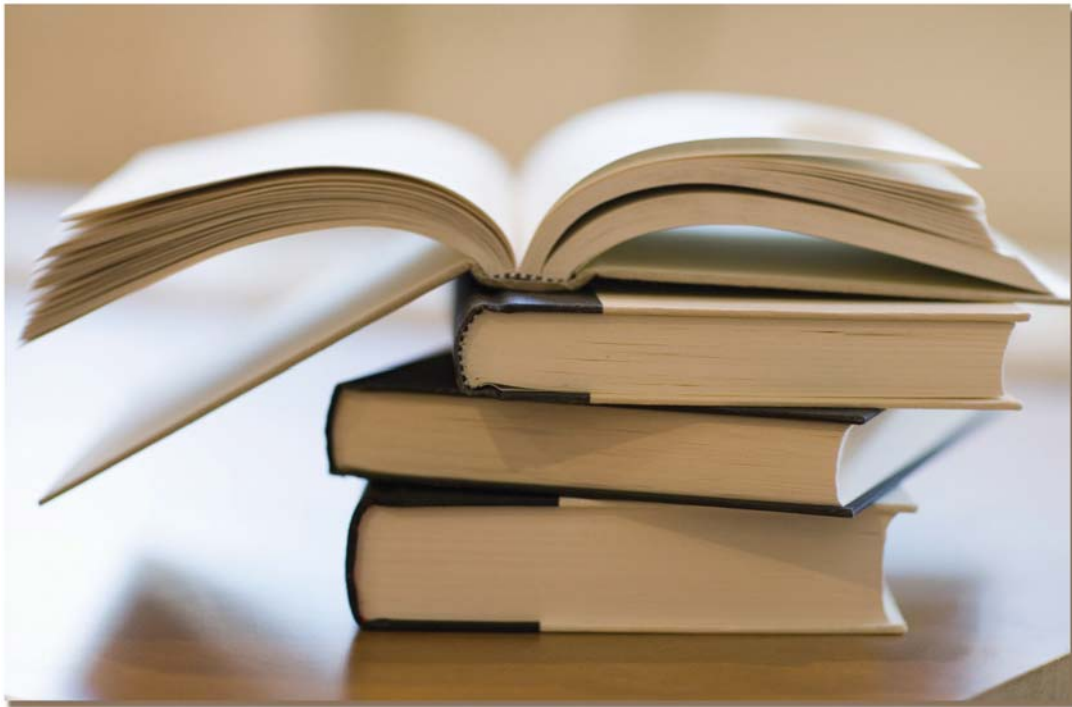


Better Health



Better Health

A Shared Challenge for Hospitals and Primary Health Care



REPORT HOPE AGORA 2011

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HOPE AND THE EXCHANGE PROGRAMME 2011

HOPE, the European Hospital and Healthcare Federation, is a non-profit organization representing national organizations of public and private hospitals and hospital owners in the Member States of the European Union and Switzerland. HOPE gathers 32 organizations: national hospital associations, national federations of local and regional authorities and national health services. HOPE mission is to promote improvements in the health of citizens, high standard of care, efficiency and humanity in hospital and healthcare services throughout Europe.

One of the basic objectives of HOPE is to support the exchange of knowledge and expertise in Europe. To this end, since 1981, HOPE organises the Exchange Programme, 4-week training in a foreign country targeted to hospital and healthcare professionals involved in management. The programme aims at leading a better understanding of the functioning of healthcare and hospital systems in Europe. Each year a different topic is associated to the programme. At the end of the training, participants gathered by country of destination work together to prepare a presentation about what they have learned. During a final conference, hosted and organised by a HOPE Member, the annual topic is discussed and participants show their findings, underlying what they have discovered and learned about their hosting country.

The HOPE exchange programme has reached in 2011 its 30th edition and in this long history, the chosen topics have always mirrored needs and priorities of hospitals and healthcare services in Europe. During the last years, these topics have concerned some of the most important innovations and the most relevant issues in the hospital and healthcare systems: the role of IT (2008), new roles and new skills of health professionals (2009), the clinical and economic challenge of managing effectively chronic conditions (2010). The topic chosen in 2011 "Better Health - A Shared Challenge for Hospitals and Primary Health Care" shed light on the relationships between hospitals and the other components of the healthcare system.

It is understood that the healthcare system is made of different pillars that concur to the goal of improving health for the entire population. The linkage between these components – prevention, primary care, hospitals and community – is as important as the components themselves. Harmonized efforts of all sectors are needed to be efficient and to optimize the use of resources, to be effective and to deliver the best quality of care. Thus, four notions – communication, coordination, integration and cooperation – assumed a central role in the experience of HOPE Exchange participants 2011.

Participants of HOPE Exchange Programme 2011 were invited to explore and report to their colleagues about good practices of integration and coordination within the health system of their hosting countries, highlighting the benefits for patients and citizens, for the system and for the community as a whole. The findings were presented and discussed during the **HOPE Agora 2011, held on 20 and 21 June in Turku, hosted by the HOPE Finnish Member – the Association of Finnish Local and Regional Authorities** – which gathered around 250 participants among national and local coordinators, HOPE members, guests and HOPE Exchange participants.

The present report examines the content and findings of the HOPE Agora 2011. Two sections illustrate in detail the most relevant experiences, mechanisms and instruments of integration and coordination between primary and secondary care in the European countries, as they have been presented by the participants of the HOPE Exchange programme 2011. In some cases, information from relevant international sources has been added.

Findings are presented adopting two perspectives: a comparative overview referring to five central themes – national reforms, locally implemented patterns, changes in the role of healthcare professionals, home care and use of ICTs – and a cross country analysis.

SYNTHESIS

The charter 'Key components of a well functioning healthcare system', released in May 2010 by the World Health Organization, states that one of the elements determining the effectiveness of health systems is the effectiveness of services provided; it also reckons that the level of effectiveness of these services depends, among other things, on:

- networks of close-to-client primary care, organized as health districts or local area networks with the back-up of specialized and hospital services, responsible for defined populations;
- provision of a package of benefits with a comprehensive and integrated range of clinical and public health interventions, that respond to the full range of health problems of their populations;
- key elements of quality: safety, effectiveness, integration, continuity, and people-centeredness.

Findings of the literature show that poor coordination, inconsistency between different levels of care and fragmented care may harm patients, resulting in duplications of analyses and medications and provision of unnecessary treatments; patients may have to stay longer in the system and invest more time and resources to meet different providers, which is likely to increase their uncertainty and fading their confidence in the system. Poor integration might also overburden primary or secondary care, causing inappropriate admissions, high rates of readmissions or unnecessary length of stay. In addition, weaknesses in primary care might lead to overuse of emergency and high rates of referral back from hospitals to primary care, which is likely to translate into inefficiencies and waste of resources for the overall system, and in disparities in the workloads among healthcare professionals.

The 2008 World Health Report 'Primary Healthcare: Now More Than Ever' stressed the fact that "rather than improving their response capacity and anticipating new challenges, health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear sense of direction". Instead, more communication, coordination and continuity of care lead to higher satisfaction from patients and healthcare professionals and ensure a higher sustainability of the system.

All European States, irrespectively of the system organization, are implementing strategies to create or increase the linkages between the different parts of the healthcare system, always with the final purpose of increasing effectiveness of care and efficiency in the management of the system. But all over Europe, the issue of coordination among the levels of care is being tackled with different strategies.

In numerous cases decision-makers and policy-makers identify the need of radical or at least comprehensive changes within the system. In this instance, more than the change in the mechanisms of spending and funding, more than the modification of the legal framework and more than the re-distribution of responsibilities at the macro-level, the changes look at the patient journey and aim at making his/her experience with the health system easier, shorter, and in particular very effective.

On the other hand, it is frequent that changes, reforms and innovations follow a bottom-up approach. When it is not the higher level of the system that proposes or imposes changes, those arise from regional and local networks, closer to citizens and more aware of the needs expressed on the territory. They introduce innovative models or new means, in response to the real needs of population. Often innovations concern specific pathways of care – e.g. for diabetes and other chronic diseases – or new patterns for treating specific cases or facing singular problematic.

All of these changes imply to consider diseases not anymore as simple episodes of illness, needing acute treatment and hospital admission, but as complex conditions that require the coexistence of many factors, among those the cooperation of all actors - the patient first, but also his/her family, and all professionals - and the cooperation of all sectors, from prevention to palliative care, that is more and more ensured by the introduction and development of E-health technologies and ICT solutions.

This new paradigm, that finally sees the patient as the centre of the system, fosters countries to rethink the role of professionals, which does not interfere with the principle of quality of care but conversely enhance it, increasing self-consciousness and satisfaction of healthcare workers themselves and strengthens the need to reconsider the places of care, since hospitalization and institutionalization are not the only answers and, more importantly, they rarely represent the best options for patients and for citizens, while home care patterns are developing and are proving their both social and economic effectiveness.

The following paragraphs give a brief overview of the evolution happening in the European countries and summarize the main findings of this paper, considering five topics that can be considered drivers of the evolution from fragmented patterns of care to integrated models: national reforms, locally implemented patterns, changes in the role of healthcare professionals, home care and use of ICTs.

HEALTHCARE SYSTEM ORGANIZATION AND REFORMS

In **Finland**, clinical care pathways and planning are shared between primary care and hospitals and the information flows between these two levels is guaranteed. Nonetheless, the already integrated and coordinated system has been further reinforced by the New Healthcare Act 2011, which emphasizes the rights of patients and states by law that continuity of treatment paths have to be established to guarantee integration of primary and secondary healthcare, while all public primary care providers and hospitals must publish their plans and results.

In **France** the New Governance Initiative aims at overcoming the general fragmentation of the healthcare systems. It obliges citizens to choose a referent doctor, sets up the basis for the development of multidisciplinary health centres with different health professionals under the same roof and promotes networks of health professionals to manage defined health needs of population.

With the same aims, in **Austria** the Patient Oriented Integrated Care Project (PIK) fosters cooperation and pooling of resources among a large number of stakeholders and healthcare financiers in order to introduce measures of integration such as hospital discharge management for patients with complex post-inpatient care; standardized electronic information transfer between hospitals; common web-based information platform for all health care and social services.

Germany has recently introduced throughout the country the Medical Supply Centres, outpatient care facilities placed directly in the hospital where patients are transferred before discharge, being followed by multidisciplinary teams. This system allows patients to go through a unique, high quality pathway of care and permits to save costs in the system through the share of physical resources, equipments and personnel between hospitals and Medical Supply Centres.

In the **United Kingdom**, the Government has proposed the biggest major reform in the NHS since 1948: General Practitioners (GPs), gathered in consortia, would control 80% of annual health budget, the involvement, new role and coordination of hospital doctors would undergo major changes and also hospital consultants and nurses would be more involved in the commissioning process. These reforms, still under discussion at the time this report is being written, aim at improving the National Health Service that should be "non-bureaucratic, patient-driven and clinician-led".

Bulgaria, Hungary and **Greece** are taking important steps forwards to improve their healthcare systems as a whole. In **Bulgaria**, the central role in primary healthcare is played by General practitioners, who have some competences in health promotion. **Greece** is strongly improving interactive communication between GPs and doctors, enhancing the use of medical records and e-prescriptions and strengthening the role of home care and community care. In **Hungary** the national emergency ambulance service and some specialized healthcare centres, such as the National Institute for Medical Rehabilitation, are examples of good practice. The IT architecture integration project to harmonize healthcare IT and the rational use of EU funding are leading to good results.

SPECIFIC PATHWAYS OF CARE

In psychiatric care the need of integration is fundamental to the achievement of good results.

The community mental health strategy developed in **Malta** adopts a multidisciplinary and integrated approach to support mental patients at each stage of their illness, favouring the reintegration of the person in the community and reducing the need of medications and hospitalization.

In the same way, the Psychiatric Outpatient Departments in **Germany** are composed by multiprofessional teams that meet patients before and after the hospitalization, also at home, in familiar surroundings, and offer group therapy in the long run.

In **Slovenia** the Mental Health Act approved in 2008 provides a comprehensive legislative framework for a national strategy on mental health that puts a particular focus on legal protection and community approaches to mental patients.

A further area where integrated and specific pathways of care are developed is that of chronic diseases, whenever it would include or not palliative care.

In **Malta**, the multidisciplinary shared care Diabetes Programme establishes strict clinical management guidelines and minimum standards of care at a primary level and ensures that patients are provided with timely and equitable access to secondary care specialists. The shared care programme 'fast tracks' urgent cases to the vascular surgeon and avoids unnecessary referrals to hospital of cases which can be effectively managed at primary care level. Also in Malta Hospice Movement organization provides integrated care and promotes the highest standards of palliative care for all persons with cancer, motor neurone diseases and other terminal diseases, avoiding to overburden hospitals, better targeting the needs of terminal patients and their families and guaranteeing coordination with primary and secondary care actors.

In **Poland** the General Practitioner Cancer Center is an example of excellence. It is one of the biggest oncology centres in Poland and in Europe. It provides comprehensive care to cancer patient, from prevention to treatment and palliative care. Following the higher standards of care, the centre features interdisciplinary teams providing holistic care for patients with cancers in a given location.

In the **United Kingdom** the National Stroke Improvement Programme, sets up by the English National Health System (NHS), aims to reducing the inequalities in accessibility to adequate treatment, as well as improving treatments and cost-benefits. The Programme foster collaboration between primary and acute levels through integrated care pathways and enhance higher level of patients and relatives involvement.

In **Luxembourg** continuity of care post-partum is a shared challenge between hospitals and primary care institutions. A Standard Process for postpartum care and work with a network of well-defined roles is established. Minimum four home visits after birth covered by the midwife in private practice are planned. Nursing Direction, good professional practice and good communication between physicians and midwives allow corporate coordinated activity among postpartum hospital consultations, emergency services, midwives and liberal doctors.

ROLE OF PROFESSIONALS

The role of General practitioners is strengthened.

In **Estonia** family doctors now send referrals to hospitals and vice versa the hospitals send clinical reports to family doctors. Telephone and web consulting (peer to peer) are developing.

In **Greece** the increasing interactive communication between GPs and hospital doctors is improving patients' hospital experience and are helping to reduce the hospital length of stay.

In the **United Kingdom** the GP Liaison Manager introduced in the hospitals is the permanent link between the hospital and the primary care providers on the territory, organizes regular meetings joined by GPs, consultants and further healthcare professionals.

In **Switzerland** GPs are co-located in emergency departments out of normal working hours. They are on-call, so the working hours reduce significantly, improving the quality of life, and making the profession more attractive.

In **France** with the introduction of a GP consultation coordinated with emergency telephone calls GPs and urgent care specialists manage emergency calls. This service responds to the need of reducing workload at emergency services and at the same time improves patients' satisfaction, since they can find faster and more targeted answers.

