	29	58

Table 33 Effects of Integrated HC on Patients (HOs vs. NHs) – cross table, own illustration (using SPSS)

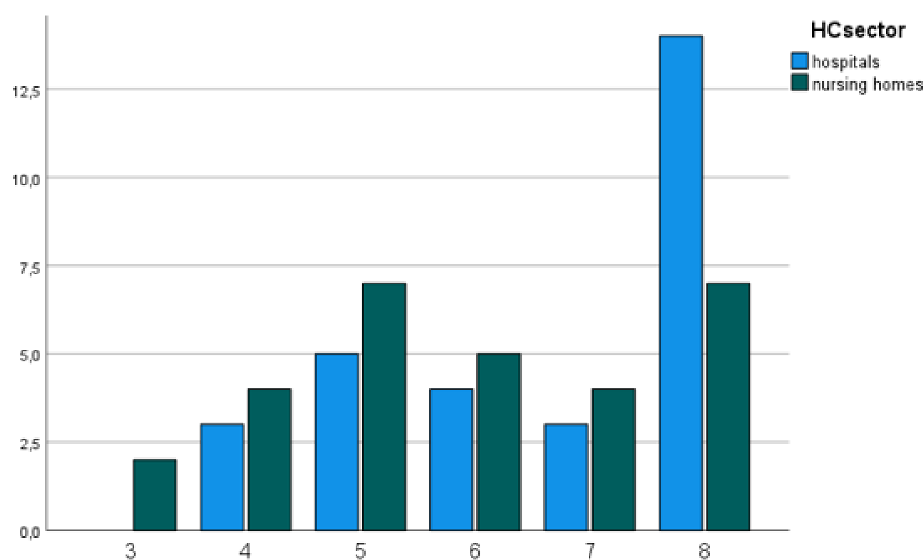


Figure 32 Effects of Integrated HC on Patients (HOs vs. NHs) – histogram, own illustration (using SPSS)

-> The result of the responses (q40) refers to various detailed questions (summarized as a sum variable: the more the higher) on the integration of care, such as "patient orientation," "clear responsibilities," "waiting and treatment times," "transparency and information flow," "quality of the care process," "stress reduction," and "(joint) co-responsibility of all actors." There are no significant differences between the two samples (HO + NH), (p= **0.058**, greater than 0.05).

The associated hypothesis $h_{0.10}/h_{1.10}$ is: There is no/a difference regarding the confidence in effects of integrated HC on patients between HOs and NHs.

The distribution shows a slight tendency on the part of the nursing homes regarding confidence in the impact of integrated health care on the patients (see table 33, figure 31). A larger sample size in both groups could further support the result of the test procedure or still bring out differences.

to **Interface Optimization of Integrated HC** (q41)

		HC sector		
		HO	**NH**	total
q41	0	1	0	1
	1	2	0	2
	2	9	11	20
	3	6	6	12
	4	9	10	19
	5	2	2	4
total		29	29	58

Table 34 Responsibilities and Competencies – cross table, own illustration (using SPSS)

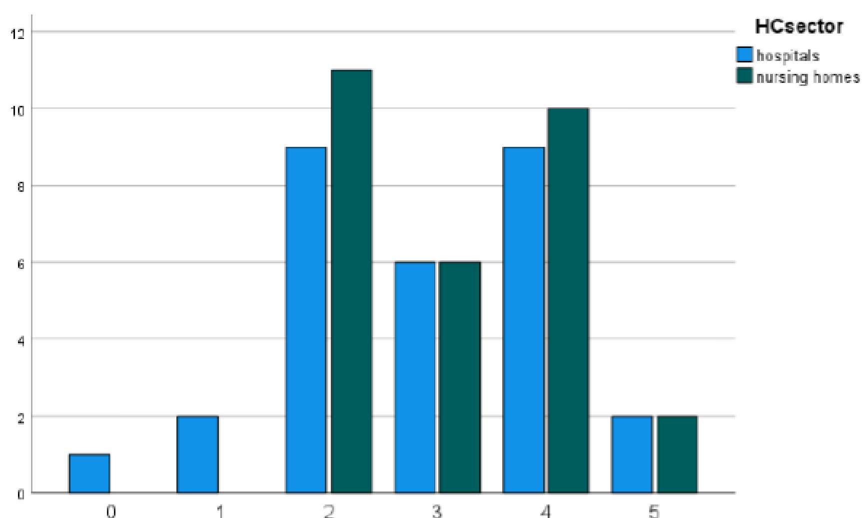


Figure 33 Responsibilities and Competencies – histogram, own illustration (using SPSS)

The distribution of answers regarding the question whether responsibilities and competences between the individual care areas (intra- and extramural) are by and large already clearly and sufficiently defined (q41) shows no significant differences between the two samples (HOs and NHs) (see table 34, figure 33).

4.3 Content Analysis

The following analysis refers on the one hand to the evaluation of the content of the expert interviews and on the other hand to the open questions that were asked as part of the quantitative survey.

4.3.1 Analysis of the Expert Survey

In the second part of the empirical survey (qualitative part), experts from health care planning, health care (strategic level, especially medicine), health economics, and health care consulting, professional associations, and boards of self-help organizations (patient perspective) were interviewed (16 responses have been received to date, some of them anonymized). A content analysis was carried out and some individual statements are served as argumentative support for the final results. At the beginning of the qualitative part of the study five main categories, each with three subcategories, were defined for further analysis, in particular within the framework of the mixed-method procedure, based on the structure of the quantitative survey section. In the course of the deductive procedure, a coding guide was created that served as the basis for the content-analytical elaboration according to Mayring (2015). Text passages typical of the content, so-called "anchor examples", as well as coding rules were continuously added in the course of the content analysis. Individual interview statements were subjected to a contextual interpretation. In addition to the categorization of the interviews, an overall categorization was made across all interviews, which in combination with the results of the quantitative part of the study contributes to answering the research questions. The main categories were (1) **Integrated Health Care**, (2) **Culture of Cooperation**, (3) **Leadership in Interprofessional Context**, (4) **Shared Cultural Understanding**, and (5) **Impact of Integrated Health Care**. The content-analytical evaluation can be seen in the following presentation:

Integrated Health Care (1)

to 'Interprofessional Cooperation'. The cooperation of the different professional groups in the Austrian health care system was described from "very good and professional" (V), expert of a university hospital, who herself is responsible for "transition management" (transition to follow-up care facilities), to "basically good" or "relatively good" (I, VII, XV) to mediocre (II, III, IV, VI, VIII, IX, XVI), such as. e.g. "not very good", "room for improvement", "in need of improvement", occasionally also with "bad" or "sometimes very bad" (X, XII, XIV). A former

hospital manager who is very experienced in the Austrian health care system and is now a consultant in areas such as change management and cultural development (XI) sees major differences in the care landscape as a given. The experts see reasons primarily in insufficient framework conditions and/or unclear competencies (I, II, IV). Other experts (VI, VII, VIII, XI, XII, XIII, XIV, XV, XVI) cite the current culture of collaboration as a critical success factor, which can be conducive or obstructive to collaboration. In particular, the chairwoman of the Board of the Federal Association of Self-Help Austria (BVSHOE), an umbrella organization of Austria's nationally active, issue-related self-help and patient organizations, points out, that patients are often not involved in decisions that are important to them, and advice and information about follow-up treatments are forgotten or suppressed.

to 'Interfaces Management'. When asked in and/or between which areas of care an improvement of interprofessional cooperation would be desirable and by which concrete measures interinstitutional, interprofessional cooperation could be improved, different interface areas were mentioned: Hospitals/nursing homes (I, V, VI, VII, XV), with all aftercare facilities (V, VII, VIII), nursing homes/mobile services (II), to primary care (general practitioner care and primary health centers) (I, VII, XV), pharmacists/physicians (II), pharmacies/hospitals (II), general practitioners/specialists (VI), to palliative care (inpatient/outpatient) (II). As concrete measures, for example, "a mixture of personal acquaintance and institutionalized cooperation" and "simple, good, user-friendly" technical equipment were mentioned (III) or digital applications as an urgent requirement to support interface management (VI, IX). The representative (VII) of an umbrella organization of nursing homes, who is also oriented toward getting to know each other personally, suggests "continuous exchange between the managers of a care region," which is also called for by other experts (X, XI, XIII, XIV, XV). One expert (IV) sees the splitting of financing and control between hospitals, family doctors, and outpatient care as "particularly obstructive": "The care process is not controlled and financed according to need, but according to the responsibilities of the individual players. Therefore, structurally and from the patient's point of view, there is inefficiency, with overall high costs of the health care system." The expert, who heads an organization for humanistic management, calls for "an overall view" of financing, control, and legal frameworks, as well as "fundamental changes that enable a patient-oriented design and integration of care (...)." An expert currently active in international consulting for integrated care (VI), points out the need for cooperation with patients "as an equal group within care", which is also demanded by the chairwoman of the Patient Representation Association (XVI).

to ‘Covid-Impact’. The coronavirus disease triggered by the corona virus SARS-CoV-2, which appeared for the first time in 2019 and led to an ongoing pandemic worldwide, also changed the interprofessional cooperation in the care facilities at the beginning of the disease wave: Crisis management was necessary in the facilities, and a novelty was that all health professionals working in care facilities were also exposed to the risk of illness themselves. As a result, the personal side of the interaction led to a direct and open exchange. In addition to the need for effective coordination of tasks, communication and cooperation improved, which was confirmed by the survey of experts. Some experts confirmed signs of a trend towards improved interinstitutional cooperation but did not want to make any predictions regarding the sustainability (I, II, III, V, VI, VII, IX). Three multi-experienced experts, who know the care landscape from different levels, answered with a clear 'no' (VIII, X, XIII). The representative of the patients' self-help association also agrees with this pessimistic attitude (XVI). Other experts even saw a deterioration in isolated cases, e.g. between acute care and nursing, as a result of the increasing separation of hospitals (II, IV). And still, others see the restrictive framework conditions or the current culture of cooperation as a hurdle to sustainable improvements (IV, VII, XI, XII, XIV). Only one physician experienced both in hospital management and in the outpatient specialist sector sees a sustainable improvement in interprofessional cooperation across institutions as a result of Covid-19.

Culture of Cooperation (2)

to ‘Culture of Togetherness’. When asked about the assessment of the current culture of cross-sectoral, interprofessional cooperation in the Austrian health care landscape and its importance for the integration of care, a very differentiated picture emerged. There was almost unanimity regarding the importance of a culture of cooperation (I, II, III, IV, V, VI, IX, XI, XIII, XIV, XV), that improved interprofessional cooperation would be desirable (I, III), but that other, improved, even favorable framework conditions were needed (I, II, III, IV, VII, IX, XI, XII, XIII, XIV) and that the focus should be on the patients (II, XV, XVI). There is also talk of a "weakly developed" or "developing" culture of cooperation (III, VI, VII, VIII, IX, X, IX, XIII, XV, XVI). One author (XI), who works in the health care sector as a consultant on issues of cultural development, advocates in particular the creation of culture-shaping spaces to replace "road shows with 'cinema seating' and 'pressure refueling'", embedded in well-considered change management projects.

to ‘Attaining a Living Organizational Culture’. As concrete measures to make the claimed culture liveable (perceptible), the framework conditions, adequate availability of capacities in all

sectors (I, VI, VII, VIII, IX, XII, XII, XVI) or outcome-oriented funding (II) as well as effective interface management (I) were once again mentioned. Awareness and perception of personal co-responsibility of the actors were also mentioned (V, VI, VII, VIII, XV), which lead to a culture of solidarity and togetherness (VI, VIII, X, XIV), as well as culture-establishing "measures to achieve mutual respect" (X, XIV, XV, XVI), especially also regarding "not so valued professional groups" (X). A large number of the experts see the creation of suitable conditions (structures, framework conditions, etc.) as the prerequisite for behavioral change (as for a culture of togetherness) (I, II, VI, VIII, IX, XII, XIII, XIV, XVI). Building structures is also mentioned regarding to joint "boards" (IX) or "regional conferences" (XIII). In particular, the representative of the patients' association, whose perspective was formed through her own experience as a result of her own chronic illness, advocates a "complete rethink", a far-reaching cultural change (VI).

to 'Optimizing Potential through Cooperation'. Almost all experts answered with a clear "yes" (I, II, III, IV, V, VI, VII, VIII, X, XI, XII, XIII, XIV, XV, VI) as to whether an organizational culture that is lived according to their demands can lead to better cooperation, especially at interfaces/transitions, and good interprofessional cooperation can also lead to resource optimization. However, one expert responsible in strategic leadership for several denominational hospitals pointed out the importance in health care of balancing optimizing thinking and empathetic patient orientation on the other hand: "Unfortunately, many professionals are socialized to be lone wolves" (II). Another expert points to the "quality of care" that needs to be considered in the context of increasing efficiency (IV). A "good organizational culture" (IX), indeed "value-oriented management culture" (XIV), or "managers as role models" (XI) are seen as essential prerequisites for sustainable resource optimization. However, appropriate framework conditions are also needed for this (VIII). According to the experts, establishing a kind of "meta culture of interinstitutional cooperation" (XIII) that is compatible with one's own organizational culture requires "clear guidelines" (VI, XIII) and good preparation (XIII).

Leadership in an Interprofessional Context (3)

to 'Education and Training'. There is unanimous agreement on the proposal for a common basic module in the training of health professionals (I to XVI). One expert calls for this to be extended to all further training courses (XI). The expert coming from the Austrian umbrella organization of care facilities puts it in a nutshell in his statement in response to the question: "Early thematization could not only increase mutual appreciation and respect, but in particular also make the different approaches clear. This would definitely emphasize that we are moving

from a rather hierarchical approach to a care and support approach that requires several professions and is ultimately more resource efficient.

to *'Different Mindsets'*. The question whether a changed mindset as well as behavioral patterns of coming generations could favor interprofessional cooperation and thus also require new leadership approaches was answered with equal clarity by the majority of the experts with "yes" (I, III, V, VI, VII, VIII, IX, X, XII, XIII, XV, XVI) and, however, prompted a number of, generally positive-critical comments: "depends on how the mindset changes and on the new leadership approaches" (I); "leaders have a salient role in anchoring integrated health care in professional action" (IV); "succeeding generations are already changing the way they work together" (VI); "established health professionals require good coordination in terms of good orchestration (VII); and, "leadership staffing is always critical" as well as "new leadership approaches such as 'just culture' (note: A working atmosphere characterized by trust) must be forced" (XV). Only one expert (II) saw a hurdle in the persistence of the status quo: "occupational group individual socialization is (...) stronger and inhibits interprofessional cooperation". However, he also added approvingly that "new leadership approaches" were needed (II). A positive-critical comment also came from an expert with a lot of practical experience and now working in cultural development consulting: "We also have to consider what people perceive at the level of the heart and gut feeling. So, we have to get creative in order to reach or pick up people holistically" (XVI).

to 'Style of Leadership'. The perception of co-responsibility of all actors of the institutions along the care pathways requires, according to the predominant opinion of the experts interviewed, a general rethinking of conventional management and leadership concepts (I, II, IV, V, VII, IX, X, XIII, XIV, XV, XVI). However, according to an experienced expert from the field of health planning (I) and another from the field of strategic hospital management (II), the change will not be brought about within a few years. Divergent opinions on this aim at the perception of management responsibility in one's own institution as a central task (II, VI, VII), but on the other hand agree with the necessity of continuous adaptation to the requirements of the time (VI, VIII, XI, XII). In any case, the goal should be to consider management and leadership concepts that result in added value "both for health professionals and - above all - for patients" (I). The experts coming from the field of "humanistic management" (IV), the fields of "culture and value work" (XI, XIV) as well as from hospital management (XV) even see co-responsibility as a basic essence of humanistic management (IV) and of the general perception

of leadership (XI, XIV, XV). A "steering intervention" favoring co-responsibility is in any case also expected from health policy (II, IV).

Shared Cultural Understanding (4)

to 'Culture Manageability'. Whether a common understanding of values ('culture of cooperation') can promote cross-institutional, interprofessional togetherness is also a unanimous picture (I to XVI), with one much experienced expert asking "HOW" or "at which points such a common understanding of values can be communicated, established and promoted in a way" (I); which is precisely the central question of this scientific contribution. An attempt to give an answer came from the expert from the Organization for Humanistic Management, saying that this must be "held together and grounded at the values and goals level" and "positively influence" behavior across organizations "over a longer period so that it becomes visible and noticeable" (IV). The expert coming from Consulting for Integrated Care adds that it would need a "corresponding organizational maturity" that would be conducive to the "culture of collaboration" (VI). The expert from the Austrian umbrella organization sees the "dismantling of hierarchies" as necessary in the cooperation between the different health care institutions (VII), similarly the physician and health economist, who argues for a more thoughtful discussion of system development issues (XII). For a common understanding of values, "value sensitivity of the individual", "culture that is exemplified from above", or "values that are also thematized" speak out from different areas ('health care planning', 'hospital management' and 'care management of long-term care facilities') (XIII, XIV, XV). The representative of the patient organizations states that "already in education" and "namely in school" must be started in order to "achieve such thinking and understanding of values (note: 'a culture of equal coexistence')" (XVI).

to 'Mission Statements Performance'. Regarding the advantages of common guiding values and the development of a guiding culture, the majority of the experts (I, II, III, IV, V, VI, VII, VIII, IX, XIV, XV, XVI) spoke out in favor of such a culture, especially since this can contribute to a uniform goal orientation and thus also to supporting interprofessional cooperation (I, II, III, IV, VII, VIII, IX, XV, XVI). The representative of the Organization for Humanistic Management (IV) advocates a "holistic" approach of "cultural work in the systemic sense": "Values are not primarily static but develop dynamically and will prevail when they are recognized as beneficial. Then they can facilitate and support an orientation towards common goals, which is crucial in integrated care". An expert from the fields of medicine and health economics (XII) takes a sceptical view of this and doubts that "such cultural work can thrive in our system architecture", especially since structures and framework conditions in the institutions would also

have to be adapted. An expert from the field of health planning (XIII) also sees both advantages and disadvantages: "Danger of a pseudo-culture emerging that is not lived and is all the more smiled at behind closed doors" The expert (XIII) fears that the required culture might not match the real culture and sees the challenge in establishing a "kind of meta-culture of interinstitutional cooperation that has to harmonise with one's own organizational culture". An expert experienced in value work (XIV) sees this positively and refers to his experiential knowledge: "The individual people are also challenged in their function as persons, the work gets experienced meaning and there is living joy and the patients feel the human-oriented approach that the professions live with each other". The expert (XIV) adds: "The motivation of all those involved increases, which in the end also pays off economically and a high workload can be managed more easily". He sees a danger when "expectations are raised but cannot be fulfilled". In his opinion, it is important that the management gives the cultural work the "necessary importance" and enables the development of a structure to "keep the cultural work going" (XIV). The expert of the patients' association (XVI), who also sees an improvement in care, puts it in a nutshell: "A better climate of cooperation also leads to less competition and ultimately to better and faster care for patients", which, according to the expert, would result in "patients feeling more comfortable" and "the healing processes bring a quicker success" (XVI).

to 'Mission Statements' Functionality'. How an understanding of values in integrated care that promotes inter- and multi-professional cooperation can be developed, maintained and effectively controlled across sectors and institutional boundaries, is the subject of a heterogeneous body of opinion. "Institutionalized communication" and "common objectives" appear to be of central importance (I, II, III, IV, VII, VIII, IX, XIII). The expert from humanistic management (IV) adds "applied ethics, on macro-, meso- and micro-levels" as well as "strategic coordination of individual measures over a longer period of time, attentiveness to obstacles and intermediate successes, learning from individual experiences, culture-building processes", and others. Similarly, the expert from consulting in the field of integrated care (VI): "Living values can be controlled through common visions" and the accompanying "established management systems". Regional health authorities should be supportive, "demand and promote dialogue" and "identify needs and align structures accordingly" (VII, VIII). The expert from the field of medicine and health economics (XII) sees the problem once again in the system architecture of the health system: "As soon as it leaves the level of individual initiatives, the incentives of the completely fragmented system become effective (XII). The expert from the field of health planning (XIII) also has similar concerns as with the topic "Performance of Mission Statements", but suggests: "The best way to try to realize this is through a clearly structured program with goals, measures

and ongoing evaluation". The representative of the patient organization (XVI) explicitly calls for the ongoing "involvement of patients". In her view, this is the only way to succeed in "managing togetherness".

Impact of Integrated Health Care (5)

to 'Transferability of Integrated Health Care Models'. The answers to the question of whether and in what form model regions - such as the German health care region "Gesundes Kinzigtal" - can be transferred in the opinion of the experts are strongly related to the professional background of the expertise. For the experts working in health planning (I, XIII), the model region Gesundes Kinzigtal is a "health sociological experiment that is controlled by health economic incentives in order to bring about a targeted coordination between the care areas within the region". In Austria, too, one of these experts (I) points out, "coordination between the areas of care" is already anchored as a central goal in both the "health plans" and the "target control health". However, he adds that Austria and Germany have different health care systems and a number of adjustments would be necessary (I). A number of other experts agree with considerations on transferability (II, IV, VII, IX, XV, XVI), while others are sceptical (III, VI, VIII, XII), especially because of the high costs of an adaptation.

to 'Integrated Health Care Interface Optimization'. Likewise, the answer to the question on the prerequisites (framework conditions) for successful interprofessional cooperation between the care sectors (hospital, nursing home, GP, etc.) was closely related to the expertise of the respondents. The expert from health planning, who works in a leading position, pointed out a number of conditions that would be necessary for successful interprofessional cooperation: "More intensive mutual information about the respective care functions covered, joint analysis of problem situations, especially at the interfaces or points of contact" and at the same time offered a structural measure such as "regional health conferences". Furthermore, in his opinion, "the definition of common objectives", "regular communication between all relevant service providers in a region" as well as "the joint evaluation of the achievement of objectives" would be necessary. The same is demanded by another expert, also from the field of health planning (I, XIII). This was supplemented by an expert from the strategic hospital management sector (II), who - like other experts - calls for a "digital platform for open data exchange" (II, III, V, VI, X, XV, XVI) as well as "more feedback from patients to the care institutions involved in the process in a transparent manner" (II, IV, V) and "financing of the overall result and not of partial services" (II, X). The physician and head of a rehabilitation clinic (III) also calls for "clear responsibilities" (III), which is supplemented by the expert working in consulting for

integrated care (VI): "Data and knowledge must be exchanged, cultures and worlds of action must merge" (VI). The chairman of the association for nursing homes (VII) also calls for an "upgrading of all health professionals", "especially nursing", so that an "encounter at eye level becomes possible" as well as a "needs-based distribution of resources, oriented to the problem situations" and also a "systematic and structured exchange between the care settings, supported by the regional health authorities" (VII). The physician and health economist sees the only solution in "reforms of the Austrian federal constitution" (VII) (note: distribution of competences). From the patient's perspective, the representative of the patients' association (XVI) once again advocates an improvement of communication on a personal level. She notes that "confidence-building measures are indispensable" (XVI).

to 'The Individual's Influence of Health Care Integration'. When asked what the individual can contribute to the integration of care, especially from the perspective of the expert himself, the experts from the field of health care planning almost unanimously point out that "traditional structures must be critically questioned" and that there must be a "willingness to make improvements", which in particular also improve "interprofessional cooperation" (I, XIII). In terms of personal tasks, one of the experts sees his contribution in the improvement of the "quality of interface management" (I), the other in his "advisory activity", in the permanent contribution of his expertise (XIII). This is also the view of the expert coming from medical hospital management: "Participation in improvement projects", the expert working in consulting for integration, as well as the expert coming from hospital management: "Setting an example in everyday work", the expert working in the association of nursing homes: "Contribution to awareness raising", the expert working in management consulting: "raise understanding", the expert working in the professional association for medical-technical professions: "advocate for equal cooperation", the expert coming from hospital IT: "improve digital interfaces", the medical doctor and health economist: "emphasize the importance of integrated health care", (III, VI, VII, VIII, X, XII, XV). Quite a few experts stressed the importance of taking the patient focus into account in all measures (XVI). The one from the field of values and culture work refers to the anchoring of the culture of aspiration and puts it in a nutshell: "Becoming aware of one's own values, keeping them alive and cultivating the sources of this liveliness of values" (II, V, IX, XIII, XIV). According to the expert, who comes from "humanistic management", it is important to combine "ethics and leadership" (IV).

4.3.2 Analysis of the open-ended Questions of the quantitative Survey

The following part reflects the opinions and approaches of the interviewed members from board and management functions in hospitals and nursing homes, which resulted from some open questions in the quantitative survey.

In the course of the quantitative survey, in which representatives of hospitals and nursing homes in management and board functions were interviewed, individual questions were also asked as open-ended questions. The open-ended questions related to aspects of the care pathways (see transcriptions: Annex G). Specifically: "**Interfaces**" (q3) that required optimization; "**Proposed measures**" (q4) to improve them; "**Critical Points at Interfaces**" (q42); "**Prerequisites for Interface Optimization**" (q43); "**Topicality of Leadership**" to meet current challenges (q20); "**Contribution Possibilities of the individual actors**" in the health care system (q44). Finally, a personal question to the interviewees, what is their "**Own Contribution**" to system optimization (q45).

to q3: When asked between which areas of care, at which interfaces, there would be potential for improvement in the Austrian care system in the opinion of the respondents, a very varied picture emerged. While nursing home managers mainly emphasized the interface "nursing home - hospital" (far more than half of the respondents), representatives of hospitals drew a varied picture. In addition to the interfaces "family doctors - specialists", "rescue transport - care facility", "nursing homes - mobile care" etc., the interface "nursing home - hospital" was explicitly mentioned only three times. In addition, the interface "intramural - extramural" was generally mentioned, and occasionally also "all interfaces" in the health care system, as well as intraorganizational coordination needs. It is also interesting to note that above all in the nursing home sector, a number of less noticed interfaces were mentioned, whose optimization was needed: "Nursing home - specialists", In addition, there would be a need for better coordination of the care areas on a personal, multidisciplinary level, on an institutional, organizational level ("discharge management") as well as on an IT-technical, organizational level ("transmission of findings"). Suggestions were also made regarding the structural optimization, e.g. telemedical care, specialist home visits, etc.

to q4: When asked which concrete measures would be suitable for optimizing interfaces, institutionalized measures such as "cross-sectoral exchange platforms" and opportunities for "interprofessional meetings" or "jour fixes" were found in both forms of care. It was striking that

nursing homes frequently objected to an improvement in "coordination and cooperation in discharge management". Nursing homes also called for a rapid expansion of digitization and the associated integration of nursing care into the electronic health record (ELGA). In general, an increased call for improved coordination of the areas of care and, in particular, for joint management and financing can be seen in both types of facility. Overall, the importance of a common culture in dealing with each other (from HOs: "sensitization of the topic of cooperation" or "common mission in health care", from NHs: "appreciative communication towards nursing staff from long-term care by nursing staff and physicians from acute care" or "mutual understanding, consideration") was also emphasized. In addition to the behavioral aspects "cooperation, coordination, communication", relationship-related aspects such as a common documentation system, uniform financing and general structural optimization have emerged as key concepts.

to q42: When asked what the critical points at the interfaces were, both sides once again mentioned the importance of "cooperation, coordination & communication" as well as "cultural work", the active discussion of "patient or home resident orientation", "questions of appreciation", "individual treatment and care goals" (best point of service), in addition to the structured transfer of information ("technical information transfer"). "Knowledge updating" and the expanded understanding of the respective other areas of care were also noted.

to q43: Regarding the framework conditions needed for good interprofessional cooperation in cross-sectoral interaction, "clear interfaces", "clear roles", "information security" in transmission, in particular also "multi-professional documentation systems", institutionalized "joint exchange opportunities", "process design" ("transparent processes"), a uniform financing system, and "appreciative interaction" ("cross-sectoral cultural work" or "appreciation, communication at eye level") were mentioned as normative prerequisites.

to q44: Asked specifically how "interprofessional cooperation in integrated care" could be improved, the emphasis on "appreciative interaction" ("politeness, talking at eye level, being able to listen well", "interest in and understanding of one's counterpart") was particularly noticeable in nursing homes. Also "goal orientation" as well as "motivation" and "empowerment" of the employees were found in the comments. In the area of hospitals, there were also demands for "appreciative and understanding interaction", "honest commitment to patients" or "promoting cooperation on a human-collegial level"), but also management-accentuated contributions (such as: "networking in care", "tackling problems constructively" or "testing each other's limits").

However, objectives such as "ensuring optimal care for patients at the interfaces" were also emphasized.

to q45: The question about the "own contribution to the optimization of care" was again answered by the representatives of the hospitals in many different ways and enriched with numerous suggestions. In addition to "appreciation, respect and understanding" and "exemplifying values," "being a role model" and "cultivating personal dialogue" were also mentioned. Also creating framework conditions ("permanently demanding adapted framework conditions", "framework conditions for cooperation") or networking ("local networking project", "networking work"), supplemented by perception of communication levels ("regular meetings", "increased contact with nursing homes"), process design ("interdisciplinary team working on regional problems regarding the health care and interfaces") and participation in structural measures ("setting up health centers", "recognizing the importance and significance of discharge management", "promoting case management"). Finally, participation in further qualification measures was also indicated. Similarly, on the side of the nursing home managers, "creating/negotiating framework conditions" was also mentioned in addition to "exemplifying appreciation and respect" and "value-oriented action". Networking in "working and exchange groups" and in the context of "regular management meetings" is also a topic. "Permanent competence development" is also cited as an important requirement.

to q20: Finally, the question was raised as to whether the current management model is still up to date. In Austria, according to the Hospital Act, the management board in hospitals exists in the form of a so-called "collegial management", consisting of the administrative director, the nursing director and the medical director (see point 3.4.1). About a quarter of the interviewed hospital boards are in favor of establishing an overall management. In this context, one participant suggested a "leadership alternating every two years by a member of the collegial leadership". In addition, some weaknesses of this management body became clear in the statements: "Can only function in interaction across the occupational groups" or "only if each member of the collegial management assumes management responsibility and does not see himself as a representative of his occupational group, can the collegial management function well" or "the administrative director is in charge, the administrative director and the nursing director take care of the organization and processes together, the doctor is well heard but is only responsible for treatment". One participant pleaded for "moving away from the assignment of professional groups"; in his opinion, one board member should be responsible "for direction and strategy", another for "process-oriented operational organization" and the third member "for finances".

Interesting was also the opinion of a board member who apparently comes from nursing: "The process-controlling professional group needs more competences in decision-making; a nurse can learn business administration, but a business economist can hardly learn nursing". Also normative statements such as "Leading by leading well - leadership should not be out for own advantage" or "Taking the concerns of the staff seriously. Open, clear and direct communication. Do not hide/conceal anything. Open cooperation". Interesting was also the statement on a cross-institutional perspective: "The management of a hospital should first and foremost have the well-being of the patients, the staff as well as the entire region in mind and not [sic] (note: better 'only') the budget". Overall, the striving for lived participation is also clear: "Responsibility and competence must [sic] (note: better 'also') be delegated to lower hierarchical levels." Likewise, numerous nursing home managers speak out for a flattening of hierarchies and the assumption of co-responsibility by employees: "responsibility of the individual, flat hierarchies, targeted promotion of employees, continuous feedback to employees, letting them experience joy in their work" or "adapting to the new expectations"; furthermore: there is a need for "agile teams, self-organization and personal responsibility of employees, participation in decisions, influence on the organization". Normative issues are also brought into play here: "mindfulness and appreciation of employees and their needs - aware that needs are constantly changing" and finally: "the needs of the younger generation must be taken into account organizationally (work-life balance). Incentives to motivate (salary adjustment)". In the description of the expectations of the authorities, the backwardness of the relevant stakeholders was clearly expressed: "The directive structure and the bureaucratic approach of the authorities no longer fit the competence of the GDA (note: 'health service providers'), they should be accepted as partners", which speaks for a general paradigm shift of all participants and stakeholders regarding the management concepts.

4.4 LIMITATIONS

The aim of the methodological approach was to pay attention to scientific quality in all phases of the research process, although methodological limitations did arise.

In order to shed light on the theoretical background in a suitable manner, the search for relevant literature focused primarily on the scientific nature of the available sources. A systematic approach was a prerequisite. On the basis of defined key words, such as "health care", "integrated

care", "interdisciplinarity" or "interprofessional collaboration", a systematic search of scientific library catalogs and relevant databases was carried out. Of course, not all globally available databases could be searched. However, careful research and, in particular, checking for topicality, quality and trustworthiness ensured that a good selection of discoverable sources was made. This made it possible not only to refine the research questions but also to specify the hypotheses and the questions during the expert survey.

An equally systematic approach was chosen for the quantitative study. The choice of the analysis methods used was preceded by precise preparation. To obtain meaningful data, all relevant characteristics of the empirical reality and, in the course of this, valid measurement criteria regarding suitable characteristic values were determined in advance. The aim was to achieve the highest possible information content of the data. The data collection itself was based on a structured, electronic survey. Based on a random sample selection, hospital managers and managers of nursing homes were interviewed using an online questionnaire tool. The aim was to generate a sufficiently accurate miniature image of the population. A total of 29 data sets from hospitals (29 of 75 addressed questionnaires were answered) and, coincidentally, 29 data sets from nursing home managers (of 57 addressed questionnaires) could be evaluated. The time of the Corona pandemic is admittedly a limiting factor in this survey phase. However, to keep the influences low, a period was chosen as the survey phase in which infection figures were flattened (July to August) and Corona could be kept low as an obstacle to possible question responses. On the other hand, this phase coincided with the general vacation season. Although in the course of sending out the electronic questionnaires the greatest care was taken regarding the correctness of the mail addresses - the addresses were provided by association organizations from both care sectors - isolated error messages suggest that there was nevertheless a fluctuation in management positions. In addition, in one federal state (Lower Austria) there was a restriction that persons in public health care in management positions may only be interviewed with the express consent of the state health care agency. For organizational reasons, it was therefore not possible to interview the managers of this federal state. The evaluation of the data as a whole was carried out according to emphatically scientific criteria by means of a software-supported data analysis.

To represent a complementary spectrum of opinions and to capture different perspectives of proven experts, opinions from different relevant areas of the Austrian health care system were collected in addition to the quantitative survey. From health care planning, the strategic view of important health care institutions, from the field of health economics, from established health

care consulting, from association organizations at the level of health care institutions as well as at the level of professional groups, and finally also from the perspective of patients by interviewing representatives of self-help organizations. Ultimately, this represents a deliberate preselection, but this selection was made carefully, and care was taken to ensure a multi-perspective view of all relevant target groups. Following the categories of the quantitative survey, the qualitative part of the survey also focused on aspects of integrated health care and its effectiveness, and in particular on the culture of multi-professional cooperation and ways and means of achieving a common cultural understanding, and ultimately also on the importance of leadership in the interprofessional context. Admittedly, only a limited mix of perspectives, but nevertheless of decisive importance.

5. RESULTS AND FINDINGS

In the previous chapters, the problem context relevant to the research topic of the present work was concretized by means of an extensive theoretical analysis. At the beginning of the work, the research question is asked (see point 2.1) how a controllable value management system can be sustainable within the framework of integrated care, which serves to create and maintain conducive framework conditions for interorganizational, interprofessional cooperation, which is ultimately expressed in the optimization of care paths. After thorough research and processing of the relevant specialist literature on the subject, well-founded hypotheses were derived, which are checked using empirical data using statistical test procedures. This was completed by an ongoing discourse using qualitative data from an equally extensive expert survey.

5.1 Results of the quantitative research

The comparison of the sample composed of hospital directors with the sample of nursing home directors shows a significantly higher proportion of over 50-year-olds among hospital directors. Two thirds of the hospital directors had an age of over 50. About 80 % of the nursing home directors were younger or equal to 50 years of age. In terms of educational levels, two thirds of the hospital directors and about half of the nursing home directors have a diploma or master's degree. Only individual participants also have a doctorate degree. About two-thirds of participants per sample are from public health care providers. Five hospitals and four nursing homes were denominational owned, the others privately owned.

Half of the survey participants from hospitals have a nursing background, half an administration or management background. In nursing homes, the proportion of managers coming from nursing professions was about two-thirds, and one-third came from the administrative sector. The expertise of the medical experts was asked exclusively in the course of the qualitative survey. On the one hand, physicians in the field of intramural care are not so involved in the organization of institutional transfer of patients to the same extent as nursing or administrative managers, and on the other hand, nursing home managers usually come from the field of nursing or administrations. When asked about management experience, the proportion of members from hospitals predominates. Of the hospital board members, only five have less than five years of management experience, compared with ten of the home directors.

The aspects how interprofessional collaboration is currently taking place in the health care institutions as well as between the institutions, also across sectors (H_1), showed no statistically significant differences between the samples (p is 0.643, i.e., greater than 0.05). Some open questions specifically related to interface management were aimed on the one hand at naming areas whose interfaces need to be improved, and on the other hand at proposing concrete measures to improve them. The evaluation of the content of these questions is included in the summarized presentation of results (see point 4.3.2). When asked whether the Covid-19 phase, in which increased collaboration between professional groups as well as between care institutions took place, would lead to a lasting improvement in collaboration, an almost uniformly optimistic picture emerged. The question as to whether a sustainable improvement in coordination, cooperation and communication within one's own institution could be expected, was answered rather in the affirmative. Regarding the feasibility of implementing best points of service in the Austrian health care system, the picture is close but nevertheless clear (test result: p is 0.08, i.e., slightly greater than 0.05). Accordingly, no statistically significant differences were detected between the two areas of care (H_2).

The aspect culture of togetherness and its influence on inter-institutional and cross-sectoral cooperation. The current culture in cross-sectoral and interprofessional cooperation in the Austrian health care system also was investigated (H_3). The results show no statistically significant differences between the two health care settings (p is 0.720 respectively 0.277, in both cases greater than 0.05). The results of the influence potential of the organizational culture showed also no significant differences between the two groups. Most participants affirmed positive effects emanating from a lived organizational culture and appreciative cooperation. Almost all participants see an optimization of resources through good cooperation. The group comparison shows no statistically significant differences to it (p is 0.683, i.e., greater than 0.05). Also aspects about possible savings potential through improved framework conditions, measured in terms of their daily working time, showed no significant differences between the two samples (p is 0.134, i.e., greater than 0.05). The estimation of the savings potential was possible in a range of 0 to 30%. Finally, nursing home managers have shown a marginally higher degree (H_4).

When asked whether different occupational groups bring different leadership expectations with them (H_5), the result shows a statistically highly significant difference between hospital board members and nursing home directors (p is 0.008, or less than 0.05). However, responses from those over 40 showed no difference between generations (p is 0.205, i.e., greater than 0.05).

The responses on the need for interprofessionality in the education and training of health professionals, especially on the aspect of whether a common basic module for all health care professions would be conducive to interprofessional collaboration in health care practice, the result shows no significant difference between hospital directors and nursing home directors (p is 0.339, i.e., greater than 0.05). The aspect about differences in the mindset of future generations relates to the associated changes in leadership expectations, i.e., whether a new understanding of leadership will be necessary (H_6). There was no significant difference between hospital board members and nursing home directors (p is 0.930, greater than 0.05). Also, the aspect related to co-responsibility of upstream and downstream care settings revealed no significant differences in views between the two samples (p is 0.971, greater than 0.05). An open-ended question on this, is included in the content analysis of the results section of the paper (see also point 4.3.2).

Different results emerge regarding the performance of mission statements. The results of the aspects "Ethical basic attitude must be an integral part of the leadership and management function" and "Ethics is not a contradiction to economics" show no significant differences between hospital members and nursing home members (p is 0.517, i.e., greater than 0.05). In the second part, "Mission statements touch one's attitude and provide orientation for everyday life", "Mission statements promote interprofessional cooperation" and "If you can't measure it, you can't manage it", there are significant differences in the views of the two samples ($p = 0.006$, i.e., less than 0.05). The testing has shown that nursing home managers' confidence in the performance and importance of mission statements is significantly higher than that of hospital managers (H_7). When asked about the functionality of mission statements (H_8), there were almost no statistically significant differences ($p = 0.068$, i.e., greater than 0.05).

Regarding the influence of cultural work (H_9), the sum result showed no statistical difference between the two samples ($p = 0.376$, i.e., greater than 0.05). The result is composed the following statements: "Culture of togetherness is just as strategically important in health care institutions as in cross-institutional and cross-sectoral collaboration"; "Management level must ensure that employees understand and identify with value concepts"; "Good organizational culture requires the creation of framework conditions that are conducive to an attitude of entitlement" and "The goal of value work is in particular to make required values tangible for employees and patients, also at the interfaces in the course of transition."

In terms of confidence in the impact of integrated HC on patients, the summary result of responses was related to several aspects, such as "patient orientation," "clear responsibilities,"

"waiting and treatment times," "transparency and information flow," "quality of the care process," "stress reduction," and "shared responsibility of all stakeholders" (H_{10}). It has been shown that there are no significant differences between the two samples (p= 0.058, i.e., greater than 0.05). Last but not least, the question whether responsibilities and competences between intramural and extramural care areas are by and large already clearly and sufficiently defined shows no significant differences. The distribution of responses to these aspects also shows no significant differences between the two samples.

hypotheses	Hypothesis Testing Results	significance level α = 0.05	
Hypothesis H_1	**Interprofessional cooperation** There is a difference between HOs and NHs regarding the view of interprofessional collaboration.	**rejected** result of the significance test	asymp. sig. (2-sided) p = 0.643
Hypothesis H_2	**Best point of service** From the organizational point of view of HOs, the realization of BPoSs is evaluated significantly higher than from the point of view of NHs.	**rejected** result of the significance test	asymp. sig. (2-sided) p = 0.08
Hypothesis H_3	**Culture of togetherness** In highly developed socio-technical systems like HOs, the culture of togetherness is more highly assessed than in NHs.	**rejected** result of the significance test	asymp. sig. (2-sided) p = 0.720
Hypothesis H_4	**Optimizing potential through cooperation** In highly developed socio-technical systems like HOs, the assessment of savings (optimization) potential is significantly lower than the assessment in long-term care, as NHs.	**rejected** result of the significance test	asymp. sig. (2-sided) p = 0.134
Hypothesis H_5	**Different leadership approaches** There is a difference between HOs and NHs regarding the view that different health professions need different leadership approaches.	**accepted** result of the significance test	asymp. sig. (2-sided) p = 0.008
Hypothesis H_6	**Different mindsets** There is a difference in the view of HOs and NHs that upcoming generations have changed leadership expectations due to a different mindset.	**rejected** result of the significance test	asymp. sig. (2-sided) p = 0.930
Hypothesis H_7	**Mission statements performance** There is a difference between HOs and NHs regarding the view of the importance of mission statements for the organization.	**accepted** result of the significance test	asymp. sig. (2-sided) p = 0.006
Hypothesis H_8	**Mission statements' functionality** There is a difference regarding trust in guiding principles between HOs and NHs in general.	**rejected** result of the significance test	asymp. sig. (2-sided) p = 0.068
Hypothesis H_9	**Impact of cultural work** There is a difference regarding the importance of cultural work between HOs and NHs in general.	**rejected** result of the significance test	asymp. sig. (2-sided) p = 0.376
Hypothesis H_{10}	**Confidence in the effects of integrated HC** There is a difference regarding the confidence in the effects of integrated HC on patients between HOs and NHs.	**rejected** result of the significance test	asymp. sig. (2-sided) p = 0.058

Table 35 Hypothesis testing results summarized

5.2 RESULTS OF THE QUALITATIVE RESEARCH

In addition to the statistical analysis, the qualitative survey is based on written interviews with 16 experts who have extensive expertise in the Austrian health care system as well as in international comparison. The content analysis of the survey results was carried out in five categories, each of which is subdivided into three subcategories. The main categories are "Integrated Health Care", "Culture of Togetherness", "Leadership in interprofessional Context", "Common cultural Understanding" and "Impact of integrated Health care". The content analysis is supplemented by the evaluation of open questions posed to hospital board members and nursing home management as part of the quantitative survey (see point 4.3.2). The open questions refer to aspects such as 'problematic interfaces' as well as 'critical points at interfaces', 'concrete measures for their optimization', 'prerequisites for interface optimization', 'contribution possibilities of the individual actors' in the health care system, 'own possibilities to contribute' to system optimization as well as the 'topicality of manage-ment' approaches to cope with current challenges.

Integrated health care. *'Interprofessional Cooperation':* With the exception of one person, the majority of experts described collaboration between the various professional groups as "basically or relatively good" with three responses, and as "mediocre" and "in need of improvement" with more than ten responses. However, major differences in the supply landscape were also noted. Insufficient framework conditions and unclear responsibilities were cited as reasons. Quite a few, namely nine experts, see the current culture of cooperation as a critical success factor. It was also noted that patients are often not involved in decisions. *'Interface management':* specific interface areas were also named as "in need of improvement" in interprofessional collaboration: between hospitals and nursing homes, generally to aftercare facilities, between nursing homes and mobile services, between primary care physicians and primary care centers, primary care physicians and pharmacies, and pharmacies and hospitals, and between primary care physicians and specialists, toward palliative care facilities. A mixture of personal acquaintance and institutionalized cooperation was mentioned as a prerequisite for successful cooperation, and simple and good technical equipment proved to be advantageous. A regular and continuous exchange between the heads of the health care facilities in the care region was suggested several times, by more than one third. Occasionally, the different financing of the facilities and care areas was seen as an obstacle and an overall view of the financing, control and legal framework was called for. Instead, the care process should be financed and managed according to need, and patient-centered design and integration of care should be made possible. Patients

should be viewed as an equal group within the care delivery system. *'Covid impact':* Experts disagreed on whether the direct and open exchange between professional groups that took place in the course of Covid-19 had a lasting impact. About half of the experts confirmed the trend toward improved collaboration, but were unwilling to make predictions about sustainability. Others expressed pessimism, including the expert from the Patient Self-Help Association. In isolated cases, a deterioration between acute care and nursing was also perceived. Around a third of the experts see the existing restrictive framework conditions and the current culture of cooperation as a hurdle to sustainable improvements.

