Northern Dimension
Partnership in Public Health
and Social Well-being
www.ndphs.org

Primary Health &Prison Health Systems Expert Group
Sixth Meeting
Druskininkai, Lithuania
March 7-8, 2013

Reference	PPHS 6/7/Info1
Title	Project concept on Integrated care for senior citizens around the Baltic Sea – a project concept developed in the frame of the NDPHS project funded by ENPI.
Submitted by	ITA
Summary / Note	Further steps should be taken – development of application to EU BSR Programme

Simo Kokko
Arnoldas Jurgutis
Aigars Miezitis
NDPHS, Expert Group of Primary Health Care
and Prison Health Care Systems

November 22, 2012

Integrated care for senior citizens around the Baltic Sea – a project concept

Rationale, general objectives expected benefits

Health services can be divided into three main types according to the goals of the service: (1) preventive, (2) diagnostic and curative and (3) rehabilitation and care (of long term illnesses).

The diagnostic and curative services have been the main platform of huge advances in medical care. The history of past decades shows conquests in the control of communicable diseases, major leaps in the treatment of coronary heart disease, asthma, cancer, surgical care etc. Preventive care has advanced and seems to be continuously advancing, but when life-style changes are needed, there seem to be limits to what can be achieved.

Care of patients with chronic illnesses has undergone also major changes although this segment of services has somehow been overshadowed by acute medicine. Diseases that were lethal or lead to rapid deterioration of health can now be stabilized with treatments that are affordable and acceptable in terms of low occurrence of side effects and interference to normal living. The

prevalence of chronic illnesses has somewhat paradoxically increased, since life expectancy has prolonged and people develop several chronic illnesses in their older age.

Care of chronic illnesses has become a priority in the health care systems of many countries. More and more resources are needed, both human and monetary for drugs and new technology. Interest in chronic illnesses can be divided in two fields of service activity and subsequent two set of challenges:

(1) Chronic care to patients with established chronic disease or several diseases with onset at the middle age or around the retirement age. More than one in ten will have hypertension, and more than one in twenty will have diabetes (type 2). At best, the chronic care becomes a routine, where the patient accepts a leading role and the services of professionals are used infrequently or only in situations of unexpected turns or complications. Use of modern technology to assist self-care and self-monitoring of care is growing in importance.

(2) Chronic care to older patients with multiple illnesses remains a challenge. If the chronic illnesses or old age alone have impaired the functional and possibly also the cognitive capacity, the roles of caregivers must remain strong. In traditional societies and even recently in rural settings the care of those belonging to the oldest generation has been a duty of the children and/or families. In the industrial societies, where families must move with employment opportunities and where men and women alike are often in full-time work, arrangements for care and nursing are changing. In the Nordic states, where the responsibility of the public sector has traditionally been broad in care and nursing, this has lead to professional carers taking care of tasks that earlier used to belong to the families. This shift of responsibility can, in turn, lead to unexpected and even exaggerated developments, such as the common trend of placing older people to institutional care in Finland in the 1970-90's. During a short period of time, Finland became a country with perhaps the highest proportion of older people placed in institutional care. It has taken – and still will take – a long time to move away from the patterns of care learned during that period. Now many countries, with different social and historical development backgrounds face the challenges of having growing numbers of older people with multiple illnesses with severe consequences to health and functional capacity living in the communities, but the younger generation has had to move away in search of employment. How to provide sufficient and humane care without resorting to 24/7 institutional care?

The responsibility for the care of persons with chronic illnesses is falling to the hands of Primary Health Care. The care of many chronic illnesses has moved from the hospitals to PHC, often after the establishing of the initial diagnosis and initiation of treatment. Primary Health Care and PHC doctors see management of multiple illnesses to be a special area of their expertise. PHC need to take responsibility for post-hospitalization care in many countries. Similarly, care at the end of life, or palliative care is a task of the PHC team.

Modern medicine divides into numerous narrow specialties. The contributions of these specialties in the diagnosis and treatment of persons of all ages is highly valuable, but the multiplicity and superimposing of symptoms, side-effects can be hard to handle for the world of narrow specialism.

This project idea initiated from discussions in which the experiences of the Finnish Primary Health Care were shared in an expert group representing several countries from the Baltic Sea region. The Finnish primary health care centres were left with the legacy of an extensive network of local hospitals, most of which were placed under the administration of PHC centres and under the clinical

leadership of general practitioners. In the course of several decades, these hospitals have survived many structural changes. These hospitals now account for about 20 % of all hospital admissions in the country and for more than 35 % of the overall hospital capacity. For a lengthy period in 1970-2000's almost half of the care given was long-term care. Now this care is moving away to private homes, small service homes and nursing homes. Finland is now updating and reviewing the role of the small general practitioner lead hospitals in short term care. It seems clear that these hospitals will have an important role in the future, especially in the care of older people with multiple illnesses.

