Päivi Ripatti, Clarine Sies, Riitta Haverinen, Guus Schrijvers, Ilmo Keskimäki

“All Together Now: Exploring the Many Faces and Facets of Integrated Care”
Recent Developments in Integrated Care in Europe and North America
Programme and abstracts

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DISCUSSION PAPERS 19/2010

Päivi Ripatti, Clarine Sies, Riitta Haverinen, Guus Schrijvers, Ilmo Keskimäki

The 10th International Conference on Integrated Care

"All Together Now: Exploring the Many Faces and Facets of Integrated Care"

Recent Developments in Integrated Care in Europe and North America
Programme and abstracts
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Welcome notes

Dear Participant,

Welcome to the 10th International Conference on Integrated Care

On behalf of the International Network for Integrated Care (INIC), the National Institute for Health and Welfare (THL) and the co-organisers - the City of Tampere, the University of Tampere and the Pirkanmaa Hospital District - as well as on behalf of the Scientific and Local Organising Committees, we wish you warmly welcome to the 10th International Conference on Integrated Care.

This year the overall theme of the Conference is "All together now: Exploring the Many Faces and Facets of Integrated Care - Recent Developments in Integrated Care in Europe and North America". With the title, the Conference organisers have wished to express their firm belief in the importance of benchmarking and learning from others as a way forward to develop integrated care. There is a need to understand the similarities and differences of contexts, models, management and structures for integrated care. For the purpose, international exchange has a pivotal role.

While integrated health and social services may have many forms and integrated care models vary from country to country, there is a common objective: to improve the services to match the clients' and patients' individual needs. While the people in need for health and social services are entities, it is not rational to break down responding to their needs according administrative or professional boundaries. The appropriate answer is to integrate.

For the past ten years, the Annual Conference of the International Network of Integrated Care (INIC) and the International Journal for Integrated Care (IJIC) have given us an excellent opportunity to follow the international development of integrated care. However, both scientific conference and journal are joint ventures. Without readership and audience they are empty and sterile. By definition, conferences and journals are for sharing knowledge experiences and ideas, but the conference organizers and journal editors are just facilitators who try to create a common framework for the conference speakers and participants and journal authors and readers who finalise the task.

Regarding this year's International Conference on Integrated Care, we hope that we, the Conference Organisers, have managed to create a pleasant and productive framework for you to enjoy your participation in and out of plenaries and workshops and to complete the Conference from your part by sharing your knowledge and experiences and getting new ideas as well as making new contacts.

We wish you inspiring two days at the 10th International Conference on Integrated Care - and we wish you agreeable time in Tampere.

On behalf of the Scientific and Local Organizing Committee of the Conference,

Ilmo Keskimäki   Riitta Haverinen   Päivi Ripatti
Dear Participants,

Welcome to Tampere, the third largest city of Finland and during the 16th-18th of June, the world capital of Integrated Care. We have managed to bridge cultural and organisational gaps, technical interfaces and strained resources to bring to you the INIC10 – which you will hopefully enjoy to remember.

During the 10th Annual Conference on Integrated Care we discuss the theme: "All Together Now: Exploring the Many Faces and Facets of Integrated Care".

On the agenda are very many aspects of Integrated Care in Europe, North America and Asia, like Integrated Care for people with dementia; Community Mental Health Services; integrated Care and Economic Evaluation; Strategies and Perspectives; Concepts and Models of Integrated Care; Care for the elderly; Diabetes Care; Youth health care; Case management, Organisation of Integrated care and tools for evaluation; Health technology assessment. Including challenges and lessons learned.

In this conference we aim for the same as in the previous nine conferences: to bring together researchers, policy makers and practitioners interested in transmural cooperation and coordination between different providers of health and social care in order to exchange knowledge and experiences. We also like to generate new ideas, new research and new projects on Integrated Care.

Integrated Care has become a wide-spread concept across health systems and countries in response to the common challenges of the 21st century: an ageing society, chronic disease and multi-morbidity. Countless projects and a great variety of models have been developed over the past years to overcome systemic, professional and cultural barriers in order to smooth out patient pathways and information flow. This has had its successes and challenges still to be solved. The International Network and the International Journal of Integrated Care have established themselves to bring together researchers, practitioners, policy and decision makers active in the health and social care systems and so create a vibrant platform for exchange and innovation.

The International Network of Integrated Care and the International Journal of Integrated Care represents an international community of researchers, policy analysts, managers and professionals drawn together by the common belief that the better integration of services can lead to improved quality of services and cost-effective solutions from the point of view of services users, carers, professionals and management.

All of these efforts would have been superfluous, if it weren’t for you, the participants of INIC10 and your willingness to join us in Tampere.

Guus Schrijvers
Editor in chief of the
International Journal of Integrated Care
Dear Participants,

Integration of health and social services is a dominant feature in many national, regional and local reforms. Entire health and social care systems are being reformed in many countries in Europe and elsewhere. In Finland, local authorities, municipalities are responsible for organising health and social services to citizens. We have just restructured municipalities fairly radically and cut down their number by around a quarter in few years. Now we are gradually moving to the next stage of the reform process and start to restructure our health and social services by promoting deeper integration of care.

Often integration appears a modern panacea to several topical problems. It is maintained to secure sustainable financing of health and social services in ageing societies, as well as to improve efficiency in service delivery. Yet there is little research evidence on how effective and feasible instrument integration is in different societal and cultural settings and how it affects stakeholders.

In Finland, we see increasing administrative and functional integration of health and social services at local and regional level. Social services and primary care have started to co-operate actively and barriers between primary care and hospital care are becoming lower. The aim of integration is to provide wide range of timely services to patients, to create service chains that are seamless and flexible to patients and to treat individuals respecting their body and soul.

The goals, ambitions and expectations for integrated care are set high. Practical experience is piling up, but there is less researched evidence on costs, benefits and un-aimed side-effects, emerging new problems and challenges of integrated care. Yet we need to know how and why some variants of integrated care function as expected and why some models do not. There is clearly a great need for comparative health and social services research which could help decision makers to adopt best integrated care models to implement.

While it is rarely possible to directly adopt and implement models that are deemed viable in other countries it is important to analyse and understand differences and similarities of the integrated care models applied in different contexts.

The 10th International Conference on Integrated Care in Tampere provides an excellent opportunity to exchange research results and ideas with colleagues. There is increasing quest for cost-effective models of integrated care that would bring marked benefits to patients, and at the same time ensure sustainable future for health and social services.

I wish you all enjoyable and rewarding discussions and networking In Tampere INIC conference.

Markku Pekurinen
Director, Department of Health and Social Services
National Institute for Health and Welfare, Finland
Dear participants of the 10th International Conference on Integrated Care,

As indicated in literature, organization of care differs not only between countries but also between geographical areas within a country, such as hospital authorities and municipalities. These differences may not affect only availability, access and utilization of care, but also resources consumed and perhaps even health outcomes.

It is quite evident that success in care integration is one of the most critical points in delivery of care in highly professional, hierarchical and separated care settings. However, our understanding of relationship between health care system characteristics and, for instance, populations’ health is limited. Therefore, quite obviously, both theoretical and empirical scientific research is needed in assessment of the effects of differences in care patterns on the performance of health care systems. Naturally, we all aim at improving health care to better meet the needs of the populations and societies. For these reasons, care integration forms a major interest within the field of health services research also at the Tampere School of Public Health.

We are greatly honored to be a partner in hosting the 10th International Conference on Integrated Care. The Tampere School of Public Health, at the University of Tampere, is one of the main academic institutions in the field of public health and health services research in Finland and in the Nordic countries. In addition to educational tasks, we are active in research within some strategic areas, including health services research. Therefore, we look forward to having a successful conference, which approaches care integration from a multidisciplinary point of view, and which critically and creatively attempts to analyze and solve most important questions in care integration.

On behalf of the Tampere School of Public Health at the University of Tampere, I am happy to welcome you to the 10th International Conference on Integrated Care and to Tampere.

I wish you the most successful Conference!

Pekka Rissanen
Director, Tampere School of Public Health
Professor, Health Economics
Dear Participants of the 10th International Conference of Integrated Care,

Warm welcome to the city of Tampere and to the Tampere University Hospital. The Tampere University Hospital is the second largest hospital in Finland. Its mission is to provide specialised health care services for 0.5 million people living in the Tampere Region and advanced tertiary level services for the wider catchment area covering 1.2 million people. The total number of patients exceeds annually 150 000. The current number of employees is 7200 and the total operating revenue is €600 million per year. The organization is owned by 24 municipalities which also pay the major part of all costs.

The Tampere University Hospital is considered to be a forerunner in Finnish health care in terms of finding new innovative ways to meet its responsibilities for its owner municipalities as well as for the other hospital districts. Of several systemic innovations within the University Hospital we like to mention the Laboratory Centre, Coxa Hospital for joint replacement services, Heart Center, Imaging Centre and Mänttä Health District as a center for integrated services. In addition to these business level innovations, we have identified a chain of management system innovations at corporate level that have set the scene for the business level developments.

Primary care is an essential element of any health care delivery system in Finland. Primary care involves a set of services which include preventive care and screening. While primary care addresses common health problems, it is necessary for every individual. At our organization, value-based care delivery units mean, for instance, integrated practice units which we call "focus hospitals" inside the University Hospital. In this context, primary care has an important role of the locus for initial diagnosis and guiding patients to the appropriate focus hospitals. The focus hospitals include the specialties and services necessary during the cycle of care, including those needed to anticipate and to treat common co-occurrences and complications. Good co-operation between primary, secondary and tertiary level health care organizations is elementary to deliver fast track and high level services to patients.

To cope with upcoming tasks in medicine, public health care and financial challenges, we have to be open-minded about new innovative ideas in health care. The Conferences of the International Network of Integrated Care are one of the best forums to all of us to obtain valuable take home messages. I wish all participants a motivating and stimulating exchange of information and ideas during the Conference.

Dr. Jaakko Herrala, Ph.D., MBA
Administrative Medical Director
Tampere University Hospital
Pirkanmaa Hospital District
I bid you a warm welcome to Tampere!

On behalf of the City of Tampere, I warmly welcome you to our city. The theme of your conference is very topical in many places, and Tampere is no exception. The number of senior citizens is increasing rapidly, as is the need to develop new preventive social and health care services.

The largest Finnish industrial operators first started life in Tampere, which is currently the second largest centre of growth in Finland. The city is still a significant centre of export, even though the majority of its population works in post-industrial sectors such as information technology, welfare services, and creative fields.

Tampere has several times been chosen Finland’s most attractive city. The factors that contribute to its popularity include excellent work and educational opportunities, good connections, and lively cultural life. Tampere is a city of education, which is easy to see: nearly every fourth person in the city is a student.

Tampere offers excellent opportunities for studying and research in two universities, a university of applied science, and several other educational institutions. The city offers top level training and research in medicine and health care with successful businesses based on bio-medicine that specialize in the development of vaccines, bio implants, and the like.

The increasing need of social and health care services is a challenge that Tampere shares with many other cities. The number of senior citizens is growing, which is reflected in the increasing need of home care services, new forms of care, and preventive health care. Tampere aims to reduce reliance on institutional care of the elderly and improve the availability of services provided at home. This requires cooperation between the city, organizers, and businesses. This is especially vital for preventing increasingly common illnesses such as diabetes, dementia, and various mental problems.

Extensive international cooperation is required to solve these problems; cooperation between researchers, those who work with the practical applications, and the decision-makers. For this, your conference provides an excellent setting.

I bid you all welcome to Tampere once more and wish you a rewarding and enjoyable conference!

Timo P. Nieminen
Mayor of Tampere
We want to thank our partners and sponsor for their support

In cooperation with:

- National Institute for Health and Welfare
- International Network of Integrated Care
- University Medical Center Utrecht
- University of Tampere
- Pirkanmaa Hospital District
- Tampere Convention Bureau
Programme INIC 2010 Tampere

Thursday, June 17 2010

08.00 Registration and Coffee

09.00 Welcome to INIC10 and Opening Address
  Professor Ilmo Keskimäki, President of INIC10, National Institute for Health and Welfare and University of Tampere
  Dr Nick Goodwin, Member of INIC Board and IJIC Editor
  Mr Timo P. Nieminen, Mayor City of Tampere
  Dr Markku Pekurinen, Director of Service Delivery System Department, National Institute for Health and Welfare

09.50 Integrated Care as an Answer to the Financial Crisis
  Professor Guus Schrijvers, Member of INIC Board and IJIC Editor-in-Chief

10.35 Coffee Break

11.00 Clubhouse model and supported employment - examples of community-based services
  Dr Kristiina Härkäpää, Research Manager, Centre for Rehabilitation Research & Development, Rehabilitation Foundation: Community Mental Health Services

12.00 Lunch

13.00 Parallel Sessions 1
  1. Integrated care for patients with dementia in the Netherlands and France
     Dominique Somme, MD PhD Service de Gériatrie-Pôle Urgence Réseaux, Hôpital Européen Georges Pompidou Paris and Ina Diermanse, MSC Senior Consultant Dutch Institute for healthcare improvement CBO

  2. Integrated care for diabetes patients in Holland
     Jeroen Struijs, senior researcher at National Institute for Public Health and the Environment

  3. Virtual studytrip to community mental health services in Finland
     Esko Hänninen, Director, National Institute for Health and Welfare (THL)

  4. Workshop: Integrated care and economic evaluation, strategies and perspectives
     Hendrik Vondeling, Professor in Health Economics, Sylvia Evers, Associate Professor in Health Economics and HTA at Maastricht University and Torben Larsen, Chief Consultant, CAST, University of Southern Denmark
5. Paper session on Integrated Primary Health Care
13.00 Primary health care services in activation and employment
Peppi Saikku, Researcher M.Soc.Sc. THL
13.30 A model for the integration of primary health care services in the Province of KwaZulu-Natal, South Africa
MN Sibiya (PhD), Senior Lecturer, Durban University of Technology and NS Gwele (PhD), Deputy Vice Chancellor, Durban University of Technology
14.00 From controlled and specialized opioid substitution treatment to pharmacy delivery of buprenorphine-naloxine and to treatment in primary health care: the views of patients and personnel
Jouni Tourunen et al. Research Manager, D.Soc.Sc A-Clinic Foundation, Järvenpää Addiction Hospital Finland

6. Paper session on concepts and models of integrated care from Finland
13.00 Evidence-based modelling of a generic integrated home care and discharge practice
Marja-Leena Perälä, PhD, RN, Research Professor, Adjunct Professor THL et al.
13.45 The Regional Discharge Model Development Project
Tiina Mäenpää, PhD student, MNSc Research Assistant, Satakunta Hospital District, Finland.

7. Paper session on Integrated Care for the Elderly in Holland
13.00 The Dutch National Care for the Elderly Programme: integrated care for frail elderly persons
CCM Jonkers, The Netherlands Organisation of Health Research and Development (ZonMw), The Hague, The Netherlands et al.
13.45 Detection and management of frail elderly in the primary care: evaluation of the effects of screening elderly people in order to detect frailty at an early stage
Inge GP Duimel-Peeters, PT, MSc, PhD Maastricht University Medical Centre, Dept. of Integrated Care et al.
14.30 Coffee Break

15.00 Finland could become the world leader in horizontal and vertical integration – reason for enthusiasm or worry?
Adjunct professor Simo Kokko, National Institute for Health and Welfare
15.45  **Parallel Sessions II**

1. **Virtual studytrip to integrated care for diabetes patients in Germany**
   *Lutz Altenhofen*, Doctor Projectleitung DMP-Programme, Diabetes, Brustkrebs und KHK, Zentralinstitut für die kassenärztliche Versorgung

2. **Virtual studytrip to integrated primary health care in Holland**
   *Leo Kliphuis* director at National Organization for Integrated Care The Netherlands

3. **Community mental health services in The Netherlands: Quo Vadis?**
   *Peter van Splunteren*, senior researcher Care innovation programme Trimbos Institute and *Simone van de Lindt*, sociologist/social psychologist Trimbos-institute

4. **Workshop on implementation strategies for Integrated Care projects**
   *Dirk Wijkel*, medical coordinator stichting THEMA and *Ingrid Mur*, Associate professor Maastricht University

5. **Paper session on Disease Management in Germany and the UK**
   15.45 Does Integrated Care lead to both Improved Health Outcomes and Lower Care Cost? Interim results of an Evaluation of “Gesundes Kinzigtal Integrated Care” in Germany
   *Achim Siegel*, Department of Medical Sociology, Freiburg University, Germany et al. presented by Regina Waldeyer

   16.30 ‘All together….how? Service Models for Promoting Continuity of Care for People with Long-term Neurological Conditions (LTNCs)
   *Fiona Aspinal*, Social Policy Research Unit, University of York, Heslington, York UK

6. **Paper session on Concepts and Models for Integrated Care from the UK**
   15.45 Integrated Care Pilot Programme – UK Department of Health
   *Mo Dewji* Doctor– Clinical Advisor, ICP Programme, Department of Health

7. **Paper session on Integrated Care for the Elderly in France**
   15.45 Diagnostic, design and implementation of an integrated model of care in France: A bottom-up process with a continuous leadership

   16.30 Institutional integration in France – Health Regional Agencies and Integrated Services Delivery
   *Dominique Somme*, MD PhD, Service de Gériatrie-Pôle Urgence Réseaux, Hôpital Européen Georges Pompidou Paris et al.

