Integration in Health and Healthcare

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SPECIAL INTEREST GROUP:

WORKSHOP ON HEALTH WORKFORCE MANAGEMENT

22 JUNE 2011 – 13.00 – 15.00

GEMINI 1
DOCTORS IN MANAGEMENT: THE LAUNCH OF THE EUROPEAN ALLIANCE OF MEDICAL MANAGERS TO MEET THE GLOBAL ADVOCACY FOR A JOINT ACTION

Agnese Lazzari 1,2,3, Jenny Simpson1, Alessandro Campana 1,4, Leonardo la Pietra 1,3,5, Walter Ricciardi 1,2,3.
1European Alliance of Medical Managers (EAMM), Italy; 2Catholic University of Sacred Heart, Rome, Italy; 3Italian Association of Medical Managers (SIMM), Italy; 4Kia-Knowledge into Action, Italy; 5European Institute of Oncology (IEO), Italy.

Context:
The global advocacy for a major involvement of doctors in management is undoubtedly calling for action. Doctors involved in leadership roles, in partnership with excellent managers, have proved to perform the most effective healthcare systems. A small number of well-established groups/associations of doctor/managers have been set up in Europe; however most of individual clinicians holding these roles are isolated, with no peer support.

Methods:
The European Alliance of Medical Managers’ (EAMM) role, as a network of doctors and organisations, is to promote a multidisciplinary approach to medical management across all clinical specialties in primary, hospital and community-based care, through: (1) Standards of competencies for facilitating quality accreditation and mobility; (2) Research that result in the best outcomes; (3) Education and training. A mapping exercise of clinical leaders, professionals and institutions, committed to the principles of medical management and leadership has been run at the time of writing.

Results:
By creating a European Alliance, we will provide a network for the existing national associations, as well as a “home” for clinicians in countries without an existing association. The Dutch ongoing experience with EAMM is confirming, after the British-Italian joint action, the effectiveness of sharing the findings within a scientific community and support the development of organised movements of doctors into management.

Discussion:
Since the beginning, doctors in management have been considered only tenuous profile within the medical profession community. As a result of a 30 years discussion, the increasing contribution of medical management to healthcare has been put at the top of national agendas in many countries. Doctors’ managerial and leadership expectations/needs must be addressed to better facilitate the cultural shift, influence processes and guarantee quality.
NEXT GENERATION HEALTHCARE LEADERS

Naomi Chambers, Guy Lubitsh.
University of Manchester, United Kingdom; Ashridge Business School, United Kingdom.

Context:
Despite the generous salaries, vacancies for top manager positions in the UK NHS do not always attract many candidates. Indeed there is some evidence of an ‘inverse leadership law’, with the more challenged organisations less able to fill key vacancies. The NHS chief executive called for a new systematic approach in 2007 to senior leadership development and talent management. This initiative attempts to address this problem for the NHS in London.

Methods:
A partnership between Ashridge Business School, MBS and Unipart was formed to deliver a programme for a cohort of thirty six ‘high potential’ healthcare directors. Participants came from all parts of the NHS in London including primary care, general and tertiary hospitals. This was not an attempt to deliver a ‘how to fix the NHS’ learning programme but a focus on building competence and resilience in participants. The programme included learning forums, stakeholder events, action learning and coaching and utilised the expertise of the providers in international leadership development, health policy knowledge and service improvement methodology.

Results:
Sharing perspectives on the NHS across London was evaluated as the learning forum with the most impact. Participants were also deeply impressed by the rigour and integrated nature of the improvement methodology at Unipart. 41% participants cited improved awareness of self and impact on others as a major difference, and 20% felt more able to negotiate more effectively. In addition to qualitative changes to the management style and performance of participants, eight individuals were successful in securing a promotion.

Discussion:
The results show the impact of integrating high potential leaders across different parts of the NHS family and integrating learning across the three domains of personal leadership, policy insight and understanding of service improvement approaches. For the next cohort, the accountability and involvement of the participants’ sponsors will be strengthened to ensure that new skills and approaches can be practiced and spread in the workplace. In addition, given the unprecedented radical reforms under way in the English NHS, particular attention will be paid to the leadership of change, managing complexity and personal resilience.
ACHIEVING HEALTH CARE INTEGRATION THROUGH HUMAN RESOURCES DEVELOPMENT

Claudia Leone, Luis Lapão, Gilles Dussault.
Institute of Hygiene and Tropical Medicine, Lisbon, Portugal.

Context:
The creation of a network of 73 groups of Primary care centers (ACES) in 2008, was part of a Reform intended to leverage the integration of management and clinical-governance in the Portuguese Health System, having an Executive Director (ED) as their main responsible. This integration aim represents a clear disruptive change in primary-care professionals’ working culture.

Methods:
The objective of this study is to explore the 73 ED’s professional profiles, with special attention to their leadership and management skills. A first picture of the impact of the ED in addressing the population’s health needs and the challenges of the health professionals involved in the Reform was created through two methodologies: descriptive and exploratory statistical methods into two sets of questionnaires (SPSS), within the context of a management training (PACES); and developing a content analysis of their participation in one session of Focus Group.

Results:
The ED identified that transforming the several vertical structures into one horizontal and integrated network, without decreasing the quality of service, was their main challenge. In order to achieve this, according to the ED, the leaders’ main characteristics should be: strategic vision and change initiative, negotiation and teamwork skills. Focus Group findings also confirmed their need to emphasize leadership skills and attitudes. Trough organizational culture assessment instruments, one could also noticed a swift form a Hierarchical organizational culture at the beginning of the Reform to a Clan culture one year after. This transformations came along with other changes like increased number of meetings and the use of email to manage the ACES.

Discussion:
The ED first years of activity have been characterized by many demands from the environment (budget cuts, demographic changes), which is pushing primary-care towards a significant transformation. This is creating a demand for higher quality management with comprehensible leadership skills. In order to facilitate change and move forward to integration, it is needed to focus on their human resources. Even tough, some positive changes are identifiable in some ACES, where clinical-governance and managerial integration are being applied, others are being managed without focusing on leadership; which leads to lacks of support to human resources development.
STRATEGIC MANAGEMENT OF HUMAN RESOURCES: EMPIRICAL FINDINGS FROM THE ITALIAN NHS

Americo Cicchetti, Ilaria Piconi.
Catholic University of the Sacred Heart, Rome, Italy.

Context:
The Italian NHS (INHS) reforms in the 1990s have focused mainly on the so called corporatization of hospitals, which today are almost totally free to make decisions and undertake strategic actions as autonomous agents within the market. Our research provides a snapshot that highlights, within a sample of Italian health care organizations, how HR functions are structured and managed in the INHS.

Methods:
We gathered data through a national online survey administered by the Ce. Ri.S.Ma.S. The data were collected on both the organization of HR functions and the rate of adoption of HR practices. The questionnaire was submitted to 295 Italian hospital CEOs from April to October 2010. 59 organizations completed the survey. We classified the development of HR functions through the two following indicators: Function’s Complexity, i.e. the number of hospital’s HR Organizational Units (OUs) on total hospital’s HR OUs; Strategic Orientation, i.e. the number of hospital’s HR OUs dedicated to professional development and training, on total hospital’s HR OUs.

Results:
Our findings highlight that in the INHS, HR is mainly an in-line function of Chief Finance Officer (65%). Firstly, above 70% of HR function’s staff is assigned to managing administrative tasks, while only 15% is devoted to professional development and training. Secondly, main findings show that recruitment activity is led by a top-down process, whereas job evaluation is decentralized in clinical department. Finally, 26% of the surveyed healthcare organizations show a level of Function’s Complexity and Strategic Orientation above the average.

Discussion:
Notwithstanding the managerial reforms in the 90s, our results suggest that the development of effective HR management practice is in a pipeline phase. As far as the diffusion of strategic HR practices is concerned, organizations’ behaviors seem to be very heterogeneous and delayed by the bureaucratic culture that characterizes the public system as a whole. The corporatization of the Italian hospital has been the first step towards the improvement of the INHS’ efficiency. Now the challenge for Italian policymakers is to support organizations while developing an effective HR management practice. Our results are a starting point in this direction.
QUALITY AND COST OF PRIMARY CARE IN EUROPE

Antonio A Sarria Santamera, María Auxiliadora Martín Martínez, Virginia V. Del Pino, Elizabeth E Parody Rua, Carlos C. Segovia Pérez, Almudena Albertos.
Instituto de Salud Carlos III, Madrid, Spain.

Context:
Common Framework to describe primary health models in the European Union is not available and not yet developed a trans-national consensus on how to define quality of primary care (PC). EUPRIMECARE is a project funded by the 7th Framework which aims to describe different PC models in Europe, assess their quality in different dimensions and determine their costs.

Methods:
The project has been structured in 8 work packages. The WP PRIMARY CARE MODELS IN EUROPE WP2 is aimed towards describing how is financing, regulation, organization, paying, behaviour, of primary care in several countries, identifying patterns in the way these functions are performed, define and validate models of primary care to overcome analysis by countries. A template to obtain relevant information from the countries participating in the consortium was developed. The template considered five control knobs as the main domains: financing, regulation, payment, organization and organizational behaviour. Information was gathered, collected and analyzed through Principal Component Analysis (PCA). Those analysis were complemented with a descriptive review of the most significant issues as well as with a literature review.

Results:
The PCA two first components explained, respectively, 29% and 21% of the overall variance. The variables with higher coefficients in those two components were: gate-keeping specialist, voluntary private insurers, public facilities, adapted clinical guidelines, clinical education compulsory, out off pocket, provision of basic primary coverage national, quality management PC, professional income in public capitation, solo practice, and group practice. The descriptive analysis suggested the existence of a typology of primary care services which three main modes of delivery: solo practice, group practice and network.

Discussion:
This work represents an initial approach to identify the main domains and variables that could be used to determine a typology of the existing primary care models in Europe.
PARALLEL SESSION

HOSPITAL PERFORMANCE

23 JUNE 2011, 11.00 – 12.30

ARIANE 1
MULTIDIMENSIONAL EVALUATION MODEL OF HOSPITALS PERFORMANCE IN LOMBARDY REGION

Michele Castelli, Paolo Berta, Giorgio Vittadini. University of Milan Bicocca, Italy.

Context:
Lombardy Region developed a particular model based on subsidiarity principle and coexistence of public and private provider. In this model performance evaluation is a key aspect to regulate and improve overall health system performance and delivery of health services. The aim of this study is to present a new model recently developed by CRISP to evaluate the performance of Lombardy Hospital with a multidimensional set of indicators.

Methods:
Evaluation model includes five dimension. For every dimension a set of indicators was selected as follows:
Outcome evaluation: Voluntary discharges, patients transfer between hospitals, readmission for the same MDC, readmission to operating room, total mortality. Efficiency: technical efficiency measured with a stochastic frontier model. Appropriateness: cream skimming, upcoding, readmission and results of specific controls made by LHA (local health authorities). Accessibility: customer satisfaction surveys results and waiting times list. Quality standard evaluation: Joint Commission indicator on Patient Safety. The analysis was conducted at a ward level: ten wards were selected in every hospital and their activity was evaluated in those five dimensions.

Results:
With this performance evaluation model is possible to evaluate overall hospital activity and every single ward activity. Results shows differences between hospitals but, in particular, differences inside every hospital, showing very good results in some wards more than in other ones. At the moment this model is at a testing stage but it's already possible to show some results.

Discussion:
The main important aspect of this evaluation model is the multidimensional set of indicators that allows to analyse hospital activity from different point of view. Secondarily Lombardy has almost 10 million inhabitants and 200 hospitals so results obtained are very important and relevant. This model can be used by regional Health Directorate to monitor hospital activity and to improve regional health planning and by every hospital to improve his activity taking into account the sectors where it perform better or worse.
A REVIEW OF EMPIRICAL RESEARCH BASED ON ANALYSES OF THE NATIONAL ADULT INPATIENT SURVEY FROM 2002 TO 2009

Anna De Courcy, Elizabeth West.
University of Greenwich, United Kingdom.

Context:
The national patient survey programme (NPS) is an important indicator of the drive in UK health policy to make the NHS more ‘patient centered’. Since 2002, there has been little evidence of significant improvement in areas most important to patients. This presents the question, has the NPS had an impact on standards of care in acute trusts? This paper seeks to identify and synthesize published empirical research based on the NPS to understand how results have been analyzed and disseminated to determine how patient experiences and feedback could be used to greater effect.

Methods:
Databases, journals and websites were systematically searched using predefined terms, keywords and MeSH. Searches were conducted in July 2010 and repeated in October by two independent researchers. Studies included those that analyzed England’s national adult inpatient survey, from 2002. Briefing notes, trust level reports and those based solely on any other survey were excluded. No exclusions applied to language or country. Experts in the field were consulted and a search conducted by the Royal College of Nursing.

Results:
Duplicates were removed and criteria applied to identified works. Full text were sourced (60), with non-applicable papers removed (27). Papers produced by organisations not involved with the survey (42%) explored the relationship between patient experience and staff, management and culture. Most studies produced by organisations involved with the survey relied on descriptive statistics; recent years include trend analyses, significance tests, with some investigating the role of locality and social deprivation. The main findings seem to be that few areas of care have improved except those which have been the focus of major national initiatives.

Discussion:
As one of five domains of the NHS Outcomes Framework 2011/12, patient experience and feedback is integral to improving standards of care. National trends are addressed in identified studies, though little evidence showed sub-level analyses. Studies did address influences of the holistic patient experience. It has become clear that the adult inpatient survey is under used as a resource for improving patient centered care. This presents an opportunity for further research and development to improve services and practice based on patient feedback.
THE PUBLIC DISCOURSES ON THE OPTIMAL SIZE OF DUTCH HEALTHCARE ORGANIZATIONS

Jeroen Postma, Kim Putters. Erasmus University Rotterdam, Netherlands.

Context:
The last ten years an increasing number of mergers and acquisitions between traditional Dutch healthcare organizations is taking place. At the same time there is a rapid rise of new small-scale healthcare organizations. These trends cause a lot of debate in Dutch politics, society and the healthcare sector on the optimal size of a healthcare organization.

Methods:
We performed a discourse analysis to study the public debate on the optimal size of Dutch healthcare organization (with special attention to the arguments that are being used). First, we studied articles from major Dutch newspapers and several healthcare magazines from the time period 2000 – 2010. Second, we looked at discussions in Parliament, policy reports from the Ministry of Health, and advisory reports. We used Atlas-ti to group and further analyse the perspectives.

Results:
We identified three dominant ideal type discourses. The economic discourse is most dominant. In this discourse, a healthcare organization has reached its optimal size when it can operate cost effectively and can execute power over its stakeholders. The second dominant discourse is that of principals and agents. In this discourse stakeholders battle over control of the organization, and thus over the size of the organization, in order to gain (personal) profits. The third discourse focuses on networks. Not the size of a healthcare organization in itself matters, but the way the organisation is connected to other private and (semi-) public parties.
Despite the ideal type discourses, in practice the different perspectives and arguments are often being used intertwined. This leads to several paradoxes and conflicts between governmental and social actors.

Discussion:
The data provides several indications of a new, healthcare specific discourse on the optimal size of healthcare organizations. In this discourse, elements from the ideal-type discourses are being combined and redefined. Further research, on meso- and micro-level, is necessary to assess whether this really is a new discourse.
The data shows several developments in the public and political debate. In the late 2000s, the dominance of the economic discourse seems to decline in favor of the other discourses. The time frame of the study however is too limited to support this.
CLINICAL DIRECTORATE ANALYSIS IN THE ITALIAN NHS. EVIDENCES FROM THE NATIONAL MONITORING FRAMEWORK SYSTEM

Americo Cicchetti, Daniele Mascia, Federica Morandi, Ilaria Piconi.
Catholic University of the Sacred Heart, Rome, Italy.

Context:
Clinical directorates represent semiautonomous hospital divisional units in which several clinical wards are integrated. During the 1990s, directorates were introduced into the Italian NHS. Many authors have investigated the model of clinical directorates, but there is little evidence about the organizational criteria required in order to reach efficacy and effectiveness through such a model. The aim of this study is to bridge this gap.

Methods:
We gathered data through a survey administered in collaboration with the Italian Ministry of Health during 2008-2010. A semi-structured questionnaire was used during on site visits in order to obtain information about clinical directorates. We interviewed 30 hospital CEOs and 60 Clinical Directorate Managers. Questionnaire items were related to three organizational criteria, considered strategic for designing clinical governance oriented directorates. Decentralization degree (of administrative and clinical activities); Level of Integration; Level of Standardization. Each item contributes to determining the score reached by clinical directorates.

Results:
Decentralization of administrative activities and decentralization of clinical activities were found to be directly correlated ($\rho = 0.785; p \leq 0.01$). Decentralization of administrative activities is correlated both to integration ($\rho = 0.645; p \leq 0.01$), and to standardization ($\rho = 0.641; p \leq 0.01$). Decentralization of clinical activities and integration are positively correlated ($\rho = 0.767; p \leq 0.01$). Both correlation coefficients between decentralization of clinical activities and standardization ($\rho = 0.916; p \leq 0.01$), and between integration and standardization ($\rho = 0.612; p \leq 0.01$) show high indexes.

Discussion:
Results show a high variability in the departmentalization process as well as different degrees of implementation of clinical governance tools. The original framework of the analysis allows to examine features, autonomy and coordination within clinical directorates. The scores assigned by our framework enable policymakers to identify the best practices, to imitate successful experiences and to improve the quality of care. In future research we will focus on the correlation between organizational design criteria and performance data.
PARALLEL SESSION

VERTICAL INTEGRATION I

23 JUNE 2011, 11.00 – 12.30

ARIAINE 2
COORDINATION OF CARE BETWEEN HOSPITAL AND GENERAL PRACTICE: THE WAY NORWEGIAN HOSPITAL PHYSICIANS SEE IT

Pål E Martinussen.
SINTEF, Norway.

Context:
The role of physicians are of particular interest for the coordination of care, since both their professional training and their role in supervising service quality may stimulate specialisation and fragmentation rather than coordination of care. Furthermore, Norway makes for a particularly interesting case in terms of studying this subject, since the responsibility for primary and secondary health services are divided between the state and municipalities.

Methods:
Data were collected through postal questionnaires to 2500 publicly employed hospital physicians randomly selected from the records of the Norwegian Medical Association. Combining the survey data with 1) hospital data on activity and performance and 2) data from the municipalities in the hospitals’ catchment areas, the analysis employs multi-level techniques to study how individual and hospital-specific factors affect the satisfaction with coordination of care with general practice.

Results:
Lack of coordination between the healthcare levels is not perceived as a significant problem by the hospital physicians. The multivariate analysis shows that regular meetings with GPs improve satisfaction with coordination. Also, the medical speciality of the physicians matters for how the coordination with the GPs is valued. Furthermore, both inadequate information in GP referrals and too many ‘wrongful’ GP referrals are sources of poor coordination. Of the hospital-specific variables, GP coverage in the hospital’s catchment area and hospital efficiency exerts a positive effect on the hospital physicians’ satisfaction with coordination.

Discussion:
The results suggest that the problems of coordination is not first and foremost experienced between hospital physicians and GPs, but rather by other key healthcare professionals in the primary healthcare services. Future studies should therefore examine coordination of care using a broader range of healthcare professionals, thereby also capturing the experience of those facing the coordination challenges from the perspective of the municipality services. The main contribution of this study lies in the attempt to address the macro and micro barriers to coordinated care, thus increasing the knowledge on how contextual, institutional and professional factors affect coordination of care.
INTERACTION BETWEEN GENERAL PRACTITIONERS AND HOSPITALS: THE EFFECT OF COOPERATION INITIATIVES ON GPS SATISFACTION

Lars Erik Kjekshus¹, Trond Tjerbo².
¹University of Oslo, Norway; ²Norwegian Institute for Urban and Regional Research (NIBR), Norway.

Context:
The levels of health care are closely related and the characteristics of the organizations and use of resources on one level of care effect the providers on the other levels of care. Several organizational solutions have been implemented in order to improve the interaction between the primary and the secondary level. This paper examine the effect of different interaction initiatives in Norwegian hospitals.