When asked at which interfaces of the health care system there was a need for optimization, the hospital and nursing home directors named interfaces of all kinds. In addition to deficits in interprofessional cooperation, there was also a need for improvement in the structural area, such as "telemedical care that has long been necessary" or "home visits by specialists". As critical points at interfaces, both hospital boards and nursing home management mentioned the importance of "cooperation, coordination & communication" as well as "cultural work", especially regarding the "patient orientation". Regarding the "best point of service", "individual therapy goals" as well as "structural professional communication" were increasingly mentioned. Also "knowledge update" and "getting to know the respective other care areas", were considered essential. Cross-sectoral exchange platforms" and "regular interprofessional meetings" were also mentioned. Nursing home managers particularly pointed out optimizations in the "discharge management" of hospitals as well as the necessary "integration of nursing care into the electronic patient file". In general, a better coordination of the care areas as well as a joint overall control and financing is loudly called for. Hospital boards and nursing home managers also demand "clear interfaces", "clear assignment of roles", "information security" as well as "flawless process design" and "multi-professional documentation systems". Appreciative interaction" and "communication at eye level" are also important as normative requirements. All in all, the answers of the hospital and nursing home managers reflect the statements of the experts from the qualitative survey.

Culture of Togetherness. *'Culture of Togetherness':* Regarding the importance of a culture of collaboration, there was almost unanimous agreement that improved interprofessional collaboration would be desirable. Here, too, unfavorable framework conditions were cited as hurdles. In addition, it was repeatedly pointed out that the patient and his or her care needs should indeed be placed at the center. The current culture of collaboration is seen as poorly developed or in the process of development. It was also argued that developing the culture requires carefully

thought-out change management projects. *'Lived organizational culture:'* As concrete measures to make the required culture tangible, the experts believe that framework conditions such as sufficient availability of capacities in all areas are required, but above all awareness and perception of ownership for a culture of solidarity and togetherness. Accompanying measures such as achieving mutual respect and structures and frameworks that promote behavioral changes toward a culture of togetherness. Measures to promote mutual understanding such as "joint board levels" or "regional conferences" are also mentioned. *'Optimizing potential through cooperation':* There was unanimity on the question of whether a lived organizational culture would lead to better coordination, especially at interfaces, as well as to good interprofessional cooperation and ultimately to an optimization of resources. A good organizational culture, a "value-oriented management culture" and "managers as role models" are seen as essential prerequisites for sustainable resource optimization. Suitable framework conditions are also cited as favorable prerequisites. In order to establish a kind of "metaculture of interinstitutional cooperation," however, the experts believe that "clear guidelines" and good preparation are needed.

When hospital boards and nursing home managers were asked specifically how "interprofessional cooperation in integrated care" could be improved, what stood out most in the nursing homes was the emphasis on "appreciative interaction": "politeness", "meeting at eye level", "being able to listen well" and "showing interest and understanding for the other person" were mentioned. Goal orientation" as well as "motivation and "empowerment of staff" were also found in the comments. In the area of hospitals, "appreciative and understanding interaction", "honest commitment to the patients" as well as "promotion of cooperation on a human-collegial level" were probably mentioned, but also management-oriented contributions such as: "networking in health care", "constructive handling of problems" or "testing each other's limits". Common goals were also emphasized in this group, such as "ensuring optimal care for patients at the interfaces".

Leadership in Interprofessional Context. *'Education and Training':* The proposal for a common basic module in the training of health professionals meets with unanimous approval. One expert calls for this to be extended to all continuing education courses. A paradigm shift is also called for: away from a marriage mindset and toward an appreciative, process-oriented approach to nursing and care that is multi-professional and ultimately more resource-efficient. *'Different Mindset':* a majority also agreed that a change in mindset and behavior of the coming

generations would favor interprofessional collaboration and thus require new management approaches. It was noted that leadership plays a key role in the development of integrated health care in professional activities that future generations will already have different approaches to collaboration and health professionals will always require good coordination in terms of orchestration. In any case, a "trusting working atmosphere" (culture) is required. An inhibiting factor is also seen in the current "profession-specific socialization." An expert working in culture development consulting expressed the opinion that creativity is needed to "reach people holistically." *'Leadership style':* According to the overwhelming opinion of the experts, the shared responsibility of all actors along the care path requires a general rethinking of conventional management and leadership concepts. However, the change will not take place in just a few years. In general, the need for continuous adaptation to the requirements of the times is accepted. According to the experts, new management and leadership concepts should always take into account an improvement of both health professionals and patients. "Culture and value work" form the "basic core of humanistic management." Favorable "steering interventions" are also expected from health policy.

Finally, the hospital boards and nursing home managements were also asked whether the current management model is still up to date. About a quarter of the surveyed hospital boards are in favor of establishing an overall management, partly also in a rotating system of board members. Also, departmental allocations should be made according to management considerations. In the course of this, more attention should be paid to the overall organization and especially to the process. Also, for taking a cross-institutional perspective, "looking at the welfare of patients as well as staff and the region as a whole". "Participation in practice is also called for, with "flat hierarchies" and "strengthening the personal responsibility of staff". The "needs of the younger generation must also be taken into account organizationally" and incentives, such as "salary adjustment", must be created. "The directive structure and the bureaucratic approach of the authorities no longer fit the competence of the health care providers", was also mentioned. Overall, there is a need for "a paradigm shift in terms of management concepts", was objected by the facility managers.

Common cultural Understanding. *'Culture Manageability':* It was unanimously stated that a common understanding of values ("culture of cooperation") can promote interinstitutional, interprofessional cooperation. How a common understanding can be achieved was answered in particular by the expert from the Organization for Humanistic Management: A kind of grounding at the level of values and goals is required in order to be able to "positively influence" cross-

organizational behavior "over a longer period of time, i.e.," visibly and perceptibly. According to other experts, the prerequisite for this is a "corresponding organizational maturity" that is conducive to the "culture of cooperation." Here, too, a "dismantling of hierarchies" in the co-operation between the various health care institutions is considered necessary. Experts from various fields advocate a common understanding of values. Mutual understanding is also seen as a task for society as a whole: "In training", or much earlier, "already in school", must be started in order to achieve "a 'culture of equal togetherness'". *'Performance of Mission Statements':* Regarding the common guiding values and the development of a guiding culture, the vast majority of experts were in favor, especially since this "can contribute to a uniform goal orientation and thus also support interprofessional cooperation." The expert on humanistic management advocates a holistic approach: "culture work in a systemic sense." In his view, values "are not primarily static, but develop dynamically and assert themselves when they are recognized as conducive." This favors "an orientation toward common goals, which is indispensable in integrated care." Other experts once again see an adjustment of structures and framework conditions as a prerequisite. There is also the "danger that a pseudo-culture will emerge" that is "not lived but smiled at." Another expert argues for the establishment of a "kind of metaculture of interinstitutional cooperation" that must harmonize with the respective "organizational cultures." An expert experienced in cultural work sees positive impulses in the development of a value-based culture: "Individuals are challenged in their function as human beings. Work acquires a meaning that is experienced, and a joy of life is created and the patients feel it as human beings," and further: "The motivation of all those praying increases, which ultimately also pays off economically and a high workload can be more easily managed. He sees a danger when "expectations are raised but cannot be met." The management should give the cultural work the "necessary importance" and enable the establishment of a structure that "can keep the cultural work going." Ultimately, "patients feel more comfortable" and "healing processes produce faster results." *'Functionality of Mission Statements'*: how an understanding of values in integrated care can promote interprofessional collaboration across institutional boundaries and how it can be managed effectively also depends on "institutionalized communication" and "shared goals," according to the experts. The expert from humanistic management sees above all "applied ethics, at the macro, meso and micro levels" as well as "strategic coordination of all measures" and "culture-building processes" as essential prerequisites for this to be "steered" by shared visions "and accompanying" established management systems. Once again, the importance of involving health policymakers and regional health authorities is emphasized, who should "demand and promote dialogue" to "identify needs and align structures accordingly."

Individual experts also call again for the adaptation of the framework conditions: "As soon as it leaves the level of individual initiatives, the incentives of the completely fragmented system become effective" and regarding the "implementation of models" clearly structured programs with goals and measures are to be realized "as well as" an ongoing evaluation" are required. The "involvement of patients" is also called for again. According to the experts, this is the only way to "steer cooperation".

In answering the open questions in the quantitative survey, both hospital boards and nursing home managers make clear the importance of a common culture in dealing with each other. Statements by hospital boards referred e.g. to "raising awareness of the issue of cooperation" or emphasizing the "common mission in health care". Nursing home directors spoke of "appreciative communication towards nursing staff from long-term care by nursing staff and doctors from acute care" or of "mutual understanding and consideration". "Cooperation, coordination, communication" became elementary terms of togetherness in the statements of both management groups.

Impact of integrated Health care. *'Transferability of Integrated Health Care Models':* More than a third of the experts agree with considerations based on model regions such as the "Healthy Kinzigtal," but others are skeptical, primarily because of the high costs of adaptation. Experts from Austrian health planning see this model region as a "health sociology experiment steered by health economic incentives to achieve targeted coordination between care areas within the region." These experts argue that "coordination between care sectors" is already anchored in both "health plans" and "target management health" in Austria, and that Austria and Germany have different health care systems that would require several adjustments. *'Interface optimization of Integrated Health Care':* This category was primarily concerned with the framework conditions for successful interprofessional collaboration. As a structural measure, "regional health conferences" were again suggested by the experts from health planning, in which "common goals are defined" and "a regular exchange between the relevant service providers in the region" can take place. In addition, several experts called for greater use of digital capabilities, such as the creation of a "digital platform for open data exchange." "More transparency in processes" and "greater patient involvement" in care processes are also called for. "Financing the overall outcome" was also called for, as were "clear responsibilities." Once again, the "upgrading of all health professionals, especially nursing" is called for, so that an "encounter at eye level" is possible. An expert from the field of health economics also addresses one of the biggest

legal hurdles in health care, the "distribution of competencies in the Austrian federal constitution." But the "needs-based distribution of problem-oriented resources" is also objected to. From the patient's point of view, the representative of the patients' association again pleads for an improvement of personal communication and states that "confidence-building measures are indispensable." *'Influence of the individual on the Integration of Health Care':* When asked about the personal contribution to improving the health care system, one expert sees this in the improvement of "interface management", others in "consulting activities", in "participation in improvement projects" or in the "role model function in daily work". Experts who work in associations see their work in "raising awareness" or "promoting equal cooperation." Others see their contribution in "awakening understanding for the essentials" or "improving digital interfaces." Quite a few experts see their role as "demonstrating the importance of integrated care" or constantly "taking patient orientation into account." The expert, who comes from the field of cultural work, refers to anchoring the aspiration culture in the organizations: "Becoming aware of one's own values, keeping them alive and cultivating the sources of these values."

The question about "one's own contribution to the integration of care" in the context of the open questions was answered in a very diverse way, especially by the representatives of the hospitals, and enriched with numerous suggestions. In addition to "appreciation, respect and understanding" and "exemplifying values", "being a role model" and "maintaining personal dialogue" were also mentioned. Also the creation of framework conditions ("demand permanent adaptation of framework conditions", "especially framework conditions for cooperation") or networking, supplemented by "regular cross-sectoral meetings at management level" etc. were mentioned. Similarly on the part of the nursing home managers: In addition to "exemplifying appreciation and respect" and "value-oriented action", the "creation/negotiation of framework conditions" was also mentioned. Networking and "regular management meetings" was also a topic. What is striking about nursing home management compared to hospital management is the emphasis on joint action. Overall, the mentions of the "own contribution of the interviewee" hardly differed from the demands of the other group. The demands mentioned also did not differ from the contributions of the experts from the qualitative interviews.

5.3 Overall result of the quantitative and qualitative research

Interprofessional collaboration in the Austrian health care system is seen as in need of improvement both by health policy decision-making bodies and by proven experts in the health care system and managers of health care facilities. Patients are generally not or insufficiently involved in decisions, both regarding their own therapies and the implementation of structural optimization measures. Inadequate legal and administrative frameworks pose hurdles, as do unclear responsibilities. The distribution of competencies in the Austrian federal constitution is seen as one of the biggest legal barriers in the Austrian health care system. However, the culture of cooperation is also becoming a critical success factor: cooperation, coordination and communication as well as "culture work" are gaining importance. There is consensus that a living organizational culture would lead to better coordination of care pathways overall and ultimately to optimization of care resources. In addition to direct personal contacts, communication technologies as well as documentation systems across professional groups are seen as prerequisites for successful collaboration, especially in intersectoral cooperation. Furthermore, a regular and continuous regional exchange between the management of the health care facilities as well as overarching financing concepts and demand-oriented management are called for. The concept of "best point of service" is becoming increasingly important. In addition to better networking in health care, a constructive approach to challenges and problems is required. Existing institutions, such as discharge management in hospitals, are to be subjected to a continuous improvement process. Interprofessional collaboration is to be promoted through a joint basic module right at the start of training. The mentality and behavior of future generations is seen as favoring this and requires a rethinking of leadership and management approaches. Co-responsibility of the entire care paths by all facility managers becomes a prerequisite, participation becomes the word of the future. Change cannot be achieved in a few years. In general, however, the need for continuous adaptation to the requirements of the times is recognized. Leadership by example becomes a requirement. Direct structures and bureaucratic approaches are increasingly seen as inappropriate. Flat hierarchies and personal responsibility are gaining in importance. Overarching and regional control is expected from health policy. Dialogue is to be promoted by involving health policy makers and regional health authorities, needs are to be identified and structures are to be aligned accordingly. "Culture and value work" will become the basis of humanistic management in health care. However, common basic understanding in integrated care requires a certain grounding at the level of values and goals. Not least in order to be able to influence

cross-organizational behavior over longer periods of time. A prerequisite for this is organizational maturity, which is conducive to a culture of collaboration. Regarding the common guiding values and the development of a guiding culture, holistic systemic approaches as well as uniform goal orientations are required, especially since values are not static phenomena but develop dynamically and only prevail if they are recognized as conducive. In addition, the emergence of a guiding culture of interinstitutional cooperation requires adjustments to structures and framework conditions. A culture that can ultimately serve as the basis for quality-oriented, cooperatively networked, efficient health care that is as effective as it is targeted.

The findings can also be supported by international comparisons, such as the work of Shaw et al. (2011). With reference to the British National Health Service (NHS), the team of authors led by medical sociologist Sara Shaw illustrates the different interests and perspectives of the various actors in the British health care system. The main stakeholders whose perspectives need to be taken into account when setting up and maintaining integrated care were examined. According to the findings of this thesis, different, partly overlapping approaches of relevant actors require the creation of spaces in which, on the one hand, the different interests are reflected and, on the other hand, a joint development for the targeted orientation of health care to the needs of the respective time becomes possible. In addition to the perspective of the affected persons themselves, the patients, Shaw et al. (2011) see the health care providers, whose task ultimately consists in the coordination of services across professional, organizational and system boundaries, health professionals in the client-oriented area, who care for patients and also stand by them quasi as advocates, policy-makers, who are committed to the design of integration-friendly policies and whose task it is to ensure suitable framework conditions, financing models, care pathways and quality standards as well as to contribute to holistic evaluation models for integrated care. Regional and supra-regional health administrations, which act as supervisors and, on the other hand, as evaluators for valid measurements of the integration of care services. Last but not least, managers are also mentioned, who serve to build and maintain a common culture and shared values, and are responsible for the deployment of resources, management of funding streams, coordination of objectives, supervision of different staff and management of organizational structures.

5.4 Overall result summarized

The coordination of care areas in the Austrian health care system is generally in need of improvement. Inadequate framework conditions need to be reconsidered. Increased interorganizational cooperation, coordination and communication are gaining importance at both the technical and personal levels. Improved coordination would ultimately also lead to resource optimization. Networking is the order of the day, and patient-centered care that meets needs as closely as possible through best points of service is the goal. Interprofessional collaboration is becoming increasingly important. According to survey data, the cooperation of the various health professionals should already be practiced in training, and management concepts should be reconsidered regarding contemporary requirements and the changed behavior patterns of future generations. In their overall view, responsible, visionary managers are needed just as much as socially competent health managers. "Culture work" to serve as the basis for a guiding culture based on humanistic management concepts, both within and between the health care sectors. Proven integrated health care models must be considered regarding benefit aspects for the respective care region as well as regarding the adaptation efforts. Integration of care has long since found its way into all Austrian health plans. - It (still) needs doing.

6. NEW SCIENTIFIC STATEMENT (THESIS)

At the end of this paper, the research question underlying the thesis (see also point 2.1) is answered, followed by the scientific added value for health services research as well as the added value for health services practice and education.

6.1 ANSWERING THE RESEARCH QUESTION

The main research question of the thesis addresses the implementation and maintenance of a shared culture in integrated care, how integrated care management can be lived based on sound values. The sub-research questions relate to the controllability, management of values-based organizational cultures, and their influence on interprofessional collaboration in health care.

To bring about a contemporary adaptation of the Austrian health care system, it is necessary to adapt both the framework conditions (circumstances) and behavioral aspects, especially a broad consensus on the cooperation of all participants. The present work can only shed light on one, albeit significant, area, the interprofessional cooperation of health care providers - interprofessional cooperation is expected at all levels of health care. It is important to include all actors as well as all stakeholders. It is essential: to make the participants (all those active in health care as well as relevant stakeholders) into affected parties and the affected parties (patients, service users, etc.) into participants.

The legal and administrative framework as well as the in many places unclear distribution of roles must be clarified. The often-cited division of competencies in the Austrian Federal Constitution will not be eliminated so quickly, especially since this would require a qualified parliamentary majority (increased quorums) and should therefore be seen as the basis for further decisions. However, improving cooperation, coordination, and communication, especially at the interfaces, is essential. The fact that this also entails the optimization of resources was clear to almost all respondents in the surveys. Of course, the digital tools that are already technologically available but far too little used must also be put to extensive use, such as documentation that can be used by all health professionals and is available in all areas of care, or possibilities for telemedical consultations. All in view of the central criterion, an increase in the quality of care through the realization of best points of services.

From the theoretical analysis of the thesis and in all the interviews it emerged that health care should be considered from a regional point of view and managed accordingly. The experts from health planning rightly claim that this demand has long been included in the health goals and all health plans. Day-to-day work, as is evident in practice, usually requires better coordination, even within the facilities themselves. The worlds of the various professional groups, the cultures of the various care facilities and the interests of the various service providers are still too different. Even within one and the same professional group, different views prevail. Physicians in private practice themselves often see the distribution of tasks between specialists, hospital physicians and their own area as unclear. Accordingly, there is a lack of mutual understanding, both on a personal and professional level, not only between the various health professionals, but also within their own discipline. Culture as a link in social coexistence is therefore also becoming increasingly important in professional interaction. It is indispensable that values that are claimed jointly are also made visible, i.e., can be experienced by all those involved. Ideally, of course, this should begin at the societal level. For the health care system, according to prevailing opinions in literature and surveys, multidisciplinary cooperation should begin at the beginning of training, in a common basic module.

Networking is becoming the order of the day. This requires visionary leadership and contemporary management. Guiding values not only anchored in mission statements, but as a culture that can be experienced throughout. Always aware of who the health care system is there for. Always focusing on the patient with his or her individual care needs along the entire care path and his or her personal expectations. The leader as coach and enabler of multi-professional, cross-sector collaboration. Health policy and health administration in recognition of current needs, creating favorable conditions for health care. How can a guiding culture for inter-institutional collaboration be created and maintained in order to overcome the usually noticeable discrepancy between aspiration and reality? By getting to know each other on a personal and professional level. Not only in professional meetings. By incorporating patient perspectives as a central element in all areas of professional education, training, and continuing education, as well as in all health care practice. By establishing structures for culture work that enable comprehensive change toward a guiding or target culture and ensure the effective and efficient maintenance of normative values within organizations and across sectors. To ensure controllability, a congruent and truthful presentation of the required values is necessary both internally and externally. In addition to executives, who are to act as role models for values-based behavior, representatives of health care facilities are needed who are responsible for maintaining values work and are located either in the human resources department or, as in the best practice in

Vincent Group facilities presented in the literature section of the paper, at board level. The task of these representatives is to consider measures that will be incorporated into all organizational areas of health care facilities and into continuing education and training concepts. To maintain a guiding culture that also has an effect at the interfaces and across sectors, it is necessary to control the implementation of culture-related goals not only within the organization, but also to establish cross-organizational or supraregional control mechanisms. Both the boards of the health care facilities and the experts repeatedly suggested regional coordination conferences of managers from the various sectors in the survey. Measures to promote mutual understanding, especially among the various professional groups, were also called for. The institutionalization of regional conferences would offer the opportunity to cultivate both professional and personal and, in particular, value-related exchange. In addition to the usual satisfaction measurements of patients and health professionals, outcome measurements of integrated care pathways and, in particular, the degree to which needs are met in terms of best points of service can serve as measurement methods for controlling value-related goals. Linking satisfaction measurements with outcome measurements both at the level of medical care and in terms of the cost-effectiveness of comparable facilities enables benchmarking that could meet the highest standards of humanistic management.

Health policy makers are increasingly expected to manage health care across organizations as well as regions. This also requires the increased involvement of regional health politicians as well as those responsible for health in the administrative authorities in strategic events. The success of regional health care management that is in line with demand and needs and meets health policy objectives therefore requires a common basic understanding of integrated health care and the common cultural values on which it is based.

6.2 Scientific added value for health services research

To make integrated care possible, there is a need for improved interprofessional and, above all, interinstitutional cooperation, more efficient communication between service providers, patient-centered care and overall coordination of the care system, especially regarding the regional health care needs, as well as stakeholder management that meets high standards, makes use of the experiential knowledge of patients, especially the chronically ill, and increasingly involves political decision-makers in the needs and requirements of the care regions.

The scientific added value of this thesis is the realization that no new instruments need to be found for a contemporary adaptation of health care systems, but that existing and proven instruments can be used. Also, it is basically nothing new that leadership concepts are needed that are not so much imposed but are in harmony with the people and their tasks to be fulfilled in a contemporary manner. As can be seen from the interviews, there is both awareness of what can be considered coherent and knowledge of how to apply the knowledge. However, structures that have usually evolved both within the organization and at the interfaces also often no longer fit the tasks. The constraints of these realities, as well as the compensatory work that must be done, consume resources that would be better invested elsewhere in the delivery system. Mission statements would also be exhaustively available. What is mostly lacking is implementation. It is a fact that more is needed than just formulating intentions. This is also evident from the demands of the survey participants. In addition, framework conditions are usually outdated and do not allow for developments, even if they have become conscious. The reason for this is often the overly pragmatic approach of decision-makers in health policy and administration. It is important to turn those participants (including those in the surrounding areas) into affected and those affected (e.g. as patient representatives) into participants. This requires "spaces" in which developments can take place, as well as greater involvement of everyone in structural adaptations and, in particular, in process optimization – also intersectoral.

Regarding the culture as an important link in care, Amelung, Chase & Reichert (2017) agree that high-quality health care requires the creation of a common understanding, a "collective consciousness". This is also consistent with the results of this thesis. They speak of "professional culture", which is expressed through teamwork and subsequently through communication skills and transparency in action. The authors also advocate effective leadership and management, which is needed in a more complex and demanding health system. Amelung, Chase & Reichert (2017) refer to the "post-heroic leadership model" postulated by business psychologist Kim Turnbull James (2011), which includes multiple actors with leadership roles who work together across organizations and professional boundaries. Post-heroic leadership understanding is not only aimed at leadership behavior in the narrower sense, but stands for organizational interventions, especially as it is equally relevant in cross-sectoral health care (Amelung, Chase & Reichert, 2017). The psychologist and systemic organizational consultant Marion Schenk (2020) sees in post-heroic leadership the possibility of increased involvement and co-responsibility of the led. In post-heroic leadership, problem-solving competence lies in the organization as a whole and is in constant exchange with it and its environments. All those involved in and

with the organization are given co-responsibility, which is a requirement especially in integrated care models.

The more in-depth study of integrated health care shows that more attention needs to be paid to the topic, especially in applied research. The present work offers good follow-up opportunities for further research. In particular, the question of common understanding, the creation of common cultures within and between institutions, needs appropriate answers for science and practice. Hierarchies also need to be questioned and the initiation of a post-heroic era considered. This requires research at all levels of health care. The work can make a comprehensive contribution to this and offers a number of starting points for further scientific discourse. - The focus should always be on the people who are actually at stake, the patients who entrust themselves to health care systems and rightly trust in well-coordinated health care.

6.3 Added value for health care practice and education

The added value for practice as well as the added value for education can be derived directly from the research findings. Especially since it is also a finding of this work that the gap between scientific findings and lived practice is usually irresponsibly large and should be closed quickly, not least for reasons of the resource scarcity argument that is repeatedly cited in health care practice. Considerations regarding the proven health care models could also have been made in a more in-depth manner long ago. For example, there is no real obstacle to thinking about joint training concepts for health professionals on a multi-professional basis or to involving representatives of self-help groups, who generally have a great deal of knowledge of the system and experience, in health care planning or structural optimization. Similarly, it would not be out of bounds to establish regional conferences and invite responsible persons from the regional health care sectors. Does it take competence building among decision-makers in health policy or in administrations? Does it need courage? In any case, it takes a certain amount of seriousness to want to tackle things that have been known for a long time, as well as fewer "barriers" and more "enabling thinking." After all, the time spent just talking about it, especially when it is many a project that has been recognized as beneficial and the discussion about it has already dragged on for many years, even decades, consumes resources. - Here, too, a more demanding culture in the performance of tasks would have a beneficial effect.

Finally, a condensed presentation of both problem aspects and solution approaches that serve the realization of integrated care paths and, in particular, an improvement of interprofessional cooperation in health care practice, will be presented in a compact manner.

(1) **Interprofessional collaboration** in need of improvement
- Already included in health policy objectives
- Need for improvement recognized by experts and managers
- Intra- and inter-organizational process design deficient

(2) **Patient participation** inadequate
- Too little involved in therapy decisions
- Patient needs largely disregarded
- Usually uninvolved in structural optimizations

(3) **Framework conditions** outdated
- Change of competence in B-VG unrealistic
- Lack of role clarity
- Transparent organization and processes

(4) Meeting of **different worlds**
- Common understanding as critical success factor
- Cooperation, coordination & communication as key skills
- Multi-professional training paths (such as common basic module)

(5) **"Cultural work"** gains importance
- Establishment of a consensual guiding culture
- Improved coordination of care pathways through lived organizational culture
- Optimization of resources through linking of meaningful tasks

(6) **Socio-technical system** design
- Personal and technology-supported communication (such as telemedicine)
- Documentation systems across occupational groups
- Team composition according to socio-technical aspects

(7) **Demand-oriented health care** management
- Cross-sectoral financing concepts
- Intersectoral exchange relationships (especially at management level)
- Regional care coordination and control

(8) **"Best point of service"** as a supply claim
- Transparency in networking structures
- Co-responsible transition management
- Establishment of a supply controlling system

(9) Contemporary **understanding of leadership**

- Participative post-heroic leadership approach
- Gate-opening instead of gatekeeping
- Manager as culture-forming role model

(10) **Integrated health care** management

- Support and co-responsibility of the integrative care process
- Creation of framework conditions conducive to care
- Promotion of multi-professional cooperation regarding health care goals

The final presentation is intended to illustrate both, recommendations for health care practice as well as conditions for the successful optimization of interprofessional collaboration in integrated health care (see table 36).

Conditions for Implementation	
Improvement potentials	full implementation of existing health targets
	increased use of practical experience
	efficient process design
Involvement of patients	strengthening patient competence
	consideration of personal patient needs
	use of structural knowledge of chronically ill patients
General conditions	adaptation of framework conditions
	clear responsibility and distribution of roles
	transparency of intra- and inter-organizational processes
Recommendations for Integrated Health Care Practice	
Different professional worlds	connecting different professional worlds
	cooperation, coordination, communication as key competencies
	multi-professional education and training
Proactive "culture work"	establishing a guiding culture along the care pathway
	realization of a common organizational understanding
	optimization of resources through meaningful task design
Socio-techn. system design	coordination of personal and technology-based communication
	optimization through socio-technical team building
	interprofessional access to documentation systems
Demand orientation	regional overall control of health care
	cross-sectoral financing concepts
	cross-sector exchange relationships
Point of services	transparency in networking structures
	co-responsible health care transition management
	regional cost and outcome controlling
Leadership	participative post-heroic leadership
	gate-opening instead of gatekeeping
	leadership as a culture-building role model
Integrated health care management	shared responsibility of all managers and stakeholders
	promotion of good conditions for integrated care
	promotion of multiprofessional togetherness

Table 36 Findings and Recommendations for Health Care Practice, own illustration

7. CONCLUSION

The importance of integrated care, especially for the chronically ill, is made clear once again in an article on the platform of the online medical publisher MedMedia at the end of November 2021. According to its own description, MedMedia (2021a) sees itself as a platform in constant exchange with leading opinion leaders in the Austrian health care landscape, with the aim of improving communication between the professional community and the demanders of health care services in Austria. According to Statistics Austria (2020), around 2.8 million people aged 15 and older suffer from a permanent illness or chronic health problem, 1.5 million of whom are male and 1.3 million females, according to the "Austrian Health Survey 2019." In addition, according to the Competence Center for Integrated Care (CCIV, 2021) of the Austrian Regional Health Insurance Fund (ÖGK), the proportion of chronically ill people rises sharply with increasing years of life. Integrated care in connection with health care areas such as primary care centers, interface management or disease management programs is becoming increasingly important, according to the common tenor at a symposium of the Competence Center for Integrated Care on the topic of "Lifeworlds of chronically ill people in the area of conflict between health care sectors". Nevertheless, it was objected, one should "refrain from too great expectations". "Cause and history" of the largely fragmented Austrian health care system must be taken into account, says medical organization theorist Peter Berchtold (2021) of the German speaking University of Bern: "It is practically impossible to define 'the' integrated care." According to Berchtold, there are historical as well as factual reasons why many expectations tend to converge, especially regarding efficiency gains. In his view, service delivery is "characterized by professionalism and a rigid division of labor." According to Berchtold (2021), the health care system is already "fragmented in its core and principles." Berchtold sees this as the "normal state" of the health care system and a prerequisite for the provision of "highly efficient" services of "the highest quality".

In this thesis, it has been shown that, despite a certain degree of unchangeable fragmentation, there is potential for optimization with a not inconsiderable increase in efficiency and improvement in results. However, as indicated for the added value for care practice (see section 6), the continuous improvement of care pathways and of regional health care systems also requires regional controlling systems, a quasi-thought-out overall target control. To improve the coordination of care services, there is a need for an accompanied transition of services with appropriate target group differentiation, especially at the interfaces: Regina Roller-Wirnsberger

(2021), an expert in geriatrics, especially in the Austrian Platform for Interdisciplinary Issues of Aging (ÖPIA), sees differentiation as inevitable even for chronically ill patients. In general, says Roller-Wirnsberger, it is necessary to distinguish between "chronically ill people with one disease" and "multimorbid people", with both groups requiring different care processes.

So what makes health care providers more successful than others? "The secret to our success can be summed up in seven words from the clinic's founder, Dr. William Mayo, and which everyone who works at the Mayo Clinic still lives by in their daily lives: Patient needs come first," explains Janine Kamath, Head of Systems and Procedures at Mayo Clinic in the USA (Heuer, 2015). Founded in 1864, Mayo Clinic is a health care enterprise consisting of a network of community hospitals and clinics that provide services in the three U.S. states of Iowa, Minnesota, and Wisconsin (Mayo Clinic Health System, 2020). Accordingly, the mission statement of the clinic's founder has survived to this day, a mark of success shared in particular by Austrian religious hospitals ("Meeting the need of the times," Sisters of Mercy (BHS, 2020); "Doing good and doing it well," Brothers of Mercy (BBR, 2020); "Look and act!", Elisabethinen, 2020). Accordingly, the claim to put the needs of the patient first is deeply rooted in the culture and is actually lived. A second statement by Kamath also makes one sit up and take notice: "Medicine is a team effort. There are no stars here, but constellations of professionals who want to work together" (Heuer, 2015), a statement that could also apply as a maxim for action in many Austrian hospitals. The demand for a high level of personal and professional togetherness was clearly expressed in the empirical study of this thesis. Experts from health care institutions and from the environment of the institutions clearly articulated the livability of values and mission statements. It is now up to decision-makers at all levels to make this possible, and to leaders and managers in health care facilities to establish and maintain humanistic management-oriented value management and a common guiding culture in health care facilities according to proven best practices.

What about the tension between patient well-being and economy? The result of a qualitative study in which health economist Naegler & medical-sociologist Wehkamp (2018) managing directors and other doctors ask to what extent economic decisions conflict with patient interests, led to a finding by the authors that can certainly be regarded as ambivalent: "Normative guidelines would protect the doctor and thus prevent him from making patient-related decisions more economical. The more detailed justification of the authors offers some clarification, but they also do not provide any clear guidelines: "It is the lack of normative specifications that are both committed to the professional ethics of the physician and take into account the limited resources

that leads to the economization of patient-related decisions", in which Naegler & Wehkamp (2018) see the necessity of a basic decision in health policy, especially since they consider even hospital managers to be overtaxed with this question. Therefore, it is obvious that the state of tension "patient interests versus economy" cannot be eliminated and that a certain degree of tension will probably remain in all health systems. What health policy can do, however, to take the edge off the "conflict" by taking appropriate measures. Once again, the fact that the gap between the different worlds, there the world of health policy and public health administration, there the world view of the care institutions, requires closing, is confirmed in all studies. There is a need for a common orientation towards those for whom the care system exists, the patients. And increasingly also on public health aspects, to promote joint developments.

Heinz Naegler and Karl-Heinz Wehkamp (2018) provide a brief historical summary of the pronounced patient orientation of the original founders and operators of hospitals in the past. Hospitals at that time were organized purely based on demand. The authors' article talks about "places of mercy." Of course, it is also interesting to note that patient-related decisions were made by physicians alone "exclusively for the benefit of the patients they treated" and that "interests of other parties involved" therefore "did not have to be taken into account". At the same time, it is pointed out that in the meantime "even in facilities organized according to need" such as precisely hospitals, the "principle of economic efficiency must be observed". However, it should not need any more explanation whether ethics is a contradiction to economy. - Also, in the present Thesis in the context of the empirical inquiry the question was asked whether ethics and economics would be a contradiction. Both the literature and health care practice revealed a well-founded demand for "responsible economics" in health care.

Finally, it should be remembered once again that the historically rooted and thus evolved care structures must not only be questioned, but also changed with courage and prudence. Too much friction, especially at the interfaces, both for the service providers and for the patients, ties up energy that could be used more sensibly in the health care systems as well as more beneficially regarding the patients. Integrated care offers state-of-the-art concepts both for the population and specifically related to indications. Interprofessional collaboration across institutions is a sine qua non of integrated care. The results of this work show that, in addition to appropriate health policy frameworks, a common culture of collaboration across institutional and sectoral boundaries is the link or lubricant for well-organized and coordinated care pathways on which to build with quality care services. Strategies based on shared guiding principles, followed by participatory co-ownership by all leaders, managers, and policymakers of well-coordinated care

sectors, are among the most influential factors in the contemporary design of health care delivery systems - and especially in **interprofessional collaboration in integrated health care**.

Best Point of Service
"Curative care at the right time in the right place with optimal medical and nursing quality as cost-effectively to the economy as a whole."

Integrated health care
"Patient-oriented, continuous, cross-sectoral, interdisciplinary and/or multi-professional health care."
(Both according to Article 3 of the Austrian Health Targets Steering Act, according to the Act's definitions.)

It is the patients
"…who are the reason hospitals are operated; it's their reason we work there."
(Eugen Hauke)

8. REFERENCES

Allgemeine Ortskrankenkasse (AOK). (2016). *Gesundheitswesen* (Glossary). Available at: https://aok-bv.de/lexikon/g/index_00369.html [15.05.2020]

Amelung, V., Chase, D., & Reichert, A. (2017). Leadership in Integrated Care. In Volker Amelung, Viktoria Stein, Nicholas Goodwin, Ran Balicer, Ellen Nolte and Esther Suter (Eds.): *Handbook Integrated Care.* Cham: Springer. ISBN: 978-3-31956-101-1. DOI 10.1007/978-3-31956-103-5.

Amelung, V., Stein, V., Goodwin, N., Balicer, R. Nolte, E., & Suter, E. (Eds.). (2017). *Handbook Integrated Care.* Cham: Springer. ISBN: 978-3-31956-101-1. DOI: 10.1007/978-3-31956-103-5.

Armitage, G., Suter, E., Oelke, N., & Adair, C. (2009). Health systems integration: State of the evidence. In *International Journal of Integrated Care* (IJIC), 9(2), 1–11. ISSN: 1568-4156.

Austrian Parliament. (2015). *Question concerning 'Best Point of Service'* (Parliamentary parliamentary question of 05.05.2015). Available at: https://www.parlament.gv.at/PAKT/VHG/XXV/J/J_04905/imfname_408519.pdf [15.05.2020]

Bachner, F., Bobek J., Habimana, K., Ladurner, J., Lepuschutz, L., Ostermann, H., Rainer, L., Schmidt, A. E., Zuba, M., Quentin, W., & Winkelmann, J. (2019). *Das österreichische Gesundheitssystem – Akteure, Daten, Analysen.* European Observatory on Health Systems and Policies. WHO. 20 (3). ISSN: 1817-6127

Barmherzige Brüder (BBR). (2020). *„Gutes tun und es gut tun"* (Brothers of Mercy Leitspruch des Gründers, Johannes von Gott, 1495-1550). Available at: https://www.barmherzige-brueder.at/site/wien/seelsorgehospitalitaet (Website) [15.05.2020]

Barmherzige Schwestern (BHS). (2020). *„Der Not der Zeit begegnen"* (Sisters of Mercy, Leitspruch des Gründers, Vinzenz von Paul, 1581-1660). Available at: https://www.bhswien.at/wir-ueber-uns/das-krankenhaus/unsere-geschichte (Website) [15.05.2020]

Becka, S., Schauppenlehner, M. (2011). *Integrierte Versorgung – Aufbruch zu neuen Wegen* (Short version). Available at: ww.sozialversicherung.at/cdscontent/?contentid=10007.844688&portal=svportal [20.07.2020]

Berchtold, P. (2021). Fragmentierung – warum eigentlich nicht? (Congress contribution). In CCIV (2021). *„Lebenswelten chronisch kranker Menschen im Spannungsfeld der Sektoren"* (online symposium, 24.11.2021).

Bertelsmann Foundation. (2008). *Wertemanagement und Wertschöpfung in Unternehmen: Fallstudien international erfolgreicher Unternehmen.* Gütersloh: Publisher Bertelsmann Foundation. ISBN: 978-3-86793-002-4.

Berwick, D. M., Nolan, Th. W., & Whittington, J. (2008). *The Triple Aim: Care, Health, And Cost. Health Affairs,* Vol. 27 (3), pp. 759-769. Doi.org/10.1377/hlthaff.27.3.759.

Bhavnani, S. P., Narula, J., & Sengupta, P. P. (2016). Mobile technology and the digitization of health care. In *European Heart Journal*, 37 (18), pp. 1428-1438. Available at: https://www.gsma.com/iot/wp-content/uploads/2013/06/Socio-economic_impact-of-mHealth_EU_14062013V2.pdf [10.05.2020]. ISSN: 0195-668X.

Bibliographical Institute. (2020). *„Professionalität“* (Wörterbuch der deutschen Sprache). In Duden – online dictionary. Available at: https://www.duden.de/suchen/dudenonline/Professionalit%C3%A4t [25.05.2020]

Bleicher, K. (1994). *Normatives Management: Politik, Verfassung und Philosophie des Unternehmens.* Frankfurt, New York: Campus. ISBN: 978-3-59335-069-1.

Bleicher, K., Abegglen, C. (2017). *Das Konzept Integriertes Management: Visionen – Missionen – Programme.* Frankfurt am Main: Campus. ISBN: 978-3-59350-599-2.

Bode, D. (2015). Die Bewertung von immateriellen Werten im Krankenhaus. In W. Zapp (Ed.) *Werteorientierte Konzeptionen im Krankenhaus: Analyse – Verfahren – Praxisbeispiele.* Wiesbaden: Springer, pp. 47-107. ISBN: 978-3-65807-837-9.

Bollinger, H., Gerlach, A., & Pfadenhauer, M. (Eds.). *Gesundheitsberufe im Wandel: Soziologische Beobachtungen und Interpretationen.* Frankfurt am Main: Mabuse. ISBN: 978-3-93593-493-5.

Braunecker, C. (2016). *How to do Empirie, how to do SPSS: Eine Gebrauchsanleitung.* Wien: Facultas. ISBN: 978-3-82528-685-9.

Brenzel, G. (2013). „Innere Qualität“ – Herausforderungen aus pflegerischer Perspektive. In *Das Krankenhaus*, 3, pp. 253-256. ISSN: 0340-3602.

Brock, H. (2018). Systemtheorie und organisationale Umsetzung: Ist die zielorientierte Führung von Krankenhäusern überhaupt möglich? In *Qualitas - Zeitschrift für Qualität und Entwicklung in Gesundheitseinrichtungen*. Wien: Schaffler Verlag, pp. 4-9. ISSN: 2224-0055.

Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz (BMASGK). (2019a). *Gesundheitsziele Österreich. Weiter denken. Weiter kommen. – Versorgungsqualität.* Available at: https://gesundheitsziele-oesterreich.at/glossar/ versorgungsqualitaet/ [15.05.2020]

Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz (BMASGK). (2019b). *The Austrian Health Care System Key Facts* (Updated edition 2019). Available at: file:///C:/Users/Peter/Downloads/BMASGK_The-Austrian_Health-Care-System__KeyFacts__WEB.PDF [15.05.2020]

Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz (BMASGK). (2019c). *Gesundheitsberufe in Österreich.* Available at: file:///C:/Users/Peter/Downloads/gesundheitsberufe_2019,_mai_2019%20(1).pdf [15.05.2020]

Bundesministerium für Arbeit, Soziales, Gesundheit und Konsumentenschutz (BMASGK). (Ed.). (2020). *Österreichischer Strukturplan Gesundheit 2017, inklusive Großgeräteplan.* (ÖSG, Stand: 18.12.2020). Wien: BMASGK. ISBN: 978-3-903-09927-2.

Bundesministerium für Digitalisierung und Wirtschaftsstandort (BMDW). (2021). *Internationaler Pakt über wirtschaftliche, soziale und kulturelle Rechte* (UN Sozialpakt, ratified 1978). Available at: ttps://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10000629 [30.06.2021]

Bundesministerium für Gesundheit (BMG). (2014a). *Health Literacy erhöhen – Capacity Building bei Vertreterinnen von Patienten und Konsumenten von Gesundheitsleistungen* (Endbericht). Available at: https://oekuss.at/sites/oekuss.at/files/inline-files/Health%20Literacy%20erhöhen.pdf [20.05.2021]

Bundesministerium für Gesundheit (BMG). (2014b). *Das Team rund um den Hausarzt* (Broschüre). Wien: BMG. n. No.

Bundesministerium für Gesundheit (BMG). (2015). *Austrian National Action Plan for Rare Diseases* (Executive Summary). Available at: http://www.europlanproject.eu/DocumentationAttachment/Austrian%20National%20action%20plan%20for%20rare%20diseases%20(2014-%202018)_Executive%20Summary-%20english%20(en).pdf [03.05.2019]

Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz (BMSGPK). (2020a). *Gesundheitswesen* (Gesundheit.gv.at: Öffentliches Gesundheitsportals Österreich). Available at: https://www.gesundheit.gv.at/gesundheitsleistungen/gesundheitswesen/inhalt [15.05.2020]

Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz (BMSGPK). (2020b). *Monitoringbericht Zielsteuerung Gesundheit - Monitoring nach Vereinbarung gemäß Art 15a B-VG Zielsteuerung-Gesundheit und Zielsteuerungsvertrag* (Bundes-Zielsteuerungskommission, Juni 2018). Available at: file:///C:/Users/Peter/Downloads/monitoringbericht_2019_final_nach_bzk%20(1).pdf [15.05.2020]

Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz (BMSGPK). (2020c). *Klassifikation der österreichischen Krankenanstalten.* Available at: http://www.kaz.bmg.gv.at/fileadmin/user_upload/Publikationen/klassifikation_krankenanstalten.pdf [20.05.2020]

Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz (BMSGPK). (2020d). *Betten nach Rechtsträgertypen 2018. Tatsächlich aufgestellte Betten.* Available at: http://www.kaz.bmg.gv.at/fileadmin/user_upload/Betten/10_G_Betten_RT.pdf [20.05.2020]

Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz (BMSGPK). (2020e). *Gesundheitsberufe in Österreich*. Wien: Sozialministerium. ISBN: 978-3-85010-529-3.