17.15  **End of Day 1**

18.30  **Conference dinner**
Friday, June 18th 2010

09.00  **Key note speaker, title speech tulossa**  
Professor Tuula Tamminen, University of Tampere

09.45  **Parallel Sessions III**

1.  **Workshop: Do’s and don’ts if supporting disease management with IT**  
*Hero Torenbeek*, Solutions Manager VitalHealth Software

2.  **Virtual studytrip to integrated primary health care in Finland**  
*Simo Kokko*, Adjunct Professor, National Institute for Health and Welfare

3.  **Integrated preventive child health care in the Netherlands**  
*Henk van Stel*, Assistant Professor Julius Center UMC Utrecht, *Elly de Leeuw*, MD  
Head of Public Health Education, youth health care doctor, University Medical Center  
Utrecht

4.  **Paper session on Case management, Organisation of Integrated Care and tools for evaluation**  
09.45 Integrating research into the inter-organisational relationship: towards a theoretically-rooted tool for evaluation  
*Simon Douglas*, UK Mental Health Research Network / Newcastle University UK  
10.15 From organizational integration to clinical integration. Analysis of the path between one level of integration to another employing official documents  
*Matey Mandza*, École nationale d’administration publique, Canada et al  
10.45 Study of the composition of the various forms of coordination in the case management practice  
*Sebastien Carrier*, University of Sherbrooke, Louis Demers École nationale d’administration publique, Canada et al.

5.  **Paper session on Concepts and Models for Integrated Care from the UK and Italy**  
09.45 Shaping the future of integrated care: what can we learn from history?  
10.15 Are there any logics to the Integration of Care?  
*Mike Martin*, Visiting Professor, Newcastle University Business School, Newcastle University UK et al.  
10.45 An “Inclusive” Model of Integrated Care  
*Helen Tucker* et al., University of Warwick

6.  **Paper session on Integrated Care for the elderly in Singapore**  
09.45 Integrating Aged Care in Singapore – The Action Framework  
*Ann Yin*, Agency for Integrated Care, Singapore et al.  
10.30 Characteristics of elderly patients receiving care coordination: The role of Telephonic review and home visit  
*A Amran*, Agency Integrated Care, National University Hospital Singapore et al.

11.15  **Coffee Break**
11.30 Parallel Sessions IV

1. Workshop: Health technology assessment as comprehensive multidisciplinary evaluation of integrated care focusing integrated home care as prototype
   Torben Larsen, Chief consultant, coordinator homecare, Centre for Applied Health Service Research and Technology Assessment (CAST) Southern Danish University, Odense

2. Virtual study trip: Future options for integrated primary health care policies and practice in Europe
   Sara Shaw, Senior Research Fellow, Nuffield Trust, London and Geoff Meads, Hon Prof of International Health Studies, Warwick Medical School UK

3. Integrated Care and the financial crisis
   Guus Schrijvers, Professor of Public Health, Unit Innovation in Care, Julius Centre, University Medical Centre Utrecht, The Netherlands

4. Paper session on Community Mental Health
   11.30 The impact of transdisciplinary multi agency cooperation in local medical treatment
      Anne-Lise Holmesland, Research fellow, Soerlandet Hospital Trust, Norway, et al
   . . 12.00 The client-centredness in the rehabilitation course TÄSMÄ: The schizophrenia
client’s expertise in changing service system
      Suvi Raitakari, University of Tampere Finland, et al.
   12.30 Pregnancy and Psychiatry
      W. KleinNagelvoort, Project manager, P&P in Almere, the Netherlands, et al.

5. Paper session on Telemedicine in Germany and UK
   11.30 Limits to Integration: Lessons from Implementation in the cases of Telecare and
      Joined up Assessment
      Rob Wilson, Newcastle University Business School, Newcastle University UK
   12.15 Telemedicine in integrated care

6. Paper session on Concepts and Models of Integrated Care from Canada and Sweden
   11.30 Studying integrated health care systems with a structurationist approach
      Louis Demers, École nationale d’administration publique Université de Sherbrooke
   12.00 Services integration, professional autonomy and standardization. Representations of
      standardization among social workers in the case of integrated service networks
      implementations
      Emilie Rousseau-Trembla, University of Sherbrooke, Quebec, et al.
   12.30 Patient choice and health care integration: a review of the consistency between two
      Swedish policy concepts
      Bengt Ahgren, MpolSc, PhD, Senior Lecturer, Nordic School of Public Health,
      Göteborg, Sweden et al.

7. Paper session on Integrated Care for the elderly in Canada and the UK
   11.30 Collaboration between case managers and family caregivers in a context of
      integrated care for the frail elderly
      Yves Couturier, University of Sherbrooke, Canada et al.
   12.00 The effectiveness and cost-effectiveness of a community based case management
      approach for older people with multiple comorbidities
      Marina Lupari RGN, RHV, Bsc(Hons), MSc, Head of Nursing- Research &
      Development, Northern Health & Social Care Trust / PhD student University of
      Ulster, Northern Ireland
12.30 Challenges of integrated working between primary health care services and care homes for older people from the Approach study

Sue Davies, University of Hertfordshire, Centre for Research in Primary and Community Care et al.

13.00 Lunch

14.00 Parallel Sessions V

1. Integrated Care in the Netherlands
   Josefien Kursten, Unit Manager and Femke van der Voort, MSc, Project Manager Unit Strategy & Advice NZa (Dutch Care Authority)

2. Network Management and Care Integration
   Timo Järvensivu, D.Sc. Research Manager, Doctor of Science (Economics) Aalto University School of Economics and professor Carsten Schultz, Dipl.-Ing. Christoph Bogenstahl, Berlin Institute of Technology, Germany

3. Paper session on Integrated Youth health in Finland
   14.00 Integrating health and social services into the environment of childhood growth from birth to starting school: the systematic review of effective cooperation interventions
   Nina Halme MNSc, RN, Special Researcher, National Institute for Health and Welfare, et al.
   14.45 Integration of services for Youth with Psychiatric Symptoms
   Kaisa-Elina Hotari Department of Social Work Research University of Tampere Finland

4. Paper session on Patient Satisfaction for integrated care
   14.00 Using Case Mix to detect Disease and Improve the Delivery of Care
   Linda Dunbar, Johns Hopkins HealthCare, et al.
   14.45 Benefits and challenges perceived by patients with cancer when offered a nurse navigator; a qualitative study.
   Thygesen MK et al.

5. Paper session on Integrated Care for the elderly in Germany and Finland
   14.00 Dental care in geriatric patients - a cross-sectorial service

6. Paper session on Integrated Care for the elderly in Holland
   14.00 ‘Thuis Voelen’ A guide written for family and nursing home; companions to accomplish worthy care. Practical lessons.
   Hetti Willemse, Executive director, Senior adviser, Publicarea, Amsterdam, Holland and Tineke van den Klinkenberg, Advisor Associate, Publicarea, Amsterdam, Holland
   14.45 The association between chronic care management activities and the quality of thrombosis care.
   H.W. Drewes et al
15.30 Denmark's Approach to Integrated and Quality Care
Presentation INIC11 Odense, Denmark by Torben Larsen

15.45 Closing Remarks
Nick Goodwin, Member of INIC Board and IJIC editor, Senior Fellow The King’s Fund, UK

16.00 Coffee and Farewell
Key note June 17-18.2010

Keynote 1: Thursday, June 17, 09.50 – 10.35

Integrated Care as an answer to the financial crisis

Keynote address by prof. Guus Schrijvers, professor of Public Health Julius Center, University Medical Center Utrecht, The Netherlands

The financial crisis can be answered with two answers from the perspective of long term care financing:

1. All care providers go back to what they think of to be their core business
2. Care providers feel a shared responsibility and try to raise integrated care, with emphasis on
   - Prevention of disease and care
   - Self management by patients and their families
   - Increase of productivity
   - A shift from public payment towards private payments
   - A reduction of quality of care.

To think about this, each country is a laboratory for the other countries.

I hope to clarify the two above mentioned answers to the financial crisis followed by a discussion about the contributions that countries have provided to come to this answers and make them more concrete.

Keynote 2: Thursday, June 17, 11.00 – 12.00

Clubhouse model and supported employment - examples of community-based services.

Keynote address by Dr.Kristiina Härkäpää, PhD, Research Manager Centre for Rehabilitation Research & Development, Rehabilitation Foundation: Community Mental Health Services

Keynote 3: Thursday, June 17, 15.00 – 15.45

Finland could become the world leader in horizontal and vertical integration – reason for enthusiasm or worry?

Keynote address by professor Simo Kokko, Adjunct National Institute for Health and Welfare: Integrated primary health care
Keynote 4: Friday, June 18, 09.00 – 09.45

Integrated services for children and their families - visionary goal or impossible dream?

Keynote address by professor Tuula Tamminen, University of Tampere: Integrated Youth/Family Centers
Parallel session 1

Thursday June 17
13.00 – 14.30

1.1 Integrated care for patients with dementia in the Netherlands and France
Dominique Somme, MD PhD Service de Gériatrie-Pôle Urgence Réseaux, Hôpital Européen Georges Pompidou Paris and Ina Diermanse, MSC Senior Consultant Dutch institute for healthcare improvement CBO

In June 2002 the Ministry of public health, welfare and sport asked two organisations in partnership with the Dutch Alzheimer Association (DAA) to develop an nation-wide programme for regional providers of care, welfare an cure to improve dementia care from client perspective. The result, of the Dutch National Dementia improvement program (NDP), is almost nationwide implemented. (95%).

In this workshop we would like to discuss the Dutch results, and also what worked and didn't work.

We will present the methodology of evaluation and first results of the French National Alzheimer Plan, implemented in 17 areas in France. The pilot program for a public policy aims to create “Homes for the Integration and Autonomy of people suffering from Alzheimer’s or associated disorders”. The pilot program is ongoing and will end in December 2010. It is aimed to re-organize services, change practices and improve the quality of interventions. The ministry of health has asked for and funded a continuous, multi-sites assessment of the implementation of the program. All the methodology will be presented with first results. We assume that results can help to define the level, the role and the strategies of factors of the change management when integration is being implemented in a public policy and not in an independent initiative. The other kind of results is related to the knowledge about policy implementation methodology.

After these two presentations (30 min), a one hour discussion period will be employed to identify common problems and topics across diverse health care systems of all participants. We will notably look for mutual outcomes, for methodology of implementation and of assessment of integrated care for the very vulnerable population of people suffering from Alzheimer’s disease and associated disorder.

1.2. Integrated care for diabetes patients in Holland
Jeroen Struijs, senior researcher at National Institute for Public Health and the Environment
1.3. Virtual studytrip to community mental health services in Finland
Esko Hänninen, MSc (Soc) Senior expert of social inclusion and accessibility

Content: Virtual study trip to community mental health in Finland includes several examples about how the local mental health services are organised and which methods are used in the coordination and integration processes of services for people with mental illness (e.g. public services, private services, voluntary organisations and other NGOs of and for people with mental illness, psychosocial rehabilitation and the empowering clubhouse rehabilitation network in Finland).

Time division: Introduction and general overview to the workshop theme by Esko Hänninen (10’), service providing NGO’s presentation (15’), service users’ experiences about the Finnish community mental health services (2 x 10’), other participants of the workshop are telling about situations in their countries & discussion (45’).

Educational results: Learning to understand the welfare mix approach and how to manage the mix while organising coordinated and integrated multi-stakeholders’ community mental health services.

1.4. Workshop: Integrated Care and Economic Evaluation, Strategies and Perspectives
Hendrik Vondeling, Professor. in Health Economics and Sylvia Evers, Associate Professor in Health Economics and HTA at Maastricht University, Torben Larsen, Chief Consultant, CAST, University of Southern Denmark

The workshop will start with an introduction by Dr. H. Vondeling of some of the key concepts and basic typology of economic evaluation studies, which will be illustrated by means of economic evaluations of integrated care programmes (15 minutes).

This is followed by a presentation by Dr. S. Evers on a trend analysis of economic evaluation studies in integrated care. An analysis of the numbers and specific fields focused upon in economic evaluations in integrated care programmes over time will be presented (15 minutes).

Finally, Dr. T. Larsen will present an innovative approach to economic evaluation that may be relevant for integrated care projects in the field of public health and health promotion, based on insights from Neuroeconomics (15 minutes).

A plenary discussion will round off the one-hour workshop, which will result in increasing awareness of the audience on the contribution of economics to inform choices on the allocation of scarce resources in the field of integrated care.
1.5. Paper session on Integrated Primary Health Care:

13.00 Primary Health Care Services in Activation and Employment
Peppi Saikku, M.Soc.Sc., Researcher, National Institute for Health and Welfare (THL), Helsinki, Finland

Introduction: The evaluation research was conducted to establish the role of primary health care in the process of rehabilitation, activation and employment of the long-term unemployed citizens. Empirical data was gathered from 17 municipal projects. Projects aimed to develop health care services for the unemployed and to improve co-operation between health care services and local activation and employment services.

Theory: The theory of transitional labour markets was used as a framework for the evaluation [1]. The aim of activation is to encourage people to make transitions towards the labour markets or other desired activity (education, pension etc.). Health care services were constructed as one possible factor enabling transitions from unemployment. Inter-agency co-operation between state and municipal actors is crucial in activation processes.

Methods: The research was conducted from the perspective of process evaluation. Data consists of surveys, interviews and case-studies. Data from the surveys was analyzed with SPSS using descriptive statistics. Content analysis was used for the qualitative data.

Results and conclusions: Many of the long-term unemployed clients needed health care services and counselling besides social and employment services. Transitions to rehabilitation or pension become possible only after a medical assessment of persons' working ability has been made. During the evaluation period transitions to work, rehabilitation or pension were very rare among the clients. Co-operation between primary health care and activation services improved during the projects. The public health nurses in the projects worked as case-managers. The level of integration of health care services and activation services varied in the municipalities. The role of primary health care is important in recognizing health factors that can hinder employment and in initiating rehabilitation processes.

13.30 A Model for the integration of Primary Health Care Services in the Province of Kwazulu-Natal, South Africa
MN Sibiya, Senior Lecturer, Nursing Programme, Durban University of Technology, South Africa

Introduction: In South Africa, Integration of Services Policy was enacted in 1996 with the aim of increasing health service utilization by increasing the accessibility of all services at primary healthcare level. However, the problem with the policy arises in the implementation of integrated primary healthcare as there is no agreed upon understanding of what this phenomenon means in the South African context.

Aims: Analyse integration of primary healthcare services and ultimately develop a model for the integration of primary healthcare services.

Results: It emerged that there were three core categories that were used by the participants as discriminatory dimensions of integrated primary healthcare in South Africa. These core categories were (a) comprehensive health care, (b) supermarket approach and (c) one stop shop.
Conclusion: The phenomenon, integrated primary healthcare meant different things in different contexts.

14.00 From controlled and specialized opioid substitution treatment to pharmacy delivery of buprenorphine-naloxine and to treatment in primary health care: the views of patients and personnel
Jouni Tourunen et al. Research Manager, D.Soc.Sc A-Clinic Foundation, Järvenpää Addiction Hospital Finland

Introduction: There are 4000-5000 opioid abusers and about 1700 patients in opioid substitution treatment in Finland. New legislation (2008) allows less restrictive treatment models than before.

Aims: To assess advantages and disadvantages of pharmacy delivery of buprenorphine-naloxine and referral of stable patients into primary health care.

Theory and Methods: The setting was five Finnish outpatient clinics involved in treatment of opioid dependence in 2008-2009. 74 patients (75% males, mean age 33, ½ -8 years in treatment) were interviewed. A questionnaire regarding the patients’ situation was filled in by the nurses (n=166 patients). The view of personnel was studied in five group interviews (n=24) and through a questionnaire (n=36). Qualitative and quantitative methods were used.

Results: Most patients were unemployed, had psychiatric problems, and had heavy history of drug abuse. Transition to pharmacy delivery and to primary health care was more difficult and time consuming than expected. This was due to patients’ insistent personal need for psychosocial treatment or concerns of the personnel. Financial and organizational factors also played an important role.

Conclusions: A variety of treatment models, careful evaluation of the patients’ situation, and training of personnel of clinics and health centres, and pharmacy staff is needed. Both patients and personnel were willing to move towards less restrictive models, if they were flexible enough.

1.6. Paper session on Concepts and Models of Integrated Care from Finland

13.00 Evidence-based modelling of a generic integrated home care and discharge practice
Marja-Leena Perälä, PhD, RN, Research Professor, Adjunct Professor, National Institute for Health and Welfare, Helsinki, Finland and Teija Hammar, PhD, RN, Senior Researcher, National Institute for Health and Welfare, Helsinki, Finland

Introduction: The focus is to describe the process of evidence-based modelling, and the evaluation of the suitability and the effects of a model. The development and evaluation of a generic integrated home care and discharge practice is used as an example.

Aims: The aims are (1) to develop a generic practice based on scientific and practical knowledge, its evaluation criteria and an embedding method and (2) to evaluate its impacts on clients/patients, relatives (informal caregivers) as well as health and social care personnel.