If the role of General practitioners is being extended, nurses are taking over some of the tasks reserved in the past to doctors. In particular, today the nurse often takes the role of first point of contact between the citizen and the healthcare system.

In **Switzerland** when a citizen contacts "Medicphone" – a single central telephone number – seeking for help a triage nurse assesses the condition of the person and decide if refer he/she immediately to the hospital, immediately to a GP or postpone the visit with a GP on the following day.

In **Sweden** citizens can contact the national help line 1177 – a 24-hour nurse-led service that allows patients to talk to a nurse for first advice and indications when there are simple symptoms of disease. Moreover, in Sweden a nurse is also the first contact of patient admitted both in a primary healthcare centre and in a hospital. The nurse has the task of assessing patient conditions and referring him/her to the most appropriate doctor.

In **Belgium** home nurses are part of the system. In case of necessity and whenever the families of elder people ask for it, the mutualities (health funds) can send a home nurse to take care of patients with limited autonomy, allowing them to remain home. The families may also engage home nurses from independent organizations. Home nurse and social nurses also participate to the assessment of the possibility of institutionalize the patient.

In the hospitals of the **United Kingdom** the so called Admission Discharge Transfer Nurse follows the entire trendcare of patients: prepares for new admission, completes nursing assessment, identifies patients who are for discharge or for transfer during the shift, plans and organizes patient discharges, and facilitates the transfer as soon as possible. This role allows cutting length of stay, avoiding wasting of time and resources both for the patient and for the system and favours the appropriateness of care.

In **Luxembourg** the continuity of care management process for post partum is prioritized for example by the Centre Hospitalier du Luxembourg (CHL) and in particular its nursing director. The private practice midwives are not an isolated part of the woman's health project. Obstetrical hospital clinic (expert level) and the private practice midwife (primary) improve short-and long-term health of women and newborns through coordination and continuity of care at home.

A further role that has acquired particular importance within hospitals is that of pharmacy manager. In the **Netherlands**, after discharge the hospital pharmacist shares information with the local pharmacist and with the hospital doctor and delivers information to the patient, ensuring the better continuity of care.

HOME CARE

In **France**, the model of hospital at home has been developed as an alternative to traditional hospital care and allows the coordinated management at home of patients with complex needs.

In **Latvia**, the medical care service at home is provided if the patient needs a regular outpatient treatment but due to medical reasons he/she is unable to attend healthcare institutions. The family doctor refers for medical home care and receives feedbacks from the medical home care teams.

In **Portugal**, one of the most important innovations is the mobile support unit for home care, coordinated with the social services. This unit offers support to patients at home in a state of chronic disease and dependence on technologies and allows to support continuity of care after hospitalization.

In **Belgium** home care, provided by home nurses, is always offered to patients.

In **Sweden**, when discharged home, the patient can receive if needed a mobile team formed by a nurse, an occupational therapist, and sometimes a doctor for following up him/her; staff from the municipality provides up to 9 visits during the day plus visits at night and the district nurse might visit weekly.

USE OF INFORMATION AND COMMUNICATION TECHNOLOGIES (ICTS)

In **Greece** the development of medical records and e-prescriptions are fundamental to a more integrated approach to healthcare and improve patient safety, quality and continuity of care.

In **Estonia** hospitals and primary care institutions share information through technologies, they have uniform electronic prescriptions and the E-health system links all healthcare services providers (ID card).

In **Finland** the effective communication throughout the system is ensured, since more than 90% of public health organizations have e-patient records.

In **Luxembourg** paper patient records, computer records and the extracts of the medical records ensure data access and exchange in real time and enable the involvement and awareness of patients.

In the **United Kingdom** chronically ill patients use tools of telehealth to monitor their conditions, staying at home and being completely independent. When their health condition changes they contact the GP who can refer them to the hospital doctor.

Some good examples of the use of ICTs in healthcare can be mentioned.

In **Spain**, the Multi-channel Health Service Centre (MHSC), developed in particular in the Basque region, uses all the available channels of interaction (Web, telephone, SMS, Digital Television,...) between the citizen and the health system in order to facilitate the care procedures. It enables administrative procedures to be carried out - primary care appointment management, reminder and/or confirmation of appointments, medical certificate reports, TIS (personal health card management). It makes general health service information available to the users - range of services, health centre directory, night clinics and duty pharmacies; it provides a telemedicine home care service - remote assessment systems and telemetric monitoring - for domiciliary chronic patients, multipathology patients and those with advanced or unstable pathologies; provides medical advice and enables citizens to access information regarding their health (personal health file).

In **Denmark** Medcom – for professionals – is a cooperative venture between the public and private sector to quality that assures electronic information and communication systems. Sundhek.DK is the official Danish e-health portal, and provides high quality, accurate, up to date information accessible to citizens and professionals. The unique citizen CPR number is issued at birth and covers every interaction of the citizen with the state of Denmark, including healthcare use.

In **Sweden**, each citizen is identified by a 10 digit unique identification number through which all health information about him/her can be accessed and shared within the system; when patients are admitted to the hospital all information from primary care is accessible to the staff in the hospital. Lean is the tool that many county councils are using to ensure that processes are efficient and add value to the patient's experience. Vårdlink is a computer system that allows discharge arrangements to be made. All the health information on treatment during hospitalization is inputted into national, disease specific quality registers, which is accessible to all health professionals.

Finally, **Malta** has developed a single computerised register of all patients with diabetes that allows providing information on the actual costs of diabetes care and the burden on the national health budget, allowing documentation of each patient's progress within the system and enhancing communication between the members of the interdisciplinary teams.

STRATEGIES AND GOOD PRACTICES IN EUROPE COMPARATIVE OUTLOOK

In the following paragraphs a complete comparative overview of the most relevant experiences of integration and coordination among the different levels of care in the European countries is presented, as reported by the participants of the HOPE Exchange programme 2011.

This transversal analysis focus on five topics that, as seen before, can be considered drivers of the evolution from fragmented patterns of care to integrated models:

- > Reforms developed within countries and aimed, among other things, at improving continuity of care.
- > Examples of good practices concerning specific cases, patterns of integrated care responding to the needs of specific categories of patients and citizens.
- > The role of healthcare professionals and the way their professional qualification have been enhanced to respond to the needs of the system, of patient and of professional satisfaction.
- > The role of home care that is today a major mean to ease the system, link its different parts and guarantee quality of care.
- > The best examples of use of Information and Communication Technologies (ICTs) in healthcare, lingering on the central role ICTs play today in fostering communication and coordination in the healthcare systems.

HEALTHCARE SYSTEM ORGANIZATION AND REFORMS

In a period of economic constraints and increasing demand of care and quality from the population, many countries are introducing reforms to streamline the system and make it more responding to the real needs of citizens.

While some States - like the United Kingdom, France, Finland and Austria - are trying to modify and improve the structure of the system, others - e.g. Bulgaria and Hungary - are rethinking their system looking for good examples elsewhere in Europe and are fostering good practices of coordination and continuity of care.

AUSTRIA

In 2005, the Austrian Federal Health commission promoted one of the biggest reform pool projects financed by the Federal Health Funds. Called **Patient Oriented Integrated Care** – PIK (Patientinnenorientierte integrierte Krankenbetreuung) the project is a population and patient-centred care approach, aimed at bridging the sectoral boundaries of Austrian federal health care system by cooperation through cross-boundary e-pathways allowing an interdisciplinary discharge planning and a standardized information transfer for the discharge of patients with complex post-inpatient care needs, the core target group of the project.

The project foresees the cooperation among a large number of stakeholders, and the pooling of financial resources of different healthcare financiers and financing sources, considering in particular five measures:

- > hospital discharge management for patients with complex post-inpatient care;
- > standardized electronic information-transfer between hospitals;
- > home care organizations and general practitioners;
- > promotion of contacts to self-help groups during hospital stay;
- > development of a common web-based information platform for all health care and social services;
- > standards for the prescription for medical devices and equipments at home.

The new health platforms make now arranged decisions about the inpatient and the outpatient sectors, as well as about the cooperation strategies between the two. The platforms consists of representatives of federal states, social health insurance institutions, medical association, patient advocacy, churches (as carriers of clerical hospitals), one representative of the state and one of the Main Association of Austrian Social Insurance Institutions. Decisions regarding both the in- and the outpatient sector are made democratically. Decisions for cooperation require a clear agreement between the federal states and the social health insurance institutions. Crucial instruments of the project are the interdisciplinary discharge report and the electronic admission/discharge letter.

The PIK project so far has proven to be successful, bringing positive outcomes in many aspects:

- > decrease in care-related re-admission rates and length of stay;
- > improvements in the continuity of care result due to timely and high quality information;
- > increase in data security and transmission reliability due to high degree of utilization of the electronic admission/discharge report;
- > quality improvements (less errors, comprehensive and complete information);
- > increase in satisfaction of health professionals and administrative efficiency.

FINLAND

In Finland, the already integrated and coordinated system has been further reinforced by the **New Healthcare Act 2011**, which emphasizes the rights of patients and, among the other things, establishes that:

- > patients can choose the health care centre and the hospital where they want to be treated;
- > all health care providers must have plans for quality control and patient safety;
- > public primary care providers and hospitals must publish their plans and results;
- > continuity of treatment paths have to be established to guarantee integration of primary and secondary healthcare.

The prevention on the territory embraces the areas of work-life balance, occupational health care, promotion of family well-being and healthy lifestyle, minimizing the risks of direct access to healthcare institutions. All health care providers must have plans for health promotion.

The primary care services - offered in Primary Health Centres (PHC) - effectively hold the role of gate-keepers, with a share of 95% of successful resolutions. In the PHC nurses assess patients' conditions at the arrival. The centres offer a full range of diagnostics, oral health and are provided with in-patient wards.

The PHC in Finland are always integrated with social services, and in this way the appropriateness of access to hospitals and the effectiveness of care are guaranteed. Hospitals must support the primary care in planning and providing health promotion and disease prevention.

Effective communication throughout the system is ensured, since more than 90% of public health organizations have e-patient records.

The effectiveness of hospital care benefits from the integration with primary care:

- > the information flows between primary care and hospitals is guaranteed by technology;
- > clinical care pathways and planning are shared between primary care and hospitals;
- > there is continuum education and training exchange between specialists and General practitioners.

The social services and rehabilitative structures provide elderly care, occupational support and self-management, they also manage home care services and are normally activated by the primary or secondary healthcare, thanks to the high level of integration.

FRANCE

In 2009, the French Government introduced legislative changes addressed to overcome the issue of general fragmentation in the system and poor integration between different levels of care.

The measures established look towards the reconciliation of the independent culture of French GPs with the need for more collaboration with other professionals and organizations, also in the wider framework of resource constraints and shortage of certain professionals.

The **New Governance Initiative**:

- > establishes that patients should now choose a referent doctor – if they do not, they receive less reimbursement for their contributions;
- > sets up the basis for the development of multidisciplinary health centers with different health professionals under the same roof (maisons de santé);
- > promotes networks of health professionals to manage defined health needs of the population.
- > introduces the new hospital organization in multidisciplinary teams (pôles);
- > establishes new finance initiatives with payment according to activity;
- > puts the basis for the development of common prevention guidelines for GPs and specialists, to be detailed by the INPES (Institut National de Prévention et Education pour la Santé);
- > establishes the introduction of a personal electronic health record and a personal medication record.

GERMANY

The German healthcare system is evolving towards a better integration among sectors, and the **Medical Supply Centers** (Medizinischen Versorgungszentrum) – outpatient care facilities placed directly in the hospital – are to be considered example of good practices throughout the country.

The Medical Supply Centers allow cost savings through the share of physical resources, equipments and personnel, but in particular they allow the patient to go through a unique pathway of care which starts with hospitalization, continues with the transfer to the Medical Center and ends with discharge. In the Medical Supply Center the patient receives care from a multidisciplinary team of specialists that can use hospital equipments, know the doctors who were in charge of the patient before and have full access to the patient records from the hospital stay, so that its members can deliver the best quality integrated care.

Advantages of the Medical Supply Centers are:

- > time saved, e.g. they make possible for the patient to see several specialists in one day;
- > improved patient safety, e.g. they help to prevent the same examination to be made twice;
- > cost saved, because they shorten and make cheaper and more efficient the permanence of the patient in the health care system.

GREECE

The Greek healthcare system has as its main weakness the lack of a strong gate-keeping structure and the presence of inequalities across the country. Nonetheless the country is working to foster improvements and some successful experiences of integration and continuity of care are emerging.

The increasing interactive communication between GPs and hospital doctors are improving patients' hospital experience and help reducing the length of stay, thanks to a better exchange of information. The development of medical records and e-prescriptions are fundamental to a more integrated approach to healthcare and improve patient safety, quality and continuity of care. Home care and community care are improving and nurses now play a fundamental role in the system; the head hospital nurses follow the patient journey and whenever necessary they contact the social workers on the territory, being in touch with them.

HUNGARY

The Hungarian system is taking important steps towards the modernization and integration of its healthcare system. In fact, notwithstanding the difficult economic situation of the last years, the high bureaucracy which characterises the country and the progressive loss of healthcare professionals leaving abroad, the country's healthcare system is steadily improving, adapting the still complex and out-of-date structure of the system to the increasing needs of quality and flexibility expressed by the population. In the area of prevention the country's vaccination coverage reaches a rate by 98%-99%.

The new, tight tobacco control and prevention law is in place from January 2012, and a new law on junk food has been proposed. The national emergency ambulance service and some specialized healthcare centres, such as the National Institute for Medical Rehabilitation have been developed and are very high level experiences. The IT architecture integration project to harmonize healthcare IT is leading to good results. The country can make advantage from EU funding and the support from Foundations. Moreover its participation in a EU research project on the "Quality and Cost of Primary Care in Europe" helps the system to improve.

BULGARIA

In Bulgaria the Ministry of Health is responsible for Public Health, health information, emergency care, hygiene and epidemiological inspections, drug agency and national cancer register. It is also responsible for the Regional Health Centres, which manage primary care, specialized outpatient healthcare and hospital care.

In primary healthcare, the central role is played by General practitioners, who have some competences in health promotion. They are autonomous, they have contracts with the National Health Insurance Fund (NHIF), but it is also allowed for them to practice private activity. Health promotion is provided by the regional health inspection centres. Like GPs, specialized doctors working in secondary care are autonomous, have contracts with the NHIF and can practice private activity. The patient is central to the system and he/she is the owner of his/her clinical information. After hospitalization, patients receive a copy of their clinical report and they can decide to provide this information to their GP or not.

SPECIFIC PATHWAYS OF CARE

New integrated patterns of care are often introduced when the need of continuity of care and coordination are prominent to guarantee better health and a more efficient and effective stay of patients in the system. They normally are introduced in relation to specific states of illness, such as chronic diseases (e.g. diabetes, stroke or cancer) or regarding more complex patterns of care, like those referring to mental health or palliative care.