Methods:
The effects of interaction initiatives are analysed in a dynamic multilevel model. The explanatory variables in the paper are based on a panel dataset covering the period from 2001 to 2007. The dataset covers the main areas of interaction e.g.; information technology (routines for electronic referrals, etc), structural arrangements (ambulatory teams, joint clinical guidelines etc), and competence transmissions (training schemes for GPs, internship, etc). The dependent variable is GP satisfaction based on data from two national surveys by the Research Institute of The Norwegian Medical Association, performed in 2004 and 2006 with a response rate of nearly 50%.

Results:
The percent of the GPs that where satisfied with the coordination of health care between themselves and their primary hospital was 52% in 2007 and 55% in 2005. The GPs tend to be less satisfied with the coordination of health care when they have large and more cost-effective hospitals with a high share of elderly patient as their primary hospital. This, together with the degree to which the general practitioner is involved in arenas where hospital physicians and general practitioners interact, turned out to be good predictors of general practitioner satisfaction.

Discussion:
The results indicates that interaction is affected by a complicated structure of variables in both levels of care. To improve coordination between GPs and specialists, one should focus upon the structural traits within the hospitals in different regions as well as creating common arenas where the GPs can interact with the hospital. Contrary to this findings the hospitals are reducing the arenas for such activities in the period of analysis.
DO EXPANSION OF PRIMARY CARE SERVICES REDUCE OR INCREASE THE USE OF SPECIALIST HEALTH CARE SERVICES?

Terje P Hagen.
University of Oslo, Norway.

Context:
Numerous countries plans expansion of primary health and care services to tackle the rising costs of specialist services but few analyses has tested the effects of such policy changes.

Methods:
We linked data of the population’s use of specialist care to local government characteristics such as number of GPs, places in nursing homes and receivers of home nursing, and corrected for the population’s need of health care services by a set of demographic and socioeconomic variables. By utilizing data from a period of seven years from 430 Norwegian local governments, we were able to test out which characteristics at local level that affected use of specialist services.

Results:
Preliminary results indicated that expansion of nursing homes and home nursing reduced number of inpatient stays in departments of internal medicine for persons aged 80 or more. Expansion of most of the other primary care services had no effect on the population’s use of specialist health care services. There are indications that more GPs increases the use of specialist rehabilitation services while the effect on the use of inpatient stays is insignificant.

Discussion:
If the ambition is to reduce use of specialist health care services, expansion of primary care services is an ambiguous mean.
HEALTH PROMOTING ACTIVITIES FOR THE ENTIRE POPULATION

Ann Ekberg-Jansson, Marina Olsson, Malena Lau.
Angereds Närsjukhus, Vastra Gotalandsregionen, Sweden.

Context:
Angered local Hospital (Angereds Närsjukhus) has the aim to provide the residents of Northeast Gothenburg better access to good health care.
Despite the fact that all inhabitants of Gothenburg has equal right and access to health care, analysis has shown that the population in Northeast Gothenburg more often suffers from lifestyle related diseases. The mortality in Obstructive Lung Disease is for example three times as high, compared to the rest of the country.

Methods:
Obstructive Lung Disease is strongly associated with smoking and can easily be detected by a lung function test, spirometry. With early disease detection treatment can be initiated at an earlier stage.
Northeastern Gothenburg is a multicultural population area where the knowledge of self care is limited. The ability to assimilate information in Swedish is not obvious and alternative means of communication in the health promoting activities is often necessary.
In February 2009 three hours for drop-in reception with free spirometry were set aside one day each month. An information campaign was also conducted to reach a majority of the population in Northeastern Gothenburg. The goal was that 50% of those who came to the open spirometry receptions would be women and 50% would not have Swedish as their mother tongue.

Results:
- The message about the dangers of smoking, together with information about the drop-in reception at the local hospital was translated in all the major languages and then transmitted in various community radio stations.
- Advertisements about the drop-in receptions was regularly put in the local newspapers
- An invitation went out to all the local associations where they were offered to take part in a lecture about smoking, its harmful effects and ways to quit smoking. The lecture was held by a medically qualifies person in four different languages.
Drop-in clinics have shown to be very successful and each drop-in reception is visited by an average of 30 people each occasion. 55% of the patients were women and 75% did not have Swedish as their mother tongue. About 40% of all people who had a spirometry at these receptions were diagnosed with Obstructive Lung Disease and put under treatment.

Discussion:
Since September 2010 these free spirometry receptions is integrated in the ordinary business at Angereds Närsjukhus.
PARALLEL SESSION

LONG TERM CARE

23 JUNE 2011, 11.00 – 12.30

GEMINI 1
INTEGRATING STROKE SERVICES: CHALLENGES FOR SWEDEN & ENGLAND

J Baeza, A Boaz, A Fraser.
King's College London, United Kingdom.

Context:
Despite significant investment in health research, challenges remain in translating research into policies and practices that improve patient care. As part of an EUFP7 Programme, comparative case studies were conducted of stroke research implementation in England & Sweden. The evidence suggests that better integration between primary, acute and community services improves outcomes for stroke patients. This paper presents early findings examining various integration issues in England & Sweden.

Methods:
Comparative case studies, consisting of semi-structured interviews of key stakeholders in acute and primary care. This paper focuses on the results from two case studies in Sweden and England. Informants included a range of clinical and managerial staff involved in stroke services in acute, primary and community care settings. The interviews examined issues relating to the barriers and facilitators to implementing stroke research evidence into practice. The data were analysed using the interview schedule as a framework for content analysis.

Results:
In both countries acute provision was perceived as being prioritised over community and rehabilitation care. Post-stroke care is managed by non-specialised general practitioners, their quality of care and knowledge of stroke was characterised as inconsistent by acute and community staff. Communication between acute, primary and community clinicians was problematic. Staff recruitment, training and retention were considered challenging in the community sector. The evidence base of community rehabilitation is more disputed than acute interventions, adding to service disparities. The data suggest that while Sweden has made more progress with organizational integration, both countries face challenges in moving towards integration.

Discussion:
There are broad similarities in England and Sweden. Informants, whilst positive of stroke services in acute settings, had concerns on discharge management, community care and rehabilitation provision. Training, network participation, evidence and leadership were critical to stroke service integration. Stroke service integration is universally difficult but some contextual differences were noted. In England, the problem was perceived as a persistent health system issue. In Sweden policy trends limiting access to rehabilitation was also significant. Integration remains a challenge for both.
WHEN HOSPITAL AND TERRITORY ARE INTEGRATED: THE STORY OF A SUCCESSFUL PROJECT

Emanuela Foglia1, Daniela Malnis2, Emanuele Porazzi1, Ilario Stefani3, Umberto Restelli1, Luca Casartelli1, Giovanni Beghi2, Antonino Mazzone3, Carla Dotti3.
1Università Carlo Cattaneo - LIUC, Italy; 2Local Health Authority Milan 1, Italy; 3Hospital Authority Ospedale Civile Legnano, Milano, Italy.

Context:
Many studies show benefits of an integrated approach for the treatment of chronic illnesses (Bodenheimer et al., 2002; Olivarius, 2001) and a relationship between structure of organisations and quality of care, for chronic illnesses (Solberg et al., 2009). In Italy networks and groups of GPs lead to better qualitative performance with respect to individual practitioners (Mannino et al., 2009).

Methods:
In 2008 a pilot project started to manage diseases in a non-hospital situation, with admission to hospital only if necessary, to strengthen territorial medicine and to better coordinate it with hospital activity, introducing Primary Care Groups (PCG). Local Health Authority Milano 1 (District 4 Legnano) and Hospital Authority Ospedale Civile Legnano activated 5 PCGs, with 43,500 patients.

Results:
PCGs enabled resources consumption’s direct measurement and an improvement in diagnostic and therapeutic appropriateness. There is a reduction (2008/2009) in the percentage of patients affected by chronic diseases followed by the PCG hospital admissions, compared to hospital admissions of patients followed by the PCG. The number of diabetic patients with at least one admission into hospital for diabetes decreased from 1.87% to 1.37%. In dyslipidemic patients there was a decrease in admissions into hospital for heart failure, angina, and ischemia (5.09% - 4.45%), as well as arteriosclerosis (0.52% - 0.41%) and for diabetes (0.43% - 0.35%).

Discussion:
This study demonstrates the necessity to focus on new organisational models, with the intermediation of figures close to patients and care giver.
There was evidence that, within District 4 Legnano, there was a 72 per thousand admissions rate, for patients followed by PCGs, the rate was 58 per thousand. The decision to activate PCGs, in collaboration with the Hospital Authority, lead to a reduction of the hospitalization rate by 14 per thousand (p-value <0.001).
EVALUATION OF THE EFFECTS OF A DIABETES DISEASE MANAGEMENT PROGRAM ON OUTPATIENT HEALTH CARE

Herwig Ostermann¹, Margit Raich¹, Harald Stummer³, Micheal Mueller¹².
¹University for Health Sciences, Medical Informatics and Technology, Austria; ²Social Insurance Institution for Trade and Industry, Austria; ³University for Health Sciences, Medical Informatics and Technology, Austria.

Context:
Diabetes disease management programs (DMPs) have been devised to improve coordination especially amongst outpatient health care and are intended to lead to different patterns of service utilization. The authors seek to evaluate these effects by comparing outpatient health care services received by enrolled patients to those of non-participants.

Methods:
The authors analysed the records of diabetes patients covered by the Austrian Social Insurance Institution for Business. 705,607 persons (7% of total population) were insured in 2009, out of which 21,299 were identified as diabetics. Enrolment to the DMP is voluntary without any financial incentives offered to patients. In 2009, 514 persons were enrolled with no substantial difference in terms of patients’ age or sex as compared to the group of 20,785 non-participants.

Results:
In 2009, enrolled diabetics received less reimbursed single services than non-participants (162 vs. 207 services). However, overall costs for outpatient services received by enrolled patients were higher (€1,818 vs. €1,630) due to a different pattern of health care utilization featuring increased utilization of distinct medical specialists (21 vs. 12 services) as well as laboratory services (14 vs. 9 services) but less wound care bandaging (14 vs. 42) and transport services (7 vs. 39). Adding the costs for medication (€1,056 for participants vs. €1,143), it can be shown that total costs of outpatient diabetes management for patients within the DMP exceeded the costs of regular diabetes patients by 3.6% (€2,874 vs. €2,773).

Discussion:
DMPs seek to achieve better patient outcomes at reasonable costs by the coordination of different service providers.
With reference to outpatient care for diabetics, the authors found evidence that even within a rather loose DMP enrolled patients receive a more evolved pattern of services featuring less utilization of non-medical services and medication at reasonable additional costs.
THE ROLE OF CLINICAL LEADERS IN THE IMPLEMENTATION OF INTEGRATED NETWORKS OF ELDERLY CARE

Christelle Routelous\(^2\), Isabelle Vedel\(^1\), Liette Lapointe\(^2\).
\(^1\)EHESP, France; \(^2\)McGill University, Université de Montréal, Canada.

**Context:**
Health services integration is presented as a solution to the challenges faced in the healthcare system. In France, the results of such initiatives are met with criticism: general practitioners’ lack of participation; partners’ lack of support; lack of care protocols and shared electronic health records, etc. These issues make difficult the integration of care and raise questions with regards to the relevance of existing networks. However, geriatric network that include case managers seem more successful, maybe because of the involvement of geriatricians in their implementation.

**Methods:**
We conducted a qualitative longitudinal study of 2 cases where an integrated model of geriatric care was implemented. One was set in an urban area and the second in a semi-rural one. To gather data we used face-to-face semi-structured interviews, focus groups, direct observation, documentation. All the organizations involved in elderly care were invited to participate. The respondents were selected using a snowball sampling strategy to ensure a representative sample (N = 68).

**Results:**
Three major outcomes arose from our analysis. First, the involvement of geriatricians promotes the participation of general practitioners and allows for a co-construction of interventions that fit with professional practices and values. Second, geriatricians are able to span organizational boundaries thanks to their central role in the community of practice and their knowledge network. Finally, some tools facilitate participation and reinforce the importance of networks to support the frail elderly: shared electronic medical records and common care protocols.

**Discussion:**
Thanks to their legitimacy and credibility, clinical leaders were a driving force in the implementation, identifying the issues and objectives of elderly care, defining specific medical objectives, providing accessibility to early geriatric assessment and eventually direct admission in geriatric wards. Notwithstanding, clinical leaders have to surround themselves with political and administrative leaders to ensure stability in terms of inter-institutional and multidisciplinary practice.
PARALLEL SESSION

MODELS OF INTEGRATED CARE

23 JUNE 2011, 11.00 – 12.30

GEMINI 2
POLICY INTEGRATION TO ACHIEVE COMMUNITY-BASED CARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

Joyce JPA Bierbooms¹,², Inge MB Bongers¹,².
¹GGZ Eindhoven en de Kempen (GGzE), Netherlands; ²Tilburg University, Netherlands.

Context:
Despite large-scale investments in community mental health care since the 1990s, an undesired trend towards reinstitutionalization has been visible in the Netherlands since 2002. To provide tailored types of residence for people with mental health problems, and reconcile individual and collective interests, cooperation between key organizations that have a shared responsibility for the residence of mentally vulnerable people in the community is essential.

Methods:
A scenario analysis was performed, which consisted of four steps: 1) an exploration of the external environment; 2) the identification of key uncertainties; 3) the development of scenarios; 4) the translation of scenarios into useful guidelines. We used a document study, 20 semi-structured interviews and an expert panel discussion to work out these steps.

Results:
From a range of demographic, socio-economic, and policy topics (document study and interviews), our expert panel saw the availability of financial resources for mental health care and the possibilities for successful integration in the community as key. This resulted in four scenarios: 1) Integrated and independent living in the community with professional care; 2) Responsible healthcare supported by society; 3) Differentiated provision within the walls of the institution; 4) Residence in large-scale institutions but unmet need for care. Examining the four scenarios, the panel formulated strategy guidelines aimed at fulfilling scenario 2.

Discussion:
The scenario study shows that in Eindhoven (The Netherlands) there is a need for a socially supportive and responsible society and community-based care. This demands social support systems and normalized living possibilities. It also means that cooperation between mental health care providers, social care organizations, public housing corporations, and local government is essential. The scenario study has offered concrete guidelines for creating a shared vision on types of residence for people with mental health problems, and provided a tool for understanding the implications for future strategy plans on a regional level.
INTEGRATION IN VOCATIONAL REHABILITATION – A LITERATURE REVIEW


Context:
With the increasing specialisation of services, integration has become important for health and other welfare organisations in order to address the complex problems of their patients or clients. This is particularly in care of the elderly, psychiatric care and vocational rehabilitation. The following presentation reports a review of literature on integration in vocational rehabilitation, focusing on models of integration as well as barriers and facilitators.

Methods:
The review was based on a search in scientific journals from 1995 to 2010. It generated 13132 articles, which were reduced to 1005 after an initial overview. The abstracts were read by members of the research group. Each abstract was read by two members independently. If they agreed the article was included or excluded, but if not the whole group discussed the abstract. This procedure reduced the number of articles to 205, which were read in full text. Finally, 62 articles were included for thematic content analysis.

Results:
Most of the studies came from Sweden, while others came from Canada, Australia, UK, Netherlands, Norway and Denmark. In these studies different models of integration were identified. They were classified as structural or process oriented. The structural models included case management, partnerships, co-location and financial coordination, while the process oriented models included informal contacts, interorganisational meetings and multidisciplinary teams. There were also a number of barriers as well as facilitators of integration. The barriers included structural and cultural differences, while communication, trust and continuity were important facilitators.

Discussion:
There are different models of integration, but also many combinations. Case management is often combined with interorganisational meetings or multidisciplinary teams. There are also informal contacts in all models. There is a clear mirror effect between the different barriers and facilitators. Leadership may be either a barrier or a facilitator. In the same way, differences between organisations may be both barriers and facilitators. These results seem to be valid also for other fields of integration, for example care of the elderly, psychiatric care, and other forms of community care.
THREE PRACTICAL MODELS FOR INTEGRATED CARE

Lia E Donkers.
Transmural Network Foundation Midden-Holland, Netherlands.

Context:
When it comes to integrated care everyone has a chronological pathway in mind. We found out that delivery of care more often happens simultaneously than sequentially. This involves different ways of management. We present three practice based models.

Methods:
The work has been done by the Transmural Network, a joint venture of care providers in the Gouda region. Main task is setting up integrated care for groups of people with a specific diagnosis or care demand. First we establish a multidisciplinary think tank, that analyses the care problem. We value the input from health professionals. That’s crucial because breaking down silo mindsets happens bottom up. There is no blueprint. We follow a greenprint: learning by doing. Then we start connecting the variety of professional standards into a regional guideline. Good practices are welcome. Based on the regional guideline we streamline the organisation of integrated care into a regional chain activity.

Results:
Service model.
There is a predictable treatment programme synchronically carried out by multiple providers, suitable for those with a chronic disease, capable of self management, like diabetes. One of the providers bears medical responsibility and tells the others what to do. Similar to an orchestra where everyone follows the conductor.
Transfer model
There is a predictable rehabilitation treatment programme sequentially carried out by multiple providers, suitable for patients after an accident or surgery, like stroke. Transferring the patient to the next care provider also means handing over medical responsibility. Similar to a relay race.
Team model
There is an unpredictable treatment programme synchronically carried out by multiple providers, suitable for patients with increasing self-care deficits like dementia. Shared responsibility. Teamwork and a case manager are needed because of the changing conditions of the patient. Similar to team sport and captain.

Discussion:
Management, government, and health insurers lay stress on integrated care. It is believed to be an antidote to fragmentation of care. Integration however is poorly understood. After ten years we find ourselves back in a tricky one dimensional approach. We are asked for blueprints in order to get it managed, funded or merchandised. There is no one size fits all. By presenting three models we hope to clarify that.
HIGH UTILISERS IN HEALTHCARE – A STARTING POINT FOR INTEGRATING COST AND CARE MANAGEMENT IN THE STATUTORY HEALTH INSURANCE

Matthias P Schoenermark¹, Thomas Temme², Heike Kielhorn¹.
¹Hannover Medical School (MHH), Germany; ²Schoenermark. Kielhorn + Collegen, Germany.

Context:
In Germany, the current financing scheme aggravates the cost issue of high utilisers, claiming higher than average health services in the statutory health insurance. So far, there were no care management concepts for high utilisers as the mostly multimorbid cases with complex medical conditions were judged as being beyond influence. We developed a method to reveal shortcomings in the treatment and care of this sub group to increase efficiency which improved existing structures towards a higher integration of different sectors and organizational units.

Methods:
Based on data from four subsequent years we developed a segmentation as well as a prediction model based on usage patterns. Subsequently, existing care management concepts were analyzed, adjusted and complemented to allow for cost-savings via improved and targeted care management for high utilisers. Adjusting care management for this population revealed where the organization of care was not in line with the course of the disease and its treatment, both inside and outside the insurance company.

Results:
In our approach, high utilisers were defined as the 5 % most expensive insurants accounting for 50 % of total spending. We distinguished high utilisers who caused most cost in one specific sector from those where cost occurred in multiple sectors. Ultra high utilisers were targeted separately by a specifically developed case management. Among the high utilisers targeted as groups, psychiatric diseases stood out as a challenge and starting point for integrating care inside (departments) and outside the organization (contracts). For high utilisers, an overall cost saving potential of about 2.2 % could be identified.

Discussion:
In our project, a practical system for the controlling and management of expenses caused by high utilisers has been developed. The early identification and the specific management of high utilisers in health care has shown a very high financial potential. Establishing the necessary analytics and tools caused improvements in the integration of different sectors and programmes inside the statutory health care organization as well as among the health care providers outside.
PHD STUDENT SESSION

23 JUNE 2011, 10.45 – 12.45

CHALLENGER
THE CAUSE FOR ACTION? DECISION MAKING AND PRIORITY SETTING IN INTEGRATED CARE

Viktoria Stein.  
Medical University Vienna, Austria.

Context:  
Expectations of patients and system requirements have changed since the introduction of the first public health services more than a century ago. The industrialised countries counter these challenges by a state of constant health reform. One solution to answer expectations and requirements is ‘integrated care’, a patient-centred model, which propagates better processes, coordination and cooperation between the different service providers and sectors in health care.