Methods: Several types of evidence were used in the modelling of a generic good practice. A register-based analysis (the administrative registers on stroke and hip-fracture patients) was used to find out the variance in care and discharge practices between municipalities. Surveys to the directors of social and health services (n=302), personnel of home nursing (n=302), home help (n=302) and hospital wards (n=302) were used to find out service structure, need
for development of a new practice and ongoing improvements. Also effective home care and discharge practices were searched by reviewing literature. Earlier mentioned evidence was integrated with practical expertise of home care (home nursing and home help) and hospital personnel in an action research based modelling.

Results: The generic model was embedded in the home care services in other municipalities. The impacts of the generic model on clients/patients, relatives, health and social care personnel, and cost effectiveness were evaluated in the design of a cluster randomised controlled trial. That involved 22 municipality-hospital pairs (number of inhabitants, services structure) randomly assigned between trial and non-trial group. The data was gathered using interviews of patients, questionnaires sent to informal caregivers and staff, and other documents. The patients were selected using inclusion and exclusion criteria. Both the trial and the non-trial group aimed to have 385 patients before and after implementation.

The modelling produced a generic integrated practice with evaluation criteria and an embedding method for integration in another context (which enable also unit-led implementation). The model improved vertical and horizontal integration: change of information, multidisciplinary teamwork on interfaces of organizations, patient's discharges, especially, discharge practices between hospital and home nursing, hospital and home help, home care and support services improved. Collaboration practices improved in both municipality groups but more improvements were found in the municipalities of the trial group. Continuity of care improved in both municipality groups, but in the trial-group the change was greater and in greater number of activities. Information exchange improved especially between home care and informal care givers, health centres, service houses and support services.

Conclusion: In conclusion, the embedding of the model improved collaboration between parties in home care and discharging. Also developed methods (model and guidelines) were useful tools in embedding and - The effects on clients are presented in other presentation.

13.45 The Regional Discharge Model Development Project
Tiina Mäenpää, PhD student, MNSc Research Assistant, Satakunta Hospital District, Finland et al.

Purpose/Theory: The goal of the Regional Discharge Model (RDM) project was to develop discharge models, avoid unnecessary hospitalization, and improves the transfer of the patient to the right follow-on treatment or care, utilizing the public and private sector, research and training as well as developing technologies like the Regional Health Information Systems (RHIS) in the Satakunta Hospital District area. The RDM project is part of the ‘Whole life at home’ initiative funded and administered by the Satakunta Hospital District and supports the nationwide goals definition in the Finnish Ministry of Social Affairs and Health policy.

Methods: The method used was a descriptive statistics study. The questionnaire included both structural and open-ended questions. The target group was the immediate supervisors in primary health care and social services in the Satakunta Hospital District area, (N = 147, n = 92).

Results and conclusions: There were many challenges in the discharge and follow-on treatment when transferring from special health care, such as a lack of planning with the receiving organizations and insufficient coordination between the various professionals involved. The flow of information was inadequate and often presented in paper or oral format,
rarely transferred electronically. Integrated patient care was not always well managed in primary health care and social services in the hospital district. However, continuity of care was safeguarded and discharge proceeded safely, and professionals also valued the expertise of other organizations. Generally, the organizational climate was supportive to the discharge and encouragement of patients.

Discussion: With integrated patient care, the development of discharge models is the responsibility of both special health and primary health care and social services. This requires the commitment of the professionals and the organizations to the development work throughout the region.

1.7. Paper session on Integrated Care for the Elderly in Holland

13.00 The Dutch National Care for the Elderly Programme: integrated care for frail elderly persons

C.C.M. (Karianne) Jonkers, PhD, programme officer, The Netherlands Organisation of Health Research and Development (ZonMw), The Hague, The Netherlands

Introduction: The Netherlands Organisation of Health Research and Development (ZonMw) has launched the ambitious National Care for the Elderly Programme to improve care and support for frail elderly persons. This four year programme (2008-2011) is initiated by the Ministry of Health, Welfare and Sport. The budget is 80 million euro.

Description: The programme consists of three steps. First, regional networks were formed consisting of all parties that can contribute to the organisation of care and support for frail elderly persons. Second, innovative experiments were formed within these networks. These experiments focus on a reorganisation and integration of care and support and are formally evaluated. They should lead to added value for elderly people, in terms of greater self-reliance, better retention of function, and reduced care use and treatment burden. The third step is dissemination and implementation of knowledge.

Conclusions: Eight networks are formed and continue to grow. These networks developed 13 experiments on the following topics: screening of frailty, reactivation after hospitalisation, improvement of primary care, integrated care, and new information systems. More experiments will follow.

Discussion: We aim for better integrated care and added value for frail elderly persons through formation of networks and experiments. Whether this approach works is still to be tested.
Detection and management of frail elderly in the primary care: evaluation of the effects of screening elderly people in order to detect frailty at an early stage

Inge GP Duimel-Peeters PT, MSc, PhD Maastricht University Medical Centre, Dept. of Integrated Care et al.

Background and purpose: Due to the decreasing number of youth and the strong ageing process, elderly will get less support from their children and/or the younger generation. To make an appeal to formal healthcare professionals will become a bottleneck because of the shortage of these professionals. There is a strong need for client-centered, easily accessible, integrated, preventive healthcare at community level for elderly. In the Netherlands consultation services for the elderly seems to be an upcoming phenomenon in healthcare. Assuming the fact that screening of frailty should be the first step in an integrated chain of care model, the effects of preventive consults in which elderly people are screened on (possible) frailty, the subsequent interventions and follow-up among community-dwelling frail elderly have to be evaluated before broad implementation can start. A preventive consult should contribute to healthy and active ageing, to the adequate control of one’s independency, to the early detection of health problems and to the promotion of quality of life. Systematic preventive screening will reach those elderly who have undiagnosed health problems, i.e. those in whom secondary prevention can start.

Methods: Departing from primary healthcare with the GP as process manager, preventive consults should support the elderly in maintaining an optimal physical, mental, social and cognitive health status. Therefore, a measurement instrument to distinguish between ‘frail’ and ‘not-frail’ older people (75+) will be developed and validated. This instrument consists of a list of indicators extracted from the GP Health Record File and of questionnaires about health determinants and risk factors for physical, mental, psychosocial and cognitive impairments. Protocols will be written in which the follow-up processes after referral to life style advice, treatment, social care, volunteer aid and other service supply are elaborated. With an quasi-experimental design, the psycho-clinical properties and the predictive feature for frailty of the screening instrument will be discussed, process measurements and outcomes (quality of life as well as health related outcomes) at individual level, and experiences of healthcare professionals (e.g. feasibility) will be compared between experimental and control condition.

Results and conclusions: Based on the preliminary data from the pilot study it can be concluded that an integrated care model for elderly will be adopted by professionals in the primary healthcare setting, patients and healthcare insurance companies if the consultation service can be described as ‘effective’ based on the outcome opinions (i.e. clinical parameters and questioned opinions). Finally, with proven evidence-based effects of screening the elderly within an integrated chain of care model, the feasibility of a Diagnosed Treatment Combination for frail elderly will be judged.
Parallel session 2

Thursday June 17
15.45 – 17.15

2.1. **Virtual studytrip to integrated care for diabetes patients in Germany**
Lutz Altenhofen, DR Projectleitung DMP-Programme, Diabetes, Brustkrebs und KHK, Zentralinstitut für die kassenärztliche Versorgung

2.2. **Virtual studytrip to integrated primary health care in Holland**
Leo Kliphuis director at National Organisation for Integrated Care The Netherlands

2.3. **Community mental health services in The Netherlands: Quo Vadis?**
Peter van Splunteren, senior researcher Care innovation programme Trimbos Institute and Simone van de Lindt, sociologist/social psychologist Trimbos-Institute

The workshop leaders will present a panoramic view of the community mental health care in Holland: some figures of psychiatric disorders, organizational features of mental health care, treatment of depression and anxiety disorders in primary health care, treatment and care of the severe mentally ill and public mental health solutions. They will show examples of community mental health care and indicate innovations and future trends. Advantages and disadvantages of the system will be discussed and compared with arrangements of community mental healthcare in other countries. In an interactive way participants will be invited to indicate their community mental health care so that the workshop gives the opportunity to compare and weigh current community based care for psychiatric patients and new directions.

2.4. **Workshop on implementation strategies for Integrated Care projects**
Dirk Wijkel, medical coordinator stichting THEMA and Ingrid Mur, Associate professor Maastricht University
2.5. **Paper session on Disease Management in Germany and the UK**

15.45. *Does Integrated Care lead to both Improved Health Outcomes and Lower Care Cost? Interim results of an Evaluation of “Gesundes Kinzigtal Integrated Care” in Germany*

_Achim Siegel_, Department of Medical Sociology, Freiburg University, Germany et al.
presented by Regina Waldeyer

Purpose and Context: “Gesundes Kinzigtal” is one of the few population-based integrated care approaches in Germany, organising care across all health service sectors and indications. The management company and its contracting partners (the physicians’ network in the region and two statutory health insurers) strive to reach a higher quality of care at a lower overall cost as compared with the German standard. During its first two years of operation (2006-07), the Kinzigtal project achieved surprisingly positive financial results compared with its reference value. To gain independent evidence on the quality aspects of the system, the management company and its partners provided a remarkable budget for its evaluation by independent scientific institutions.

Case description and data sources: We will present interim results of a population-based controlled cohort study. In this study, quality of care is checked by relying on health and service quality indicators that have been constructed from health insurers’ administrative data (claims data). Interim results are presented for the intervention region (Kinzigtal area) and the control region (the rest of Baden-Württemberg, i.e. Southwest Germany).

Preliminary conclusions and discussion: The evaluation of “Gesundes Kinzigtal” is in full progress. Until now, there is no evidence that the surprisingly positive financial results of the Kinzigtal system have been achieved at the expense of care quality. Rather, Gesundes Kinzigtal Integrated Care seems to be about to increasingly realize comparative advantages regarding health service quality (in comparison to the control region).

16.30- ‘*All together...how? Service Models for Promoting Continuity of Care for People with Long-term Neurological Conditions (LTNCs)*

_Fiona Aspinal_, Social Policy Research Unit, University of York, Heslington, York UK

Purpose: The purpose of this research was to better understand the outcomes of integration by asking what promotes the experience of continuity of care from the point of view of people with long-term neurological conditions.

Theory: We used the definitions of continuity of care developed by Freeman *et al.* (2001, 2003) as a conceptual framework with which to consider people’s experiences of using services within more and less integrated systems.

Methods: In-depth case studies were undertaken in six service systems across England with varying levels of social and health care integration. The findings presented here come primarily from in-depth interviews with people with LTNCs who used services in these systems. Data were thematically analysed and triangulated with other case study information.
Results and conclusion: The following service models promote continuity of care for people with LTNCs: community interdisciplinary neuro-rehabilitation teams, day opportunity services, nurse specialists and other forms of care co-ordination.

Discussion: Not everyone who might benefit from these service models is currently able to do so. How can we ensure equity of coverage and access?

2.6. Paper session on Concepts and Models for Integrated Care from the UK

15.45 Integrated Care Pilot Programme – UK Department of Health
Mo Dewji Dr – Clinical Advisor, ICP Programme, Department of Health et al.

Introduction: Integration is seen as a key building block within the strategic plan for improving the health and wellbeing of the population of England. The Integrated Care Pilot programme is a 3 year academically assessed research programme sponsored by the Department of Health, England, which aims to explore and gather evidence to support different approaches to integration.

Aims: With 16 pilot sites across England the objectives of the programme are based upon a Government commitment to test and evaluate a range of innovative models of integrated care that should help to improve patient, carer and service user outcomes. Each pilot is exploring a new approach to a key health issue within the local community, and seeking to deliver improvements in quality, service user satisfaction and local health and well-being.

Current status: The programme launched in April 2009 and all 16 pilot sites are currently implementing their integration interventions. Evaluation activities are underway with qualitative and quantitative data being collected via pilot site information systems as well as through patient and staff interviews. An interim evaluation report is due to be published in summer 2010. The programme is due to be completed in April 2011 with a further year of evaluation data collected before a final assessment is published.

2.7. Paper session on Integrated Care for the Elderly in France

15.45 Diagnostic, design and implementation of an integrated model of care in France: A bottom-up process with a continuous leadership
Matthieu de Stampa, Versailles St-Quentin University, “Santé Vieillissement” group, AP-HP, Hôpital Sainte Perine, Paris, France et al.

Purpose: To present an innovative bottom-up and pragmatic strategy used to implement a new integrated care model in France for community-dwelling elderly people with complex needs.

Context: Sustaining integrated care is difficult, in large part because of problems encountered securing the participation of health care and social service professionals and, in particular, general practitioners (GPs).

Case description: In the first step, a diagnostic study was conducted with face-to-face interviews to gather data on current practices from a sample of health and social stakeholders working with elderly people. In the second step, an integrated care model called COPA (Coordination Personnes Âgées) was designed by the same major stakeholders in order to
define its detailed characteristics based on the local context. In the third step, the model was implemented in 2 phases: adoption and maintenance. This strategy was carried out by a continuous and flexible leadership throughout the process, initially with a mixed leadership (clinician and researcher) followed by a double one (clinician and managers of services) in the implementation phase.

Conclusions: The implementation of this bottom-up and pragmatic strategy relied on establishing a collaborative dynamic among health and social stakeholders. This enhanced their involvement throughout the implementation phase, particularly among the GPs, and allowed them to support the change practices and services arrangements.

16.30 Institutional integration in France – Health Regional Agencies and Integrated Services Delivery

Dominique Somme et al., MD PhD Service de Gériatrie-Pôle Urgence Réseaux, Hôpital Européen Georges Pompidou Paris.

Introduction: The PRISMA France pilot project is ongoing since 2006. This project aims to implement an integrated services delivery (ISD) for elderly people, based on the PRISMA methodology. The experimentation is coupled with an implementation study to identify factors that facilitate and hinder the implementation. The fragmentation of public authorities represents one of the first barriers identified.

In 2009, a large-scale institutional reform has been initiated. It consists of merging various structures having strategic authorities on medical and social care within a single entity: the Health Regional Agencies (HRA). One could anticipate that this reform should facilitate the implementation of ISD.

Aims: To analyze the influence of institutional reforms on a pilot program aiming to implement an ISD. In the framework of our qualitative study we analyze the way the actors conceive the HRA.

Conclusions: The potential to facilitate ISD of the HRA has been identified. It is hope that they should reduce the institutional fragmentation. Nonetheless, the link between these agencies and the implementation of ISD in the pilot project was rarely made.

The extent of institutional change is bought into question by the past of the French system of social welfare.
Parallel session 3

Friday June 18
9.45 – 11.15

3.1. **Workshop: Do’s and don'ts if supporting disease management with IT**

*Hero Torenbeek*, Solutions Manager VitalHealth Software

Contents of the workshop:
- Global developments in healthcare IT
- United States and Mayo Clinic as a case
- VitalHealth’s projects and experiences in Mayo Clinic
- Usage and Results on Quality of Care
- Lessons learned
- Discussion

What can be learned about IT projects supporting Disease Management?
- Arguments for supporting protocol based care with IT
- Arguments for involving the healthcare professional and patients into disease management IT-projects
- The importance of integration in IT –disease management applications
- Go wide before going deep

3.2. **Virtual studytrip to integrated primary health care in Finland**

*Simo Kokko*, Adjunct Professor, National Institute for Health and Welfare (THL)

First a brief general introduction of the types of services usually encountered in a PHC centre in Finland, and the relationships/interfaces with specialist level services and social services. Then a study tour of typical health centres with photographs, organizational charts, pictures of teams at their work and at meetings, perhaps videoed interviews and hopefully some representatives of staff of health centres introduced in person in the session

3.3. **Integrated preventive child health care in the Netherlands**

*Henk van Stel*, Assistant Professor of health services research and *Elly de Leeuw*, MD, head of public health education, youth health care doctor, University Medical Center Utrecht

1) Overview of integrated preventive child health care in the Netherlands
   - goals, history, developments
   - structure, organisation and financing of preventive child health care
   - professions and competences
   - reach & results

2) Discussion in small groups on strength and weaknesses of selected key aspects and feasibility of implementation in other countries, followed by short plenary discussion

3) Presentation about centres for integrated preventive child health care in Amsterdam: Parent and Child Centers

4) Plenary discussion: how to improve and implement integrated preventive child health care in different countries
3.4. **Paper session on Case management, Organisation of Integrated Care and tools for evaluation**

**09.45 Integrating research into the inter-organisational relationship: towards a theoretically-rooted tool for evaluation**

**Simon Douglas**, UK Mental Health Research Network / Newcastle University UK et al.

**Purpose:** To enable an understanding of the complexities involved in evaluating and improving the partnerships between organisations involved in integrated working.

**Theory:** Network organisations provide a unique challenge to understanding and evaluating the processes and mechanisms through which organisations integrate. Through integrating research into this interface we propose a methodology for evaluation.

**Methods:** A Grounded Theory study of partnership working in network organisations, with data analysis to build a theoretical model of the way that partnership works in complex organisational situations.