GERMANY

In Germany, the **Psychiatric Outpatient Departments** (Psychiatrischer Institutsambulanz) make hospitalization for treatment of depression much shorter and more effective. During the care pathway patients are seen by different specialists - psychiatrist, psychologist, specially educated nurses - social workers and different therapists. This multiprofessional team meets the patient before and after hospitalization, also at home, in familiar surroundings, and offer group therapy in the long run.

Advantages of the Psychiatric Outpatient Departments are to:

- > help to minimize expenditures and keep costs for the German health care system lower;
- > give appointments with specialists without waiting time;
- > offer emergency care around the clock;
- > promote reintegration in everyday life or even avoid de-integration;
- > complete the range of hospital and ambulatory care.

SLOVENIA

In Slovenia, some of the most relevant causes of death are cardiovascular diseases, malignant diseases, but also suicides. For this reason, a specific **Mental Health Act** was approved in 2008 and came into force to be applied a year later, by August 2009. The Act provides a legislative framework for a national strategy on mental health, putting a particular focus on legal protection and community approaches to mental patients. It:

- > defines responsibilities of the government and of healthcare providers;
- > defines solutions regarding the empowerment and legal security of the most vulnerable group of mental patients (i.e. those who might be involuntarily admitted);
- > and gives a definition of community care.

The mental health programmes and the learning disabilities programmes are well developed. In primary care anti-stigma campaigns are carried out in cooperation with the mental health services, but the integration between primary and secondary care is still weak. The approach to learning disabilities is effective, adopting an educational rather than a care focus.

The educational opportunities for learning disabilities patients are very person centred. Excellent use of sensory tools such as symbols and sensory garden. The therapies are also personalized, and targeted to each individual. There is continuity between primary to secondary care in paediatric, with dedicated paediatric input for first year of life.

MALTA

Malta has introduced programmes and strategies aimed at improving the health and wellbeing of specific categories of population creating a linkage between the different healthcare sectors.

The **Maltese Community Mental Health Strategy** adopts a multidisciplinary and integrated approach to support mental patients at each stage of their illness, ensuring continuity of care – thanks to home and work visits – and favouring the reintegration of the person in the community, reducing at the same time the need of medications and hospitalization.



The **multidisciplinary shared care Diabetes Programme** establishes strict clinical management guidelines and minimum standards of care at primary care level, ensures that patients are provided with timely and equitable access to secondary care specialists, as well as routine visits to primary care and specialist diabetes services with the collaboration of key stakeholders in the area of diabetes, including the patient, family doctors, diabetes nurses, dieticians, ophthalmologists and podiatrists, thus providing a multidisciplinary and holistic approach to diabetes care.

With this protocol all patients with diabetes undergo yearly, standardised, comprehensive foot screening by a podiatrist at their respective Health Centres. If pathology is detected, the patient is subsequently referred for vascular assessment, with the possibility of further specialised assessment by a vascular surgeon if necessary. The GP also conducts screening for diabetic retinopathy, in addition to an annual ophthalmic referral for full assessment by ophthalmologists.

The shared care programme 'fast tracks' urgent cases to the vascular surgeon and avoids unnecessary referrals to hospital of cases that can be effectively managed at primary care level.

Central for the success of this programme has been the implementation of a single computerised register of all patients with diabetes in Malta in all health centres, with three major advantages:

- > providing information on the actual costs of diabetes care and the burden on the national health budget;
- > allowing documentation of each patient's progress within the system;
- > enhancing communication between the members of the interdisciplinary team.

Hospice Movement Malta is an organization that provides integrated care and promotes the highest standards of palliative care for all persons with cancer, motor neurone diseases and other terminal diseases, avoiding to overburden hospitals, better targeting the needs of terminal patients and their families and guaranteeing coordination with primary and secondary care actors. Palliative care is undertaken with an interdisciplinary, multi-professional approach, most often involving a physician, a nurse and other health care workers who have the expertise needed to respond to the physical, psychological, social and spiritual needs of the patient and the family. The services offered include home care, day care, hospital support, respite care, social work support, spiritual support, physiotherapy, complementary therapy, occupational therapy, bereavement support, family support, children summer courses and loan of equipments to patients.

THE UNITED KINGDOM

The **National Improvement Programme** has been set up by the English National Health System (NHS) to support the development of stroke care networks and the implementation of the National Stroke Strategy, with the aim of reducing the relatively high incidence rate (compared to other developed countries), reducing the inequalities in accessibility to adequate treatment, improve treatments and cost-benefits. The Programme fosters collaboration between primary and acute level (integrated care pathways) and enhances higher patients and relatives involvement. It includes a national strategy and guidelines, research and education programmes, national campaigns, the introduction of quality indicators and Stroke Networks.

The role of the networks is to improve the way that services are planned and delivered for both stroke survivors, carers and staff. Stroke care networks will help to guide the commissioning process through providing clinical expertise; support service improvement across the whole pathway of care; and enable 'clinical networking' – vital communication between the different stages of the 'patient pathway'.

POLAND

In Poland Primary Healthcare Centres (PHC) provide outpatient care and offer a wide variety of medical services, which include general practice, maternity care, child health care and dental care. The GPs act as gate-keepers, and emergency care is available for everyone.

The **General Practitioner Cancer Center** (GPCC) is one of the biggest oncology centres in Poland and in Europe. It provides comprehensive care to cancer patient, from prevention to treatment and palliative care. The GPCC offers medical services in oncological surgery, head and neck cancer surgery radiotherapy, chemotherapy, gynaecological oncology anaesthesiology, brachytherapy and diagnostics. The GPCC is the host of regional programmes against Breast Cancer and also manages prevention campaigns. In the GPCC the pharmacists are highly specialized in preparing citostatic drugs. Following the higher standards of care, the centre features interdisciplinary teams providing holistic care for patients with cancers in a given location. These teams include: physicians, psychologists, physical therapists nurses and supporting workers.

LUXEMBOURG

In the Grand Duchy of Luxembourg the strategic map of Central Hospital of Luxembourg 2008-2015 defines supply and continuity of care. **Continuity of care post-partum** is a basic principle, a challenge that hospitals and primary care institutions must share all synchronized to a common goal, and an example of excellence.

The Continuity of Care Management Process is prioritized by the Centre Hospitalier du Luxembourg (CHL) and its nursing director. The characteristics of the system include:

- > a standard process for postpartum care and work with a network of well-defined roles: there is a profile for each function and mission, midwives are directly responsible for care and have complete autonomy with clear responsibilities (identity midwife);
- > presence of a midwife at the hospital of reference for every woman;
- > planning for discharge from hospital by the fourth day for normal delivery and by the fifth or sixth day of stay for caesarean deliveries;
- > collaboration and coordinated approaches to common objectives, in particular, minimum 4 home visits after birth covered by the midwife in private practice.

A number of different tools ensure data access and exchange in real time and enable the involvement and awareness of patients:

- > paper patient records;
- > computer records - Project MetaVision that allows the automation of the report;
- > communication, transmission or oral (telephone) contact with the nearest midwife by area and region.
- > guides, counselling, workshops, brochures postpartum, health record for the child and the list of paediatricians and midwives in private practice;
- > protocols of care and organizational procedures for safety;
- > the extracts of the medical record.

The top management supports the quality of care by:

- > internal audits to analyze clinical professional practice;
- > patient satisfaction surveys with the use of quality and performance indicators of care;
- > investigation and nationwide Picker survey of leave-management.

Nursing Direction, the good professional practice, the good communication between physicians and midwives allow corporate coordinated activity among postpartum hospital consultations, emergency services, midwives and liberal doctors with major advantages:

- > the private practice midwives know they are not an isolated part of the woman's health project;
- > obstetrical hospital clinic (expert level) and the private practice midwife (primary) improve short-and long-term health of women and newborns through coordination and continuity of care at home.

ROLE OF PROFESSIONALS

One of the main implications of the reforms of integrated care is the change of the role and the improvement of qualification of healthcare professionals, in particular General Practitioners (GPs) and nurses.

The role of general practitioners is strengthened, and GPs are more and more connected to the hospitals, cooperating with hospital professionals. Nurses are taking over some of the competences reserved in the past to doctors. Their qualifications and their roles are improving, while their career possibilities are increasing.

FRANCE

In France, the introduction of a **GP consultation coordinated with emergency telephone calls** responds to the need of reducing workload at emergency services and at the same time improves the patients' satisfaction, since they can find faster and more targeted answers. This service links GPs, hospital emergency services and out-of-hours primary care services (maisons de garde). GPs and urgent care specialists manage emergency calls. Calls not needing emergency medical care are passed to a local GP for telephone advice or to make an appointment for a consultation.

The **team work in psychiatry** has also been introduced in the French system. It involves not only physicians but also nurses, in the phases of diagnosis and treatment. In particular, nurse team triages and coordinates further care with other institutions and therapeutic activities.

SWITZERLAND

As in many European countries, in Switzerland the average age of GPs is increasing, but general medicine is an unattractive medical discipline and the number of GPs is declining. GPs should be available 24/7, their missing function as gate-keepers provoke the overuse of secondary care and in particular unnecessary patients in Emergency Rooms. GP patient records are on paper and need to be electronically recorded.

Two solutions have been implemented in the country: GPs co-located in emergency departments out of normal working hours and "Medicphone" - a single central telephone number managed by triage nurse.

With **GPs co-located** in emergency departments out of normal working hours the advantages for patients consist in having a unique and secure point of access and, being opportunely triaged, access the right care at the right time, without wasting time or money and experiencing a good relationship with the GP. The GPs are on-call, so the working hours reduce significantly, improving the quality of life, and this make the profession more attractive. Moreover GPs' income depends on local contracts, they have more and more effective collaboration with hospital clinicians for a second opinion and can easily access to electronic records where available. The new system allows avoiding inappropriate admissions, with a great advantage for the hospital organization, it allows making a better a more effective use of hospital resources and facilitates improved relationships between hospital doctors and GPs colleagues. It is advantageous for the entire system since it rationalizes the use of resources, supports sustainable GP services, supports viability and reduces insurance companies' payout.

With "Medicphone" - single central telephone number - a triage nurse is the first contact with the citizen seeking for help. S/he assesses the condition of the person and can decide to refer him/her immediately to the hospital, immediately to a GP or postpone the visit with a GP on the following day.

THE UNITED KINGDOM

The **GP Liaison Manager** is the permanent link between the hospital and the primary care providers on the territory. GP Liaison Manager in the Hospital organizes regular meetings joined by GPs, Consultants and further healthcare professionals. In this way, he allows and facilitates faster and more reliable communication and exchange of information between GPs and consultants, health care professionals get to know and trust each other, beneficial clinical pathways can be established and costs are reduced.

The **Admission Discharge Transfer Nurse** (ADT) helps the patient to go through his/her pathway of care without interruption, cutting length of stay, avoiding wasting of time and resources both for the patient and for the system and favors the appropriateness of care. The ADT nurse follows the entire trendcare of patients: prepares for new admission, completes nursing assessment, identifies patients who are for discharge or for transfer during the shift (simple, short stay patient only), plans and organizes patient discharges, and facilitates the transfer as soon as possible. When there is more than one new admission, discharge or transfer, the ADT nurse will need to prioritize and plan her work with the assigned referent nurse. This service enables better collaboration with the hospital rehabilitation teams and social services, increases satisfaction and quality of care for patients and their families.

SWEDEN

Sweden offers an example of well-integrated and continuum pathway of care. From the first contact to discharge and follow up, the patient is always involved and the system is designed to support his/her journey as much effectively and efficiently as possible.

The first contact with the system can happen through the national help line : 1177. It is a 24 hour **nurse-led service** that allows patients to talk to a nurse for first advice and indications when there are simple symptoms of disease. The patient has a 10 digit unique identification number through which the nurse can immediately identify him/her and give appropriate indications about treatments and prevention. In the end she advises to contact the Primary Healthcare Centre if the patient does not improve.

The Primary Healthcare Centres (PHC) can be privately or publicly managed. The first contact is normally a nurse who can advise the patient to go there immediately or give him/her an appointment. In some counties the patient can be admitted to primary care beds managed by the GP. If the patient at home or admitted at a PHC does not improve, the general doctor can arrange the transfer to the hospital through the ambulance service. The ambulance staff is specially trained nurses. Clinical information can be sent directly from the ambulance to the ward.

In the hospital the first contact of the patient is with a nurse. In some areas of Sweden, 80% of patients have a discharge meeting before leaving the hospital. Healthcare and social workers participate in the meeting to make sure that everything patient needs has been obtained. The patient can be discharged home, in a municipality bed or to a nursing home.

When discharged home the patient can receive:

- > a mobile team – a nurse, an occupational therapist, and a doctor if needed – for following up him/her;
- > a staff from the municipality if needed. In some municipalities patients can have up to 9 visits during the day, plus visits at night;
- > the district nurse might visit weekly.

THE NETHERLANDS

In the Netherlands medication is a national quality element and is explicitly audited. **Pharmacy management** has a crucial role in the whole patient journey - from admission to discharge.

In the admission phase the hospital pharmacist talks to the patient individually and gets the information on the medicines he/she is taking. The reason is to confirm prescribed medicines, self-medication and information for the patient.

During the hospital stay the hospital pharmacist plays his/her most important part, checking and monitoring the changes in the medications prescribed by doctors, verifying the interactions, allergies, contra-indications, doses, links of prescriptions to the laboratory tests.

After discharge the hospital pharmacist shares information with the local pharmacist and with the hospital doctor and delivers information to the patient, ensuring the better continuity of care.

A good integration between hospital pharmacists, doctors, patients and local pharmacists plays a key role to improve quality of care and avoid errors. Shared communication, during the hospital stay and after discharge, increases patient safety and improves patient experience. The shared responsibilities between doctors and pharmacists, based on secure information flows help reducing mistakes, improve the quality and the timing of care and medication, with positive effects also on staff satisfaction.

LITHUANIA

In Lithuania family doctors are gatekeepers. Since the first reform of 1992 their role has been strengthened with the aim of empowering primary healthcare services, reducing hospitalization and improving the health of the population.

Since 1992 more than 2200 general practitioners have been educated, two thirds of them- former district internists and pediatricians after retraining. Postgraduate residencies in family medicine were established in 1992 and in 1995 there were the first graduates in family medicine; retraining to family physicians started in 1997 and completed in 2005. New family doctors since 2005 are trained at the University.

Family physicians take care of health of the inhabitants registered at the primary health care institutions (out-patient clinics, family doctor centers). They are responsible not only of treatment but also of disease prevention, health preservation and improvement. They are the first reference point to the patient and decide what kind of aid the patient needs. In fact, patients who need to go from the primary level to hospitals must have a referral from their family doctor, with the only exception of emergency cases.