Methods:  
Based on a discussion of theories on health systems, decision making and performance measurement in health, the first part of the thesis examined the current problem areas and conflicts of organisation and reform in health care systems. This served as a basis for the introduction of integrated care and the development of an international expert survey on decision making and priority setting. The quantitative analysis was conducted using SPSS. Based on the survey results, commonalities and differences in priority setting among actors and across health systems were analysed.

Results:  
The expert survey showed the highest priority of health care decision makers is the introduction and enhancement of management structures on all levels. The analysis demonstrated the value of a clear political framework and incentives for the promotion of integrated care, as well as the substantive demand for improved communication, coordination and information structures within and between health service providers. Policy makers can rest assured that investing in and incentivising integrated care pays. The response rate was 18%, with the majority of responses coming from Germany, the Netherlands and the USA.

Discussion:  
Integrated care has come a long way from the first experiments to a colourful array of projects and programmes, spanning from local to national level and from targeted to broad inclusion criteria, initiated, owned and financed by a mix of all stakeholders and agents in the system. Hence, integrated care developed into a ‘Jack-of-all-trades’ approach, stimulating change and confusion at the same time. Still it has not entered mainstream health care organisation and continues to struggle in proving its value. More data need to be collected on the influencing factors and interrelationships of agents and systems with regard to integrated care to develop more customised models.
MIGRANTS USE OF THE PRIMARY HEALTH CARE SYSTEM

Ursula-Georgine Småland Goth 1,2,3.
1Oslo University Hospital, Norway; 2Oslo University College, Norway; 3University of Oslo, Norway.

Context:
Norways growing diversity presents challenges to the national health care system. Hence, the ability to gain and use health information is vital. Therefore, information for migrants and their accessibility to the national health system needs to be monitored. Primary health care system includes a patient list system which caters to an increasingly diverse population.
We aimed to investigate the use of GP services vs. services provided at the Emergency Department for both majority and predominant minority populations.

Methods:
Interviews with local GPs and cultural mediators from major migrant populations provided data for the qualitative part of the project. Quantitative data for the regression analysis came from the reimbursement registry for the years 2006 and 2007. This information was linked with data from the population registry and defined for both the largest migrant populations and the total population. We tested the model for age, gender, length of residency, county/municipality and country of birth.

Results:
Qualitative results indicate that GPs define migrants in terms of socio-cultural difference and reported that migrants often seem helpless, which they attributed to language difficulties and differences in expectations. According to cultural mediators, utilization varies according to duration of residence, country of origin, reason for migration, health literacy, and language proficiency. Preliminary results from the interfaced register database show that the probability of contacting the Emergency Department varies by country after adjusting for age and gender.

Discussion:
Our findings indicate that there are large variations in usage patterns both between and within the different minority populations influenced substantially by duration of residence. Information about and within the patient list system, is not comprehended by migrants as expected from. Immigrants, recently arrived in Norway, might be inadequately informed about the organization of the public health care sector.
The study provides a deeper understanding of utilization determinants in health care services for predominant minority populations.
HEALTH OPERATIONS MANAGEMENT IN MENTAL HEALTHCARE

Tom Joosten\textsuperscript{1,2}, Inge Bongers\textsuperscript{1,2,3},
\textsuperscript{1}\textit{Tilburg University, Tilburg, Netherlands}; \textsuperscript{2}\textit{GGzE / Mental Health Care Organization Eindhoven, Netherlands}; \textsuperscript{3}\textit{Tilburg University, Netherlands}.

Context:
A growing number of papers reports on lean thinking, care programs and care pathways in healthcare. Most of this research has been carried out at hospitals. As a consequence, interest from mental healthcare organizations is rising, despite the fact that not much research has been carried out in that sector. This PhD research seeks to address this gap in the literature.

Methods:
We used a quasi-experimental design to assess the effects of lean thinking, care programs and care pathways in mental healthcare. The intervention consisted of a 1.5 year-long breakthrough project at a child and adolescent clinic of a large mental healthcare organization in The Netherlands. Results were measured on at three levels: outcome (CGAS), process measures (e.g. waiting times) and organizational climate (e.g. innovation & flexibility). These results will be compared to a similar clinic in another part of The Netherlands, at which we collected the same data.

Results:
The intervention period just ended in the last quarter of 2010. Preliminary data will be presented at the conference. Using lean thinking as a starting point, the experimental clinic among others implemented a number of care pathways, improved scheduling and planning, tried to improve problem solving techniques and started using a new electronic patient record. Preliminary analysis shows a reduction in waiting times, which at the end of the intervention were below the nationally agreed maximum. Other process measures and data about organizational climate is currently being investigated.

Discussion:
Although the data of the experimental and control group has yet to be compared, our preliminary analysis suggest that the clinic was able to significantly improve performance on a number of parameters, most notably waiting time. Straightforward application of the instruments was sometimes perceived as difficult by participants. This among others highlights the importance of improving problem solving skills, as a part quality improvement efforts. Overall, our results suggest that instruments like lean thinking and care pathways, with some adjustments, can also be used in mental healthcare.
TOWARDS AN INTEGRATED HEALTH SERVICE FOR ELDERLY PATIENTS?
EXPERIENCES FROM A SPECIALIZED SHORT TERM WARD

Anne-Kari Johannessen.
Akershus University Hospital, Norway.

Context:
Coordination of health services for the elderly is emphasized by health politicians in Norway. In an ongoing Ph.D project we explore experiences with a specialised short-term ward (SSTW) that represents an intermediate stage between hospital and municipality health services. The study unit offers health services to elderly patients who are in transition between the hospital and their own home. The unit is a collaboration concept between a University hospital and four municipalities.

Methods:
The study method is a combination of qualitative interviews and observations. We have observed HCP in their daily work and conducted interviews with patients and HCP employed in the municipalities, at the hospital and at the SSTW. The data will be analysed by a systematic text condensing inspired by Giorgi. The overall aim is to generate knowledge of how to achieve integrated, and seamless health care services for older people. We explore both patients and health care provider’s (HCP) experiences.

Results:
Patients: Mostly satisfied. The services are not in accordance with the patient expectations. They wish for more adapted training. Few patients are in need of home based services when they are discharged from the ward. Most patients are dependent of relatives when they return home. They return to old patterns of living after discharging the ward.

HCP:
Disagreement about the patient selection to the ward. The ward receives incorrect patient documentation. They have different views about: needs that patients may have, severity of patient’s disease and the admission criteria to the ward.

Discussion:
Are such wards a proper choice for future health services to elderly people? Findings indicate that cooperation about vital issues are problematic. How much time and effort is used to achieve compromises between HCP representing different levels of health care? Can disagreements on patient topics restrict the quality of care and treatment? Who’s the looser and who’s the winner in these obstinacy situations? Patients are quite satisfied with the services even though the HCP strive with the cooperation. If caring activities get less attention than hospital activities we may need to search for alternative concepts of collaboration that favor the elderly patient in a better way.
MANAGING CLINICAL INTEGRATION – A COMPARATIVE CASE STUDY IN A MERGED UNIVERSITY HOSPITAL

Soki Choi¹, Ingalill Holmberg², Jan Löwstedt³, Mats Brommels¹.
¹Karolinska Institutet, Sweden; ²Handelshögskolan, Sweden; ³Stockholm University, Sweden.

Context:
Based on the case of the Karolinska University Hospital merger, this paper explores critical factors that may obstruct or advance clinical integration efforts initiated by the new clinical management. The aim is to increase our understanding of why clinical integration succeeds or fails following a hospital merger.

Methods:
We compare two embedded cases of integration efforts following the Karolinska University Hospital merger in Sweden. Each case represents two clinical departments of the same medical specialty from each hospital site. The two cases were sampled based on maximum variance in outcomes within the same change context. We conducted 53 interviews between 2004 and 2007 with individuals representing various clinical staff categories and collected numerous documents to check data consistency.

Results:
Our study identifies three main factors that seem to be instrumental for the process and outcome of integration efforts. These are: the new clinical management’s 1) interpretation of institutional pressures, 2) design of the management system and 3) change strategy chosen. Six years post-merger (in 2010), the integration status is reported to be status quo, which indicates that the functional and dysfunctional outcomes of the two clinical cases may actually reflect long-term effects of hospital mergers.

Discussion:
The successful clinical integration observed in one of the embedded cases was largely the result of the design of a “hybrid management system”, which allowed the re-coupling and de-coupling of managerial responsibilities in a shared hybrid arena. Although Cooper et al. (1996) claim that hybrids are schizoid and unstable organizational forms, the suggestion in this study is that “hybrid systems” may have better prospects for success than “hybrid positions [i.e. physician managers]. Hybrid management systems may increase organizational legitimacy when attempts to achieve radical change are made in organizations dominated by deep structures of professionalism. In fact, such hybrid systems, as McNulty and Ferlie (2002; 2004) argue, may even show the way into a post-NPM era.
MASTERCLASS

23 JUNE 2011, 16.00 – 18.00

ARIANE 1
HOW TO ACHIEVE EFFECTIVE KNOWLEDGE TRANSFER FROM RESEARCH TO POLICY AND PRACTICE

Tit Albreht, Johan Hansen, Willy Palm, Natasha A Muscat. Centre for Health System Analyses, Institute of Public Health of the Republic of Slovenia, Slovenia; NIVEL, Netherlands Institute for Health Services Research, Netherlands; European Observatory on Health Systems and Policies, Belgium; Ministry of Health, the Elderly and Community Care, Malta.

Context:
European health care decision makers are faced with an increasingly complex environment, which calls for better identification and application of scientific evidence. Often proposed solutions to enhance this underpinning of policy decisions are to improve communication channels between the research community and decision makers and to improve the types of contributions that the research community makes.

Methods:
A special workshop, co-hosted by [EHMA,] EUPHA and HSR-Europe, addresses both issues by providing training on how to use communication tools (e.g. policy briefs) for health care research, in order to ensure better use of its outcomes. Target audiences of the session are both researchers and decision makers, as the latter are the judges to decide which type of wrapping of research evidence is effective. The session builds on the following elements:

Results:
1) A brief introductory presentation will show what is currently known from a mapping of the literature on the conference’s main topic, integration of care, and which of this is currently being used in policy.
2) To describe a number of effective mechanisms for linkage and exchange as well as share experiences and advice on how to use these in order to convey research findings to policy.
3) Next, workshop participants will have the opportunity to discuss in round table subgroups on what each group considers key messages on integration of care and then formulate a communication strategy to convey this, e.g. by means of the outline for a policy brief. One reporter per subgroup will then share outcomes of that group.
4) Invited experts from various backgrounds will provide feedback, followed by a general discussion.

Discussion:
Outcome of the session will be both an overview of key lessons, generated by the audience, on integration of care, as well as a practical training in conducting and communicating health care research in such a way that decision makers can understand it, appraise and apply it.
PARALLEL SESSION

E-HEALTH

24 JUNE 2011, 11.00 – 12.30

ARIANE 1
TELE-BASED HEALTH COACHING PROGRAM FOR CHRONIC DISEASE IN FINLAND – EFFECT ON USE OF HEALTH CARE SERVICES AND COSTS (TERVA PROGRAM)

Erja Oksman¹, Martti Talja¹, Mika Linna².
¹Päijät-Häme Social and Health Care District, Finland; ²National Institute for Health and Welfare, Helsinki, Finland.

Context:
TERVA Health Coaching Program is responded increasing challenge of chronic diseases; type 2 diabetes, coronary heart disease and heart failure. The program was launched November of 2007 and was ended December of 2009. The goal of the randomized-control study was to study what is the effect of a structured telephone-based, technology-supported health coaching program on the health behavioural and clinical signs of the people with these conditions.

Methods:
Patients with undertreated type 2 diabetes (DM), recent Myocardial infarct (MI) or Cardiac insufficiency (CI) (hospitalized <2years) were identified from regional databases. Eligibility criteria were fulfilled on 2598 patients of whom 1532 were willing to participate (DM = 1002, MI = 251, CI = 122). They were blindly randomized to intervention (n = 970) and control (n = 470) groups. Intervention group received individual health coaching support from health coaches during one year and also used normal health care services. Patient in control group used traditional health care services.

Results:
Preliminary results showed that patient with chronic disease use quite a lot health care services in primary and secondary care, median of contacts with primary care was 12 times per year. The amount of contacts with diabetic patients had no correlation with therapy results. After coaching period in intervention group the level of HbA1c was better in intervention group. The effect of coaching on blood pressure and behavioural changes was significant. Use of primary and secondary health care, diagnoses and total costs will be presented.

Discussion:
This result of this study showed that our old style to do work is not effective. The therapy result did not correlate with used manpower resources. We conclude that by adding new therapy components in seamless care pathways the whole care system must be reorganized to reach the maximal benefits from the used manpower. Health coaching itself showed to be effective method to achieve better therapy results.
INFORMATION AS THE KEY TO INTEGRATING DELIVERY OF HEALTH AND SOCIAL CARE – A SCIENTIFIC DECLARATION OF THE CHALLENGES

Michael Rigby.
Keele University, United Kingdom.

Context:
A citizen-centric holistic health view of integrated care requires health and social care delivery to be integrated. As most organisations increasingly use informatic systems, this requires operational integration of informatic systems based on common information concepts. To consider this challenge, an Exploratory Workshop was sponsored by the European Science Foundation, and resulted in a unanimous cross-disciplinary Declaration.

Methods:
Identification of a multi-national group of experts from 15 countries, covering a wide range of professions and disciplines, and organisation of an Exploratory Workshop. Creation of a core team and bibliography, resulting in a programme of issue identification followed by group discussions. Apart from the planned discussions, the group spontaneously agreed to a shared “Declaration: Social Care Informatics meets Health Care Informatics - a Holistic Citizen-Centric Vision for Information and Communication Technologies to Support Personal Health”. This declaration covers ethical, consumer and professional, and managerial issues as well as those pertaining to IT applications. Publication of a final report of the issues.

Results:
Results are enshrined in a 50 page scientific report published on the European Science Foundation website, plus the Declaration. The OECD has now requested that a presentation is made in Washington DC to a joint OECD/US National Science Foundation Workshop on Building a Smarter Health and Wellness Future. International informatics bodies have committed to addressing the issues.

Discussion:
Truly integrating services to support citizens’ Health as holistically considered challenges health and social care providers to work together. Empowerment of the citizen raises issues of balancing privacy with integration. Inclusion of informal carers raises issues of roles, responsibilities, and differential information access. Key dimensions of quality become scheduling, reliability, vision sharing, and communication. Mixed internal markets in each sector; costing and charging; and establishing common goals and care components in tandem with the citizen and carers are compounding factors. The whole agenda moves to new ground.
“HEALTHCARE” TO “HEALTH” – EVIDENCE-BASED PLANNING

Michael Wilks¹, Jacob Hofdijk².
¹CPME (Comité Permanent des Médecins Européens), Belgium; ²EFMI (European Federation for Medical Informatics), Netherlands.

Context:
It is accepted in the majority of, if not all, Member States in the EU that current healthcare systems are unsustainable, in the sense that the increasing proportion of gross national product that a Member State devotes to meeting predicted healthcare needs will eventually prove an impossible burden, while the availability of enough trained health care providers makes the future mission nearly impossible. The cost of providing “health care” will leave little or nothing in the way of resources to improve “health”.

Methods:
The most important factors that create this burden are:
- the need to provide long-term care for chronic conditions to a population that lives longer
- the impact of the unhealthy life style on the health of the population
- the costs of new technology, drugs and the healthcare workforce
- the failure to integrate policies to address the social determinants of poor health; this results in ever-increasing expenditure to treat their effects, minimizing the available resources to deal with their correction
- the missing focus of companies health policy on prevention, and integration with the healthcare delivery system
- the lack of integration of social and health care
- the curricula of medicine focus too much on specialization, and less on general medicine and surgery,
- the impact of climate change on health
- the increasing demands for the involvement of patients in their care, placing demands on information’s services to provide the necessary support.

To prevent this scenario to happen a shift in health policy is needed. Most of the health care costs are related to acute and chronic care, of which most can be prevented by a change of lifestyle of citizens and a better management of patients with chronic diseases. The focus should be on creating more value, which can be established by a structured multidisciplinary approach by care providers involving the patient as a team player in charge of his own health.

Currently member States’ spending on public health and prevention remains relatively low. In addition, the impact of policies - e.g. financial, educational, housing and nutrition - on health are usually unaddressed. Fortunately, mechanisms and tools exist to provide evidence and justification for significant changes in policy that move the focus from healthcare to health. Some of these also provide a quick “political dividend”, thereby making them attractive to policy-makers and legislators. They include:
- mapping the effects of income inequalities on health, allowing more predictability on how and where correcting these will impact on health outcomes
- reliable predictions on the reductions in healthcare costs produced by actions to reduce greenhouse gases
- the favorable impact on healthcare costs achieved by improving patient involvement in chronic care management, and better “anticipatory” care.
- the first examples of disruptive innovation by using health 2.0 which provides the citizen/patient tools to really manage his own health and become a respective member of the clinical team dealing with his/her health.

**Discussion:**
The presentation will outline the main burdens to the sustainability of current systems, offer a new paradigm for moving healthcare to “health”, and describe the initial steps needed to support such a move, based on existing evidence.
PARALLEL SESSION

24 JUNE 2011, 11.00 – 12.30

VERTICAL INTEGRATION II

ARIANE 2
THE IMPLEMENTATION DYNAMICS OF AN INTEGRATED CARE MODEL IN PRIMARY CARE

Isabelle Vedel\textsuperscript{1}, C Routelous\textsuperscript{3}, M de Stampa\textsuperscript{2}, V Ghadi\textsuperscript{1}, J Ankri\textsuperscript{2}, H Bergman\textsuperscript{1}, L Lapointe\textsuperscript{1}.  
\textsuperscript{1}McGill University, Université de Montréal, Canada; \textsuperscript{2}Versailles University, Paris, France; \textsuperscript{3}EHESP, Rennes, France.

Context:  
While integrated care is promoted as a key feature of service delivery reorganization in primary care, their implementation is still challenging. We need to identify when and under what conditions healthcare professionals adopt such innovative care models. Our objectives were: 1- to uncover the dynamics of adoption of a new model of integrated care and 2- to compare the adoption rates and motivations in order to identify how different perceptions of the model influence its adoption by healthcare professionals.

Methods:  
Design: A longitudinal qualitative study based on the Diffusion of Innovation Theory (Rogers 2003), including analysis of available documentation, observation and semi-structured interviews.  
Setting: A primary care integrated services network in Paris (France).  
Participants (Theoretical sampling): Family physicians and other care professionals (adopters and non-adopters). 54 interviews were carried out (39 with family physicians and 15 with other professionals).

Results:  
The adoption of an integrated care model is a complex process that differs for family physicians and other professionals. We distinguished four categories: early adopters, early majority, late majority and laggards, which were linked to different perceptions of the model vis-à-vis its relative advantage, compatibility, simplicity, observability and triability. The critical mass of adopters (beyond which diffusion acquires its own momentum) was attained faster by the other professionals (compared to family physicians), as they adopted it earlier and more quickly. These differences in the diffusion dynamics were related to contrasted perceptions of the model’s compatibility and relative advantage. Initial exposure to the model was another key factor affecting diffusion of the model, mainly among family physicians.

Discussion:  
The perceptions of the integrated care model’s characteristics by family physicians and other healthcare professionals play a critical role and facilitate/hinder its actual adoption. Given that the critical mass is reached more rapidly by the other healthcare professionals then by the family physicians, implementers should tailor their implementation strategies to the different profiles of adopters.
INTEGRATION OF CARE BY MEANS OF CLINICAL NETWORKS: IMPACT ON HOSPITAL REFERRALS

Rod Sheaff¹, Jill Schofield², Nigel Charles¹, Lawrence Benson³, Russell Mannion⁴ and David Reeves⁵. ¹School of Social Science and Social Work, University of Plymouth, United Kingdom; ²University of Edinburgh Business School, University of Edinburgh, United Kingdom; ³Centre for Public Policy and Management, Manchester Business School, University of Manchester, United Kingdom; ⁴Health Services Management Centre, University of Birmingham, United Kingdom; ⁵Health Sciences Group, University of Manchester, United Kingdom.