**Results and conclusions:** Integrating care involves working across multiple organisations, creating complex environments for assessment and evaluation. We show that what happens in the “spaces” between organisations involved in complex partnership arrangements is crucial and that current methods of partnership evaluation are inadequate for complex partnership situations such as network organisations. Our model for integrating research into these interfaces between organisations involved in care enables these complexities to be better understood with the potential for real improvements in complex integrated care situations. In order to achieve this it is important that a theoretically-rooted, context-specific evaluative tool can be developed. This paper presents the Model of Network Partnership which the authors believe is a crucial stage in the process of development of such a tool with the potential to promote genuine improvements in integrated working.

**10.15 From organizational integration to clinical integration. Analysis of the path Between one level of integration to another employing official documents**

**Matey Mandza,** École nationale d'administration publique, Canada et al.

**Purpose:** Services’ integration comprises organizational, normative, economic, informational and clinical dimensions. Since 2004, the province of Quebec has devoted significant efforts to unify the governance of the main health and social care organizations of its various territories. Notwithstanding the uniformity of the national plan’s prescription, the territorial integration modalities greatly vary across the province.

**Theory:** This research is based upon a conceptual model of integration that comprises six components: inter-organizational partnership, case management, standardized assessment, a single entry point, a standardized service planning tool and a shared clinical file.

**Methods:** We conducted an embedded case study in six contrasted sites in terms of their level of integration. All documents prescribing the implementation of integration were retrieved and analyzed.

**Results and conclusions:** The analyzed documents demonstrate a growing local appropriation of the current integrative reform. Interestingly however, no link seems to exist between the quality of local prescriptions and the level of integration achieved in each site. This finding leads us to hypothesize that the variable quality of the operational accompaniment offered to implement these prescriptions is a variable in play.
10.45 Study of the composition of the various forms of coordination in the case management practice
Sebastien Carrier, University of Sherbrooke, Louis Demers École nationale d’administration publique, Canada et al.

Purpose: In 2004, Quebec’s Health and Social Care Ministry implemented an integrative reform aiming to systematize coordination which employed prescriptive devices. The will to systematize coordination practices is supported by formal coordination devices such as case management. However, many obstacles lay in the path of these devices’ usage.

Theory: This presentation is based on Boltanski and Thévenot’s (1991) theory of conventions. This theory was utilized to analyze the operations that lead to the convened agreements which serve coordination in its formal and emergent aspects.

Methods: We utilized a qualitative and exploratory embedded case study design in which we employed three data collection and analysis methods: a documentary analysis of the integrative prescriptions, interviews aiming to make explicit the concrete coordination practices and direct observation of professional practices.

Results and conclusions: We identified different types of coordination systems in case management practices. Notably, the so-called “peri-professionnal” system that grants the family caregivers the role of intermediate between the frail elder and the health and social care network, as well as the so-called “virtual” system produced by the technological means of the computerized clinical files.

3.6. Paper session on Concepts and Models for Integrated Care from the UK and Italy
09.45 Shaping the future of integrated care: what can we learn from history?
Benedict Rumbold and Sara E Shaw, The Nuffield Trust, London, UK

Introduction: Published literature on integrated care usefully brings together wide-ranging definitions and concepts (e.g. breadth, function) but pays little attention to the historical record (e.g. political priorities, policy agendas, and social pressures). Historical analysis highlights how these factors have shaped the integrated care agenda over time.

Aim: To draw out lessons for future policy by considering UK policy developments around ‘integration’ since 1948.


Results and conclusions: Historical analysis reveals that policymakers have often shared a desire to improve the quality and efficiency of services by coordinating policies, processes, organisations, services and actors. Key ‘drivers’ of integration have been changing professional and public perceptions of the remit of the health services, which organisations have a part to play in safeguarding the public’s health, and how we conceptualise the boundaries of healthcare. However, history also teaches us how easily reforms currently envisaged as furthering the cause of integration can, in the long run, further cement existing gaps in service provision.
10.15 Are there any logics to the Integration of Care?  
Mike Martin, Visiting Professor, Newcastle University Business School, Newcastle University UK et al.

Purpose: To reflect on the current state of the systems and practice of care of Older People in the UK and Italy and propose a new way of framing the problem in terms of identifying and describing the implicit logics being used to design services and organisations.

Theory: The work draws on a range of theoretical work including Boudeui notions of practice and Wieck sensemaking and proposes a way of framing useful interventions for supporting service transformation.

Methods: From a range of mixed methods studies undertaken by the authors and in R&D projects in including telecare in UK and Italy.

Results and conclusions: Our work in these complex contexts of service delivery leads us to suggest that there is a need for the co-creation and cultivation of service environments with the network of users, service providers and commissioners based on an explicit understanding and accommodation of the logics of care, of service economy and of public policy.

10.45 An “Inclusive” Model of Integrated Care  
Helen Tucker, et al. University of Warwick

Purpose: To explore the presence, nature and development of integrated care in community services

Theory: To explore the concept of an “inclusive” model of integrated care, which is defined in this study as sustained integrated care for all client groups, with multiple simultaneous types of integrated working. This challenges the predominance of the model found in the literature which focuses on short term projects for older people focusing on one type of integrated working.

Methods: Secondary analysis of data from staff questionnaires for 66 community services were analysed from two case studies: The Community Hospital programme in England and the ICON programme in Ireland.

Results and conclusions: Multiple and simultaneous types of integration were recorded for community hospital services for all client groups, with an average of 4.4 types of the 8 types studied. Evidence for established integrated working was found in the literature on community hospitals as well as in the case studies. Progress with developing processes to support integrated working was recorded in the ICON programme for all client groups. The study has shown the presence of an “inclusive” model of integrated care in community services.

Discussion: The study has contributed an assessment tool and led to the development of a new ethical framework for integrated care.
3.7. **Paper session on Integrated Care for the elderly in Singapore**

*09.45 Integrating Aged Care in Singapore – The Action Framework*

_Ann Yin_, Agency for Integrated Care, Singapore, et al.

*10.30 Characteristics of elderly patients receiving care coordination: The role of telephonic review and home visit*

_A A Amran_, Agency Integrated Care, National University Hospital Singapore, et al.

Introduction: In Singapore, care coordination and transitional care nursing is a new concept of care nevertheless important but unexplored.

Aim: To explore the characteristics of elderly patients receiving care coordination, determine care gaps and intervention during home visit and telephonic review.

Research Design: A designed questionnaire was used to collect information on the patient’s demography, social and clinical profile and determine post discharge activities using Eric Coleman’s Four Pillars tool. The retrospective data from the patient’s index admission was analyzed using SPSS version 16.

Result: Total of 1011 patients was recruited in 2009, 69% were above 70 years of which 55% were female and 76% lives with their children. Clinical information demonstrates that 67% had 1-3 co-morbidities and 23% had more than 4 co-morbidities with 10% had none. Approximately 58% were taking more than five medications, 35% have an Abbreviated Mental Test score of 6 and below, 6% were depressed and delirium was present in 14% of patients. About 36% had home visits and telephonic review done whilst 64% of the remaining had only telephonic review done.

Conclusion: This study demonstrate the vital role of home visit for elderly patient to safely transit between hospital to home.
Parallel session 4

Friday June 18
11.30 – 13.00

4.1. Workshop: Health technology assessment as comprehensive multidisciplinary evaluation of integrated care focusing integrated home care as prototype Torben Larsen, Chief consultant, coordinator homecare, Centre for Applied Health Service Research and Technology Assessment (CAST) Southern Danish University, Odense

I. The workshop will start with an introduction by T. Larsen of key concepts and basic typology of health technology assessment (HTA), which will be illustrated by analytical elements from integrated home care (20 minutes).

II. Prepared questions for debate as presented and moderated by the workshop chair and complemented by T. Larsen (40 m.):
1) In which cases are HTA relevant?
   [Suggested answer: HTA is relevant in early stages of new interventions with genuine insecurity about the effects as a comprehensive evidence-based guideline for decision-makers in health care / health care policy of the potential of that specific technology]
2) How can HTA guide IC?
   [Suggested answer: As the outcome of IC often are improved activities of daily living (ADL) directly associated with savings on successive needs hospital care and/or social services, they may be fully or mostly self-financed which indicates a synergistic relationship between disciplinary and economic evaluations. In most other branches of health care socio-economic and health professional evaluations may be in more or less opposition]
3) How relates HTA to value systems as Utilinarism and moral duty?
   [Suggested answer: The inclusion of both quantitative and qualitative analysis in HTA might be interpreted as integrated evaluation of ‘classical’ empirism/utilinarism and ethical/psychological aspects]
4) What other IC-topics are relevant for HTA?
   [No premeditated answers, but open-minded listening and commenting of suggestions. Short illustrative explanations of standard, fast and mini HTA may be added]

III. Finally, a free plenary discussion will round off the workshop, which should result in increasing awareness of the audience on the contribution of HTA to both informed and comprehensive choices between alternative interventions in the field of integrated care.

4.2. Virtual studytrip: Future options for integrated primary health care policies and practice in Europe
Sara Shaw, Dr, Senior Research Fellow, Nuffield Trust, London and Geoff Meads, Hon Prof of International Health Studies, Warwick Medical School, UK

Purpose: to enable workshop participants to evaluate alternative models of primary health care organisation in relation to their particular local settings and four scenarios for future political integration in Europe

Context: After the ratification of the Lisbon Treaty different trajectories are being identified for future social policy development in Europe. These range from a defined ‘European Health Space’ based on the sustained integration of national policies with the EU increasingly as the
main basis for delivery, to a more fragmented Europe in which member states reclaim sovereign control over more diverse and separate health systems. Between these two ends of the spectrum there are a range of options for networks and knowledge exchange. Integrated primary health care offers the potential for more synchronised continental frameworks, ensuring an interprofessional and participative approach which connects firmly with patients and communities in all states. However, so far little attention has been paid in the EU to primary care and a growing range of organisational models have emerged. Recently these have included the growth of the managed care enterprise and multi-specialist polyclinic alongside the extended general practice and medical office. Not all of these enhance integrated care and it is increasingly important, therefore, to ensure that future policy and organisational developments are effectively aligned at both local and European levels.

Sources: the workshop draws on international primary care research programmes led by the authors since 2001. These include policy papers for the UK Department of Health, the European Forum for Primary Care, the TUFH Network and The Health Foundation. Current data is derived from a 2009-2010 Nuffield Trust project designed to identify lessons for the UK on integrated primary care developments in Europe. In total this draws on over 50 fieldwork visits and interviews with UK and European policy makers.

Methodology: The workshop format will be based on two Scenario Planning exercises. In these clusters of national representatives will identify their present position in terms of a spectrum of primary care organisational developments and their host countries’ policy trajectories. Using INIC criteria for Integration best future options will be explored and the potential contribution of Europe to these defined and discussed in both small group and plenary settings.

Results: the workshop will inform the forthcoming Nuffield Trust publication on European Integrated Primary Care and a proposed IJIC article; as well as being of benefit in clarifying issues for workshop participants.

4.3. Paper session on Community Mental Health

11.30 The impact of transdisciplinary multi agency cooperation in local medical treatment
Lise Holmesland, Soerelandet Hospital Trust, Norway, Jaakko Seikkula, University of Jyväskylä, Finland, and Tom Erik Arnkil, National Institute for Health and Welfare, Helsinki

Purpose: To explore the impact of personal and professional relations in transdisciplinary network meetings seen as a kind of integrated care for clients with mental health problems.

Theory: The study draws on theories of transdisciplinary team work. Transdisciplinary teams are considered to be highly context sensitive and both professionals and non professionals need to develop sufficient mutual trust in order to transcend disciplinary boundaries to facilitate a holistic approach and to create new solutions.

Method: Two focus groups consisting of professionals with experience of network meetings were conducted. One group consisted of professionals working in the healthcare sector; the other group consisted of professionals working in the social and educational sector. Each group met twice. Topics related to multi-agency work, dialogues, reflection and professional expertise in network meetings were discussed.
Results and conclusions: During the project the professionals gained more knowledge about their personal and professional differences. These differences could both facilitate new solutions but also create problems in attempts to provide a better health care service towards people with mental health problems. Problems connected to communication patterns, modes of reflection and expertise seems to be especially important. Through inclusion of professionals and non professionals from different agencies and levels, from the municipality and the national health care sector the possibility for gaining a better flexibility and continuity towards integrated health care seems improved.

12.00 The client-centredness in the innovative rehabilitation course: The schizophrenia client’s expertise in changing service system

Kirsi Günther, Postgraduate student, Researcher, Department of Social Work Research, University of Tampere, Anna Kulmala, PhD, Rehabilitation co-ordinator, Muotiala Accommodation and Activity Centre Association, Suvi Raitakari, PhD, Researcher, Department of Social Work Research, University of Tampere, Finland

Introduction: In Finland nowadays it is emphasized in the rehabilitation of the schizophrenia the importance of the seamless rehabilitation path and the service user’s expertise and experience. Research setting is the rehabilitation course which has been planned for the young adults who have schizophrenia. The rehabilitation course is a cooperation project of the third sector, hospital district and the public sector. Research has started in 2009.

Aims: is to examine and to model the innovative way of organizing the mental health rehabilitation. The model is studied from the point of view of the ones having schizophrenia and from their position. Two main objectives are to evaluate the service user’s position on the rehabilitation path and to show what kind of new ways of practices is needed so that people having schizophrenia would get a stronger expert position in their own rehabilitation.

Theory and methods: The study is anchored to the field of research of examining service users’ experiences. We also draw on research on social and human service work, in which naturally occurring data is gathered and analysed.

12.30 The becoming of integrated care around pregnancy and psychiatry in Almere, the Netherlands

W. KleinNagelvoort, Project Manager, Zorggroep Almere, the Netherlands, et al.

Introduction: The 35 year old, fast growing city of Almere with its 185.000 inhabitants and annually 2.500 births has a mass representation of young, socially at risk, immigrant people. Almost all medical caregivers like general practitioners, midwives and chemists work together in Zorggroep Almere’s health centres. Almost all clinical care takes place in the Flevoziekenhuis and psychiatric centre the Symforagroep “de Meregaard”.

Aims: To develop an integrated multidisciplinary care programme within the various institutes and disciplines to enable an early intervention programme for affective disorders with mothers (to be), and to perceive these disorders in an early stage in order to reduce harmful influences on the development of the (unborn) child.
Results: The Symforagroep “de Meregaard” noticed a huge demand on care for young parents with psychiatric disorders and developed a special programme containing an early intervention programme for young children. In 2005 they initiated a pilot project for the midwifery practice. 14% of the population tested positive after screening with the E(P)DS (Edinburgh (Postnatal) Depression Scale) and was referred to a general practitioner for diagnosis and treatment. With a community grant a project manager was appointed to realise screening for all pregnant women including those under clinical care.

The Flevoziekenhuis also noticed a big demand of those pregnant with psychiatric and psycho-social disorders i.e. problems. The Extra Zorg Poli (additional care in the obstetric outpatient department) has been launched where clinical midwives and social workers care for pregnant women with psycho-social problems. Paediatrics, gynaecologists and liaison psychiatrists launched special consultation hours for women with psychiatric disorders. All disciplines have developed an integrated treatment plan.

Together with chemists a directive for treatment with anti depressives has been made for women in their pregnancy and during the lactation period with unambiguous information. During the pregnancy of these women a postpartum plan will be made where additional care is initiated for the period straight after birth in the clinic as well as when these women get home and will have extra visits from psychiatric nurses and children’s healthcare and any additional care needed. The Symforagroep “de Meregaard“ initialized a clinical trial for these women and their partners focussing on affective disorders and the bond with their children. With this integrated care programme a specialized and multidisciplinary support plan for early intervention has been developed on the obstetric, psychiatric and social terrains in the home practices as well as in hospital.

We present the most important disabilities and abilities for the succession of this ambitious project as well as the resulting challenges

Conclusion: Integrated Care for parents (to be) at risk for psychiatric and psycho social disorders has been initiated in a pilot-setting and has been further developed

4.4. Paper session on Telemedicine in Germany and UK

11.30 Limits to Integration: Lessons from Implementation in the cases of Telecare and Joined up Assessment
Rob Wilson, Newcastle University Business School, Newcastle University UK

Purpose: To re-frame our understanding of the complexities of integration through the challenges faced by public sector deployments of telecare and joined-up assessment and propose new ways of thinking about the integration issue

Theory: Emerging socio-technical theories of multi-agency working increasingly suggest that the current discourses of integration particularly in policy and implementation are causing key problems in the deployments of service innovations.

Methods: Results from a range of mixed methods studies undertaken by the author and colleagues in partnership working including telecare and single assessment.
Results and conclusions: Research into integration indicates that current methods of describing, thinking about and doing integration are problematic. This paper presents evidence and analyses the problems from a range of case studies on telecare (as an example of vertical integration) and assessment (as an example of horizontal integration). It also suggests some ways of attempting to cultivate an environment for innovation.

12.15 Telemedicine in integrated care

Annett Kröttinger, Dr, Almeda GmbH, et al.

Context: Sectoral boundaries still cause problems in supervising chronically ill patients in Germany. Integrated care models by means of modern telemedicine can help.

Since the beginning of 2008, an agreement between the Techniker Krankenkasse (TK) and the German Foundation for the Chronically Ill has enabled a telemedical programme for asthma (see below).