While putting emphasis on primary healthcare provision, other measures have been also taken with the general aim of streamlining and improving the healthcare system:

- > decrease number of health care personnel (doctors and nurses);
- > establish prevention programs and promotion services;
- > establish new public institutions about AIDS, alcohol and drugs;
- > decrease in health care institutions budgets;
- > closing hospitals with low performance.

The positive outcomes of these measures are:

- > reduction in the number of in-hospital patients;
- > reduction in the Hospital death rate;
- > reduction in the average hospital length of stay;
- > analysis of the quality-of-life indicators and death rates by different causes demonstrate that in case of the most causes of deaths, the death rate is decreasing by 3%;
- > comparisons of morbidity indicators reveal that avoidable illnesses related to alcohol have especially positive trends.

ESTONIA

In Estonia the primary care level has a key role in the health system, given the gate-keeping responsibility of the family doctor in almost all specialties. This has allowed the development of a good coordination among the healthcare sectors and the establishment of good and effective communication channels at all levels.

The family doctors send referrals to hospitals and vice versa the hospitals send clinical reports to the family doctors. Telephone and web consulting (peer to peer) are diffused.

Primary care and hospital care **work together** for determined patterns of care. They share responsibilities and care pathways for prenatal and children care. They have clinical practice guidelines and learning sessions in common. Family Doctors, family nurses and home nurses (hospital) cooperate for the planning and development of palliative and end-of-life care.

Public health programmes, such as smoking cessation, cardiovascular diseases and screening breast cancer are always coordinated. Moreover, hospitals and primary care institutions share information technologies, they have uniform electronic prescription and the E-health system links all healthcare services providers (ID card).

HOME CARE

If avoiding hospitalization helps patients to recover better, reducing hospital admissions helps saving resources in the system. Thus, one of the main means to ensure effectiveness of care preserving also the resources of the system is the activation of home care pathways.

The utilization of home care, often managed by home nurses or directly by general practitioners, is spreading around Europe with different shapes and responding to various types of needs in the local or national systems. When developing this pattern of care continuity and integration with hospitals, primary care level and community care are essential, since the continuum monitoring of the patient has to ensure his/her timely and appropriate referral to hospital or to primary care as soon as necessary.

BELGIUM

The Belgian system is based on the mutuality (insurance funds), that accompany citizens along all their healthcare needs, from vaccination, to outpatient care and hospitalization.

In case of necessity, and whenever the families of elder people ask for it, the mutuality can send a **home nurse** to take care of patients with limited autonomy, allowing them to remain home. The families may also engage home nurses from independent organizations, in this case the mutuality will pay the costs back.

In some cases, patients and older relatives can be transferred from home to residential homes, where they receive social and health care. This decision is normally taken collectively by the family, the social nurse, the home nurse and the family doctor, who always follows and monitors the health status of the population assigned to him, having a role of gate-keeper.

In the case of palliative care provided in hospital, the closest relatives are allowed to stay with the patient, and a group of psychologists help them to cope with the situation.

FRANCE

With the introduction of the **Hospital at home** (Hospitalisation à Domicile) the coordinated management of patients with complex needs at home has been developed as an alternative to traditional hospital care. The hospitalization at home is monitored and accompanied by a multidisciplinary team that prepares and reviews the comprehensive care package for the patient. In the multidisciplinary team doctors, nurses, psychologists, pharmacists, physiotherapists and social workers across public and private sectors participate to the delivery of care, led by the patient's GP.

LATVIA

In Latvia it is very important to invest in promotion of health and to try to improve lifestyles, in order to reduce the costs of hospitalization and improve population health. Medical Home Care helps achieving these aims.

The **medical home care** teams are well integrated in the comprehensive health and social care system including primary care (general practitioner), medical services, social services, wound management. Medical care service at home is provided if patient needs a regular (permanent) outpatient treatment but due to medical reasons he is unable to attend health care institutions to receive outpatient care. So the main types of patients for Medical Home Care are: chronically ill (asthma, diabetes...), after surgery, palliative care, after trauma.

There are 189 centers for home care all over Latvia. Their main characteristics are:

- > the specific Education Programs;
- > special resources, e.g. special bag with all the equipment and material;
- > the independence of nurses, who evaluate the status of patients and provide care;
- > the assessment of the environment of the patient (hygiene, safety...).

The continuity of care is guaranteed by:

- > the good communication between the home care team and other members of the multidisciplinary team;
- > the respect of standard guidelines and protocols for medical home care;
- > the training for medical care at home involving both the members of the team and the family doctors;
- > Tthe training for the families.

Family doctors refer for medical home care and receive feedbacks from the medical home care teams.

PORTUGAL

The Portuguese system is going through a series of initiatives aimed at increasing the continuity of care. The system is well integrated. A central role is played by GPs, who manage the vaccination and education programmes in the phase of prevention and refer patients to secondary or tertiary care in a second instance.

Hospital care maintains continue contact with primary and community care. At this level, one of the most important innovations is the **Mobile Support Unit for Home Care** - Unidade Móvel de Apoio Domiciliário (UMAD) - coordinated with the social services. The unit offers support to patients at home in a state of chronic disease and dependence on a technology.

The Mobile Support Units for Home Care allow supporting continuity of care after hospitalization but in particular they help to: decrease the admissions of patients with chronic diseases; decrease the cost of hospital stay for patients and their families and for the system; improve quality of life for patients and their families in a situation of dependence on technological supports. These mobile Units are managed by multiprofessional teams including specialized doctors, nurses, and social workers.

USE OF INFORMATION AND COMMUNICATION TECHNOLOGIES (ICTS)

Today Information and Communication Technologies (ICTs) play a real crucial role in allowing coordination and continuity of care. Without patient records, electronic devices and databases, the sharing of information and the exchange of documents would not be possible. ICTs allow timely exchange of information, distance treatments, diagnoses, monitoring and follow-up, guaranteeing patients safety, effectiveness of care, and savings of resources in the systems.

DENMARK

In Denmark, patients have the freedom to choose where to receive healthcare and many national and local technological resources help them to make informed decisions.

The **effective communication and flow of information** around the system is realized through:

- > the unique citizen CPR number, which is issued at birth and covers every interaction of the citizen with the state of Denmark, including healthcare use;
- > Medcom - for professionals - cooperative venture between the public and private sector to quality that assures electronic information and communication systems;
- > Sundhek.DK - the official Danish e-health portal – that provides high quality, accurate, up to date information accessible to citizens and professionals.

The **Informed Choice and the rights of patients** are realized through the National Patient Safety Association, which represents the voice of the Danish patients, being responsible for:

- > patient handbook, which gives patients health advices, information about their rights and the standards to expect;
- > patient safety & quality check lists & accreditation processes in hospitals, which focus specifically on reducing harm and assuring high quality practice and standards;
- > the Say Sorry Policy for advice and help to health professionals and patients when errors happen;
- > the National Patient Insurance Association which deals with compensation for when things do go wrong.

This information is accessible and tailored to the needs of the user. The intention is for the information to be in the right place at the right time designed to support the citizen, the patient and the healthcare professionals in making decisions about health.

SPAIN

The **Multi-channel Health Service Centre** (MHSC), developed in particular in the Basque region, addresses the needs of chronic patients, which have to maintain the level of low intensity constant contact, in contrast with the sporadic high intensity contact which acute patients receive from traditional face-to-face care.

The service increases the number of ways in which the public can interact with the health system. The constant monitoring of patients does not interfere with their personal life and work. It allows physicians to focus on high value activities, offloading administrative procedures, monitoring activities and routine check-ups. And promotes patients' self-consciousness and the involvement of citizens with their own illnesses

The project has the following characteristics:

- > it uses all the available channels of interaction (Web, telephone, SMS, Digital Television,...) between the citizen and the health system in order to facilitate the care procedures;
- > it enables administrative procedures to be carried out - primary care appointment management, reminder and/or confirmation of appointments, medical certificate reports, TIS (personal health card management)...
- > it makes general health service information available to the users - range of services, health centre directory, night clinics and duty pharmacies;
- > it is a mean to facilitate health promotion, information and education. In particular the Patients Forums take responsibilities for the promotion of healthy lifestyles, vaccination reminders and information regarding Public Health programmes;
- > it provides a telemedicine home care service - remote assessment systems and telemetric monitoring - for domiciliary chronic patients, multipathology patients and those with advanced or unstable pathologies;
- > it provides medical advice and enables citizens to access information regarding their health (personal health file).

SWEDEN

In the Swedish system one of the main strengths and the principal mean of integration is the communication and information exchange between primary care, secondary care and patients/citizens.

All citizens in Sweden are guaranteed to be offered contact by phone or on site on the same day and a doctor's appointment, if necessary, within 7 day; a specialist within 90 days and treatment within another 90 days. All this information is accessible via the **web** to the public and citizens can find out how long the waiting list is at each hospital in each county across the country.

Each citizen is identified by a **10 digit unique identification number** through which all health information about him/her can be accessed and shared within the system.

Patients are admitted in the hospital to stay shortly, receiving the best care:

- > all information from primary care is accessible to the staff in the hospital and even if in the majority of county councils the IT systems between primary care and hospitals are different, people can see a summary;
- > **Lean** is the tool that many county councils are using to ensure that processes are efficient and add value to the patient's experience;
- > **Vårdlink** is a computer system that allows discharge arrangements to be made.

All the health information on treatment during hospitalization is inputted into **national, disease specific quality registers** that is accessible to all health professionals.

UNITED KINGDOM

The improvement of **Telehealth in Primary Care** allows patients to stay at home. It increases patients' satisfactions and reduces costs of unnecessary visits both for patients and for doctors.

With the use of tools of telehealth the chronically ill patient can continue in his daily activities, staying at home, being completely independent, but continuously monitored. As soon as his/her health condition changes he can contact the General Practitioner who can refer him to the hospital doctor.

STRATEGIES AND GOOD PRACTICES IN EUROPE COUNTRY ANALYSIS

The following paragraphs present in high detail the good practice developed by each country which have as an aim or as a consequence the increase of coordination among sectors and the provision of better patterns of care to citizens.

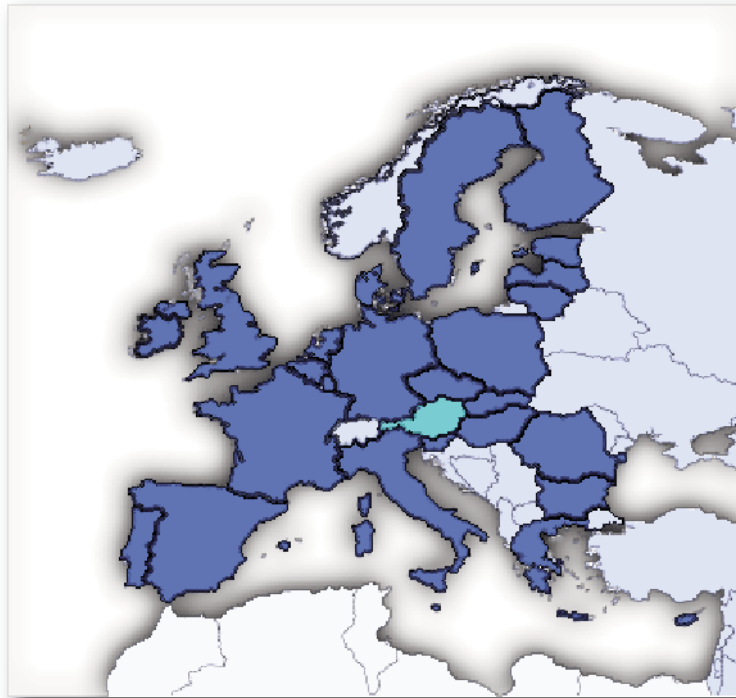


HOPE 2011 Exchange Programme Better health - A shared challenge for hospitals and primary health care Programme of Evaluation day June 21

08.30 – 09.00	WELCOME AND INTRODUCTION – <i>Dr. Aino-Liisa OUKKA, HOPE Governor for Finland</i>	
CHAIR MORNING SESSION: <i>Jussi MERIKALLIO, Director, Social Welfare and Health Care - Association of Finnish Local and Regional Authorities</i>		
09.00 – 10.00	1 ST BLOCK OF PRESENTATIONS	
09.00	CH	IT DEPENDS...
09.10	MT	MALTA, MELA, LET'S EXPLAIN!
09.20	FR	CARE TOGETHER ? THE FRENCH CHALLENGE
09.30	SI	MENTAL HEALTH AND LEARNING DISABILITY HEALTHCARE IN SLOVENIA
09.40	GB	THE "C" FACTOR – EVOLUTION OR REVOLUTION
09.50	LT	BETTER HEALTH - A SHARED CHALLENGE FOR HOSPITALS AND PRIMARY HEALTH CARE
10.00 – 10.30	BREAK	
10.30 – 11.30	2 ND BLOCK OF PRESENTATIONS	
10.30	PL	FROM THE GP TO THE GP CANCER CENTRE
10.40	ES	THE SPANISH WAY TO BETTER HEALTH
10.50	BG	BETTER HEALTH - A SHARED CHALLENGE FOR PRIMARY HEALTH CARE AND HOSPITALS. BULGARIA
11.00	GR	INTERACTIVE COMMUNICATION : A TOOL FOR BETTER PERFORMANCE IN HOSPITALS AND PRIMARY HEALTH CARE
11.10	SE	MAMMA MIA'S HEALTH JOURNEY
11.20	DE	GERTRUD'S RIDE THROUGH GERMAN HEALTH CARE
11.30 – 12.00	ART DANS LA CITE - EUROPEAN BIENNIAL OF VISUAL ARTS IN HOSPITAL	
12.00 – 13.00	LUNCH	
CHAIR AFTERNOON SESSION: <i>Risto RAIVIO, Director of Health Services, Social and Health Services - City of Lahti</i>		
13.00 – 13.50	3 RD BLOCK OF PRESENTATIONS	
13.00	NL	PHARMACY MANAGEMENT: COLLABORATION BETWEEN HOSPITAL AND PRIMARY HEALTHCARE
13.10	BE	BE HOPE
13.20	LU	QUELLES SONT LES INNOVATIONS ORGANISATIONNELLES QU'OFFRE LE SYSTÈME DE SANTÉ DU LUXEMBOURG PAR RAPPORT À LA COORDINATION DES SAGES-FEMMES HOSPITALIÈRES ET DES SAGES-FEMMES EN EXERCICE LIBÉRAL. EST-CE QU'ON ASSURE LA CONTINUITÉ DES SOINS EN RELATION AU POSTPARTUM?
13.30	DK	A DREAM COMES TRUE... BETTER HEALTH
13.40	HU	REFORM AND FUTURE OF THE HUNGARIAN HEALTHCARE SYSTEM
13.50 – 14.20	BREAK	
14.20 – 15.10	4 TH BLOCK OF PRESENTATIONS	
14.20	PT	BRIDGING THE HEALTH GAP
14.30	EE	TWO SPANISH MEN IN ESTONIA LOOKING FOR "BETTER HEALTH"
14.40	LV	MEDICAL CARE AT HOME - THE SHARED CHALLENGE IN LATVIA
14.50	AT	ONCE UPON A TIME IN AUSTRIA ... AND THEY LIVED HEALTHILY EVER AFTER
15.00	FI	FINNISH HEALTHCARE - CONNECTING PEOPLE
15.15 – 15.30	CLOSING REMARKS – <i>Pascal GAREL, HOPE Chief Executive</i>	

COUNTRY ANALYSIS AUSTRIA

A comprehensive reform for the system integration



In Austria, for many years the lack of flexibility and the fragmentation of the system brought to an overload of treatments for patients and to heavy workloads for healthcare institutions. With the economic constraints and the demographic changes happening recently, these issues have become more and more serious. Hence, in 2005, the Austrian Federal Health commission promoted one of the biggest reform pool projects financed by the Federal Health Funds.