The Finnish experiences have also shown that resorting to the local hospital can lead into distorted structure of care provision. Low admission threshold to the local hospital can lead to underdevelopment of home care and home nursing, which should be the corner stone of care at old age. In fact, a large proportion of chronic patients with debilitating illnesses and severe loss of functional capacity can live at home if the home care is sufficient and appropriate. Only in situations where dementia or exceptional anxiety and feeling of not being safe jeopardize home care, service homes or nursing homes may be needed. The emerging lesson is now that services of home care and home nursing need to be available on the 24/7 basis with sufficient presence or support from health professionals, PHC nurses and doctors. How to build the optimal set of services is a growing challenge. The discussions of the challenges and fact-finding visits to the countries considering participation in the project have shown that the questions and challenges are surprisingly similar disregarding the differences in the health systems and cultures.

We believe that the tasks and challenges could be best gathered under the name of "integrated care". The International Federation for Integrated Care (IFIC) interprets and explains the meaning of "integrated care" to refer to integration along three dimensions:

(1) Integration between health and social services
(2) Integration between primary health care and secondary (and tertiary) health care
(3) Integration in care between different professional groups, for example between doctors and nurses

This document will now envisage a project through which countries with different systems and different levels of development of integrated care could each find ways to improve and further develop their services.

General objectives

Development of integrated and flexible care for older people with multiple illnesses will prepare health care systems and especially primary health care to meet the future needs and challenges, which must be faced because of demographic and epidemiological changes. The absolute and proportionate numbers of older people will grow in many societies. In spite of the proof and expectations that the older generations will be healthier and in better functional shape on the average, prevalence of long term illnesses will increase.

Older people and older generations have in the near past had the tendency to belittle their needs and rights to have appropriate health services. This will change. The older people themselves are better informed and more capable of finding out what is possible and what benefit could be achieved. Age-based discrimination and limiting rights to necessary services will no longer be accepted.

Older people will also transform from having often been passive recipients of care prescribed by professionals to active partners in the alliance for care. This does not necessarily mean demanding the latest high tech methods of care, but this should call for giving care with dignity and respect for human rights. One of the rights is that enabling care to take place at home whenever conceivable. Home care, home nursing and offering services in the outpatient settings should have a clear priority. Hospital services should be reserved for situations defined by medical necessities.

The project is expected to contribute to all the participating countries having advanced in providing a broad and sufficient range of home care, home nursing and outpatient care. Hospital care should aim at appropriate objectives. One line of development in the hospital services for older people should be the sound and balanced use of local hospitals by or in close collaboration with the same PHC team in charge of care.

The main project activities (can be transformed to work packages)

1. Situation analysis of the states and stages of development in the participating countries

This will include mapping the regulations governing care given at the interface between PHC, hospitals and social services. Who or which sectors or service providers are entitled to be involved? How is the entitlement of the recipient of services defined? How are the services funded? Where do the dividing lines between public / publicly regulated responsibilities (paid by local municipalities or mandatory health insurance) and the responsibilities of families go?

This section would also include necessary basic statistical and monetary figures of recipients, use of services and levels of costs. The costs may have to be based on crude estimates if comparable broken down figures are not available.

The situation analysis should contain also a basic description of the current typical or dominant arrangements of care. This description should highlight existing country specific problems, inequalities of services, legal and/or financial limitations for rational organizing of care. The analysis should also give an account of existing plans for changes or envisaged future directions for development.

This information could be provided by the leading counterparts of each participating country or region.

2. Review of international experience and best practices

This review should be based on written research or/and development reports published in the international literature on the themes under focus in this project. Included should be at least

- Descriptive and comparative studies of present models of care, their strengths and weaknesses

- Conceptualization and measurement of co-morbidity (the degree to which significant chronic illnesses occur simultaneously) and of the loss of functional capacity related to this morbidity

- Review of models of advanced “community care”; assisted housing, personal services or home care etc.

- Role of the primary health care and other professional services, changing patterns of service

- Role of hospitals in caring for older people with multiple illnesses

- Role of patients and families, tools for empowerment

- Description of how services move towards multi-professional, patient-centred approaches

3. Learning from international experience (field visits, work shops)

In order to get insight and capability to be released from earlier fixed patterns of services and their delivery, exposure to selected international sites to observe and learn from other countries' experience would supplement the lessons from the literature review. There are a number of pilot sites and organizations in Europe with already lengthy experience of provision of integrated care and creating service settings in or around homes. Such examples could be found at least in Denmark, the Netherlands, and the United Kingdom and in some pilot sites in Finland.