Case description: Adult TK insured asthmatics are enrolled by participating doctors. Supervision by a telemedical support centre differs according to the severity of their condition and in coordination with participating doctors.

All patients receive electronic peak flow meters and training documents, and are phoned regularly by medically trained coaches. Major elements include information and training courses on asthma, self-management, target agreements, collection of medical data and regularly written reports to participants and doctors. High-risk patients also undergo telemonitoring of medical data via mobile phone. If values become critical, early intervention prevents escalation and medical emergencies.

Results and conclusions:
-- Over 1,500 patients enrolled since programme launch.
-- Pre-post comparison (n=1,455) shows significant medical results.
-- Increased percentage of participants receiving PRN medication (+ 10.6%) and long-term medication (by up to 40%). according to guidelines
-- Influenza vaccination rate increased by 18%; pneumococcal vaccination rate by 43%. Percentage of patients with self-management plan doubled. 64% could prevent episodes of shortness of breath; 66% no longer suffered from asthma-related coughing.

Discussion: Integrated care models by means of modern telemedicine suitable for other chronic diseases and for multimorbid patients (whole patient management)?
4.5.  **Paper session on Concepts and Models of Integrated Care from Canada and Sweden**

11.30  **Studying integrated health care systems with a structurationist approach**

_Louis Demers, PhD, Professor, École nationale d’administration publique, Quebec City, Canada_

Introduction: To implement an integrated health care system is not an easy task and to ensure its sustainability is yet more difficult.

Aim: Discuss how a structurationist approach can shed light on the stakes of these processes and guide the managers of such endeavours.

Theory and method. Structuration theory [1] has been used by numerous authors to cast new light on complex organizational phenomena. One of the central tenets of this theory is that social systems, such as integrated health care systems, are recurrent social practices across time-space and are characterized by structural properties which simultaneously constrain and enable the constitutive social actors who reproduce and transform the system through their practices. We will illustrate our theoretical standpoint with empirical material gathered during the study of an integrated health care system for the frail elderly in Quebec, Canada. This system has been implemented in 1997 and is still working well in 2010.

Results and conclusion. To implement an integrated health care system that is both effective and sustainable, its managers must shrewdly allow for the existing system and progressively introduce changes in the way managers and practitioners at work in the system view their role and act on a daily basis.

12.00  **Services integration, professional autonomy and standardization. Representations of standardization among social workers in the case of integrated service networks implementations**

_Emilie Rousseau-Tremblay, University of Sherbrooke, Quebec, et al._

Purpose: Social work (SW) practices are undergoing major transformations generated by change in the governance of health and social policies. These transformations are based on two logical performance, one managerial, resting on New Public Management principles, and another clinic, supported by evidence based practices. The implementation of integrated services is traversed by these two logics that shape it and call a relative standardization of clinical practice.

Theory: Standardization of practices should be conceived as bi-dimensional, like a normative system heterogeneous to practice of SW but also like a set of incorporated and collective routines sustaining the professional autonomy of SW.

Methods: Qualitative analysis of representations of standardization from a corpus of interviews with 17 case managers on 3 implantation sites.

Results and conclusion: Standardization appears weakly conceptualized in social workers practices. Managerial dimensions of standardization dominating in their representations. However, some forms of standardization associated to tools for information exchange and evaluation are seen by SW as vectors of efficiency in clinical practice. SW have a complex
relationship to the multifaceted nature of the standardization that requires a nuanced analysis of its effects on their practices.

12.30 Patient choice and health care integration: a review of the consistency between two Swedish policy concepts
Benf Ahgren, MpolSc, PhD, Senior Lecturer, Nordic School of Public Health, Göteborg, Sweden et al.

Purpose: Despite of an insignificant track record of quasi market models in Sweden, new models of this kind have recently been introduced in health care; commonly referred to as “choice of care”. This time citizens act as purchasers; choosing the primary care centre or family physician they want to be treated by, which, in turn, generates a capitation payment to the chosen unit. Policy makers believe that such systems will be self-remedial, that is, as a result of competition the strong providers survive while unprofitable ones will be eliminated. Because of negative consequences of the fragmented health care delivery, policy makers at the same time also promote different forms of integrated health care arrangements. One example is “local health care”, which could be described as an upgraded community-oriented primary care, supported by adaptable hospital services, fitting the needs of a local population. This paper reviews if it is possible to combine this kind of integrated care system with a competition driven model of governance, or if they are incompatible.

Theory: Interorganisational and interprofessional collaboration, accessibility of services, and provider continuity.

Method: Literature based review.

Results and conclusions: The findings indicate that some choice of care schemes could hamper the development of integration in local health care. However, geographical monopolies like local health care, enclosed in a non-competitive context, lack the stimulus of competition that possibly improves performance. Thus, it could be argued that if choice of care and local health care should be combined, patients ought to choose between integrated health care arrangements and not among individual health professionals.

4.6. Paper session on Integrated Care for the elderly in Canada and the UK

11.30- Collaboration between case managers and family caregivers in a context of integrated care for the frail elderly
Yves Couturier, University of Sherbrooke, Canada, et al.

Purpose: Case management is a human device which’s purpose is to enhance the quality of services by improving their coordination. However, the case manager is not the sole bearer of the coordination duty; the first line medical doctor, the service user himself and his family caregiver may also contribute. The family caregiver represents a very important coordinator whose contribution to case management remains feebly recognized. This communication focuses on the family caregiver’s contribution to the general coordination of services.

Theory: Even though few studies have focused on family caregivers’ roles in services’ coordination, their role is recognized as crucial. Diverse models of the family caregiver’s role will be utilized to orientate our analysis of their contributions to general coordination.
Methods: Employing an embedded case study design, we conducted eighteen paired interviews with user/caregiver dyads (six in three different integrated care networks) following a method aimed at making explicit their concrete coordination practices.

Results and conclusions: Services’ coordination is marked by a delay between the emergence of a clinical need and the implementation of a service, which is partially compensated by the family caregiver. Hence, global coordination is temporally out of phase with the user’s needs.

12.00- The effectiveness and cost-effectiveness of a community based case management approach for older people with multiple comorbidities

Marina Lupari RGN, RHV, Bsc(Hons), MSc, Head of Nursing- Research & Development, Northern Health & Social Care Trust / PhD student University of Ulster, Northern Ireland

Purpose: Research is needed to understand how case management can most effectively improve service effectiveness for patients and their carers and reduce cost of care.

Theory: The Department for Health considers the case management driven community matron role to be the best mechanism for integrating the required clinical interventions and social care needs for high risk/intensity users populations (DH, 2006). There is a substantial amount of research available on case management (Hui et al 1995, Egan et al, 2002), Kaste et al, 1995, Landi et al, 2001, Lim et al, 2003). Unfortunately while these studies involve the frail older person and provide insight into the management of single chronic conditions they do not investigate patients with comorbidities

Methods: Prospective nonrandomised controlled comparative trial.

Results and conclusions: The intervention group experienced a reduction effect on rates of emergency admission relating to avoidable hospitalisation (50% compared to 20% for control group) for a high risk population aged >65 with a history of being at risk of rehospitalisation.

Discussion (if applicable) Targeted case management approaches utilising the Chronic care model to facilitate integrated of health and social care can improve hospitalisations

12.30- Challenges of integrated working between primary health care services and care homes for older people.

Sue Davies University of Hertfordshire, Centre for Research in Primary and Community Care et al.

Introduction: Within the UK health and social care policy is placing an increasing emphasis on improving the quality of care for older people in care homes through integrated working between health and social care services. This study aims to clarify the research available on integrated working and evaluate its impact on older people in order to devise a typology for informing future service development.

Theory: Kodner and Spreeuwenberg [1] argue that patient/person centred integrated working between health and social care should include methods and models which involve the different levels of organisation, management, funding and clinical care within and between them.

Methods: Phase one included a systematic review to evaluate interventions utilising integrated working between care home staff and health care practitioners, and a survey to describe care
homes’ experiences of integrated working. Phase one will inform phase two; a case study evaluating six different approaches to integrated working currently in use in three different areas of England.

Results and conclusions: The review found evidence of integrated working between health care and care homes at the patient level of care, but minimal evidence of models that extended beyond this level. Findings from the survey, currently in progress, will also be presented.

Discussion: The discussion will provide an overview of the challenges and issues surrounding integrated working.
5.1. Integrated Care and competition in the Netherlands: The Dutch challenge
Josefien Kursten, unit manager NZa and Femke van der Voort MSc., policy advisor in the unit Strategy & Advice NZa, The Netherlands

Purpose: In this workshop we want to discuss the national approaches to implement and further stimulate integrated care. The discussion topics are quality of care and transparency of costs and quality, the costs of integrated care and the way how healthcare providers are organised to deliver integrated care.

Context: The Dutch Healthcare Authority (NZa) is the supervisory body for all the healthcare markets in the Netherlands, both healthcare providers and insurers. The NZa creates and monitors properly functioning healthcare markets. If the interests of the consumer suffers, the NZa intervenes. However, the greatest possible measure of independence for consumers and other market parties is pursued.

Case description: Since 2010, an integrated price for the 'new products' diabetes care and cardiovascular risk management is introduced in the Netherlands. Health care providers are able to receive an integral price for a chain of care. There is a principal contractor who sells the integral product to healthcare insurers. The principal contractor then contracts all the healthcare providers that are needed in the chain of care. A central issue that came into existence is the tension between competition and cooperation.

Discussion: What are the challenges, the advantages and what are the disadvantages of the Dutch(financing) system for integrated care? For example, healthcare providers are united in legal entities to ‘be able’ to offer disease management programmes. These entities are mostly mono-disciplinary organised and growing very fast (an organisation of more than 200 general practitioners). As a result, market power problems exist. Another issue is the effects on patients. Are they still able to visit the healthcare provider they prefer?
5.2. **Network Management and Integrated Care**

*Timo Järvensivu, D.Sc. Research Manager, Doctor of Science (Economics) Aalto University School of Economics*

The 90 minutes workshop will focus on network management in integrating health and social care services. The workshop will focus on the following questions:
- What is network management and how does it relate to services and innovation in health and social care?
- What are the differences between managing service networks and innovation networks?
- What are the most common caveats of network management in health care services and innovation?
- How can we improve network management in these fields?

The workshop will include two 30 minutes presentations, followed by a 30 minutes discussion open for public.

Presentations:


- **“Networked innovation in health care in Germany”**, Prof. Carsten Schultz, Dipl.-Ing. Christoph Bogenstahl, Berlin Institute of Technology, Germany.

5.3. **Paper session on Integrated Youth health in Finland**

*14.00 Integrating health and social services into the environment of childhood growth from birth to starting school: the systematic review of effective cooperation interventions*

*Nina Halme MNSc, RN, Senior Researcher, National Institute for Health and Welfare, et al.*

Introduction: The increasing need for support services and the fragmented nature of the service system challenge us to develop services for children and their families. Child and family services are provided by the public, private and third sectors, which according to research have little or no reciprocal co-operation. As many practices have moved towards family-centrality, the need for personnel and families to work collaboratively has become increasingly apparent. There is a need to understand how to promote this collaboration.

Aims: The aim of this review was to investigate and summarize studies that included an effective intervention as a specific component for the promotion of collaboration among child service professionals or between families with 0-8 years old children.

Selection Criteria: Two authors assessed identified studies for intervention studies (experimental studies, observational studies with or without control group, qualitative studies, meta-analyses and systematic reviews) that describe interventions to promote collaboration among child service professionals or between child rearing families. Studies also had to meet criteria for cultural adequacy and methodological quality.

Data Collection and Analysis: Methodological quality was independently assessed by two review authors using the Quality Criteria Checklist. Levels of evidence were used to determine the strength of the evidence available. It was not possible to perform meta-analyses because of the heterogeneity of the selected studies.

Main results: Of the 1205 titles initially identified through the search strategy, 88 studies met the inclusion criteria. In 31 of these studies the co-operation intervention was targeted at community settings or service-system level. In 23 of studies the co-operation intervention was between professionals and in 49 studies the intervention was conducted in children and families. The studies were very heterogeneous in terms of interventions, participants, and measuring instruments. In only 12 of the 88 studies the methodological quality was good. We found little evidence in effectiveness of interventions to promote collaboration among professionals and families with 0-8 years old children.

Conclusions: The review produced information on co-operation interventions used by service providers in the field of health care, social care, and education. Most of the interventions were targeted at different problem situations, and only five were identified as interventions aimed at maintaining health. The current evidence base is although too heterogeneous and sparse to draw conclusions on the overall effectiveness of the interventions to co-operation. Further high quality studies examining the effectiveness of co-operation interventions are required.

14.45 Integration of services for Youth with Psychiatric Symptoms
Kaisa-Elina Hotari, Department of Social Work Research, University of Tampere, Finland

Our paper examines the construction of joint understanding of collaboration and division of work between social workers in helping youth with psychiatric symptoms. Social workers from psychiatric hospital, school and municipal child protection participated. The project (from August 2009 to the end of December 2009) was implemented in the Pirkanmaa Hospital district with 23 municipalities. The managerial demand of effectiveness contributes to the need of looking at the allocation of professional resources in organizations and the regional professional collaboration and division of work.

The model of participative action research was used in the implementation of the project. Data collected consists of tape-recorded seminars, participative observations, survey questionnaires, and interviews. In the project we confronted with problems known from literature and practice of interdisciplinary work. One of the challenges seems top be the different conceptualization of client situations in different organizations, another challenge is the inadequate knowledge of the basis of work of partners in co-operation, especially between psychiatry and child protection. The findings implicate that it is necessary continuously to develop shared understanding between partners who are working with same service users.
5.4. Paper session on Patient Satisfaction for integrated care

14.00 Using Case Mix to detect Disease and Improve the Delivery of Care
Linda Dunbar, Johns Hopkins HealthCare, et al.

Purpose: To demonstrate the contribution of case-mix in improving the delivery of an integrated health care system.

Theory: Through the application of case-mix, limited resources can be better targeted toward the patients who most need them and the providers who care for those patients. The advantages that case mix offers toward more efficient management of patient care are not restricted to the hospital setting. As populations age, the burden of chronic illness increases. As numerous studies have shown, most patients have multiple diseases which complicate a single care path approach.

Case-mix can facilitate:
- Identifying the patients most in need of care management intervention and recognizing their morbidity profile will ensure more appropriate programs.
- Ensuring that the patient’s complete health status is taken into consideration for intervention assessment.
- assessing the performance of providers by adjusting for the disease burden presented by their patient load

Methods: Johns Hopkins HealthCare contracts with the US Department of Defense (DOD) to provide fully capitated health care services to 30,000 DOD beneficiaries. One example of the successful integration of case-mix into a health care system will be discussed. In order to understand and meet the healthcare needs of their member population, Johns Hopkins HealthCare uses the ACG Case-Mix System to perform a population health analysis and identify patients for a variety of population health management interventions. Programs such as health coaching, disease management and case management have been developed and implemented to help this population improve health, improve the patient’s experience with the healthcare system, and reduce healthcare expenditures.

The process of: 1) population analyses; 2) identifying and stratifying appropriate patients for interventions; 3) development of intervention programs, and 4) monitoring of results of an intensive case management program, Guided Care (GC) for Patients with Multi-morbidity will be presented.

Conclusions: The program for members with multi-morbidity, Guided Care, improved patients’ quality of care, physicians’ satisfaction with care, patients’ quality of life and efficiency of resource use, as well as led to desirable outcomes for other stakeholders in chronic care.
14.45 - Benefits and challenges perceived by patients with cancer when offered a nurse navigator; a qualitative study.

Thygesen MK et al. PhD student, MHSc., RN, Department of Gynecology and Obstetrics, Odense University Hospital, Institute of Clinical Research and Research Unit for General Practice

Introduction: Development has fragmentized healthcare systems in many countries, and coherence is now desired. Among suggested interventions to reduce the fragmentation and improve delivery are help from patient navigators, where patients are offered extra help in a defined area by e.g. a nurse (nurse navigator (NN)). Patients’ experiences with this are of major interest, but have seldom been investigated.

Aims: To explore the experiences of patients with cancer who were offered a nurse navigator in their course of illness before the in-hospital period.

Methods: A phenomenological-hermeneutical longitudinal study was performed among Danish gynecological patients from before an in-hospital period to two months after discharge. NN offered extra information, coordination, logistic services and emotional talk. Semi-structured interviews provided data to the primarily open-minded analysis.

Results: Not all could use the help from NN. Those who could, attached affectional bands to NN, and experienced benefit from her presence as well as her help. Many had a feeling of deep-felt disappointment and felt rejected when the contact to NN stopped.

Conclusion: Resources for NN should be prioritized to patients who can use it, and not stop prematurely. The traditional division and thinking by healthcare professionals are challenged, if all patients should be helped.

5.5. Paper session on Integrated Care for the elderly in Germany

14.00 - Dental care in geriatric patients - a cross-sectorial service


Purpose: Evaluation of a customer-designed dental service network across the service sectors for geriatric patients.

Context: The lack in accessibility of dental services and the non-awareness of possible dental causes to medical problems by clinicians often prevents the geriatric patient from receiving the dental care needed. In cooperation with the Dental Board a geriatric dentist was appointed, multiprofessional rounds, training in oral hygiene organized and a documentation system for cross-references to other medical conditions and the nutritional status implemented.