The project **Patient Oriented Integrated Care** – PIK (PatientInnenorientierte integrierte Krankenbetreuung) is a population and patient-centred care approach, aimed at bridging the sectoral boundaries of Austrian federal health care system by cooperation through cross-boundary e-pathways allowing an interdisciplinary discharge planning and a standardized information transfer.

The project foresees:

- > the cooperation among a large number of stakeholders,
- > the pooling of financial resources of different healthcare financers and financing sources in order to support projects of integrated healthcare.

In fact, the new health platforms now make arranged decisions about the inpatient and the outpatient sectors, as well as about the cooperation strategies between the two. The platforms consist of representatives of federal states, social health insurance institutions, medical association, patient advocacy, churches (as carriers of clerical hospitals), one representative of the state and one of the Main Association of Austrian Social Insurance Institutions.

Decisions regarding both the in- and the outpatient sector are made democratically, decisions for cooperation require a clear agreement between the federal states and the social health insurance institutions.

The PIK project foresees cooperation in five measures:

- > hospital discharge management for patients with complex post-inpatient care;
- > standardized electronic information-transfer between hospitals;
- > home care organizations and general practitioners;
- > promotion of contacts to self-help groups during hospital stay;
- > development of a common web-based information platform for all health care and social services;
- > standards for the prescription for medical devices and equipments at home.

The comprehensive roll-out and combination of the first two measures enable a consistent interdisciplinary cross boundaries pathway for the discharge of patients with complex post-inpatient care needs, the core target group of the project.

Crucial instruments of the project are:

- > the interdisciplinary discharge report;
- > the electronic admission/discharge letter;

These two instruments realize a multidisciplinary plan of care covering principles of collaborative working and engage stakeholders to provide detailed guidance for care delivery at each stage of the whole patient journey, considering specific care needs or complex post-inpatient care needs.

The project so far has proven to be successful, bringing positive outcomes in many aspects:

- > decrease in care-related re-admission rates and length of stay;
- > improvements in the continuity of care results due to timely and high quality information;
- > increase in data security and transmission reliability due to high degree of utilization of the electronic admission/discharge report;
- > quality improvements (less errors, comprehensive and complete information);
- > increase in satisfaction of health professionals and administrative efficiency.

COUNTRY ANALYSIS BELGIUM

A mutuality-based model accompanying citizens along their entire life



The Belgian system is based on the mutualities (healthcare funds). At birth, each citizen is covered by the mutuality of his/her parents, afterwards he/she can chose to change it.

The mutuality accompanies citizens along all their healthcare needs.

- > From vaccination, to outpatient care and hospitalization, whenever needed. In the two cases mentioned the mutuality pays back to the patient about 75% of the fee for the examination or hospital charge, both for private and for public hospitals.
- > Often the mutuality also takes care of sending invitations to screening programmes for cancer, and of course it covers the costs.
- > In case of necessity, and whenever the families of elder people ask for it, the mutuality can send a home nurse to take care of patients with limited autonomy, allowing them to remain home. The families may also engage home nurses from independent organizations, in this case the mutuality pays the costs back.
- > In some cases, patients and elder relatives can be transferred from home to residential homes, where they receive social and health care. This decision is normally taken collectively by the family, the social nurse, the home nurse and the family doctor, who always follows and monitors the health status of the population assigned to him, having a role of gate-keeper.
- > In the case of palliative care provided in hospital, the closest relatives are allowed to stay with the patient, and a group of psychologists help them to cope with the situation.

COUNTRY ANALYSIS BULGARIA

A system centred on the autonomy of patients and doctors



In Bulgaria, the Ministry of Health is responsible for Public Health, health information, emergency care, hygiene and epidemiological inspections, drug agency and national cancer register. It is also responsible for the Regional Health Centres, which manage primary care, specialized outpatient healthcare and hospital care.

In primary healthcare, the central role is played by general practitioners, who have some competences in health promotion. They are autonomous, have contracts with the National Health Insurance Fund (NHIF), but it is also allowed to them to practice private activity. Health promotion is provided by the regional health inspection centres.

As well as the GPs, also specialized doctors working in secondary care are autonomous, have contracts with the NHIF and can practice private activity.

The patient is central to the system and he/she is the owner of his/her clinical information. After hospitalization patients receive a copy of their clinical report and they can decide if provide this information to their GP or not.

COUNTRY ANALYSIS DENMARK

The patient as a full member of the healthcare team:
a key to continuity of care



In Denmark, patients have the freedom to choose where to receive healthcare and many national and local resources help them to make informed decisions. The principle of patient centeredness is realized through two means: an 'Effective Communication and Information Flow' and the 'Freedom of Informed Choice of Patient'.

The **effective communication and flow of information** around the system is realized through:

- > the unique citizen CPR number, which is issued at birth and covers every interaction of the citizen with the state of Denmark, including healthcare use;
- > Medcom - for professionals - cooperative venture between the public and private sector to quality that assures electronic information and communication systems;
- > Sundhek.DK - the official Danish e-health portal – that provides high quality, accurate, up to date information accessible to citizens and professionals.

The **informed choice and the rights of patients** are realized through the National Patient Safety Association, which represents the voice of the Danish patients, being responsible for:

- > patient handbook, which gives patients health advices, information about their rights and the standards to expect;
- > patient safety & quality check lists & accreditation processes in hospitals that focus specifically on reducing harm and assuring high quality practice and standards;
- > the Say Sorry Policy for advice and help to health professionals and patients when errors happen;
- > the National Patient Insurance Association which deals with compensation for when things do go wrong.

This information is accessible and tailored to the needs of the user. The intention is for the information to be in the right place at the right time designed to support the citizen, the patient and the healthcare professionals in making decisions about health.

COUNTRY ANALYSIS ESTONIA

Communication and coordination between the hospital and the family doctor



In Estonia the primary care level has a key role in the health system, given the gate-keeping responsibility of the family doctor in almost all specialties.



This has allowed the development of a good coordination among the healthcare sectors and the establishment of good and effective communication channels at all levels:

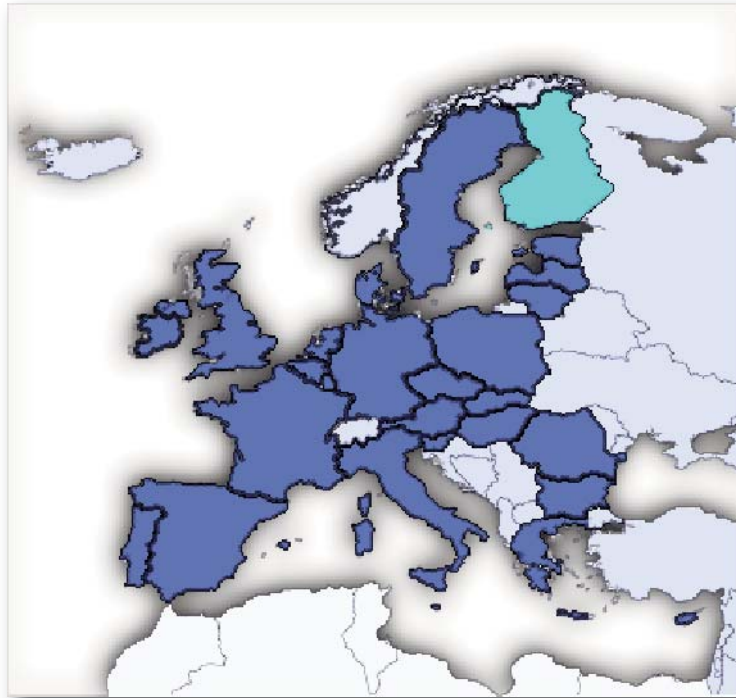
- > family doctors send referrals to hospitals and vice versa the hospitals send clinical reports to the family doctors;
- > telephone and web consulting (peer to peer) are diffused;
- > hospitals and primary care share information technologies, they have uniform electronic prescription and the E-health system links all healthcare services providers (ID card).

Moreover, primary care and hospital care work together for determined patterns of care:

- > they share responsibilities and care pathways for prenatal and children care;
- > they have clinical practice guidelines and learning sessions in common;
- > family doctors, family nurses and home nurses (hospital) cooperate for the planning and development of palliative and end-of-life care;
- > public health programmes, such as smoking cessation, cardiovascular diseases and screening breast cancer are always coordinated.

COUNTRY ANALYSIS FINLAND

An integrated system for an efficient and effective patient journey



Finland presents a coordinated system that follows the patient's journey from the phase of prevention to the phase of rehabilitation guaranteeing continuity of care and integration.

The prevention on the territory embraces the areas of work-life balance, occupational health care, promotion of family well-being and healthy lifestyle, minimizing the risks of direct access to healthcare. All health care providers must have plans for health promotion.

The primary care services, offered in Primary Health Centres (PHC), effectively hold the role of gate-keepers, with a share of 95% of successful resolutions.

In the PHC nurses play a central role for the assessment of patient conditions at the arrival; the centres offer a full range of diagnostics, oral health and are provided with in-patient wards; they are always integrated with social services, and in this way the appropriateness of access to hospitals and the effectiveness of care are guaranteed.

The effectiveness of hospital care benefits from the integration with primary care.

- > The information flows between primary care and hospitals is guaranteed by technology, more than 90% of public health organizations in fact have e-patient records.
- > Clinical care pathways and planning are shared between primary care and hospitals, in particular hospitals must support the primary care in planning and providing health promotion and disease prevention.
- > There is continuum education and training exchange between specialists and general practitioners.

The social services and rehabilitative structures provide elderly care, occupational support and self-management, they also manage home care services and are normally activated by the primary or secondary healthcare, thanks to the high level of integration.

Important innovations in the Finnish health system have been introduced with the **New Healthcare Act 2011**, which reinforces the rights of patients and, among the other things, establishes that:

- > patients can choose the health care center and the hospital where they want to be treated;
- > all health care providers must have plans for quality control and patient safety;
- > public primary care providers and hospitals must publish their plans and results;
- > continuity of treatment paths have to be established to guarantee integration of primary and secondary healthcare.

COUNTRY ANALYSIS FRANCE

A new government initiative and good practices to pave the way to coordination



In France, primary care and secondary care are in general not integrated: primary care is managed by general practitioners, nurses and paramedical professionals which are independent practitioners; secondary care is managed by public, private for profit and private not for profit hospitals. The actors in primary and secondary care must compete to generate their outcome. The culture of cooperation and integration is not diffused and also health promotion and integrated primary care are difficult.

In 2009, the **New Governance Initiative** introduced some legislative changes addressed to overcome these issues. It in particular:

- > Establishes that patients should now choose a referent doctor – if they don't, they receive less reimbursement for their contributions.
- > Sets up the basis for the development of multidisciplinary health centers with different health professionals under the same roof (maisons de santé).
- > Promotes networks of health professionals to manage defined health needs of the population.
- > Introduces the new hospital organization in multidisciplinary teams (pôles).
- > Establishes new finance initiatives with payment according to activity.
- > Put the basis for the development of common prevention guidelines for GPs and specialists, to be detailed by the INPES (Institut National de Prevention et Education pour la Santé).
- > Establishes the introduction of a personal electronic health record and a personal medication record;

The measures established look towards the reconciliation of the independent culture of French GPs with the need for more collaboration with other professionals and organizations, also in the wider framework of resource constraints and shortage of certain professionals.

In parallel to the change described above also a series of good practices concerning cooperation and coordination of activities among primary and secondary care are developing in France.

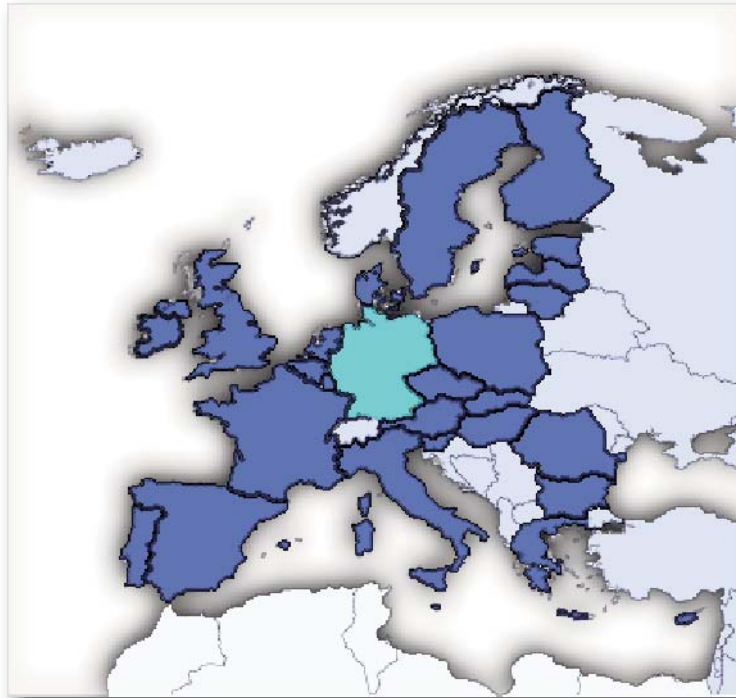
- > With the introduction of the Hospital at Home (Hospitalisation à Domicile) the coordinated management of patients with complex needs at home has been developed as an alternative to traditional hospital care. The hospitalization at home is monitored and accompanied by a multidisciplinary team that prepare and reviews the comprehensive care package for the patient. In the multidisciplinary team doctors, nurses, psychologists, pharmacists, physiotherapists and social workers across public and private sectors participate to the delivery of care, leaded by the patient's GP.



- > The introduction of a **GP consultation coordinated with emergency telephone calls** responds to the need of reducing workload at emergency services and at the same time improves the patients' satisfaction, since they can find faster and more targeted answers. This service links GPs, hospital emergency services and out-of-hours primary care services (maisons de garde). GPs and urgent care specialists manage emergency calls; calls not needing emergency medical care are passed to a local GP for telephone advice or to make an appointment for a consultation.
- > The **team work in psychiatry** involves not only physicians but also nurses in the phases of diagnosis and treatment. In particular, nurse team triages and coordinates further care with other institutions and therapeutic activities.