Bundesministerium für Soziales, Gesundheit, Pflege und Konsumentenschutz (BMSGPK). (2021). *eHealth in Österreich.* Available at. https://www.sozialministerium.at/Themen/Gesundheit/eHealth/eHealth-in-Oesterreich.html. [25.06.2021]

Busse, R., & Schreyögg, J. (2010). Management im Gesundheitswesen - eine Einführung in Gebiet und Buch. In Reinhard Busse, Jonas Schreyögg, & Oliver Tiemann (Eds.). *Management im Gesundheitswesen*, Heidelberg: Springer, pp. 1-8. ISBN: 978-3-64201-335-5.

Busse, R., Schreyögg, J., & Tiemann, O. (2010). *Management im Gesundheitswesen*, Heidelberg: Springer. ISBN: 978-3-64201-335-5.

Büssing, A., & Glaser, J. (Ed.). *Dienstleistungsqualität und Qualität des Arbeitslebens im Krankenhaus*. (Schriftenreihe Organisation und Medizin). Göttingen, Bern, Toronto, Seattle: Hogrefe Publishing. ISBN: 978-3-80171-745-2.

Competence Center Integrierte Versorgung (CCIV). (2021). *„Lebenswelten chronisch kranker Menschen im Spannungsfeld der Sektoren“* (online symposium, 24.11.2021).

Chamberlain-Salaun, J., Mills, J., & Usher, K. (2013). *Terminology used to describe health care teams: an integrative review of the literature*. In *The Journal of Multidisciplinary Health care* (JMDH). 2013 (6), pp. 65-74. ISSN: 1178-2390.

Czypionka, Th., Kraus, M., Riedl, M., & Sigl, C. (2012). *Aufgabenorientierung im österreichischen Gesundheitswesen* (Studie im Auftrag des Hauptverbands der österreichischen Sozialversicherungsträger). Wien: Institut für Höhere Studien. Available at: https://www.sozialversicherung.at/cdscontent/load?contentid=10008.714701&version=1594031953 [20.05.2020]

Czypionka, Th., Kraus, M., Reiss, M., Röhrling, G., & Karadakic, R. (2016). Multiple chronische Erkrankungen als Herausforderung der Zukunft. – Was kann integrierte Versorgung leisten? In Hauptverband der Österreichischen Sozialversicherungsträger (Ed.). *Soziale Sicherheit*, 2016 (6), Supplement „Health System Watch", 2016 (II). Wien: SV, pp. 285-300. n. No.

Detels, R., McEwin, J., Beaglehole, R., & Tanaka, H. (Eds.). (2002). *Oxford textbook of public health.* Oxford: Oxford University Press. ISBN: 978-0-19850-959-2.

Drucker, P. F. (1997). Not enough generals were killed (Foreword). In Frances Hesselbein, Marshall Goldsmith, & Richards Beckhard (Eds.). *The Leader of the Future: New Visions, Strategies, and Practices for the Next Era.* San Francisco: Jossey Bass, pp. xi-xv. ISBN: 978-0-78790-935-2.

Drucker, P. F. (2002). *Was ist Management? Das Beste aus 50 Jahren.* München: Econ. ISBN: 978-3-43012-239-9.

Dorner, T. E. (2016). *Public Health. - Von den Gesundheitsbedürfnissen der Gesellschaft zu klinischen Implikationen.* Wien: Facultas. ISBN: 978-3-70891-419-0.

Döring, N., & Bortz, J. (2016). *Forschungsmethoden und Evaluation in den Sozial und Humanwissenschaften.* Heidelberg: Springer. ISBN: 978-3-64241-088-8.

Eger, K., Sandholzer, K. (2007). *Integrierte Versorgung in Österreich – eine Bestandsaufnahme* (2nd Carinthian Health Conference). Pörtschach: Vernetzte Versorgung (conference presentation, 18.09.2007).

Ehlert, G. (2019). *Professionalisierung* (socialnet dictionary). Available at https://www.sicialnet.de/lexikon/Professionalisierung [15.05.2020]

Eichhorn, G. (2019). *Best Point of Service - Where does the road take us? Health policy forum* (discussion paper from 02.05.2019). Available at: https://www.gesundheitspolitischesforum.at/rueckblick-104-gpf-mai-2019/ [15.05.2020]

Elisabethinen (2020) *„Schau hin und handle!"* (Elizabethinen, Leitspruch der Gründerin, Elisabeth von Thüringen, 1207-1231). Available at: https://www.elisabethinen.at/orden/ [15.05.2020]

Eschenbach, R., Kreuzer, C., Kriegler-Lenz, A., Haschka, A., & Kast, J. (2007). *Controlling macht Schule! Ein Lehrbuch für die kaufmännische Ausbildung.* Eisenstadt: Weber. ISBN: 978-3-85253-515-9.

Europäische Kommission (2021). *State of Health in the EU.* Available at: https://ec.europa.eu/health/state/summary_de [25.06.2021]

Fuchs-Heinritz, W., Klimke, D., Lautmann, R., Rammstedt, O., Stäheli, U., Weischer, C.. & Wienold, H. (Eds.). (2011). *Lexikon zur Soziologie.* Wiesbaden: VS Verlag für Sozialwissenschaften. ISBN: 978-3-53116-602-5.

Gara, St. (2019). *Best Point of Service - Where does the road take us? Health policy forum* (discussion amount from 02.05.2019). Available at: https://www.gesundheitspolitisch-esforum.at/rueckblick-104-gpf-mai-2019/ [15.05.2020]

Gerlach, A. (2008). Akademisierung ohne Professionalisierung? In H. Bollinger, A. Gerlach & M. Pfadenhauer (Eds.). *Gesundheitsberufe im Wandel: Soziologische Beobachtungen und Interpretationen.* Frankfurt am Main: Mabuse, pp. 71-102. ISBN: 978-3-93593-493-5.

Gesundheit.gv.at. (2020). *"Lege artis".* Available at: https://www.gesundheit.gv.at/lexikon/l/lexikon-legeartis [15.05.2020].

Gesundheit Österreich GmbH (GÖG). (2020). *Evaluation.* Available at: https://goeg.at/Evaluationen [12.09.2020]

Giddens, A. (2004). *Sociology.* Cambridge, Oxford: Polity Press in association with Blackwell Publishing Ltd. ISBN: 978-0-74562-310-7.

Glaser, B. G. & Strauss, A. (1998). *Grounded Theory: Strategien qualitativer Forschung.* Bern: Huber. ISBN: 978-3-45684-212-7.

Grass, P., & Hille, S. (2017) Werte und Kultur als Faktoren für den Unternehmenserfolg. In Institut für angewandte Arbeitswissenschaft (Ed.). *Betriebspraxis & Arbeitsforschung: Zeitschrift für angewandte Arbeitswissenschaft*, 2017 (230), pp. 53-57. n. No.

Grossmann, R., & Lobnig, H. (2013). Organisationsentwicklung im Krankenhaus – Grundlagen und Interventionskonzepte. In Huber Lobnig & Ralph Grossmann (Eds.): *Organisationsentwicklung im Krankenhaus.* Medizinische Verlagsgesellschaft. ISBN: 978-3-95466-002-5.

Grossmann, R., Pellert, A., & Gottwald, V. (Eds.). (1997). *Besser Billiger Mehr. Zur Reform der Expertenorganisation, Krankenhaus, Schule, Universität* (iff Texte, Band 2). Wien: Springer Verlag. ISSN: 1433-2760. DOI: 10.1007/978-3-7091-6539-3.

Grossmann, R., Pellert, A., & Gottwald, V. (1997). Krankenhaus, Schule, Universität: Charakteristika und Optimierungspotentiale. In R. Grossmann, A. Pellert & V. Gottwald (Eds.): *Besser Billiger Mehr. Zur Reform der Expertenorganisation, Krankenhaus, Schule, Universität* (iff Texte, Band 2). Wien: Springer Verlag, pp. 24 – 35. ISSN: 1433-2760. DOI: 10.1007/978-3-7091-6539-3.

Grossmann, R., & Scala, K. (Eds.). (2002). *Intelligentes Krankenhaus: Innovative Beispiele der Organisationsentwicklung in Krankenhäusern und Pflegeheimen.* (Contributions by Katharina Heimerls, Andreas Heller and Georg Zepke). Wien: Springer. ISBN: 978-3-21183-702-3.

Grossmann, R., & Scala, K. (2002). Krankenhäuser als Organisationen steuern und entwickeln. In R. Grossmann, K. & Scala (Eds.). *Intelligentes Krankenhaus: Innovative Beispiele der Organisationsentwicklung in Krankenhäusern und Pflegeheimen.* Wien: Springer, pp. 12-31. ISBN: 978-3-21183-702-3.

Güntert, B. J. (2007). *Integrierte Versorgung im österreichischen Gesundheitswesen – Chancen und Gefahren aufgrund verschiedener Erfahrungen in Deutschland und der Schweiz* (2nd Carinthian Health Conference). Pörtschach: Vernetzte Versorgung (conference presentation, 18.09.2007).

Hagenbichler, E. (2005). *Grundlagen und Praxis der medizinischen Versorgung.* Wien: TU Wien. n. No.

Häfelinger, M., & Von Trotha, H. (2020). *Metaphorisches Branding.* Available at: https://unternehmercoaches.de/themen/marketing/metaphorisches-branding/ [18.08.2020]

Hartmann H. (1972). Arbeit, Beruf, Profession. In Thomas Luckmann & Walter Sprondel (Eds.). *Berufssoziologie.* Köln: Kiepenheuer & Witsch, pp. 36-52. ISSN: 0548-3018.

Hatzinger, R., & Nagel, H. (2013). *Statistik mit SPSS – Fallbeispiele und Methoden.* München: Pearson. ISBN: 978-3-86894-182-1.

Hauke, E. (2003). *Patientenorientierung. Laut gedacht – Wegweiser zur Umsetzung der Patientenrtechte.* Available at: https://www.patientenanwalt.com/download/Expertenletter/Patient/0312_pzent_hauke.pdf [15.05.2020]

Hauke, E., Holzer, E., & Offermanns, G.. (2012). Die Patientenperspektive wird vernachlässigt! Einleitung und Inspiration zu einer neuen Betrachtungsweise. In Elke Holzer, Guido Offermanns, & Eugen Hauke (Eds.). *Patientenperspektive: Ein neuer Ansatz für die Weiterentwicklung des Gesundheitssystems.* Wien: Facultas, pp. 21-23. ISBN: 978-3-70890-793-2.

Hauke, E., Mayer, P. J., Holzer, E., & Offermanns, G. (2014). Aspekte bildungspolitischer Herausforderungen ausgewählter Gesundheitsberufe in Österreich. In Volker Heyse & Max Giger (Eds.). *Erfolgreich in die Zukunft: Schlüsselkompetenzen in Gesundheitsberufen. Konzepte und Praxismodelle für die Aus-, Weiter- und Fortbildung in Deutschland, Österreich und der Schweiz.* Heidelberg: medhochzwei Verlag, pp. 43-58. ISBN: 978-3-86216-184-3.

Hauptverband der Sozialversicherungsträger (HVB-SV). (2012). Strategien für die Gesundheitsversorgung: Lösungsansätze des Competence Centers Integrierte Versorgung. In *Soziale Sicherheit* 2012 (1). Available at: https://www.sozialversicherung.at/cdscontent/load?contentid=10008.714138&version=1391184544 [15.05.2020]

Heinisch, M. (2019). *"Es zählen ausschließlich die Bedürfnisse der Patienten". European Forum Alpbach 2019* (Report on the discussion of 20.08.2019 on the topic "The liberated patient: from digitisation to individualisation"). Available at: https://www.ingo-news.at/gesundheitspolitik/forum-alpbach.html [15.05.2020]

Hesse, H. A. (1968). *Berufe im Wandel: Ein Beitrag zum Problem der Professionalisierung.* Stuttgart: Ferdinand Enke Verlag. ISBN: 978-3-86216-184-3.

Hesselbein, F., Goldsmith, M., & Beckhard, R. (1997). *The Leader of the Future: New Visions, Strategies, and Practices for the Next Era.* San Francisco: Jossey Bass. ISBN: 978-0-78790-935-2.

Heuer, St. (2015). Schritt für Schritt durchdacht: Die Mayo-Klinik gilt als einer der besten und renommiertesten Gesundheitsdienstleister der USA. Hinter den Kulissen des Mega-Krankenhauses sorgt ein über 100 Jahre hinweg optimiertes System für reibungslose, größtmögliche Effizienz. – Ein Besuch. In *Change: Das Magazin der Bertelsmann Stiftung*, 2015 (3), pp. 52-59. n. No.

Heyse, V., & Erpenbeck, J. (2004). *Kompetenztraining: 64 Informations- und Trainingsprogramme*. Stuttgart: Schäffer-Poeschel. ISBN: 978-3-79102-263-5.

Heyse, V., Erpenbeck, J. & Ortmann, S. (Eds.). (2010). *Grundstrukturen menschlicher Kompetenz: Praxiserprobte Konzepte und Instrumente.* Münster: Waxmann. ISBN: 978-3-83092-335-0.

Heyse, V. (2014). Schlüsselkompetenzen: Erfolgreiche Brücken zu selbstbestimmten Patienten. In Volker Heyse & Max Giger (Eds.). *Erfolgreich in die Zukunft: Schlüsselkompetenzen in Gesundheitsberufen. Konzepte und Praxismodelle für die Aus-, Weiter- und Fortbildung in Deutschland, Österreich und der Schweiz.* Heidelberg: medhochzwei Verlag, pp. 5-28. ISBN: 978-3-86216-184-3.

Heyse, V., & Giger, M. (Eds.). (2014). *Erfolgreich in die Zukunft. Schlüsselkompetenzen in Gesundheitsberufen; Konzepte und Praxismodelle für die Aus,- Fort- und Weiterbildung in Deutschland, Österreich und der Schweiz* (Gesundheitsmarkt in der Praxis). Heidelberg: medhochzwei Verlag GmbH. ISBN: 978-3-86216-184-3.

Heyse, V., & Schircks, A. D. (2012). *Kompetenzprofile in der Humanmedizin: Konzepte und Instrumente für die Ausrichtung von Aus- und Weiterbildung auf Schlüsselkompetenzen.* Münster: Waxmann. ISBN: 978-3-83092-748-8.

Hildebrandt, H, Pimperl, A., Schulte, T., Hermann, C., Riedel, H., Schubert, I., Köster, I., Siegel, A., & Wetzel. M. (2015). Triple Aim – Evaluation in der Integrierten Versorgung Gesundes Kinzigtal – Gesundheitszustand, Versorgungserleben und Wirtschaftlichkeit. In *Bundesgesundheitsblatt - Gesundheitsforschung – Gesundheitsschutz*, 2015 (4-5). (Germany, published online: 05.02.2015). Heidelberg: Springer, pp. 383-392. n. No.

Hildebrandt, H., Werner, U., Wetzel, M., & Hynek, S. (n. Y.) *Gesundes Kinzigtal.* Available at: https://www.msd.de/fileadmin/user_upload/default/documents/gesundheits-preis/project_2012_2014/Gesundes-Kinzigtal.pdf?eID=googleAnalyticsTracking [15.05.2020]

Hofmarcher-Holzhacker, M. M. (2013). *Das Österreichische Gesundheitssystem: Akteure, Daten, Analysen.* Berlin: MWV. ISBN: 978-3-95466-052-0.

Holzer, E., Offermanns, G., & Hauke, E. (Eds.). (2012). *Patientenperspektive: Ein neuer Ansatz für die Weiterentwicklung des Gesundheitssystems.* Wien: Facultas. ISBN: 978-3-70890-793-2

Homann, K. (1994). Marktwirtschaft und Unternehmensethik. In Siegfried Blasche (Forum für Philosophie, Bad Homburg). (Ed.). *Markt und Moral: die Diskussion um die Unternehmensethik*, pp. 109-130. Bern: Haupt. ISBN: 978-3-25805-017-1.

Hug, Th., & Poscheschnik, G. (2015). *Empirisch forschen.* München: UTB. ISBN: 978-3-82524-304-3.

Hussy, W, Schreier, M, & Eichterhoff, G. (2013). *Forschungsmethoden in Psychologie und Sozialwissenschaften.* Berlin: Springer. ISBN: 978-3-642-34361-2.

Hüster, P., Hobelsberger, H., & Hellwig, A. (Eds.). (2016). *Christliche Organisationskultur prägen: Ansätze im kirchlichen Gesundheitswesen.* Freiburg: Lambertus. ISBN: 978-3-78412-880-1.

International Business Machines Corporation (IBM). (2020). *IBM SPSS-Software.* Available at: https://www.ibm.com/analytics/at/de/technology/spss/ [15.09.2020]

Johner Institut. (2018). *Digital Health* (blog post of 18.12.2018), Johner Institut. Available at: https://www.johner-institut.de/blog/medizinische-informatik/digital-health-e-health/ [15.05.2020]

Jungert, M. (2013). Was zwischen wem und warum eigentlich? Grundsätzliche Fragen der Interdisziplinarität. In Michael Jungert, Elsa Romfeld, Thomas Sukopp, & Uwe Voigt (Eds.). *Interdisziplinarität: Theorie, Praxis, Probleme.* Darmstadt: Wissenschaftliche Buchgesellschaft, pp. 1-12. ISBN: 978-3-53423-054-9.

Jungert, M., Romfeld, E., Sukopp, T. & Voigt, U. (Eds.). (2013). *Interdisziplinarität: Theorie, Praxis, Probleme.* Darmstadt: Wissenschaftliche Buchgesellschaft. ISBN: 978-3-53423-054-9.

Kaba-Schönstein, L., & Kälble, K. (Eds.). *Interdisziplinäre Kooperation im Gesundheitswesen: Eine Herausforderung für die Ausbildung in der Medizin, der Sozialen Arbeit und der Pflege* (Ergebnisse des Forschungsprojektes MESOP). Frankfurt am Main: Mabuse-Verlag. ISBN: 978-3-93305-097-9.

Kälble K. (2004). Berufsgruppen- und fachübergreifende Zusammenarbeit - Terminologische Klärung. In Kaba-Schönstein Lotte, & Kälble Karl (Eds.). *Interdisziplinäre Kooperation im Gesundheitswesen: Eine Herausforderung für die Ausbildung in der Medizin, der Sozialen Arbeit und der Pflege* (Ergebnisse des Forschungsprojektes MESOP). Frankfurt am Main: Mabuse-Verlag, pp. 29-41. ISBN: 978-3-93305-097-9.

Kälble, K. (2005). Modernisierung durch wissenschaftsorientierte Ausbildung an Hochschulen. In H. Bollinger, A. Gerlach, & M. Pfadenhauer (Eds.). *Gesundheitsberufe im Wandel: Soziologische Beobachtungen und Interpretationen.* Frankfurt am Main: Mabuse, pp. 31-53. ISBN: 978-3-93596-493-7.

Kane-Urrabazo, Ch. (2006). Management's role in shaping organizational culture. In *Journal of Nursing Management*, 14, 2006, pp. 188–194. ISSN: 1365-2834.

Keller, Daniela (2021). Statistischer Vergleich von zwei Gruppen (Contribution in: *Statistik Beratung*). Available at: https:// statistik-und-beratung.de/2013/07/statistischer-vergleich-von-zwei-gruppen/ [05.11.2021].

Kempter, G. & Lofner, H. (Eds.). (2013). *Grenzenlos kooperieren – Forschung im Dialog mit Gesellschaft und Wirtschaft* (Proceedings of the 7th Research Forum of the Austrian Universities of Sciences. Berlin: Scientific publisher. ISBN: 978-3-86573-709-0.

Kickbusch, I., Pelikan, J., Haslbeck, J., Apfel, F., Tsouros, A D. (Eds.). (2016). *Gesundheitskompetenz. Die Fakten* (WHO, German version). Zürich: Careum. n. No.

Kirchner, B. (2007). *Benedikt für Manager: Die geistigen Grundlagen des Führens.* Wiesbaden: Gabler. ISBN: 978-3-40919-194-1.

Kluge, F. (2002). *Etymologisches Wörterbuch der deutschen Sprache.* Berlin: De Gruyter. ISBN: 978-3-11022-364-4.

Kodner, D. L., Spreeuwenberg, C. (2002). Integrated care: meaning, logic, applications, and implications – a discussion paper. In *International Journal of Integrated Care*, 2, pp. 1-6. ISSN: 1568-4156.

Korosec, I., & Pichlbauer, E. G. (2007). *Gesunde Zukunft: Österreichs Gesundheitsversorgung neu* (Diskussionsgrundlage zu neuen Strategien im Gesundheitswesen). Wien: Steinbauer. ISBN: 978-3-90249-427-6.

Krystek, U., Müller-Stewens, G. (1993). *Frühaufklärung für Unternehmen: Identifikation und Handhabung zukünftiger Chancen und Bedrohungen.* Stuttgart: Schäffer-Poeschel. ISBN: 978-3-79100-639-0.

Kuehn, A. (2004). The Kaleidoscope of collaborative practice. In Joel Lucille (Ed.). *Advanced Practice Nursing Essentials for Role Development.* Philadelphia: F. A. Davis Company, pp. 301-335. ISBN: 978-0-80361-119-1.

Kühmayer, F. (2016). *Leadershipreport 2016: Digitale Disruption. Frankfurt: Zukunftsinstitut.* ISBN: 978-3-94564-03-5.

Kühn, H. (2003). Ethische Probleme der Ökonomisierung von Krankenhausarbeit. In André Büssing & Jürgen Glaser (Ed.). *Dienstleistungsqualität und Qualität des Arbeitslebens im Krankenhaus*. (Schriftenreihe Organisation und Medizin). Göttingen, Bern, Toronto, Seattle: Hogrefe Publishing, pp. 77-98. ISBN: 978-3-80171-745-2.

Kühn, H. (2011). Die Sorge um die Patienten: Grundlage der Personalarbeit im Krankenhaus. In *Personalmanagement im Krankenhaus – Grundlagen und Praxis.* Heinz Naegler (Ed.). Berlin: Wissenschaftliche Verlagsgesellschaft, pp. 25-48. ISBN: 978-3-93906-945-4.

Laimböck, M. (2008). *Die Zukunft des österreichischen Gesundheitssystems: Wettbewerbsorientierte Patientenversorgung im internationalen Vergleich.* Wien: Springer. ISBN: 978-3-21184-789-3.

Laloux, F. (2015). *Reinventing Organizations: Ein Leitfaden zur Gestaltung sinnstiftender Formen der Zusammenarbeit.* München: Vahlen. ISBN: 978-3-80064-913-6.

Lancet Commission. (2010). *Eine neue globale Initiative zur Reform der Ausbildung von Gesundheitsfachleuten: Education of Health Professionals for the 21 Century* (Lancet Report 2011). Zürich: Careum. DOI: 10.1016/S0140-6736(10)61854-5.

Lobnig, H., & Grossmann, R. (2013). *Organisationsentwicklung im Krankenhaus.* Berlin: Medizinische Verlagsgesellschaft. ISBN: 978-3-95466-002-5.

Lohmann, H. (2004). *Mut zum Wandel. Texte zur Entwicklung der Gesundheitswirtschaft.* Melsungen: Bilbliomed. ISBN: 978-3-89556-030-9.

Lohmann, H. (blog post v. 04.12.2018). Der Wandel erfasst alle! Mich etwa auch? In BibliomedManager – Das Portal für Entscheider im Krankenhaus (Orientierungswert). H. Lohmann (Ed.). *„Orientierungswerte“*. Available at: https://www.bibliomedmanager.de/zeitschriften/artikeldetailseite-ohne-heftzuweisung/36991-der-wandel-erfasst-alle-mich-etwa-auch/ [15.05.2019]

Likar, R., Pinter, G., Janig, H., & Waldenberger, F. (2020). *Im Kranken Haus. – Ärzte behandeln das Gesundheitssystem.* Wien: Ueberreuter. ISBN: 978-3-80007-742-7.

Lischka, M. (2016). Moral im Management. “Unethisches Verhalten hängt selten von einzelnen Personen ab”. In *Personal Manager*, 4, 2016, pp. 8-9. ISSN: 1612-2836.

Loewit, G. (2019). *7 Milliarden für nichts: Ein Landarzt rechnet mit dem Gesundheitssystem ab.* Wien: Edition a. ISBN: 978-3-990001-396-0.

Lombriser, R., & Abplanalp, P. A. (2018). *Strategisches Management. Vision entwickeln. Erfolgspotenziale aufbauen. Strategien umsetzen.* Zürich: Versus. ISBN: 978-3-03909-299-4.

Luckmann, T., & Sprondel, W. (Eds.). (1972). *Berufssoziologie.* Köln: Kiepenheuer & Witsch. ISSN: 0548-3018.

Mahler, C., Gutmann, T., Karstens, S., & Joos, St. (2014). Begrifflichkeiten für die Zusammenarbeit in den Gesundheitsberufen – Definition und gängige Praxis. In *Zeitschrift für Medizinische Ausbildung*, 2014, Vol. 31(4), pp. 1-5. ISSN: 1860-7446.

Malik, F. (2014). *Führen Leisten Leben: Wirksames Management für eine neue Welt.* Campus: Frankfurt am Main. ISBN: 978-3-593-50127-7.

Marckmann, G. (2018). *Berufsgruppenübergreifendes Wertemanagement – Wert-Schätzung als zentrale Führungsaufgabe.* (Tagung des Berliner Forums der Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V., AWMF, Lecture from 28.11.2018: „Medizin und Ökonomie“) Available at: https://www.awmf.org/fileadmin/user_upload/Die_AWMF/Veranstaltungen/Berliner_Forum/BerlinerForum-2018/20181128_BF_Marckmann_Wertemanagement_AWMF_Forum_Berlin_2018-11-28.pdf [15.09.2020]

Marckmann, G., & Maschmann, J. (2014). Does ethics pay off? Need and perspectives of value management in hospitals. In *Zeitschrift für Evidenz Fortbildung und Qualität im Gesundheitswesen 108*, 2014, pp. 157-165. ISSN: 2212-0289.

Mayer, P. J. (2012). Leistungsbedarf und Patientenbedürfnisse – zwei unterschiedliche Ansichten. In E. Holzer, G. Offermanns, & E. Hauke (Eds.). *Patientenperspektive. Ein neuer Ansatz für die Weiterentwicklung des Gesundheitssystems.* Wien: Facultas-Verlag. ISBN: 978-3-70890-793-2.

Mayer, P. J. (2016a). "Cultural Work" - A Success Factor in Health care Facilities. In M. Škare (Ed.). *Conference Proceedings of the Second International Scientific Conference for Doctoral Students and Young Researchers.* Eisenstadt: University of Applied Sciences Burgenland, pp. 160-182. ISBN: 978-3-95024-529-5.

Mayer, P. J. (2016b). *Integrierte Versorgung – Zurück zum Natürlichen, zum grundlegenden menschlichen Empfinden* (blog post v. 06.05.2016). University of Applied Sciences Burgenland. Available at: http://blog.fh-burgenland.at/2016/05/06/integrierte-versorgung/ [25.12.2019]

Mayer, P. J. (2017). Integrierte Versorgung als Zusatzkompetenz in den Gesundheitsberufen. In Ute Seper (Ed.). *BILDUNG in den Gesundheitsberufen WEITER DENKEN: Weiterbilden – Weiterdenken – Weiterkommen.* Graz: Leykam, pp. 31-44. ISBN: 978-3-70110-373-7.

Mayer, P. J., Mut, M., & Weghofer, A. (2018). Netzwerkaufbau in der integrierten Versorgung. In *Das österreichische Gesundheitswesen* (ÖKZ). 2018 (12), pp. 33-34. ISSN: 0472-5530.

Mayer, P. J. (2019). Qualität im Kontext der Integrierten Versorgung. Quality in the context of integrated health care. In *Public Health Forum*, 2019. 27 (3). De Gruyter, pp. 208-210. Doi.org/10.1515/pubhef-2019-0040.

Mayer, P. J., & Leyrer, B. (2013), E-Patientenakte – Neue Chancen und Herausforderungen für die Kooperation im Gesundheitswesen. In G. Kempter & H. Lofner (Eds.). *Grenzenlos kooperieren – Forschung im Dialog mit Gesellschaft und Wirtschaft* (Proceedings of the 7th Research Forum of the Austrian Universities of Sciences. pp. 526-527. Berlin: Scientific publisher Berlin. ISBN: 978-3-86573-709-0.

Mayer, S. (2016). Finanzierung der Gesundheitsversorgung. In Thomas E. Dorner (Eds.). *Public Health. - Von den Gesundheitsbedürfnissen der Gesellschaft zu klinischen Implikationen.* Wien: Facultas, pp. 30-33. ISBN: 978-3-70891-419-0.

Mayo Clinic Health System. (2020). *Annual Report 2017: Report to our Community* (last available report). Available at: https://www.mayoclinichealthsystem.org/locations/la-crosse/about-us/annual-reports [15.05.2020]

Mayring, P. (2015). *Qualitative Inhaltsanalyse: Grundlagen und Techniken.* Basel: Berlitz. ISBN: 978-3-40725-730-7.

McCallin, A. (2001). Interdisciplinary practice - a matter of teamwork: an integrated literature review. In *Journal of Clinical Nursing* (JCN). 2001, 10(4), pp. 419-428. ISSN: 0962-1067.

Medizinische Universität Graz. (2016). *Zukunftskonferenz „Innovative Modelle in der Primärversorgung"* (Institut für Allgemeinmedizin und evidenzbasierte Versorgungsforschung, 08. to 09.04.2016). Available at: https://allgemeinmedizin.medunigraz.at/fileadmin/institute-oes/allgemeinmedizin/symposium-2016/downloads/160409-16_Korsatko_Gruendungssitzung-Oesterreichisches-Forum-Primaerversorgung.pdf [15.05.2020]

MedMedia (2021a). *„Gesundheitskommunikation mit System".* Available at: https://www.med media.at/home/ueber-uns/ [26.11.2021]

MedMedia (2021b). *„Integrierte Versorgung für chronisch Kranke besonders"*. In *MedMedia* (Online article, 26.11.2021). Available at: https://www.medmedia.at/relatus-med/integrierte-versorgung-fuer-chronisch-kranke-besonders-wichtig/ [26.11.2021]

Meyer, J. (2020) KI in der Gesundheitsversorgung: Untersuchung zu Folgen der digitalen Transformation für Belegschaften und Organisationen. In *Das Krankenhaus*, 2020 (4), pp. 328-330. ISSN: 0340-3602.

Mieg, H. A. (2018). *Professionalisierung: Essays zu Expertentum, Verberuflichung und professionellem Handeln.* Potsdam: Verlag der Fachhochschule Potsdam. ISBN: 978-3-93432-986-7.

Morgan, G. (2006). *Bilder der Organisation.* Stuttgart: Klett-Cotta. ISBN: 978-3-60891-760-4.

Naegler, H., & Wehkamp, K.-H. (2018). *Medizin zwischen Patientenwohl und Ökonomisierung: Krankenhausärzte und Geschäftsführer im Interview.* Berlin. Medizinisch Wissenschaftliche Verlagsgesellschaft. ISBN: 978-3-95466-364-4.

Nolte, E. (2016). Integrierte Versorgung. In *Gesundheit Österreich GmbH - GÖG-Colloquium* (Lecture from 14.12.2016). Available at: https://goeg.at/Integrierte_Versorgung [15.05.2020]

Northouse, P. G. (2018). *Leadership: Theory and Practice.* Los Angeles, London: Sage Publishing. ISBN: 978-1-50636-231-1.

OptiMedis. (2016). *Das Gesundheitssystem – Wir gestalten es neu.* (OptiMedis AG – Partner für regionale Integrierte Versorgung). Available at: https://optimedis.de/files/Publikationen/Broschueren/2016/OptiMedis_Unternehmensbroschuere_2016.pdf [15.05.2020]

OptiMedis. (2020). *OptiMedis AG – Partner für regionale Integrierte Versorgung.* Available at: https://optimedis.de/ueber-uns [15.05.2020]

Organization for Economic Co-operation and Development (OECD). (2017). Österreich: Länderprofil Gesundheit 2017. In *European Observatory on Health Systems and Policies.* (State of Health in the EU: Länderprofil Gesundheit 2017). Brüssel: OECD Publishing. ISBN: 978-9-26428-504-0.

Österreichische Ärztekammer (ÖÄK). (2020). *Daten & Fakten: Zahlen für das Jahr 2018.* Available at: https://www.aerztekammer.at/daten-fakten [15.05.2020]

Österreichische Gesellschaft für Public Health (ÖGPH). (2016). *Allianz zur Förderung der Primärversorgung in Österreich* (report). Available at: http://www.oeph/index.php/15-arbeitsgruppen/90-allianz-zur-Foerderung-der-primärversorgung-in-oesterreich [15.05.2021]

Österreichische Gesundheitskasse (ÖGK). (2020). *Krankenhausaufenthalt: Ambulanter, tagesklinischer, stationärer Krankenhausaufenthalt.* Available at: https://www.gesundheitskasse.at/cdscontent/?contentid=10007.847918&portal=oegksportal [20.05.2020]

Pichelhöfer, O., & Maier, M. (2015). Unregulated access to health-care services is associated with overutilization-lessons from Austria. In *European Journal of Public Health*. Vol. 25, pp. 401-403. ISSN: 1101-1262. Doi.org/10.1093/eurpub/cku189.

Pilz, S. (2019). *Best Point of Service – Wohin führt uns der Weg? Gesundheitspolitisches Forum* (Contribution to the discussion from 02.05.2019). Available at: https://www.gesundheitspolitischesforum.at/rueckblick-104-gpf-mai-2019/ [15.05.2020]

Pimperl, A. (2018). *Gesundes Kinzigtal –Lessons Learned - Disruption des „traditionellen“ Gesundheitssystems* (Österreichischer Primärversorgungskongress 2018, 21. April 2018, Graz). Available at: https://allgemeinmedizin.medunigraz.at/fileadmin/institute-oes/allgemeinmedizin/symposium-2018/downloads/Sa01_Pimperl_Gesundes_Kinzigtal.pdf [15.05.2020]

Pfaff, H. (2003). Versorgungsforschung. Begriffsbestimmung, Gegenstand und Aufgaben. In Holger Pfaff, Matthias Schrappe, Karl W. Lauterbach, Udo Engelmann, & Marco Halber (Eds.). *Gesundheitsversorgung und Diseasemangement. Grundlagen und Anwendungen der Versorgungsforschung.* Bern: Hans Huber. ISBN: 978-3-45684-026-0.

Pfannstiel, M. A., Rasche, Ch., & Mehlich, H. (Eds.). (2016): *Dienstleistungsmanagement im Krankenhaus: Nachhaltige Wertgenerierung jenseits der operativen Exzellenz.* Wiesbaden: Springer Verlag. ISBN: 978-3-65808-428-8.

Pfeiffer, W. (1993). „Profession" (Etymologisches Wörterbuch des Deutschen). In *Digitales Wörterbuch der deutschen Sprache* (DWDS). Available at: https://www.dwds.de/wb/etymwb/Profession [25.07.2020]

Pöttler, G. (2020). *Gesundheitswesen in Österreich: Organisationen, Leistung, Finanzierung und Reformen übersichtlich dargestellt.* Wien: Goldegg-Verlag. ISBN: 978-3-99060-169-3.

Raab-Steiner, E., & Benesch, M. (2010). *Der Fragebogen: Von der Forschungsidee zur SPSS/PASW-Auswertung.* Wien: Facultas. ISBN: 978-3-82528-406-0.

Rasche, Ch., & Braun von Reinersdorff, A. (2016). Krankenhäuser als Expertenorganisationen. In Mario A. Pfannstiel, Christoph Rasche, & Harald Mehlich (Eds.): *Dienstleistungsmanagement im Krankenhaus: Nachhaltige Wertgenerierung jenseits der operativen Exzellenz.* Wiesbaden: Springer Verlag, pp. 1-23. ISBN: 978-3-65808-428-8. DOI: 10.1007/978-3-658-08429-5.

Rechkemmer, K. (2012). „Exzellenzinitiative Innere Qualität". In *Das Krankenhaus 9*, 2012, pp. 879-884. ISSN: 0340-3602.

Rechkemmer, K. (2013). „Innere Qualität und Personalgewinnung". In *Das Krankenhaus 9*, 2013, pp. 920-926. ISSN: 0340-3602.

Robert-Bosch-Stiftung. (2010). *Memorandum Kooperation der Gesundheitsberufe – Qualität und Sicherung der zukünftigen Gesundheitsversorgung.* Stuttgart: Robert Bosch Stiftung. ISBN: 978-3-93957-425-5.

Roller-Wirnsberger, R. (2021). „Der chronische Patient im Labyrinth der Sektoren" (Congress contribution). In *Competence Center Integrierte Versorgung (CCIV)*. „Lebenswelten chronisch kranker Menschen im Spannungsfeld der Sektoren" (online symposium, 24.11.2021).

Rüegg-Stürm, J. (2002) *Das neue St. Galler Management-Modell: Grundkategorien einer integrierten Managementlehre: Der HSG-Ansatz.* Bern: Haupt: ISBN: 978-3-25806-629-5.

Rudolf-Bosch-Stiftung. (2010). *Kooperation der Gesundheitsberufe: Qualität und Sicherstellung der zukünftigen Gesundheitsversorgung* (Memorandum). ISBN: 978-3-93957-425-5.

Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen (SVR). (2007). *Kooperation und Verantwortung – Voraussetzungen einer zielorientierten Gesundheitsversorgung* (Gutachten 2007), Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen. Available at: https://www.svr-gesundheit.de/index.php?id=15 [25.05.2020]

Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen (SVR). (2018). *Bedarfsgerechte Steuerung der Gesundheitsversorgung* (Gutachten 2018), Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen. Berlin: Medizinisch Wissenschaftliche Verlagsgesellschaft. ISBN: 978-3-95466-421-4.

Salfeld, R., Hehner, St., & Wichels, R. (2009). *Modernes Krankenhausmanagement. Konzepte und Lösungen.* Berlin: Springer. ISBN: 978-3-54087-398-3.

Schenk, M. (2020). Die Paradoxie in Veränderungsprozessen. In *Zwischen Selbststeuerung und Führung* (Magazin der Paritätischen Akademie Berlin, Guest comment). Available at: https:// akademie.org/zwischen-selbststeuerung-und-fuehrung/ [10.01.2022]

Schölkopf, M. & Pressel, H. (2017). *Das Gesundheitswesen im internationalen Vergleich: Gesundheitssystemvergleich, Länderberichte und europäische Gesundheitspolitik.* Berlin: Medizinisch wissenschaftlicher Verlag. ISBN: 978-3-95466-304-0.

Schreyögg, G., & Koch, J. (2020). *Management: Grundlagen der Unternehmensführung. Konzepte - Funktionen – Fallstudien.* Wiesbaden: Gabler. ISBN: 978-3-65826-513-7.

Schreyögg, J., Weinbrenner, S., & Busse, R. (2010). Leistungsmanagement in der Integrierten Versorgung. In Reinhard Busse, Jonas Schreyögg & Oliver Tiemann (Eds.). *Management im Gesundheitswesen*, pp. 101-121. Berlin: Springer. ISBN: 978-3-64201-335-5.

Schroeder, G. (2010). *Professionalisierung durch interprofessionelle Bildung?! Schweizer Berufsverband der Pflegefachfrauen und Pflegefachmänner* (SBK). (Congress lecture from 26.05.2010). Luzern: Weiterbildungszentrum für Gesundheitsberufe & Careum-Stiftung. Available at: https://www.careum.ch/documents/20181//132548//2010-Slides-Schroeder-Professionalisierung-Interprofessionelle-Bildung-SBK.pdf.pdf [25.07. 2020]

Schweiger, M. (2020). *„mHealth“ - Eine Analyse der österreichischen Versorgungslandschaft.* (master thesis). Eisenstadt: Fachhochschule Burgenland. n. No.

Schumm, B. (2016). *Integrierte Versorgung im Ländervergleich zwischen Österreich, Deutschland und der Schweiz: Aus Sicht der Patientinnen und Patienten* (Diplomarbeit). Pinkafeld: University of Applied Sciences Burgenland, n. No.

Sedmak, C. (2013). *Mensch bleiben im Krankenhaus: Zwischen Alltag und Ausnahmesituation.* Graz: Styria. ISBN: 978-3-22213-399-2.

Seper, U. (Ed.). (2017). *BILDUNG in den Gesundheitsberufen WEITER DENKEN: Weiterbilden – Weiterdenken – Weiterkommen.* Graz: Leykam. ISBN: 978-3-70110-373-7.

Shaw, S., Rosen, R., & Rumbold, B. (2011). *What is integrated care? An overview of integrated care in the NHS* (Research report). London: The Nuffield Trust. Available at: https://www.nuffieldtrust.org.uk/files/2017-01/what-is-integrated-care-report-web-final.pdf [10.01.2022]

Siegel, A., Kotterer, A., Manuel, A., & Niebling, W. (2015). *GeKiM – Gesundes Kinzigtal Mitgliederbefragung.* (Freiburg: Universitätsklinikum Freiburg). Available at: https://optimedis.de/files/Publikationen/Studien-und-Berichte/2016/Studie_GeKiM_Bericht-zur-zweiten-Mitgliederbefragung-2015.pdf [15.05.2020]

Siegel, A., & Niebling, W. (2018). Individueller Patientennutzen im „Gesunden Kinzigtal" – Zwischenergebnisse einer Trendstudie. In *Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen* (ZEFQ). 2018 (130), pp. 35–41. ISSN: 1865-9217.

Siller, H. (2011). *Normatives Controlling.* Wien: Facultas. ISBN: 978-3-82528-459-6.

Simsa, R., & Patak, M. (2008). *Leadership in Nonprofit-Organizationen: Die Kunst der Führung ohne Profitdenken.* Wien: Linde. ISBN: 978-3-71430-130-4.

Škare, M. (Ed.). (2016). *Conference Proceedings of the Second International Scientific Conference for Doctoral Students and Young Researchers.* Eisenstadt: University of Applied Sciences Burgenland. ISBN: 978-3-95024-529-5.

Smolle, J. (2019). *Best Point of Service – Wohin führt uns der Weg? Gesundheitspolitisches Forum* (Diskussionsbetrag vom 02.05.2019). Available at: https://www.gesundheitspolitischesforum.at/rueckblick-104-gpf-mai-2019/ [15.05.2020]

Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. In *Journal of Business Research*, 2019 (104), pp. 333–339. ISSN: 1873-7978.

Sottas, B. (2013). Interprofessionelle Zusammenarbeit – Herausforderung für die Gesundheitsberufe. In *Biomed Austria –Fachzeitschrift für Biomedizinische AnalytikerInnen*. (06) 2013, pp. 24-26. ISSN: 1997-5503.

Spitzer, St. G. (2020). Mit integrierter Versorgung sektorale Schranken überwinden (online). In *Der Internist* (9) 2020. Springer Medizin Online-Verlag, pp. 903-911. Doi.org/10.1007/s00108-020-00843-8.

Sprenger, R. K. (2015). *Das anständige Unternehmen: Was richtige Führung ausmacht – und was sie weglässt.* München: DVA-Verlag. ISBN: 978-3-42104-706-9.

Sprenger, R. K. (2018). *RADIKAL DIGITAL – 111 Führungskonzepte.* München: DVA-Verlag. ISBN: 978-3-42104-809-7.

Staehle, W. H., Conrad, P., & Sydow, J. (1999). *Management: Eine verhaltenswissenschaftliche Perspektive.* München: Vahlen. ISBN: 978-3-80062-344-0.

Stärker, L. (2014). Gesundheitsreform - Gesucht: Best Point of Service. In *Österreichische Ärztezeitung*, Nr. 4 (aerztezeitung.at vom 25.02.2014). Available at: https://www.aerztezeitung.at/archiv/oeaez-2014/oeaez-4-25022014/kommentar-dr-lukas-staerker-gesundheitsreform-best-point-of-service.html [15.05.2020]

Statista. (2020a). *Bruttoinlandsprodukt (BIP) pro Kopf in den Mitgliedsstaaten der Europäischen Union im Jahr 2019.* Available at: https://de.statista.com/statistik/daten/studie/188766/umfrage/bruttoinlandsprodukt-bip-pro-kopf-in-den-eu-laendern/ [15.05.2020]

Statista. (2020b). *Bevölkerung von Österreich von 2010 bis 2020.* Available at: https://de.statista.com/statistik/daten/studie/18642/umfrage/lebenserwartung-in-oesterreich/ [15.05.2020]

Statista. (2020c). *Fertilitätsrate in Österreich von 2009 bis 2019.* Available at: https://de.statista.com/statistik/daten/studie/217432/umfrage/fertilitaetsrate-in-oesterreich/ [15.05.2020]

Statista. (2020d). *Altersstruktur in Österreich von 2010 bis 2020.* Available at: https://de.statista.com/statistik/daten/studie/217431/umfrage/altersstruktur-in-oesterreich/ [15.05.2020]

Statista. (2020e). *Sozialausgaben für die Gesundheitsversorgung in Österreich nach Leistungsbereich von 2011 bis 2018.* Available at: https://de.statista.com/statistik/daten/studie/293390/umfrage/ausgaben-fuer-die-gesundheitsversorgung-in-oesterreich-nach-leistungsbereich/ [15.05.2020]

Statistik Austria. (2020a). *Personal in Krankenanstalten 2018: Nichtärztliches Gesundheitspersonal 2018 in Krankenanstalten nach Geschlecht, Fachrichtung und Bundesland.* Available at: file:///C:/Users/Peter/Downloads/personal_in_krankenanstalten_2018 _nach _fachrichtungen_geschlecht_und_bunde.pdf [15.05.2020]

Statistik Austria. (2020b). *Personal in Krankenanstalten 2018: Ärztinnen und Ärzte in Krankenanstalten 2018.* Available at: file:///C:/Users/Peter/Downloads/aerzte_und_aerztinnen_2018_in_krankenanstalten.pdf [15.05.2020]

Statistik Austria. (2020c). *Einrichtungen im Gesundheitswesen: Krankenanstalten und tatsächlich aufgestellte Betten.* Available at: http://www.statistik.at/web_de/statistiken/menschen_und_gesellschaft/gesundheit/gesundheitsversorgung/einrichtungen_im_gesundheitswesen/index.html#:~:text=Krankenanstalten%20und%20tats%C3%A4chlich%20aufgestellte%20Betten,tats%C3%A4chlich%20aufgestellte%20Betten%20zur%20Verf%C3%BCgung. [20.05.2020]

Statistik Austria. (2021). *Chronisch Kranke.* Available at: https://www.statistik.at/web_de/ statistiken/menschen_und_gesellschaft/gesundheit/gesundheitszustand/chronische_krankheiten/index.html#:~:text=2%2C8%20Mio.,Frauen). [26.11.2021]

Steinmann, H., Schreyögg, G., Koch, J. (2013). *Management: Grundlagen der Unternehmensführung. Konzepte - Funktionen – Fallstudien.* Wiesbaden: Gabler. ISBN: 978-3-83492-213-7.