Context:
In many countries inter-organisational networks of interested clinicians and managers in primary and secondary care have been formed to improve the coordination of care for patients (e.g. with cancer, CHD, mental health problems) whose treatment and care typically involve several different organisations. By strengthening the collaborative links between these organisations, such networks typically aim to improve the integration of care, not least the substitution, where possible, of primary for secondary care. This paper examines whether in two English networks the more connected member organisations were also those which went furthest in substituting primary care for (avoidable) secondary care.

Methods:
Two networks, one for CHD care and one for childrens services, were compared using mixed-methods i.e.:
1. Social Network Analysis of how integrated each network was, measured at both whole-network level (e.g. how densely-linked the network was) and member-organisation level (e.g. how many and how complex the links were, from each organisation to the other member-organisation).
2. Analysis of administrative data about hospital admission rates in the study sites, focussing on ICD categories whose referral rates previous research shows to be sensitive to closer integration of primary and secondary care services.
3. Tests of correlation between the measures of organisational integration into the networks (from 1) and the rates of change of integration-sensitive admissions (from 2) for the relevant memberorganisations.
4. Systematic comparison of narrative case studies of the structure and internal coordination of the study networks, to interpret and explain the patterns found at (3).

Results:
Equivocal evidence was found that greater provider integration into its network is associated with decreases in referrals sensitive to better primary-secondary care integration. On the Spearman test, provider integration into the CHD network was strongly correlated with declines in admissions preventable by primary-secondary care co-ordination ($r = -0.81$). A similar but more moderate correlation ($r = -0.56$) was also found in the children's services network. In the CHD but not the children's network the fall in referrals was also correlated with the depth of links, i.e. the variety of kinds of link that existed between network member organisations. However these correlations were not found with OLS regression. By a large margin, the one long-established university hospital on the study was both the most closely integrated into its network and showed the biggest fall in avoidable
admissions. Evidence-based clinical guidance was the most common artefact produced and distributed by the networks.

Discussion:
The results appear sensitive to the testing methods used but because OLS depends on narrower assumptions about data properties than the Spearman test does, the latter is less likely to have created a result which was a statistical artefact. On that assumption, this study suggests that provider integration into an inter-organisational network helps reduce the numbers of avoidable hospital admissions. Our case studies suggest that the networks helped to produce that effect and to integrate local care provision by encouraging member-organisations to:
1. adopt shared, evidence-based working practices
2. monitor the work of each other member-organisation
3. re-deploy staff from secondary to primary care
4. share resources (e.g. diagnostic support, staff)
5. construct new referral routes and, exceptionally, new services.

Many European health systems contain inter-organisational networks for the purpose of integrating care provision. These findings, their managerial and organisational dimension and implications, therefore appear to have wide relevance.
CLINICAL PATHWAYS IN PRIMARY CARE: WHAT IS THE EVIDENCE?

Patrizio Armeni¹, Amelia Compagni¹, Andrea Donatini², Antonio Brambilla², Francesco Longo¹.
¹Università Bocconi, Italy; ²Regione Emilia Romagna, Italy.

Context:
Over the last 20 years, in many countries, particular attention has been devoted to the development of innovative models of primary care and to strengthen its role not merely as first step to hospital care, but as a complex system integrated and coordinated with it through different mechanisms. Clinical pathways are one of the tools. They have been developed to manage patients across settings (hospital and community), across professionals (specialists and primary care professionals) and across sectors (social and health care). GP is the pivotal actor, able to coordinate his progression through the system.

Methods:
How effectively clinical pathways work in primary care and what factors contribute to their impact is still unclear.
This study was developed with an Italian regional government (>4 million inhabitants), strongly engaged in the development of its primary care system. The following research questions were addressed: i) what incentives were devised to motivate GPs to enrol patients in pathways? ii) do these incentives influence GPs’ behaviour? iii) how is the compliance to clinical pathways and outcome monitored?

Results:
The analysis was based on a regional-level database that merges administrative information flows and ad hoc surveys. To complete these data and identify additional categories of incentives, GPs’ contracts were analysed for years 2008-2009. The number of GPs participating in clinical pathways and the patients’ enrolment rate were taken as dependent variables, while the number of clinical pathways, the number of dissemination tools, the nature of monitoring systems and of monetary and non-monetary incentives were the explanatory variables.
Incentives related to clinical pathways are present in 60% of physicians’ contracts. However, the nature and entity of incentives largely vary.

Discussion:
Few monitoring tools are activated to assess compliance of GPs as well as of patients to clinical pathways. Our regression analyses show that GPs’ adhesion to each pathway is positively correlated with the number of available pathways. Patients’ enrolment rate is higher if dissemination tools are numerous and if incentives for participation in clinical pathways exist.
EVIDENCE-BASED GUIDELINES: A NEW FRONTIER FOR MANAGEMENT OF STROKE IN PRIMARY CARE

Kristina H Popova.
Faculty of Public Health – MU- Sofia, Bulgaria.

Context:
The epidemiological and economic analyses suggest that policy-makers should undertake serious efforts to tackle stroke more effectively. Research indicates that trends in incidence, lifetime risk, severity, and 30-day mortality of stroke over the past decades show a lack of rigorous population based interventions. The aim of this study was to identify new clinical and organizational technologies for improving care for stroke patients.

Methods:
The study consists of two parts, clinical examination and treatment of stroke patients, and one year later – a self reported questionnaire inquiry. A total of 510 cases participated in the study, which was carried out in the Sofia University hospital during the period January – June 2009. The NIH Stroke Scale was used to assess stroke severity categorized as mild (<5), moderate (6 to 13), or severe (>14). Stroke severity and mortality were calculated one year later using Kaplan-Meier method and Cox regression analysis. Stroke Specific Quality of Life Scale (SS-QOLS) was applied to measure the effect of stroke on patient’s quality of life.

Results:
According to the data for the last five years only 0.04 - 0.08% of stroke patients in Bulgaria and 0.1 - 0.25% of them in Sofia are treated with the new thrombolytic therapy within the first 3 hours after the onset of stroke symptoms. Kaplan-Meier analysis showed that just about 50% of patients with severe stroke have one year survival. The level of SS-QOLS is unsatisfactory – 3.39 for males and 3.23 for females. Patients need a formal social support for their everyday functions. Of the 73% who fall into this category only 7% believe their health to be good. Analysis of social determinants of health shows that 75% of stroke patients have financial difficulties in the process of illness.

Discussion:
Analysis show that very few patients have health care that met quality standards in integrated delivery system. Successfully managing stroke requires not only effective drugs but also effective self-management of the stroke patients and wider social policy. Organizational change should aim to facilitate the exchange of new technologies and evidence for the benefits of supporting stroke patients. The exchange of experience should facilitate health professionals to fulfil their new responsibilities.
PARALLEL SESSION

SERVICES FOR OLDER PEOPLE

24 JUNE 2011, 11.00 – 12.30

GEMINI 1
A SYSTEMATIC REVIEW ON THE IMPACT OF INTEGRATED CARE PROGRAMS FOR THE ELDERLY

Modesta Visca1,2, G Damiani1,2, Bellentani1,2, B Federico1,2, W Ricciardi1,2, F Moirano1,2.
1Agenas, Italy; 2UCSC, Italy.

Context:
A critical challenge facing industrialized health care systems is effectively delivering seamless integrated care for aged people with complex medical and social needs.
This study systematically reviews published studies that assessed the health impact of the existing integrated models of care for the elderly population.

Methods:
A systematic review of the studies with a comparative approach was conducted in order to identify evidence related to evaluation studies of effective integrated care models for aged people.
The research was performed throughout electronic databases (Embase, Medline, AgeLine, and Google Scholar, Cochrane Library). Randomized controlled trials, quasi-experimental and observational studies were examined.
Only articles and papers focused on comprehensive or coordinated integration of care (acute and Long Term Care) in the elderly were included. We excluded studies on the coordination of care for specific diseases.
The information abstracted from the selected articles concerned authors, year of publication, objective, design, program, location and setting type, population and its characteristics, evaluated outcomes.

Results:
Of the 32 studies included, 31% were conducted in USA, 25% in Canada, 25% in Europe, 19% in Australia. In these studies the integration process was characterized by the following phases: a single point of entry or a gateway system (41%), multidimensional evaluation including definition of care plan (100%), coordination and case management (100%), reassessment (81%). Hospitalization (75%), functional and cognitive status (respectively 69% and 63%), patient satisfaction (63%), institutionalization (50%) were the outcomes more frequently evaluated; costs (44%), caregiver burden (28 %) and mortality (38%) were also considered.
In comparison to non-integrated programs, integrated care programs showed small reduction in mortality (3%), reduction in costs (34%), improvement in functional (44%) and cognitive status (38%), higher patient satisfaction level (53%).

Discussion:
This review synthesize the impact of community models enhancing integrated care for the elderly resulting to be effective in better health status, satisfaction and utilization of resources, thus supporting policies and practices development.
HOW TO ASSESS THE LEVEL OF INTEGRATION IN THE FRENCH ALZHEIMER PLAN EXPERIMENTAL PROJECTS?

Dominique Somme\textsuperscript{1,2,3}, Matthieu de Stampa\textsuperscript{3,5}, Catherine Périsset\textsuperscript{4}, Olivier Dupont\textsuperscript{4}, Nadia Arnaout\textsuperscript{4}, Joël Ankri\textsuperscript{5,7}, Olivier Saint-Jean\textsuperscript{1,6}.
\textsuperscript{1}APHP-HEGP, France; \textsuperscript{2}FNG, France; \textsuperscript{3}Ministère de la Santé, France; \textsuperscript{4}CNSA, France; \textsuperscript{5}APHP- Saint Pérrine, France; \textsuperscript{6}Université Descartes, France; \textsuperscript{7}Université de Versailles, France.

Context:
One of the principle orientations of the French Alzheimer plan is the implementation of integrated services delivery (ISD) called “Homes for Integration and Autonomy for Alzheimer patients”. Alzheimer disease is taken as a model to implement ISD in the whole system. 17 experimental projects were selected in 2009 for 2 years. We tried to assess whether the experimental projects improved the integration level.

Methods:
A research team was associated to the national project team. The level of integration was assessed by crossing 3 data sources: 1) a 2 years continuing qualitative data collection by the national project team; 2) On-site semi-structured interviews by research team; 3) A simple tool made-up by consensus between the two teams, aiming to measure the integration level (the “MAIA24”) resulting in a (0-24) score. A higher score indicates a higher level of integrated care.

Results:
The 2 qualitative approaches result in 5 categories of ISD implementation: 1) good implementation (n = 3); 2) partial implementation but good diffusion of the concepts comprehension (n = 5); 3) difficulties in implementing ISD but good apprehension of the problem (n = 3); 4) difficulties in implementing ISD and ISD not being a priority (n = 4); 5) very high difficulties that seem to be irreversible in a short term (n = 2). The MAIA 24 scoring results in a score of 0-20 at the beginning and 4-21 at the end of the assessment period. The level of integration assessed by crossing the 3 analysis led to validate 15 pilot projects; 2 were closed.

Discussion:
Despite, integration is in “fashion” in healthcare, there is no consensus framework to measure the integration. The scoring system we used, showed weakness that prevents its routine use. However, we documented the value of crossing the expertise point of view and the policy makers’ point of view. All that work will be used to make a quality label in the second phase of the French Alzheimer plan. The results will be presented during the session.
PARALLEL SESSION

WORKING WITH CITIZENS

24 JUNE 2011, 11.00 – 12.30

GEMINI 2
EMPOWERMENT OF PATIENTS WITH HIP FRACTURE – IMPACT ON LENGTH OF STAY AND MORTALITY

Susanne Löfgren.
Karolinska Institutet, Sweden.

Context:
Previous studies have shown the considerable impact of hip fracture patients on the health-care system. Length of stay (LOS) and mortality are important aspects.
An empowerment program established by WHO was used together with new care tracks and information.
Empowerment was defined as ‘gaining control over and master daily activities aiming to reach as close as possible to the level of daily activities after rehabilitation as before the hip fracture’.
Research question: Could LOS and mortality be reduced by the new rehabilitation program.

Methods:
503 patients were included in a prospective comparative study at a hospital in Stockholm with two sites. The two groups were comparable. Identical surgery algorithms were used. The post-surgical process differed between the sites.
The new rehabilitation program used in site 1 was customized and consisted of:
1) Empowerment of the patient administrated by the staff. The caregivers was trained to become more sensitive and aware of the patient’s qualities and needs. They should serve more as instructors and coaches and try to make the patient take more responsibility.
2) Four different rehabilitation tracks which differed in content and expected hospital days.
3) An information package to patients and family about the operation and rehabilitation.

Results:
Mean LOS was 4 days shorter in the study group, differed between tracks and varied between age groups. Most patients were placed in track 2, meaning a well-organized, cognitively well-preserved patient with medical ailments. All patients in the study group were treated the whole care episode at the same geriatric ward. Sixty-one percent of the patients in the control group were sent to rehabilitation institutions outside the emergency hospital. During the four month period after the fracture 15.1% of the patients in the study group died versus 22.5% in the control group (p < 0.05).

Discussion:
A positive effect of the empowerment program has been demonstrated. Empowerment and personalized treatment may reduce LOS and mortality.
Possible explanations of the differences in LOS and mortality may be the combination of actions taken at site1, staff’s training and personalized rehabilitation tracks with empowerment of patients in combination with geriatric care.
A cohesive care proved to be superior to fragmented rehabilitation.
“TRANSFERRING PATIENTS TO TERTIARY HEALTH CARE: THE ROLE OF FAMILY AND PRIMARY HEALTH CARE TEAMS IN THE DECISION MAKING”

Filipa G Joaquim, Luís V Lapão.

1Instituto de Higiene e Medicina Tropical of the Universidade Nova de Lisboa, Portugal.

Context:
Primary health care within the current Portuguese Primary Health Care Reform could develop an important role, due intrinsic innovative aspects associated with new governance model, as health system entry point and patient-centered, ensuring acess and proper coordination between different care levels, in a way that empowers users.

Methods:
To explore the dynamical process of accessing to the Tertiary care we did a case study research, based on the multidisciplinary assessment and decision-making model of Beckingham & Baumann (1990) for ageing families in crisis, developed at a nursing home near Lisbon. Two embedded units of analysis were considered (Ying, 2003): families’ members and patients’ primary health care teams (PHCT), especially General Practioners. Data were collected through semi-structured interviews, questionnaire survey and document analysis. The data analysis is achieved through thematic content analysis and statistic analysis.

Results:
The main results are:
• Families consider a quality institution, a place where their relatives find a clean and friendly staff with affordable services. However, families have felt difficulties to ascertain what type of services are more adequate to relatives’ health;
• None of the relatives from the families interviewed were referred by the local primary-health-care-teams;
• Families have little support from social services, hence they rely on their social network (friends, coworkers, etc.) to select a facility;
• Information received from social services are scarce, and often limited to a short list of contacts and addresses of institutions.

Discussion:
Primary health care as the entry point of the health system, is where a comprehensive and integrated offer of care is most critical. But, regarding this problem of accessing to tertiary care, it seems that PHCT are not fulfilling their goals. PHCT should improve their ability to be more active, by enhancing their role in managing patients (collecting and assessing data for proper reference) who require long-term care, and empower them, avoiding gaps and considerable costs.
(IN) PATIENT EMPOWERMENT – PROMOTING COOPERATION OF SELF-HELP GROUPS AND HOSPITALS IN VIENNA

Iris Saliterer, Sanja Korac. Alpen-Adria University Klagenfurt, Austria.

Context:
Vienna’s population follows international trends of life expectancy and burden of chronic diseases, so self-help groups are seen as an effective way of patient empowerment and participation increasingly. In 2006-2008, a comprehensive Vienna-wide patient centered integrated health care project aiming at integration of care was carried out, where cooperation of self-help groups and hospitals was a crucial part.

Methods:
The promotion of hospitals and self-help groups cooperation to improve patient empowerment was expected to cause integration of the in- and outpatient health care sector in Vienna. The authors carried out a multi-method evaluation of the subproject instrument mix: workshops, information media, establishment of a self-help support department, and financial incentives. Multi-methods analyses e.g. expert interviews and patient questionnaires with descriptive and inference statistics analyses, site inspections and document analyses were carried out.

Results:
Assessment shows objectives and process clarity, equal partnership, but little knowledge about the partner, easily accessible information, but perception of low financial incentives. Selection criteria for the cooperation seem suitable, but capacities are left out, though crucial for the success. Information media enhance early contacts to self-help groups, satisfaction of the groups and patients increases, and doctors consultations decrease. Satisfaction of hospital staff did not increase due to extra time needed for the cooperation. Qualitative results show a positive cost-benefit-ratio, confirming literature hypotheses within that field.

Discussion:
Considering the epidemiologic and health policy trends, the cooperation of self-help groups and hospitals seems to be an effective and efficient way of empowerment. But structural quality, hospital organizational basic conditions and quality indicators have to be improved to achieve transferable positive effects. A self-help support department seems to be beneficial, but publicity is crucial, since information deficits lead to dissatisfaction. Financial contributions to self-help groups enhance cooperation, but could face implementation restrictions, as self-help groups are informal ways of patient agency and not funded by the public health system.
BUILDING A CULTURE OF EVIDENCE INFORMED DECISION-MAKING IN THE COMMUNITY

Elaine Rankin, Lindsay Peach. 
Cape Breton District Health Authority, Canada.

Context:
Decisions based on best evidence may be commonly used in the clinical setting, but less so to inform community programs. Healthcare data is collected but only a small percentage is used in meaningful ways. In Nova Scotia a Vice President and Director are using data to drive change in the community.

Methods:
Information systems in acute care allow for enhanced quality reporting & analysis that can inform health in the community. Patients seen in emergency rooms are registered & triaged - reports can be prepared to inform the following: each family physician, identifying the number of their patients attending emergency rooms who could have been seen in a primary care setting based on their triage level as well as providing anonymous peer comparisons by location, yearly trends, most common cause of injuries for residents, actual cause of injury, location & type of injury. Reports by nursing home, identifying the number of transfers to emergency rooms, hospital admissions & deaths in hospital.

Results:
Application of advanced access in a primary care setting resulted in: 28% reduction in family physician patient emergency room visits triaged as non-urgent & less urgent; 7% increase in physician revenue; improved continuity of care; improved savings to the system. Addition of a nurse practitioner to a nursing home care team resulted in: reduction in transfers & admissions to hospital; improved end of life care. The most common injury reported in emergency room data is falls. The majority of falls happen to seniors & take place in the home. Trauma Registry data is being added to the prevention strategy to support community based action on prevention.

Discussion:
Data collected & utilized in an acute setting can be used to inform practice. Duplication of data collection needs to be avoided & balanced with the need for new data sources to support change. Analysis of emergency room data has been used to show the benefits of advanced access to family physicians. Reduction in patient visits to emergency rooms translates into increased income for physicians, improved continuity of care & system savings. Nurse Practitioners in a nursing home setting have enhanced primary care to residents & supported nursing staff. This has resulted in reduced emergency room visits & hospital admissions & improved end of life care.
PATIENT FOCUSED APPROACH HELPS IMPROVE QUALITY OF THE ACCIDENT AND EMERGENCY (A&E) UNIT IN MALTESE HOSPITAL

Sandra C Buttigieg, Prasanta K Dey, Mary Rose Cassar, Antonella Grima.  
1University of Malta, Msida, Malta; 2Aston Business School, Aston University, United Kingdom; 3 A&E Department, Mater Dei Hospital, Malta, 4 Ministry of Health, Elderly and Community, Msida, Malta.

Context:
This paper develops a patient-focused analytical framework using quality function deployment (QFD) and logical framework analysis (LFA) for improving quality of the A&E unit in Maltese hospital.

Methods:
Using the case study approach, the proposed combined QFD and LFA patient-focused quality framework has six steps. In step 1, patients’ requirements are identified using survey. In step 2, services within A&E unit are determined. In step 3, relationships between patient requirements and various A&E services are established. In step 4, absolute weights of the A&E services are determined by multiplying the importance of patients’ requirements with cross relationships between customers’ requirements and A&E services, adding across the rows. In step 5, the most critical/important service that needs attention/improvement is revealed. In step 6, implementation plan for improvement project is developed using LFA.