Data Source: The scientific evaluation of >280 geriatric dental patients from 2009 to 2009 (22 with original teeth, 260 with dentures, 88 with denture problems, 32 with other affections).

Case description: Upon admission patients are screened for dental problems. Possible problems are seen by the specially trained geriatric dentist. The patient’s dental problems are photo-documented and than cross-referenced to his overall medical condition in a common
documentation sheet for an overview of possible dental causes, the nutritional situation or other conditions.

Conclusion and Discussion: The integration of a special geriatric dental service, using competence from across the sectors of medical care lead to an improved level of dental care and oral hygiene in the geriatric patients and better inter-professional understanding.

5.6. Paper session on Integrated Care for the elderly in Holland

14.00-'Thuis Voelen’ A guide written for family and nursing home; companions to accomplish worthy care. Practical lessons.

Hetti Willemse Executive director, Senior advisor and Tineke van den Klinkenberg, advisor, associate Publicarea, Amsterdam, The Netherlands

Introduction: How does the care for older people maintain of good quality, according to their needs, while still fundable? Looking at the most vulnerable group of older people with dementia, for which family and friends represent past, present and future, adjustments need to be made. Family, nurses and organization all acknowledge that nursing home care will benefit when these three parties unite their forces as partners in care.

Aims: ‘Thuis Voelen’ is a guide filled with practical suggestions to accomplish a valuable partnership between family, nurses and organization. Loosely structured conversations between these three parties aim to establish reciprocity and trust and finally to end up with a number of incentives, which concern family as well as employees and range from the moment of intake until the phase of saying goodbye. Advises in the area of architecture, furnishing, public space, human resources and ICT are provided as well.

Results: A nursing home creates its own ‘worthy care agenda,’ to accomplish small, practicable changes. Resulting in:
- a changing (physical) environment; the family enjoys visiting the nursing home and stays longer, nurses enjoy their work environment more and feel relieved.
- more mutual complicity and responsibility in wanting to improve the quality of life of elderly together.

Conclusions: ‘Thuis Voelen’ is an example of how small scale innovations, new ideas and simple things that matter can establish an improvement of the situation in nursing homes. Within an open-minded organization, family is thought of as valuable. Any moment an inhabitant and/or his relatives are satisfied and happy, will have a positive effect on the (culture in) organization; time and money will be spared.
14.45- The association between chronic care management activities and the quality of thrombosis care.
H.W. Drewes et al, Tilburg University, Tranzo, Tilburg, The Netherlands

Introduction: The oral anticoagulant therapy (OAT), used to prevent thrombosis, is associated with substantial avoidable hospitalization.

Aim: Identify the associations between chronic care management and the quality of OAT as suggested by the chronic care model (CCM) of Wagner.

Methods: Regression analysis with data of 61 thrombosis clinics and inductive analysis with 63 interviews with health care professionals of 23 thrombosis clinics.

Results: Results show substantial differences between regions in the quality of thrombosis care and the CCM activities. However, the variation in quality of care was not associated with the differences in CCM activities. The inductive analysis indicates that there are problems in the cooperation between caregivers. Several preferred CCM activities (e.g. multidisciplinary protocol) as well as the barriers to implement these activities (e.g. conflicting interests) were put forward by the health care professionals.

Conclusion: It can be concluded that there is variation in quality of thrombosis care between regions. This variation could not be explained by the observed differences in CCM activities. However, fragmentation is a major source of inefficiency according to health care professionals. The paper concludes with suggestions to improve chronic care management for thrombosis.
Posters

Denmark

Integrating innovation across organizational boundaries: lessons from a telehomecare project.

Birthe Dinesen, Assistant Professor, PhD, Master in Administration Department of Health Science and Technology, Aalborg University

Purpose: To explore how innovation is integrated across organizations when numerous public and private partners work together in a telehomecare project for patients with chronic obstructive pulmonary disease (COPD).

Theory: Inter-organisational theory and theories of user-driven innovations.

Methods: The case study approach was applied. The data included documentary materials, participant observation, qualitative interviews with healthcare professionals (n=24) and interviews with private health care firms (n= 5).

Findings: Across political levels, professions and sectors, GP’s, district nurses, staff at a healthcare centre and from a hospital have worked with private software and hardware companies to develop new preventive care and treatment concepts for COPD patients using telehomecare technologies. The parties have developed new forms of collaboration, improved coordination of patient care processes, and adapted new approaches for empowering COPD patients doing rehabilitation in their homes.

Discussion and conclusion: Innovation in the healthcare field across organizations is a set of complex and competing development processes. We need to alter our view of innovation. Instead of viewing innovation as a single process controlled by one organization, we should regard it as a set of multiple processes in an interorganizational field. New technologies seem to have the potential to challenge “traditional stalemate situations between consolidated silos” and create more rapid innovation, leading to new integrated forms of practice and interaction between healthcare professionals and COPD patients.

Medication between technology, clinicians and patients. - How is medication safety done, with which possibilities and problems – a refiguration of problem spaces for quality improvement.

Anne Hatting, Ph.D., Postdoc. Institute for Design of Organizational IT. IT-University of Copenhagen. Denmark

Purpose: The aim of this paper is to present results from ethnographic field studies aimed at investigating how ‘medication safety is done in practice’. The field is hospitals and primary care, environments where standard technologies for patient safety are continually implemented. Focus is the older patients, who are often crossing the boundaries in the healthcare sector.

Theory: the paper draws on theories of Social Anthropology and theories of Knowledge in Organizations.

Methods: the paper is based on data from ethnographic field studies in hospitals and primary care in Denmark.
Results and conclusions: ethnographic case stories of ‘safe medication practices’, and ideas for refiguration of problem spaces for safety and quality improvement

Discussion: There seems to be a ruling discourse of how to do, in order to improve safety for patients. At the same time there also seems to be some problems as far as implementation of the systems concerns. Through refiguring of the problem spaces this paper discusses the theories of quality improvement grounded in systems thinking and suggests new ways of thinking.
Finland

Improving health services for European citizens with dementia: Development of best practice strategies for the transition from formal professional public home care to institutional long-term care facilities (RightTimePlaceCare)

Helena Leino-Kilpi (for the Consortium), PhD, Professor, RN, University of Turku, Finland, Jaana Koskenniemi, MnSc, RN, researcher, University of Turku, Finland and Gabriele Meyer (Coordinator), Professor, University of Witten/Herdecke, Germany

Introduction: Given the increasing number of patients/consumers with dementia, action is required to prepares European health care services to deliver cost-effective high quality dementia long-term care. RightTimePlaceCare aims to develop best practice strategies for need-tailored dementia care throughout care sectors. Eight countries are involved in the Consortium: Finland, Estonia, France, UK, Spain, Sweden, Netherlands, Germany (coordinator, University of Witten/Herdecke).

Theory and methods: There are six work packages in 2010-2013. These include description and analysis of the European health, social care and welfare systems, advocacy and informal caregiver support systems for patients/consumers with dementia and intersectorial communication. A survey will assess factors influencing the time of admission to long-term institutional nursing care facilities, investigate living conditions and gather clinical data of patients/consumers and their informal caregivers in long-term formal professional home care and institutional nursing care facilities, and the related economic impact.

Results: Best practice strategies and models will be developed according to written documents and survey with delphi metod for intersectoral arrangements and long-term care facilities.

Conclusion: RightTimePlaceCare will empower the policy/decision makers to manage and reform dementia health care systems.

Discussion: RightTimePlaceCare will advance the state of the art in health systems research in dementia care and will improve cooperation between researchers to promote integration and excellence of European dementia care research.

Implementation of a Regional Health Information Exchange - The Preliminary Results of Outcomes in one Hospital District

Tiina Mäenpää, PhD student, University of Tampere, Department of Nursing Science, MNSc, Research Assistant, Satakunta Hospital District, Finland, et al

Purpose: The purpose of this study was to describe how regional health information exchange (HIE) has influenced healthcare delivery by investigating particular outcomes.

Theory: The development of regional HIE among healthcare organisations should improve the coordination of care and information among hospitals, health centres, physician offices, and other ambulatory care providers. Regional HIE improves laboratory and radiology data access, it could decrease the number of laboratory and radiographic tests, and reduce redundant and duplicate examinations. HIE improves communication between providers as well as public health service information processing, and could reduce emergency room visits, re-appointments and admissions for observation.
Methods: The research material consisted of viewed referrals, the utilization rate of regional health information systems (RHIS), and selected outcomes such as laboratory and radiology tests and appointments in 2004 - 2008. The analysis was based on a descriptive statistics trend analysis.

Results: The preliminary results of the selected outcomes indicate that laboratory tests mainly seem to have increased in municipal health centres. Reviews of the other preliminary results of outcomes, radiographic tests and clinician appointments, indicate a reduction in the number of tests and appointments in the member municipalities of one hospital district in 2004 - 2008.

Discussion: It is essential to investigate extensively and in the long term the impacts of HIE on healthcare delivery in the health centres of member municipalities. HIE also allows tighter integration of public health information flows within clinical information flows.

The continuity of care: the perceptions of patients, nurses and doctors
Marja Renholm., MNSc, RN, PhD-candidate University of Turku, Nursing Director, Hospital District of Helsinki and Uusimaa et al

Introduction: The continuity of care is improved by the use of critical pathways. A critical pathway is a method for the patient-care management of well-defined group of patients for a well-defined period of time (1). The use of critical pathways has a positive impact on outcomes, such as increased quality of care and patient satisfaction, improved continuity of information, and improved patient education (2). The overall purpose of critical pathways is to improve outcome by providing mechanism to coordinate care and reduce fragmentation (3). The critical pathway consists of following parts: first visit to a health care professional (after getting first symptoms of the sickness), diagnosis, and waiting for an operation and preoperative visit to day surgical unit, operation day, home care and post operative check up.

Purpose: The purpose of this study is to analyze and compare the perceptions of day surgery patients (n=400) and nurses (n=120) and doctors (n=60) about the realisation of continuity of care in day surgical patient’s critical pathway. The operations the patients underwent were either laparoscopic cholecystectomy or hernia operation. Patients undergoing laparoscopic cholecystectomy or inguinal hernia operations are ideal candidates for a critical pathway, as it is a standardized, common, and elective procedure and most patients have a predictable clinical course.

Methods: The questionnaire was developed for this study. It consisted of 24 background factors and 41 likert scale items. The items were arranged on a five-point Likert-Scale (1= strongly disagree, 5= strongly agree). Important factors in continuity of care are divided in the questionnaire to four different categories: time flow, co-ordination flow, caring relationship flow and information flow. The data is analysed statistically using SPSS software.
Good practices in services for older people
Sirpa Andersson D.Soc.Sc., Senior Researcher, National Institute for Health and Welfare

This presentation reveals good practices in services for older people. At the end of 2009, there were altogether nine good practices under this theme published on THL’s Good Practice website (www.sosiaaliportti.fi/en-GB/goodpractice). A good practice refers to an established way of acting or method of working within the field of social welfare and health care that is functional, ethically acceptable and effective in its specific context and evaluated to achieve good outcomes for the client. A good practice is always based on versatile knowledge on the effectiveness and/or functionality of the practice.

A good practice is described so as to give the reader a sufficiently clear and detailed picture of the practice. The description should also be sufficiently general, to make it applicable in more than one context. With the description, the reader is able to assess what kind of knowledge its practical effectiveness is derived from and whether this knowledge is incomplete in some respects.

Data and methods: The material consists of nine descriptions of good practices under the ‘services for older people’ theme, which have been published on THL’s website for good practices. The descriptions cover practices of services for people with memory problems, housing services, early support and rehabilitative work approaches. Four of these practices are municipal good practices and five are organisational good practices. The descriptions are often written by regional associations for dementia care.

I will integrate the descriptions into a synthesis, so as to define the principles and elements of services for older people.

Good practices come from good interaction: The described good practices show the interaction that underlies good practice theory. The interactive process starts with development work undertaken by a national organisation, and continues with reporting, research and experimentation. The second level comprises local associations, which gain access to the results of the development project, apply the results to their own units, and create their own good practice. The application, implementation and evaluation of the practice benefits from the participation of, for example, staff, group-home residents and family members of people with memory problems.

The descriptions of municipal practices bring up home care and discharging. Transferring to home care is typically a situation where information flow is of great importance.

Assessing good practice: The assessment of a good practice aims to indicate the effects, benefits and positive results of the practice, or what kind of knowledge the assessment is based on. The assessment can provide knowledge from multiple perspectives and voices, by professionals, clients or researchers.

Conclusions
After a description of a good practice has been published on the website, it is still quite “silent”. This is where information flow, experimentation and interactive learning come into the picture. One of the forums that can be used here is learning networks of good practices.
Services for families with children and integration of services
Marja-Leena Perälä PhD, RN, Research Professor, National Institute for Health and Welfare et al

Background: Despite improvements during the past decades in Finland, inequalities in health and wellbeing have increased among children. The spiral of inequality can often start even before birth. The worst situations can be for children whose families are experiencing financial difficulty in addition to other psychosocial risk factors, such as a narrowed social support network, problems in human relations, drug dependency and depression. Further, the diversity of the family structures has increased the complexity of families' daily life. We aim to study the whole system of services for children and their families, including services for multicultural and drug dependence families. The main focus is going to be on services provided to families by parental and child welfare clinics, school health care, day care, preschool education and schools, including the horizontal operational integration (between authorities, sectors, service providers) of those services (liaison structures, forms and content). Moreover, we will study the interfaces between specialized health and social services.

Aim: This study focuses on the present state of services in the fields of municipal health care, social care and education/training for families. Questions are (a) what services do the families need and use and which factors are connected to those, (b) how does cooperation work between service providers, particularly in the transitional phases related to a child’s life (from maternity clinic to child welfare clinic client and starting of day care or preschool or school), (c) what services or cooperation interventions are needed and what are available and (d) how well-designed is the functional integration (liaison structures, forms and content) of the service providers (between the authorities, sectors, service providers, and occupational groups)

Methods and conclusions: Data will be collected with nationwide surveys targeted at families (family survey), at service providers (employee survey) and from the sphere of authority managers (manager survey). (a) The family survey would be targeted at fathers and mothers who have children aged 0–8 years. The questionnaire will also include space for children’s own assessment of services. In addition, the data will be supplemented by interviews of families experiencing drug dependence. (b) The employee survey will be targeted at employees' immediate superior working in child welfare clinics, school health care, day care, preschool education and school. (c) A manager survey will be aimed at managers. Data are to be collected in 2009 and preliminary results will be presented in the conference.

Conclusions: This study produces information for decision-makers about services for children and for families from several viewpoints, including education and children's own impressions, which have not been studied previously. Nationwide surveys can be used as the baseline assessments of many interventions, and be repeated when necessary.
France

Analysis of the continuity of services from the viewpoint of clinical files in the perspective of quality improvement
Louise Belzile and Yves Couturier

Purpose: According to the most recent conceptual model, the continuity of services is increasingly recognized as a robust quality indicator. However, while many authors estimate that clinical files are, in principle, good observatories of continuity; very few have studied continuity from the files’ viewpoint.

Theory: Global continuity comprises three dimensions, i.e. informational continuity, management continuity and relational continuity. These three forms of continuity can be observed in clinical files by identifying continuity moments and events.

Methods: In the context of a larger embedded case study, we analyzed twenty-one clinical cases, equally distributed in three different integrated care networks, of users followed by case managers. Their content was decorticated using a validated clinical information extractor and then transposed to a temporal line allowing a sequential identification of continuity moments and events.

Results and conclusions: The clinical files allow a better understanding of the specific deployment patterns of the three types of continuity which appear to be dependant of the different contexts’ tools and norms of completion of the files.

Practices of writing integration from the viewpoint of clinical files in the context of implementation of PRISMA-France
Louise Belzile, Émilie Rousseau-Tremblay, Yves Couturier, Dominique Gagnon and Dominique Somme

Purpose: This communication aim to understand the adaptation of an integrated care model from the practices of writing clinical files by new case managers.

Theory: According to a socio-linguistic approach, the translation of an innovative model in clinical files is a very good indicator of the adoption by users of this innovation. It’s offer a direct access to the semantic space of practitioners.

Methods: In the context of a case study of a pilot-project (PRISMA-France), we analyzed the first twenty-two clinical files wrote by six new case managers in two different sites. With a socio-linguistic method of content analysis, we identified the way they present to their partners the six components of the PRISMA model.

Results and conclusions: The clinical files allow an original and interesting viewpoint for best comprehension of the specific deployment patterns of the components. We saw how case manager construct the integration as a specialized set of professional practices dedicated for very complex clinical cases.
Mexico

Integrated Health Care Model for adult in Mexico.
Pérez-Hernández G. Metropolitan Autonomous University, Mexico City, Mexico.et al

Purpose: To describe and analyze the implementation process of an Integrated Health Care Model in Mexico.

Context: Mexico faces a demographic and epidemiologic transition and the challenge to provide health care to more than 50 million people population on chronic and aging diseases, infectious diseases and mental health. The current model of acute-care centered provision of healthcare has to transform as Integrated Health Care Model which is offering new services and developing linkages to cater for the health needs. The model is centered on high causes of mortality and morbidity focus in primary mental health services, aging health care, primary care for chronic diseases, prevention and primary care of HIV and other infectious diseases.