Stock, St., & Radaélli, M. (2019). Kooperation der Gesundheitsberufe. In Jens Baas (Ed.). *Zukunft der Gesundheit: vernetzt, digital, menschlich.* Berlin: Medizinisch Wissenschaftliche Verlagsgesellschaft, pp. 251-274. ISBN: 978-3-95466-467-2.

Stoi, R. (2003). Management und Controlling von Intangibles: Die unternehmerische Herausforderung des 21. Jahrhunderts. In *Controlling*, (03-04) 2003, pp. 175-183. ISSN: 0935-0381.

Szabo, E. (1998). *Organisationskultur und Ethnographie: Fallstudie in einem österreichischen Krankenhaus.* Wiesbaden: DUV-Verlag. ISBN: 978-3-82444-296-6.

Tarigan, N. P. (2012). Managing the Nonprofit Organization versus the Theory and Practice of Leadership. In *International Journal of Humanities and Applied Sciences* (IJHAS), Vol. 1, No. 4 (2012). ISSN: 2277–4386.

Tsai, Y. (2011). Relationship between Organizational Culture and Job Satisfaction. *BMC Health Serv Res* 11, 98 (2011). https://doi.org/10.1186/1472-6963-11-98.

Turnbull James, K. (2011). *Leadership in context: Lessons from new leadership theory and current leadership development practice* (Commissioned by The King’s Fund to inform the Commission on Leadership and Management in the NHS). Available at: https://www.kingsfund.org.uk/sites/default/files/leadership-in-context-theory-current-leadership-development-practice-kim-turnbull-james-kings-fund-may-2011.pdf [10.01.2022]

Veit, A. (2004). *Professionelles Handeln als Mittel zur Bewältigung des Theorie-Praxis-Problems in der Krankenpflege.* Göttingen: Hogrefe. ISBN: 978-3-45684-114-4.

Vinzenz Gruppe. (2020a). *Über die Vinzenz Gruppe* (Website). Available at: https://www.vinzenzgruppe.at/wir-ueber-uns/wuensche-an-das-krankenhaus-der-zukunft [15.05.2020]

Vinzenz Gruppe. (2020b). *25 Jahre Vinzenz Gruppe* (Sonderausgabe). Available at: https://www.vinzenzgruppe.at/fileadmin/Vinzenz_Magazin/RZ_vinzmag_25-Jahre_200930_screen_LV.pdf [20.05.2020]

Vinzenz Gruppe. (2020c). *Medizin mit Qualität und Seele.* Available at: tps://www.vinzenzgruppe.at/fileadmin/user_upload/MedizinmitSeeleDerWegderWerte_2014.pdf [20.05.2020]

Vinzenz Gruppe. (2020d). *Organizationsstruktur Vinzenz Gruppe* (Sonderausgabe). Available at: https://www.vinzenzgruppe.at/wir-ueber-uns/organizationsstruktur [20.05.2020]

Vinzenz Gruppe. (2020e). *Unsere Werte: Werte bewahren und erlebbar machen.* Available at: ttps://www.vinzenzgruppe.at/wir-ueber-uns/unsere-werte/unsere-kultur-und-unsere-werte/wertemanagement [20.05.2020]

Vinzenz Gruppe. (n.y.). *Wertemanagement.* Available at: https://www.vinzenzgruppe.at/fileadmin/user_upload/Wertemanagement.pdf [20.05.2020]

Vranken, D. & Attallah, U. (2016). "Kulturrat" statt Betriebsrat. In *Personalmagazin.* (07) 2016, pp. 74-77. ISSN: 1438-4558.

Wieland, J. (2007). *Die Ethik der Governance* (Studien zur Governanceethik, Band 1). Marburg: Metropolis. ISBN: 978-3-89518-606-6.

Wiener Gebietskrankenkasse (WGKK). (2006). *WGKK wird neues bundesweites Competence-Center für integrierte Versorgung im Gesundheitswesen* (Presse-Archiv). Available at: https://www.ots.at/presseaussendung/OTS_20061214_OTS0211/wgkk-wird-neues-bundesweites-competence-center-fuer-integrierte-versorgung-im-gesundheitswesen [15.05.2020]

World Health Organization (WHO). (1978). *Declaration of Alma-Ata. International Conference on Primary Health Care* (WHO, Alma-Ata). Available at: http://www.who.int/publications/almaata_declaration_en.pdf [20.05.2021]

World Health Organization (WHO). (1997). *Health Promotion Glossary*. (WHO Europe). Available at: https://www.who.int/healthpromotion/about/HPR%20Glossary%201998 .pdf [03.08.2021]

World Health Organization (WHO). (2008a). *The Tallinn Charter: Health Systems for Health and Wealth* (WHO Europe). Available at: https://www.euro.who.int/__data/assets/pdf _file/0008/88613/E91438.pdf [03.08.2021]

World Health Organization (WHO). (2008b). *The World Health Report 2008.* Available at: http://www.who.int/whr/2008/en/ [20.05.2021]

World Health Organization (WHO). (2010). *Framework for Action on Interprofessional Education and Collaborative Practice.* Geneva, World Health Organization, 2010. Available at: https://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_ 10.3 _eng.pdf;jsessionid=5DF4F8A909814821DC759110CC25EC98?sequence=1 [25.05. 2020]

World Health Organization (WHO). (2011a) *mHealth - New horizons for health through mobile technologies* (based on the findings of the second global survey on eHealth). Global Observatory for eHealth series, Vol. 3. Switzerland: World Health Organization. ISBN: 978-9-24156-425-0.

World Health Organization (WHO). (2011b). *Public health in Austria. An analysis of the status of public health* (on behalf of the European Observatory on Health Systems and Policies). UK: WHO. ISBN: 978-9-28900-249-3.

World Health Organization (WHO). (2018). *Austria Health system review* (Health Systems in Transition). Available at: https://www.euro.who.int/__data/assets/pdf_file/0009/ 382167/hit-austria-eng.pdf [15.05.2020]

World Health Organization (WHO). (2000). *The World Health Report 2000: Health Systems improving performance*. Geneva, World Health Organization, 2000. ISSN: 1020-3311.

World Health Organization (WHO). (2020). *eHealth.* Available at: https://www.who.int/ ehealth/about/en/ [15.05.2020]

9. ANNEX

ANNEX A - LIST OF LEGAL NORMS (used)

ABGB *Austrian "Allgemeines bürgerliches Gesetzbuch"*, i.d.g.F. (as amended). Available at: https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10001622 [18.08.2020].

ÄrzteG *Austrian "Ärztegesetz"*, i.d.g.F. (as amended). Available at: https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10011138 [18.08.2020]

ASVG *Austrian "Allgemeines Sozialversicherungsgesetz"*, i.d.g.F. (as amended). Available at: https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10008147 [18.08.2020].

GQG *Austrian „Gesundheitsqualitätsgesetz"*, i.d.g.F. (as amended). Available at: https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=20003883 [31.08.2020].

G-ZG *Austrian „Gesundheits-Zielsteuerungsgesetz"*, i.d.g.F. (as amended). Available at: https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=20009791 [31.08.2020].

KAKuG *Austrian "Kranken- und Kuranstaltengesetz, Grundsatzgesetz"*, i.d.g.F. (as amended). Available at: https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10010285 [18.08.2020]

ANNEX B - HOSPITAL QUESTIONNAIRE (QUANTITATIVE SURVEY)

'Integrated care' is described in the Austrian health care system as "patient-oriented, continuous, cross-sectoral, interdisciplinary and/or multi-professional (...) care".

Q 1) How do you assess the cooperation of the different professional groups in the intramural care sector (within the hospital sector)?

Please give your assessment!

○ very good ○ good ○ satisfactory ○ sufficient ○ insufficient

Q 2) How do you rate the cooperation of your hospital with other care sectors (general practitioners, specialists, nursing homes)?

○ very good ○ good ○ satisfactory ○ sufficient ○ insufficient

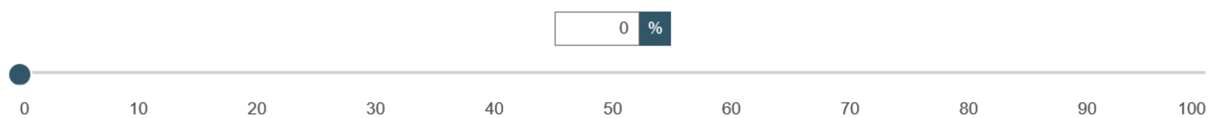
Q 3) Between which areas of care (at which interfaces) would an improvement in cooperation be desirable?

Please answer in key words in the text field!

Q 4) What concrete measures could improve cooperation at the interfaces? *Please answer in the text field!*

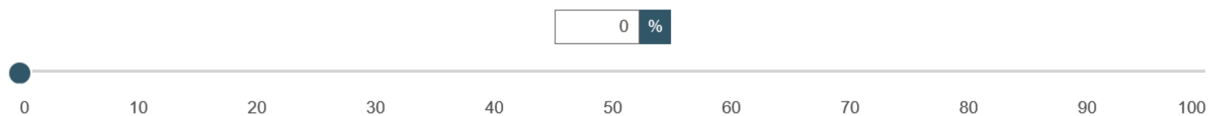
Q 5) Has Covid-19 and the need for better coordination between the care sectors led to a sustainable improvement in cooperation and communication between the care sectors?

Please indicate the degree of possible improvement in percent using the slider - please move it with the cursor!



Q 6) Has Covid-19 also had a lasting effect on inter- and multiprofessional cooperation in your hospital?

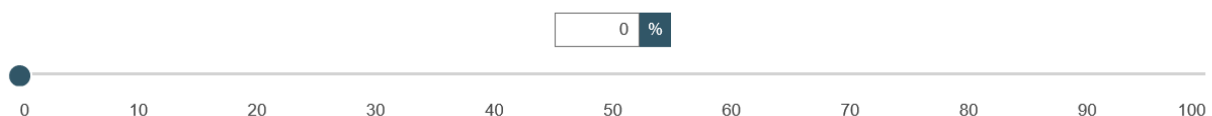
Please indicate the extent of the possible improvement in percent with the slider!



The term 'Best Point of Service' is discussed in the Austrian health care system as "care at the right time at the right place", admittedly under health economic conditions.

Q 7) How do you generally assess the status quo in the Austrian health care landscape with regard to the individual degree of achievement of a "Best Point of Service"?

Please give your assessment in percent!



Q 8) In your opinion, how important is the culture of togetherness in interinstitutional or interdepartmental cooperation?

○ high importance ○ rather high importance ○ neither nor ○ rather low importance ○ low importance

Q 9) In general, how do you assess the current culture of cross-sectoral, interprofessional cooperation in the Austrian health care system?

○ high ○ rather high ○ neither nor ○ rather low ○ low

Q 10) A culture of values is reflected in staff members who are motivated by appreciation and recognition and who also tackle difficult everyday situations.

Please indicate to what extent this applies in your opinion!

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 11) An organizational culture that lives up to its expectations also contributes to better cooperation at the care interfaces.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 12) In a culture based on esteem, smooth processes and handovers in particular become more important in addition to collegial cooperation.

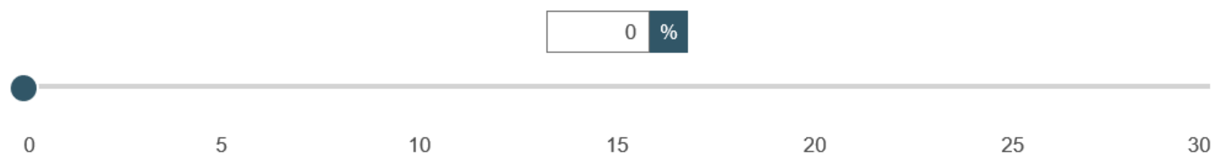
○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 13) Good interprofessional cooperation usually also leads to optimization of resources.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 14) How high would you estimate the possible savings potential with good/better conditions (framework conditions), measured in terms of your daily working time?

Information can be given using a slider - 0% to 30% (and more).



Q 15) Different professional groups have different leadership expectations.
To what extent do you think this is true!

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 16) Interprofessionality and cooperation across care areas (intramural/extramural) should be addressed in all training areas of the health professions.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 17) A common multiprofessional basic module in the training of all health professions would make sense.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 18) Changed mindset and behaviour of younger generations favor interprofessional cooperation.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 19) Leadership must be rethought in relation to the behavior and expectations of future generations.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 20) The collegial leadership model ("Modell der Kollegialen Führung") as a whole is proving to be outdated.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

My suggestion regarding the leadership body of the future would be as follows:

Please enter in the text box!

Q 21) Shared responsibility for interprofessional, cross-institutional and patient-**centered** care also requires new leadership styles to be considered.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

On the culture of togetherness:

Q 22) A basic ethical attitude must be an integral part of all management.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 23) Ethics is not an antithesis to economics, a better understanding would be: "Ethically responsible economics!"

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 24) Mission statements touch on one's own attitudes and provide guidance for everyday life.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 25) Mission statements promote interprofessional cooperation, especially across sectors (intra/extramural).

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 26) "If you can't measure it, you can't manage it!" also applies to mission statements.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 27) Mission statements can usually only be implemented to a limited extent in everyday life.

Please indicate to what extent the following statements apply!

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 28) Mission statements sometimes contain exaggerated formulations.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 29) The choice of words in mission statements is usually 'glossed over'.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 30) Mission statements do not reflect real everyday life.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 31) Mission statements are usually difficult to implement due to existing structures and/or departmental boundaries.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 32) Where the mission statement now hangs, it would be more appropriate to put up a mirror.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 33) Culture cannot be imposed on anyone, not even on another institution.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 34) You cannot manage values, but you can create spaces in which values can develop.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 35) Working for a living culture of values is a managerial task.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 36) A culture of togetherness is just as strategically important in health care institutions as it is in cross-institutional and cross-sectoral cooperation.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 37) The management level has to ensure that employees understand and identify with value concepts.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 38) Good organizational culture requires the creation of framework conditions conducive to a culture of aspiration.

- agree completely
- tend to agree
- neither nor
- tend to disagree
- disagree at all

Q 39) The aim of values work is in particular to make claimed values tangible for staff and patients, also at the interfaces in the course of transition.

- agree completely
- tend to agree
- neither nor
- tend to disagree
- disagree at all

Q 40) Integration of care (especially cross-sectoral cooperation)...

Do you agree with the following statements? (Multiple ticks possible.)

- ...leads overall to stronger patient orientation
- ...requires good management at the transitions with clear responsibilities
- ...ultimately leads to shorter waiting and treatment times
- ...requires transparency and increased information flow
- ...leads to an improvement in the quality of the entire care process
- ...leads to optimization of resources, e.g. by eliminating duplicate and multiple examinations
- ...leads to a reduction in stress, e.g. in the case of radiation exposure
- ...is the joint responsibility of all actors involved in the entire care process

Q 41) Responsibilities and competences between the individual areas of care (intra- and extramural) are by and large already clearly and sufficiently defined.

- agree completely
- tend to agree
- neither nor
- tend to disagree
- disagree at all

Q 42) In my opinion, the following critical points at the interfaces between intra- and extramural care areas should be given special attention:

Please provide your expertise in keywords!

Q 43) In my opinion, the following conditions (framework conditions) must be created in order to optimize interprofessional cooperation between intra- and extramural care areas:

Q 44) What can the individual contribute to improve interprofessional cooperation and communication between intra- and extramural areas:

Q 45) What could be your personal contribution to the realization of patient-centered, cross-sectoral (intra/extramural) care characterized by continuity and good interprofessional coopera-
tion?

ANNEX C - NURSING HOME QUESTIONNAIRE (QUANTITATIVE SURVEY)

'Integrated care' is described in the Austrian health care system as "patient-oriented, continuous, cross-sectoral, interdisciplinary and/or multi-professional (...) care".

Q 1) How do you assess the cooperation of the different professional groups in the care sector of inpatient long-term care?

Please give your assessment!

○ very good ○ good ○ satisfactory ○ sufficient ○ insufficient

Q 2) How do you rate the cooperation of your hospital with other care areas (general practitioners/specialists/ hospitals)?

○ very good ○ good ○ satisfactory ○ sufficient ○ insufficient

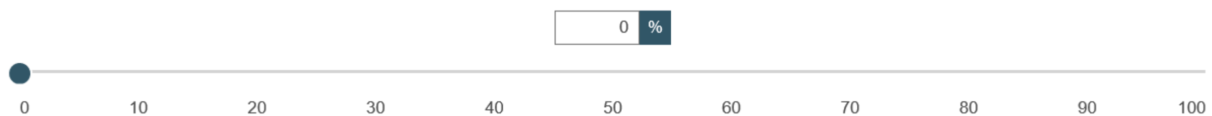
Q 3) Between which areas of care (at which interfaces) would an improvement in cooperation be desirable?

Please answer in key words in the text field!

Q 4) What concrete measures could improve cooperation at the interfaces? *Please answer in the text field!*

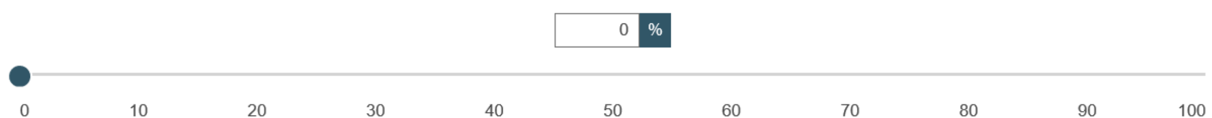
Q 5) Has the cooperation and communication between hospitals, nursing homes, outpatient services and general practitioners improved in the long term as a result of Covid-19 and the need for better coordination between the care sectors?

Please indicate the degree of possible improvement in percent using the slider - please move it with the cursor!



Q 6) Has Covid-19 also had a lasting effect on interprofessional cooperation in your nursing home?

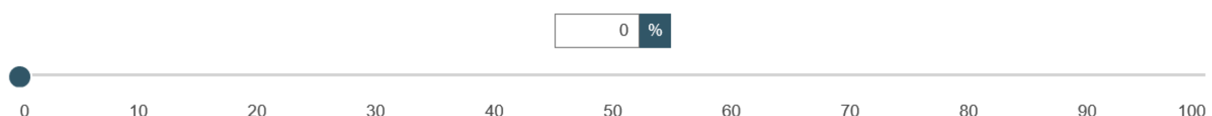
Please indicate the extent of the possible improvement in percent with the slider!



The term 'Best Point of Service' is discussed in the Austrian health care system as "care at the right time at the right place", admittedly under health economic conditions.

Q 7) How do you generally assess the status quo in the Austrian health care landscape with regard to the individual degree of achievement of a "Best Point of Service"?

Please give your assessment in percent!



Q 8) In your opinion, how important is the culture of togetherness in interprofessional cooperation between hospitals, nursing homes, outpatient services, etc.?

○ high importance ○ rather high importance ○ neither nor ○ rather low importance ○ low importance

Q 9) In general, how do you assess the current culture of interprofessional cooperation between the care sectors?

○ high ○ rather high ○ neither nor ○ rather low ○ low

Q 10) A culture of values is reflected in staff members who are motivated by appreciation and recognition and who also tackle difficult everyday situations.

Please indicate to what extent this applies in your opinion!

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 11) An organizational culture that lives up to its expectations also contributes to better cooperation at the care interfaces, e.g. hospital/nursing home.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 12) In a culture based on appreciation, smooth processes and handovers - e.g. from the hospital to the nursing home - become more important in addition to collegial cooperation.

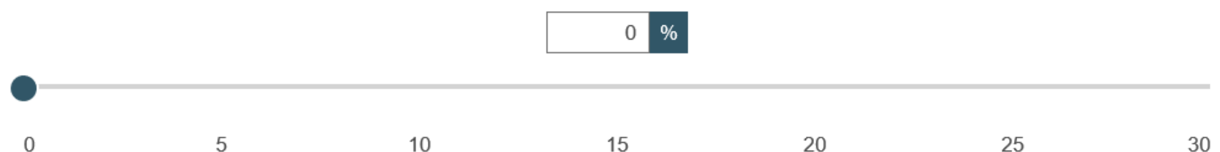
○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 13) Good interprofessional cooperation usually also leads to optimization of resources.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 14) How high would you estimate the possible savings potential with good/better conditions (framework conditions), measured in terms of your daily working time?

Information can be given using a slider - 0% to 30% (and more).



Q 15) Different professional groups have different leadership expectations.

To what extent do you think this is true!

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 16) Interprofessionality and cooperation across care areas (hospital/nursing home/family doctors/outpatient services, etc.) should be addressed in all training areas of the health professions.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 17) A common basic module in the training of all health professions (nursing/medicine/medical-technical services) would make sense.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 18) Changed mindset and behavior of younger generations favor interprofessional cooperation.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 19) Leadership must be rethought in relation to the behavior and expectations of future generations.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 20) Current models of leadership are no longer up to date.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

My suggestion regarding the leadership body of the future would be as follows:

Please enter in the text box!

Q 21) Co-responsibility to inter-professional, cross-institutional care (e.g. hospital/nursing home) also requires us to consider new leadership styles.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

On the culture of togetherness:

Q 22) A basic ethical attitude must be an integral part of every leadership/management.

○ agree completely ○ tend to agree ◉ neither nor ○ tend to disagree ○ disagree at all

Q 23) Ethics is not an antithesis to economics, a better understanding would be: "Ethically responsible economics!"

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 24) Mission statements touch on one's own attitudes and provide guidance for everyday life.

○ agree completely ○ tend to agree ○ neither nor ○ tend to disagree ○ disagree at all

Q 25) Mission statements promote interprofessional cooperation, especially across departments (hospital/nursing home/out-patient services).

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 26) "If you can't measure it, you can't manage it!" also applies to mission statements.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 27) Mission statements can usually only be implemented to a limited extent in everyday life.

Please indicate to what extent the following statements apply!

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 28) Mission statements sometimes contain exaggerated formulations.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 29) The choice of words in mission statements is usually 'glossed over'.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 30) Mission statements do not reflect real everyday life.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 31) Mission statements are usually difficult to implement due to existing structures and/or departmental boundaries.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 32) Where the mission statement now hangs, it would be more appropriate to put up a mirror.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 33) Culture cannot be imposed on anyone, not even on another institution.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 34) You cannot manage values, but you can create spaces in which values can develop.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 35) Working for a living culture of values is a managerial task.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 36) A culture of togetherness is just as strategically important in health care facilities as it is in cross-institutional and cross-sectoral cooperation, e.g. between hospitals and nursing homes.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 37) The management level has to ensure that employees understand and identify with value concepts.

agree completely · tend to agree · neither nor · tend to disagree · disagree at all

Q 38) Good organizational culture requires the creation of framework conditions conducive to a culture of aspiration.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 39) The aim of values work is in particular to make claimed values tangible for staff and patients also at the interfaces (hospital/nursing home) in the course of transition.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 40) Integration of care (especially cross-sectoral cooperation)...

Do you agree with the following statements? (Multiple ticks possible.)

- ...leads overall to stronger patient orientation
- ...requires good management at the transitions with clear responsibilities
- ...ultimately leads to shorter waiting and treatment times
- ...requires transparency and increased information flow
- ...leads to an improvement in the quality of the entire care process
- ...leads to optimization of resources, e.g. by eliminating duplicate and multiple examinations
- ...leads to a reduction in stress, e.g. in the case of radiation exposure
- ...is the joint responsibility of all actors involved in the entire care process

Q 41) Responsibilities and competences between the individual care areas (hospital/nursing home/outpatient services, etc.) are by and large already clearly and sufficiently defined.

agree completely | tend to agree | neither nor | tend to disagree | disagree at all

Q 42) In my view, the following critical points at the interfaces (e.g. hospital/nursing home) require special attention:

Please provide your expertise in keywords!

Q 43) In my view, the following prerequisites (framework conditions) must be created in order to optimize interprofessional cooperation between intra- and extramural areas (e.g. hospital/nursing home):

Q 44) What can the individual do to improve interprofessional cooperation and communication between the care sectors (hospital/nursing home/family doctors/outpatient services)?

Q 45) What could be your personal contribution to the realization of patient-centered care across care settings and characterized by good interprofessional cooperation?

ANNEX D - SUM SCORES (QUANTITATIVE SURVEY)

Comparison hospital perspective (HO) - nursing home perspective (NH)

HO 75 adress. / 29 resp., excl. 3 with n.a.	**NH** 58 adress. / 28 resp. + 1 GC resp.	expert estimation of the "interprofessional cooperation" — $h_{0,1}/h_{1,1}$: There is no/a difference between HO and NH with regard to the view of interprofessional collaboration.		"substainable impact of covid-19" on interprofessional togetherness *(in %)*		on scientific discourse: *"Do crises need to bring about change?"*		expert estimation of the "BPoS" in AUT HC sector — $h_{0,2}/h_{1,2}$: In the organizational view of a hospital, the BPoS is rated significantly better in comparison to the nursing home view.		expert estimation of the "culture of togetherness" in AUT HC sector		$h_{0,3}/h_{1,3}$: In highly developed socio-techn. systems as HOs, the culture of togetherness is higher assessed and more optimistically than in NHs.		expert estimation of the "influence potential of organisational culture" — on scientific discourse: "Organizational development potential through the demands of a lived organizational culture ..."		expert estimation of the "savings potential"		$h_{0,4}/h_{1,4}$: In highly developed socio-technical system as HOs, assessment of savings potential is significant lower than the assessment in NHs.		current mindset of leadership — $h_{0,5}/h_{1,5}$: Over 40-y-olds agree to a significant greater extent that different health professionals require different leadership.	
serial no. of the responses		Σ q 1 + q 2		q 5		q 6		q 7		q 8 *(target)*		q 9 *(actual)*		Σ q 10 to q 12		q 13 *(ressources)*		q 14 *(working time: 0 - 30 %)*		q 15 *(diff. Leader-ship expectations)*	
HO	**NH**	**HO**	**NH**	**HO**	**NH**	**HO**	**NH**	**HO**	**NH**	**HO**	**NH**	**HO**	**NH**	**HO**	**NH**	**HO**	**NH**	**HO**	**NH**	**HO**	**NH**
1	1	4	6	10	10	*n.a.*	10	70	30	2	1	3	4	3	3	1	1	20	30	1	1
2	2	2	4	89	75	99	90	73	55	1	2	2	2	3	3	1	1	30	20	2	1
3	3	6	7	5	1	12	20	23	25	4	1	4	4	3	3	1	1	20	5	1	4
4	4	4	3	50	10	90	81	70	10	1	1	2	4	4	4	1	1	21	20	2	2
5	5	4	6	70	30	60	20	20	10	2	1	3	4	2	5	1	1	10	28	1	2
6	6	4	6	20	*not specif.*	20	50	50	10	2	4	2	4	6	3	3	1	10	30	2	2
7	7	3	6	65	*not specif.*	40	*not specif.*	30	31	2	2	2	4	6	6	2	1	25	5	1	2
8	8	5	5	70	3	90	30	20	6	1	4	4	4	4	6	1	1	25	6	2	2
9	9	5	5	*0 or not specified*	70	20	19	10	10	3	1	3	3	6	4	1	1	10	20	1	2
10	10	5	5	*0 or not specified*	30	50	30	40	41	2	4	3	3	6	5	1	1	20	30	1	2
11	11	4	6	75	16	50	54	80	15	2	1	3	4	8	6	1	2	*n.a.*	20	1	2
12	12	8	3	5	*not specif.*	10	*not specif.*	10	50	4	1	4	3	6	5	2	1	20	10	1	1
13	13	3	4	1	*not specif.*	80	*not specif.*	70	78	1	2	2	2	3	4	1	1	2	25	1	3

Comparison hospital perspective (HO) - nursing home perspective (NH)

serial no. of the responses		Σ q 1 + q 2		q 5		q 6		q 7		q 8 *(target)*		q 9 *(actual)*		Σ q 10 to q 12		q 13 *(ressources)*		q 14 *(working time: 0 - 30 %)*		q 15 *(diff. Leader-ship expectations)*	
14	14	5	4	30	*not specif.*	20	60	40	40	0	4	0	4	4	4	2	1	7	*not specif.*	1	2
15	15	4	4	10	20	25	31	20	10	1	2	3	2	3	4	1	1	10	25	2	2
16	16	6	9	*0 or not specified*	80	40	40	40	36	1	1	4	4	8	3	2	1	10	30	4	5
17	17	5	10	20	31	54	49	60	20	1	1	3	4	4	4	1	1	15	25	1	2
18	18	6	4	60	10	16	20	1	10	2	1	2	3	4	4	1	2	22	10	3	1
19	19	5	4	50	60	51	60	33	60	2	1	4	2	4	4	1	1	15	10	1	2
20	20	3	7	*0 or not specified*	31	80	65	50	35	1	1	3	3	3	3	1	1	25	20	1	2
21	21	6	5	30	10	10	20	20	33	1	1	4	4	3	4	1	1	15	15	2	4
22	22	5	5	50	*not specif.*	21	50	65	10	1	2	3	4	4	5	1	1	12	30	2	2
23	23	6	3	*0 or not*	80	*0 or not*	50	10	50	2	2	4	2	3	3	1	1	23	25	1	1
24	24	6	4	*0 or not*	70	60	70	80	50	1	2	3	4	3	3	1	1	8	20	1	2
25	25	5	7	*0 or not*	5	50	3	100	31	2	1	4	4	3	4	1	1	*n.a.*	30	1	4
26	26	7	5	13	*not specif.*	40	50	20	30	1	1	4	4	4	4	1	1	5	20	2	1
27	27	4	5	25	10	90	80	40	31	1	1	4	3	3	9	1	2	12	15	4	2
28	28	5	4	20	64	10	30	20	33	4	3	4	2	4	6	1	2	20	8	2	3
29	29	6	5	45	50	70	50	60	20	2	1	2	2	4	4	1	1	15	10	2	4
29	29	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø
49,1%	**38,7%**	**4,9**	**5,4**	**37,0%**	**34,8%**	**46,6%**	**43,5%**	**30,0%**	**42,2%**	**1,72**	**1,72**	**3,03**	**3,31**	**4,2**	**4,3**	**1,21**	**1,14**	**15,8%**	**19,4%**	**1,6%**	**2,2%**

response rate

HCsector
- hospitals
- nursing homes

Socio-demographic characteristics & professional references of the participants															
serial no. of the responses		sex		age		education		type of HC facility		original profession		mgmt. experience		professional experience	
HO	NH	HO	NH	HO	NH	HO	NH	HO	NH	HO	NH	HO	NH	HO	NH
1	1	2	2	4	3	4	4	1	1	3	3	2	1	3	3
2	2	2	2	4	3	1	1	2	1	1	3	3	3	3	3
3	3	1	2	4	3	4	4	2	1	1	3	2	2	3	3
4	4	1	1	2	3	4	3	5	1	1	3	1	3	3	3
5	5	1	2	4	2	4	4	1	5	3	3	2	2	3	2
6	6	1	2	5	3	3	1	1	5	3	3	3	3	3	3
7	7	1	1	4	3	4	4	1	1	1	3	3	3	3	3
8	8	1	2	4	1	4	4	0	1	1	3	3	1	3	1
9	9	1	1	2	4	4	5	2	1	1	1	1	3	1	3
10	10	1	2	4	4	5	4	1	1	1	3	3	3	3	3
11	11	2	2	2	3	4	3	1	5	3	1	2	3	2	2
12	12	1	2	4	2	4	4	1	1	5	5	3	2	3	2
13	13	1	2	4	2	4	3	1	2	1	3	3	1	3	2
14	14	1	2	4	2	4	4	1	1	1	1	2	1	3	1
15	15	2	2	3	2	4	2	2	2	1	1	1	*no indic.*	3	2
16	16	1	2	3	4	4	3	1	2	1	3	2	3	2	3
17	17	1	2	3	4	4	4	2	1	1	3	3	3	2	3
18	18	1	1	4	3	2	4	1	1	3	3	3	3	3	3
19	19	2	2	4	3	1	3	0	1	3	3	3	1	3	3
20	20	1	2	4	2	3	3	1	1	1	3	2	1	3	2
21	21	2	1	4	3	2	4	1	1	3	3	2	3	3	3
22	22	2	2	3	2	4	4	1	2	3	1	1	*no indic.*	2	2
23	23	2	2	3	3	4	2	1	*no indic.*	3	3	0	1	2	3
24	24	0	2	4	4	4	5	5	1	3	1	2	3	3	2
25	25	2	2	4	1	4	2	1	3	3	3	3	1	3	1
26	26	2	2	1	3	2	4	1	1	3	3	2	3	1	3
27	27	2	2	4	3	3	4	1	3	3	1	3	1	3	2
28	28	1	2	2	2	4	1	1	3	3	3	1	1	2	2
29	29	1	1	5	4	4	5	1	1	1	3	3	3	3	3

HCsector

- hospitals
- nursing homes

Comparison hospital perspective (HO) - nursing home perspective (NH)																			
interprofessional education on scientific discourse: *"Is joint interprofessional training for all professional groups a basic requirement for good cooperation?"*		mindset of the next gen. and effects on leadership $h_{0,6}/h_{1,6}$: The views of those under 40 differ from those over 40 and / or the views of male managers differ from those of women.		pressure to change with regard to future-ready leadership on scientific discourse: *"...only to reveal a general tendency for or against"*		ethics as the basis of successful health management on scientific discourse: *"Is an ethical attitude another basic requirement for good interprofessional cooperation?"*		performance of mission statements $h_{0,7}/h_{1,7}$: There is no/a difference between H and NH regarding the view of the importance of mission statements for the organization.		trust in the functionality of mission statements $h_{0,8}/h_{1,8}$: There is no/a difference with regard to trust in guiding principles between denomat. and other instit. (HO+NH) and also betw. HO and NH		common understanding of culture on scientific discourse: *"...perspectives on the understanding of culture"*		impact of cultural work $h_{0,9}/h_{1,9}$: There is no/a difference with regarding the importance of cultural work betw. denominat. and other inst. (HO+NH) and also betw. HO and NH.		confidence in the effects of integrated HC on patients h0.10/h1.10: There is no/a diff. with regarding regarding the confidence in effects of integrated HC on patients between HOs and NHs.		...are there clear responsibilities? on scientific discourse: *"Are there clear responsibilities in the AUT HC sector?"*	
Σ q 16 + q 17		Σ q 18 + q 19		Σ q 20 + q 21		Σ q 22 + q 23		Σ q 24 to q 26		Σ q 27 to q 32		Σ q 33 to Q 35		Σ q 36 to q 39		Σ q 40		q 41	
HO	NH	HO	NH	HO	NH	HO	NH	HO	NH	HO	NH	HO	NH	HO	NH	HO	NH	HO	NH
2	2	5	3	4	2	2	2	11	10	16	8	3	7	7	4	8	5	3	2
2	3	4	3	1	2	3	3	6	5	11	18	4	7	6	8	4	6	2	3
2	3	6	4	2	3	2	2	11	6	8	11	4	10	9	6	8	8	5	2
4	3	4	6	2	3	2	2	12	7	11	15	3	8	5	8	7	7	2	4
2	2	3	4	2	2	2	2	6	5	15	12	8	8	8	7	8	6	4	4
3	4	4	7	3	4	4	2	9	9	12	7	6	7	7	8	4	7	3	5
6	2	4	5	2	3	2	3	8	6	8	21	4	7	9	6	5	4	2	3
2	4	3	2	1	2	2	4	6	6	10	18	6	9	4	12	5	4	4	2
2	3	2	4	2	2	2	4	6	5	22	17	6	5	5	6	8	8	4	2
5	2	4	4	3	2	4	2	11	5	16	14	5	9	8	8	6	5	2	4
4	2	6	4	3	2	2	2	8	7	12	7	8	3	10	5	8	6	0	3
2	3	3	3	1	2	3	4	7	7	15	15	5	5	7	6	8	8	4	3
2	3	5	5	2	1	2	2	5	4	10	19	7	10	6	5	8	4	2	3

Comparison hospital perspective (HO) - nursing home perspective (NH)																			
Σ q 16 + q 17		Σ q 18 + q 19		Σ q 20 + q 21		Σ q 22 + q 23		Σ q 24 to q 26		Σ q 27 to q 32		Σ q 33 to Q 35		Σ q 36 to q 39		Σ q 40		q 41	
3	2	3	5	2	2	2	3	8	5	7	14	4	5	5	7	8	7	2	2
2	3	4	5	2	3	2	4	13	10	14	11	8	4	7	5	5	6	3	5
3	3	5	2	2	1	2	2	10	7	11	13	4	3	6	5	8	5	4	4
2	2	5	3	2	2	2	3	14	4	19	17	7	6	4	6	7	8	1	4
3	3	3	5	2	2	4	2	7	5	7	13	11	6	7	7	6	6	2	4
2	2	3	3	0	2	3	2	11	6	11	20	4	6	7	6	5	5	1	2
2	2	2	3	1	1	2	2	6	6	12	14	3	3	4	4	5	5	3	4
2	3	4	4	2	1	2	2	8	5	13	17	5	6	4	4	8	5	4	2
3	2	4	5	2	2	3	2	5	6	15	18	7	5	7	7	4	8	4	4
2	2	7	4	2	4	2	2	5	3	9	21	9	7	4	5	8	7	5	2
2	3	5	3	2	2	2	4	12	8	10	18	4	6	5	8	7	4	4	4
2	3	3	5	4	2	2	2	12	10	10	8	3	7	4	7	8	8	2	2
3	2	5	2	2	1	2	2	10	11	7	6	5	6	6	8	6	3	4	4
2	2	5	2	2	1	3	2	6	3	24	13	3	4	5	6	8	5	2	2
2	4	3	4	2	2	2	2	5	6	8	13	5	7	5	8	6	3	3	3
2	2	2	6	2	2	2	3	6	10	17	14	7	6	6	6	8	8	3	2
Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø
2,6	**2,6**	**4,0**	**4,0**	**2,0**	**2,1**	**2,4**	**2,5**	**8,4**	**6,4**	**12,4**	**14,2**	**5,4**	**6,3**	**6,1**	**6,5**	**6,7**	**5,9**	**2,9**	**3,2%**

ANNEX E - VARIABLE VIEW OF THE QUANTITATIVE SURVEY ON INTEGRATED HEALTH CARE (HO PERSPECTIVE vs. NH PERSPECTIVE)

	Name	Typ	Breite	Dezimals...	Beschriftung	Werte	Fehlend	Spalten	Ausrichtung	Messniveau	Rolle
1	HCsector	Numerisch	1	0		{1, hospitals...	Ohne	8	Rechts	Nominal	Eingabe
2	sex	Numerisch	1	0		{1, male}...	Ohne	8	Rechts	Nominal	Eingabe
3	age	Numerisch	1	0		{1, up to 30 ...	Ohne	8	Rechts	Ordinal	Eingabe
4	educat	Numerisch	1	0		{1, basic vo...	Ohne	8	Rechts	Ordinal	Eingabe
5	HCinst	Numerisch	1	0		{1, public}...	Ohne	8	Rechts	Nominal	Eingabe
6	primprof	Numerisch	1	0		{1, administ...	Ohne	8	Rechts	Nominal	Eingabe
7	mgmtexp	Numerisch	1	0		{1, less tha...	Ohne	8	Rechts	Ordinal	Eingabe
8	professexp	Numerisch	1	0		{1, less tha...	Ohne	8	Rechts	Ordinal	Eingabe
9	intprofcoop	Numerisch	2	0	Q1 + Q2	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
10	substcovidimp	Numerisch	2	0	Q5	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
11	togethcovidi...	Numerisch	2	0	Q6	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
12	assessBPoS	Numerisch	3	0	Q7	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
13	targetculture	Numerisch	2	0	Q8	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
14	actualculture	Numerisch	2	0	Q9	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
15	assessinflu...	Numerisch	2	0	Q10 to Q12	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
16	ressourcess...	Numerisch	2	0	Q13	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
17	workingtime...	Numerisch	2	0	Q14	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
18	actmindsetl...	Numerisch	2	0	Q15	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
19	intprofeduca...	Numerisch	2	0	Q16 + Q17	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
20	effectleadmi...	Numerisch	2	0	Q18 + Q19	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
21	changefutur...	Numerisch	2	0	Q20 + Q21	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
22	ethicsbasics	Numerisch	2	0	Q22 + Q23	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
23	performmiss...	Numerisch	2	0	Q24 to Q26	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
24	trustmissstate	Numerisch	2	0	Q27 to Q32	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
25	understandc...	Numerisch	2	0	Q33 to Q35	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
26	cultworkimp	Numerisch	2	0	Q36 to Q39	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
27	effinteghcpat	Numerisch	2	0	Q40	Ohne	Ohne	8	Rechts	Metrisch	Eingabe
28	clearrespons	Numerisch	2	0	Q41	Ohne	Ohne	8	Rechts	Metrisch	Eingabe

ANNEX F - SPSS STATISTICAL ANALYSIS DATA
(QUANTITATIVE SURVEY: HO PERSPECTIVE VS. NH PERSPECTIVE)

	HCsector	sex	age	educat	HCinst	primprof	mgmtexp	professexp	intprofcoop	substcovidimp	togethcovidimp	assessBPoS	targetculture
1	1	2	4	4	1	3	2	3	4	10	.	70	2
2	1	2	4	1	2	1	3	3	2	89	99	73	1
3	1	1	4	4	2	1	2	3	6	5	12	23	4
4	1	1	2	4	5	1	1	3	4	50	90	70	1
5	1	1	4	4	1	3	2	3	4	70	60	20	2
6	1	1	5	3	1	3	3	3	4	20	20	50	2
7	1	1	4	4	1	1	3	3	3	65	40	30	2
8	1	1	4	4	0	1	3	3	5	70	90	20	1
9	1	1	2	4	2	1	1	1	5	.	20	10	3
10	1	1	4	5	1	1	3	3	5	.	50	40	2
11	1	2	2	4	1	3	2	2	4	75	50	80	2
12	1	1	4	4	1	5	3	3	8	5	10	10	4
13	1	1	4	4	1	1	3	3	3	1	80	70	1
14	1	1	4	4	1	1	2	3	5	30	20	40	0
15	1	2	3	4	2	1	1	3	4	10	25	20	1
16	1	1	3	4	1	1	2	2	6	.	40	40	1
17	1	1	3	4	2	1	3	2	5	20	54	60	1
18	1	1	4	2	1	3	3	3	6	60	16	1	2
19	1	2	4	1	0	3	3	3	5	50	51	33	2
20	1	1	4	3	1	1	2	3	3	.	80	50	1
21	1	2	4	2	1	3	2	3	6	30	10	20	1
22	1	2	3	4	1	3	1	2	5	50	21	65	1
23	1	2	3	4	1	3	0	2	6	.	.	10	2
24	1	0	4	4	5	3	2	3	6	.	60	80	1
25	1	2	4	4	1	3	3	3	5	.	50	100	2
26	1	2	1	2	1	3	2	1	7	13	40	20	1
27	1	2	4	3	1	3	3	3	4	25	90	40	1
28	1	1	2	4	1	3	1	2	5	20	10	20	4
29	1	1	5	4	1	1	3	3	6	45	70	60	2