COUNTRY ANALYSIS GERMANY

The efforts towards more straightforward linkages within the system



The German healthcare system offers a great deal and high quality care opportunities, but the interchange from one system to the other, which means from in-patient to out-patient care, is difficult and the communication and continuity of care often get lost.

The system is then evolving towards a better integration among sectors, and two major models of cross-sectoral healthcare can already be looked at as good examples.

The **Medical Supply Centers** (Medizinischen Versorgungszentrum) are outpatient care facilities placed directly in the hospital. They allow cost savings through the share of physical resources, equipments and personnel, but in particular they allow the patient to go through a unique pathway of care which starts with hospitalization, continues with the transfer to the Medical Center and ends with discharge.

In the Medical Supply Center the patient receives care from a multidisciplinary team of specialists, which can use hospital equipments, knows the doctors who were in charge of the patient before and has full access to the patient records from the hospital stay, so that its members can deliver the best quality integrated care.

The advantages both for the patient and for the system can be summarized in:

- > time saved, e.g. it makes possible for the patient to see several specialists in one day;
- > improved patient safety, e.g. it helps to prevent the same examination to be made twice;
- > costs saved, in particular because it shortens and makes cheaper and more efficient the permanence of the patient in the health care system.

The **Psychiatric Outpatient Departments** (Psychiatrischer Institutsambulanz) make hospitalization for treatment of depression much shorter and more effective.

In fact, during the entire care journey patients are seen by different specialists - psychiatrist, psychologist, specially educated nurses - social workers and different therapists. This multiprofessional team meets the patient before and after the hospitalization, also at home, in familiar surroundings, and in the long run group therapy is offered.

The multiple advantages of the Psychiatric Outpatient Departments are:

- > they help to minimize expenditures;
- > give appointments with specialists without waiting time;
- > offer emergency care around the clock;
- > promote reintegration in everyday life or even avoids de-integration;
- > complete the range of hospital and ambulatory care;
- > and keep costs for the German health care system lower.

COUNTRY ANALYSIS GREECE

Examples of coordination across the country



The Greek healthcare system has as its main weakness the lack of a strong gate-keeping structure across the country.

However, despite the system is very dissimilar and there are many inequalities, some successful experiences of integration and continuity of care are emerging. In particular:

- > the increasing interactive communication between GPs and doctors are improving patients' hospital experience and help reducing the length of stay thanks to a better exchange of information;
- > the development of medical records and e-prescriptions are fundamental to a more integrated approach to healthcare and improve patient safety, quality and continuity of care;
- > home care and community care are improving and nurses play a fundamental role now in the system. The head hospital nurses follow the patient journey and whenever necessary they contact the social workers on the territory, being in touch with them.

The system still needs these processes to spread throughout the country and the number of GPs to increase, covering also the more isolated areas, but during the last few years important steps in the right direction have been taken.

COUNTRY ANALYSIS HUNGARY

Moving towards a more integrated system



The Hungarian system is taking important steps towards the modernization and integration of its healthcare system. In fact, notwithstanding the difficult economic situation of the last years, the high bureaucracy which characterises the country and the progressive loss of healthcare professionals leaving abroad, the country's healthcare system is steadily improving, adapting the still complex and out-of-date structure of the system to the increasing needs of quality and flexibility expressed by the population.

The Hungarian system has developed and is being developing the following successful measures.

- > In the area of prevention the country's vaccination coverage reaches almost the entire population, with a rate by 98%-99%. The new, tight tobacco control and prevention law is in place from January 2012, and a new law on junk food has been proposed.
- > The country can count on high quality professionals and develops a high quality healthcare university training.
- > Some high level experiences, such as the national emergency ambulance service and some specialized healthcare centres, i.e. the National Institute for Medical Rehabilitation have been developed.
- > The country can make advantage from EU funding and the support from Foundations. Moreover its participation in a EU research project on the "Quality and Cost of Primary Care in Europe" helps the system to improve.
- > The IT architecture integration project to harmonize healthcare IT, in progress, is leading to good results.

COUNTRY ANALYSIS LATVIA

Medical Home Care Model



In Latvia it is very important to invest in promotion of health and to try to improve lifestyles, in order to reduce the costs of hospitalization and improve population health. Medical Home Care helps achieving these aims. The medical home care teams are well integrated in the comprehensive health and social care system including primary care (general practitioner), medical services, social services, wound management.

The **medical care service** at home is provided if patient needs a regular (permanent) outpatient treatment but due to medical reasons is unable to attend health care institution to receive outpatient care. The main types of patients for Medical Home Care are chronically ill (asthma, diabetes...), after surgery, palliative care, after trauma.

There are 189 centers for home care all over Latvia. Their main characteristics are:

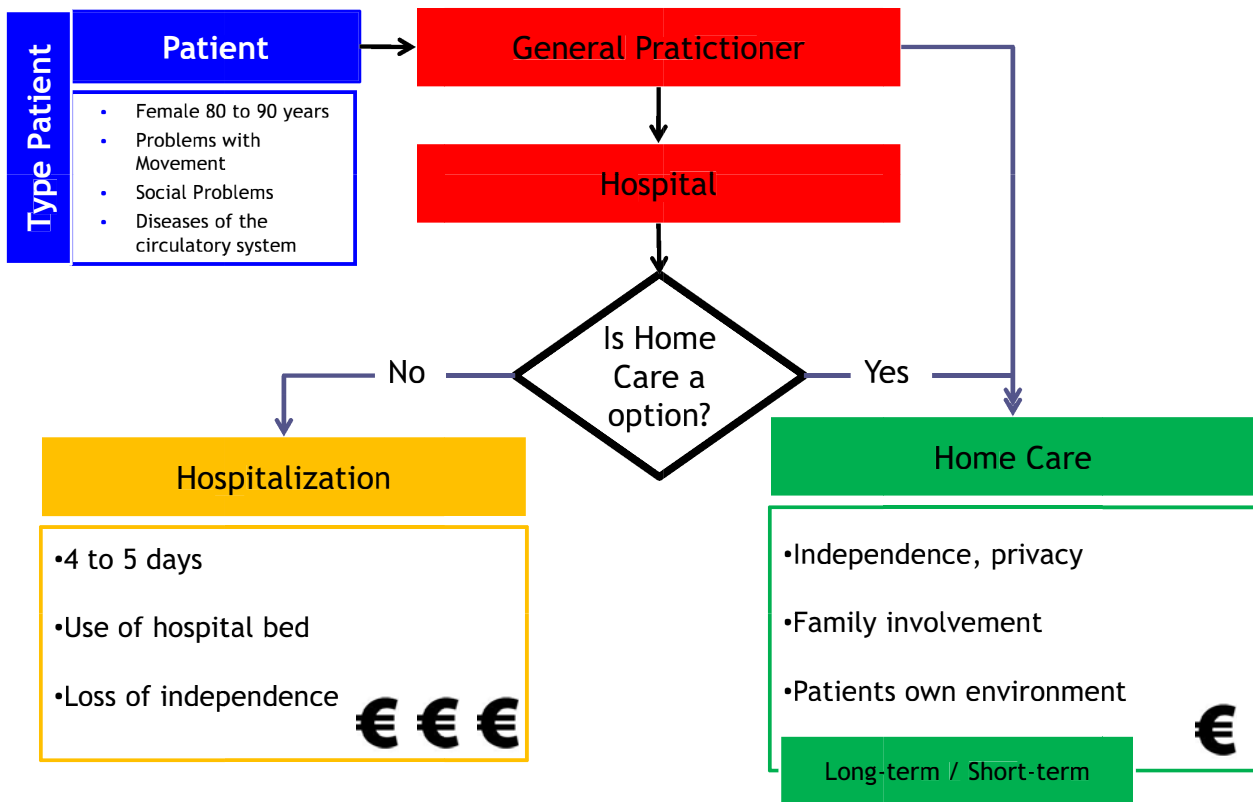
- > the specific Education Programs;
- > special resources, e.g. special bag with all the equipment and material;
- < the independence of nurses, who evaluate the status of patients and provide care;
- > the assessment of the environment of the patient (hygiene, safety...).

The continuity of care is guaranteed by:

- > the good communication between the home care team and other members of the multidisciplinary team;
- > the respect of standard guidelines and protocols for medical home care;
- > the training for medical care at home involving both the members of the team and the family doctors;
- > the training for the families.

Family doctors refer for medical home care and receive feedbacks from the medical home care teams.

Patient Home Care Latvia - Example



COUNTRY ANALYSIS LITHUANIA

Strengthen the role of Primary Care to improve the performance of the system



In Lithuania family doctors are gatekeepers. Since the first reform of 1992 their role has been strengthened with the aim of empowering primary healthcare services, reducing hospitalization and improving health of population.

Since 1992 more than 2200 General practitioners have been educated, two thirds of them- former district internists and pediatricians after retraining; postgraduate residencies in family medicine were established in 1992 and in 1995 there were the first graduates; retraining to family physicians started in 1997 and completed in 2005. New family doctors since 2005 are trained at the university.

Family physicians take care of health of the inhabitants registered at the primary health care institutions (out-patient clinics, family doctor centers). They are responsible not only of treatment but also of disease prevention, health preservation and improvement. They are the first reference point to the patient, decide what kind of aid the patient needs. In fact, patients who need to go from the primary level to hospitals must have a referral from their family doctor, with the only exception of emergency cases.

While putting emphasis on Primary healthcare provision, other measures have been also taken with the general aim of streamlining and improving the healthcare system:

- > decrease number of health care personnel (doctors and nurses);
- > establish prevention programs and promotion services;
- > establish new public institutions about AIDS, alcohol and drugs;
- > decrease in health care institutions budgets;
- > closing hospitals with low performance.

The positive outcomes of these measures are visible in the:

- > reduction in the number of in-hospital patients;
- > reduction in the Hospital death rate;
- > reduction in the average hospital length of stay;
- > analysis of the quality-of-life indicators and death rates by different causes demonstrate that in case of the most causes of deaths, the death rate is decreasing by 3%;
- > comparisons of morbidity indicators reveal that avoidable illnesses related to alcohol have especially positive trends.

The further steps of the Lithuanian government consist in continuing optimizing the costs of health care according to the needs; optimize the number of hospitals, maintain and improve a good quality of health care system and enhance cooperation between primary health care and hospitals by improving e-health systems.

COUNTRY ANALYSIS LUXEMBOURG

Continuity of care in relation to postpartum: the new role of midwives



Poor or no, health coordination at the exit of motherhood for a woman who has just given birth can have many negative consequences: more readmissions, inappropriate admissions or abuse of emergency services, duplication of tests, increase in workloads for professionals.

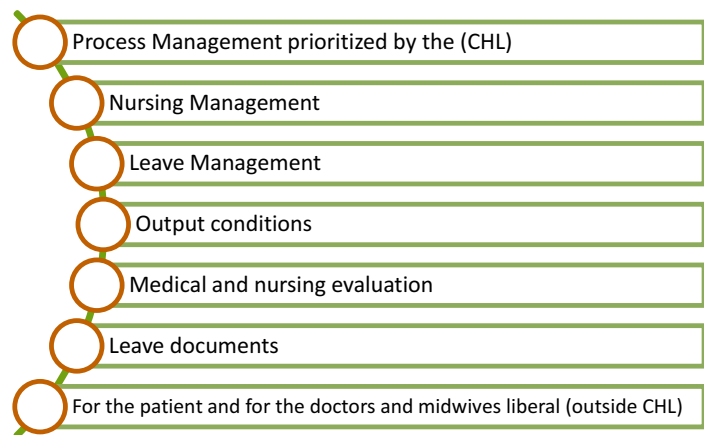
In the Grand Duchy of Luxembourg the strategic map of Central Hospital of Luxembourg 2008-2015 defines supply and continuity of care. Continuity of care post-partum is a basic principle, a challenge that the two sectors of health - hospital and primary - must share all synchronized to a common goal: postnatal care in case of home birth, returned home early or even after the stay in hospital classic. All midwives have a shared responsibility for the care of women. All are involved in parallel with clearly defined roles.

Professional midwives work in different sectors: public hospitals, private, liberal or in the clinics, and also with different skills:

- > the midwife in a hospital meets the patients at prenatal clinics, delivery room, in a service post-partum, as part of various preparations in the birth;
- > the midwife in private practice meets the patients to her office, in home birth, prenatal care, childbirth preparation, childbirth and postnatal care at home.

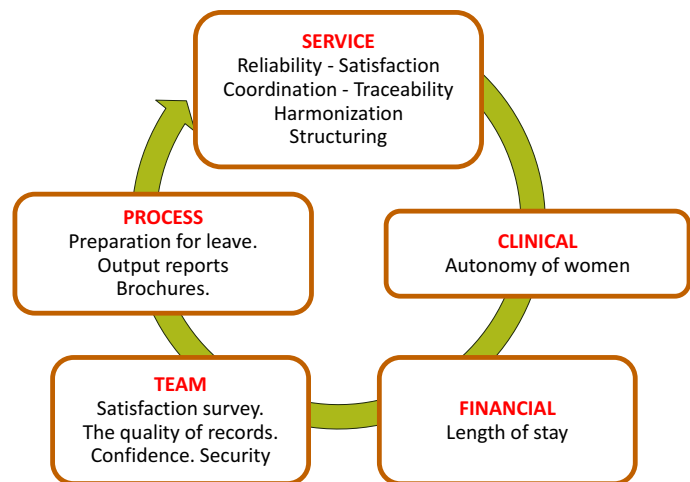
The Continuity of Care Management Process is prioritized by the Centre Hospitalier du Luxembourg (CHL) and the nursing director. The characteristics of the system include:

- > a Standard Process for postpartum care and work with a network of well-defined roles: there is a profile for each function and mission, midwives are directly responsible for care and have complete autonomy with clear responsibilities (identity midwife);
- > presence of a midwife at the hospital of reference for every woman;
- > planning for discharge from hospital by the fourth day for normal delivery and by the fifth or sixth day of stay for caesarean deliveries;
- > collaboration and coordinated approaches to common objectives, in particular, minimum four home visits after birth covered by the midwife in private practice.



A number of different tools ensure data access and exchange in real time and enable the involvement and awareness of patients:

- > paper patient records;
- > Computer Records (Project MetaVision) that allows the automation of the report;
- > communication, transmission or oral (telephone) contact with the nearest midwife by area and region.
- > guides, counseling, workshops, brochures postpartum, health record for the child and the list of pediatricians and midwives in private practice;
- > protocols of care and organizational procedures for safety;
- > the extracts of the medical record.