Data Sources: National Health Program of Mexican Government 2006-2012.

Case description: Development of Integrated National Health Services.

Conclusions: Integrated health care model is an innovative model in Latin America, represents an opportunity for all healthcare team to work together towards to improving the state of health and healthcare for adult patients in a context of developing country.

Discussion: Implementation of an integrated model and challenges in clinical and social context, implications related to human resources for health.
Traces of Integrated Care – can we find them in referral and discharge letters within mental health care in Norway?

Hartveit, Miriam (RN, MSc) 1. Research Network on Integrated Health Care in Western Norway, Valen Hospital, Helse Fonna HF, Norway

Purpose: The aim of the study is to investigate how and to what extent referral and discharge letters serve as tools for planning and integrating mental health care services.

Theory: Referral and discharge letters are the most common communication tools between community and specialist services in mental health care [1, 2]. However, there is almost no knowledge about whether and how these letters reflect the integration of care interventions.

Method: Fifty consecutive referral- and 50 discharge letters drawn retrospectively from the electronic patient record system of a public specialist mental health service, representing a total population of 165,000 at the Western coast of Norway, were analyzed. These documents were screened with regard to whether or not they contain information about integration of health care planning and interventions. Theory driven predefined codes were used to analyze the documents.

Results and conclusions: Out of 50 referral- and 50 discharge letters, the existence of a plan for the integrated care was mentioned in only three referral letters, and in none of the discharge letters. Four discharge letters contained some information about interventions planned in case of relapse, and four information on socio-economic interventions made. Thirteen referral letters gave information about other public services involved in the care. In conclusion, this inspection of referral and discharge letters shows few signs of comprehensive planning and integration in mental health care. Further research is needed on the quality of these letters, its impact on the care, and how it could be enhanced.
Singapore

Characteristics of elderly patients receiving care coordination: The role of telephonic review and home visit.
Amir Amran

Introduction: In Singapore, care coordination and transitional care nursing is a new concept of care nevertheless important but unexplored.

Aim: To explore the characteristics of elderly patients receiving care coordination, determine care gaps and intervention during home visit and telephonic review.

Research Design: A designed questionnaire was used to collect information on the patient’s demography, social and clinical profile and determine post discharge activities using Eric Coleman’s Four Pillars tool. The retrospective data from the patient’s index admission was analyzed using SPSS version 16.

Result: Total of 1011 patients was recruited in 2009, 69% were above 70 years of which 55% were female and 76% lives with their children. Clinical information demonstrates that 67% had 1-3 co-morbidities and 23% had more than 4 co-morbidities with 10% had none. Approximately 58% were taking more than five medications, 35% have an Abbreviated Mental Test score of 6 and below, 6% were depressed and delirium was present in 14% of patients. About 36% had home visits and telephonic review done whilst 64% of the remaining had only telephonic review done.

Conclusion: This study demonstrate the vital role of home visit for elderly patient to safely transit between hospital to home.

Improving transitional care needs: Predicting risk factors for readmission using the HARP tool in a teaching hospital in Singapore
Kan Hongqing, abstract will be presented by Amran Amir

Aim: To identify the readmission risk factors of the elderly patients aged above 65 using the Hospital Admission Risk Profile (HARP).

Introduction: Elderly patients have high readmission rate due to their complex medical needs. Aimed to coordinate the transition of patient from hospital to the community, a project called Aged Care Transition (ACTION) commenced in June 2008.

Methods: A questionnaire was used to collect data on patient profile and clinical condition. All patients under CC service had their risk stratified using the HARP tool.

Results: Total of 160 patients were recruited, 28% (n=44) aged more than 84; 85% (n=136) had functional decline; 67% (n=107) required rehab. About 71% (n=113) patients’ Instrumental Activity of Daily Living (IADL) was 0-5; 54% (n=87) had normal Abbreviated Mental Test (AMT) score of 7-10; 61% (n=97) patients’ Mini Mental Serial Examination (MMSE) was 0-14. There were 46% (n=74) of patients were self caring prior to admission, 45% (n=72) had a full time carer. About 56% (n=90) had 1-3 co-morbidities, 78% (n=124) had 2 to 3 care issues requiring Care Coordinator (CC) intervention. History of previous admission within 30 days were present in 10% (n=16) of subjects. Using HARP
tool, 41% (n=65) patients had high risk of readmission of which 25% (n=16) and 15% (n=10) were readmitted within 30 and 15 days post discharge respectively.

Conclusion: The use of the HARP tool have helped the team to identify patients at risk for readmission, hence activity like home visits and referral to community care services can be rendered to reduce readmission to hospital.
Spain

Risk stratification models: validation and development at the basque health system
Itziar Vergara Micheltorena, MD, MPH, Project Management and Methodological Support Basque Foundation for Innovation and Health Research, Pza Asua 1, 48150 Sondika, Bizkaia et al

Introduction: The needs of people suffering chronic diseases and comorbidity are poorly answered through most of the acute-oriented health care provision systems. To provide appropriate care to this population, the Health Department of the Basque Government is developing a comprehensive strategy for people living with multiple chronic conditions. The characterization of patients in disease burden level groups, and the identification of those with complex needs, is a necessary step for the implementation of management programs.

Purpose: The project’s objectives are to study the predictive ability, in our milieu, of several models based on different case mix systems to prospectively identify people that will require very high medical resources use, and to determine the potential improvement in the predictive validity produced by adding to the models additional socioeconomic variables.

Method: We will carry out a cross-sectional study with data pertaining to two 12 month consecutive time periods. Predictive models based on the data of the first period (age, sex, deprivation area index, clinical diagnosis, procedures and pharmaceutical prescriptions) will be constructed to predict the medical resources use (medical services, hospitalizations and expenditures) during the second period. Predictive models will be estimated by using multilevel regression analysis, considering the hierarchical structure of the data (patients, physicians, and health center). The predictive ability of the models will be compared by means of receiver operating curve (ROC) analysis.

Results: This research group started working in October 2009. Preliminary results are expected by June 2010 and will be presented at the INIC 10 Conference.
The Netherlands

“Organisation of Emergency Obstetric Care in the Netherlands”
J. de Borst, MSc, T.A. Wiegers, PhD, NIVEL, Netherlands Institute for Health Services Research

Purpose: The purpose of this study is to gain more insight into the organisation and regional differences of emergency obstetric care in the Netherlands, focusing on transportation, responsibilities concerning the transfer of care and communication between different caregivers. The cooperation in emergency obstetric care between midwives and other caregivers i.e. GP’s, ambulance personnel and caregivers on obstetric hospital wards is being researched. The aim of this research is to contribute to the improvement of evidence-based best practice in emergency obstetric care by means of presenting recommendations.

Theory: Cooperation in emergency obstetric care is of uttermost importance in improving the care process and outcome.

Methods: Qualitative data of the current organisation of emergency obstetric care, including experiences of caregivers, was collected through 21 face-to-face, semi-structured interviews. Based on the qualitative data questionnaires for a quantitative survey were developed. These questionnaires were sent to caregivers and clients.

Results and conclusions: The results of the qualitative data collection are being processed, the results of the quantitative data-analyses of the caregivers are expected in May 2010 while the results of the clients questionnaires are expected in July 2010.

Can we help? The role of the Healthcare Inspectorate in the implementation of integrated care
Corry Ketelaars Phd, RN, Senior Inspector integrated care Dutch Health Care Inspectorate and
Wieny Tietema Msm. RN. Dutch Health Care Inspectorate

Purpose: The implementation of integrated care faces many obstacles. The Healthcare Inspectorate can speed up the process of implementation.

Context: While it is now widely accepted that a strong primary healthcare system can help to improve coordination in healthcare, the Dutch system has recently begun to move in this direction. In 2008 the Ministry of Health introduced policy reforms and enabled integrated care programs combined with an integrated payment system.

Case description: Implementation of integrated care programs for diabetic patient groups, cardiovascular risk management and COPD has started throughout the country, but many hurdles have yet to be overcome. Though it goes without saying that responsibility lies with healthcare providers to deliver high quality and safe care, in the Netherlands we also recognize the benefit and necessity of external supervision.

The instruments of the inspectorate are: advice, stimulation, urges and (if necessary) coercion enforced by law. The aim is to discover the best practices and use them as good examples for others. The Healthcare Inspectorate in the Netherlands is about to face changes due to the introduction of integrated care. Hospitals, general practitioners and preventive care will no longer be supervised separately. In the future the focus will also be on the supervision of patient groups such as COPD and diabetes, and on the quality of chain care.
Conclusions: The implementation of integrated care means that many obstacles should be adequately overcome. The Inspectorate may prove to be helpful in this implementation process.

Discussion: Integrated care requires integrated supervision. The challenge for the Inspectorate is to transform the supervision process and use effective supervision methods such as advice and stimulation. Publishing the inspection results may speed up the process of implementation.

**Telemonitoring of home infusion technology**  
*Sonja Jutte, ZorgBrug, Gouda, The Netherlands*

Background: The specialized registered nurses working in the technologic homecare team of our organization are highly qualified in technical nursing. One component of their job is the intravenous administration of medication to patients in their own home by using an infusion pump. In a hospital setting you can ask a colleague nurse to check the installation of the pump and the dose of medication. In the home situation of a patient this is not possible. The Inspection for Healthcare in the Netherlands has mentioned this problem in a report about home infusion technology, for the absence of a double check means a higher risk of making mistakes. This was a motivation to look for a safe solution for this problem by using telemonitoring.

Method: To conceive this method we found an enthusiastic technical installation company (Focus Cura) to develop a portable telemonitoring device which can film and record. The device allows a colleague to receive the recorded pictures simultaneously while at another location. After editing a list of requirements made together with the team of specialized nurses, Focus Cura made the first prototype of a portable suitcase with all the equipment.

Result: The result is a portable suitcase with a camera that makes high quality video images, which are sent by a safe and protected connection to the notebook of a colleague at another location in the region. We have developed a protocol which describes the use of telemonitoring to aid home infusion technology.

Conclusion: Thus, specialized nurses working in an area of about 100km (62 miles) can reach each other in order of a safe double-check. A simple method which improves the safety of the patient and professional.
Integrated hospital care with primary care for patients with atopic dermatitis or food allergy by an online program on self-management
Harmieke van Os-Medendorp PhD, UMC Utrecht, department of dermatology and allergology, Utrecht, the Netherlands et al.

Introduction: Self-management is a key-issue in the treatment of patients with chronic diseases. In the Netherlands, most patients with atopic dermatitis and/or food allergy are treated in primary care. At the moment, additional care in self-management for these patients is mostly offered only in hospitals. Therefore a lot of patients do not receive state-of-the-art support in self-management. The purpose of this project is to integrate state-of-the-art support, as given in the hospital, in primary care by an online self-management program for adults and parents of children with atopic dermatitis and/or food allergy.

Description of care: The UMC Utrecht is developing two online self-management programs for adults and parents of children with atopic dermatitis or food allergy. Patients can follow the program while being treated by a general practitioner. The programs are aimed to improve competencies and knowledge of the patient. Information, instruction films, experiences of other patients and practical exercises with tailored feedback online by specialized nurses (in collaboration with dermatologists-allergologists) are included. The programs will be integrated into the Digital Eczema Centre Utrecht. The patient as well as the general practitioner will have access to this centre, which facilitates online multidisciplinary collaboration and e-consultation.

Conclusion and discussion: E-learning and e-consultation may improve integrated care between the primary care and hospital medical care and treatment. Further research is needed to evaluate the efficiency of this form of integrated care.

Treatment of Heart Failure at Home.
Erna Vrijland, Nurse Practitioner and Jaap Brienen, General Practitioner, Gezondheidscentra Delft and Rotterdam University

An alternative for treatment and control of patients aged 80 years and more suffering from heart failure.
It is known that a substantial proportion the elderly suffer from heart failure. Patients of advanced age do prefer to be treated at home. They find it a burden to go the hospital and being examined. At the same time it is known that treatment for heart failure in this advanced age is more difficult and less evidence based as in younger years.

A nurse practitioner working for the family practice examined and controlled 63 elderly over 80 at home by visiting them and controlling them with a limited number of examinations.

We saw them every three months and controlled weight, blood pressure, condition, shortness of breath, edema of the ankles, enlargement of the liver, BNP, Hb, Creatinine. If necessary we controlled diet, and changed medication.

It was able to stabilize the condition and to prevent hospital admission. The quality of life was improved, the satisfaction of the patients much better and the mortality of heart failure minimized. In this way we were able to give an alternative to hospital heart failure policlinics for a group of elderly, who are not easy movable any more.
Explaining processes of collaboration between agriculture and care

Jan Hassink, Researcher Agriculture and Care, Plant Research International Wageningen University and Research Center

We developed a framework that is helpful in understanding the development and success or failure of different types of initiatives for care farming. We identified three types of initiatives: a) development of a care farm in addition to traditional (agricultural) farming; b) regional foundations of care farmers; and c) care institutions collaborating with a group of farmers at regional level.

Care farming constitutes a novel practice or a change in existing practices that demand structural change. The dynamic interplay between agency and structure at different scales appears at the centre of understanding the development of initiatives. We combine insights from transition theory, entrepreneurship and social movement theory to deepen the understanding of agency and structure aspects. We explore how an integration between concepts from these fields is helpful in understanding how care farming initiatives develop and the unfolding of a new sector bringing together the care and farming domains. Earlier studies concluded that competent and committed entrepreneurs are a decisive factor in most initiatives. Our analysis helps to uncover those features of entrepreneurship that are most crucial for promoting a system innovation towards care farming. The relative importance of factors differs between the different types of initiatives and local and regional level.
United Kingdom

Theoretical Determinants of Integrated Primary Health Care
Dr. Gloria Ansa, Prof. John Walley, Dr. Xiaolin Wei and Dr. Kamran Siddiqi, Nuffield Centre for International Health and Development, University of Leeds, England

Introduction: Primary health care (PHC) means essential health care made accessible through health systems. However health systems mostly provide specialised curative care and fragmented services. Integration seeks to address this, making access to comprehensive and continuous care a reality. This paper identifies concepts underlying integration, and their influence on integration in health.

Theory: Integration improves efficiency and effectiveness, and in health care provides access to complete and comprehensive care. Change has a context, content and process, reflecting the complexity and interdependence of organisational components. This demonstrates that successful change results from an interaction between the content, context and process. Change management is about formulating an intervention with respect to the context of change, and making it work through effective implementation.

Discussion: Integration is an initiative used to change the process of care through management of the context of integration and the interventions. Change management in integrated health services delivery is therefore about the formulation and implementation of interventions in order to change the care process. Integration of PHC can be achieved through analysis of operational issues, and factors arising from stakeholders.

Conclusion: PHC can be successfully integrated only if forces for and against integration are addressed through change management.
Preconference Seminar for Postgraduate Students

In order to give special emphasis on training and education in integrated care research the National Institute for Health and Welfare, University of Tampere (Department of Social Work Research and Tampere School of Public Health) and International Network of Integrated Care will organise a one-day seminar for young researchers and postgraduate students to present their research projects.

The day will be divided into two parts, lectures and paper presentations. The lectures are given by Representatives of International Network for Integrated organization, Professor Juhani Lehto Tampere School of Public Health: Relationship between system level and individual level in integration, Senior Lecturer Anna Metteri, Boundary spanning.

Programme
9. 15 - 9.30 Welcome - Professor Kirsi Juhila
9.30 - 10.15 Professor Juhani Lehto: Borderline between social services and health care
10.15 - 10.30 Break
10.30 - 11.15 Senior Lecturer Anna Metteri: Boundary spanning
11.30 - 12.30 Lunch - Juvenes
12.45 - 13.15 PhD Student Hannu Kauppi: A good working career as a shared objective of a career related services chain
13.15 - 14.30 PhD Student Kaisa-Elina Hotari: Co-clientship of child protection and youth psychiatry
14.30 - 14.45 Break
14.45 - 15.30 Professor Guus Schrijvers: Concluding remarks
1. Primary health care

Excellent care in the spirit of Hatanpaa

General
Hatanpaa Hospital is a specialized acute care Unit of Tampere City Healthcare services. The hospital has 239 beds and employs 600 persons, out of which 86 are doctors. It is situated by the lake Pyhajarvi and surrounded by a garden offering a view of natural beauty. The connections to the city centre are extremely good.

We provide outpatient services, surgical services and inpatient care. Supporting services include fully digitalised medical imaging services, anaesthesia services and medical instrument maintenance services.

Outpatient Care
Outpatient Clinic offers wide range of services for patients that do not require hospitalization. The patients come in with referral. The specialties we cover are: gastroenterology, orthopaedics, urology, internal medicine (cardiology), gynaecology, otorhinolaryngology, rheumatology, Physical and Rehabilitation Medicine, Dermatology and Allergology. Our medical staff is competent, enthusiastic and open-minded while serving customers.

Surgical Care
Surgical services are either given in day surgery or in main operation theatres. We are specialized especially in scopic surgery in gastroenterology, orthopaedics and urology. Our goal is to minimize the time patient has to stay in hospital. That is why we have modern and independent day surgery. It operates fast and efficiently without compromising quality of care, patient safety and customer satisfaction.