	HCsector	sex	age	educat	HCinst	primprof	mgmtexp	professexp	intprofcoop	substcovidimp	togethcovidimp	assessBPoS	targetculture
30	2	2	3	4	1	3	1	3	6	10	10	30	1
31	2	2	3	1	1	3	3	3	4	75	90	55	2
32	2	2	3	4	1	3	2	3	7	1	20	25	1
33	2	1	3	3	1	3	3	3	3	10	81	10	1
34	2	2	2	4	5	3	2	2	6	30	20	10	1
35	2	2	3	1	5	3	3	3	6	.	50	10	4
36	2	1	3	4	1	3	3	3	6	.	.	31	2
37	2	2	1	4	1	3	1	1	5	3	30	6	4
38	2	1	4	5	1	1	3	3	5	70	19	10	1
39	2	2	4	4	1	3	3	3	5	30	30	41	4
40	2	2	3	3	5	1	3	2	6	16	54	15	1
41	2	2	2	4	1	5	2	2	3	.	.	50	1
42	2	2	2	3	2	3	1	2	4	.	.	78	2
43	2	2	2	4	1	1	1	1	4	.	60	40	4
44	2	2	2	2	2	1	4	2	4	20	31	10	2
45	2	2	4	3	2	3	3	3	9	80	40	36	1
46	2	2	4	4	1	3	3	3	10	31	49	20	1
47	2	1	3	4	1	3	3	3	4	10	20	10	1
48	2	2	3	3	1	3	1	3	4	60	60	60	1
49	2	2	2	3	1	3	1	2	7	31	65	35	1
50	2	1	3	4	1	3	3	3	5	10	20	33	1
51	2	2	2	4	2	1	4	2	5	.	50	10	2
52	2	2	3	2	6	3	1	3	3	80	50	50	2
53	2	2	4	5	1	1	3	2	4	70	70	50	2
54	2	2	1	2	3	3	1	1	7	5	3	31	1
55	2	2	3	4	1	3	3	3	5	.	50	30	1
56	2	2	3	4	3	1	1	2	5	10	80	31	1
57	2	2	2	1	3	3	1	2	4	64	30	33	3
58	2	1	4	5	1	3	3	3	5	50	50	20	1

	actualcult ure	assessinfl upotcult	ressource ssavpot	workingti mesavpot	actminds etleaders hip	intprofedu cattrainin g	effectlead mindnext gen	changefut urelead	ethicsbas ics	performmi ssstate	trustmiss state	understan dcult	cultworki mp	effinteghc pat	clearresp ons
1	3	3	1	20	1	2	5	4	2	11	16	3	7	8	3
2	2	3	1	30	2	2	4	1	3	6	11	4	6	4	2
3	4	3	1	20	1	2	6	2	2	11	8	4	9	8	5
4	2	4	1	21	2	4	4	2	2	12	11	3	5	7	2
5	3	2	1	10	1	2	3	2	2	6	15	8	8	8	4
6	2	6	3	10	2	3	4	3	4	9	12	6	7	4	3
7	2	6	2	25	1	6	4	2	2	8	8	4	9	5	2
8	4	4	1	25	2	2	3	1	2	6	10	6	4	5	4
9	3	6	1	10	1	2	2	2	2	6	22	6	5	8	4
10	3	6	1	20	1	5	4	3	4	11	16	5	8	6	2
11	3	8	1	.	1	4	6	3	2	8	12	8	10	8	0
12	4	6	2	20	1	2	3	1	3	7	15	5	7	8	4
13	2	3	1	2	1	2	5	2	2	5	10	7	6	8	2
14	0	4	2	7	1	3	3	2	2	8	7	4	5	8	2
15	3	3	1	10	2	2	4	2	2	13	14	8	7	5	3
16	4	8	2	10	4	3	5	2	2	10	11	4	6	8	4
17	3	4	1	15	1	2	5	2	2	14	19	7	4	7	1
18	2	4	1	22	3	3	3	2	4	7	7	11	7	6	2
19	4	4	1	15	1	2	3	0	3	11	11	4	7	5	1
20	3	3	1	25	1	2	2	1	2	6	12	3	4	5	3
21	4	3	1	15	2	2	4	2	2	8	13	5	4	8	4
22	3	4	1	12	2	3	4	2	3	5	15	7	7	4	4
23	4	3	1	23	1	2	7	2	2	5	9	9	4	8	5
24	3	3	1	8	1	2	5	2	2	12	10	4	5	7	4
25	4	3	1	.	1	2	3	4	2	12	10	3	4	8	2
26	4	4	1	5	2	3	5	2	2	10	7	5	6	6	4
27	4	3	1	12	4	2	5	2	3	6	24	3	5	8	2
28	4	4	1	20	2	2	3	2	2	5	8	5	5	6	3
29	2	4	1	15	2	2	2	2	2	6	17	7	6	8	3

	actualculture	assessinflupotcult	ressourcessavpot	workingtimesavpot	actmindsetleadership	intprofeducattraining	effectleadmindnextgen	changefuturelead	ethicsbasics	performmissstate	trustmissstate	understandcult	cultworkimp	effinteghcpat	clearresp ons
30	4	3	1	30	1	2	3	2	2	10	8	7	4	5	2
31	2	3	1	20	1	3	3	2	3	5	18	7	8	6	3
32	4	3	1	5	4	3	4	3	2	6	11	10	6	8	2
33	4	4	1	20	2	3	6	3	2	7	15	8	8	7	4
34	4	5	1	28	2	2	4	2	2	5	12	8	7	6	4
35	4	3	1	30	2	4	7	4	2	9	7	7	8	7	5
36	4	6	1	5	2	2	5	3	3	6	21	7	6	4	3
37	4	6	1	6	2	4	2	2	4	6	18	9	12	4	2
38	3	4	1	20	2	3	4	2	4	5	17	5	6	8	2
39	3	5	1	30	2	2	4	2	2	5	14	9	8	5	4
40	4	6	2	20	2	2	4	2	2	7	7	3	5	6	3
41	3	5	1	10	1	3	3	2	4	7	15	5	6	8	3
42	2	4	1	25	3	3	5	1	2	4	19	10	5	4	3
43	4	4	1	.	2	2	5	2	3	5	14	5	7	7	2
44	2	4	1	25	2	3	5	3	4	10	11	4	5	6	5
45	4	3	1	30	5	3	2	1	2	7	13	3	5	5	4
46	4	4	1	25	2	2	3	2	3	4	17	6	6	8	4
47	3	4	2	10	1	3	5	2	2	5	13	6	7	6	4
48	2	4	1	10	2	2	3	2	2	6	20	6	6	5	2
49	3	3	1	20	2	2	3	1	2	6	14	3	4	5	4
50	4	4	1	15	4	3	4	1	2	5	17	6	4	5	2
51	4	5	1	30	2	2	5	2	2	6	18	5	7	8	4
52	2	3	1	25	1	2	4	4	2	3	21	7	5	7	2
53	4	3	1	20	2	3	3	2	4	8	18	6	8	4	4
54	4	4	1	30	4	3	5	2	2	10	8	7	7	8	2
55	4	4	1	20	1	2	2	1	2	11	6	6	8	3	4
56	3	9	2	15	2	2	2	1	2	3	13	4	6	5	2
57	2	6	2	8	3	4	4	2	2	6	13	7	8	3	3
58	2	4	1	10	4	2	6	2	3	10	14	6	6	8	2

ANNEX G - OPEN QUESTIONS (QUANTITATIVE SURVEY: TRANSCRIPTION)

(I) Open questions from HOs *(HCsector 1: q3, q4, q42, q43, q44, q45 and q20)*

to q3: Between which areas of care (interfaces) would an improvement in cooperation be desirable?

„Hausärzte – Fachärzte"; „Rettungstransport – Versorgungseinrichtungen"; Pflegeheime - mobile Pflege"; „Zusammenarbeit mit einzelnen Personen und Playern unterschiedlich gut"; „Hauskrankenpflege, Pflegeheime, Hausärzte"; „Strukturoptimierung & Finanzierungssystem: fehlende vertragliche extramurale Versorgungseinheiten schaffen, damit KH sich auf tatsächlich notw. KH (note: Hospital) *Leistungen reduzieren kann oder Finanzierung ändern"; „Kommunikation Ärzte"; „über die Versorgungsstufen hinweg, zwischen Primär- und Sekundärversorgung / intramural vs. extramural"; „Pflegeheime – Hausärzte: niedergelassene Ärzte Pflegeheime, niedergelassene Ärzte"; „Schnittstelle intramural - extramural, Doppeluntersuchungen, für Patienten zeitaufwändige Abklärung im niedergelassenen Bereich"; „generell an der Schnittstelle extra-/intramural"; „Niedergelassene generell, vor allem Allgemeinmediziner"; „Krankenhaus- Pflegeeinrichtungen"; „Hausärzte – Rettung"; „Krankenhaus - Pflegeheim bzw. Hauskrankenpflege bzw. ganz allgemein zu poststationären Nachsorgeeinrichtungen"; „Arzt – Pflege"; „DGKP* (note: Certified Health and Nursing Care Person) *– Ärzte"; „Hausärzte, Fachärzte"; „Arzt-Pflege, Arzt-Angehörige, Arzt-Patient, Pflege - Angehörige, Krankenhaus - pflegende Angehörige und Patienten, Entlassungsmanagement und Behörden"; „Zuweiser* (note: Referring Doctor) *– Krankenhaus"; „Interne – Chirurgie"; „Pflegeheime, hängt von der Persönlichkeit der Führungskraft ab"; „Krankenhaus und mobile Dienste"; „Intramuraler Bereich: Intensiv mit anderen Stationen, Ärzte - Pflegepersonal, Psychologen, Physio etc. - mit Pflege; Extramuraler Bereich Hausarzt – LKH"* (note: Federal State Hospital)*; „Ärzte, ÖGK"* (note: Austrian Health Fund)*; „Klinik zu HKP* (note: Home Nursing) *bzw. Pflegeheimen"; „zwischen extramuralen Bereich - einweisende Ärzte - in den intramuralen Bereich".*

to q4: What concrete measures could improve cooperation at the interfaces?
„regelmäßige Treffen, z.B. gemeinsame Fortbildungen, Ärzte des extramuralen Bereiches sollten direkt Termine (online) für ihre Pat. buchen können"; „bessere Kommunikation, Konferenzen, Jour-fix, Qualitätszirkel"; „unkomplizierte Kommunikationsmöglichkeiten/Datenschutz-bestimmungen reduzieren"; „Plattform für gegenseitigen Austausch"; „Austauschtreffen, gemeinsame Fortbildungen, Hospitationstage"; „Finanzierung aus einer Hand, Neuüberdenken der Wahlarztordinationen, Zusammenarbeit Pflegeheim - Krankenhaus stoßt immer wieder auf rechtliche Themen"; „Digitalisierung, Schnittstellentreffen"; „Schaffung von Gesundheitsnetzwerken"; „übergreifende Dienste (Ärzte und Pflege), gemeinsame IT-Plattform, gemeinsame Finanzierung"; „bessere Kommunikation, Kommunikationstool, bessere Information evtl. wie bei ELGA (note: Electronic Health Record) *auch für Pflege"; „Gruppenpraxen von Fachärzten mehrerer Fachrichtungen und engere Vernetzung mit z.B. Hauskrankenpflege"; „Gemeinsame Finanzierung"; „elektronische Befundübermittlung ausbauen / verbessern / vereinfachen"; „intensivere Kommunikation, Förderung digitaler Datenaustausch"; „Themen sind meist übergeordnet angesiedelt (ÖGK etc.)"; „Wenn die Finanzierung gesichert wäre - es sollte nicht an jeder Sektorengrenze eine neue Regel gelten ... Finanzierung aus einer Hand?"; „Aufwertung Pflege bzw. Funktionsübertragung; z.B. Wundmanagement"; „Ein Miteinander für den Patienten"; „Zuweiser-Treffen, Informationsveranstaltungen für Zuweiser, Flächendeckende Nutzung von ELGA* (note: Electronic Health Record) *im Zuweiser-Bereich, elektronische Terminvergaben auf Ambulanzen für Zuweiser"; „gegenseitiger Respekt, Zeitdruck nehmen (alles muss gleich erledigt werden - dadurch oft keine sinnvolle Koordination von Untersuchungen, Gesprächen, etc."; „mehr*

Informationsaustausch, Kontaktpflege, mehr IT-gestützte Prozesse wie Terminambulanzen, OP-Termine, etc.“; „interdisziplinärer Kontakt - nicht nach dem Motto das ist MEIN Patient, den gebe ich nicht ab“; „Sensibilisierung des Themas Zusammenarbeit. Gemeinsamer Auftrag in der Gesundheitsversorgung“; „einheitliche digitale Datenweitergabe, egal ob intramuraler oder extramuraler Bereich“; „2x Jährlich gemeinsame Besprechung, Wertschätzender - Unterstützender Umgang miteinander“; „Heruntergebrochen sehe ich ein Wissensdefizit in den Bereichen. Was wird gebraucht, was ist möglich, was benötigt man um es umzusetzen (z.B. festgefahrene Strukturen versus Notwendigkeiten für Patienten)“; „Definierte Übergaben bzw. Transferberichte; persönlichen Kontakt und Austausch“; „Lieferung von medizinischen Daten vom extramuralen in den intramuralen Bereich verbessern und ausweiten“.

to q42: In my opinion, the following critical points at the interfaces between intra- and extramural care areas should be given special attention:
„Verweildauer im KH (note: Hospital) *wird immer kürzer! (z.B. OP häufig tagesklinisch). Versorgung durch Hausärzte muss gesichert sein, ansonsten unnötige KH-Wiederaufnahmen“; „Finanzierungsmodelle harmonisieren. Einzelunternehmer Arzt?“; „zu viele Doppelgleisigkeiten, zu wenig extramurale Versorgungsstrukturen, wie z.B. PHC* (note: Primary Health Care Center)*“; „Personalkapazitäten, fachliche Kompetenz, Erfahrung“; „dort wo extramuraler Bereich versagt, springt in der Regel der intramurale ein“; „berufsständisches Denken, Finanzierung“; „Verrechnungsmodelle fehlen“; „die Zuständigkeiten sind klar, aber klar getrennt für sich und es gibt keine definierten gemeinsamen Zuständigkeiten“; „wir sind noch immer zu sehr abhängig von Einzelmeinungen, vernetztes Denken der Experten wird immer notwendiger, Ethik muss mehr einbezogen werden“; „Gesprächskultur“; „Informationsfluss KH/ etc. Bereich (FA/HA)* (note: Specialist/General Practitioner) *insb. bei komplexen u/o fachübergreifenden Krankheitsbildern“; „es fehlt der Blick auf das große Ganze, statt kooperiert wird gemauert“; „Verfügbarkeit, Termintreue, Informationsfluss, Abstimmungsprozesse“; „Die Finanzierung ist nicht reibungslos geregelt. Die Schnittstellen sind an sich klar beschrieben“; „Respekt“; „KH-Arzt* (note: Hospital Doctor) *– Hausarzt (Generika, Verbandsmaterial, Suchtmittel), bei Entlassung von Problemfällen (Verwahrlosung, keine Angehörigen, Delogierung) keine Ansprechpartner“; „IT-gestützte Prozesse, mehr Kommunikationsaustausch“; „Übergabe, Prioritäten“; „Übermittlung von Arztbriefen bzw. Pflegebefunden, gemeinsamer Brief (Medizin & Pflege) sollte das Ziel sein“; „Management - mit tieferen Ebenen, Hausärzte - Ärzte LKH* (note: Federal State Hospital)“*; „Blick über den Tellerrand, Patient im Mittelpunkt, keine Befindlichkeiten, Leistungsspektrum“; „Vereinbarte Ziele hinsichtlich Reha bzw. häusliche Versorgung; präklinisch ABS* (note: Admission Information, Accompanying Information, Social History)*“; „sektorenübergreifende Kooperation: Definition dessen, was man vom jeweiligen Gegenüber erwarten muss und kann!“.*

to q43: In my opinion, the following conditions (Framework conditions) must be created in order to optimize interprofessional cooperation between intra- and extramural care areas:
„nicht nur Pflegekräfte, auch Ärzte sollten im EM der KH tätig sein! Eigener Dienstposten für KH Ärzte!“; „Einbeziehung der Personen vor politischen Entscheidungen“; „Einheitlicher Finanzierungskatalog. Geräte-Sharing etc.“; „Klärung der Zuständigkeiten, wenn Leistungen extramural möglich sind, sollten diese nicht ins KH überwiesen werden“; „Gemeinsame FB (note: Advanced Training) *Veranstaltungen, regelmäßiger Austausch, gemeinsame Teilnahme an Visite, Implementierung Case Management“; „Motto sollte sein: Geld folgt Leistung“; „einheitliches Finanzierungssystem“; „Incentives und rechtliche Rahmenbedingungen“; „rechtliche und finanzielle Rahmenbedingungen“; klare Aufgabenverteilung, die auch der Bürger versteht, Lenkungsstelle wie z.B. 1450* (note: Austrian Support via Telephone Health Advice) *in der Pandemie“; „mehr Arbeitskräfte für mehr Zeit“;*

„ELGA (note: Electronic Health Record) *ausbauen, Datenschutz auf das Wesentliche reduzieren. Teilweise auch Ressourcen schaffen (Pflegeplätze: Nachsorge, Übergangspflege)"; „Bewusstseinsschaffung, Gesetzliche Verpflichtungen, unabhängige Koordinationsstellen schaffen"; „Erhöhung des Durchdringungsgrades von Informationen, Abstimmungsprozesse optimieren"; „Finanzierung aus einer Hand"; „gemeinsamer Austausch und Respekt"; „vermehrter Datenaustausch, Zuständigkeiten regeln, extramurale Bereich muss auch in der Nacht, am Wochenende und Feiertag ausreichend erreichbar und kompetent sein"; „Ziele formulieren - dann interdisziplinäre Arbeitsgruppen bilden – unter Umständen gehören auch Patienten, Bürgermeister, Regionalpolitiker, Vertreter von Behörden zum Team"; „derzeit erfolgt wenig Austausch; hier müsse man Synergien nutzen zur Optimierung von Prozessen und letztendlich Qualität & Effizienz"; „bessere Kontakte von z.B. Hausärzten zu behandelnden Krankenhäusern"; „Netzwerkveranstaltungen, Verständnis für den anderen Bereich schaffen"; „regelmäßiger Austausch zwischen Versorgungsbereichen"; „Treffen halbjährlich"; „regelmäßiger strukturierter Austausch, klar definiertes Leistungsspektrum, extramurale gut qualifizierte Ansprechpartner, breit aufgestellt, Community Nurse"; „Prozesssteuernde Person soll auch entsprechend Kompetenzen haben - siehe Wundmanagement und Verordnung durch Hausarzt"; „Gleiches Geld für gleiche Leistung!".*

to q44: What can the individual contribute to improve interprofessional cooperation and communication between intra- and extramural areas?
„zeitgerechte Information an den extramuralen Bereich"; „mehr Miteinander, den anderen zuhören"; „ein Finanztopf für alle"; „Kommunikation"; „gemeinsame Schulungen, Fortbildungen, Veranstaltungen"; „Verantwortung wahrnehmen, respektvoller Umgang - hart aber herzlich"; „aktiv sein"; „lokale Vernetzungsprojekte"; „klares Commitment"; „auf menschlich-kollegialer Ebene das Miteinander fördern. Kaum direkter Einfluss auf Kommunikationstechnologien. Meinungsbildung / Multiplikatoren"; „Respekt vor der Expertise des anderen haben, Lösungsorientierung im Sinne des Patienten"; „Ruhe bewahren, sachlich bleiben, relevante Informationen weitergeben, zuhören"; „Haltung, sich für die Patientinnen ehrlich einsetzen"; „wertschätzender Umgang"; „Kommunikation, Information"; „dass man die anstehenden Probleme konstruktiv anpackt! Bin nicht zuständig ist out!! Die Rahmenbedingungen und Grenzen des Anderen kennenlernen"; „Wertschätzung untereinander, Konzepte zur Zusammenarbeit entwickeln"; „Ziel soll die optimale Versorgung der Patienten an den Schnittstellen sein"; „Wertschätzender, verständnisvoller Umgang miteinander"; „Offenheit gegenüber den Themen des anderen, gute Kommunikation, Wertschätzung, Patient im Mittelpunkt"; „eigene Kompetenzbereiche gut kennen, auf Augenhöhe kommunizieren, evidenzbasiert VOR eminenzbasiert" (note: 'eminence-based' - usually meant critically: an expert, by virtue of his or her authority, overrides a well-reasoned recommendation or doctrinal opinion)*; „laufenden Kontakt halten und laufende Abstimmung".*

to q45: What could be your personal contribution to the realization of patient-centered, cross-sectoral (intra/ extramural) care characterized by continuity and good interprofessional cooperation?
„Gesundheitszentren aufbauen, nicht ärztliche Bereiche stärken (Gemeindeschwester)"; „Organisation von oben erwähnten Aktivitäten, Vorleben von definierten Wertvorstellungen..."; „permanente Einforderung angepasster Rahmenbedingungen, stetig Lösungsvorschläge präsentieren bei gleichzeitigem Aufzeigen der Schwachstellen"; „Werte vorleben, Schaffung von Rahmenbedingungen für die Zusammenarbeit"; „lokales Vernetzungsprojekt"; „mache ich schon"; „Erfahrung, Prozessgestaltung bzw. -optimierung, Konzentration oder auch Reduktion der Information auf das Wesentliche. Dabei das persönliche Gespräch nicht ganz aufgeben"; „nicht könnte, was ist mein Beitrag: Vorbild für die Mitarbeiter sein, Verhalten geprägt von Wertschätzung, Respekt und Verständnis

gegenüber allen unabhängig von Status und Profession, Entscheidungen treffen, Lösungsorientierung, persönliche Befindlichkeiten hinten stellen, das Ergebnis zählt"; „tägliches Bemühen und entsprechend für nahtlosere Übergänge auch politisch lobbyieren"; „verstärkter Kontakt mit den Heimen unserer Patienten"; „Kommunikation, Information"; „Mitarbeit in einem interdisziplinären Team, das die regionalen Probleme bezüglich Versorgung und Schnittstellen bearbeitet. Speziell geht es um das Entlassungsmanagement. Hier gibt es viele Baustellen in der Zuständigkeit. Es ist aber zu wenig, dass jeder Beteiligte seine Zuständigkeiten und Nichtzuständigkeiten mitteilt. Es muss anhand von konkreten Fällen (Beispielen aus der Praxis) eine konstruktive Lösung erarbeitet werden. Dazu muss auch ein Vertreter vom Land (Geldgeber, Steuerzahler) etc. mit im Boot sein, ansonsten bleibt es bei Absichten. Jeder von uns könnte einmal auf der anderen Seite landen - was würde ich mir dann vom Gesundheitssystem erwarten dürfen?"; „Vernetzungsarbeit"; „Weitergabe von wichtigen bereichsübergreifenden Informationen an die Vorgesetzten"; „würde mich für Zusammenarbeitsoptionen zur Verfügung stellen und meine Erfahrungen gerne teilen - mein Expertenwissen teilen"; „Wichtigkeit und den Stellenwert des Entlassungsmanagements erkennen und die MA (note: Employees) *hinsichtlich Qualifikation, wie ANP* (note: Advanced Nursing Practice), *fördern. Case Management implementieren. Augenmerk auf personelle Ressourcen im EM legen. Instrument zur Identifikation der Hochrisikopatienten --> poststationäre Versorgung --> Vermeidung von Re-Hospitalisierung…"; „auf Umgangston achten, Verständnis mitbringen"; „regelmäßige Meetings, Bedarfserhebungen, Querdenken, weg von alten Mustern, innovative mutige Wege beschreiten, gute Kommunikation. Förderung von Case Management, gute Fort- und Weiterbildungen für MA* (note: Employees)*"; „Prozessgestaltung; Beratung, Schulung, Anleitung; Forcierung des Gate-Keeper-Zugangs in meinen Bereichen"; „Teilnahme an einem Projekt zur Abstimmung der Nahtstelle!".*

to g20) Is the model of collegial leadership (note: ‚Kollegiale Führung') already outdated?
„durch ein Mitglied der KoFü (note: ‚Kollegiale Führung'). *Zwei-Jahresrhythmus"; „kann nur im Zusammenspiel über die Berufsgruppen hinweg funktionieren"; „Geschäftsführung"; „wenn jedes Mitglied der KoFü seine Führungsverantwortung wahrnimmt und sich nicht als Vertreter seiner Berufsgruppe sieht, dann kann KoFü gut funktionieren"; „eine Gesamtverantwortung unabhängig welche Berufsgruppe"; „Verantwortung und Kompetenz muss in niedrigere Hierarchieebenen delegiert werden; das Gremium an sich passt"; „passt wie es ist"; „Verwaltungsdirektor führt. VWD* (note: Administrative Director) *und Pflege kümmern sich gemeinsam um Organisation und Prozesse. Arzt wird gehört, aber nur für die Behandlung zuständig"; „es braucht eine Letztentscheidung je Krankenhaus"; „Führungspersonen eines KH* (note: Hospital) *sollten vor allem das Wohl ihrer Patienten, Angestellten und der gesamten Region im Blick haben und nicht das Budget"; „es bedarf einer Hierarchie, denn irgendwer muss Entscheidungen treffen; sonst macht jeder was er will, irgendeine Regel ist besser als gar keine"; „Führung durch gutes Führen - Führung sollte nicht auf den eigenen Vorteil aus sein"; „Mitarbeiter Sorgen ernst nehmen, offene klare direkte Kommunikation, nichts verschweigen/vertuschen, offenes Miteinander"; „Weg von der Berufsgruppenzuordnung, ein Mitglied Richtung Strategie, Betriebsorganisation - Prozessorientiert, ein Mitglied Finanzen. Festgelegte Kompetenz"; „Prozesssteuernde Berufsgruppe braucht mehr Kompetenz in der Entscheidungsdurchsetzung; BWL* (note: Business Administration) *kann ich einer DGKP* (note: Certified Health and Nursing Care Person) *lernen, einem BW (note: Business Economist) schwer Pflege"; „Stärkung der Letztentscheider - Gesamtleiter, Geschäftsführer…"*

Open questions from NHs *(HCsector 2: q3, q4, q42, q43, q44, q45 and q20)*

to q3: Between which areas of care (interfaces) would an improvement in cooperation be desirable?

„Krankenhäuser, Entlassungsmanagement der Krankenhäuser verbessern"; „Entlassungsmanagement der Krankenhäuser in Bezug auf Tageszeit der Entlassung, Visitenzeiten in Pflegeheimen"; „Behörden Bezirk/Land, Ärzte, Krankenhäuser, Apotheken"; „Vernetzung Krankenhaus- Hausärzte- Pflegeheim"; „in allen Bereichen - mobil sowie stationär und teilstationär"; „Krankenhaus"; „Krankenhaus"; „PH - KH (note: Nursing Home – Hospital), *PH - Apotheke, PH - Ärzte (nach Dienstzeiten, Wochenende), PH – Gesundheitstelefon"; „alles Übergeordnete in der Patientenversorgung ist fragmentiertes Stückwerk"; „Krankenhäuser"; „Hausärzte Fortbildung Geriatrie / Palliative Betreuung, Umgang mit dementen Patienten verbessern"; „mit Fachärzten (niedergelassen und im Krankenhaus) - Telemedizinische Betreuung und Hausbesuche"; „KH – LZ* (note: Hospital – Long-time Care)*"; „Krankenhaus – Pflegewohnheim"; „Arzt/Krankenhaus/Pflegeheim"; „Fachärzten und Krankenhäuser"; „Hausärzte, Fachärzte, Sozialarbeit, Entlassungsmanagement der KH* (Note: Hospital)*"; „Seniorenwohnhaus – Krankenhäuser"; „Befundübermittlung nach Untersuchung"; „Krankenhäuser!!"; „Fachärzte - Psychiatrie, Neurologie"; „Pflegeheim – Krankenhaus, Hauskrankenpflegeorganisationen, Psychiater"; „Fachärzte in der direkten Umgebung. Minimum zu einem Facharzt sind bei uns 30 Minuten"; „Krankenhaus - Befunde digital - Fachärztemangel großes Problem im ländlichen Bereich"; „Krankenhaus"; „Facharzt"; „Ambulanzen generell, Fahrtendienste/Krankentransporte vor allem für Rücktransporte nach Ambulanzterminen".*

to q4: What concrete measures could improve cooperation at the interfaces?
„wertschätzende Kommunikation gegenüber dem Pflegepersonal aus der Langzeitpflege durch das Personal (Pflege, Ärzte) in der Akutpflege"; „Entlassung (Überstellung) in ein Pflegeheim vormittags durchführen; Ärzte kommen zu vorgegebenen Zeiten zur Visite in ein Pflegeheim"; „Anpassung der gesetzlichen Anforderungen hinsichtlich Personalressourcen, Ärzte: Übernahme von Organisation und Überwachung d. Kontrollen - Blut, FA, KH, Med-Check (note: Specialist, Hospital, Medical Check), *Ausbildungsstätten - Abstimmung Schulungsinhalte mit Bedarf in der Praxis, Apotheken"; „regelmäßiger Austausch, entsprechende Arbeitsgruppe"; „Digitalisierung zur Vernetzung vermehrt nutzen, Ausbau von Case- und Care Management, Bessere Ausbildungsmöglichkeiten"; „mehr mündliche Kommunikation mit dem gleichen Arzt oder DGKP; dass der Stand des Wissens immer der Gleiche ist, um Fehler zu vermeiden"; „Festlegen fixer Punkte (Entlassungen), Ärzte auch in Bereitschaft, Gesundheitstelefon DGKP ruft DGKP* (note: '…one certified health and nursing care person calls the other') *an?"; „‚public integrated': Fin. & Bereitst. med. Vers.* (note: Financing and Provision of Health Care) *aus einer Hand)"; „Informationsaustausch"; „Fortbildung/ Informationen"; „verstärkte Verschränkung der Sektoren (Langzeitpflege - Gesundheitsversorgung; stationär - niedergelassen); Finanzierung der Leistungen"; „mit KH besser abstimmen"; „Aufklärung - Wissen schaffen; unterschiedliche Interessen & Hintergründe verstehen lernen"; „gemeinsames Doku-System, einheitliche Informationsweitergaben"; „bei den Fachärzten gibt es zu wenig Angebot um flächendeckend gute Qualität leisten zu können (Psychiatrie, Neurologie, Palliativmedizin,...) in Bezug auf das Krankenhaus wäre eine intensivere Kommunikation mit den Entlassungsmanager*innen hilfreich"; „Information, Kooperationsbereitschaft der Stellen, Klärung der Finanzierungsfragen von Krankenhausbetten, Erwachsenenschutzrecht ist lückenhaft"; „elektronische Partnerplattform (Befunde, Berichte, Dokumentenübermittlung:..)"; „persönlicher Kontakt erleichtert vieles; Abläufe der einzelnen Partner besser darstellen, bewirkt Verständnis und könnte Lösungswege aufzeigen"; „gegenseitiges Verständnis, Rücksichtnahme, Wissen über jeweilige Situationen und Kompromisse; Freundlichkeit"; „mehr Kassenstellen und die Möglichkeit von Hausbesuchen der Fachärzte*

als normale Vorgehensweise in Langzeitpflegeeinrichtungen"; „Kommunikation & Kooperation: vermehrte Kommunikation - Todesfälle oft nicht gemeldet von Seiten des Krankenhauses"; „Koordination: Vernetzung mit HKP (note: Home Nursing) *mache ich selbst aktiv, wird positiv wahrgenommen. Niedergel. Psychiater sind oft mit Terminen voll, auch auf der psychiatrischen Amb. im KH* (note: Psychiatric Outpatient Clinic in the Hospital) *sind Wartezeiten!"; „Fachspezifikationen in der Umgebung"; „runde Tische - jeder hält sich an vereinbartes - Protokolle - neue Leitungen müssen vorgestellt werden – Zuständigkeiten"; „bessere Kommunikation"; „bessere Koordination, Priorisierung, ...".*

to q42: In my view, the following critical points at the interfaces require special attention:
„Kennen der Probleme und Möglichkeiten der Pflegeheime und Wille darauf Rücksicht zu nehmen - Hausärztemangel, 1450 (note: Austrian Support via Telephone Health Advice) *ist nicht hilfreich u. überfordert*"; *„Versorgungssituation eines Erkrankten außerhalb des KH, Sicherstellung einer optimalen Weiterversorgung nach Entlassung"; „Wertschätzung für die Langzeiteinrichtung durch Akutversorgung, Anerkennung, dass auch in der Langzeitpflege professionelle Pflege erfolgt"; „Krankenhaus schickt an Hausarzt d. Arztbrief, d. Pflegeheim nicht; Hausarzt auf Urlaub, Pflegeheim kennt die Maßnahmen nicht; i.V. Infusionen Antibiotikum"; „individuelle Behandlungsziele und Versorgungsziele* (note: ‚Best Point of Service - BPoS') *"; „z.B.: Vorläufiger Entlassungsbericht - Medikamentenliste stimmt oft nicht mit kompletten Arztbericht überein, welcher per Post nachgeschickt wird"; „Wissenstransfer und Kompetenzregelung"; „Bewertung von Befunden"; „gegenseitiges Verständnis aufbringen, Arbeitsabläufe/Finanzierung/ärztliche & therapeutische Versorgung etc. sind in beiden Bereichen extrem unterschiedlich"; „mangelnde Informationen"; „Station /KH / Arzt / Pflegepersonal und Entlassungsmanagement - lesen der Transferierungsberichte aus dem Pflegewohnhaus ins KH und danach handeln..."; „APH* (note: Retirement and Nursing Home) *sind keine KH* (note: Hospital) *für Senioren, Wissen über die Strukturen fehlt jeweils, Notwendigkeit der Vorbereitung (Medikamente, ärztliche Versorgung etc.)"; „Übergabe, Berichte, Befunde, Rettungs-/Krankentransport, Erreichbarkeit von Verantwortlichen"; „klare Ansprechpartner und klare Anweisungen in komplexen Situationen"; „was kann ein Pflegeheim auch wirklich leisten? Und nicht die Auferlegung von Krankenhäusern was ein Pflegeheim zu leisten hat"; „entsprechende Ansprechpersonen, die sich dessen verbindlich annehmen fehlen sehr oft - Bemühen und Wille dazu leider auch (...geht mich nichts an...)"; „Informationsweitergabe"; „man muss den Anspruch sehen, der sich dahinter versteckt: KH möchte vor dem WOE* (note: Weekend) *viele Pat.* (note: Patients) *entlassen, kann argumentieren, Delir sei im Griff, usw."; „strukturierte Informationsweitergabe sollte, damit nichts vergessen wird"; „Sterbebegleitung - Psychiatrische Bewohner können nicht ausreichend versorgt werden in Langzeiteinrichtungen, Langzeiteinrichtungen sind kein Altenwohnheim"; „Objektivität bzw. PatientInnenorientierung versus Bettendruck in Spitälern".*

to q43: In my opinion, the following prerequisites (framework conditions) must be created in order to optimise inter-professional coop. between intra- and extramural areas (e.g. hospital/nursing home):
„ziehen an einem Strang. Bessere Kommunikation untereinander mit Wertschätzung! Bestmögliche Versorgung der Klienten ist das Ziel"; „Jour fixes, Gegenseitiger Check durch Feedbackbögen, (Punkte wie: ausreichend Info durch Überleitungsbogen, Rücktransporte zeitlich koordiniert"; „Informationsaustausch, Arbeitsgruppen mit den handelnden Personen"; „gegenseitige Wertschätzung, gemeinsame Zielverfolgung"; „Organisationsabläufe sollten einheitlich gestaltet werden und Richtlinien erarbeitet, welche im Team vorgestellt werden und danach gearbeitet wird"; „Ressourcen anpassen, Verantwortliche definieren"; „Abstimmungstreffen in Versorgungsregionen gem. ÖSG (note: according to the 'Austrian Structural Plan for Health') *mit Wertschätzung"; „regelmäßiger Aus-*

tausch"; „Kommunikation / Wertschätzung der anderen Berufsgruppe und wechselseitiges Anerkennen des fachlichen Know-hows"; „Informationen müssen ankommen!"; „hoher Informationsfluss, Gemeinschaftliches Dokumentationssystem, bessere Einbindung von Heimärzten"; „die relevanten Personen müssen miteinander in kontinuierlichem Kontakt stehen, sich kennen, austauschen, kommunizieren und im Sinne des Bewohners handeln; „Kennenlernen des anderen Bereiches, unterschiedliche Finanzierungssysteme (Gesundheit=Versicherung, Alter = Soziales)"; „gemeinsame Dokumentation, gemeinsame Plattform für Daten, Befunde, Berichte, Übergaben, gemeinsamer Austausch"; „transparente Abläufe, für jeden ersichtlich"; „Sensibilität dafür in allen Berufsgruppen des Gesundheitswesens. Klarheit, dass wir ALLE am selben Ziel quasi arbeiten (Makroebene)"; „verbindliche Vorgaben, dazu betriebsintern und zeitliche Ressource für entsprechende (zuständige) Personen"; „entsprechende Kommunikationslinien"; gute Kommunikation, Glauben an die Beobachtungen der jeweils anderen Seite, sich gegenseitig Gehör schenken, sensibel sein!"; „einheitliches Dokumentationssystem, IT Stand muss überall gleich und stabil sein"; „FACHÄRZTE in den Häusern die regelmäßig kommen"; „bessere Übergangsstrukturen, integrierte Versorgung zu Hause verbessern, Remob-Einrichtungen (note: Remobilisation Facilities)*".*

to q44: What can the individual do to improve interprofessional cooperation and communication between the care sectors (hospital/ nursing home/family doctors/outpatient services)?
*„Wertschätzung, Kommunikation auf Augenhöhe"; „Interesse und Verständnis für sein Gegenüber: Was weiß ich gesichert, eventuell Jobrotation um besseren Einblick zu erhalten"; „persönlicher Austausch, regelmäßige Kontakte, ehrliches Feedback"; „konsequente und ehrliche Aufklärung und Information über Behandlung und Ziele der Patienen/Klienten/ Bewohner, Aufwertung der Pflege"; „sich an Vereinbarungen und Vorgaben halten"; „Eigenverantwortung"; „aktiv einfordern"; „offene Kommunikation, so viel Information wie möglich"; „durch radikale Bewohner*innen/ Patient*innen Orientierung und ganzheitliche Sichtweise des Menschen"; „positive Gesprächsbereitschaft, Kooperationsbereitschaft, Abbau von hierarchischen Strukturen"; „Verantwortung übernehmen, kollegiale Haltung, Kultur des Miteinanders"; „Höflichkeit, Gespräch auf Augenhöhe, gut zuhören können"; „Kooperationen immer wieder forcieren, viel Kommunikationsarbeit anstatt böse werden"; „aktiv diese einfordern und Kontakt aufnehmen"; „nicht egoistisch auf den eigenen Bereich achten, sondern im Sinne des Patienten/der Patientin MITEINANDER arbeiten"; „gute Vernetzung, gute Kommunikation, schriftlicher Pflegetransferbericht im Voraus wird übermittelt, im Voraus wird Kontakt mit den Angehörigen aufgenommen"; „gewissenhaftes strukturiertes Arbeiten"; „sprechen!!!!!"; „Wertehaltung, PatientInnenorientierung, persönliches Engagement (gerne arbeiten, für Menschen da sein wollen).*

to q45: What could be your personal contribution to the realization of patient-centered, cross-sectoral (intra/extramural) care characterized by continuity and good interprofessional cooperation?
*„Möglichkeit gut ausgebildete und motivierte Mitarbeiter zu rekrutieren, vor allem im Bereich des gehobenen Dienstes, Wertschätzung und Respekt vorleben, optimale Organisation, Kommunikation mit den betreffenden Stellen fördern, gemeinsam Lösungen finden"; „Teilnahme an Jour-fixes bzw. periodische Treffen; Mitgestaltung an einheitlichem schlüssigen Überleitungsbogen; um Doppelerhebung zu vermeiden, Mitteilung bereits durchgeführter Assessments und Screenings, Info über Pflegediagnosen"; „Arbeits-und Austauschgruppen organisieren, regelmäßige Führungstreffen, auch online"; „Erarbeiten von Richtlinien"; „unzählige Vorträge"; „weitermachen"; „Aufklärung & Verständnis in der Bevölkerung schaffen"; „über die Gremien, in denen ich tätig bin, können Probleme auf der Metaebene definiert und bearbeitet werden - oftmals verlaufen die Dinge aber im Sand, da jeder seine eigenen Probleme hat und die Zusammenarbeit bereichsübergreifend nicht prioritär erscheint werteorientiertes Handeln und Involvierung von Mitarbeiter*innen in Entscheidungen genauso wie die permanente*

*Kompetenzentwicklung von Mitarbeiter*innen verstehen sich für mich von selbst"; „Mitarbeit an der Schaffung/Einführung einer derartigen gemeinsamen Versorgung"; „Höflichkeit, gut zuhören und mitdenken, nachfragen im Gespräch, Abläufe der einzelnen Bereiche/Personen den MA vor Ort aufzeigen und dadurch Verständnis bei den MA bewirken"; „Haltung an Mitarbeiter weitergeben, Sensibilisieren"; „klare Vorgehensweise in meiner Einrichtung und darauf achten, dass diese auch genau und immer eingehalten wird (z.B. bei KH Einweisung vorab anrufen und Infos geben - entsprechende Unterlagen mitgeben - tgl. tel. Kontakt mit KH* (note: Daily Telephone Contact with the Hospital) - *Infos einholen und proaktiv weitere Vorgehensweise besprechen"; „Kommunikationswege klar definieren"; „bin PDL* (note: 'I'm Head of Nursing'). *Vernetze mich mit der zuweisenden Stelle, fordere Informationen auch in schriftlicher Form im Voraus an, kontaktiere die Angehörigen im Vorfeld, um deren Erwartungen kennenzulernen und zu sehen welche Vorstellung sie haben, kommuniziere im Vorfeld und spreche auch an, wenn es sich um unrealistische Erwartungen handeln würde. Frei nach dem Motto: durch Reden kommen die Leute zusammen. Gebe meine Telefonnummer für Rückfragen her"; „runde Tische - in Kontakt bleiben"; „ich versuche mit meiner Wertehaltung und großer Wertschätzung gegenüber meinen MitarbeiterInnen Vorbild zu sein. Respektvolles Miteinander, Anregung zu mehr Integration der Angehörigen, Orientierung am Machbaren ... Rahmenbedingungen schaffen".*

to q20) Are current leadership models still up to date?
*„es muss organisatorisch auf die Bedürfnisse der jüngeren Generation eingegangen werden (Work Life Balance). Anreize zur Motivation (Gehaltsanpassung)"; „für Führungsarbeit entsprechende Zeitressourcen bereitzustellen hat Priorität und die Tätigkeit einer Führungskraft anzuerkennen"; „transparente Kommunikation (Kennen), Erweitern der Kompetenzen (Können), Sinnfindung, Motivation (Wollen), Partizipation u. Empowern (Sollen)"; „eine gute Führungskraft ist zeitlos, passt sich den Bedürfnissen an, agiert teilweise als Coach, aber auch als Vorbild"; „die Anweisungsstruktur und das bürokratische Vorgehen von Behörden stimmen mit der Kompetenz der GDA nicht mehr überein, diese sollten als Partner akzeptiert werden"; „Transparenz, den Mitarbeiter*innen viel Möglichkeit bieten mit zu entscheiden, als Führungskraft die Arbeit der Mitarbeiter*innen kennen – Respekt"; „agile Teams, Selbstorganisation und Eigenverantwortung der Mitarbeiter*innen, Involvierung von Mitarbeiter*innen in Entscheidungen, die Organisation betreffend"; „Abbau von Hierarchien, Überdenken der Professionen in den Führungsfunktionen, Mischung der verschieden Disziplinen/Ausbildungen in Führung"; „Ideenpools, Betroffene beteiligen, Workshops, alle Berufsgruppen beteiligen"; „mehr Verantwortung des Einzelnen, flache Hierarchie, gezielte Förderung der MA, Feedback an MA kontinuierlich, Freude an der Arbeit erleben lassen"; „'Lean', weniger Hierarchie, auf Augenhöhe, in manchen Versorgungsbereichen sogar agil; klare und Kommunikation, gemeinsamer Strang"; „Achtsamkeit und Wertschätzung den Mitarbeiter*innen und ihren Bedürfnissen gegenüber - sich bewusst sein, dass die Bedürfnisse sich ständig verändern"; „wertschätzend auf Augenhöhe quer durch alle Berufsgruppen"; „jedes Pflegeheim müsste in Anbetracht der vielen gerontopsychiatrischen Bewohner/ Neuaufnahmen (!) einen zuständigen FA für Psychiatrie haben!!"; „vor allem Fachspezifische Kommunikation, Rückhalt von rechtlicher Seite, Intensiverer Austausch mit anderen Leidensgenossen"; „Führung bedeutet Empathie - ein gelerntes Handwerk gerade in der Pflege - nicht nur Ausbildung sondern das Wissen über Abläufe!"; „sich an neuen Erwartungen anzupassen"; „Vorstand mit Aufsichtsrat, in dem alle Berufsgruppen vertreten sind".*

ANNEX H - QUESTIONNAIRE OF THE EXPERT INTERVIEW

Q 1) How do you generally rate the cooperation between the different professional groups in Austrian health care?

Q 2) In and/or between which areas of care would an improvement of interprofessional cooperation nevertheless be desirable (hospital/nursing home/family doctor/outpatient services etc.) and through which concrete measures could cross-institutional, interprofessional cooperation be improved?

Q 3) In your opinion, has intersectoral cooperation and communication improved in the long term as a result of Covid-19 and the need for increased coordination between the care sectors?

Q 4) In general, how do you assess the current culture of intersectoral, interprofessional cooperation in the Austrian health care landscape and what is the importance of the 'culture of cooperation' in the interinstitutional context in your opinion?