Results:
The combined QFD and LFA framework was an effective method for managing quality in healthcare. QFD helped identify and analyze quality issues and LFA facilitated the development of a plan for improvement. The study revealed that patients/relatives emphasized on faster patient flow, expert triage, and shorter waiting time in the A&E unit. The QFD analysis determined the most important dimension of services (availability of emergency consultant during peak hours) that needed improvement. Accordingly, the hospital management decided to implement consultant-based services within the A&E unit. The LFA approach helped plan the entire project successfully and subsequent patient satisfaction survey revealed substantial improvement.

Discussion:
There are numerous quality management frameworks that have been applied in healthcare. Although both QFD and LFA have been separately applied for improving quality in healthcare, a combined approach has not yet been utilised. Therefore, the proposed QFD and LFA approach extends the healthcare quality management literature.
PARALLEL PRESENTATIONS

THE ROLE OF MANAGEMENT IN HEALTH SYSTEM CHANGE

24 JUNE 2011, 11.00 – 12.30

CHALLENGER
EFFECTIVE MANAGEMENT IS AN ESSENTIAL ELEMENT OF EVOLVING HEALTH SYSTEM

Nurgul K Khamzina, Kuanыш A Yergaliyev, Timur B Umralin.
Ministry of Health, Astana, Kazakhstan.

Context:
As result of sweeping reforms, Kazakhstan has introduced Unified National Health System (UNHS), which aims at improving health of citizens through free choice of providers, introduction of new financial models (money follows patient). Reform plans to increase autonomy of providers by transforming government organizations into economically managed state entities: healthcare managers allowed to allocate revenues to appropriate expenditures, including workforce incentives, and are held accountable for results. Objectives for paper were to resume first year of reforms and to address role of effective management within UNHS.

Methods:
A retrospective analysis of data on health systems performance based on 2 319 832 inpatient cases treated in 2010. Source of data is Ministry of Health (MoH), reports by consulting company EPOS provided to MoH under Kazakhstan Health Technology Transfer and Institutional Reform World Bank Project.

Results:
Number of inpatient cases were 9% less than in 2009. Number of beds decreased from 75.6 in 2009 to 72.3 in 2010. Length of stay decreased from 10.0 in 2009 to 8.6 in 2010. 25 % of patients used their right to choice doctor and hospital. 79% of patients were waiting for hospitalization up to 3 days and 14.1% from 4 to 10 days. Day care patients in 2010 were 219% more than in 2009. Total number of hospitals participated in UNHS was 848. 13% were private organizations and 6.2% were state-owned providers with right to economic management. Number of cases of highly specialized medical care (HSMC) provided by Regional hospitals has increased from 814 cases in 2009 to 3932 cases in 2010 i.e. makes 483% growth.

Discussion:
Introduction of UNHS created a base for competitive environment in Kazakh healthcare system. Healthcare providers are reimbursed on basis of fee for services. A few organizations implemented incentives systems, and therefore official average salaries of medical professionals remain low. These findings have shown urgent need for national health care management capacity building system, as well as introduction of institute of professional health management. Since human resources are important factor in process of systemic integration of healthcare system, effective management is essential element to support high-quality, accessible and efficient UNHS.
FUTURE SCENARIOS FOR THE NHS IN ENGLAND: THE UNCERTainties OF CHANGE

Duncan M. Ross, Rebecca Malby, Martin Fischer.
University of Leeds, United Kingdom.

Context:
Following the recent publication of the White Paper Liberating the NHS in the UK it is clear that the NHS faces a significant period of change. In some quarters this has been characterized as the most significant potential reform since the formation of the NHS in 1948. Certainly, debate about the shape and direction of the health service into the future is at fever-pitch. This inquiry was conducted in order to understand how leaders in the system are working with the new direction and the potential impact on the integration of services.

Methods:
Semi-structured qualitative long interviews with 18 senior leaders across the UK health and social care sector were conducted in August and early September 2010. The leaders interviewed included both those from national bodies, NHS trusts, PCTs, the private and third sector. The interviews were analyzed to gather leaders’ views on the current and future system operation. System opinions were then relationally assessed and abstracted to give underlying assumptions and dilemmas.

Results:
Five contrasting scenarios emerged from the interviews:
1) Localism wins: local commissioning takes off
2) Regulator rules: regulation drives the system forward
3) Providers trump: providers are the dominant entities in determining the shape and outcomes of health services
4) Muddle through: here, the system actually carries on much as before
5) Dominos falling: things go seriously awry, significant disruption occurs and the NHS as we know it is imperilled.

Discussion:
The purpose of this research was to make visible the current potential future scenarios for the NHS that are in use in the system, albeit not formally adopted anywhere. We are not saying these scenarios will happen; the key point is that in current leaders views they might happen, and leaders are constructing their leadership around these scenarios. Everyone we interviewed has only a partial picture of what is happening; no single person had a view around how the whole thing works. All are acting from a partial view. This lack of a scenario that works for the whole we find significant, and helps describe the emotional roller coaster and lack of clarity people experience working in the system now. Without a scenario for the whole, the system cannot function to realise the policy intent.
INTEGRATION: THE PROBLEM FOR COUNTRIES IN TRANSITION

George Boulton¹, Ivan M Jekic², Annette G Katrava³, Nicholas Koumpis², Miroslav Obrovacki. ¹Independent Consultant in International Health Policy, Financing and Management, United Kingdom; ²Tertiary Care Services Serbia, European Investment Bank (EIB) Project, Serbia; ³EU-Funded Project Implemented by EPOS Health Management, Serbia.

Context:
‘Integration’ features on health reform agendas throughout Europe, including CEE countries in transition, where a major reform aim is to replace traditionally organized Semasko and socialist health systems with more efficient, effective and client-focused integrated care models. Attempting to increase value from scarce resources, governments strive to transform traditional ‘curative’ focused health systems, to ones able to deliver population health improvement. Theory is fine; practice far from straightforward. This paper draws on the authors’ experiences to identify key implementation issues in health system transition, many of which rarely appear on the reform agenda, but which are critical to successful outcomes.

Methods:
The presentation draws on practice and experience of those working within health systems to engineer change and consultants with extensive experience of health system reform in over 14 central and eastern European countries, particularly the Balkan region and Serbia, since the 1989 landmark political transition. Most health reform policies are sound; written strategies persuasive, but conversion of policy to action continues to present major challenges despite, in many cases, international donor support. The ethos of ‘old style’ European health systems is deeply engrained. The contemporary challenge, therefore involves coherent, complex multi-faceted culture change- societal, professional and managerial, addressing all issues which stimulate and facilitate change, and minimize the lag effect of important barriers. Implementation often ignores key political, cultural and systemic factors which counteract absorption of new care approaches and integrated models, some of which are hidden deep in cultural and historical legacies and in present system and economic realities.

Results:
Key issues include:
Policy and power
- Power resides in major centralised institutions
- Professional power matched by local and National Political power
- Health promotion/prevention don’t make for ‘sexy’ politics
Culture and history
- Secondary/tertiary level institutions perceived as pinnacle
- Hierarchical medical professions
Financing
- Inflexible accountability and financing disciplines
- ‘Free’ capital sustains institutional rather than service approaches
Organisation
- Legacy of hierarchical and compartmentalised institutional framework
- Vertical programme implementation
Human resource development
- Fundamental reform of undergraduate and post-graduate professional education
- Low status of primary care, nurses and lack of team culture
Planning and Information systems
- Weak planning, performance management and management accounting systems
- Under-developed EBHC and HTA to support innovation
Perverse influences
- Societal expectations
- Pharmaceutical industry impact on physician behaviour
- Universal employment structures and impact of low salaries on work patterns Corruption – legacies of the old systems.

Discussion:
Health system transition is a common aim of most CEE countries. Policies and strategies are similar, using WHO and recently EU (now more active on health policy issues) prescriptions. Common features include a shift to population health improvement emphasis; a family medicine focus operating as the gatekeeper to and coordinator of integrated approaches to health care and integrated pathways of care crossing institutional and professional boundaries – cancer networks, stroke units, trauma centres, integrated chronic disease management systems etc. Successful implementation will depend upon many positive activities. It will also need to address many deep, sometimes hidden, historical and cultural issues. Is it realistic to expect that countries in transition can shortcut the development process or are issues so deeply embedded in history and culture, that progress will only be possible through the same long and painful adaptive process of health delivery system reform, experienced in much of western Europe.
MULTIDISCIPLINARY TUMOUR BOARD-MTB – POTENTIALS IN IMPROVEMENT OF ONCOLOGICAL CARE WITH THE CLINICAL STAGING OF CERVICAL CANCER – CASE OF THE CLINICAL CENTRE OF SERBIA

Aleksandar Ljubic1, Tatjana Bozanovic1, Vojislav Zizic1, Milan Apostolovic2, Snezana Vidakovic1, Slavica Aksam1, Vladimir Boskovic1, Djordje Bajec3, Ivan M Jekic4, Annette G Katrava5.

1Institute for Gynecology and Obstetrics, Clinical Centre of Serbia-CCS, Serbia; 2Special Orthopedic Hospital Banjica, Serbia; 3Institute for Digestive Surgery, Clinical Centre of Serbia-CCS, Serbia; 4Tertiary Care Services Serbia, European Investment Bank (EIB) Project, Serbia; 5EU-Funded Project Implemented by EPOS Health Management, Serbia.

Context:
In Serbia there is no subspecialty in gynecological oncology. Advanced ovarian cancer was not adequately operated in many cases since gynecologists are not educated for bowel resections, operations on urinary system etc. Usually after suboptimal surgery patients were transferred to other hospitals for adjuvant chemo therapy. Additionally, clinical staging of cervical cancer was inadequate in almost 30% of patients, which was published by previous Tumor Board in 2009.

In January 2010 a Multidisciplinary Tumor Board (MTB) was introduced at the Clinical Centre of Serbia. Improvement was measured by comparing the clinical staging of cervical cancer to previous Tumor Board results.

Methods:
The importance of accurate and complete patient information is highlighted in Serbia’s new Cancer Reform Strategy (2008). Oncology patients deserve highly educated personnel and all technology available in order to be provided with optimal therapy. Gynecological malignancies are often systemic diseases and therefore sometimes difficult to be evaluated by only gynecologists.

Previous data about treating oncology patients were worrisome and needed changes. The new Director of the hospital initiated structural changes to the Tumor Board in January 2010 in the form of a multidisciplinary approach to care. Its membership now consists of three gynecologists, pathologist, radiotherapist, chemotherapist, radiologist, surgeon, urologist, and anesthesiologist. The previous Tumor Board consisted of two gynecologists, pathologist, radiotherapist and chemotherapist. An electronic database with all patients was also established which allows proper follow up. The multidisciplinary approach to oncology patients was also completed by significant increase in imaging technology.

Results:
From January 2010 to December 2010 MTB evaluated 374 cases of oncology patients. There were 146 cases of cervical cancer, 87 have been staged as Ib – IIA for radical operation, 59 patients have been staged as advances stage of the disease and radiotherapy was proposed as well as combined radio-chemo in some cases.

Every Thursday, the MTB works in the Institute for Gynecology and Obstetrics of the Clinical Centre of Serbia. Standard analyses of laboratory and imaging tests are required to be prepared for MTB. After the gynecological examination, members of the MTB discuss each patient case and subsequently directly talk to patients to explain the decision about future therapy. Patients who were recommended to have surgical treatment were seen again post operatively with the histopathology report and adjuvant
therapy was discussed with patients according to the International Federation of Gynecology and Obstetrics (FIGO) recommendations.

Discussion:
Structural changes to the Tumor Board have made a significant improvement in oncology care of patients, primarily because of a multidisciplinary approach to gynecological malignancies and additional imaging performed in all cases of cervical cancer for better insight in the spread of the disease. The accuracy for clinical staging of cervical cancer was 94.3% which represents significant improvement of oncology care. Only 5.7% of cervical cancer patients were under diagnosed and postoperative histology reports revealed more advanced stage of the disease. Since there is no formal training and subspecialty in gynecological oncology it seems that multidisciplinary approach is even more important and it significantly improves quality of treatment. Additionally, FIGO clinical staging could be improved by using MRI.
Individual approach to the patient, patient information and multidisciplinary model of planning the therapy are key issues for obtaining optimal oncology therapy.
CONNECTING THE NATIONAL QUALITY STRATEGY AND IMPROVEMENT PLAN IN SERBIA

Annette G Katrava1, Ivan M Jekic2, Miroslav Obrovacki3, George Boulton1, Nevena Karanovic3, Snezana Manic4 and Maja Vuckovic-Krcmar5.
1EPOS Health Management, Serbia; 2Tertiary Care Services Serbia, European Investment Bank (EIB), Serbia; 3Ministry of Health, Serbia; 4Agency for Accreditation of Health Care Institutions in Serbia, Serbia and 5Delegation of the European Union to the Republic of Serbia, Serbia.

Context:
The Republic of Serbia is developing ambitious plans for improving the quality of healthcare for the population. The national quality improvement strategy (2009) aims to set out a framework for the ways in which the quality of healthcare services delivered to the population will be improved. It describes the aspirations of the government and sets an international context for these. The national strategy sets out the reasons why healthcare quality improvement is important in terms of assuring effective, efficient and clinically sound healthcare.

Methods:
A European Union (EU) funded project implemented by consortium led by EPOS Health Management from June 2009 – April 2011, assisted the Ministry of Health with the approach and implications of an integrated quality policy. It is extremely important that there is a “whole system”, as the aims for equitable access to healthcare cannot be achieved through anything less than system reform. Many fragments of a quality system have been developed independently in Serbia by Ministry of Health institutes, commissions and international donors. The vision of the national quality strategy was to integrate a system of standards, measurement and improvement; policy cannot achieve this without including clinical practice and without an effective management system for coordinated implementation.

Results:
Systematic mapping (by EPOS project) identified multiple potential contributors (agencies, committees, departments and organizations) whose status, function and accountability are unclear, unrelated or in conflict. Weak management, planning and data flow systems reflect this organizational uncertainty at all levels. Furthermore, the Republic Committee for Quality improvement is dominated by public health; it does not represent stakeholders in quality and safety, especially patients, clinicians and managers. The results of extensive consultation with key stakeholders highlighted the need for: a comprehensive quality policy (especially clinical practice); integration of standards, measurements and action; to involve all contributing organizations; active coordination and management of implementation.

Implementation of the policy will require translation of the goals into specific responsibilities and tasks of national bodies, and incorporation into their respective operational plans. Priority should be given to linking a proportion of health insurance funding to institutions which comply with published standards and objectively demonstrate superior performance.

Discussion:
The successful transfer of quality improvement methods, which have proved effective in other countries, depends more on culture and environment than on the technical competence of the intervention. “Solutions” such as performance indicators, clinical guidelines and accreditation have little impact unless accompanied by management and information systems, decentralized authority,
professional self-regulation, clear accountability and responsibility, national coordination—and financial incentives for improving performance. There was broad agreement on the need for national coordination in planning, implementing and evaluating of quality systems. Credit was due to the Commission for CQI and patient safety for spearheading the national strategy but implementation must be the business of management, not the Commission, or the Agency. The Ministry of Health and the Government itself must accept this responsibility.
POSTER SESSION
THE LOADI ROLE IN SUPPORTING FOUR HOSPITAL IMAGING DEPARTMENTS’ INTEGRATION

Cristina Almeida, Luís Lapão, Ivo Carvalho.
1Centro Hospitalar Lisboa Central, Portugal; 2Universidade Nova de Lisboa, Portugal; 3Centro Hospitalar Lisboa Central, Portugal.

Context:
Four Hospitals went through an integration process, and now they are sharing the same management structure—the Centro Hospitalar Lisboa Central. CHLC was designed aiming at leveraging scale efficiency gains and streamlining human resources, without compromising accessibility and quality of care. One of the Board’s first decisions was to create an Imaging Department, centralizing the former four imaging departments, each one with different technologies and care specificities profiles.

Methods:
Speed and the share of reliable information between the four teams. The imaging departments integration’s communication was addressed with a tool to register working incidents. This tool, named LOADI, was developed internally by the Informatics Department, obeying to functional requirements: accessibility only to ADPI radiographers and user friendliness; as well as to technical requirements: to run on the computers and browsers available in the four hospitals as a web application. This tool is supposed to enable communication to enhance response to everyday problems: equipment failure, workflow constraints, and organizational processes.

Results:
LOADI web-portal started operating in April 2010. On the first month were registered: 102 users, 488 visits, 1.32 GB of traffic, 25,985 pages generated, 293,177 clicks, and 730 new posts. Between April and December were reported 3,495 incidents in the four imaging teams: Hospital1 1567; Hospital2 987; Hospital3 448; and Hospital 4 476. These incidents could be organized in the following typology: technical malfunctions (93), working procedure (57), scientific information (14), and the others general scope.

Discussion:
More than a management tool, LOADI emerges as a tool that allows the organization of knowledge and improves communication within ADPI. The complexity of the organizational integration challenges highlights the importance of the contribution made by developing management tools that enable integration of different teams as a bridge to overcome problems and motivate professional involvement. Health organizations need to be supported by new technologies that enable integration and collaboration effort to ensure and improve the quality of care provided.
THE STRUCTURE AND DYNAMICS OF HEALTH CENTRES IN THE NETHERLANDS: AN INSTITUTIONAL ANALYSIS

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Context:
Health centres are seen as a preferred organization of the modernized and integrated primary care. They are expected to facilitate an accessible contact point for medical care as close to people’s homes. Also, health centres are expected to deliver care in an efficient and effective way, minimizing the referring of patients to care and cure institutions.

Methods:
The population of health centres in the Netherlands is described by analysing the dynamics of (currently nearly 200) members of the Dutch branch organizations for Organized Primary Care. In addition, information is collected from their websites and yearend reports. In parallel, we reconstruct the policy and legal arrangements of the Dutch government with regard to the financial support of health centres. To explain the interaction between the behaviour of health centres and developments of the policy environment over time, we apply Porters’ five forces model and the institutional isomorphism theory.

Results:
Historical analysis shows that the establishment of health centres accelerated in the seventies, then follow a much slower growth rate during the mid-eighties, and then stabilized during the nineties. During the last decade, the establishments of health centres started to grow again, but mainly due to mergers and up-scaling resulting in enlarging health centres. Towards 2000, the financial support by the government was reduced and largely discarded by the Dutch health system reform in 2006. Health centres strategically reacted by mergers and consolidation, to deal with the new power of health insurers.

Discussion:
The question remains whether public funding should focus on the establishment or the consolidation of new health centres. The potential value of multidisciplinary collaboration seems to develop properly in new residential areas, but its funding also disentangle with the growth of healthcare providers and recipients. Alternatively, public-private partnerships can be considered as new ways to establish integrated primary health care at district level.
IMPLEMENTATION OF A SCREENING PROGRAM FOR THE EARLY DETECTION OF DIABETIC RETINOPATHY USING A NON-MYDRIATIC CAMERA IN PRIMARY CARE

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CASAP Can Bou, Spain.

Context: 
Diabetes is highly prevalent in our country and retinopathy is one of the main causes of blindness. Waiting lists for screening in hospital ophthalmologist take too long time. We plan to screen diabetic patients in primary care to increase accessibility, resolution in primary care and services’ integration. We perform the screenings using a non-mydriatic camera (CROC) by family medicine doctors.

Methods: 
Transversal, descriptive study. Primary care team of the Metropolitan area of Barcelona. Sample of 1744 patients with a Diabetes Mellitus diagnosis. Patients with a diagnosis of diabetic retinopathy or alteration of intraocular pressure are excluded. 

Variables: Number of patients on which CROC was used, results (mild, moderate or severe RNDP, myosis, media opacity, elevated alteration of intraocular pressure).

Statistical analysis: Descriptive analysis calculating mean and standard deviation of the quantitative variables and percentages of the qualitative variables.

5 family medicine doctors were trained to interpret the photos taken using CROC. The ophthalmologist only evaluated pathology.

Results: 
1481 photos were taken (85% of the diabetic population). Of these, 869 were normal (60%), and 198 (13%) had retinopathy. 407 (30%) were referred to the ophthalmologist, which correspond to moderate, severe and proliferate cases of RDNP, as well as media opacity (7%) or myosis (7%). 1037 visits to the ophthalmologist were saved.