The direction supports the quality of care by:

- > internal audits to analyze clinical professional practice;
- > patient satisfaction surveys with the use of quality and performance indicators of care;
- > investigation and nationwide Picker survey of leave-management.

In conclusion, the high participation and involvement of the Nursing Direction, the good professional practice, the good communication between physicians and midwives allow corporate coordinated activity among postpartum hospital consultations, emergency services, midwives and liberal doctors, with major advantages:

- > the liberal midwives know they are not an isolated part of the woman's health project;
- > obstetrical hospital clinic (expert level) and the liberal midwife (primary) improve short-and long-term health of women and newborns through coordination and continuity of care at home.

COUNTRY ANALYSIS MALTA

Measures of integration to fight strategic areas of diseases



Malta has introduced programmes and strategies aimed at improving the health and wellbeing of specific categories of population creating a linkage between the different healthcare sectors.

The **multidisciplinary shared care diabetes programme** establishes strict clinical management guidelines and minimum standards of care at a primary care level, ensures that patients are provided with timely and equitable access to secondary care specialists, as well as routine visits to primary care and specialist diabetes services with the collaboration of key stakeholders in the area of diabetes, including the patient, family doctors, diabetes nurses, dieticians, ophthalmologists and podiatrists, thus providing a multidisciplinary and holistic approach to diabetes care.

The shared care programme 'fast tracks' urgent cases to the vascular surgeon and avoids unnecessary referrals to hospital of cases which can be effectively managed at primary care level. In fact, through this protocol all patients with diabetes undergo yearly, standardised, comprehensive foot screening by a podiatrist at their respective Health Centres. If pathology is detected, the patient is subsequently referred for vascular assessment, with the possibility of further specialised assessment by a vascular surgeon if necessary. The GP also conducts screening for diabetic retinopathy, in addition to an annual ophthalmic referral for full assessment by ophthalmologists.

Central for the success of this programme has been the implementation of a **single computerised register** of all patients with diabetes in Malta in all health centres, with three major advantages:

- > providing information on the actual costs of diabetes care and the burden on the national health budget;
- > allowing documentation of each patient's progress within the system;
- > enhancing communication between the interdisciplinary team.

Hospice Movement Malta is an organization that provides integrated care and promote the highest standards of palliative care for all persons with cancer, motor neurone diseases and other terminal diseases, avoiding to overburden hospitals, better targeting the needs of terminal patients and their families and guaranteeing coordination with primary and secondary care actors.

Palliative care is undertaken with an interdisciplinary, multi-professional approach, most often involving a physician, a nurse and other health care workers who have the expertise needed to respond to the physical, psychological, social and spiritual needs of the patient and the family.

The services offered include home care, day care, hospital support, respite care, social work support, spiritual support, physiotherapy, complementary therapy, occupational therapy, bereavement support, family support, children summer courses and loan of equipments to patients.

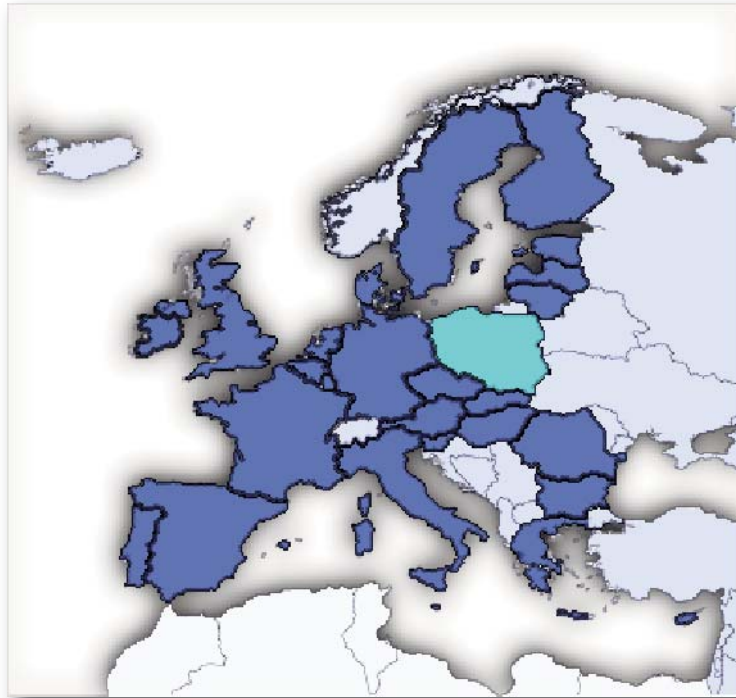
The **Community Mental Health Service** adopts a multidisciplinary and integrated approach to support mental patients at each stage of their illness, ensuring continuity of care – thanks to home and work visits – and favouring the reintegration of the person in the community, at the same time reducing the need of medications and hospitalization.

The main focus of the national mental health strategy is to empower citizens to improve their mental well-being through integrated and comprehensive services ranging from health promotion to treatment that addresses the needs of society and patients and their social network.



COUNTRY ANALYSIS POLAND

From the GP to the GP Cancer Centre



In Poland health promotion and disease prevention are some of the most important activities carried out by several non-profit organizations, hospitals, oncology centres and the Ministry of Health. Primary Health Care Centres provide outpatient care and offer a wide variety of medical services, which include general practice, maternity care, child health care and dental care. The GPs act as gate-keepers, and emergency care is available for everyone.

The **General Practitioner Cancer Center (GPCC)** is one of the biggest oncology centres in Poland and in Europe. It provides comprehensive care to cancer patient, from prevention to treatment and palliative care. The GPCC offers medical services in the fields of oncological surgery, head and neck cancer surgery radiotherapy, chemotherapy, gynecology, oncology, anesthesiology, brachytherapy and diagnostics. The GPCC is the host of regional programmes against Breast Cancer. The Centre has also managed prevention campaigns. In the GPCC the pharmacists are highly specialized in preparing citostatic drugs. Following the higher standards of care, the centre features interdisciplinary teams providing holistic care for patients with cancers in a given location. these teams include physicians, psychologists, physical therapists, nurses and supporting workers.

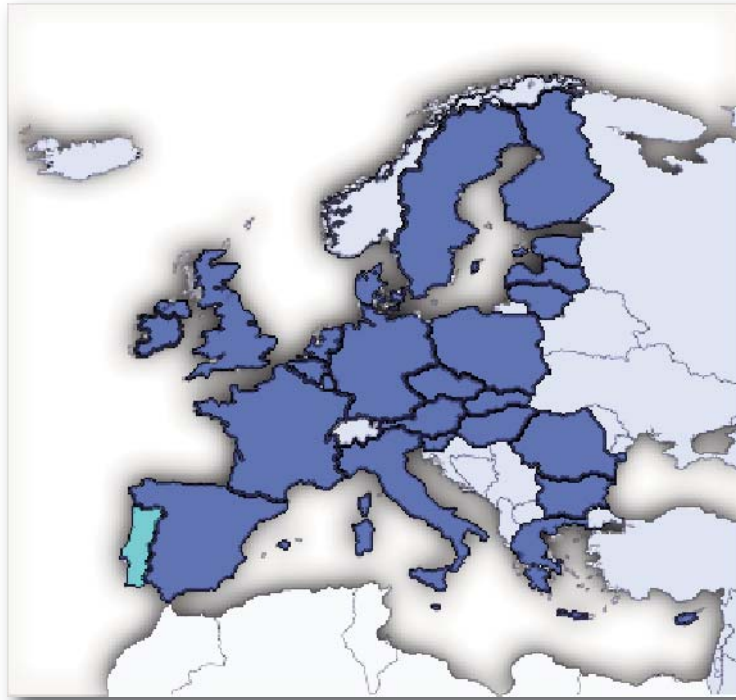
The centre's modern Nuclear Medicine Department is one of few in Poland to have the PET/CT apparatus, which facilitates detection of a very early stadium of cancerous processes and precise location of metastases.

The centre also has an Immunology laboratory where the samples are analyzed and several lines of research programs are carried out.



COUNTRY ANALYSIS PORTUGAL

Building a bridge between primary care and hospital care



The Portuguese system is going through a series of initiatives aimed at increasing the continuity of care. The system is well integrated. A central role is played by GPs, who manage the vaccination and education programmes in the phase of prevention and refer patients to secondary or tertiary care in a second instance;

Hospital care maintains continue contact with primary and community care. At this level, one of the most important innovations is the **Mobile Support Unit for Home Care** - Unidade Móvel de Apoio Domiciliário (UMAD) - coordinated with the social services. The unit offers support to patients at home in a state of chronic disease and dependence on technology. These units allow supporting continuity of care after hospitalization but in particular they help to:

- > decrease the admissions of patients with chronic diseases;
- > decrease the cost of hospital stays for the patients and their families and for the system;
- > improve the quality of life for patients and their families in a situation of dependence on technological supports.

These mobile Units are managed by multiprofessional teams including specialized doctors, nurses, and social workers.

COUNTRY ANALYSIS SLOVENIA

Mental health and learning disabilities



In Slovenia, some of the most relevant causes of death are cardiovascular diseases, malignant diseases, but also suicides. For this reason, a specific **Mental Health Act** was approved in 2008 and came into force to be applied one year later by August 2009. This has given great emphasis on the mental health programme and it helps to ensure safe and regulated practices. The Act provides a legislative framework for a national strategy on mental health. Putting a particular focus on legal protection and community approaches to mental patients, it:

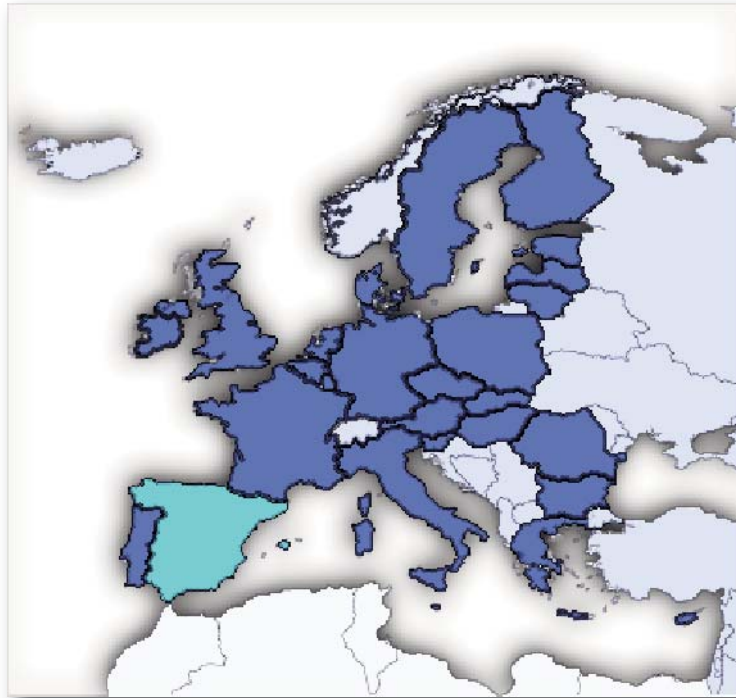
- > defines responsibilities of the government and of healthcare providers;
- > defines solutions regarding the empowerment and legal security of the most vulnerable group of mental patients (i.e. those who might be involuntarily admitted);
- > and gives a definition of community care.

Concerning the mental health programmes and the learning disabilities programmes, some strengths and weaknesses of the system can be highlighted at the moment.

- > The staff is extremely highly educated, but the role of nurses is often underestimated and underused.
- > In primary care anti-stigma campaigns are carried out in cooperation with the mental health services, but the integration between primary and secondary care is still weak.
- > Despite the important focus on a model of care very personalized, the location of hospitals for mentally ill people are very isolated and integration is not enhanced.
- > The approach to learning disabilities is effective, adopting an educational rather than a care focus.
- > The educational opportunities for learning disabilities patients are very person centred. Excellent use of sensory tools such as symbols and sensory garden. The therapies are also personalized, and targeted to each individual.
- > There is continuity between primary to secondary care in paediatric, with dedicated paediatric input for first year of life.

COUNTRY ANALYSIS SPAIN

A model of integration of all levels of care through ICTs and the support of citizens



In the Spanish system, the healthcare responsibilities are decentralized to the regional level, however all over the country there is a comprehensive primary health system, with centres geographically located and deeply interconnected.

Social and healthcare integrated initiatives throughout the country include:

- > the exchange of workforce between primary care (Primary Healthcare Centers) and hospitals (providing secondary care) especially for the emergencies services and the on-call presence;
- > the presence of structured pathways for the transfer of patients from acute care to other levels of social care and tertiary care (mid-care beds). These pathways are activated within the hospitals through specific procedures and the categories of patients suitable for them are clearly listed;
- > the use of Information & Communication Technology (ICT)
 - electronic healthcare Cards (TIS);
 - integrated electronic patient records;
 - tele-medicine ;
- > the integration of social workers, professionals, patients and citizens, making informal carers active partners in providing care.

In the Basque region, the **Multi-channel Health Service Centre (MHSC)** addresses the needs of chronic patients, which have to maintain the level of low intensity constant contact, in contrast with the sporadic high intensity contact which acute patients receive from traditional face-to-face care. The service increases the number of ways in which the public can interact with the health system, with three important effects:

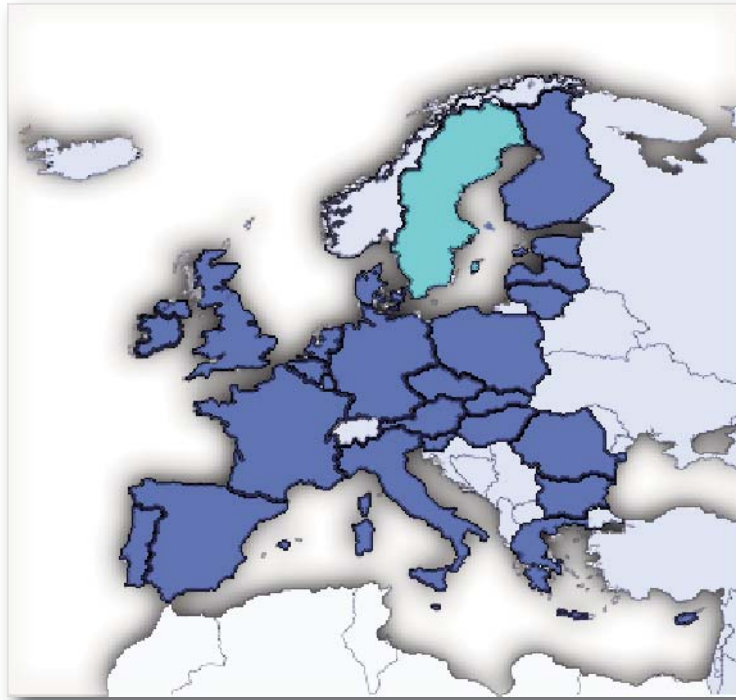
- > the constant monitoring of patients does not interfere with their personal life and work;
- > allowing physicians to focus on high value activities, offloading administrative procedures, monitoring activities and routine check-up;
- > promoting patients' self-consciousness and promote the involvement of citizens with their own illnesses.