Q 5) Would you agree that a coherent organizational culture that is lived according to its demands contributes to better cooperation, especially at interfaces/transitions, and that good interprofessional cooperation can usually also lead to optimization of resources?

Q 6) Do you think that multi-professionality and cross-sectoral cooperation should already be addressed in the training of health professionals - e.g. as a common basic module in the training of health professionals?

Q 7) Do you think that a changed mindset and behavioral patterns of future generations could favor interprofessional cooperation and would therefore also require new approaches to leadership?

Q 8) Does co-responsibility in interinstitutional, patient-centered care - as part of the leadership of the participating care areas - generally require a rethinking of conventional management and leadership concepts?

Q 9) In your opinion, can a common understanding of values ('culture of cooperation') promote interinstitutional, interprofessional cooperation?

Q 10) What advantages arise from common guiding values and what challenges do you see in any coordinated 'culture work' (development of a common culture)?

Q 11) In your opinion, is it possible to realize coordinated care regions in the care areas - as is the case, for example, in the model region 'Healthy Kinzigtal' in Germany - also in Austria in the long term?

Q 12) What concrete measures would have to be taken regarding the structures and processes as well as at management levels in order to make the jointly claimed culture liveable (perceptible) for the patients concerned, but also for all staff involved - along the care pathways, in particular also at interfaces?

Q 13) In your opinion, what conditions (framework conditions) would have to be created in order to improve interprofessional cooperation and communication between the areas of care (hospital, nursing home, general practitioner, etc.)?

Q 14) How could an understanding of values in integrated care that promotes inter- and multi-professional cooperation be developed, maintained and effectively managed across sectors and institutional boundaries?

Q 15) What can individuals do to improve interprofessional cooperation and communication between intra- and extramural areas and what could be your personal contribution - within the framework of your area of responsibility - to the realization of patient-centered, cross-sectoral care characterized by continuity and good interprofessional cooperation?

ANNEX I - RESULTS OF THE EXPERT SURVEY

point of view	name and background	question 1	question 2	question 3	question 4
	expertise	How do you generally rate the cooperation between the different professional groups in Austrian health care? - **'Interprofessional Cooperation'** (Cat. 1.1)	In and/or between which areas of care would an improvement of interprofessional cooperation nevertheless be desirable (hospital/nursing home/family doctor/ outpatient services etc.) and through which concrete measures could cross-institutional, interprofessional cooperation be improved? - **'Interface Management'** (Cat. 1.2)	In your opinion, has intersectoral cooperation and communication improved in the long term as a result of Covid-19 and the need for increased coordination between the care sectors? - **'Covid-Impact'** (Cat. 1.3)	In general, how do you assess the current culture of intersectoral, interprofessional cooperation in the Austrian health care landscape and what is the importance of the 'culture of coop' in the interinstitutional context in your opinion? - **'Culture of Togetherness'** (Cat. 2.1)
		Frage 1	**Frage 2**	**Frage 3**	**Frage 4**
	Expertise	**Wie schätzt Du generell die Zusammenarbeit der unterschiedlichen Berufsgruppen in der österreichischen Gesundheitsversorgung ein?**	**In und/oder zwischen welchen Versorgungsbereichen wäre dennoch eine Verbesserung der interprofessionellen Kooperation wünschenswert (Krankenhaus/ Pflegeheim/Hausarzt/ambulante Dienste etc.) und durch welche konkreten Maßnahmen könnte die institutionen-übergreifende, interprofessionelle Kooperation verbessert werden?**	**Hat sich Deiner Meinung nach durch Covid-19 und dem Erfordernis einer erhöhten Abstimmung zwischen den Versorgungsbereichen die intersektorale Kooperation und Kommunikation nachhaltig gebessert?**	**Wie schätzt Du generell die gegenwärtige Kultur des sektorenübergreifenden, interprofessionellen Mitei-nanders in der österreichischen Versorgungslandschaft ein und welche Bedeutung kommt dabei Deiner Ansicht nach der ´Kultur des Miteinanders´ im institutionenübergreifen-den Kontext zu?**

Health System Planning & Care System Research (I)	**Dr. Gerhard Fülöp** heads the Department of Planning and System Development at Gesundheit Österreich GmbH (GÖG). His work and research focuses on Austrian health system planning, health care system research, epidemiology, the Austrian Health Information System (Österreichisches Gesundheitsinformationssystem - ÖGIS) and implementation and decision support in the Austrian health care system. In addition, Gerhard Fülöp devotes himself to lecturing activities at home and abroad as well as working on international projects of WHO, EU and World Bank with a focus on health information systems, health reporting, health system planning.	Grundsätzlich gute Zusammenarbeit, allerdings im Hintergrund bisweilen Konflikte bei der **Abgrenzung der Kompetenz-Sphären** v.a. zwischen Ärzten/-innen, MTD-Berufen und (diplomiertem) Pflegepersonal bestehend, die **trotz relativ klarer berufsrechtlicher Regelungen** bis heute nicht in allen Punkten gelöst sind.	Verbesserung der interprofessionellen Kooperation wäre punktuell im **stationären Bereich (innerhalb von Krankenanstalten und Pflegeheime sowie** auch **zwischen diesen Institutionen**) wünschenswert. Im **Bereich der hausärztlichen Versorgung** bestünden in den kommenden Jahren besondere **Chancen zur Verbesserung** der interprofessionellen Kooperation im Rahmen von neu zu schaffenden **Primärversorgungseinrichtungen** im Sinne der Primärversorgungsgesetzes (PrimVG).	Soweit ich das beurteilen kann, hat Covid-19 zwar zur **Tendenz des gemeinsamen Ziehens an einem Strang** gegen die die Pandemie geführt, eine **Verbesserung der intersektoralen Kooperation/Kommunikation** in einem allgemeinen Sinn kann ich allerdings **nicht erkennen**. Wobei sich aktuell eine besonders schwer aufzulösende Zäsur in Bezug auf die Versorgung von Covid-19-Patienten/-innen zwischen den Akut-Krankenanstalten und den Rehabilitationseinrichtungen ergibt, deren Details derzeit gerade im Rahmen der Arbeitsgremien der Zielsteuerung-Gesundheit diskutiert werden.	Zur gegenwärtigen Kultur siehe Frage 1. Eine **institutionenübergreifende Kultur des Miteinanders** ist **im Interesse der Patienten/-innen höchst wünschenswert**, auch um den Patienten/-innen die (ohnehin schon **schwierigen**) **Patientenpfade** zu erleichtern - dabei sollten auch die Möglichkeiten von **e-Health noch intensiver genutzt** werden als bisher (vgl. z.B. **beschleunigte Umstellung auf e-Medikation** während der Pandemie).
Hospital Management & Strat. Management (II)	**Expert II** (the interview is reproduced anonymously on request) is Managing Director on the strategic management level of several confessional nonprofit general hospitals. In addition, he lectures at an University of Applied Sciences in the part-time Master's programme in "Health Management and Integrated Care".	Generell natürlich schwer zu beurteilen, da ich eher eine Binnensicht auf einige wenige Krankenhäuser habe. Generell kann ich also nur aus meiner Erfahrung ableiten, und vor allem aus Beobachtung der Medien. Ich **denke nicht, dass die Zusammenarbeit der Berufsgruppen sehr gut ist**. Bestes Beispiel aktuell: Die Diskussion zwischen ÄK und Apothekerkammer ums Impfen (Kompetenzsstreit) oder auch die Debatte um Kassenverträge für niedergelassene Pflege (von ÄK seit Jahren blockiert)... . Wir haben sehr **viel Abgrenzung im System**, sehr **viele Berufsgesetze**, sehr **viel berufsständisches Lobbying**, ... Oft wird Arbeitsteiligkeit (**Skill&Grade Mix**) auch **falsch verstanden (Abschieben von unliebsamem auf andere**) oder führt zu zu viel Abgrenzung (Arbeitsteilung hat auchGrenzen - insb. dann, wenn dadurch für den Patienten **zu viele Schnittstellen** (Reibungsverluste durch Wartezeiten, Informationsverluste, ...).	Ärzte und Apotheker. **Medikamentenabgabe sollte auch Spitälern gegen Verrechnung mit der Kasse möglich sein** (ist ja unlogisch, dass **Patienten nach dem Spitalsaufenthalt in eine Apotheke müssen**, um verordnete Medikamente abzuholen). Im **Wundmanagement könnte viel verbessert werden** (Kassenverträge für niedergelassene im Bereich Wundmanagement verbessern, ...). **Ambulante Palliativteams** sind zu wenig gut ausgebaut. Die **Hospizversorgung viel zu gering** ausgebaut. Gerade jetzt in der Zeit wo der assistierte Suizid kommen wird braucht es bei Palliativ / mobile Dienste / Hospiz ... **Nahtlose Übergänge in Pflegeheime**, ... viel mehr	**Teilweise ja**. Die **Bundesländer haben sehr gut kooperiert**, die verschiedenen Spitalsträger auch. **Zwischen Heim und Krankenhaus wurde es** sogar **schwieriger** (Schutzmaßnahmen, übertriebene Testerfordernisse, ...). Mit den Finanziers wurde die Zusammenarbeit besser (Krise hat zusammengeschweißt). Ob das nachhaltig sein wird, wird man sehen.	**ganz wichtig**. Die **Lösung** kann nur ein **konsequenter Blick auf die Interessen der Patientinnen und Patienten** sein - eine **gemeinsame Zielorientierung** hilft. Eigeninteressen (Beruf, Träger, ...) schaden.

Med. Hospital Management & Med. Doc. (III)	**Expert III** (the interview is reproduced anonymously on request) is a member of the collegial leadership and medical director of a rehabilitation facility (Special Hospital). In addition, he lectures at a Medical University and at an University of Applied Sciences in the part-time Master's programme in "Health Management and Integrated Care", which he himself also completed. He also supervises Master's theses on problems of integrated care.	Es gibt eine **solide Basis mit viel Luft nach oben**.	Grundsätzlich immer intramural mit extramural und natürlich auch zwischen unterschiedlichen extramuralen und ambulanten Einrichtungen. Das gilt innerhalb der ärztlichen Versorger genauso wie zwischen Ärzten und anderen Berufsgruppen oder auch zwischen verschiedenen nicht-ärztlichen Dienstleistern (wobei ich hier nur begrenzten Einblick habe). Maßnahmen: Eine **Mischung aus persönlichem Kennenlernen und institutionalisierter Kooperation** (was z.B. mancherorts Allgemeinmediziner mit dem nächsten Krankenhaus haben), **einfache, gute, benutzerfreundliche** (!!!) **technische Grundlagen** (z.B. ELGA mit guter Beschlagwortung / Suchmaschine und guter Struktur). Anreize ELGA oder dergl. zu verwenden (z.B. elektronische Medikamentenspeicherung in sicherem Format, die man einfach überspielen kann und nicht jedes Mal abtippen muß). etcetc	**gebessert ja**, aber **nicht nachhaltig**, fürchte ich	siehe dazu auch Frage 2. Die **Kultur des Miteinanders** wird gelebt, aber hier ist **noch viel Verbesserungsmöglichkeit**. Ich denke, daß man hier zT offene Türen einrennen würde mit **guten Ideen und Angeboten**. Es geht dabei **auch um zeitliche Ressourcen und natürlich um finanzielle**.
Social Management & Humanistic Management Consulting (IV)	**Expert IV** (the interview is reproduced anonymously on request) is lecturer in social ethics at universities and universities of applied sciences. He also heads an organisation of humanistic management. He is owner of a company for consulting, coaching and educational offers for the implementation of social innovations.	Die **Rahmenbedingungen für gelingende Zusammenarbeit der Berufsgruppen sind leider im internationalen Vergleich als schlecht zu bezeichnen** - trotz eines der besten Gesundheitssysteme. Nicht dass sich die einzelnen Berufsgruppen als unfähig erweisen würden, aber der **Mangel entsteht aufgrund der zersplitterten Zuständigkeiten** zwischen den einzelnen Sektoren, Akteuren und Bund und Ländern und ist vor allem **historisch und gesetzlich grundgelegt**. **Defizite an den Nahtstellen** führen zu Beeinträchtigung der Qualität der medizinischen Versorgung - insbesondere aus PatientInnen-Perspektive. **Informationen über den gesamten Verlauf** müssen meist **von den Betroffenen selbst** mit massivem Aufwand eingeholt werden. Zu messen sind die Mängel auch an den relevanten gesellschaftlichen Entwicklungen, die eine grundlegende Anpassungen der Versorgung dringend erforderlich machen. Das sind etwa **steigende Lebenserwartung** und Tendenz hin zu **chronischen Erkrankungen**. Die **Gesundheitsreform 2012** ff hat dennoch einige Wegmarken eingesetzt, die in die richtige Richtung führen: Ein **sektorenübergreifen-des System der Zielsteuerung**, das auch Versorgungs- und **Finanzziele** für den gesamten Gesundheitsbereich umfasst. Es soll das **Umherschieben von PatientInnen** – etwa vom Spital in den niedergelassenen Bereich – durch gemeinsame Finanz-verantwortung vermeiden. Die bereits vereinbarten **Ziele und Maßnahmen** sind als **große Chance für die Integrierte Versorgung** zu bewerten. Ob diese von den Partnern der Zielsteuerung-	besonders hinderlich ist die **Aufsplitterung von Finanzierung und Steuerung von Krankenanstalten, Hausärzten und Pflege**. Der Versorgungsprozess wird nicht nach dem Bedarf gesteuert und finanziert, sondern nach den Zuständigkeiten der einzelnen Akteure. Daher kommt es strukturell und aus PatientInnensicht zu Ineffizienz bei insgesamt hohen Kosten des Gesundheitswesens. Also benötigen wir bei Finanzierung, Steuerung und bei den gesetzlichen Grundlagen eine gesamthafte Sicht und entsprechend grundlegende Veränderungen, die eine patientInnen-orientierte Gestaltung und Integration der Versorgung erst ermöglichen. Behandlungsprozesse sind an Nahtstellen unterorganisiert, Informationsweitergabe ist äußerst mangelhaft. Erforderlich wäre eine über die sektorale Logik der einzelnen Dienstleister hinaus gehende ganzheitliche Organisation der Abläufe. Genau hier sind die Probleme auch in den gewachsenen mentalen und organisatorischen Mustern einzuordnen. Mit am wichtigsten in Zukunft wird die angemessene und sektorenübergreifende Versorgung von chronisch und mehrfach erkrankten Patienten in höheren Altersgruppen. Im Sinne von Disease und Case Management. Handlungsbedarf besteht bei: Akzeptanzmanagement und Schaffen von rechtlich-organisatorischen Rahmenbedingungen, bei Professionalisierung der Veränderungsprozesse und nachhaltiger Umsetzung. Gefahren liegen in einer einseitigen Betonung von Finanzzielen, in Trägheit des Gesamtsystems (Prinzip der Einstimmigkeit – gegenseitige Blockaden), der eingeschränkten Berücksichtigung des Langzeitpflegebereichs.	Die **Pandemie** hat die vorher strukturell grundgelegten Herausforderungen des österreichischen Gesundheitssystems im **wesentlichen deutlich aufgeworfen** und massiv **verschärft**. Deutlich wurden **Nahtstellenproblematiken zwischen** den Bereichen **Gesundheit und Pflege**, die massive Überlastung von pflegenden Angehörigen und das fragile System der 24-Stunden-Betreuung. Neben Sofortmaßnahmen zB. zur Wertschätzung der Beschäftigten **braucht es langfristig krisentaugliche Pandemiepläne**, **neue Formen der Personalbemessung**, die auch Sonderaufgaben wie z. B. COVID-19 besser abbilden, arbeitsmarktpolitische Maßnahmen zur Bewältigung des Personalmangels, und vor allem eine **Gesamtschau auf eine integrierte Versorgung in Österreich**.	Gerade angesichts der oben ausführlicher geschilderten Probleme kommt einer **solchen Kultur des Miteinanders entscheidende Bedeutung** zu. Allerdings muss sie **durch** Strukturen **ermöglicht** werden bzw. auch andersherum **strukturwirksam und - verändernd** werden. Zumal bereits unser **Bildungssystem** von Kindesbeinen an eher **auf individuelle Performance** ausgerichtet ist und wir daher **Räume benötigen**, um **kritisch reflektierend** solche Prägungen überwinden und **Kollaboration** entlang gemeinsamer höherer Ziele **erst lernen** müssen. **Organisationen sollten solche Räume bereitstellen**, besser noch mehrere Organisationen sollten solche Räume **institutionenübergreifend** schaffen und gestalten können.

supplementary details (IV)	**ad Q1)** Ob diese von den Partnern der Zielsteuerung-Gesundheit genützt werden, bleibt kritisch zu reflektieren. Das hängt vom Willen der Partner der Zielsteuerung und ihrer Bereitschaft zur Zusammenarbeit unter Aufgabe eigener Zuständigkeiten zu Gunsten gemeinsamer Verantwortung ab. Und vom des Gelingen des Einbindens der Gesundheitsprofessionals und der Bevölkerung. **Weiters:** *Ergänzung(a):* als **„kritische Erfolgsfaktoren"** zu verstehen (wörtl. zitiert, Übersetzung): Bei den Konzepten der integrierten Versorgung konnten **sieben Aspekte** identifiziert werden, die besonders von den Strukturen in anderen Sektoren abweichen und als potenzielle Fallstricke betrachtet werden können ... - Zunächst einmal sind die **Governance-Strukturen und die Prozesse der Leistungserbringung** wichtig. - Die integrierte Versorgung muss die Governance-Strukturen anpassen, um die Patienten durch das System zu lenken. - Die Governance-Strukturen sind die Gesundheitspolitik auf der Makroebene, der Prozess der Gesundheitsversorgung auf der Mesoebene und der einzelne Patient auf der Mikroebene. - Wie bereits erwähnt, ergibt sich die Komplexität für die Führung in der Gesundheitsversorgung aus der Bedeutung der Patienten (und der Gemeinschaften) sowie aus der hochkomplexen Gesetzesstruktur. - Die Gesundheitspolitik umfasst in der Regel Fragmente anderer Fachbereiche, wie z. B. der Justiz- oder Sozialbehörden. - Die Leistungserbringung (Prozess) findet in drei (vereinfachten) Sektoren statt, in erster Linie in der ambulanten Versorgung, der stationären Versorgung und der Rehabilitation. - In der Praxis ist die Leistungserbringung jedoch viel komplexer, da sie in einem ganzen System von Akteuren stattfindet. - Neben den typischen Sektoren sind weitere Bereiche wie Pflegedienste, Apotheker, Medizintechnik, Dienstleister und verschiedene andere beteiligt. - Menschenbezogene Fallstricke - Der zweite Bereich umfasst die **Dimensionen der Berufsgruppen und Kulturen**. - Die integrierte Versorgung muss verschiedene Berufsgruppen einbeziehen, die sich durch starke, über Jahre gewachsene Berufskulturen auszeichnen (z. B. Pflegekräfte und Ärzte). - Die Ärzteschaft weist ausgeprägte innere Differenzierungen auf (Fachärzte vs. Allgemeinmediziner, ambulante vs. stationäre Ärzte). - Die Führung in der integrierten Versorgung muss auf die Akzeptanz dieser Berufe und Kulturen hinwirken. - Es wird jedoch deutlich, dass Führung nicht zu einer "weiteren Last, die mit dem Job einhergeht" für die Fachkräfte werden sollte - sondern dass die Menschen in Führung ausgebildet werden müssen und dass sie für Führung bezahlt werden müssen. - Es ist ein ausgewogener Ansatz erforderlich: Die King's Fund Commission on Leadership and Management in the NHS (Kommission für Führung und Management im NHS) geht darauf ein, wie viel die Systeme in professionelles Management investieren. - Während die Primary Care Trusts in England etwa 1-2 % ihres Budgets für das Management ausgeben, gibt es amerikanische Organisationen, die etwa 12,5 % ihres Budgets für professionelles Management und Führung investieren (The King's Fund 2011). - Wir gehen davon aus, dass eine ausgewogene Investition unabdingbar ist, um professionelle Führung im Gesundheitswesen zu erhalten. - Organisationsbezogene Fallstricke - Der dritte Bereich ist komplexer und umfasst die **Dimensionen der verschiedenen Zielsysteme und Unternehmensmentalitäten** sowie den Grad der Professionalisierung. - Bei der integrierten Versorgung kommen häufig Public-Private-Partnership-Ansätze zum Einsatz, was bedeutet, dass grundsätzlich unterschiedliche Zielsysteme in Einklang gebracht werden müssen. - Auf der einen Seite stehen am Gemeinwohl interessierte Akteure (z.B. Kommunen), auf der anderen Seite Non-Profit-Organisationen, wie kirchliche Krankenhäuser, und private Institutionen wie Pharmaunternehmen. - Für die Führung ist es notwendig, diese unterschiedlichen Mentalitäten zu verstehen, damit sie zusammenarbeiten können. - Darüber hinaus unterscheiden sich der Professionalisierungsgrad und die Organisationsstruktur der verschiedenen Akteure. - In der integrierten Versorgung müssen staatliche und andere öffentliche Organisationen, die nach öffentlichem Recht handeln, möglicherweise mit privaten Geschäftsmodellen aller Größenordnungen zusammenarbeiten. - Diese Organisationen benötigen alle eine Führung, allerdings mit unterschiedlichen Anforderungen an diese. - Führung im Gesundheitswesen bedeutet nicht Regulierung oder aufgezwungener Wandel. - Es **bedeutet, dass es Menschen gibt**, die - neben ihrem medizinischen Beruf - die **Notwendigkeit eines strategischen Ansatzes für eine höhere Qualität verstehen**. -				
Discharge Managem. & Clin. Social Work (V)	**DGKS Elfriede Lampel:** After several years as a member of the board (head of the nursing service) of a denominational, private-community special hospital (Orthopaedic Hospital Speising, Vinzenz Group), she is in charge of bed management, discharge management and clinical social work at the Vienna General Hospital (AKH) - University Hospital.	**sehr gut und professionell**	**Übergang** von der **Akutpflege** in **generell Nachsorgeeinrichtungen** in Bezug auf die **Bürokratie**	kann kein klares JA/Nein geben da sich die Nachsorgebereich fast alle ausschließlich auf LONG COVID 19 bezogen; und ein **fast Wettrennen wer der Beste ist**.	Die Kultur ist dann zu spüren, wenn sich das Unternehmen **damit positionieren kann**.

HC Consultant & Expert Integrated Health Care (VI)	**Expert VI** (the interview is reproduced anonymously on request) was a research assistant at the University of Applied Sciences Burgenland. For about a year he has been working in the international consulting sector with a focus on health care management and integrated care.	Mein tägliches Umfeld spiegelt mir wider, dass das Bewusstsein für eine **interdisziplinäre Zusammenarbeit vielfältiger Berufsgruppen zunimmt**. Gründe sind u.a. die Corona-Krise, neue Arbeitsformen, sich **verändernde Denk- und Handlungsweisen** sowie die **Digitalisierungswelle**. Als diese Faktoren bringen einzelne Mitglieder der unterschiedlichen Gruppen dazu, die **Zusammenarbeit zu überdenken und neu auszurichten**.	Aus meiner Erfahrung wäre eine Verbesserung vor allem **zwischen AllgemeinmedizinerInnen und FachärztInnen** wünschenwert. Zudem muss eine **engere Zusammenarbeit** aller Versorgungsbereiche **mit dem Nachsorgebereich** angestrebt werden. Nicht zu vergessen ist die **<u>Zusammenarbeit mit den PatientInnen</u>**, die als **<u>gleichwertige Gruppe</u>** innerhalb der Versorgung zu verstehen sind. Die Anwendung von digitalen Gesundheits- und Pflegeanwednungen ist hier eine optimale Unterstützung. Softwareanwendungen bilden die gesamte PatientInnengeschichte über alle Versorgungsbereiche hinweg ab und zwingen zur Abstimmung und somit verbesserten Zusammenarbeit.	Die Covid-19 Krise **erfordert(e) neue Formen der Zusammenarbeit und Kooperation**. Viele GesundheitsakteurInnen behandeln und **kommunizieren nun vielmehr digital** über den gesamten Behandlungsweg von PatientInnen. Somit sind **Abstimmung häufiger und patientenzentrierter**. **Entscheidungen sind agiler**. Zudem sind **mehr ExpertInnen einbezogen**, da digitale Gesundheitsanwendungen auch bei komplexen Krankheitsbildern **ortunabhängige Meetings ermöglichen** - Bsp. Tumorkonferenzen. Einen **nachhaltige Besserung der Kommunikation und Kooperation** ist noch **nicht festzumachen**, jedoch stehen (wie erwähnt) zahlreiche neue Kanäle bereit, die eine optimale Zusammenarbeit ermöglichen könnten.	Die **Kultur des Miteinanders** ist meiner Meinung nach **in einer Entwicklungsphase**. Aktuell sind **viele Akteure des Gesundheitswesen mit der Formung der eigenen Kultur** beschäftigt. Aufgrund des Mangels an Fachkräften, Fluktuationswellen, Covid-19, etc. besteht oftmals eine hohe Dynamik, die eine **Festigung einer langfristigen Kultur erschwert**. Die Kultur des Miteinanders auf Versorgungsebene ist somit nicht prioritär, hat aber einen **steigenden Wert für Institutionen**.
President of the Austrian Federation of Nursing Homes (VII)	**Expert VII (the interview is reproduced anonymously on request)** is President of a federal association of nursing homes and was formerly the home and nursing service manager of a nursing home. His goals include further competence development of the health professions (gerontology and geriatrics), the expansion of hospice and palliative care as well as quality work.	Grundsätzlich erachte ich die **Zusammenarbeit als relativ gut**, wenngleich auf Grund der sehr **ausgeprägten berufspolitischen Interessen der Ärztekammer** die möglichen **Potenziale anderer Gesundheitsberufe**, insb. der Pflegeberufe, bis dato **nicht ausgeschöpft** werden können. Dadurch wird eine mögliche Optimierung der Versorgungssysteme nach wie vor verhindert.	**Gerade in der COVID-19-bedingten Krisensituation haben wir unzulängliche Abstimmungen zwischen den Settings Krankenhaus - Pflegeheim - Hausarzt** feststellen müssen. Dabei **fehlte ein übergeordneter und gut abgestimmter Auftrag** für die Krise. Insbesondere der Umstand, dass Verantwortliche der Pflegeeinrichtungen nicht in Krisenstäbe eingebunden waren, führte dazu, dass kaum ein Bewusstsein für die Herausforderungen und Problemstellungen in diesem Setting vorherrschte. Verbesserungen könnten dadurch erreicht werden, dass es nicht nur, aber auch für den Krisenfall, klar definierte Versorgungsaufträge ausgegeben werden, welche sich auf entsprechende Ressourcen stützen. Zudem **sollte ein kontinuierlicher Austausch der Führungskräfte einer Versorgungsregion (zB Gemeinde, Bezirk) forciert werden**.	Teilweise ja, dies ist aber **vielfach einzelnen Akteuren geschuldet**. Ein zukunftsweisendes System sollten derlei Verbesserungen jedoch **nicht an einzelnen Personen** festmachen, sondern es **sollte in der Systematik liegen**, also eine **Evaluierung** erfolgen, welche Rückschlüsse auf die vorhandenen Prozesse und deren Verbesserungsbedarf zulässt.	Eine **Kultur des sektorenübergreifenden, interprofessionellen Miteinanders** in der Versorgungslandschaft ist **deutlich zu schwach ausgebildet**. Auch auf **Grund einer nicht vorhandenen überregionalen Koordinierungsstelle** (zB Gesundheitsbehörden) verfolgen die einzelnen Versorgungssettings vornehmlich ihre eigenen Ziele - diese sind mitunter eher monetär intendiert, als vom Willen einer optimalen Gesundheitsversorgung geprägt.

Former HCM in hospitals & Consultand ans Lecturer (VIII)	**FH-Professor Dr. Gerhard Pöttler, MBA MEd:** He is a self-employed health economist and has experience from various executive and management positions in non-profit, public and private hospitals as well as religious hospitals, old people's and nursing homes and rehabilitation clinics in different Austrian provinces. In addition, he is a lecturer at numerous universities of applied sciences and universities in the fields of health care and finance, and he is also the author of a book on the Austrian health care system: "Gesundheitswesen in Österreich. inkl. Gesundheits- und Sozialversicherungsreform: Organisationen, Leistungen, Finanzierung und Reformen" (3. Aufl.), ISBN: 978-3-99060-169-3.	**zur Zeit ist alles im Umbruch**, daher empfinde ich die **Zusammenarbeit** als **deutlich verbesserungswürdig**	in **so ziemlich allen Bereichen** Die Interdisziplinarität fehlt aus meiner Sicht deutlich	**nein**	ein **wirkliches Miteinander hat es selten gegeben** und wird es auch, **wenn es nicht klare Zuordnungen gibt, weiter nicht geben**
Chairperson Association of Med. Techn. Services (IX)	**Mag.a Gabriele Jaksch:** She is President and member of the Executive Board of MTD-Austria, the umbrella organisation of Austria's higher medical-technical services. She is the central point of contact for professional policy issues of the medical-technical services and represents their interests, in particular also vis-à-vis the Federal Ministry of Health. In her function as President of MTD-Austria, she is also a member of numerous working groups, such as the Health Professions Conference or working groups of Gesundheit Österreich GmbH. In addition, she works as a freelance physiotherapist and as a lecturer at MTD university of applied sciences courses.	in **50 %** der Gesundheitseinrichtungen im extra- und intramuralen Bereich **sehr gut**	**einheitlicher Zugang** zu ELGA für alle Gesundheitsberufe; **GLEICHWERTIGE Entlassungsdokumente** für ALLE Gesundheitsberufe;	in 50% der Institutionen - JA	die **Kommunikation und der Austausch auf Augenhöhe ist die wichtigste Grundlage** für die täglich Arbeit aber auch für die zukunftsträchtige Zusammenarbeit aller Gesundheitsberufe; dh dies muss mehr gelebt werden **in der täglichen Tätigkeit** als Gesundheitsberufe, **aber auch auf politischer Ebene**

Chair of Assoc. Med. Technology & Hospital ICT (X)	**Mag. Herwig Loidl, MBA MSc:** He is owner of LOIDL Consulting GmbH. With CareCenter, he has developed an all-in-one software solution for inpatient facilities and outpatient services and made it the market leader. He is represented in numerous working groups at state and national level. In addition, he teaches as a lecturer in the field of information and communication technologies (ICT) in healthcare, is the spokesperson of the eHealth Experts Group of the Austrian Chamber of Commerce, a board member of "Integrating the Health Care Enterprise" (IHE) in Austria, which serves to promote and integrate IT and medical technology in healthcare, and a member of several working groups of the "Elektronischen Gesundheitsakte" (ELGA).	Die Zusammenarbeit ist **vor allem im Extramuralen Bereich so gut wie nicht vorhanden**. **Innerhalb einer Einrichtung ab und zu** ganz gut funktionierend. Dort auch manchmal sehr schlecht.	**Mehr Interdisziplinäre Boards und Projekte**	**nein** - nicht nachhaltig	**Da sehr wenig Interdisziplinarität existiert** ist hier auch die Frage der Kultur nur **schwer zu beantworten**. Teilweise ist sicherlich der **nötige Respekt** zu anderen Berufsgruppen vor allem bei Ärzten nicht ausreichend vorhanden
Former Hospital Director & Health Care Consultant (XI)	**Dr. Gerhard Knor:** He has experience from areas of domestic and foreign health care. His focus is on strategy development, organisational development, change management and cultural development. He works at the organisational level as well as at the overall system level and can refer to the exercise of management functions in the private non-profit and public care sector (St. Josef Hospital in Vienna, Haus der Vinzenz Group, and University Hospital Krems). He has many years of experience in consulting (SOLVE Consulting and Integrated Consulting Group - ICG), with a focus on 'strategic and operational management, internal and external communication and culture development ('lived values') and he is a lecturer in areas such as 'integrated care management' and 'hospital management'.	Die Qualität der interprofessionellen Zusammenarbeit **unterscheidet sich sehr zwischen den einzelnen Einrichtungen** bzw. **sogar zwischen einzelnen Abteilungen** / Organisationseinheiten. Es gibt viele hervorragende Beispiele, in denen ein sehr gutes Miteinander die Zusammenarbeit prägt. Leider gibt es nach wie vor auch negative Beispiele. **Maßgeblich** dafür ist die **persönliche Haltung** der einzelnen MAinnen, die aber **durch Rahmenbedingungen** der Organisation **maßgeblich geprägt** werden. Entscheidend sind die Ausrichtung an gemeinsamen Zielen und das Wissen um die Bedeutung der Beiträge der jeweils anderen Gruppen. **Oft** gibt es auch **Fehlsteuerungen, die die Qualität der Zusammenarbeit negativ prägen.**	* **Gemeinsame Regelkommunikation entlang gemeinsamer Ziele** (z.B. Optimierung übergeordneter Prozesse) * **Übergreifende Projekte** und Herausforderungen (Positive Effekte wurden vielerorts auch in der Phase der Pandemie spürbar) * **Steuerung und Führung: Vermeidung von lokalen Optimierungen** zugunsten der Optimierung des Gesamtsystems (herausfordernd durch getrennte Budgets und Führungsverantwortungen inkl. Budgetdruck) * Aufnahme **übergreifender Zielsetzungen in Zielvereinbarungen mit Führungskräften** / Vermeidung individueller Optimierungen zulasten des Gesamtoptimums * Vor Entscheidung über weitreichende Maßnahmen zur Kostensenkung verpflichtende Evaluation der Folgekosten auch bei anderen Systempartnern	Es werden vielerorts positive Erfahungen berichtet (einander kennen, um die Bedarfslage und den Druck andernorts wissen, ...). Diese Erfahrungen prägen sich nachhaltig in den Köpfen ein und können nachhhaltig wirken. Insgesamt haben viele die Erfahrung gemacht, dass Veränderung nicht von vornherein abzulehnen ist, sondern bloß klug angegangen werden muss. Ich habe den Eindruck, **viele Player sind fast erschrocken, was alles auch anders funktionieren kann**. Ob das tatsächlich der Fall sein wird, **hängt davon ab, wie von übergeordneten Instanzen gesteuert** wird. Wenn die Steuerungssysteme positiv in Richtung Nachhaltigkeit und Gesamtsystemoptimierung verändert werden, wird die Nachhaltigkeit größer sein.	**Entscheidend sind alle Ebenen**: * **Systemebene** (z.B. **innovative Finanzierungsmodelle**, die **die sektorenübergreifende Optimierung fördern**) - langsam, sehr langsam, aber doch mahlen die Mühlen; viele kleine Schritte in die richtige Richtung bringen das System auch weiter; manchmal **braucht es aber auch den Mut**, auf Systemebene auch große Brote zu backen (Big Deals) - Dabei sind die unterschiedlichen Lobbys leider sehr erfahren und auch erfolgreich im Verhindern. * **Einrichtungsebene** (z.B. **formalisierte Verbünde, aber auch instiutionalisierte Kooperationen**) - hier ist **Bewegung in die richtige Richtung erkennbar**; Leidensdruck schafft Kreativität und Mut (Da gehört Kostendruck dazu.) * **Individuelle Ebene**: **Je mehr die einzelnen Akteure/innen auch das Gesamtsystem inkl. Wirkmechanismen wenigstens ansatzhaft kennen**, desto eher verstehen sie, dass Veränderungen Sinn machen können, und was den anderen Seiten hilft, zuzustimmen. **Systemkenntnis auf Gesamtsystem- und**

Health Economist & Medical Doctor (XII)	**Ass.-Prof. Dr. Ernest G. Pichlbauer:** Before turning to health services research, he worked as a university assistant at the Pathology Institute of the Vienna General Hospital (AKH). He was significantly involved in the Austrian Structural Health Plan (Österreichischer Struktrurplan Gesundheit - ÖSG) and wrote Health Technology Assessment (HTA) reports for the German Federal Government. He is a book author, independent health expert and blogger ('https://www.rezeptblog.info). He lectures at the Sigmund Freud Private University Vienna (focus on 'health services sciences' and 'public health'). His research covers the relevance of health care science and the impact of health policy activities.	Generell, wenn damit gemeint ist, dass es eine offizielle oder inoffizielle Norm zur Zusammenarbeit gibt, dann ist dies **schlecht**. Die Zusammenarbeit in der VERSORGUNG (ist nicht mit BEHANDLUNG oder SYSTEM zu verwechseln) **hängt überwiegend von den handelnden Akteure ab**. **Systematisch wird eher der Berufsgruppenkonflikt geschürt** und **Bruchgrenzen zwischen Versorgungssektoren** (Pävention-Kuration-Reha-Pflege-Palliativ) fixiert und damit sogar die Motivation handelnder Akteure gedämpft	Eine Interessante Fragestellung, da Versorgungsbereiche als Strukturen definiert werden, obwohl VERSORGUNG ein Prozess ist. **Solange dieser Prozess nicht implementiert** wird und so eine **kontinuierlich und integrative Versorgung ermöglicht** wird, solange wird es **keine Verbesserung** geben können, die über Privatinitiativen (die nicht selten strukturellen und institutionalisierten Grenzbestimmungen beugen!) hinausgeht. Konkret müsste **in ALLEN Curricula aller Gesundheitsberufe die Kooperation um eine patientenorientierte Versorgung zu realisieren aufgenommen** werden - Es **ist der NAchwuchs, der vielleicht dahingehend unterrichtet werden kann**, die **strukturellen und institutionalisierten Grenzen zu Gunsten des Patienten aufzubreche**n - bei den Alten sehe ich keine Option mehr	Da ich meine Meinung auf Basis von datengestützten Hypothesen und bilde, kann ich gar nichts sagen! **Mag sein, mag nicht sein**! Wenn ich aber an die Wiedereinführung des Krankschreibens durch den Arzt denke, und mir die Begründung dafür (aus der WKO) anhöre, bin ich pessimistisch, dass sich irgendwas nachhaltig geändert haben könnte	Es **gibt derart viel Evidenz**, dass die **sektorenübergreifende, interprofessionelle Versorgung bei dem heutigen Patientenmix**, der viel stärker durch chron.Krankheiten und Altersdegeneration geprägt ist, als vor 50-60 Jahren, **effektiver UND effizienter** ist. Da unsere **Versorgungslandschaft jedoch strukturell und institutionell irgendwo zwischen 1930 und 1950 stecken geblieben** ist, **gibt es keine sektorenübergreifende, interprofessionelle Versorgung**, die rechtlich gedeckt und breit umgesetzt werden kann. Es **bleibt alles Einzelinitiative** und nicht selten unter Beugung von Normen.
Health System Planning & Care System Research (XIII)	**Mag. Andreas Birner** is an employee of the Department of Planning and System Development at Gesundheit Österreich GmbH (GÖG). His work and research focuses on Austrian health system planning, health care system research, epidemiology, the Austrian Health Information System (Österreichisches Gesundheitsinformationssystem - ÖGIS) and implementation and decision support in the Austrian health care system. In addition, he is lecturer in universities of applied sciences, even in 'integrated care management' and 'hospital management', and scientific consultant in health care planning, implementation and health care assurance.	Hierzu **zwei Einschätzungen**, einmal zur Dynamik in Richtung Zusammenarbeit und das andere Mal zum Status: **Dynamik:** Hier hat sich in den **letzten Jahren sicher einiges verbessert**, was zum Teil auf ein gestiegenes **Bewusstsein der Gesundheitsdienstleisterinnen und -leister** (GD), zum Teil auf einen **Generationenwechsel** bei den GD, aber auch auf einen steigenden Druck einer immer größer werdenden **mündigen Patientenschaft** zurückgeht. Wichtig sind auch die sich ständig **verbesserten technischen Möglichkeiten sich zu vernetzen**, sowie die **steigende Zahl an Klinikverbünden** in Österreich. Status: Hier sind wir noch ein schönes Stück Weg vom Status der notwendigen Zusammenarbeit entfernt (vom Optimalzustand gar nicht zu sprechen). Da **fehlt es oft schon am einzelnen KH-Standort an der absolut notwendigen Kommunikation**. Andererseits gibt es auch **gute Beispiele**, wo **Hausärzte schon in den 1990er Jahren sehr gut vernetzt** mit anderen GD in der Region zusammengearbeitet haben.	In **allen Versorgungsbereichen**, wäre sie wichtig. Meine eigenen persönlichen Erfahrungen im letzten Jahrzehnt zeigen, dass es hier überall z.T. **unverständlich hohes Verbesserungspotenzial** gibt. Maßnahmen: **Kooperation und Kooperation muss ein hochpriorisiertes Ziel beim GD und bei den Zahlern (SV) werden**. (Operative Ziele definieren, messen, evaluieren) **Standardisierte Kooperationsprozesse** (technisch, ablauforganisatorisch) **Bewusstsein schaffen, stärken Gutes tun, darüber reden** : Beispiele guter Praxis **fordern, fördern und standardisiert kommunizieren.**	**Nein.**	Die **gegenwärtige Kultur** ist meiner bescheidenden Einschätzung nach (es gibt Menschen mit sicher besseren Einblick) sehr **stark von den technischen Entwicklungen getragen** (z.B. IT-Netzwerke, z.T auch international), der **Notwendigkeit und gelebten Praxis innerhalb der Disziplin selbst** (z.B. Intensivmediziner und Intensivpflegekräfte im gleichen Team), sowie - wie immer - auch vom **Engagement einzelner Frauen und Männer** in den verschiedenen Berufsgruppen, die sich dafür engagieren. Es gibt aber auch die **Trägheit des Systems, die Veränderung bremst**. Die **Kultur des Miteinander im institutionenübergreifenden Kontext**: Die **Bedeutung ist natürlich hoch**, die **Umsetzung schwer**, weil es schwer ist institutionenübergreifend in Teams zu Denken. Deshalb sind dort **Prozesse und Standards besonders wichtig, um Kultur zu schaffen und nachhaltig zu etablieren**.