Discussion:
Population screening of diabetic retinopathy using CROC has been increased, so has accessibility to public health services, with respect to previous years new. Further diagnosis of retinopathy has been done. The program avoided 1037 visits to the ophthalmology service in one year. The 400 patients that were referred already had a diagnostic orientation.
Family doctor training and pathway integration allows better health results and improves accessibility.
FACILITATING CONTINUOUS AND SUSTAINABLE INNOVATION WITHIN HEALTH CARE

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Context:
Continuous and sustainable innovation lead to added value for patients, employees, health care organisations and the health care system as a whole. Without this continuous process of adding value, quality of care eventually declines. The facilitation and structural integration of innovation within health care, however, is a major challenge. ‘How to do this’ will be reflected upon taking mental health care as an example.

Methods:
Two key conditions for successful and sustainable innovation will be explored: 1) \textbf{Open innovation}: the central idea behind open innovation is that in a world of widely distributed knowledge, organisations cannot afford to rely entirely on their own way of creating knowledge. An open mind, looking over boundaries of own worlds and working multi-disciplinary to integrated different views and knowledge is essential to improve and innovate health care processes. 2) Innovation is a \textbf{cyclic process} with continuous feedback loops in which \textit{exploration} and \textit{exploitation} go together. An innovative idea (exploring) is only an innovation when it is disseminated and implemented in daily world (exploitation).

Results:
Open innovation can be facilitated by creating Third Spaces: platforms in which health care institutes work together with industry and/or universities. In third spaces an integration of practice based knowledge and science based knowledge is created which facilitates the bridge between the exploration and exploitation processes of innovation. The inventing process (exploration) as well as the application and dissemination process (exploitation) is fueled by practice and science together.

Discussion:
In this reflection the key conditions to facilitate and structurally integrate innovation in health care will be underpinned. A Third Space in the field of mental health care in the southern part of the Netherlands will be outlined. In this third space, a mental health care institute works together with technological industry and the social faculty of Tilburg University and the University of Technology, Eindhoven. The joint business case is managing stress and crisis by technological applications within the environment of inpatient wards.
PATIENT FOCUSED APPROACH HELPS IMPROVE QUALITY OF THE ACCIDENT AND EMERGENCY (A&E) UNIT IN MALTESE HOSPITAL

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Context:
This paper develops a patient-focused analytical framework using quality function deployment (QFD) and logical framework analysis (LFA) for improving quality of the A&E unit in Maltese hospital.

Methods:
Using the case study approach, the proposed combined QFD and LFA patient-focused quality framework has six steps. In step 1, patients’ requirements are identified using survey. In step 2, services within A&E unit are determined. In step 3, relationships between patient requirements and various A&E services are established. In step 4, absolute weights of the A&E services are determined by multiplying the importance of patients’ requirements with cross relationships between customers’ requirements and A&E services, adding across the rows. In step 5, the most critical/important service that needs attention/improvement is revealed. In step 6, implementation plan for improvement project is developed using LFA.

Results:
The combined QFD and LFA framework was an effective method for managing quality in healthcare. QFD helped identify and analyze quality issues and LFA facilitated the development of a plan for improvement. The study revealed that patients/relatives emphasized on faster patient flow, expert triage, and shorter waiting time in the A&E unit. The QFD analysis determined the most important dimension of services (availability of emergency consultant during peak hours) that needed improvement. Accordingly, the hospital management decided to implement consultant-based services within the A&E unit. The LFA approach helped plan the entire project successfully and subsequent patient satisfaction survey revealed substantial improvement.

Discussion:
There are numerous quality management frameworks that have been applied in healthcare. Although both QFD and LFA have been separately applied for improving quality in healthcare, a combined approach has not yet been utilised. Therefore, the proposed QFD and LFA approach extends the healthcare quality management literature.
THE TIME HAS COME: TRAINING TO ACCELERATE EVIDENCE INFORMED CHANGE

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Context:
CHSRF is leading efforts to create a culture of evidence use in Canada’s by building capacity for evidence-informed decision-making to improve performance. Training supports leaders in developing skills to apply the best evidence to improve the health of Canadians, capacity to govern healthcare organizations & tools for evidence-informed solutions to today’s challenges.

Methods:
EXTRA trains leaders to use evidence to inform decision priorities/services using blended learning methods—residency sessions, e-learning, intervention projects, mentoring, & networking—to develop skills to find, assess, adapt & apply research; build organizational capacity for change; and foster collaboration.
Effective Governance for Quality and Patient Safety helps boards in developing evidence-informed approach to governance/leadership including better understanding of core functions, measures of quality, & use of tools, structures, processes and priorities for improved practice.
Health System Transformation Project builds capacity within the Northwest Territories(NWT) to develop integrated chronic disease management models in 3 key service delivery areas: renal disease, diabetes and mental health.

Results:
Evaluations show 81% of EXTRA fellows’ organizations engaged in evidence-informed change management strategies based on their project. 97% reported that colleagues increased their capacity to critically examine actions related to problem-solving and decision-making.
Over 200 leaders attended governance sessions and completed pre- and post- surveys to measure their understanding of drivers for effective practices. All reported increased knowledge and understanding of effective governance and organizations agreed to changes geared toward better patient outcomes.
Following 1 workshop 96% of participants rated the training as effective in supporting access and expertise in identifying, acquiring and adapting the evidence needed to define their delivery problem, and 100% effective in the ability to address challenges associated with improvement and strategies supporting change.

Discussion:
Training of health system leaders is vital in building capacity for evidence-informed, sustainable decision-making.
This poster describes the suite of training platforms, and present strategies for programs designed to support leaders in meeting the demands of health service delivery and policy going forward.
FROM A STRATEGIC NICHE FORMATION PROCESS TOWARDS A BUSINESS CONCEPT FOR INTEGRATED HEALTHCARE DELIVERY: MICROECONOMIC APPROACH TO CHANGE THE HEALTHCARE SYSTEM

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Context:
Today’s fragmented healthcare system is under pressure being challenged by slowly but surely changing external influences such as an aging population and decreasing government budgets while simultaneously being challenged by internal structures such as supply-driven healthcare. Consequently, changes are needed to be able to develop an integrated, demand-driven healthcare system. The goal of this study is to demonstrate how strategic niche management can help actors to initiate change within the healthcare system. An integrated healthcare and area development concept is developed through the application of strategic niche management.

Methods:
The multi-level perspective on transitions is used as a general framework. Foremost, methods need to be developed that capture the dynamic effects of strategic niche management. Therefore, a longitudinal case study is pursued using a constructivist methodology that produces knowledge for both, practitioners and researchers. The data is gathered in form of ethnographic interviews from a healthcare project in the Netherlands. Predominantly, it is about a network of companies who set up and learn from several niche experiments in order to develop a business model that can be applied in new and bigger projects that thrive for systematic change in the Netherlands.

Results:
Based on the concept of strategic niche management the analyses reveal several barriers of the niche-experiments. The biggest problems are associated with setting up the experiments and overcoming barriers such as enabling voluntary care. Other barriers are the unwillingness of employees to change, clients’ rejection to change and open collaboration among the different care providers of the project. Moreover, it seems rather difficult to set up a business concept for an integrated healthcare and area development project from experiments since one to one translations are challenging. It seems even more difficult to get commitment among care providers for future collaboration in spite of their shared visions. Furthermore, key value drivers and critical moments that influence the outcome of the niche-experiments are identified during the longitudinal research process. Thereby, various solutions and problem solving processes can be developed that reduce or even eliminate the barriers.

Discussion:
This paper is particularly relevant for the conference due to its innovative approach, applying strategic niche management in order to develop a horizontally integrated healthcare system which delivers high quality services. Predominantly, healthcare studies focus on changes within the existing, fragmented system while this study’s approach aims at changing the whole system, integrating it with other systems. The multi-level perspective of transitions illustrates how niche-experiments on the micro-level can influence the healthcare system. This study further demonstrates how to be engaged in the research process and why strategic niche management is an appropriate theoretical concept for changing the fragmented healthcare system into an integrated system. Future research has to emphasize the interaction between micro-level and macro-level institutions in order to see how far the impact of micro-level actors reaches. It will be interesting to see if policy changes occur on the macro-level and if the business concept is getting implemented.
IMPLEMENTATION OF THE CASE MANAGEMENT AND INTERDISCIPLINARY APPROACH IN AN INNOVATIVE INTEGRATED SERVICES DELIVERY IN FRANCE

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Context:
The 2008-2012 French Alzheimer plan is marked by the experimental implementation of “Homes for Integration and Autonomy for Alzheimer patients” with implementation of intensive case management process for people in complex situation. In 17 experimental sites, teams of case managers (CMs) have been implemented with a total of 67 case managers for performing an intensive case management.

Methods:
We conducted a qualitative study to develop a full understanding concerning the implementation of the case management process and the links with the interdisciplinary approach. Focus groups were conducted in 2010 to explore the perceptions of case managers 6 months after their recruitment concerning their relationships into the team and with the other clinical professionals.

Results:
During the implementation phase, interdisciplinary approach inside the case managers’ team has been rapidly constructed to resolve the complex situations, homogenize practices and help to create the new competency. Multidisciplinary and proximity team, common training and difficulties to get the good fit with professionals increased the interdisciplinary approach inside the case managers’ team. Interdisciplinary approach between case managers and clinical professionals was few implemented because of the high level of fragmentation and lack of case managers legitimacy. Systematic integration lobbying, using tools and methodology and having good return from situations by case managers could improve the links with clinical professionals.

Discussion:
Implementation of intensive case management in an innovative integrated services delivery showed a stronger interdisciplinary approach between case managers compared to with clinical professionals.
THE INTEGRATION OF PRIMARY CARE AND HOSPITAL CARE AND EVALUATION OF THE LOCAL HEALTH UNIT MODEL IN PORTUGAL

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Context: 
Some experiences linking primary and hospital care have already been implemented in Portugal, however, the results achieved so far have been insufficiently evaluated, a process that requires new metrics, considering interorganizational and interprofessional collaboration. In this work we propose to identify the building blocks of integration in healthcare and we also aim to agree on indicators of successful integration.

Methods: 
The conceptual model was constructed based on literature review and 15 semi-structured interviews. We will then conduct a comparative analysis between results of a setting operating under the local health unit model, an experience of formal merging of primary care and hospital care in Portugal, and a traditional organizational model, involving an acute care hospital and health centers located in geographic proximity but operating independently (comparative case studies). This study will focus on emergency service and outpatient consultations. Gathered data and information will be subject to qualitative and quantitative analysis.

Results: 
The conceptual model encompasses the following constructs: governance model, financing model, patient empowerment, human resources and patient information. Some indicators for the comparative analysis have already been identified: % of referral from primary care for emergency service; % of patients grouped by clinical priority; average waiting time for a first specialty consultation; % of first specialty consultation referred by primary care that did not generate subsequent consultation.

Discussion: 
The boundaries between levels of care are still difficult to surpass in Portugal, with deeply rooted professional cultures, which hinders the fast incorporation of available knowledge in the process of care in order to promote continuity and efficiency. The merging of institutions may not be a prerequisite to successful integration, but it may influence decisions regarding human resources, information systems and funding models.
CATCHING THE SLIPPERY FISH: USING Q METHODOLOGY TO EVALUATE INTEGRATED CARE

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Context:
Despite integration being an important concept across health and social care communities in many areas of the world, we know remarkably little about the impacts of collaboration in terms of service user outcomes. Some commentators have suggested that one of the reasons for this is that integration is notoriously difficult to evaluate effectively: and one of the main reasons for this is the lack of clarity about outcomes. Although integration is often advocated on the basis that it will improve services user outcomes, often there is little more specificity about what this will actually look like in practice.

Methods:
This paper reports on a research approach which utilises Q methodology as a way of eliciting the implicit logics about what it is that integration should achieve. The paper describes the design of the POETQ tool, which encompasses a Q-methodol approach in order to aid the elicitation of outcomes. Q method effectively integrates quantitative and qualitative approaches in order to identify different ways of talking about particular issues. In this case the Q approach has been integrated into a piece of software in order to identify the ways in which individuals talk about the outcomes of integrated care. This online software has been used by a number of case study sites in order to evaluate integrated working.

Results:
By incorporating a Q methodology approach researchers are able to identify a number of different ways of talking about what it is that integrated working should achieve. In this paper we report on the use of the POETQ approach in evaluating joint commissioning in an English context and the advantages that this approach offers. We found that participants were willing to engage with this approach, found it simple to use and appreciated the confidential elements of the online software.

Discussion:
It is clear that joint commissioning arrangements are often characterised by the presence of a range of different drivers. What this means in practice is that there are many different reasons why these integrated care arrangements exist. The use of a Q approach allows us to surface these and proved a simple tool for participants to engage with. We reflect on what this means in terms of future approaches in evaluating integrated care.
THE CAMPUS APPROACH OUTCOME ENHANCEMENT, PATIENT SATISFACTION AND COST CONTAINMENT IN THE CONTINUUM OF CARE

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Context:
As a consequence of the “Aging Society Phenomena” and due to the implicit incentive rules of the DRG reimbursement system:
- The co morbidity and complexity level of patients increased
- Length of stay was shortened
- Complication after discharge from the acute hospital went up
- Patients starting rehab treatment depicted a worse medical and psychological condition and significantly need advanced medication therapy schemes under rehab.

Methods:
In order to figure out whether the campus approaches is superior to other organisational types of treating and steering the patient. The performance of non-campus institutions has been compared to campus results, based on selected key figures and performance indicators such as
- Length of time between discharge from acute hospital to admission in a rehab clinic
- Complication rate
- Percentage of patients being not in the condition to receive physiotherapy during the first 5 days in rehab
- Patient satisfaction and HADS Score.

Results:
The intensity of cooperation between acute-care hospitals and rehab clinics is a crucial success factor for an effective medical treatment and the costs occurring along the life-cycle of care.
As it turned out the Campus Approach developed and practiced in Kerckhoff Clinic is a high-ly efficient and effective type of cooperation, this in terms of “Total Cost of Treatment”, “Length of stay in the Healthcare System”, “Medical Outcome” and “Patient Satisfaction”.

Discussion:
The Kerckhoff Campus Approach is a successful pilot for improving resource management and enhancing patient outcome over the entire cycle of care and may be an advanced blueprint to be rolled out in other European Countries.
CHANGE IN HEALTHCARE ORGANIZATIONS: AN EMPIRICAL EXAMINATION INTO THE FACTORS THAT GOVERN THE WAY THAT CHANGE UNFOLDS

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Context:
In this PhD research we develop the framework for the unfolding of planned change efforts at the Greek Public Healthcare Organizations (GPHO) that are undergoing radical change during the implementation of New Operational System (NOS). We investigate change processes with respect to the presence and interplay of 4 change motors—Evolutionary (E), Life-Cycle (LC), Dialectical (D) and Teleological (T)—and we recognise how a major change effort unfolds within the HO and how the development process will be affected by them.

Methods:
A quantitative analysis was used to uncover causal relations and influential factors in relation to the research questions. A questionnaire survey was developed and the study sample was consisted of 4 employees on each of the 40 HO that had introduced the NOS. For analysis of the survey data, correlations enabled discrete examinations of the relationships between groups of variables. For the analysis of a system of interrelated relationships simultaneously Structural Equation Modeling has been used.

Results:
The three basic stages of the unfolding of a planned change effort that has been identified are:
- Planning phase which consists of situation analysis, change definition and communication.
- Implementation phase which consists of acceptance of the change, change interventions and maintaining momentum.
- Outcome/evaluation phase that consists of measuring the outcome, consolidating the new state and institutionalizing the change. The factors that affect the unfolding of change are: E: Environment push, Technology, Social characteristics, LC: HO size, HO structure, Routines, Inertia, Managerial cognitions, D: Conflicts, Political Dynamics, Resistance, T: Managerial actions, Goal formulation, Leadership style, Decision-making.

Discussion:
The aim of the PHD research was to identify the factors that affect the way that change unfolds. It focuses on assessing the importance of different driving forces and inhibitors, managerial as well as employees’ cognitions and actions, and strategic, structural and organizational variables influencing the unfolding of HO change. The ambition is to build on the most recent achievements in the area, contribute to the field by developing measurements and empirically test the influence forces.
PATIENT PORTABILITY IN EUROPE: AN EXAMPLE IN NEURORADIOLOGY


Context:
Comparative exams are extremely important in vascular pathology. The need of comparative exams - CT scans or MRI - in patients with previous pathology is important for the quality of reading. Here is presented the state of electronic exam portability in Portugal.

Methods:
This paper shows the analysis of a preliminary European project in exam portability between European countries. Analysis regarding study of times, IT feasibility and opportunity for improving were shown. We study the examples of 5 different hospitals in Portugal and the possibility of portability in different healthcare administrations.

Results:
Portability is possible in institution under the same administration in Portugal but not allowed in among different institution. However hospitals do have IT support 24 hours per day/7days per week and do have PACS systems installed. However they were acquired from different vendors and compatibility is a problem. New nation guidelines are necessary to implement a national project.

Discussion:
It is technically possible to establish a network in Portugal to exchange radiological images, medical data and scientific knowledge on those subjects. Therefore, the concept of a truly global Radiology would exist when patients could visit any European physician without their CDs or films. [figure1]
SCENARIOS FOR COMMUNITY PHARMACISTS IN 2020: OPPORTUNITIES FOR INTEGRATION IN PRIMARY HEALTH CARE

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Context:
Community pharmacists in Portugal had traditionally been able to cope with change and new challenges. In 2007, new regulations enabled the community pharmacist with the possibility of providing new services, beyond the dispensing of medicines. Along with the trend of patient-focused health care, the technological innovations and the present Primary health care (PHC) reform, there’s now an opportunity to perfect the role of the community pharmacist in the Portuguese health system.

Methods:
To make this study, we used the scenario analysis method, aiming to define three alternative scenarios for the future of the Portuguese community pharmacist. To build these scenarios we invited a number of experts from academia and practice settings, for two scenario analysis workshops. After identifying the main driving forces behind the future of community pharmacists, various sets of assumptions were made and from them plausible and diverse scenarios were constructed.

Results:
The information collected during the first workshop allowed us to identify the critical uncertainties behind the community pharmacist’s future. Two driving forces emerged as the ones that will most determine this future: The Development and innovation of services driver, reflecting the differences in innovation between pharmacies, from low to high innovation; and the Legislative environment driver, reflecting a high or low tendency towards liberalization of the pharmacy market and of the Health system itself. These analyses provided a logical framework in which we identified three alternative stories for the future of community pharmacists, that we named “THE SUPERVISOR”, “THE CAREGIVER” and “THE INNOVATOR SALESMAN”.

Discussion:
In “THE SUPERVISOR” scenario, pharmacist’s role will be one of mainly controlling and supervising medicine dispensing in the pharmacy. In “THE CAREGIVER” scenario, emphasis is made on the health service delivery, as a provider of new services for the health system. In “THE INNOVATOR SALESMAN” scenario, community pharmacists will be pushed to develop new services, in order to gain profits for the pharmacy. Regardless of any scenario, there are signs that the community pharmacist of the future will have to obtain new skills in areas not traditionally linked with pharmacy, namely IT and management skills.
THE PLANNING PROCESS REGARDING INFLOW IN GP TRAINING IN THE NETHERLANDS: BETWEEN POLICY AND PRACTICE

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Context:
Shortages and oversupply of health care personnel are a major concern of policy makers and professional bodies. It is commonly acknowledged manpower planning can be an important instrument to control these fluctuations. In the Netherlands, there has been a long period of experience with health manpower planning (planning of GPs in particular). There is also a long tradition of GP monitoring. In this paper we analyze the role of stakeholders involved in the decision making process regarding GP planning.

Methods:
We perform a historical policy analysis describing the system of GP manpower planning and its stakeholders from 1970 onwards. For this description, we analyze the trends in planned and realised entry numbers in GP training. In parallel, we describe the stakeholders that were involved in this decision making process and the different policy positions they have. We explain the history of policy decisions made in this period, by interconnecting the trends in the GP labour market and training entry with developments in policy and practice in the same period.