In the operation theatres we treat breast cancer among other things. The patients are transported to recovery after operation and further to inpatient care in order to be rehabilitated home.

Inpatient care
Inpatient care is provided to patients who remain in the hospital before, during, and after receiving medical services at Hatanpaa hospital. The wards are under renovation. They have been planned in cooperation with medical staff thus guaranteeing satisfactory work place for employees and comfortable stay for patients. We have internal medicine wards, surgical wards and wards for infectious diseases. Our goal is to rehabilitate patients fast and prevent institutionalization for example by giving physical therapy.

Acute home care
Whenever home is the most convenient place for acute care, we provide staff and resources for that. We can offer several treatments such as IV antibiotic care, wound care, pain care, IV nutrition, fistula care and enteral nutrition. In addition we can take care of postoperative surgical patients and those suffering from congestive heart failure. Diabetics, post stroke patients and chronic obstructive lung disease and asthma patients are served as well. Acute home care is not intended for patients, who does not want home care or do not require acute medical care.
Supporting services

Imaging services
We offer an extensive array of fully digitalised imaging services, starting from breast cancer screening up to MRI diagnostics, including CT scanning, too. Images are available at the point of care whenever needed. We use RIS, MIS and PACS systems for streamlining our workflow.

Anaesthesia Services
Anaesthesia services provides general and regional anaesthetics for a large variety of surgical procedures. The unit supplies also postoperative and chronic pain management. In addition, anaesthesia department takes care of emergency services including resuscitations inside the hospital and consultations of the critical situations on the ward. Co-operation with internists includes mainly giving general anaesthesia for the arrhythmic patients. Anaesthetists also take care of the patients in the acute postoperative ward after major operative procedures.

Instrument Maintenance Services
The Department of Instrument Maintenance provides cleaning, disinfection and sterilisation services for instruments used at Hatanpaa Hospital for patient care.

Social services
Social workers inform and advice patients about social services and social security issues. They can also give practical assistance for patients if needed. In co-operation with ward personnel social workers evaluate patients need for facilities and services in daily life. They coordinate and arrange home care services in collaboration with municipal home care department, private and informal sector. In addition social workers can provide psychosocial support to patient with acute, chronic or terminal illness, not forgetting relatives.

2. Social services in Tampere

Adult social work in Social Welfare office
In Finland, social care and customer’s rights are defined, among other things, be The law of welfare and The law of client’s status and rights. Law requires municipalities to arrange the necessary social services.

In Tampere, municipal social work is organized in two ways: office of Adult social service and three offices of Family social services. Social work office for families gives comprehensive support for families with children.

Adult social work
Social worker leads the process of clients including individual and activation plans, counselling, motivation and activation. In addition, it includes client’s advocacy, structural social work and inform service needs. Social work with clients who have drug addiction or mental health problems is part of the special social work. Social worker can also make the decision of income support.

Clients in adult social services are 18 years old and over, who lives alone or childless couples. Social work is planned and rehabilitative work. In co-operation with the client, social worker makes an individual plan. The plan includes client’s history of education, work and possible rehabilitations. They make together a plan how to go on and what kind of services the client needs and where to start. Social worker has knowledge about different kinds of services for example rehabilitation, education and work practice. When needed, social worker can send the client to special services.
In social welfare office client can also get service and support from social counsellor. Social counsellor work is based on the individual plan made with the social worker. Social counsellor is in contact with the client weekly.

**Income Support and Social Work - Sarvis Social Welfare Office and Department of Benefit Assessment**

**Welfare and Social Security**
A central feature of welfare and social security is to provide support to people in vulnerable situations. The aim of statutory social insurance in Finland is to safeguard people's income in a range of eventualities: having children, old age, work incapacity, sickness, unemployment and in the event of financial loss due to the death of the family provider. Social insurance income security includes health insurance, unemployment insurance, accident insurance and pension insurance.

Social insurance benefits in Finland fall into two categories: earnings related benefits and minimum benefits. Income support is a last resort for individuals and families who have no other means of income.

**Income Support**
The income support is a last-resort measure in financial support. It is intended for situations whereby the applicant, her/his family's income or property is not sufficient to cover necessary daily expenses.

The income support can be granted to a municipal resident who is in need of assistance and cannot receive income from work, enterprise activities, benefits insuring income, property or from other earnings.

Before granting the income support, it is necessary to clarify the applicant's and his/her family's possibility to obtain income from other sources, most especially from the labour market and enterprise activities. Benefits such as old-age pension, unemployment allowance, sickness allowance, family allowance (child benefit), housing allowance and study grant are the primary benefits. Clients have to fill in application form and present all necessary additional documents.

The right to receive the income support is obtained by adding together an applicant's or his/her family's basic and other expenses, which are taken into account in the remaining part. The basic part includes expenses such as food and clothing as well as minor health care cost. The amount of the basic part varies according to the size of the family and the age of underage children in guardianship. In the remaining part, for example electricity bills and day care fees for the children are taken into account.

The decision on the minimum income support is always made in writing, and it is generally posted to the client. The decision is based on The Act on Social Assistance. The granted income support is transferred into the client's bank account. In case of dissatisfaction concerning the statement, it is possible to appeal against it.

All available income and property of the applicant and/or his/her family is subtracted from the approvable expenses.

The difference after subtraction becomes the amount of the income support received. Generally, the income support is granted for one month at a time. If the total amount of
income and property exceeds approvable expenses, rights to the income support do not exist.

**Sarvis Social Welfare Office**

When applying for the income support for the first time in Tampere or when clients have not been benefiting from the income support for over two years, an appointment is arranged in Sarvis Social Welfare Office.

Applications for income support are handled by social workers or benefit assessors, together with the client at an appointed time or on the basis of a written application. Clients who are in crisis or are in need of social work, visit social workers. Social workers also make individual plans for clients under 25 years, who have no income.

**Department of Benefit Assessment**

Clients who have received income support earlier send their applications to Department of Benefit Assessment. Applications must be sent by post, Department of Benefit Assessment has no reception or advising of clients except phone service. Applications for income support are handled by benefit assessors. If clients need guidance, they can contact Advising Service, which is located in the centre of Tampere.

**Rehabilitating Work Experience**

Rehabilitating work experience is a part of social security system of every Finnish municipality. Rehabilitating work activities aim at assisting long-term unemployed individuals in increasing their capacity and opportunities to get employed. The Division’s clients are the unemployed, who receive living allowances (income support) or labour market subsidy.

Rehabilitating work activities are based on an activation plan defining the means to activate the client for future vocational training or work.

The activation plan is made in cooperation with the client, a municipal social worker and an advisor from the employment office. An invitation is sent either by the social welfare office or the employment office requesting a client to visit and prepare an activation plan. Information about the rehabilitating work experience can also be obtained from the local social welfare office or the Division for Rehabilitating Work Experience.

Participation in work activities is compulsory for unemployed persons. Young people under the age of 25 are guided to the rehabilitating work experience after a shorter period of time than people over the age of 25. The goal is to put an end to the unemployment of young people and to prevent them from being socially excluded at an early stage.

In Tampere work activities are organized in various departments of the city as well as in various (over 20) associations. In 2009 13 % of the work activities were carried out within various departments of the city, 87 % within associations. Work activities may include assistance at day care centres, nursing homes, food service or libraries; or crafts such as restoration or fixing bicycles. The client’s individual capabilities, talents, wishes and goals are taken into account.

The work activity period includes personal guidance and can last between 3 and 24 months. Rehabilitating work experience takes place on one to five days during each calendar week, four to eight hours per day.
At the end of rehabilitating work experience the authorities who have made the activation plan get a report of the period, which gives a good base to continue the work with a client.

3. Treatment of Diabetes

The Finnish Diabetes Association
The Finnish Diabetes Association (founded 1955) is a national public-health and patient organization and the central body for 107 local branches, a national association for young people with diabetes and four professional associations (Association of Finnish Diabetes Nurses, Finnish Diabetes Research Society, Finnish Diabetes Education Study Group, Finnish Association of Podiatry). The institutional members of the Association had a total individual membership of 58,624 at the end of 2009.

The Diabetes Centre in Tampere is the national headquarters of the Finnish Diabetes Association, housing the Central Office and the Education and Training Centre. The Diabetes Centre has a beautiful location on the shore of Lake Näsilinjärvi in the community of Aitolahdenkoti some 20 kilometres from Tampere city centre. Built in 1980 the Diabetes Centre today provides courses for 1,600—1,700 people (both people with diabetes and health care professionals) each year and employs about 60 staff.

Activities in the Finnish Diabetes Association are grouped into responsibility areas, like general administration and international affairs, Development Programme for the Prevention and Care of Diabetes (Dehko), training for both people with diabetes and professionals, public awareness, communication and publishing, organizational matters, financial management, marketing and human resources.
www. pages: www.diabetes.fi

Diabetes care at Tampere region / Pirkkaa Hospital District
Diagnostics and treatment of diabetes in Pirkanmaa hospital district are organized to health and occupational health centers and to specialized hospital clinics. Health centers operate in every rural district close to the local residents. Hospital chain includes Regional hospitals (3), Tampere City Hospital and Tampere University Hospital. The community runs health care system and it is financed by taxpayers. Occupational health centers are run by major companies for their employees. Some private clinics also deliver comprehensive diabetes care.

Tampere University hospital is a full service teaching hospital affiliated with Tampere University Medical School. Both nursing and medical students get their basic training at this institution. There are about 900 beds and virtually all medical specialties.

Diabetes care is mainly delivered as outpatient service. This includes endocrine services, education and long term follow-up. Closely collaborating units include departments for eye, kidney, vascular, heart health and maternity just to mention some. Several inpatient wards take care of diabetic patients depending on the major condition or disease. Acute conditions are taken care by the emergency department Acuta.

Outpatient clinic
Several doctors and nurses work at the outpatient clinic daily. Also other professionals like dietitians, podiatrists, physiotherapists and social workers are available. The problems of the patients vary widely from initiation of diabetes therapy to severely complicated and disabled. Patient flow comes from the emergency clinic or by referral from health centers or private practitioners. The referrals are usually problem oriented. The outpatient clinic has consultative role and works in close relationship to health centers. The means include...
patient education for self care, use of various drugs, insulin delivery devises like pumps and continuous blood glucose monitoring system.

**Education and scientific work**
As a University Clinic scientific work and development of methods is among the major tasks. Aim is to develop better and comprehensive care for the community. Also prevention of diabetes epidemics by changing life style and other modifiable risk factors is our aim. This task is done by educating nurses and young doctors.

**Collaboration**
Close relationship with health centers, diabetes education center (Finnish Diabetes Association) and local Diabetes association form the foundation to the work.

**4. COPD (chronic obstructive pulmonary disease) diagnostics and treatment in Pirkanmaa Hospital District**

In Finland it has been agreed on that the diagnostics and follow-up care of the chronic obstructive pulmonary disease will take place mainly in the primary health care. Those patients who have separation diagnostic problems, a doubt about the work-related reasons or already advanced chronic pulmonary insufficiency or who are in risk of it quick development is examined in the special health care. The acute exacerbations of COPD, which require a hospital treatment, are also managed in the special health care.

The hospital district of Pirkanmaa produces the public health service to 470 000 inhabitants to its 23 member municipalities. Department of pulmonary medicine in Tampere University Hospital is the only pulmonary unit in Pirkanmaa district, which means, that we also examine and take care in a little amount of the patients of the basic level.

In the department of pulmonary medicine in Tampere University Hospital, the follow-up of the patients with chronic respiratory failure, who receive long term oxygen therapy (LTOT) or/and long-term non-invasive ventilation (NIV) is arranged in a multidisciplinary outpatient department. These patients suffer from end-stage COPD, but also obesity hypoventilation syndrome, neuromuscular disorders and restrictive thoracic disorders. During the control visits, the patients meet special trained nurses, a physiotherapist, a dietician, a rehabilitation nurse and a social worker. After the assessment of pulmonary physician during the diagnostic evaluation, patients meet physicians only at agreed, long intervals. Furthermore, the nurses have always the possibility to consult physicians. Acute COPD exacerbations, which require hospitalisations, are managed in pulmonary wards. Patients who need acute non-invasive ventilation are treated in the wards (normal bed), and the more severe cases with NIV in the respiratory monitoring unit within pulmonary ward. Patients who need invasive ventilation are cared in the intensive unit.

The feedback that has been received from the patients has been good and they prefer the outpatient day visits lasting also for several hours to staying overnight in the ward. Because the majority of the patients suffering chronic pulmonary failure are disabled, a need to develop control activity between the units of the different public health service is current. The objective is, that the control visits could be carried out as near the patient as possible and still remaining a high quality of the visits. We have started this year the experiment project with the Tampere Kotisairaala (Hospital at home) from Tampere City Hospital, in which we pilot, if some of these controls could be arranged at the patient’s home.
5. Services for Elderly

VIOLA HOME
Viola Home Association

Principles of Care and Nursing in Viola Home
- Support for the individual and active life of the residents
- Attempt to create a safe and happy life in a pleasant environment
- Customer-orientation: services are planned and organised according to the needs of the customers
- Support for independent activity with regard to the physical abilities of the customer
- Respect for individuality and autonomy
- Respect for the elderly person’s own opinion.

It is also considered important to listen to relatives.

Housing Services
Sheltered housing is divided into supported housing, sheltered housing, and intensified sheltered housing. The content of the services has been determined in the service and nursing plan that is designed for each customer individually.

Supported Housing
- 24-hour alarm system for help
- nurse’s reception office
- meals and other support services available
- wide choice of recreation, exercise, and cultural activities

Sheltered Housing
- 24-hour alarm system for help
- daily services of a nurse, if needed
- help in daily activities according to one’s needs
- meal and other support services available
- wide choice of recreation, exercise, and cultural activities

Intensified Sheltered Housing
- 24-hour alarm system for help
- 24-hour care and nursing services
- meal service
- wide choice of recreation, exercise, and cultural activities

For Living and Enjoying
Viola Home has a very simple and easily accessible layout. There are one-room flats and two-room flats. All flats have partially glazed balconies. There are 48 flats for sheltered housing; in addition there are three flats for people who need temporary housing. There are group flats for those older adults who need care for 24 hours per day.

Individual and Safe Sheltered Housing in the City Centre
Viola Home provides a safe place to live in the city centre, in Tampella area, Juhlatalonkatu 4.
The flats are rental flats and they are furnished with the resident’s own furniture. The nursing staff can be reached seven days a week, 24 hours a day, if needed.
Rehabilitation Supports Daily Life
Rehabilitation is used in Viola Home in order to support the resident's physical activity in daily routines. There is a fitness studio equipped according to the needs of the elderly. Water gymnastics is arranged in the warm water pool. Even those who are in poor health can get into the pool with the help of a pool lift. Physiotherapy and chiropody services are available in Viola Home.

Daytime Activities for the Elderly Who Live at Home
Viola Home's day centre services are meant for elderly residents in Tampere. The goal of the activities is to:
- support the customer's life in his/her own home
- support the care given by close relatives and their coping with the task
- ease loneliness and insecurity
- bring recreation into everyday life

Restaurant Viola Offers Home-made Food and Excellent Facilities for Festivities.
Breakfast, lunch and dinner are prepared every day in the restaurant in Viola Home. Cafeteria and restaurant services are also available for those living outside Viola Home. Restaurant Viola is a popular venue for family parties and for anniversaries and other special occasions.

Viola Services Inc.
Viola Services Inc. is owned by Viola Home Association. It provides home care services for those seniors who live in the immediate surroundings of Viola Home. Through Viola Services Inc. it is possible to get help with housekeeping, running errands, outings, organising family parties, etc. Banqueting services can be provided at the customer's home, or the party can be organised in the facilities of Viola Home. Home care services are tax deductible.

Privacy – in the Centre of Tampere
"Viola Home Association was founded in 1994 to improve the social situation, the living conditions, and housing services, and the mental and physical condition of the handicapped and the elderly."

6. Community Mental Health Services

MENTAL HEALTH ASSOCIATION TAIMI: RUUSA’S CAFETERIA
Koulukatu 11, 33200 Tampere, www.mielenterveys-taimi.fi

The Mental Health Association TAIMI in Ruusantalo (Ruusa’s House)
- Is an open house for everyone.
- An association for people interested in mental health issues, about 1100 members.
- Many of the people active in Taimi have own experience in mental health problems, some as a patient and some as a relative to a patient.
- Taimi provides different kinds of services and activities that members can develop through their own activity.
- Our cafeteria is a meeting place for people to come drink coffee, eat lunch, read newspapers or just relax
- Free time room for members is open from Monday to Thursday 16-19 and on special seasons like Christmas.
Community Mental Health services: Sopimusvuori
Sopimusvuori offers social psychiatric rehabilitation programs to persons who are recovering from mental illness. These services for 500 clients per a day are served in rehabilitation homes, small homes, day centers, sheltered workshops and in the Clubhouse. The Clubhouse Näsinkulma was the first Clubhouse to begin a Fountain House type program in Finland, in 1995. In addition to social psychiatric rehabilitation work Sopimusvuori offers nursing home care in 11 homelike houses for 128 persons who have dementia. The basic idea of all units of Sopimusvuori is to apply the principles of a therapeutic community up-to-dated in the circumstances of nowadays.