Managing Dir. & former "Value Manager" (XIV)	**Mag. Rainer Kinast** is a theologian, management consultant, psychotherapist (existential analyst), managing director of a care organization, trainer at the Academy for Social Management. For 13 years he was head of the central competence area for value management in the Vinzenz Group (association of religious hospitals and non-profit health institutions). His areas of expertise include specialty areas: Spirituality and Management, Ethics in Management, and Ethics in Medicine and Nursing. He is the author of the book "Value-Oriented Management Culture: Theory and Practical Implementations", published by Lambertus Verlag, 2021, Freiburg. ISBN: 978-3-78413-316-4.	**Ambivalent.** Es **gibt tolle Ansätze** bereits, dass in Krankenhäusern und anderen Einrichtungen berufsübergreifend gearbeitet wird. Aber: **Überall, wo Ressourcen knapp werden** (Reduktion der Arbeitszeiten der Ärzte, Fachpersonalmangel, Herausforderungen durch Pandemie) etc. besteht die **Tendenz, dass jede und jeder nur darauf schaut, den eigenen Auftrag zu schaffen und sich gut abzugrenzen**.	z.B. Umgang mit Menschen mit Demenz: Günther Schranz, Pflegedienstleiter vom Pflegehaus Mater Salvatoris, hat eine **Plattform gegründet, um Verantwortliche von stationärer und mobiler Pflege, Krankenhäuser, Krankentransportwesen etc. an einen Tisch zu bringen**, um Probleme in der Versorgung von Menschen mit Demenz auf den Tisch zu legen und Lösungen zu finden. Es war ein Äußerst mühsamer Weg, tatsächlich dieses Forum ins Leben zu rufen. Leider ist dieses Forum durch die Pandemie wieder in den Hintergrund getreten.	**ja und nein**. Da **oft die klare Orientierung von behördlicher Seite gefehlt hat** (diese waren mit den neuen Problemen ja selbst überfordert), sind **viele Einrichtungen und Institutionen, die sonst Konkurrenz spielen, zusammen gerückt, um gute Wege zu finden**. Andererseits ist der Egoismus (ich schaue, dass ich Überleben kann) und die **Reduktion von informellen persönlichen Kontakten ebenso gut zu beobachten**. Die Chance der neuen Kommu-nikationswege und der gemeinsamen Hilflosigkeit hat doch einiges bewirkt.	Trotz allem, was an Gutem lauft: Der **Profilierungsdrang vieler Persönlich-keiten**, das **Konkurrenzdenken** (auch zwischen Landesinstitutionen und Privaten Organisationen), die **knappen Ressourcen** und das **Kämpfen um das Personal** am Personalmarkt **erschweren** de facto, eine **institutionsübergreifende Kultur aufzubauen**.
	Supplement (XIV) per Mail.	**Befragung zielt speziell auf institutionsübergreifende Kultur ab**. **Ist nochmals eine Herausforderung**, weil politisch und weltanschaulich unterschiedliche Weltbilder auf einandertreffen. Die **Kunst und die Chance besteht eben**, **gemeinsame Werte zu finden**, die aber auch in der Profilierung der einzelnen Institutionen			
Head of Depart. & former Med. Head of Hospitals (XV)	**Primarius Dr. Kurt Resetarits** is Head of the Department of Gynecology and Obstetrics at the Feldbach-Fürstenfeld Regional Hospital (Styria). Before that, he was medical director for the two hospitals Oberwart and Güssing (Burgenland) for five years. In addition, he is the owner of a specialist practice (elective practice) for gynecology in Güssing. Thus, in his extensive professional activity, he was always also involved in questions of integrated health care and was able to create a very broad perspective and occasionally also a profound perspective in integrated health care.	Im **Grossen und Ganzen** ist die Zusammenarbeit **gut**. Es **hängt immer von der Führung** ab. Wenn Wert auf Zusammenarbeit gelegt wird und Tools geschaffen werden, funktioniert es auch	**Spital/Pflegeheim funktioniert nicht überall optimal**. Im **hausärztlichen Bereich ist bei bestimmten Erkrankungen eine Verbesserung der Zusammenarbeit notwendig (Beispiel Diabetes oder psychische Erkrankungen** etc.) Es **gibt nur eine klare Verbesserungshilfe:** Das ist die **Kommunikation zwischen den Institutionen und die gemeinsam Erarbeitung von Informationslisten** (Checklisten etc.). Und **diese Kommunikation muss immerwährend sein** und **kann nicht nur einmalig sein** und dann wird es schon gehen...	Ja, sie **hat sich gebessert**. Die Stakeholder mussten kommunizieren.	Es **gibt Vorreiter und Vorbilder** und es gibt, wie überall, schwarze Schafe. Im Gesamten **gibt es Verbesserungen**. Die **Kultur des Miteinanders ist ganz entscheidend**. Ohne dem geht es nicht. Sonst bleibt der Patient/die Patientin auf der Strecke

Chairwoman Federal Association of Self-Help Austria (XVI)	**Angelika Vidhalm** is Chairwoman of the Board of the Federal Association of Self-Help Austria (BVSHOE), an umbrella organization of Austria's nationally active, issue-related self-help and patient organizations. The Federal Association of Self-Help Austria records and bundles the common concerns and interests of the issue-related self-help organizations at the federal level, advocates for them, accompanies and drives implementation and is an important, recognized and legitimized contact for politics and the health care system at the federal level for the creation of connections to political processes. Angelika Vidhalm, herself a former chronic patient, was the first liver transplant patient in Europe to be cured with the help of a new interferon- and side-effect-free therapy. Since then, she has been able to participate fully in life again and, as the former chairwoman of Hepatitis Hilfe Österreich and now chairwoman of the Federal	Diese ist entwicklungsbedürftig. **Als Patientenvertreter stellt man immer wieder anstatt eine fachlich einwandfreie Betreuung, schwere Gegensätze fest**, die oft sehr umsatzorientiert sind. Der **Patient wird oft nicht in sehr wichtige Entscheidungen einbezogen** und die **Beratung und Informationen über ergänzende Einrichtungen wird oft einfach vergessen oder unterdrückt .**	**Miteinbeziehung der Patientenorganisationen in alle Entscheidungsbereiche**, so wie von der EU-Commission **gefordert**. Es muss eine engere und ehrlichere Zusammenarbeit zwischen den Gesundheitseinrichtungen erreicht werden. Die Informationen über Möglichkeiten dürfen keine Geheimnisse sein, die Patienten nur über geheime Wege bekommen. Ein Bereich fällt da ins Entlassungsmanagement hinein. Hier ist noch vieles im Argen. Wenn der Patient aus dem Spital entlassen wird, muss er sich alleine durchkämpfen, was bei bettlägrigen oder pflegebedürftigen Patienten oft nicht möglich ist. So liegen die Patienten dann oft ohne Versorgung zu Hause und werden nicht mobilisiert.	**Auf lange zeit gesehen NEIN**.	Der **Bedarf ist da**, es liegt an den ausführenden Organen. Man kann ein **jahrzehntelang erlerntes Verhalten nicht von heute auf morgen ändern**. Tatsache ist, dass es **für den Patienten von großem Vorteil wäre.**

point of view	name and background	question 5	question 6	question 7	question 8	question 9	question 10
	expertise	Would you agree that a coherent organi-sational culture that is lived according to its demands contributes to better coop., especially at interfaces/transitions, and that good interprofessional cooperation can usually also lead to optimisation of resources? - **'Optimi-zing Potential through Coope-**	Do you think that multiprofessionality and cross-sectoral cooperation should already be addressed in the training of health professionals - e.g. as a common basic module in the training of health professionals? - **'Education and Training'** (Cat. 3.1)	Do you think that a changed mindset and behavioural patterns of future generations could favour interprofessional cooperation and would therefore also require new approaches to leadership? - **'Different Mindset'** (Cat. 3.2)	Does co-responsibility in inter-institutional, patient-centred care - as part of the leadership of the participating care areas - generally require a rethinking of conventional management and leadership concepts? - **'Leadership Style'** (Cat. 3.3)	In your opinion, can a common under-standing of values ('culture of coop.') promote interinstitu-tional, interprof. Coop.? - **'Culture Manageability'** (Cat. 4.1)	What advantages arise from common guiding values and what challenges do you see in any coordi-nated 'culture work' (deve-lopment of a common culture)? - **'Performance of Mission Statements'** (Cat. 4.2)
		Frage 5	**Frage 6**	**Frage 7**	**Frage 8**	**Frage 9**	**Frage 10**
	Expertise	**Würdest Du dem zustimmen, dass eine stimmige, ihren Ansprüchen nach gelebte Organisationskultur zu einer besseren Zusammenarbeit, insbesondere auch an Schnittstellen/ Übergängen beiträgt und gute interprofessionelle Zusammenarbeit in der Regel auch zu Ressourcenoptimierung führen kann?**	**Findest Du, dass Multiprofessionalität und sektorenüber-greifende Zusammenarbeit bereits in der Ausbildung der Gesundheitsberufe - z.B. als gemeinsames Grundmodul der Ausbildung von Health Prof. - thematisiert gehörte? - category 'Multiprofessionality in education and training**	**Meinst Du, dass ein verändertes Mindset sowie Verhaltensweisen nachkommender Generationen das interprofessionelle Miteinander begünstigen könnte und demnach auch neue Führungszugänge erfordern würde?**	**Braucht Mitverantwortung in institutionenübergreifender, patienten-zentrierter Versorgung - als Teil des Leaderships der beteiligten Versorgungsbereiche - generell ein Überdenken herkömmlicher Management- und Führungskonzepte?**	**Kann Deiner Ansicht nach durch ein gemeinsames Werteverständnis ('Kultur der Zusammenarbeit') institutionenüber-greifendes, interpro-fessionelles Miteinander gefördert werden?**	**Welche Vorteile ergeben sich durch gemeinsame Leitwerte und welche Herausforderungen siehst Du bei einer allfälli-gen abgestimmten 'Kultur-arbeit' (Entwicklung einer gemeinsamen Kultur)?**

Health System Planning & Care System Research (I)	**Dr. Gerhard Fülöp** heads the Department of Planning and System Development at Gesundheit Österreich GmbH (GÖG). His work and research focuses on Austrian health system planning, health care system research, epidemiology, the Austrian Health Information System (Österreichisches Gesundheitsinformationssystem - ÖGIS) and implementation and decision support in the Austrian health care system. In addition, Gerhard Fülöp devotes himself to lecturing activities at home and abroad as well as working on international projects of WHO, EU and World Bank with a focus on health information systems, health reporting, health system planning.	Grundsätzlich ja - wobei die Konsequenz, dass eine **gute interprofessionelle Zusammenarbeit in der Regel auch zu Ressourcenoptimierung** führen kann, zwar naheliegend ist, andererseits aber auch zumindest exemplarisch einer **Evaluierung auf Basis von real world data** zugeführt werden sollte.	Ja, unbedingt - und zwar in der **Ausbildung von ALLEN Health Professionals**.	Das hängt von der **Art und Weise der Veränderung des Mindsets** und von den neuen Führungszugängen ab (an manchen Stellen hat sich bereits ein Abkehr von den immer noch häufig bestehenden streng hierarchischen Strukturen in Richtung eigenbestimmtes Teamwork entwickelt, vgl. z.B. Beschreibung von Buurtzorg unter https://science.orf.at/stories/3202831/).	Aus meiner Sicht ja, allerdings wird diesbezüglich eher in Jahrzehnten als in Jahren zu denken sein. Und es wird **zu klären** sein, **WELCHE Management- und Führungskonzepte** gegenüber den derzeit gängigen Konzepten tatsächlich einen **Mehrwert** (sowohl für die Health Professionals als auch v.a. für die Patienten/-innen) bringen.	Ja, natürlich. Die Frage wäre für mich allerdings eher, **WIE bzw. an welchen Stellen** man ein solches gemeinsames Werteverständnis in einer Weise vermitteln, etablieren und fördern kann, dass sich daraus dann auch tatsächlich eine Unterstützung des interprofessionellen Miteinanders ergibt.	**Gemeinsame Leitwerte** (z.B. **gemeinsame Orientierung an der Ergebnisqualität und/oder an der Patientenzufriedenheit**) können wohl zu einer **einheitlichen Zielorientierung** und damit auch zur **Unterstützung des Team-Gedankens** sowie zur **Entwicklung einer** entsprechenden gemeinsamen **Kultur** beitragen.
Hospital Management & Strat. Management (II)	**Expert II** (the interview is reproduced anonymously on request) is Managing Director on the strategic management level of several confessional nonprofit general hospitals. In addition, he lectures at an University of Applied Sciences in the part-time Master's programme in "Health Management and Integrated Care". *(unidentified Expert Mag. David Pötz, MSc, LL.M. is Managing Director of the general hospitals Herz-Jesu Krankenhaus and Hospital Göttlicher Heiland in Vienna. In addition, he lectures at the University of Applied Sciences Burgenland.)*	ja. Egoistisch im Kleinen --> Egoistisch im großen. Und umgekehrt. Wir **brauchen in der kleinsten Zelle** (in dem Fall Mitarbeiter im Gesundheitswesen) **einfach Menschen**, die **zur Empathie und Patientenorientierung** und damit auch **zu Altruismus fähig** sind - dann gelingt es auch auf Ebene der Institutionen. Leider werden **viele Professionisten zu Einzelkämpfern sozialisiert.**	**ja. Unbedingt.**	nein - die **berufsgruppenindividuelle Sozialisierung** ist mE **stärker** und **hemmt das interprofessionelle Miteinander** (das beginnt schon ganz früh. Es **würden nie Pflegepraktikanten und Famulanten gemeinsam an einem Tisch sitzen**, wenn sie frei entscheiden können (auch wenn beide absolut grün hinter den Ohren sind) - z.B. in einem Mitarbeiterspeisesaal). ABER: **Natürlich braucht es** unabhängig davon **neue Führungszugänge…**	eine **Anpassung ist immer notwendig**. Ganz auflösen wird sich die Führungssicht für die Organisation (Ambulatorium, Ordination, ... Spital) nicht lassen. Es ist ja auch eine fundamentale Führungsaufgabe auf die eigene Organisation zu achten. Insofern darf man nicht zu viel Bewegung von den Führungskräften der einzelnen Organisationen erwarten. Da **muss schon die Politik steuernd eingreifen**.	**ja**.	**gemeinsame Leitwerte machen die Entscheidungen im Einzelfall einfacher**. Man **kann sich aufeinander verlassen** und wird, im positiven Sinne, **berechenbar für die Partner**.

Med. Hospital Management & Med. Doc. (III)	**Expert III** (the interview is reproduced anonymously on request) is a member of the collegial leadership ("Kollegiale Führung") and medical director of a rehabilitation facility (Special Hospital). In addition, he lectures at a Medical University and at an University of Applied Sciences in the part-time Master's programme in "Health Management and Integrated Care", which he himself also completed. He also supervises Master's theses on problems of integrated care. *(unidentified Expert Univ.-Prof. Prim. Dr. Georg Stummvoll, MSc is a member of the collegial leadership and medical director of a special hospital for rehabilitation. In addition, he lectures at the Medical University of Vienna and at the*	**JA !!!**	**JA**	Ja, aber s. auch Frage 4. Ich denke, man könnte **mit (etwas) mehr zeitlichem Aufwand viel Qualität** gewinnen. Der erhöhte zeitliche Aufwand pro Patient oder auf Grund eines Besuchs in entsprechenden Kolloquien / Fortbildungen / Qualitätszirkeln/ Kooperationen darf kein finanzieller Nachteil werden.	**eigentlich nein**. Man müßte nur bestehende Konzepte ein - und durchführen.	**Ja**	**qualitative Vorteile** aber mehr Zeitaufwand. **Schwierigkeit**, **klare und gute Strukturen** zu schaffen mit der **notwendigen Freiheit einerseits und Verbindlichkeit andererseits.**
Social Management & Humanistic Management Consulting (IV)	**Expert IV** (the interview is reproduced anonymously on request) is lecturer in social ethics at universities and universities of applied sciences. He also heads an organisation of humanistic management. He is owner of a company for consulting, coaching and educational offers for the implementation of social innovations. *(unidentified Expert Dr. Markus Glatz-Schmallegger lectures as a social ethicist at universities and universities of applied sciences in lectures as philosophy/economics, systems theories, environmental/economic ethics. He heads the Austrian Chapter of Humanistic Management Network which is working towards discovering, analyzing and mitigating systemic weaknesses of our dominant economic paradigm. He is owner of the company "ValUse" for consulting, coaching and educational offers for the implementation of social innovations.)*	**Absolut**. Allerdings bleibt zu beachten, dass aus dem win-win -Ziel beides geachtet wird: **Zuerst die Qualität der Versorgung und die Erhöhung der Effizienz**.	Das gehört schon **weitaus vorher von der Grundschule an grundgelegt**, indem die Fokussierung auf individuelle Performance kritisch erweitert wird um eine Ausrichtung auf **Kollaboration und Kooperation. Dann** gehören die **Ausbildungswege für Gesundheitsberufe entsprechend geändert**.	**Führungskräfte** haben eine **herausgehobene Bedeutung für die Verankerung integrierter Versotgung** im beruflichen Handeln und in den entsprechenden mental maps der ProfessionistInnen. **Aufgrund ihrer Entscheidungsbefugnis** - weil sie einen Unterschied machen aus Sicht der Mitarbeitenden - und **aufgrund ihrer Möglichkeit**, Kultur durch **eigenes Vorleben** indirekt mitzugestalten über längere Zeiträume und durch ihre Funktion für die Rahmenbedingungen in der Organisation.	**Eindeutig**. Dieses Anliegen prägt unser Engagement zB. im weltweiten **Humanistic Management** Network , von dem es seit letztem Jahr auch ein Austria Chapter gibt. **Leadership ist eine Antwort** auf diese Herausforderung - **mehr als** gesteigerte **Macht** der leaders . Ohne persönliche Übernahme dieser **Mitverantwortung** wird es kaum zu einem nachhaltigen Wandel kommen. Dieser ist aber wie oben dargestellt erforderlich. Gerade die Tragweite und der grundsätzliche Charakter der erforderlichen Veränderungen macht eine solche **Transformation im Denken und Ausüben von Führung** erforderlich.	Das muss **auf der Werte und Zielebene zusammengehalten und grundgelegt** werden und es muss **von oben bis unten** das **Verhalten auch positiv beeinflussen** über einen längeren Zeitraum, damit es sicht- und spürbar wird.	Eine solche **Kulturarbeit** muss **im systemischen Sinn** entwickelt werden, kann **nicht linear, sondern** muss **gesamthaft** angelegt und implementiert werden und sich **gegen Werte und Logiken in einzelnen Subsystemen durchsetzen**. **Werte** sind nicht primär statisch sondern **entwickeln sich dynamisch** und werden sich **dann durchsetzen, wenn sie als vorteilhaft erkannt** werden. Dann können sie eine **Ausrichtung an gemeinsamen Zielen erleichtern** und tragen, was ja **bei integrierter Versorgung entscheidend** ist.

supplementary details		*Ergänzung (b): was es jedenfalls braucht:* **transparente Strukturen und Arbeitsabläufe:** • Professionelle Prozessbegleitung. Es muss ein klar strukturierter Prozess etabliert werden. Dabei Erfahrungen bereits bestehender integrierter Versorgungsangebote nutzen Klares, netzwerk- oder unternehmensweites Organigramm mit einer starken operativen Führung bzw. einem Führungsteam, in dem alle wichtigen Leistungsbereiche vertreten sind (die Führungsstruktur ist zentral und frühzeitig zu definieren). **klare Kompetenz- und Verantwortungsbereiche** • Klar definierter Ordnungsrahmen sorgt für Aufgabenteilung, Überprüfung und den Ausgleich zwischen der strategischen und operativen Führungsebene. **Sowie eine funktionstüchtige Vernetzung und Kooperation gleichberechtigter Leistungserbringer – ein Miteinander anstelle eines Nacheinanders.** • Die Führung schafft und finanziert Strukturen für die interprofessionelle Zusammenarbeit, evaluiert diese im Rahmen eines kontinuierlichen Qualitätsmanagements. • Informations- und Kommunikationstechnologie (Digitalisierung mitdenken), die alle Prozesse und Interprofessionalität effizient unterstützt. • Entscheidungsträger sind rechtzeitig und wiederholt abzuholen. • Bereitschaft zu einem schrittweisen Vorgehen (ein modularer Aufbau ermöglicht, nach und nach das Modell zu entwickeln). **Setzt auch voraus:** • die professionelle Pflege aus ihrer bisherigen Randposition in den Kreis medizinischer Leistungserbringer als gleichwertigen Partner und Akteur aufzunehmen, so dass Pflegende in der Prozesssteuerung und der Entscheidungsvorgabe mit ihrem umfassenden Denkansatz und Fokus auf die lebensweltliche Gesamtsituation von Betroffenen Schlüsselpositionen einnehmen • hierarchische Muster der Zusammenarbeit zu Gunsten aufgabenförmiger Modelle der Verantwortungs- und Arbeitsteilung aufzugeben • die Frage der Versorgungskontinuität – sozusagen die Patientenseite der Medaille – in den Mittelpunkt der Auseinandersetzungen zu rücken • einen vorrangig krankheitszentrierten Zugriff zu vermeiden und damit nicht weiter auf „cure“, statt auf „care“ Aspekte zu reduzieren • Eine über papierförmige Produkte und Willensbekundungen hinausgehende integrierte und multiprofessionelle Versorgung ist nur zu realisieren indem herkömmliche Kooperationsroutinen verändert und ohne bestehende Professionsgrenzen und -hierarchien angegangen werden.					
Discharge Managem. & Clin. Social Work (V)	**DGKS Elfriede Lampel:** After several years as a member of the board (head of the nursing service) of a denominational, private-community special hospital (Orthopaedic Hospital Speising, Vinzenz Group), she is in charge of bed management, discharge management and clinical social work at the Vienna General Hospital (AKH) - University Hospital.	Dem stimme ich **zu 100%** zu	Seit Jahren **fehlt dieser Aspekt in der Ausbildung** von Gesundheitsberufen. Gerade im operativen Spitalsalltag - Stichwort Entlassungs-management - ist dies spürbar. Die Menschen in den Gesundheitsberufen sollen sich **in ihrer Professionalität begegnen und nicht im Konkurrenzkampf** der Pseudomacht. In diesen Fällen ist die uns **anvertraute Patientin /** der uns **anvertraute Patient** bez. Klientin / Klient **immer der Benachteiligte**.	Das ist eine Möglichkeit die ja seit Jahren in den Medien diskutiert wird. Gemeinsamer Unterricht in ausgewählten Fächern für Gesundheitsberufe / Ärzte / Med. Tech. Ass / Sozialarbeit **würde das Bewusstsein der gebündelten Kräfte zum Vorteil für den Patienten schärfen**.	Selbstverständlich - **Management und Führungskonzepte müssen zu der Zeit passen**. Z.B. professionelle Mitarbeiter*innen sollen keine Ängste oder Machtverlust beim Management hervorrufen sondern Stolz und Freude.	**Selbstverständlich** - wenn der **MENSCH/PATIENT/KLIENT das Verbindende und Fokus ist und dieses Werteverständnis** gefördert wird	Entwicklung einer gemeinsamen Kultur kann **dann gelingen,** wenn der **kleinste gemeinsame Nenner des Leitwertes mitentschieden, mitgetragen und spürbar gelebt und erlebt** wird.

HC Consultant & Expert Integrated Health Care (VI)	**Expert VI** (the interview is reproduced anonymously on request) was a research assistant at the University of Applied Sciences Burgenland. For about a year he has been working in the international consulting sector with a focus on health care management and integrated care. *(unidentified Expert Michael Mut, BA MA: After completing a Bachelor's degree in Health Promotion and Health Management and a Master's degree in Health Care Management and Integrated Care, he was a research assistant at the University of Applied Sciences Burgenland. For about a year he has been working in the international consulting sector with a focus on health care management and integrated care.)*	Ja, eine **gefestigte Organisationskultur sowie die Klarheit über eigene Prozesse / Schnittstellen** führen dazu, dass sich Institutionen **auch mit übergreifenden Kulturen** und Prozessen beschäftigen. **Solang dies nicht gefestigt** ist, bestehen **viele Gefahrenquellen für Doppelungen**, **unklare Wege. Informationsverlust**, etc. was Schlussendlich zu keiner Effizienz im Umgang mit Ressourcen führt.	**Nicht nur thematisiert, sondern auch gelebt. Ausbildungen der betroffenenen Berufsgruppen müssen gemeinsam erfolgen**, wodurch auch die spätere Zusammenarbeit eine andere wäre.	**Nachkommende Generationen verändern bereits die Art der Zusammenarbeit**. Meine Erfahrung zeigt, dass für nachkommende Generationen die **Zusammenarbeit innerhalb der Einrichtung und außerhalb einen höheren Stellenwert** hat. **Führung muss sich dahingehend anpassen**, dass Arbeitsweisen künftig durch eine hohe Selbstbestimmtheit, Individualität, Sinnhaftigkeit und Agiltiät bestimmt sind. Daher treten Führungsmethoden wie SCRUM mehr in den Fokus. (eig. Anm.: Scrum wurde in den 1990ern von Jeff Sutherland und Ken Schwaber entwickelt und seither stetig verfeinert - aus dem Rugby-Sport Scrum (= „Gedränge“) Hirotaka Takeuchi und Ikujiro Nonaka verfassten wiss. Artikel.)	Nein, viele Managementkonzepte und **Führungsstile passen sich laufend an**, je nach gesetz. Vorgaben, gesellschaftlichen - und institutionellen Veränderungen, etc. **Viel wichtiger ist die Kombination der Stile / Konzepte** und die zeitnahe Anpassung bei Veränderungen.	Eine **Kultur der Zusammenarbeit kann mit ensprechender Organisationsreife vorgegeben und dadurch gefördert werden**. Als Beispiel: Hat Klinik XY eine Vision darüber, wie institutionsübergreifende bzw. interprof. Zusammenarbeit aussehen soll und richtet danach alle Strukturen, Prozesse und Ergbenisse aus, so fügen sich auch die Mitarbeitenden darin ein und übernehmen diese Kultur. Ausreißer gibt es natürlich immer.	Eine **institutionsübergreifende Kultur sorgt schlussendlich für eine verbesserte Versorgung** (Qualität und Effizienz). Aneinander stoßende Kulturen minimieren Wissensaustausch, Zusammenarbeit in komplexen Fälle, gemeinsame Verwendungen von Strukturen etc.
President of the Austrian Federation of Nursing Homes (VII)	**Expert VII (the interview is reproduced anonymously on request)** is President of a federal association of nursing homes and was formerly the home and nursing service manager of a nursing home. His goals include further competence development of the health professions (gerontology and geriatrics), the expansion of hospice and palliative care as well as quality work. *(unidentified Expert Markus Mattersberger, MMSc MBA: He is President of the Federal Association Lebenswelt Heim and was formerly the home and nursing service manager of a nursing home in Lower Austria. His goals include further competence development of the health professions, the expansion of hospice and palliative care as well as quality work.)*	**Ja**	Unbedingt! Insbesondere der **Thematik Multiprofessionalität sollte in den verschiedenen Versorgungssettings große Aufmerksamkeit geschenkt werden**. Durch eine frühzeitige Thematisierung könnten nicht nur die gegenseitige Wertschätzung und Respekt gesteigert werden, sondern insbesondere auch die unterschiedlichen Zugänge klar gemacht werden. Dies würde durchaus betonen, dass wir von einem eher hierarchischen Ansatz zu einem Versorgungs- und Betreuungsansatz kommen, der mehrere Professionen erfordert und **schlussendlich auch ressourcenschonender** ist.	Ja, insbesondere dann, wenn berufspolitische Überlegungen hintangehalten werden und einer Versorgungsoptimierung weichen. Vor allem gut **etablierte Gesundheitsprofessionen erfordern eine gute Koordination im Sinne einer guten Orchestrierung**.	Dazu **geeignete Management- und Führungskonzepte liegen mE durchaus bereits vor**, sie **müssen aber in der Praxis gelebt werden können**. Insbesondere sind die **verschiedenen Versorgungssettings** mit den erforderlichen **Ressourcen** sowie mit den entsprechenden **rechtlichen wie fachlichen Kompetenzen auszustatten**, sodass Optimierungen ermöglicht werden und MitarbeiterInnen **vermehrt Sinnfindung in ihrem Tun** erfahren.	Ja, dabei darf nochmals auf einen **erforderlichen Abbau an Hierarchien** verwiesen werden. Dies betrifft nicht nur jene der Aufbauorganisation innerhalb eines Settings, sondern **auch der Struktur des gesamten Versorgungssystems**.	Primär kann/soll sich dabei **jedes Setting auf seinen Versorgungsauftrag konzentrieren** - daraus ergibt sich eine **Optimierung des Ressourceneinsatzes**. Damit geht aber auch die **Verteilungsfrage von monetären Mitteln** einher, welche nicht nur vom jeweiligen Versorgungsauftrag, sondern auch von politischen Überlegungen geleitet wird. So sind **Investitionen in akutstationäre Bereiche imageträchtiger als Investitionen in mobile Pflege oder Pflegeeinrichtungen**. **Gut abgestimmte Kulturarbeit** erfordert die Schaffung eines **gegenseitigen Verständnisses und einer Mittelverteilung**, welche sich auf den einen konkreten, gut abgestimmten Versorgungsauftrag stützt.

Former HCM in hospitals & Consultand ans Lecturer (VIII)	**FH-Professor Dr. Gerhard Pöttler, MBA MEd:** He is a self-employed health economist and has experience from various executive and management positions in non-profit, public and private hospitals as well as religious hospitals, old people's and nursing homes and rehabilitation clinics in different Austrian provinces. In addition, he is a lecturer at numerous universities of applied sciences and universities in the fields of health care and finance, and he is also the author of a book on the Austrian health care system: "Gesundheitswesen in Österreich. inkl. Gesundheits- und Sozialversicherungsreform: Organisationen, Leistungen, Finanzierung und Reformen" (3. Aufl.), ISBN: 978-3-99060-169-3.	**ja definitiv**, aber diese allein reicht auch nicht aus wesentlich sind **klare politische Vorgaben oder Rahmenbedingungen**	**ja unbedingt**	auch hier ein **klares JA** von meiner Seite	das muss nicht unbedingt sein, aber **wenn jede Berufsgruppe ein wenig zurücktritt, würde es jetzt schon gut funktionieren**	**ja unbedingt**	**Respekt, Vertschätzung, gemeinsames Verständnis füreinander, bessere Abstimmung untereinander.**
Chairperson Association of Med. Techn. Services (IX)	**Mag.a Gabriele Jaksch:** She is President and member of the Executive Board of MTD-Austria, the umbrella organisation of Austria's higher medical-technical services. She is the central point of contact for professional policy issues of the medical-technical services and represents their interests, in particular also vis-à-vis the Federal Ministry of Health. In her function as President of MTD-Austria, she is also a member of numerous working groups, such as the Health Professions Conference or working groups of Gesundheit Österreich GmbH. In addition, she works as a freelance physiotherapist and as a lecturer at MTD university of applied sciences courses.	eine **gute Organisationskultur ist ein wichtiger Bestandteil in der interprofessionellen Zusammenarbeit**	....meine Rede seit langer Zeit ist das **Aufbrechen der Bildungssilos** - es **braucht mehr interprofessionelles Lernen ALLER Gesundheitsberufe -** ein gemeinsames Grundmodul aller Health Professionals wäre ein Beginn	**davon gehe ich aus**	**ja**	**ja**	**gemeinsame Leitwerte sind ein Grundbaustein und müssen mit Leben befüllt werden** - zB der/die Patient/in im Mittelpunkt - bei jedem/jeder PatientIN hat ein anderer Gesundheitsberuf mehr Relevanz - der **Lead eines Gesundheitsberufes bei einem/einer Patienten/in ist wichtig** - dies kommt aber auf die Thematik/Diagnose etc an und dies **kann einmal eine PsychologIn sein, einmal eine ÄrztIn** und ein nächstes Mal eine PhysiotherpeutIn/DiätologIn/ErgotherapeutIn/OrthoptistIn/LogopädIn/Biomedizinische AnalytikerIn/RadiologietechnologIn......etc sein

Chair of Assoc. Med. Technology & Hospital ICT (X)	**Mag. Herwig Loidl, MBA Msc:** He is owner of LOIDL Consulting GmbH. With CareCenter, he has developed an all-in-one software solution for inpatient facilities and outpatient services and made it the market leader. He is represented in numerous working groups at state and national level. In addition, he teaches as a lecturer in the field of information and communication technologies (ICT) in healthcare, is the spokesperson of the eHealth Experts Group of the Austrian Chamber of Commerce, a board member of "Integrating the Healthcare Enterprise" (IHE) in Austria, which serves to promote and integrate IT and medical technology in healthcare, and a member of several working groups of the "Elektronischen Gesundheitsakte" (ELGA).	**ja**	**JA - wäre sehr wichtig - auch die Vermittlung der übergreifenden Prozesse** wäre sehr wichtig	**ja**	**ja**	**ja**	k.A.
Former Hospital Director & Health Care Consultant (XI)	**Dr. Gerhard Knor:** He has experience from areas of domestic and foreign health care. His focus is on strategy development, organisational development, change management and cultural development. He works at the organisational level as well as at the overall system level and can refer to the exercise of management functions in the private non-profit and public care sector (St. Josef Hospital in Vienna, Haus der Vinzenz Group, and University Hospital Krems). He has many years of experience in consulting (SOLVE Consulting and Integrated Consulting Group - ICG), with a focus on 'strategic and operational management, internal and external communication and culture development ('lived values') and he is a lecturer in areas such as 'integrated care management' and 'hospital management'.	Natürlich ist die **Organisationskultur sehr wichtig**. Dabei ist aber zu berücksichtigen, dass **Organisationskultur sehr vielschichtig und komplex** ist und ihre Prägung besondere Anforderungen stellt. Meine Antworten zu dem Thema übersteigen den hier gegebenen Rahmen; gerne in anderem Setting mehr. Ein Thema sei genannt: **Das gelebte Vorbild der Führungskräfte (und Aufsichtsorgane)** - ein **schlecht gelebtes Vorbild kann durch Investitionen in Leitbilder und Druckwerke nicht wettgemacht werden**.	Ja, siehe oben (Frage 4); **nicht nur in der Ausbildung** sondern **auch in (übergreifenden und einrichtungsspezifischen) Weiterbildungen** und **in gelebten Führungs- und Steuerungssystemen**.	Dazu gibt es (leider) sehr gegensätzliche Trends. Dazu eine Analogie: So wie wir in Europa trotz aller Integration in den letzten Jahren sehr viel Nationalismus ausgebrütet haben, obwohl die Vorteile der Integration doch (für den Verstand) auf der Hand liegen. Während auf EU-Ebene vieles auf der Ebene des Denkens und der Rationalität abgehandelt und unter großen Mühen weiterentwickelt wird, kommen wir immer mehr darauf, dass die Verbesserungen von vielen nicht als solche wahrgenommen werden. Wenn die Verbesserungen keinen Spaß machen, werden die Menschen auf der Ebene des Wollens nicht mitgehen. Dass die Menschen nur dann mitgehen, wenn sie es auch WOLLEN (landläufig: sexy finden). Wenn sie es nicht wollen, glauben sie eher Fake-News, die einer rationalen Prüfung nicht standhalten. Fazit (auch für das Gesundhetiswesen): **Mind set alleine reicht nicht**. Wir **müssen uns auch überlegen, was die Menschen auf Ebene des Herzens und im Bauchgefühl wahrnehmen**. Wir müssen also kreativ werden, um die Menschen ganzheitlich zu erreichen bzw. abzuholen. **Klug UND beherzt** :) Fazit zur Frage: Selbstläufer und Automatismen gibt es leider nur höchst selten. **Bildung (des Verstands und des Herzens) spielt eine zentrale Rolle**.	Siehe oben • **Zielvereinbarungen** • **Konsequenzen des Handelns auch institutionenübergreifend thematisieren und berücksichtigen** (z.B. nicht Lieferanten bis zum Letzten ausquetschen, um damit deren Konkurs mitzuverursachen) • **Unerlässliche Vorbildwirkung der Führung** • Nachhaltigkeit bei Projekten und Investitionsentscheidungen noch konsequenter systematisch berücksichtigen • Die Magie der (vor-)schnellen PR-Meldung / der Jubelmeldung im Aufsichtsrat sehr kritisch hinterfragen (vieles, was beim ersten Hinhören bestechend klingt, steht bald ohne Lack da und verursacht Kopfweh) • Fairness statt kurzfristige Optimerung zu Lasten anderer • **Leadership schlägt Management** •	**Ja**, wenn sie **ehrlich und nachhaltig gelebt** und auch **laufend reflektiert** wird.	k.A. (s. Ergänzung)

Health Economist & Medical Doctor (XII)	**Ass.-Prof. Dr. Ernest G. Pichlbauer:** Before turning to health services research, he worked as a university assistant at the Pathology Institute of the Vienna General Hospital (AKH). He was significantly involved in the Austrian Structural Health Plan (Österreichischer Strukturplan Gesundheit - ÖSG) and wrote Health Technology Assessment (HTA) reports for the German Federal Government. He is a book author, independent health expert and blogger ('https://www.rezeptblog.info). He lectures at the Sigmund Freud Private University Vienna (focus on 'health services sciences' and 'public health'). His research covers the relevance of health care science and the impact of health policy activities.	ich würde weitergehen - es **gibt Evidenz, die zeigt, dass, ein System mit klaren Systemzielen vorausgesetzt, PHC-Zentren effizienter sind als PHC-NEtzwerke**. Soweit ich mich erinnern kann, wird angegeben, dass die kurze Kommunikation - also das gemeinsame Arbeiten an einem Ort und der damit mögliche und auch stattfindende **unstrukturierte, inoffizielle Informationsaustausch - dafür wesentlich verantwortlich ist**.	**JA** - wie oben schon angerissen	**JA** - wie oben bereits angedeutet	ich bin keine Organisationsexperte, womit meine Meinung eher laienhaft zu werten ist. die extremen Hierarchien und die Konsequente **Bedienung der Berufsgruppenkonflikte durch Koll.Führung und Gewerkschaften** (in Spitälern werden grosso modo alle Gesundheitsberufe ausgebildet, womit der **Berufsgruppenkonflikt Teil des Selbstbildes ist und bleibt**) sind **zu überdenken!** mehr noch, zu beenden.	**Natürlich**, aber erst, wenn die Betonmischer der Vergangenheit angehören. Und das wird leider noch dauern - denn obwohl es ausreichend Evidenz gibt, **wie schlecht unsere Chroniker versorgt** sind und **wieviele QALYs durch die fehlende Integration der Pflege ins Gesundheitssystem verloren gehen**, ändert sich nichts	Ich denke, **eine derartige Kulturarbeit kann in unserer Systemarchitektur nicht gedeihen** - sie würde nur den Frust der Mitarbeiter erhöhen. Denn was hilft es, wenn alle zustimmen, dass man alte Menschen sowenig wie möglich ins Bette pflegen soll, wenn dann im Spital zu wenig zeit für aktivierende Pflege ist und extramural der Fokus auf informelle Pflege liegt? Ich unterrichte meinen Studenten immer, dass Sie **konkrete Patientengruppen identifizieren** sollen, **bei denen es VERSORGUNGS-Probleme gibt und dann nur diese Probleme lösen - also hochgradig konkret und dezentral. Keinesfalls an der Systemarchitektur anstreifen!**
Health System Planning & Care System Research (XIII)	**Mag. Andreas Birner** is an employee of the Department of Planning and System Development at Gesundheit Österreich GmbH (GÖG). His work and research focuses on Austrian health system planning, health care system research, epidemiology, the Austrian Health Information System (Österreichisches Gesundheitsinformationssystem - ÖGIS) and implementation and decision support in the Austrian health care system. In addition, he is lecturer in universities of applied sciences, even in 'integrated care management' and 'hospital management', and scientific consultant in health care planning, implementation and health care assurance.	**Ja zum Teil direkt** (wenn vielleicht auch nicht immer), **indirekt und für das Versorgungssystem** gesamthaft gesehen **auf jeden Fall**. Für die **Patientinnen und Patienten** und die z.T. auch die Angehörigen **ganz bestimmt** (geringerer Zeit- und Kommunikationsaufwand für die Betroffenen).	Sehr **gute Idee, würde ich sehr unterstützten!**	**Ja ich stimme zu**, wenn das Mindset der nachkommenden Generationen auch in diese Richtung verstärkt ausgerichtet ist. Das ist aber **kein Selbstläufer, das muss unterrichtet, geübt, vorgelebt werden**. Beispiele guter Praxis sind da sehr wichtig, die Erfolge müssen herzeigbar sein und hergezeigt werden. **Wer nach diesen Verhaltensweisen arbeitet muss in der Aufgabe selbst erfolgreich sein** und diesen **Erfolg auch gerne teilen**. Dann **sollten** diese Erfolge auch **kritische Erfolgsfaktoren für die persönliche Karriere sein**.	**Ja**, im Sinne des oben in Frage 7 angeführten Argumente **in Richtung Ergebnisorientierung und Karriereförderung**.	Das ist **sogar unabdingbar**. Und diese **Kultur muss von oben vorgelebt werden**, sonst wird es sie nicht geben. Und mit vorgelebt meine ich tatsächlich so leben und **nicht nur in ein Letibild reinschreiben**, was sicher auch sehr wichtig ist. Und es **muss auch für die betroffenen Menschen spürbar positiv sein** (besseres Arbeitsklima, bessere Arbeitserfolge, wichtig für beruflichen Aufstieg).	Vorteile: **effektivere und in seiner Gesamtsicht auch effizientere Arbeit**; **Gemeinsamer Erfolg** sich schöner als Einzelerfolge (die es ja eigentlich eh fast nie wirklich sind), **mehr Patientenwohl, mehr fachlicher Austausch, weniger Druck auf den Einzelnen durch geteilte Verantwortungen**; es gibt sicher noch mehr.... Nachteile: **Gefahr**, dass die Sache zu einer **platten Pseudokultur** wird, die **nicht gelebt** aber hinter vorgehaltener Hand **umso mehr belächelt** wird (meiner Erfahrung nach v.a. dann, **wenn die geförderte Kultur mit der eigenen** (österreichischen?) **Kultur nicht zusammen-passt**, was z.B. durch Anwendung US-amerikanischer Management-instrumente leider zu oft passiert). Herausforderung: **Etablierung einer Art Metakultur der interinstitutionellen Zu-sammenarbeit**, die **mit der eigenen Organisationskul-tur harmonieren** muss, kann schwer sein... *(continued below)*
	supplement (XIII)						
	ad Q10) Etablierung einer **Metakultur der interinstitutionellen Zusammenarbeit**, die mit eigener Organisationskultur harmoniert, kann insb. bei Zielkonflikten schwer sein. Hier müssen **klare Richtlinien** existieren, um den Einzelnen aus der Verantwortung zu nehmen. Eine weitere Herausforderung kann auch darin bestehen, dass die **neue Kultur** zumindest **in bestimmten Bereichen zeit- und ressourcenintensiver** ist. **Muss gut vorbereitet**						

Managing Dir. & former "Value Manager" (XIV)	**Mag. Rainer Kinast** is a theologian, management consultant, psychotherapist (existential analyst), managing director of a care organization, trainer at the Academy for Social Management. For 13 years he was head of the central competence area for value management in the Vinzenz Group (association of religious hospitals and non-profit health institutions). His areas of expertise include specialty areas: Spirituality and Management, Ethics in Management, and Ethics in Medicine and Nursing. He is the author of the book "Value-Oriented Management Culture: Theory and Practical Implementations", published by Lambertus Verlag, 2021, Freiburg. ISBN: 978-3-78413-316-4.	**Davon** bin ich hundertprozentig **überzeugt**. Vor allem durch die **eigene Erfahrungen** (s. Rainer Kinast (2021), Werteorientierte Führungskultur. Theorie und praktische Umsetzungen. Freiburg: Lambertus)	**Ja**, natürlich gehört das **in der Ausbildung**. Aber, was nicht zu unterschätzen ist: Die Menschen werden **durch die praktische Ausbildungen de facto sozialisiert**. Wenn ein **auszubildender Arzt** sein KPJ macht, **lernt** einfach, wie sich die Ärzte vor Ort die anderen Berufsgruppen behandeln, **erlebt die Vorteile von dem vorhandenen Rollenverhandeln** und **bekommt wenig kritischen Reflexionsraum**. Das heißt, man müsste in den Institutionen vorort ansetzen. Das wird aber nur funktionieren, wenn die obersten Verantwortlichen einen Nutzen für sich und die eigene Aufgabe erkenne und diese Kooperationen	Ich glaube, die Frage nicht ganz verstanden zu haben. (verändertes Mindset? Was meinen Sie damit) Die nachkommende Generation ist gut im Sich-Abgrenzen. Da braucht es schon gute Führungsqualitäten.	Ich glaube, dass grundsätzlich **Mitverantwortung von Mitarbeitenden viele Führungskräfte noch nicht leben bzw. haben nicht verstanden**, was das an Führungshaltungen und Führungsverhalten erfordert. Da reden wir noch gar nicht von **Mitverantwortung in der Zusammenarbeit**. Dazu positive Erfahrungen: Nochmals **Hinweis auf die Führungskultur**, **die Eigenvernantwortung von Mitarbeitenden stärkt** und im Buch Werteorientierte Führungskultur in Theorie und vor allem mit vielen praktischen Beispielen beschrieben ist (u.a. Kap. 4).	Es **braucht ein gemeinsames Verteverständnis**, aber es **braucht vor allem auch eine Verte-Sensibilität der Einzelnen**. Die **Kunst des Führens** besteht gerade in dem **Zusammenspiel von Organisations- oder Unternehmensverten** (wie man sie halt nennen mag) und den situativen **persönlichen Verten der einzelnen** (siehe Buch Werteorientierte Führungskultur Kap. 2.3)	Vorteile: - die **einzelnen Menschen sind auch in ihrer Funktion als Personen angefragt** - das **Arbeiten bekommt erlebten Sinn und es entsteht lebendigte Freude** - die **Patienten spüren den menschenorientierten Zugang, den** die **Professionen miteinander leben** - Die **Motivation aller Beteiligten steigt, was sich letztlich auch betriebswirtschaftlich rechnet - hohes Arbeitspensum kann leichter bewältigt werden**. Gefahr: - **Venn bei den Mitarbeitenden Erwartungen geweckt werden, die nicht erfällt werden** - Wenn das **Management den Stellenwert nicht ernst nimmt** und damit **mehr Frustrationen streut als**
Head of Depart. & former Med. Head of Hospitals (XV)	**Primarius Dr. Kurt Resetarits** is Head of the Department of Gynecology and Obstetrics at the Feldbach-Fürstenfeld Regional Hospital (Styria). Before that, he was medical director for the two hospitals Oberwart and Güssing (Burgenland) for five years. In addition, he is the owner of a specialist practice (elective practice) for gynecology in Güssing. Thus, in his extensive professional activity, he was always also involved in questions of integrated health care and was able to create a very broad perspective and occasionally also a profound perspective in integrated health care.	**Absolut ja**..	Ja, **je früher desto besser**	Auch hier **kann ich nur bejahen**. Die **Besetzung der Führungskräfte ist immer entscheidend**. Neue Führungszugänge wie just culture , Fehlerkultur etc sind zu forcieren	**Ja.** Es **geht nicht mehr Top Down**. Es **müssen die Leute in einer flachen Hierarchie geführt werden** und **nicht durch Anordnungen von oben sondern durch ihr Arbeitsprofil**, dass **genau definiert wird**, ihre Leistungen erbringen.	**Ja**. Zum Beispiel sind **gelebte Verte ein wichtiger Bestandteil**. Diese **müssen niedergeschieiben werden, geschult** und **besprochen** werden. Wichtig ist auch, dass sie **gemeinsam erarbeitet** werden. Wenn **Dinge, die die Verte nicht repräsentieren** passieren, dann muss man die **Mitarbeiter darauf aufmerksam machen**.	**Besseres Teamwork**, **besseres Arbeitsklima**. Das **wirkt sich auch auf alle Stakeholder aus, auf PatientInnen und auch auf andere Partner** die mit dem Krankenhaus zusammenarbeiten