Results:
Planning for health professionals started in the 1970s, when numerus clausus was introduced. The government explored different approaches to determine this clausus. In the 70s/80s, committees advised the government regarding this topic. Then, the government developed their own planning models. This lasted until 1992, when the government withdrew from this planning. It was left to the professions. In 1999 it was decided to re-centralize the planning, by founding the Capacity Body. A simulation model was introduced, but the policy positions about entry numbers remained a potential point of conflict. Notably, since 2006, the gap between the preferred levels of GP training inflow became smaller as the stakeholders tend to agree to a larger extent with the Capacity Body.

Discussion:
This paper showed that before the final decision about the inflow in GP training is made, multiple policy processes with stakeholders take place. The results of this study suggest that stakeholders became used to the current system of decision making as governed by the Capacity Body. Still, planning workforces is a matter of stakeholder management. The question therefore remains how solid this process of decision making will be in the future.
CHILDHOOD OBESITY RISK FACTORS: THE NEED FOR INTEGRATED CARE

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Context:
The prevalence of childhood obesity is increasing in Israel, as in other developed countries, and is considered today a major threat to public health. Previous studies indicate that obesity is the result of many mutually dependent factors, including genetic, nutrition, life-style, familial and environmental factors. The objective of this study was to identify specific risk factors for childhood obesity in Israel at both the family and child level.

Methods:
The study included families with children aged 4 to 11 years old, registered with Maccabi Healthcare Services at two community clinics. During 2008, 439 mothers completed comprehensive questionnaires to measure a large variety of possible risk factors. Trained interviewers weighed and measured their 814 children. There was a 50% response rate. Multivariate analysis was conducted using logistic regression taking into account the inter-dependence between siblings in the family.

Results:
Multivariate analysis revealed predictors of having at least one overweight child in the family: Father’s origin, time of immigration and education level; Mother’s age, history of overweight, and lack of control over eating habits. At the child’s level, predictors of overweight were: age below 7 years old; not fussy eaters, maintenance of an inactive lifestyle; eating of the main daily meal at a day-care center or school at least once a week.

Discussion:
Children and their parents are considered a top priority target population for obesity prevention programs. Nevertheless, the accumulating data show that overall most intervention programs have not been successful in either preventing or treating obesity among children. The multi-factorial risk factors empirically identified in this study suggest the need for integrated care to address childhood obesity. In treating families with obese children, cooperation between primary care providers, schools and daycare centers, social services and parental counseling services have the potential to achieve more effective outcomes. Options for provision of pro-active integrated care will be discussed.
INFLUENCE OF KNOWLEDGE SHARING ON THE ABILITY TO INNOVATE IN PATIENT-CENTERED HEALTH CARE TEAMS FOR RARE DISEASES!

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Context:
Although rare diseases represent a very small prevalence of less than 5 out of 10,000 patients, about 6000 different rare diseases exist. In this context, where standardized health care processes and concepts are mainly lacking, and a deficit of knowledge induces uncertainty, multidisciplinary health care teams, are stressed to come up with individual, patient-centered solutions to improve patient’s long-term care situation.

Methods:
To cope with the complexity of rare diseases, for both idea generation and implementation of innovative care concepts the overall inclusion of expertise is necessary, including patients. Hence, this study focuses on the evaluation of different factors as team commitment, psychological safety, team diversity and dynamism of team structure to enhance communication processes within patient-centered health care teams to foster the generation of explorative solutions.
The study comprises a multi-method approach integrating qualitative and quantitative research. Questionnaires were sent to 230 patients in Germany, as well as to their health care professionals. Additionally semi-structured telephone interviews with 80% of the patients, were conducted.

Results:
Preliminary results show that intensive knowledge exchange significantly affects explorative outcomes. This study explored different individual and team factors to explain potential barriers, which hinder innovative behavior in the daily work with patients suffering from rare diseases. On an individual level the more team members feel psychologically safe and have a high level of commitment for their team, they tend to actively interact with each other exchanging valuable information. On a team level the results show a significant positive influence of a stable team structure within teams on active knowledge sharing processes.

Discussion:
Referring to the underlying theoretical framework health care teams with norms for intensive knowledge sharing (considering health care teams as a whole integrating particularly the patients themselves), encourage the constitution of individual innovative care concepts. Hence, this study aims to provide unique information on the most important individual and team factors for improving the long-term care situation of patients with rare diseases.
STRATEGIES TO IMPROVE THE REPORTING OF ADVERSE DRUG REACTION AMONG PHYSICIANS IN NORTHERN PORTUGAL

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Context:
Spontaneous reporting of adverse drug reactions (ADRs) constitutes a fundamental component of post marketing surveillance. Several studies suggested that spontaneous reporting of suspected ADRs by health professionals is fundamental to drug safety surveillance, and constitutes a commonly used method for generating signals about unexpected ADRs. Nevertheless, the effectiveness of the system is compromised by under-reporting, being estimated that only 6% of all ADRs are actually reported. This study aimed at evaluates the results of an educational outreach in physicians, designed to improve the effectiveness of reports of ADRs.

Methods:
A cluster-randomized controlled trial was conducted with physicians working in Northern Portugal, in 2008. After randomization, 1481 physicians were placed into the intervention group (1056 in telephone interviews and 425 in workshops). The control group was comprised of 5098 physicians. The following issues were approached in the educational intervention: the problem of ADRs and spontaneous reporting. Concerning to relevance, adverse reactions were classified into severe and unexpected. Statistical analysis was performed, based on the intention-to-treat principle, and generalized of linear mixed models were applied, using the penalized quasi-likelihood method.

Results:
The intervention by workshops increased \( p = 0.001 \) the rate of spontaneous reporting of ADRs \( (RR = 3.971; 95\% CI 3.863; 4.083) \), compared to the control group \( (RR = 0.924; 95\% CI 0.293; 2.912) \). Conversely, the intervention by telephone interviews was less efficient. No significant difference \( (p = 0.052) \) was observed \( (RR = 1.020; 95\% 1.000; 1.041) \) when compared with the control group \( (RR = 1.724; 95\% 0.766; 3.878) \).

Discussion:
During a period of up four months, educational interventions by workshops increased significantly the effectiveness of spontaneous reporting of ADRs by physicians in Northern Portugal. Moreover, it was observed that educational intervention by workshops was more efficient than educational intervention by telephone interviews.
INTEGRATING EATING DISORDER TREATMENT

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Context:
The Dutch health care system is changing how care is provided through disease management and integrated care. This paper focuses on an eating disorder center that show these changes. With funding from the Netherlands Organization for Health Research and Development, the center has developed 4 new projects. Rather than operate these projects as independent entities, the center is working to create a team approach to transform compartmentalized care into integrated care.

Methods:
Nine interviews were done with project leaders at the center. The interviews included an description of projects, barriers, team dynamics, and the integration of the projects into the larger system. Two meetings about the projects and the integration of the projects into the larger system were observed. Notes, personnel charts, and plans were analyzed. This case study focuses on the process of developing and doing projects with the context of the existing infrastructure, the eating disorder center.

Results:
As observed, the integration is seen as a positive change. Relationships between departments are frequently discussed. Integration is seen as positive due to of the strengthening of connections between departments, the ability to have continuous care for clients, and the possibility to meet needs more effectively. The meetings are positive, as they connect staff to discuss and debate the changes. While the connection of staff is viewed as key to the transformation process, it is not without challenges. “It’s very difficult to connect the clinic with the outpatient clinic. It’s the same old story with all professionals in health care.” Team manager.

Discussion:
Integrating new projects and improving the care provided is seen to require a complete transformation of the current care structure. This transformation has not been without fear of change and other challenges. The projects involve an altered form of client participation and adjustments in the responsibilities of new, veteran, and future staff. Understanding how this move from professionals with “too much focus on their own little business” (team manager) to a community of colleagues in integrated care is key to understanding the process of integration. This paper explores the process of how integrated care happens through partnerships, team development, reorganization, and new connections.
DO INTEGRATED HEALTH AND SOCIAL CARE SERVICES DELIVER BETTER CARE FOR CHILDREN WITH INTELLUCTUAL DISABILITIES?

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Context:
The project focuses on two local services in Wales that have recently moved to (what they call) an integrated health and social care learning disabilities service (learning disabilities/LD is the UK term equivalent to intellectual disabilities/ID in the US). The research asked the following questions.
1. What are the main changes in service provision, case management, care pathways and multi-agency working through the introduction of integrated children’s LD services?
2. What are the advantages and disadvantages of service integration as viewed by professionals with respect to continuity of care for young people with learning disabilities and partnership working?

Methods:
We conducted 8 semi-structured interviews with key professionals in both local services and carried out an online survey of all professionals in both areas affected by the organisational changes plus a control area.

Results:
The services differed significantly in their set of practices. Integration of care pathways was the shared minimum of integration yet many other steps towards fully integrated services were missed, such as pooled budgets. In effect, both services would be more accurately described as close partnership working with some selective elements of service integration. Professionals were also skeptical of the effects of the organisational changes on quality of care for children with LD and their carers.

Discussion:
The study demonstrates the wide variety of meaning attached to service integration. It contributes to a better understanding of those factors that should define organisational integration between health and social care services. We are critical of labeling embryonic integration such as those in our cases as service integration in the real meaning of the term.
RESOURCES USE EFFICIENCY ESTIMATION AT THE LEVEL OF MEDICAL ORGANIZATIONS

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Context:
Kazakhstan has objective factors causing increase of expenses on health services and expensive medical technologies. Population requirements to conditions and quality of the health care have increased. In these conditions the economic analysis of activity of medical institution is important for acceptance of administrative decisions.

Methods:
Objects of our research were two regional hospitals. Research methods included analysis of expenses efficiency, allowing to estimate useful effects of health services. A factor of expenses efficiency was used as measurement indicator. Principles of the resources use efficiency estimation included medical, social, economic efficiency. We had developed a degree estimation Card of the medical standard performance at the treated patient which allows to monitor the appointed services. Registration documents for comparison of actual treatment technology to medical-economic tariffs (MET) were the inpatient card and an invoice on the finished case of treatment.

Results:
We carry out calculation of medical and economic efficiency on the basis of definition of factor of rupture. The estimation principles consists from the analysis of a rupture degree between the actual expenses and due expenses on treatment, according to MET, and from the analysis of performance degree of manipulations recommended by MET. The percent of MET performance varied from 0,23% to 19%, thus the share of coincidence with MET was 10 times more in diagnostics cases. We had attracted attention on high rupture- a share of MET performance which fluctuates from 2 to 103 times. Thus MET default is system phenomenon.

Discussion:
Use of these factors as an estimation criteria create a platform for discussion and perfection of MET, that will positively affect on quality of MET and quality of treatment. The set of these criteria helps to estimate hospital work in dynamics and compare hospitals of one branch. Hospital manager has possibility to find out and correct the reason of possible problems before it becomes significant. These factors allow to plan, supervise their work, and motivate the personnel.
INTEGRATED CARE IN GERMANY – EXPERIENCE OF A SOCIAL HEALTH INSURANCE FUND

Susanne Klein
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Context:
Under the Health Care Reform Act 2000, the legislator has provided the possibility of entering into integrated health care contracts in Germany. It is the aim to terminate the sectorial division into outpatient, inpatient, and other service provision. The players in the health care system are given more margin in the shaping of contracts in order to enable approaches to cross-sectorial care and eliminate double and inappropriate health care, respectively.

Methods:
Integration contracts for various indications have been concluded. Parties to the contracts are service providers (physicians, hospitals, etc.) or management companies. The primary objectives of activities under individual contracts mainly comprise the improvement of the quality of care as well as the development of an economically efficient and transparent care. Subject of the contracts are service components (waiting time, making of appointments, etc.) and quality commitments (time for consultations, quality parameters, innovative diagnostic and therapeutic facilities, etc.). The assignment of the patients to the contracts is primarily made by the service providers, but also by Social Health Insurance Funds itself. Pay for performance as a financing system is becoming more and more important in Germany.

Results:
The experience has shown that a professional partner, quality of information and communication, assumption of responsibility and quality of care are important for the success of an integrated health care contract. It has turned out that a lack of economic efficiency of a contract leads to problems in the long term. Individual contracts often are connected with high transaction costs. But it also can be shown that integrated care is an instrument to reduce cost of sick pay and time of hospital treatment and pay for performance is helpful in improving quality of care.

Discussion:
Consistently using the legal framework conditions provided for under Article 140 a – d SGB [Social Security Code] V, a varied supply of services tuned to social health insurance funds could be established, health care processes could be optimized as to quality, economic efficiency as well as service elements, a high transfer of knowledge in the sector of individual contracts could be generated.
IMPROVING HEALTH CARE IN WOMEN WITH UTERINE FIBROIDS BY USING AN INTEGRATED CARE MODEL

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Context:
Treatment with magnetic resonance-guided focused ultrasound (MRgFUS) is an example of how Techniker Krankenkasse (TK), a social health insurance company in Germany, used an integrated care model to improve quality of health care in women with symptomatic uterine fibroids. Our goal was to adequately inform the relevant women about all their therapeutic options and to decrease the rate of hysterectomies and other invasive procedures. This should be achieved with a better cooperation between radiologists and gynecologists.

Methods:
At the beginning of 2010, a selective contract was concluded with one of four sites in Germany which offers MRgFUS. The contract links and regulates the interdisciplinary and cross-sectorial cooperation of the participating players. Thus, a special consultation hour could be established and TK insured women gained access to this innovative, non-invasive treatment of symptomatic fibroids. The success of the integrated care model and the achievement of the set goals were evaluated by assessing internal data and the satisfaction of women attending our model.

Results:
Until now 155 women have been enrolled to our integrated care model. Of these, 77 were suitable for MRgFUS and were consequently treated. Only two of them needed additional operation later on due to relapse. Currently, a questionnaire on the satisfaction of participating women is being initiated. Results will presumably be available by end of March 2011 and can be presented then.

Discussion:
As measured by the prevention of invasive treatment, due to cross-linking of inpatient and outpatient care, as well as interdisciplinary cooperation, integrated care could be achieved which improves the quality of health care for TK insured women with symptomatic fibroids. Moreover, reactions from other health care providers, interested in contracting MRgFUS with TK, show that our commitment also serves to promote an innovative therapeutic procedure. As MRgFUS is not yet a service in the catalogue of benefits offered by the social health insurance funds, integrated care models are an applicable tool for a social health insurance company to actively design the health care system in Germany.
DEVELOPING COLLABORATIVE SOLUTIONS TO SUPPORT INFORMATION SHARING

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Context:
Quality health and social services depend on good information. Through increased availability of reliable data, higher quality of information (for international comparisons) and facilitative tools, examples of service innovation resulting from better understanding of how to deliver effective care may be found throughout Europe. However there are also challenges for the potential capacity of even basic information systems to be realised. Many of these are not technological but cultural and require a different way of thinking about how we work to ensure that all societal groups are able to access, understand and use the information necessary for their care.

Methods:
This paper will present two complementary areas of research in order to highlight the critical relationship between policy development and practice solutions which has promoted the collaboration between the two authors. The first analyses from a policy context the results of a UK national government consultation on changing radically the way that information is managed across the whole health economy. This consultation received over 750 responses from differing informants and based on thematic analysis demonstrates key areas for future information system development. The second piece of research, again concentrating on information systems but at a micro level, investigated the complexities in the development and embedding of self-reported symptom assessment e-technology within palliative cancer care. It considered the processes involved in developing suitable e-technology for care from which challenges to the system were located. Fourteen semi-structured interviews were undertaken with managers and clinicians to determine facilitators and barriers to take-up.

Results:
In this jointly presented paper, the practice based research did clearly show that the technological solution to support the E-health intervention was challenged by complexity and policy such as: multi-stakeholder input; the community setting; general/individual disease symptoms; varying patient information and developing clinical algorithms and ‘bite-sized’ screen intelligence. Take-up was influenced more by the clinicians than policy; the patient group; working practices; readiness to engage with the technology and system structure. Similarly we can also learn from the policy consultation that although there was a willingness to share information in order to enhance care outcomes the practicalities of doing this are real and can be problematic, for example, patient groups seeking assurances about data security, different use of language across services settings and information availability being seen as the main solution to improve poor service design.

Discussion:
Too often in the development of technology and supporting information systems there has been a disconnect between policy and practice and a readiness in multi-stakeholder environments to blame one another when things go wrong. What this paper shows is that there is often at practitioner and manager level a shared understanding of what actually needs to happen with respect to outcomes. There is also a recognition that the physical and cultural boundaries that separate care settings and users and carers are challenging and less clear and yet it does not appear to be anyone’s job to sort out what should happen to the flow of information and its governance. This is quite clearly a leadership issue in a field where leadership has little investment and hence the solutions will require some novel and different collaborations such as joint working between researchers and policy makers – a point for discussion.
MULTI-METHOD EVALUATION OF AN INTEGRATED NETWORK BASED DEMENTIA CARE MODEL

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Context:
Austrian health care increasingly deals with potentials of future cost minimization by improvement of health services. An identification and prioritization process of strategically significant diseases carried out by the social health insurance showed the need of health service improvement for dementia, as prevalence and incidence rates of dementia are expected to double within few decades. Health care of these patients is characterized by multiple doctor consultations, high length of stay and multi-morbidity, and missing coordination of professionals.

Methods:
An integrated care model shall enhance interface management and coordination in dementia care, aiming at efficient service and longer home care. The thesis deals with a multi-method evaluation of the model, taking the overlying objectives of quality of life (field 1) and cost-benefit improvement (field 2) into account. The evaluation consists of pre-implementation phase with extensive desktop research, the implementation phase, starting with the implementation of the model, and the review phase following the data collection and interpretation.

Results:
The pre-implementation phase resulted in an evaluation framework and will be revised within several workshops with network actors. Evaluation of field 1 is carried out by applying standardized quality-of-life (QOL) measurement tools. Affiliated QOL is assessed by WHOQOL-BREF, and patients’ QOL by DEMQOL and QUALID. Dementia care mapping completes assessment in late stage patients. Performance in field 2 is measured by cost-benefit analyses and before-after comparisons of efficiency, effectiveness, and flexibility of service. Evaluation here follows approaches of supply chain management (SCM) as the model states a health care service integrating network.

Discussion:
As instruments of quality of life measurement selected are already proven in practice and cost-benefit analyses form usual assessment in Austrian health care, little adjustments of this tool mix are expected. The challenge in fact is the evaluation of the network model, as the approach of applying SCM to health care service processes is highly innovative. The evaluation therefore is formative, giving the possibility of expert revision and model adjustment to ensure practicability of the theoretical network assessment framework.
ISSUES AND PRIORITY SETTING IN IMPLEMENTING THE CHRONIC CARE MODEL (CCM)

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Context:
While Quebec has a history of policies aiming at integration of health and social services, improvements are needed in caring for patients with multiple chronic diseases (MCD).

Objectives
Identify the clinical, operational and strategic issues in implementing the CCM.
Develop a consensus on change priority in care for MCD patients i.e with complex and fluctuating needs and frequent services transitions.

Methods:
A two-step qualitative study conducted in a Montreal university hospital and its affiliated partners (community and long-term care centers)
20 semi-structured interviews with key clinicians and managers
A two-round Delphi (111 clinicians and managers identified via snowball sampling)
1-rating of the importance of 54 clinical, operational and strategic issues - participation 57%
2-identification of priorities - 51%.

Results:
Key challenges in implementing the CMM 6 elements:
Organization of services: lack of coordination of the specialists who care for MCD patients; budgets for hospitals and community services managed separately, leading to sub-optimal patients trajectories; Emergency rooms are still the main point of entry to care.
Self-management: Functional and cognitive impairments hinder patients participation in the care process; self-management programs are developed for single disease, not for MCD.
Clinical decision support: Assessment tools are underused; variation between clinicians in patients’ needs assessment; complexity of patients’ needs and risk of adverse outcomes complicate treatment decisions; lack of clinical guidelines for MCD.
Information systems: Lack of shared systems, leading to communication issues.
Community: Poorly involved community-based agencies.
Health system: Focus shifting from acute care to program designed for single chronic disease management lacking global approach for MCD patients.