Since extensive travelling with larger numbers of participants would be disproportionally expensive, some elements of this learning could be arranged as work shops or "virtual study tours" to the types of places listed above. For such work shops the speakers would travel instead the participants.

A realistic plan could be to organize one or two round-trip type of a study tours with 2-3 participants from each participating country during the project.

4. Identification of pilot areas or sites for the project

The project would work through activities and developmental processes in selected pilot sites. Each participating country could provide one or two such sites. The project leaders should then be familiarized with these sites or areas, their populations, care-giver organizations and with the key persons and working groups participating in the actual project activities. The key professionals of the pilot areas would become active participants of the project. Therefore, the interest and commitment of these professionals should be ascertained in advance.

If the rules of the project funding expect a contribution or share of the total costs from the local partners, the financial arrangements should be carefully planned.

If the legal or other regulatory restraints would severely limit or become an obstacle to the process of the project, all attempts should be made to remove such restraints with temporary orders or special arrangements for the pilot activities.

5. Setting objectives and describing the envisaged changes in care in the pilot areas

For each pilot site, the local and national teams together with the international advisory group to be set for the project would review the general arrangements of home and outpatient care for persons with multiple illnesses; PHC team, home nursing, home-based social services and with

representation from the local general hospitals joining into this development process. These combined teams would then produce sets of new development objectives. These objectives would describe the aim of how the services should operate in the future.

Written care plans, produced jointly by integrating teams and inviting the care recipient and if appropriate the key caregivers in the family, would become a leading tool in support for change. These plans would be collected and plans for monitoring the progress through indicators and other landmarks to be monitored would be in the centre of the project processes.

A special segment of the project would concentrate in each country on the arrangements for hospital care in situations when high tech diagnostics or/and consultations or care is not needed or can be retrieved on an outpatient or day service basis. The participating hospitals would develop holistic, person-centred approaches to care. They would engage the PHC doctors and nurses in the process, especially at the point of discharge from the hospital.

Special challenges for the teams of home care, PHC and local hospitals could be highlighted using experiences of following situations of care:

1) Palliative care and home and in the hospital
2) Rehabilitation as a cross-cutting principle in integrated care
3) Psychiatric and neuro-psychiatric problems and challenges in patients with multiple illnesses, for example confusion, delirium-like symptoms
4) Working with patients with dementia and needing protection due to dementia
5) Offering relief to family caregivers
6) Working in communities with long distances

In order to ensure that the project caters for the actual needs of each participating pilot site and/or region, the project could provide a range of optional developmental modules. The precise subject areas and titles for the modules would be determined soon after the launch of the project based on the situational analyses. Just for purposes of illustration, the list of modules could look like the following:

(1) Acute care, both local hospital and at home with intensified home nursing
(2) Building systematic chronic care based on care guidelines and care plans
(3) New developments of tasks between the professional groups in PHC
(4) Engaging ambulance services to become part of home care
(5) Palliative care
(6) Appropriate and feasible modern means of communication for integrated care

6. Envisaged progress of the project

(1) Each pilot site should do a thorough situation analysis of their current arrangements of services with assistance from the international experts provided by the project.

(2) The pilot sites should set their initial objectives of changes to be introduced.

(3) Each site would start implementation of the first steps of development of integrated care – starting from the point of development reached by the time of launch. The leading idea is that each country would develop its services towards the general direction pointed out in this project plan, but would follow its own timetable, would take into account its own

preferences and limitations. Thus the goal is not to try to lead countries with different backgrounds and systems of care to uniformity, but to benefit from the modern practices of integrated care.

(4) Each pilot site would engage several service teams. The teams will collect information and experiences; develop new ways of working, share tools and methods. The representatives of these teams meet at regular intervals locally (perhaps 1-2 times a month?) and internationally across the whole project (once in about 6 months) to assess and discuss the progress of the project.

(5) Each pilot site could go deeper in the areas of the optional modules (see chapter 5).

(6) The project coordinators will collect and aggregate information, which is expected to be both qualitative and quantitative. The overall progress of the project is evaluated using set target indicators, which will be set soon after the launch of the project.

7. Special focus on information management with the aim of supporting establishment of integrated care

Integrated care is essentially built on co-operation of various actors and professionals in the process of providing service. Sometimes, smallest teams can build their co-operation on direct interaction in team meetings or in settings where professionals interact in the transition phases of patient care (for example upon discharge from hospital, or in situations when it becomes obvious that the earlier services are not sufficient and more efforts are needed).

This project will build on the individualized care plan as the corner stone of integrated care. A typical plan would describe the problems and chronic diseases that constitute the need and rationale for receiving services. The different caregivers would then design and commit to give the necessary services. The text in the plan would be informative enough to enable the plan to become the vehicle through which important core information is passed between caregivers and also between the receiver of care and his/her family members. The plan would be a core element in the patient or client records. The records can be electronic or hand-written.