The project has the following characteristics:

- > it uses all the available channels of interaction (Web, telephone, SMS, Digital Television,...) between the citizen and the health system in order to facilitate the care procedures;
- > it enables administrative procedures to be carried out, e.g. primary care appointment management, reminder and/or confirmation of appointments, medical certificate reports, personal health card management;
- > it makes general health service information available to the users, such as range of services, health centre directory, night clinics and duty pharmacies;
- > it is a mean to facilitate health promotion, information and education. In particular the Patients Forums take responsibilities for the promotion of healthy lifestyles, vaccination reminders and information regarding public health programmes;
- > it provides a telemedicine home care service - remote assessment systems and telemetric monitoring - for domiciliary chronic patients, multipathology patients and those with advanced or unstable pathologies.
- > it provides medical advice and enables citizens to access information regarding their health (personal health file).

COUNTRY ANALYSIS SWEDEN

An example of integrated health journey for patients



Sweden offers an example of well-integrated and continuum pathway of care. From the first contact to discharge and follow up, the patient is always involved and the system is designed to support his journey as much effectively and efficiently as possible.

- > The first contact with the system can happen through the **national help line** – 1177. It is a 24 hour nurse-led service that allows patients to talk to a nurse for first advice and indications when there are simple symptoms of disease. The patient has a 10 digit unique identification number through which the nurse can immediately identify him/her and give appropriate indications about treatments and prevention. In the end she advises to contact the Primary Healthcare Centre if the patient does not improve.
- > The Primary Healthcare Centres (PHC) can be privately or publicly managed. The first contact is normally a nurse who can advise the patient to go there immediately or give him/her an appointment. In some counties the patient can be admitted to primary care beds managed by the GP.
- > If the patient at home or admitted at a PHC does not improve, the general doctor can arrange the transfer to the hospital through the ambulance service. The ambulance staff are specially trained nurses. Clinical information can be sent directly from the ambulance to the ward.

- > Patients are admitted in the hospital to stay shortly, receiving the best care:
 - the first contact the patient has is with a nurse;
 - all information from primary care is accessible to the staff in the hospital and even if in the majority of county councils the IT systems between PHC and the hospitals are different, people can see a summary;
 - **Lean** – is the tool that many county councils are using to ensure that processes are efficient and add value to the patient's experience;
 - **Vårdlink** is a computer system that allows discharge arrangements to be made. The system can be accessed by primary health care staff as well as the municipality staff. In some areas of Sweden, 80% of patients have a discharge meeting before leaving the hospital. Healthcare and social workers participate in the meeting to make sure that everything patient need has been obtained. The patient can be discharged home, in a municipality bed or to a nursing home.

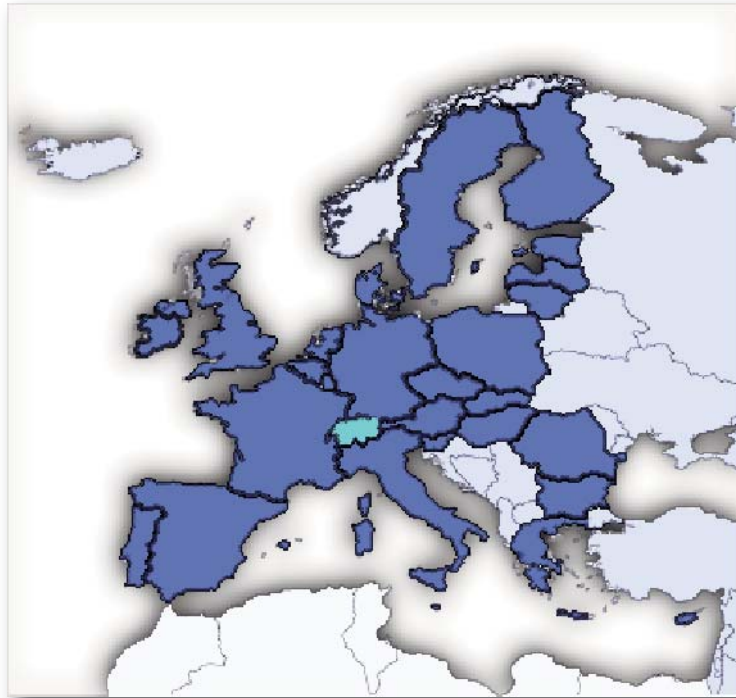
- > When discharged home the patient can receive:
 - a **mobile team** – a nurse, an Occupational Therapist, and a doctor if needed – for following up him/her;
 - staff from the municipality if needed. In some municipalities patients can have up to 9 visits during the day, plus visits at night;
 - the district nurse might visit weekly.

- > For patients over the age of 65 the nurse completes a Senior Alert - a risk assessment tool that looks at risk indicators, i.e. food fluid and nutrition, pressure ulcers and the risk of falls. This is completed with all people, whether they are looked after by the district nurse at home, whether they are in a primary care beds.

- > Finally, one of the main strengths and the principal mean of integration in the Swedish system is the communication and information exchange between primary care, secondary care and patients/citizens.
 - All citizens in Sweden are guaranteed to be offered contact by phone or on site on the same day. And a doctor's appointment, if necessary, within 7 day; a specialist within 90 days and treatment within another 90 days. All this information is accessible via the web to the public and citizens can find out how long the waiting list is at each hospital in each county across the country.
 - All the health information on treatment during hospitalization is inputted into **national disease specific quality registers** – which like the waiting time information is accessible to all health professionals.

COUNTRY ANALYSIS SWITZERLAND

A new role for the General Practitioner as a win-win strategy for all



As many European countries, Switzerland faces the same relevant challenges regarding healthcare professionals' role and availability. This in particular concerns GPs:

- > the average age of GPs is increasing, but general medicine is an unattractive medical discipline and the number of GPs is declining.
- > GPs should be available 24/7, their missing function as gate-keepers provoke the overuse of secondary care and in particular unnecessary patients in emergency rooms.
- > GP patient records are on paper and need to be electronically recorded.

The main issue to solve these problem concerns the resources availability. The solution found includes:

- > **GPs co-located** in emergency departments out of normal working hours.
- > **Medicphone** - Single central telephone number - managed by triage nurse.

With medicphone a triage nurse is the first contact with the citizen seeking for help. She assesses the condition of the person and can decide if refer him/her immediately to the hospital, immediately to a GP or postpone the visit with a GP on the following day. In this system, the advantages for patients consist in having a unique and certain point of access and, being opportunely triaged, access the right care at the right time, without wasting time or money and experiencing a good relationship with the GP. The GPs are on-call, so the working hours reduce significantly, improving the quality of life, and this make the profession more attractive. Moreover GPs' income depends on local contracts, they have more and more effective collaboration with hospital clinicians for a second opinion and can easily access to electronic records where available. The new system allows avoiding inappropriate admissions, with a great advantage for the hospital organization, it allows making a better and more effective use of hospital resources and facilitates improved relationships between hospital doctors and GPs colleagues. It is advantageous for the entire system since it rationalizes the use of resources, supports sustainable GP services, supports viability and reduces insurance company payout.

COUNTRY ANALYSIS THE NETHERLANDS

Pharmacy management as a key to collaboration
between hospitals and primary care



The role of pharmacy management is often underestimated, but in many countries a considerably high number of deaths per year are due to medication errors.

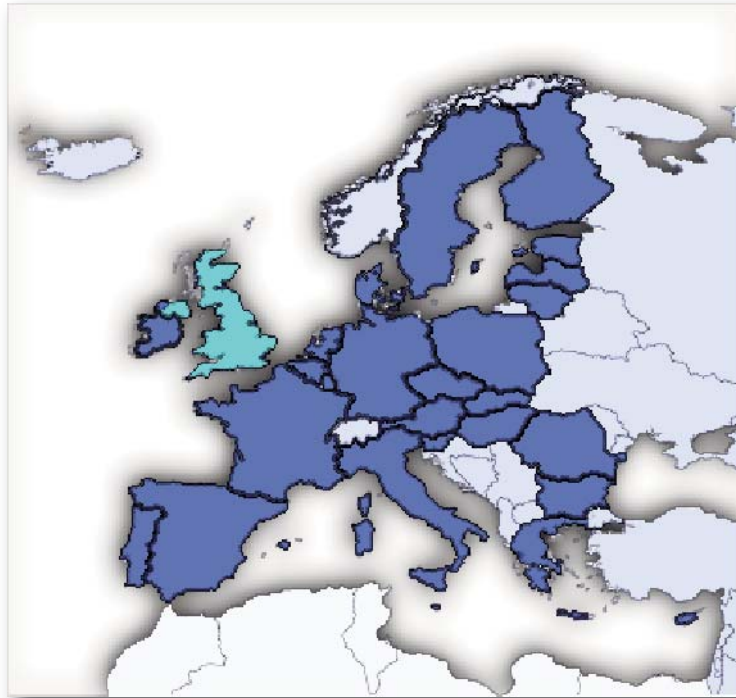
In the Netherlands, medication is a national quality issue and is explicitly audited. Pharmacy management has a crucial role in the whole patient journey - from admission to discharge - since a good integration between hospital pharmacists, doctors, patients and local pharmacists plays a key role to improve quality of care and avoid errors.

In the admission phase the hospital pharmacist talks to the patient individually and gets the information on the medicines he/she is taking. The reason is to confirm prescribed medicines, self-medication and information for the patient. During the hospital stay the hospital pharmacist plays his most important part, checking and monitoring the changes in the medications prescribed by doctors, verifying the interactions, allergies, contra-indications, doses, links of prescriptions to the laboratory tests. After discharge the hospital pharmacist shares information with the local pharmacist and with the hospital doctor and delivers information to the patient, ensuring the better continuity of care.

Shared communication, during the hospital stay and after discharge, increases patient safety and improves patient experience. The shared responsibilities between doctors and pharmacists, based on secure information flows help reducing mistakes, improve the quality and the timing of care and medication, with positive effects also on staff satisfaction.

COUNTRY ANALYSIS THE UNITED KINGDOM

A debated reform and several good practices in place



The UK Government has proposed the biggest major reform in the NHS since 1948: General Practitioners, gathered in consortia, would control 80% of annual health budget, hospital consultants and nurses would be more involved in the commissioning process, the involvement, new role and coordination of hospital doctors has been and is being widely discussed. The reform would aim at an improved health service that is "non-bureaucratic, patient-driven and clinician-led", but so far nothing certain has been defined yet.

Meanwhile, several good practices, demonstrating the coordination and integration between the different levels of care are in place in various areas of the UK for the benefit of patients.

- > The **Admission Discharge Transfer Nurse** (ADT) helps the patient to go through his/her pathway of care without interruption, cutting length of stay, avoiding wasting of time and resources both for the patient and for the system and favors the appropriateness of care. The ADT nurse follows the entire trendcare of patients: prepares for new admission, completes nursing assessment, identifies patients who are for discharge or for transfer during the shift (simple, short stay patient only), plans and organizes patient discharges, and facilitates the transfer as soon as possible. When more than one new admission, discharge or transfer, the ADT nurse will need to prioritize and plan her work with the assigned referent nurse. This service enables better collaboration with the hospital rehabilitation teams and social services, increase satisfaction and quality of care for patients and their families.

- > The improvement of **Telehealth** in Primary Care allows the patient to stay home. It increases patients' satisfactions and reduces costs of unnecessary visits both for patients and for doctors. With the use of tools of telehealth the chronically ill patient can continue in his/her daily activities, staying at home, being completely independent, but continuously monitored. As soon as the health condition changes, the patient can contact the General Practitioner who can refer him/her to the hospital doctor.
- > The **National Stroke Improvement Programme** implemented in England was set up to support the development of stroke care networks and the implementation of the National Stroke Strategy, with the aim of reducing the relatively high incidence rate (compared to other developed countries), reducing the inequalities in accessibility to adequate treatment, improve treatments and cost-benefits. The Programme includes a national strategy and guidelines, research and education programmes, national campaigns, the introduction of quality indicators and Stroke Networks. Role of the networks is to improve the way that services are planned and delivered for both stroke survivors, carers and staff. Stroke care networks will help to guide the commissioning process through providing clinical expertise; support service improvement across the whole pathway of care; and enable 'clinical networking' – vital communication between the different stages of the 'patient pathway'. The Programme foster collaboration between primary and acute level (integrated care pathways) and enhance higher level of patients and relatives involvement.
- > The **GP Liaison Manager** is the permanent link between the hospital and the primary care providers on the territory. GP Liaison Manager in the hospital organizes regular meetings joined by GP's, Consultants and further healthcare professionals. In this way, he allows and facilitates faster and more reliable communication and exchange of information between GP's and consultants, Health Care Professionals get to know and trust each other, beneficial clinical pathways can be established and cost are reduced.

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DEFINITIONS AND REFERENCES

DEFINITIONS

PUBLIC HEALTH

Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease.

Source:

<http://www.who.int/trade/glossary/story076/en/index.html>

PRIMARY HEALTH CARE AND PRIMARY CARE

Primary health care (PHC) is health care received in the community, usually from family doctors, community nurses, staff in local clinics or other health professionals. It should be universally accessible to individuals and families by means acceptable to them, with their full participation and at a cost that the community and country can afford. Primary health care refers to the concept elaborated in the 1978 Declaration of Alma-Ata, which is based on the principles of equity, participation, intersectoral action, appropriate technology and a central role played by the health system.

Primary care (PC) is more than just the level of care or gate keeping; it is a key process in the health system. It is first-contact, accessible, continued, comprehensive and coordinated care. First-contact care is accessible at the time of need; ongoing care focuses on the long-term health of a person rather than the short duration of the disease; comprehensive care is a range of services appropriate to the common problems in the respective population and coordination is the role by which primary care acts to coordinate other specialists that the patient may need. PC is a subset of PHC.

Source:

<http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/primary-health-care/main-terms-used>

HOSPITALS

Hospitals are health care institutions that have an organized medical and other professional staff, and inpatient facilities, and deliver medical, nursing and related services 24 hours per day, 7 days per week. Hospitals offer a varying range of acute, convalescent and terminal care using diagnostic and curative services in response to acute and chronic conditions arising from diseases as well as injuries and genetic anomalies. In doing so, they generate essential information for research, education and management. Traditionally oriented on individual care, hospitals are increasingly forging closer links with other parts of the health sector and communities in an effort to optimize the use of resources for the promotion and protection of individual and collective health status.

Source:

<http://www.who.int/topics/hospitals/en/>

HOME CARE

Home care aims at satisfying people's health and social needs while in their home by providing appropriate and high-quality home-based health care and social services, by formal and informal caregivers, with the use of technology when appropriate, within a balanced and affordable continuum of care.

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