Chairwoman Federal Association of Self-Help Austria (XVI)	**Angelika Vidhalm** is Chairwoman of the Board of the Federal Association of Self-Help Austria (BVSHOE), an umbrella organization of Austria's nationally active, issue-related self-help and patient organizations. The Federal Association of Self-Help Austria records and bundles the common concerns and interests of the issue-related self-help organizations at the federal level, advocates for them, accompanies and drives implementation and is an important, recognized and legitimized contact for politics and the health care system at the federal level for the creation of connections to political processes. Angelika Widhalm, herself a former chronic patient, was the first liver transplant patient in Europe to be cured with the help of a new interferon- and side-effect-free therapy. Since then, she has been able to participate fully in life again and, as the former chairwoman of Hepatitis Hilfe Österreich and now chairwoman of the Federal	**Ja auf jeden Fall.**	**Absolut ja.**	**Ja auf jeden Fall.**	**Ja auf jeden Fall.**	Man muss hier **bereits in der Erziehung beginnen und zwar in der Schule**, um ein derartiges Denken und Werteverständnis zu erreichen.	Ein **besseres Klima in der Zusammenarbeit, weniger Konkurrenzdenken und letztendlich eine bessere und schnellere Versorgung** der Patienten. D.h. am Ende, es geht den Patienten rascher besser, sie fühlen sich wohler und die Heilungsprozesse werden rascheren Erfolg bringen. Im Endeffekt gewinnen dabei alle Beteiligten.

point of view	name and background	question 11	question 12	question 13	question 14	question 15	yes (1) no (2)
	expertise	In your opinion, is it possible to realise coordinated care regions in the care areas - as is the case, for example, in the model region 'Healthy Kinzigtal' in Germany - also in Austria in the long term? - **'Transferability of integrated HC models'** (Cat. 5.1)	What concrete measures would have to be taken with regard to structures and processes as well as at management levels in order to make the jointly claimed culture liveable (perceptible) for the patients concerned, but also for all staff involved - along the care pathways, in particular also at interfaces? - **'Lived Organizational Culture'** (Cat. 2.2)	In your opinion, what conditions (framework conditions) would have to be created in order to improve interprofessional cooperation and communication between the areas of care (hospital, nursing home, general practitioner, etc.)? - **'Interface Optimization of integrated HC'** (Cat. 5.2)	How could an understanding of values in integrated care that promotes inter- and multi-professional coop. be developed, main-tained and effect. managed across sectors and institutional boundaries? - **'Functionality of Mission State-ments'** (Cat. 4.3)	What can individuals do to improve interprofessional cooperation and communication between intra- and extramural areas and what could be your personal contribution - within the framework of your area of responsibility - to the realisation of patient-centred, cross-sectoral care characterised by continuity and good interprofessional cooperation? - **'Influence of the Individual on the Integration of Health Care'** (Cat. 5.3)	consent to the naming of the person
		Frage 11	**Frage 12**	**Frage 13**	**Frage 14**	**Frage 15**	
	Expertise	**Lassen sich Deiner Ansicht nach in den Versorgungs-bereichen abgestimmte Versorgungsregionen - wie es z.B. in der Modellregion ´Gesunde Kinzigtal´ in Deutschland der Fall ist - langfristig auch in Österreich realsieren?**	**Welche konkreten Maßnahmen hinsichtlich Strukturen und Abläufe sowie auf Managementebenen müssten gesetzt werden, um die gemeinsam beanspruchte Kultur den betroffenen PatientInnen, aber auch allen beteiligten MitarbeiterInnen - entlang der Versorgungs-wege, insb. auch an Schnitt-stellen - lebbar (spürbar) werden zu lassen?**	**Welche Voraussetzungen (Rahmenbedingungen) müssten Deiner Ansicht nach geschaffen werden, um interprofessionelle Zusammenarbeit und Kommunikation zwischen den Versorgungsbereichen (Spital, Pflegeheim, Hausarzt etc.) zu verbessern?**	**Wie könnte ein das inter- und multiprofessionelle Miteinander förderndes Werte-verständnis in der integrierten Versor-gung entwickelt, über Sektoren und institutionelle Grenzen hinweg aufrechterhalten und wirksam gesteuert werden?**	**Was kann die oder der Einzelne zur Verbesserung der interprof. Zusammenarbeit und Kommunikation zwischen intra- und extramuralen Bereichen betragen und worin könnte Dein persönlicher Beitrag - im Rahmen Deines Auf-gabenbereichs - zur Realisie-rung einer patientenzentrierten, bereichsübergreifenden sowie von Kontinuität und guter interprof. Zusammenarbeit geprägten**	

Health System Planning & Care System Research (I)	**Dr. Gerhard Fülöp** heads the Department of Planning and System Development at Gesundheit Österreich GmbH (GÖG). His work and research focuses on Austrian health system planning, health care system research, epidemiology, the Austrian Health Information System (Österreichisches Gesundheitsinformationssystem - ÖGIS) and implementation and decision support in the Austrian health care system. In addition, Gerhard Fülöp devotes himself to lecturing activities at home and abroad as well as working on international projects of WHO, EU and World Bank with a focus on health information systems, health reporting, health system planning.	Nach meinem (allerdings eher bescheidenen) Wissensstand über die Modellregion Gesundes Kinzigtal handelt es sich hier eher um eine Art gesundheitssoziologisches Experiment, das über gesundheitsökonomische Anreize gesteuert wird als um eine gezielte **Abstimmung zwischen den Versorgungsbereichen** innerhalb einer Versorgungsregion. Grundsätzlich ist die Abstimmung zwischen den Versorgungsbereichen **seit** dem ersten **ÖSG** im Jahr 2006 ein **zentrales Ziel** eben des ÖSG bzw. der RSG wie auch der Zielsteuerung-Gesundheit - zur Herstellung dieser Abstimmung wird es in Österreich schlussendlich (aufgrund der Unterschiede der Gesundheitssysteme in D und in Ö) etwas andere Ansätze brauchen.	Aus meiner Sicht sollten sich die Maßnahmen einerseits auf eine **adäquate Verfügbarkeit von Kapazitäten in allen Sektoren** (akutstationären Bereich, Spitalsambulanzen, niedergelassener Bereich, stationäre und ambulante Rehabilitation sowie alle Sektoren der Alten-/Langzeitversorgung) sowie andererseits auf die **Etablierung eines wirklich funktionierenden Nahtstellenmanagements** in jeder ÖSG-Versorgungsregion bzw. in jedem politischen Bezirk beziehen (vgl. z.B. https://www.nahtstellenmanagement.at/cdscontent/?contentid=10007.753378&portal=nahtstellenmanagementportal).	Intensivere **gegenseitige Information über die jeweils abgedeckten Versorgungsfunktion**, gemeinsame Analyse von Problemlagen v.a. an den Schnittstellen bzw. Nahtstellen, d.h. beim Übergang der Pat. von Versorgungsbereich A in den Versorgungsbereich B (z.B. im Rahmen von **regionalen Gesundheitskonferenzen** oder von Workshops), Festlegung von **gemeinsamen Zielsetzungen**, **regelmäßige Kommunikation** zwischen allen relevanten Leistungserbringern in einer Region sowie schlussendlich gemeinsame **Evaluierung der Zielerreichung**.	Siehe dazu Frage 13 - wobei mir die Elemente einer **regelmäßigen und institutionalisierten Kommunikation** sowie der **Festlegung von gemeinsamen Zielsetzungen** von zentraler Wichtigkeit erscheinen.	Der **Einzelne** müssen bereit sein, althergebrachte **Abläufen/Strukturen kritisch zu hinterfragen**, für Änderungen/Verbesserungen **offen sein** und außerdem bereit sein, solche Änderungen/Verbesserungen auch in seinem eigenen Bereich **in Richtung einer verbesserten interprofessionellen Zusammenarbeit** umzusetzen. Im Rahmen meines eigenen Aufgabenbereichs konzentriere ich mich auf den o.e. Aspekt einer adäquaten **Verfügbarkeit von Kapazitäten** in allen Sektoren (Aufgabenstellungen von ÖSG und v.a. RSG) sowie ggf. auf weitere **regionale Analysen der Qualität des Nahtstellenmanagements** (wie z.B. in OÖ vor einigen Jahren im Rahmen von regionalen Workshops bereits erprobt).
Hospital Management & Strat. Management (II)	**Expert II** (the interview is reproduced anonymously on request) is Managing Director on the strategic management level of several confessional nonprofit general hospitals. In addition, he lectures at an University of Applied Sciences in the part-time Master's programme in "Health Management and Integrated Care". *(unidentified Expert Mag. David Pötz, MSc, LL.M. is Managing Director of the general hospitals Herz-Jesu Krankenhaus and Hospital Göttlicher Heiland in Vienna. In addition, he lectures at the University of Applied Sciences Burgenland.)*	langfristig? Ja sicher ... Aber halt **sehr langfristig**. Das Gesunde Kinzigtal hat übrigens angeblich seine Verträge verloren, weil nicht evidenzbasiert erfolgreich?	Ideal wäre eine **outcomeorientierte Finanzierung**. Und zwar so, dass alle Beteiligten am Prozess **erst dann honoriert** werden, **wenn es am Ende gut ausgegangen ist**. Problem: Definition von gut ausgegangen und Bewertung der Teilleistungen der einzelnen Prozesschritte .	**Digitale Plattform für offenen Datenaustausch**, Mehr Feedback des Patienten an die am Prozess beteiligten Partner (für alle Partner einsehbar). **Finanzierung des Gesamtergebnisses, und nicht von Teilleistungen**.	persönlicher Austausch. **Offenes Feedback der Patienten** an alle verteilt, ... und **von allen diskutiert und nach Lösungen gesucht**	Sich bei Entscheidungen **gedanklich in die Situation des Patienten versetzen**. Wie hätte ich es gern, wenn ich Patient wäre? Das kann helfen ...

Med. Hospital Management & Med. Doc. (III)	**Expert III** (the interview is reproduced anonymously on request) is a member of the collegial leadership ("Kollegiale Führung") and medical director of a rehabilitation facility (Special Hospital). In addition, he lectures at a Medical University and at an University of Applied Sciences in the part-time Master's programme in "Health Management and Integrated Care", which he himself also completed. He also supervises Master's theses on problems of integrated care. *(unidentified Expert Univ.-Prof. Prim. Dr. Georg Stummvoll, MSc is a member of the collegial leadership and medical director of a special hospital for rehabilitation. In addition, he lectures at the Medical University of Vienna and at the*	mit **viel Aufwand** und **fraglichem Erfolg**.	Diese **Frage** ist mir **inhaltlich zu groß** zur kurzen schriftlichen Beantwortung. Vieles wurde aber in anderen Fragen schon beantwortet.	**klare Zuständigkeiten** auf freiwilliger Basis (zB **in größeren Ballungszentren: Kooperation mit EINEM KH**, aber **kein Zwang** zu einem bestimmten Partner), direkte Kommunikation, gute benutzerfreundliche EDV.	**Institutionen zum Gedankenaustausch schaffen**. **Veranstaltungen ähnlich** einem **Kongreß**, aber **interprofessionell** mit viel Möglichkeit zur Interaktion. **Gute, definierte Ansprechpartner** (Idee: zB Vertreter der Physiotherapeuten auf Bezirksebene wählen, oder Ideen in diese Richtung). **Finanzielle Abgeltung des Mehraufwands**. Auch die Gesundheitsberufe müssen einen **persönlichen Mehrwert erkennen** und dürfen keinen Nachteil haben. Aus der ELGA - Einführung lernen	**Mitarbeit bei Entwicklung und Durchführung** der oben skizzierten oder anderer, noch besserer Projekte.
Social Management & Humanistic Management Consulting (IV)	**Expert IV** (the interview is reproduced anonymously on request) is lecturer in social ethics at universities and universities of applied sciences. He also heads an organisation of humanistic management. He is owner of a company for consulting, coaching and educational offers for the implementation of social innovations. *(unidentified Expert Dr. Markus Glatz-Schmallegger lectures as a social ethicist at universities and universities of applied sciences in lectures as philosophy/economics, systems theories, environmental/economic ethics. He heads the Austrian Chapter of Humanistic Management Network which is working towards discovering, analyzing and mitigating systemic weaknesses of our dominant economic paradigm. He is owner of the company "ValUse" for consulting, coaching and educational offers for the implementation of social innovations.)*	Das wäre ein **hilfreicher Weg**, der **auch bei den Betroffenen Akzeptanz schaffen hilft**. Er **macht integrierte Versorgung anschaulich und erlebbar**.	*siehe Ergänzung (a)*	Ich denke, dazu konnte ich oben einiges schreiben. Es geht darum, die **gemeinsame Ziel- und Finanzierungssteuerung** (im Zuge der Gesundheitsreform) wirklich **nachhaltig zu implementieren** und das **Wissen aus diesem Prozess transparent zu reflektieren** und zu diskutieren. Dabei gehören die **Perspektive der PatientInnen und im Feld Tätigen** hoch gewichtet.	Dazu bietet die **angewandte Ethik** viele Wege und **Optionen, auf Makro- Meso- und Mikro-Ebene**. Ausbildung, Reflexion, Evaluation, **klare Orientierung an gemeinsamen Werten und Zielen**, **Transparenz** bei Wert- und Zielkonflikten, insbesondere **strategische Abstimmung** einzelner Maßnahmen über einen längeren Zeitraum., **Achtsamkeit** für Hindernisse und Zwischenerfolge, Lernen aus einzelnen Erfahrungen, Wissensmanagement im Sinne einer professionellen Organisation, **kulturbildende Prozesse**.	Ich bin vor allem in der Ausbildung für Gesundheitsberufe tätig. Hier sehe ich **viele Möglichkeiten, in Lehrveranstaltungen zur Ethik und zu Leadership** oder in dem Lehrgang für **interkulturelles Pflegemanagement**, den ich mitentwickelt habe. Es geht insbesondere dann, wenn **transformationales Lernen** möglich ist, also ein **Einbeziehen der individuellen Bewertungsmuster** und Kommunikation darüber. Wenn es nur um Stoff geht, dann ist der Effekt eingeschränkt.

Discharge Managem. & Clin. Social Work (V)	**DGKS Elfriede Lampel:** After several years as a member of the board (head of the nursing service) of a denominational, private-community special hospital (Orthopaedic Hospital Speising, Vinzenz Group), she is in charge of bed management, discharge management and clinical social work at the Vienna General Hospital (AKH) - University Hospital.	Ja, wenn die **interessierten Personen in den örtlichen Kommunen den präventiven, gesundheitlichen Stellenwert** bekommen und auch erarbeiten wir z. B. die Feuerwehren. Dazu bedarf es Humanressourcen, finanzielle Sicherheit , Empathie und die **richtige Einschätzung und Schwerpunktsetzung** welche Art von Gesundheits Versorgung passt und angenommen wird.	Jeder der Beteiligten sollte den **persönlichen und öffentlichen Mehrwert** , die Richtigkeit der Maßnahmen und die **Win-Win-Situation** erkennen und das stimmige Gesamtbild des Erfolges in angemessener Zeit.	**einheitliche Information intern und extern rasch abrufbar** erhalten - moderne Medien die das elektronisch einfach und rasch erfüllen - **Vertrauen und Kommunikation auf Augenhöhe** - die gleiche Sprache sprechen - **den Fokus auf die Betroffene / den Betroffenen** unter **Einbeziehung des familiären ,sozialen Umfeldes** und **realistischer Machbarkeit** richten	siehe Frage 13 (vorherige Frage)	Den **Fokus auf den Patienten / Klienten** richten - **klare Kommunikation** sowohl auf die Person als auch auf Inhalte der Information **angepasste Bürokratie** ohne Zeit - und Datenverlust durch Mehrfach-kommunikationen **Respekt und Akzeptanz** eines Interpro-fessionellen Teams **Vorteile aufzeigen** / Probleme klar, kurz, zeitnah prägnant aufzei-gen und **Lösungsvorschläge von Seiten der Betroffenen** umsetzen
HC Consultant & Expert Integrated Health Care (VI)	**Expert VI** (the interview is reproduced anonymously on request) was a research assistant at the University of Applied Sciences Burgenland. For about a year he has been working in the international consulting sector with a focus on health care management and integrated care. *(unidentified Expert Michael Mut, BA MA: After completing a Bachelor's degree in Health Promotion and Health Management and a Master's degree in Health Care Management and Integrated Care, he was a research assistant at the University of Applied Sciences Burgenland. For about a year he has been working in the international consulting sector with a focus on health care management and integrated care).*	Solche Versorgungsmodelle sind **bedingt übertragbar**. Das Modell Gesundes Kinzigtal wurde in Deutschland bereits mehrmals übertragen, jedoch stets **unter anderen Rahmenbedingungen** (verschied. Versorgungsstrukturen, Zielpopulationen, etc). **Derartige Modelle basieren auf gewissen Prinzipien** (Finanzierungsmodelle, Stakeholder-Beteiligung, Zielgruppen-Partizipation), die je nach Ausgangslage übertragbar sind. Beispielsweise wurde ein **Gesundheitskiosk in einem Hamburger Bezirk** mit hohen Versorgungsdefiziten etabliert, der Teilaspekte des Modells enthält. Daher ist eine **umfangreiche Auseinandersetzung mit den vorherschenden Bedingungen essentiell**.	Auf Managementebene einzelner Einrichtungen ist wichtig zu identifizieren, wo Versorgungsstrukturen übergreifen. **Viele Personen auf Managementebene haben kein Bewusstsein für bestehende Strukturen und Anknüpfungspunkte auf operativer Ebene** (gesetzlich und strategisch besteht zumeist ein Bewusst-sein). Durch einfache Prozess-beschreibungen auf interdis-ziplinärer bzw. akteursüber-greifender Ebene wäre eine Ausgangsbasis geschaffen. Natürlich **müssen daraus entsprechende Hand-lungen folgen**. Zudem gilt es, die **Welle der Digitalisie-rung zu nutzen**. Damit wird **automatisch eine engere Verbundenheit erstellt und eine Kultur erzeugt**. Diese gilt es zu Formen.	**Rechtliche und strukturelle Bedingungen müssen neu ausgerichtet** werden, sodass **keine Sektorentrennung** erfolgt. Blickt man in **andere Länder, so sind Gesundheitsberufler bzw. Einrichtungen mehr oder weniger gezwungen zu kooperieren und kommunizieren**. Daten und Wissen müssen somit ausgetauscht werden. **Kulturen und Handlungswelten verschmelzen.**	Wie bereits erwähnt, durch eine **Änderung der Strukturen und Rahmenbedingungen**. Zudem ist eine **systematische Kulturarbeit notwendig**, das heißt die einzelnen Player und VertreterInnen müssen **gemeinsame Werte identifizieren**, Verständnis schaffen und so eine **Werteboard schaffen**. **Steuern lassen sich gelebte Werte durch geteile Visionen, etablierten Managementsystemen und Zertifizierungen**.	Einzelpersonen können gezielt Impulse setzen, indem sie Vorschläge ins Team / Einrichtung / etc. bringen und ihre **kooperative Denke im Arbeitsalltag vor(leben)**.

President of the Austrian Federation of Nursing Homes (VII)	**Expert VII (the interview is reproduced anonymously on request)** is President of a federal association of nursing homes and was formerly the home and nursing service manager of a nursing home. His goals include further competence development of the health professions (gerontology and geriatrics), the expansion of hospice and palliative care as well as quality work. *(unidentified Expert Markus Mattersberger, MMSc MBA: He is President of the Federal Association Lebenswelt Heim and was formerly the home and nursing service manager of a nursing home in Lower Austria. His goals include further competence development of the health professions, the expansion of hospice and palliative care as well as quality work.)*	Ja, dabei **müssen aber versorgungspolitische und nicht berufspolitische Überlegungen im Vordergrund stehen**.	Zunächst muss man den **Mut haben, die Dinge anzugehen**. Dabei sollte das Bewusstsein entwickelt werden, das **Investitionen** in diesen Bereichen weniger als Kostenfaktoren denn **als Wirtschaftsfaktoren zu sehen** sind - dies sind **volkswirtschaftliche Überlegungen**! Wir brauchen **mutige Politik**, die sich **mehr an den Lebensrealitäten** und -situationen der Menschen **orientiert**, und sich **weniger vor den Androhungen der Interessensvertretung eines vorherrschenden Gesundheitsberufes** instrumentalisieren lässt. Die Systeme müssten so aufgebaut werden, dass Bürgerbeteiligung belohnt und Fehlreize vermieden werden.	**Aufwertung der anderen Gesundheitsberufe** (Pflege, Therapeuten etc.), sodass eine Begegnung auf Augenhöhe möglich ist - in der Bezahlung, rechtliche Kompetenzen, Einbindung in Entscheidungen,.... **Bedarfsgerechte Verteilung der monetären Mittel** - der **Bedarf** soll sich jedoch **nicht an den Systemen orientieren**, sondern **an den Problemen der Menschen**. **Systematischer und strukturierter Austausch zwischen den Versorgungssettings** - dazu bedarf es eines **Leaderships durch regionale Gesundheitsbehörden**!	**Regionale Gesundheitsbehörden habe hier einen klaren Auftrag**. Sie **müssen den Dialog fordern und fördern, Bedarfe erheben und die Strukturen danach ausrichten**. Dabei geht es wiederum nicht um die Bedarfe bzw. Bedürfnisse der Settings, sondern **jene der Gesellschaft**! Es braucht eine **gute Balance zwischen den einzelnen Professionen - aktuell gibt es ein massives Ungleichgewicht zu Gunsten der Ärzteschaft**. In **dieser Imbalance treten vermehrt berufspolitische Begehrlichkeiten zu Tage und verhindern eine gutes Miteinander**.	**Professionelles Agieren, vertiefter Austausch, gute Kommunikation und Bewusstseinsbildung** im Sinne einer **an der Gesellschaft orientierten Versorgungslandschaft**.
Former HCM in hospitals & Consultand ans Lecturer (VIII)	**FH-Professor Dr. Gerhard Pöttler, MBA MEd:** He is a self-employed health economist and has experience from various executive and management positions in non-profit, public and private hospitals as well as religious hospitals, old people's and nursing homes and rehabilitation clinics in different Austrian provinces. In addition, he is a lecturer at numerous universities of applied sciences and universities in the fields of health care and finance, and he is also the author of a book on the Austrian health care system: "Gesundheitswesen in Österreich. inkl. Gesundheits- und Sozialversicherungsreform: Organisationen, Leistungen, Finanzierung und Reformen" (3. Aufl.), ISBN: 978-3-99060-169-3.	nur dann, **wenn es von allen Beteiligten auch wirklich getragen** werden kann	1. nach innen und außen ein **wirklich gelebtes Miteinander** - dann ist es für jede und jeden offensichtlich 2. es braucht gar nicht so viele gesetzliche Regelungen, die **Beteiligten müssen es wollen und umsetzen** 3. **wenn das nicht klappt, dann gesetzliche Rahmenbedingungen**	es ist **immer schwer**, mit gesetzlichen Regelungen zu argumentieren, denn es ist fast alles da nur es muss einfach umgesetzt werden, und daran scheitert es - es **fehlt am Willen der Beteiligten**	siehe oben durch **das Wollen, das gelebte Zusammenleben** und **ggf durch gesetzliche Vorgaben und Rahmenbedingungen**	selbst **ein wenig vom eigenen Standpunkt zurücktreten**, mehr Verständnis für die und den anderen finden es ist wie in unsereer Gesellschaft - dann gäbe es weniger Streit und Zank und die Menschen würden viel mehr miteinander als gegeneinander arbeiten

Chairperson Association of Med. Techn. Services (IX)	**Mag.a Gabriele Jaksch:** She is President and member of the Executive Board of MTD-Austria, the umbrella organisation of Austria's higher medical-technical services. She is the central point of contact for professional policy issues of the medical-technical services and represents their interests, in particular also vis-à-vis the Federal Ministry of Health. In her function as President of MTD-Austria, she is also a member of numerous working groups, such as the Health Professions Conference or working groups of Gesundheit Österreich GmbH. In addition, she works as a freelance physiotherapist and as a lecturer at MTD university of applied sciences courses.	...kann ein Lösungsansatz sein.....**Vernetzung auf Augenhöhe ist wichtig in welcher Form auch immer....**	...es **braucht Boards oder Gremien in denen viele/alle relevanten Berufe vertreten sind** - als Beispiel die KOFÜ - zB Sachverständigenrat könnte installiert werden, „**Regional Health University** wäre auch ein sehr wichtiger Ansatz in Ö......	....einerseits wie oben erwähnt - **breit aufgestellte Gremien in allen Gesundheitsbereichen** bzw. **Novellierung uralter Berufsgesetzte** von Gesundheitsberufen **uvm**	..Antwort ist in vielen vorangegangen Beantwortungen enthalten....	...**nicht müde werden**, den/die Patient/in bzw. den Menschen(zB in Bezug auf Prävention...) **in den Mittelpunkt des Handelns von Gesundheitsberufen zu stellen**, auf allen Ebenen betonen, wie **bereichernd** es für das Gesundheitssystem ist, **wenn ALLE Gesundheitsberufe an relevanten Entscheidung mitarbeiten** (und sie dadurch auch tragen)
Chair of Assoc. Med. Technology & Hospital ICT (X)	**Mag. Herwig Loidl, MBA Msc:** He is owner of LOIDL Consulting GmbH. With CareCenter, he has developed an all-in-one software solution for inpatient facilities and outpatient services and made it the market leader. He is represented in numerous working groups at state and national level. In addition, he teaches as a lecturer in the field of information and communication technologies (ICT) in healthcare, is the spokesperson of the eHealth Experts Group of the Austrian Chamber of Commerce, a board member of "Integrating the Healthcare Enterprise" (IHE) in Austria, which serves to promote and integrate IT and medical technology in healthcare, and a member of several working groups of the "Elektronischen Gesundheitsakte" (ELGA).	sicherlich - **Modellregionen sind immer ein guter Ansatz** - es sollte jedoch schon beim Aufsetzen der Modellregion der komplette Rollout mitgeplant sein	**Maßnahmen zur Erreichung gegenseitigen Respekts - Programme zur Vertschätzung der nicht so wertgeschätzten Berufsgruppen**	**bessere digitale Vernetzung und kommunikation - Finanzierungsmodelle für interdisziplinäre Arbeit**	**Anreize - finanziell und in emotionalen Projekten**	**digitale Schnittstellen Probleme**

Former Hospital Director & Health Care Consultant (XI)	**Dr. Gerhard Knor:** He has experience from areas of domestic and foreign health care. His focus is on strategy development, organisational development, change management and cultural development. He works at the organisational level as well as at the overall system level and can refer to the exercise of management functions in the private non-profit and public care sector (St. Josef Hospital in Vienna, Haus der Vinzenz Group, and University Hospital Krems). He has many years of experience in consulting (SOLVE Consulting and Integrated Consulting Group - ICG), with a focus on 'strategic and operational management, internal and external communication and culture development ('lived values') and he is a lecturer in areas such as 'integrated care management' and 'hospital management'.	k.A. (s. Ergänzung)	k.A. (s. Ergänzung)	k.A. (s. Ergänzung)	k.A. (s. Ergänzung)	k.A. (s. Ergänzung)
Health Economist & Medical Doctor (XII)	**Ass.-Prof. Dr. Ernest G. Pichlbauer:** Before turning to health services research, he worked as a university assistant at the Pathology Institute of the Vienna General Hospital (AKH). He was significantly involved in the Austrian Structural Health Plan (Österreichischer Strukturplan Gesundheit - ÖSG) and wrote Health Technology Assessment (HTA) reports for the German Federal Government. He is a book author, independent health expert and blogger ('https://www.rezeptblog.info). He lectures at the Sigmund Freud Private University Vienna (focus on 'health services sciences' and 'public health'). His research covers the relevance of health care science and the impact of health policy activities.	"on the long run we ar all dead"	Konkret geht sowas **nur, wenn man von der Wissenschaft ganz klar definierte Patientenwege hat** (also Versorgungs-Pfade, **wie sie international längst üblich** und Instru-mente des Gesundheitsmanagements sind) und **anhand seiner Patienten feststellen kann, dass es eine SOLL-IST-Abweichung gibt**. Und dann braucht man eben den, der dann für seine Patienten diese SOLL-IST-Analyse macht und konkrete Maßnahmen implementiert. Dezentral geht das, so-lange eben keine Reform dafür benötigt wird. Und das bedeutet eben es nur für wenige umsetzen zu können, allerhöchstens auf der eigenen Abteilung. **Ethisch ist das natürlich fragwürdig, weil**	**VERFASSUNGS-REFORMEN**	Ich denke, **in unserer Systemarchitektur gar nicht. Sobald es die Ebene der Einzelinitiativen verlässt, werden die Anreize des völlig fragmentierten Systems wirksam.** Die Subsyteme werden, um sich abzugrenzen, jegliche Entwicklung boykottieren. Es geht eher darum, **ob dezentral ein mutiger Kopf sitzt**, der Dinge zuläßt und den Rücken freihält.	Ich unterrichte Gesundheitsberufe dahingehend, dass ich Ihnen zeige, **was integrierte Versorgung bedeutet, was es bedeutet, wenn sie fehlt und wie man anhand der Porter'schen Wertkette für seine eignen (wenigen) Patienten eine SOLL-IST-Analyse durchführen kann und dabei mit geringen Mitteln unterhalb des Radars Verbesserungen erzielen kann**.

Health System Planning & Care System Research (XIII)	**Mag. Andreas Birner** is an employee of the Department of Planning and System Development at Gesundheit Österreich GmbH (GÖG). His work and research focuses on Austrian health system planning, health care system research, epidemiology, the Austrian Health Information System (Österreichisches Gesundheitsinformationssystem - ÖGIS) and implementation and decision support in the Austrian health care system. In addition, he is lecturer in universities of applied sciences, even in 'integrated care management' and 'hospital management', and scientific consultant in health care planning, implementation and health care assurance.	**Ja**, aber natürlich **nicht 1:1**, **sondern auf die österreichischen und regionalen Rahmenbedingungen angepasst**. Vielleicht wäre da das **Konzept der Gesundheits- und Sozialsprengel** (ÖBIG-Konzept von vor ca. 20 Jahren, glaube ich) ein guter Ansatz, der meines Wissens nach **in dieser Form aber nur in Deutschland verwirklicht** wurde.	Im Hinblick auf wirklich konkrete Managementmaßnahmen zur Umsetzung bin ich in den letzten Jahren zu wenig in der realen Arbeit in diesen Strukturen tätig gewesen, um hier sinnvolle Tipps zu geben. Aus meiner Beratungspraxis würde ich jedenfalls **in regelmäßigen Abständen** (z.B.) 2x im Jahr) **gemeinsame Regionalkonferenzen** empfehlen, die auch fachlich **(inhaltlich und prozessbegleitend) begleitet** werden. Dazu braucht es grundsätzlich eine **gemeinsame Strategie, Ziele und Maßnahmen**; aber auch schon ein **moderierter Austausch** (z.B. auch mit **Beispielen guter Praxis** aus anderen Regionen, **Besprechung aktuelle Probleme** und **Herausforderungen der regionalen Versorgung**) wäre hilfreich.	Strategische Ebene: **abgestimmtes Konzept und Umsetzungswille auf der obersten Managementebene** - setzt **klares politisches Ziel** voraus Skelett: **einheitliche operative Kommunikationsstandards** (technische, sprachlich, terminlich etc.), **gemeinsam definierte und gelebte Prozesse gemeinsame Kultur entwickeln**: Sich kennenlernen, sprechen, austauschen (z.B. Regionalkonferenzen, wie oben skizziert)	Wie in den Antworten zu den Fragen 12 und 13 skizziert. Es **geht nur über die Menschen und über definierte zwischenmenschliche Austauschprozesse** (z.B, regelmäßige Regionalkonferenzen), die entsprechende **Strukturen/Skelette die es mit Leben zu füllen gilt** und die **politische Vorgaben und** die **Managementvorgabe** (am besten durch ein **klar strukturiertes Programm mit Zielen, Maßnahmen und laufender Evaluierung zumindest in der ersten 5 Jahren** und danach Intensität der Programmvorgaben herausnehmen).	Jeder einzelne Mensch: **grundsätzlich positive Einstellung zu Veränderung und Kooperation, Willen zur Zusammenarbeit und zum Austausch,** Bereitschaft die Komfortzone zu verlassen Persönlicher Beiträge: FH-Lektor: In den **Studierenden das Bewusstsein dafür zu schärfen** und die Vorteile und Herausforderungen klar ansprechen und diskutieren. Wissenschaftlicher Berater: In **geeigneten Projekten**, den Verantwortungsträgerinnen und -trägern die Möglichkeiten aufzeigen und mit ihnen **geeignete Produkte entwickeln**. Patient/Angehöriger: Bei den **GD auf die Thematik hinweisen,** und auch sagen, wo es für mich als Patient oder Angehöriger nicht funktioniert und wo es vielleicht besser geht und wie (**positive Beispiele**). Zusammenarbeit durchaus auch aktiv einfordern.
Managing Dir. & former "Value Manager" (XIV)	**Mag. Rainer Kinast** is a theologian, management consultant, psychotherapist (existential analyst), managing director of a care organization, trainer at the Academy for Social Management. For 13 years he was head of the central competence area for value management in the Vinzenz Group (association of religious hospitals and non-profit health institutions). His areas of expertise include specialty areas: Spirituality and Management, Ethics in Management, and Ethics in Medicine and Nursing. He is the author of the book "Value-Oriented Management Culture: Theory and Practical Implementations", published by Lambertus Verlag, 2021, Freiburg. ISBN: 978-3-78413-316-4.	Die **Bezirksregionen würden sich ja anbieten. Versuche dazu gibt es ja ansatzweise schon** (der demenzfreund-liche Bezirk: 3. Wiener Gemeindebezirk mit Caritas Soziales als Motor des Projektes)	Sorry, daran müsste eine Projekt-gruppe arbeiten. Es ist bereits eine **Herausforderung, nur in einr Institution Strukturen zu schaffen** (siehe Werteorientierte Führungs-kultur , Kapitel 7). Es braucht auf alle Fälle primär ein **gemeinsames Menschenbild** über alle politischen Hintergründe hinweg) **oder ein Zielbild**, dass **für alle beteiligten Institutionen attraktiv** ist, um Struk-turen zu entwickeln und diese auch lebendig zu halten.	siehe Frage 12	siehe Frage 12	**Sich die eigenen Vertehaltungen bewusst machen**, diese **lebendig halten** und die **Quellen dieser Lebendigkeit der Vertehaltungen pflegen**.

Head of Depart. & former Med. Head of Hospitals (XV)	**Primarius Dr. Kurt Resetarits** is Head of the Department of Gynecology and Obstetrics at the Feldbach-Fürstenfeld Regional Hospital (Styria). Before that, he was medical director for the two hospitals Oberwart and Güssing (Burgenland) for five years. In addition, he is the owner of a specialist practice (elective practice) for gynecology in Güssing. Thus, in his extensive professional activity, he was always also involved in questions of integrated health care and was able to create a very broad perspective and occasionally also a profound perspective in integrated health care.	**Wenn die Politik mitmacht** und **es lokale Champions gibt**, die das machen , dann schon.	Das **Management muss die Kultur zu einem gemeinsamen Leitbild werden lassen**. Da muss man **Maßnahmen setzen** und das **auch über Medien öffentlich machen**, z. B.: wir **schulen die soziale Kompetenz unserer Mitarbeiter**. Ein wichtiger Punkt ist die Fehlerkultur. Mitarbeiter die in einem positiven Fehlerkulturumfeld arbeiten haben keine Angst. Das wirkt sich sowohl auf die Mitarbeiter und PatientInnen aus	**Kommunikation ist Pflicht**. **Elektronische Zusammenarbeitsmöglich keiten**, **nicht nur mit dem Hausarzt**, sondern **auch mit anderen Einrichtungen wie Pflegeheime**, etc. um die Kommunikation zu beschleunigen. Neben den bisher genannten Maßnahmen spielt die Digitalisierung eine große Rolle.	Ich glaube ich habe oben alles niedergeschrieben. Es ist nicht viel. Es muss nur in die Hände gespuckt und getan werden	Ich **muss es vorleben**. **Vorbild ist alles**. Und ich wiederhole mich: **Leitbild, Werte,Vorbild, Fehlerkultur und das Wollen**. Man muss diese Dinge umsetzen wollen
Chairwoman Federal Association of Self-Help Austria (XVI)	**Angelika Widhalm** is Chairwoman of the Board of the Federal Association of Self-Help Austria (BVSHOE), an umbrella organization of Austria's nationally active, issue-related self-help and patient organizations. The Federal Association of Self-Help Austria records and bundles the common concerns and interests of the issue-related self-help organizations at the federal level, advocates for them, accompanies and drives implementation and is an important, recognized and legitimized contact for politics and the health care system at the federal level for the creation of connections to political processes. Angelika Widhalm, herself a former chronic patient, was the first liver transplant patient in Europe to be cured with the help of a new interferon-and side-effect-free therapy. Since then, she has been able to participate fully in life again and, as the former chairwoman of Hepatitis Hilfe Österreich and now chairwoman of the Federal	Man **sollte es auf jeden Fall probieren**. Dann nur so gewinnt man Erfahrungen. Aber die Finanzierung sollte nicht nur von der jeweiligen Region vorgenommen werden, sondern vom Bund, da ansonsten zu große Unterschiede aufgrund der finanziellen Ressourcen gegeben sind.	Da ist vieles nötig. Ein **komplettes Umdenken ist sicher nötig**. Das beginnt in der Schule und geht hinauf bis in die Universitäten bis hin zur Managementschulung. Die **Nutzniesser wären alle Beteiligten**, weil ein Arbeiten ohne Konkurrenzdenken einfach entspannter sein kann und dann letztendlich zum Wohle des Patienten und zur Kostenreduzierung des Gesundheitswesens beitragen könnte.	Verbesserungsmöglichkeiten der **Kommunikation ist nötig**, wobei dabei zu beachten ist, dass dazu auch **vertrauensbildende Maßnahmen unabdingbar** sind. Die **Aufwertung der Hausärztekompetenz** ist nötig und die **Kommunikation untereinander muss eine Selbstverständlichkeit werden** und kann nicht so wie jetzt meist der Fall, eine Ausnahme darstellen.	So etwas zu steuern, bedeutet **grundlegende Verständnisarbeit** und ein dementsprechendes Wollen. Man sieht am Ergebnis, ob die Maßnahme Wirkung hat oder nicht. Da sind auch **arbeitspsychologische Beratung von Vorteil**. Etwas **zu steuern verlangt viel Feingefühl und viel Verantwortung** und vor allem **gute Ausbildung der Beteiligten**. Druck erzeugt Gegendruck, das darf man nicht vergessen. Es ist das gesamte Programm der Kommunikation bedacht einzusetzen mit viel Feingefühl. Einbeziehung der Beteiligten in den Entscheidungsprozess ist unabdingbar, aber auch die **Patienten müssen voll mit einbezogen werden**, denn schließlich geht es um die im Gesundheitswesen.	**Miteinbeziehung der Patientenvertreter in alle Arbeits- und Entscheidungsgremien**. Anwendung der kompletten Kommunikationsmöglichkeiten von allen Beteiligten. Ehrlichkeit im Umgang miteinander. **Immer den Patienten und das Ziel im Fokus behalten bei allen gesetzten Maßnahmen.**

ABOUT THE AUTHOR

Peter J. Mayer was born in Baden near Vienna, Austria. He was part of the international Joint Cross-Border Ph.D. Program in International Economic Relations and Management by the consortium of collaboration with the University of Applied Sciences Burgenland (Austria), the University in Sopron (Hungary), Juraj Dobrila University of Pula (Croatia), and the University of Economics in Bratislava (Slovakia).

The author completed his Master's degree in Social and Economic Sciences (Magister rerum scialium oeconomicarumque) at the Vienna University of Economics and Business Administration (Austria) and his Master of Advanced Studies, Master of Business Administration (Health Management), and Master of Science (Management Sciences) at the Danube University Krems. The author has been lecturing and researching at the University of Applied Sciences Burgenland (Austria) for more than ten years as Professor of Health Care Sciences and heads the interdisciplinary Master's program in Health Management and Integrated Health Care. His research focus is on the health care sciences and ranges from the optimization of health care structures to interprofessional cooperation and the patient perspective in health care.

Beginning in technical-commercial project management in industrial plant construction, Peter J. Mayer's professional career extends to various management and leadership positions in the Austrian health and social services sector. As managing director at the strategic and operational level of various denominational and public health care and social institutions in the Austrian provinces of Vienna, Lower Austria, Upper Austria, and Carinthia the author was involved in the forward-looking intra- and inter-institutional further development of the Austrian health care structures.

„Choose a profession you love and you won't have to work a day in your life. “
Konfuzius (Chinese philosopher, 551-479 B.C.)

INFORMATION ON THE FORMER SUPERSVISOR

Prof. em. Dr. Dr. h.c. Josef Dézsy was born in Budapest. After his diploma studies in national economics and subsequent doctoral studies in economics at the University of Innsbruck, he was responsible for the management of several Vorarlberg provincial hospitals. From mid-1981 until the end of 2001, he was head of administration at the renowned Vienna private hospital Rudolfinerhaus. In 2005 Professor Dézsy habilitated at the West Hungarian University Sopron (since 2017: University of Sopron). In 2007 he was appointed professor at this University.

Professor Dézsy's career has been marked by numerous national and international awards. He was awarded the "Goldene Verdienstzeichen der Republik Österreich" in 1980, the "Goldene Ehrenzeichen der Republik Österreich“ in 1998 and the „Große Ehrenzeichen für die Verdienste um die Republik Österreich" in 2011. In the same year, he was also awarded the "Grand Cross of Officer of the Republic of Hungary" and the "Commander Knight" award of the Order of Saint Lazarus in Jerusalem.

Teaching assignments took Professor Dézsy to the Vienna University of Economics and Business Administration (Austria) and to the Austrian universities of Vienna, Innsbruck, and Salzburg. Since his habilitation, he has regularly taken on assignments at the University of Sopron (back then: West Hungarian University) and at Sapientia University in Budapest (both in Hungary). He was a member of the examination board for diplomas (Master), doctorates (Ph.D.), and habilitations.

A serious illness forced him to give up all his activities.

ABOUT THE SUPERSVISOR

Prof. Dr. Dr. h.c. Csaba Székely, DSc was born in Sopron. After his master's degree in agricultural economics at the University of Gödöllő and doctoral studies at the Hungarian Academy of Sciences. Fellowships took Professor Székely to the Justus Liebig University in Giessen (1977) and to the Friedrich Wilhelm University in Bonn (1981). From 1996 to 1999 Professor Székely was Rector of the University of Gödöllő, from 1991 to 1996 he held the position of Dean at the Faculty of Economics and Social Sciences of the University of Gödöllő, and from 2006 to 2013 at the Faculty of Economics of the University of West Hungary in Sopron. Most recently, Professor Székely was Head of Doctoral School at this university.

He also serves as Chairman of Editorial Boards for Perodika Gazdálkodás (Farming) and the Journal of Economy and Society. His current research areas range from strategic management and decision theory, change management, and management and leadership, to risk management and its instruments.

Professor Székely's scientific career is marked by numerous significant publications. In addition, as a member of several scientific and economic committees, he provides his rich experiential knowledge as well as high-level scientific expertise. Currently, Professor Székely represents the University of Sopron as its representative in the Consortium for International Joint Cross-Border Ph.D. Programs, in particular in the Ph.D. Program for International Economic Relations and Management, on which this thesis is based. In 2019 he was awarded the honorary title of honorary professor by the University of Applied Sciences Burgenland (Austria).

ACKNOWLEDGMENT

I would like to take this opportunity to thank all the people who have accompanied me during the last months on my path through life. Special thanks go to the Doctoral Program Director and Head of Academic Scientific Committee of the Ph.D. Program "International Economic Relations and Management", Professor Dr. Sc. Dr. h.c. Irena Zavrl, Ph.D., who has encouraged me to continue my work in her own appreciative way, even in challenging times, both personally and professionally, and has always pointed out my strengths. Special thanks also go to my highly esteemed doctoral supervisor, Professor Dr. Dr. h.c. Székely Csaba, DSc. from the Faculty of Economics of the University of West Hungary in Sopron, who has kindly taken over the supervision of my work.

I would also like to thank all those who I have met on my professional paths in the health care system and who, through their example, but also through their being and the way they act in their profession, have given me inspiration for a further critical examination of the interprofessional cooperation inpatient care. I would also like to thank Professor Dr. Eugen Hauke, who was a personal and professional role model for me during my studies of social and economic sciences at the Vienna University of Economics and Business Administration and later as my superior in the Vienna hospital network, and who taught me to always include the patient perspective in my professional thinking and acting in the health care system.

Finally, I would also like to thank the members of the Academic Scientific Committee of the PhD-program and their highly esteemed professors at the participating universities for the opportunity to write a dissertation on the topic of "Interprofessional Cooperation in Integrated Health Care", thus creating a contribution to the health care sciences and to health care practice. A contribution that should ultimately also benefit the patients themselves.

Peter J. Mayer

Baden bei Wien, 15.05.2022

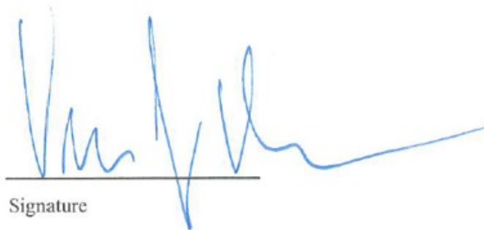
DECLARATION OF ACADEMIC HONESTY

I herewith declare on my word of honor, that I created the thesis at hand independently, that I did not use any material other than the cited resources and that I marked all results created by somebody else, be they overtaken into my thesis word for word or by a matter of meaning, accordingly.

I further declare, at the thesis at hand was not submitted to any other institution (university, university of applied sciences, university of education or other comparable institution) to obtain an academic degree.

Baden, 30th June 2022

Location, Date



Signature