The project would also analyse the stages of IT service development that the pilot areas and their teams are currently at right now. The project should not invest in IT hardware or software solutions beyond possibly some light applications. The main emphasis should be on using modern technology from the low cost end.

8. Reshaping the local hospitals to support integrated care

The participating countries have variable development histories of the local hospitals. In many cases, they have been full-service hospitals with a wide variety of services. However, development and standards in medical care have changed patterns of care. Many earlier common tasks of diagnosis and care have been moved to hospitals of higher technology. This trend will continue. One leading idea of this project is, however, that the local hospitals could have a rational and important future instead of becoming demolished – if the tasks and roles would be carefully planned to meet the future needs. However, the priorities should be set to prefer home care and outpatient care whenever feasible, but when this line of feasibility is crossed, the local hospital should act as a supplement and support to outpatient care and home care.

This thinking will lead into significant reorientations in countries and health systems, where the local hospitals continue having nostalgic feelings of how their services were like in the days of broad range acute care. The earlier hospital identity of having achievements and skills of acute care should be and could be at least partially replaced by the strengths of good Primary Health Care. Good PHC is internationally known for the capabilities of offering “three C’s”, continuity, comprehensiveness and coordination of care. Older people with multiple illnesses are a critical test to these principles.

The project expects the smaller local, (or municipal hospitals (e.g. “rayon hospitals” in Russia and Belarus) to have following features in place in their operations by the end of the project

- These hospitals have identified their PHC partner centres, partner doctors and other professionals
- The hospitals and PHC services have constructed a network through which they can communicate general management issues, pass training material, both printed and electronic, and also pass patient-related materials, such as consultation requests, referrals, feed-back letters etc.
- The hospitals and PHC services are both linked to the care plans of those older people to whom such plans have been produced. Both the hospitals and the PHC teams will contribute to the plans and the necessary changes to the plans
- The participating local hospitals have developed a future vision / business plan for their development over then 10-20 years ahead in the future. The project is expected to have major role in shaping the visions and plans.

9. Assessment of the needs to change the regulatory framework based on the project experiences

As most of the participating countries have more or less centralized models of governance of health services (governance by ministries, sometime regional authorities and insurance systems), it may turn out that some regulatory features or financial incentives should be changed to ensure that the best results of the project and be used in the future. The project should produce proposals for changes needed.

10. Lessons learned to be disseminated outside the project

Towards the end of the project, conclusions and lessons should be drawn on what other countries facing questions and challenges similar to the participating project countries could possible learn from the results of the project. This would be primarily the task of the chief leaders of the project and of the international steering group.

The results should be disseminated in the format of articles, web-publishing, learning modules and courses. The project should have a website of its own in order to help linkage between various partners and expert institutions, for example the World Health Organization, the Nordic Dimension Partnership and various national institutions in the region.

Annexes (these features to be developed further in the actual project application)

1. Management and administration of the project

The project is based on the work of project partners. There may be one or more partners from each participating country. Partners can be local actors in the pilot communities or they can have supportive role, as for example in the case of academic or research and development similar institutions. Each local partner is expected to operate pilot work in one or several pilot areas. For each participating pilot site there should be a local project coordinator, who will be the focal point and contact person for the project. Each partner should either be a service provider or be closely connected to provision of the type of services the project is all about. The types of partners and their relationship to the actual service provision will be reviewed by the time of the launch of the project. lead partner needs to be identified, responsibilities of the lead partner

The project needs a steering committee with representation from each participating country. The project or its steering committee should also have the possibility to invite and engage external experts to review possible special problems or challenges and come unexpectedly.

Since the project is envisaged to operate across countries with different language knowledge backgrounds, interpretation and translation services will be needed in all joint meetings and in the production of all joint documents.

Prelimininary choice of partners

By the time being, following countries or regions in countries have expressed their interest in participating in the project:

* Finland; Northern Savo Health Authority, Unit for PHC; pilot site: several municipalities in the area

* Latvia, National Health Service + Kraslava district as pilot site

* Lithuania; Klaipeda University, Local municipality as pilot site (to be decided in detail later); possibly also included: regional sick fund

* Belarus: Minsk Oblast health administration, BelMapo as an expert institution, Minsk District hospital /health services (to be defined later)

* Russia: Institute of Public Health and information Moscow. Ministry of Health of the Kaliningrad Oblast (the oblast may also be an associate partner); selected local rayon administration and rayon hospital in the region of Kaliningrad

Partnership is still open for new participants from the Baltic Sea region countries

2. Approximate budget of the project

The practical starting point is 2,2 million euros / total. More precise calculations are needed.