Discussion:
To meet the challenges of caring for MCD patients, a strategic implementation of clinical, technological and organizational changes is required to provide patient-centered care: strengthening primary care, developing shared information systems, improving collaboration between primary and secondary care, developing effective governance and change management strategies.
INTEGRATION OF MEDICAL AND MANAGERIAL ACTIVITIES: THE FRENCH CASE OF “CHEFS DE POLES”

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Context:
Introduced in 2005, the organization of the hospital changes into a structure in medical units managed by clinicians. The new law of hospital protracts these measures and gives a clinician, “chef de pole”, the ability to devise the policy of the hospital and organize its functioning.

Our paper analyzes this peculiar type of combination of medical and managerial activities. We intend, within this presentation thanks to the Hugues concepts of “dirty work” and “role”, to analyse how doctors embrace this managerial side of their work according to their profiles and specialized field.

Methods:
A survey associated with interviews.
We identified practitioners having these responsibilities (character, field, representation of this function, needs for training).
2000 surveys were sent to “chefs de pôle”. 130 questionnaires were handed back. This analysis and processing of data enabled us to determine the “chefs de pôle”’s profiles. The second step consisted in matching the data in order to establish the correlations between the various criteria.
We used this data to put into place a model adding depth to these primary results. It is about understanding how a practitioner takes the post of “chef de pôle” in his medical career, on one hand. On the other hand, we have looked at the representation of the work as “chef de pôle” and its subjetive value. Fifteen “chefs de pôle” from 3 hospitals have thus been part of our study.

Results:
First results we would like to present:
- Commitment to the role of “chef de pôle”: a continuance in the career
- Diversity of ways to ally both functions (clinical and managerial activities): place, role, determining aspect of the “pole” contract.
- A contrast between the value of the function and the strategic aspect of the delegated missions.
- Importance of training to better integrate medical and managerial aspects of the work.

Discussion:
The role of “chef de pôle” is in progress. There is a great diversity in its representations.
There’s a shared opinion about a representation of a work that can be valued institution- wise (participation to strategic meetings...) but doesn’t necessarily lead to a recognition by their fellows.
A closer relationship with administration enables a better integration of medical, nursing and managerial activities, that could benefit patients.
INTEGRATION AND COORDINATION OF CARE FOR INDIVIDUALS WITH ALS: A QUALITATIVE STUDY

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Context:
In Norway, a health reform (The Coordination Reform) has recently been put forward to reallocate care and treatment tasks from secondary to primary health care. Amyotrophic lateral sclerosis (ALS/MND) is a neurological condition that affects voluntary control of muscles, and patients gradually lose the ability to manage their everyday life. This ongoing functional loss calls for coordination between caregivers in order to meet patients’ needs. This study will explore how care is organized around the ALS-patient to gain knowledge of how healthcare integration works in practice.

Methods:
We will gather data from observation and in-depth interviews with family members and professional carers in primary health care and in hospital settings. According to Goffman, social interaction is characterized with a front stage where actors play out their social role, and a back stage to prepare for social expectations. The home can be understood in these terms; the living room might be a front, the bathroom back stage. In the ALS case health professionals enter the home enabling renegotiations of the boundaries between front and back stage.

Results:
No empirical results are available to date. The notion of coordination within the network of carers will be a main focus. The home, where the individual with ALS lives, with his or her family and carers, is a node in the network of ALS-care. A second node is primary health care, where health professionals and providers has long-term experience with a small number of patients. A third node is the hospital and specialized health care, where health professionals see a high number of patients for short consultations. We assume that each node operate on the basis of their own local knowledge, and act according to their own understanding of the situation. A single coherent rationale throughout the network is not expected to be found, which might pose challenges for coordination and multidisciplinary work within the network.

Discussion:
This study will provide knowledge about the boundaries of the formal health care service, and how formal and informal care providers collaborate, negotiate and understand tasks. Findings from this study might be transferable to other conditions.
EXPLORING THE OBSTACLES FOR DELIVERING COMPASSIONATE CARE: THE CASE OF THE UK NATIONAL HEALTH SERVICE

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Context:  
Improving patient experience has been one of the main focuses in health sector. In the UK, NHS Trusts have been actively involved in communicating patient-centered care practices to the public and their staff. However, recent research has shown a record increase in NHS complaints. Of these complaints staff attitude was the highest single aspect of the NHS that patients complained about. While a recent Care Commission report continued to stipulate that compassion is the basis of nursing, there has been little research on why frontline staff fails to deliver compassionate care.

Methods:  
Qualitative analysis was carried out using a thematic approach (Braun and Clarke, 2006) and data triangulation techniques. This study analysed over 200 anonymous NHS staff blogs, which mostly recorded opinions and views about NHS working conditions, their critical concerns and how changes in policies had influenced their ability to deliver quality care to patients. The blogs were examined in conjunction with government documents and related extant research.

Results:  
Despite stories in the media about nurses not being compassionate, our findings show that there is a strong belief among nurses that their profession is by nature caring and compassionate. A number of factors affected staff’s capacity to deliver compassionate care to patients were identified. These factors include inadequate levels of staffing, lack of managerial support, conflicting goals in policies, and low staff motivation. Evidence shows that the current ‘target oriented’ approach of management has created an obstacle to nurses using their time to care for patients.

Discussion:  
The analysis of staff stories revealed the fact that the emotional component in their job has not been recognised as part of the measurement of the labour output. Thus, there was no time allocation for such activities and this made it impossible for the already overloaded worker to allow any time to care for patients outside of the time required for the defined task. A more coherent approach should be taken in measuring service outcomes in order to facilitate the development of a compassionate work force.
IMPROVING PERFORMANCE THROUGH QUALITY MANAGEMENT IN HEALTH CARE ORGANISATIONS: EMPIRICAL EVIDENCE FROM PORTUGAL

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Context:
In light of the deep changes occurring in the Health Care Systems in most European countries, organisations operating in the Health Sector have been urged to meet raised expectations of higher performance and improved quality of service, while remaining economically viable. Such goals have been pursued through the implementation of concepts and management frameworks mainly derived from the private sector, which comprise, to varying degrees, principles of TQM. However, the introduction of quality programs, does not necessarily lead to better organisational performance results.

Methods:
This study employs a quantitative approach to empirically examine the proposed model on a sample of public health care organisations in Portugal. Following this approach, a questionnaire was designed based on validated construct measures derived from existing literature. The questionnaire was pre-tested to six academics and four practitioners to ensure the content validity of the measurement scales and prevent any bias in the questions.

Results:
Structural equation modeling based on Partial Least Squares (PLS) technique was chosen to conduct data analysis. The results lead us to support four of the six proposed research hypotheses. Ultimately, the results shows the importance of market orientation in driving quality while fostering performance in the healthcare sector.

Discussion:
This study shows the importance of market orientation in driving quality while fostering performance in healthcare organisations. Although the study did not validate the direct relationship between quality orientation and organisational performance; a relationship between these two constructs was found when mediated by market orientation. The results emphasise that only focusing on quality, particularly when simply associated with internal processes do not appear to have a direct impact on organisational performance. This also means that quality efforts need to be tied up with a focus on inter-functional coordination and dissemination of information as well as responsiveness, as part of a market orientation strategy.
REDUCING TOBACCO USE INITIATION: WHAT INTERVENTIONS ARE MOST EFFECTIVE IN COMBINATION WITH MASS MEDIA CAMPAIGNS? A SYSTEMATIC REVIEW

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Context:
Tobacco use is the greatest source of preventable morbidity and mortality worldwide. It’s known that mass media advertisements, school-based programs, law interventions and parents’ education could be useful in preventing the smoking initiation. Our systematic review is aimed at analyzing mass media campaigns effects when combined to other kind of interventions against the tobacco use initiation in adolescence.

Methods:
We conducted a systematic review according to protocols provided by the Cochrane Handbook 5.0.2. Criteria for study selection were: study design - RCT and cluster RCT; interventions - mass media campaigns combined with law restrictions or price strategies, bans, promotion through schools, parental education and others; outcome - evaluating the effect on smoking initiation or tobacco prevention; population - adolescent (13-18) and young adult (19-24). Studies were prescreened for relevance, assessed for inclusion by two people independently, grouped by intervention method and combined using qualitative narrative synthesis.

Results:
Starting from 167 studies prescreened for relevance, 50 were assessed for inclusion. A total of 13 studies met all the inclusion criteria. All studies used a controlled trial design. Considering the six intervention categories combined with mass media campaigns, studies were classified as follow: law restrictions (1 study), price strategies (1 study), bans (1 study), promotion through schools (5 studies), parental education (2 studies) and other interventions (3 studies).

Discussion:
Mass media interventions have been recommended fighting back the tobacco initiation in youths but little evidence shows their effects when combined to other kind of interventions. Our preliminary findings provide evidence that mass media interventions targeted to higher risk youths, especially when combined with school programs, substantially reduced the long-term prevalence of cigarette smoking among this important target population.
A SYSTEMATIC REVIEW OF HEALTH MANPOWER FORECASTING MODELS

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Context: Health manpower planning (HMP) aims at matching health manpower (HM) supply to the population’s health requirements. To achieve this, HMP needs information on future HM supply and requirement (S&R). This is estimated by several different forecasting models (FMs). In this paper, we review FMs for physician manpower planning (PMP) and their variation.

Methods: We performed a systematic literature review (SLR) of scientific papers published worldwide after 1970, describing FMs for PMP. Studies were included if: they described at least one FM; the FM was used for macro level PMP; the FM forecast S&R; and the FM was dynamic. From each study, we extracted information on country, year and type of physicians studied, data sources searched, and parameters used to estimate current and future S&R. From the data gathered, we analysed the variation between FMs.

Results: From the 994 papers identified, 35 were included in the review. They described 69 FMs, covering mostly specialists practicing in North America. Publication trends suggest the topic gained interest in the late 1970s and early 1980s, and again in the late 1990s. FMs overlapped regarding the parameters used to estimate current and future S&R. All but two FMs used workforce size to measure current supply. Future supply was estimated mostly from expected inflow of new graduates and outflow of retiring physicians. Current requirement was most frequently estimated by population size and age, age- and disease-specific utilisation, care standards or duration of care. Changes in population size and age were the most used to estimate future requirement.

Discussion: Our SLR provides the first knowledge base of international experience in physician S&R forecasting. This allows the development of a classification framework of FMs for PMP. Such a framework, unlike the traditional need/demand division, can be derived from the variation found by this SLR. Planners can benefit from previous experience, e.g. regarding data collection requirements, assumptions made, and outputs of FMs. Our knowledge base is also useful internationally to inform HMP and improve health labour market efficiency.
OPERATIONAL ACCESS TO INTEGRATED LONG-TERM CARE: FRONT-BACK OFFICE DESIGN TO IMPROVE PATIENT ORIENTATION

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Context:
Being challenged to offer a demand-based, integrated supply of services in an efficient way, providers of long term care are reconsidering the operational access to their services. The element of customer contact is essential. The front office comprises all activities executed in direct contact with customers. Back office activities do not require customer presence and have different operations requirements.

Methods:
Our research question is: How do long term care providers take front-back office aspects into account for the operational access to their services? Based on literature on front-back office configurations and access to care we developed a theoretical framework. We performed multiple case studies. The use of semi-structured interviews, field trips and documents analysis, facilitated triangulation.

Results:
Access units have evolved over time rather than being based on explicit design principles. Service concepts are hardly developed and client satisfaction is not structurally measured. To enhance availability of the access unit, some providers decentralize; other prefer centralization to realize efficient and unambiguous access processes. Front-office employees are highly educated, although their tasks include administrative activities. Most organizations choose to couple all entrance related activities in one job. This reduces handovers and fragmentation of knowledge on the client. Continuity, however, is challenged by the decoupling between access to and execution of services. Lack of integration between information systems often seriously hinders effective support of customer-oriented operational access procedures.

Discussion:
Starting from insights on customer contact in service provision, we broaden the scope towards a setting with clients searching for customized, integrated packages of care, housing and related services. The cases provide insight in front-back office trade-offs in operational access to long-term care. Managerially, the case studies suggest how deliberate front-back office design may help providers arrange their entrance unit to receive, clarify and fulfill the requirements of their clients effectively and efficiently. Implications follow for intra- and inter-organizational cooperation that enhance integrated service delivery.
IDENTIFYING AND PREPARING FUTURE GLOBAL HEALTH LEADERS

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Context:
National and international health systems will face significant challenges in the years ahead. Recent demographic changes and shortage of resources as well as an increasing demand for cooperation between different professions, such as primary and specialized care or across regional and national borders, all raise questions on how to equip the leaders who will deliver future solutions in health and health care. Without doubt the 20th century delivered great achievements in traditional health care and medical services, followed by a certain measure of success in management on a provider and system level.

Methods:
The challenge now is to define the best combination of leadership skills, interventions, and institutions that will lead to more efficient health services and better health outcomes in the 21st century. A growing body of literature states the importance of generic skills over field-specific competencies for the education in the health care management field at master level. Analytical assessment skills and competencies in communication, culture, or creativity are thus favoured at the expense of health specific expert knowledge. In order to further explore the preferences and demands of our graduate’s prospective employers, a Delphi survey is currently carried out. The Delphi method is an iterative process used to collect and distill the judgments of experts using a series of questionnaires interspersed with feedback.

Results:
Between October 2010 and March 2011 at least two written surveys are scheduled.

Discussion:
Based on the opinion of international experts we try to figure out the challenges health systems will face in the years ahead, the role of health management and national/international agencies in responding to these challenges, the requirements future health care managers should meet, and the consequences for future education in health care management.
MOBILIZING CHANGE, LEARNING FROM INNOVATION: ACCELERATING PRIMARY HEALTHCARE TRANSFORMATION IN CANADA

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Context:
Canadians expect high performing systems that are responsive to their needs and demonstrate improved outcomes for the $180 billion spent annually to deliver medically necessary services to 34 million people. Countries with strong primary healthcare (PHC) infrastructure provide efficient care at lower cost, with better outcomes and higher patient satisfaction. Despite a $800 million investment in PHC, Canada continues to rank poorly in international comparisons.

Methods:
Primary healthcare remains restricted by a system that was not designed to address today’s health issues, meet consumer expectations, or maximize clinical expertise. Believing that a great deal can be learned from peers who have led innovative initiatives, CHSRF envisaged a national dialogue centered on Canadian primary healthcare innovation. A national steering committee of recognized leaders conducted an assessment uncovering 120 primary healthcare innovations, 47 which were showcased at the Picking up the Pace (PUP): How to accelerate change in primary healthcare conference.

Results:
Held November 2010 in Montreal, PUP attracted over three hundred policy-makers, healthcare managers and clinicians engaged in a dialogue aimed at mobilizing positive change in primary healthcare. Preliminary evaluative results demonstrate that PUP’s unique approach resonates with health leaders and serves as a catalyst for change. Two main types of innovation are prominent in primary healthcare: those arising from the “trenches,” and those deployed at the provincial/territorial level (a top-down approach). In both cases, innovations arise from leaders who serve as change entrepreneurs. In addition, facilitators and barriers include governance and resource generation strategies (including personnel, facilities and knowledge), payment mechanisms and care provision models.

Discussion:
Provincial and territorial governments are looking at home and abroad for models that effectively integrate services across a continuum of care that is increasingly delivered outside the hospital. Innovation in primary health care is an important attribute of high-performance and systems. This presentation will provide an overview of primary healthcare, the PUP model, evaluative results, with special attention to the Quebec context.
FUTURE HEALTHCARE SCENARIOS AS A TOOL FOR POLICY-MAKERS: A REGIONAL EXAMPLE FROM THE NETHERLANDS

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Context:
Healthcare systems are facing multiple challenges due to several developments that may influence healthcare demand and supply. To maintain a sustainable healthcare system preventive measures need to be taken. This research focuses on the development of regional healthcare demand and supply in Noord-Brabant (population 2.4mln) until 2025 and possible solutions for a more efficient healthcare system. Future healthcare scenarios are an important tool in identifying these possible developments and its consequences for demand and supply.

Methods:
A literature review and statistical data analysis were conducted to collect data on current regional and national healthcare situation. Furthermore, four possible future healthcare scenarios were developed. A conference was organized to present the preliminary results to a preselected group of key players in Dutch healthcare. Also, the future healthcare scenarios were presented to and further explored by the group. Additional in-depth interviews were held with some participants to gain further insight into existing issues in the healthcare field.

Results:
In the last decades life expectancy in the Netherlands has increased with more than two years. While these additional life-years are generally spent in good health the increase of the ageing population has led to a rise in multimorbidity. With the continuing rise of the elderly the situation will likely worsen. This will certainly be the case in Noord-Brabant, for its population is older than average. Four future healthcare scenarios were developed based on two uncertainties: extent of supply regulation and general economic situation.

Discussion:
Scenarios should be used as a method to think outside the box rather than making predictions regarding certain topics. In this research scenarios for future healthcare were used to identify possible developments and its consequences for demand and supply. The process of scenario development has resulted in useful knowledge transfer between researchers and multiple stakeholders in healthcare, regionally and nationally. This may lead to a better understanding of existing healthcare issues and may enable a fruitful collaboration in developing policies for future healthcare issues.
GOOD MANAGING IN HEALTHCARE: THE INTEGRATION OF DIFFERENT VALUES

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Context:
Since the introduction of client based financing in the Dutch care sector, care providers no longer receive an average compensation for every client, but only get paid for the hours of care that are delivered. This new system of output finance is expected to give managers incentives to provide more affordable and client centered care. However, managers at team and unit level experience tensions between these values. By looking into the local practices of managers, light is shed on the way managers actually deal with these tensions and come up with situated solutions to integrate these two values.

Methods:
Qualitative, semi-structured interviews were conducted with 16 healthcare managers that work at unit or location level in different Dutch care organizations. In addition to operational healthcare managers, three higher managers, a personnel official and a team coordinator were interviewed to provide additional insights. All interviews were fully transcribed and coded inductively.

Results:
Since the introduction of the new financing system, managers felt considerable tensions between the values of affordability and client centeredness, which they often framed in terms of dilemmas. In order to solve these perceived dilemmas different modes of dealing with tensions were developed: 1) balancing values individually and collectively, 2) temporarily prioritizing one value over the other, 3) establishing compromises between values and 4) making healthcare workers responsible for balancing different values.

Discussion:
In public debates in the Netherlands (semi) public managers, such as healthcare managers, are frequently portrayed as single-minded actors who predominantly focus on the values of efficiency and effectiveness. This study shows that healthcare managers are quite the opposite of single minded actors, that in fact the daily groping for good healthcare management often concerns dealing with tensions between different values, such as client centeredness and affordability. These different values can be seen as varieties of goodness which have to be integrated in order to provide good healthcare management.
COST CONTAINMENT POLICIES AND LACK OF INTEGRATION BETWEEN PUBLIC DECISION MAKERS: PHARMACEUTICAL FIRMS’ ORGANIZATIONAL ANSWER FOR MARKET ACCESS

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Context:
Italy has a population size of over 58 million, with a growing proportion over age 65 and an increasing weight of chronic diseases. For the National Health Service, increased demand translates to additional financial strain. To face growing expenditure, policymakers have reseonsibilized regions for deficits, and increased the level of regulation, resulting in the proliferation of public actors relevant to pharmaceutical policy.

Methods:
This study analyses pharmaceutical companies’ market access and their organizational responses to the change of the environmental context.
The organizational response, surveyed among companies, is interpreted in terms of: (1) function(s) creation – or integration – for Market Access, (2) the perception of the principal factors that can positively/negatively condition Market Access and (3) of instruments created to favor market access.

Results:
No consensus emerges on the definition of Market Access activity, and organizational answers from firms considerably vary.
Less variability has been found in the analysis of the context. On average, patients associations and the scientific community positively influence Market Access. In general, respondents assigned a negative influence to the regional public institutions, where technical organs (therapeutic commissions) and health professionals (together with clinics), play a relevant role in determining market access. Problems arise because regions are independent and pharmaceutical policies, as well as different policymakers’ objectives conflict with a national strategy of firms.

Discussion:
Regionalization and increasing regulation in the pharmaceutical market have not been associated to coordination mechanisms to ensure integration between public decision makers. This results in increasing barriers to market access for pharmaceutical companies. Their organizational reaction and perceptions about barrier-factors are of the greatest interest in order to underline that cost-containment should not be the unique common aspect of pharmaceutical policies.
HEALTHY AGEING IN BULGARIAN_REGIONS – OPPORTUNITIES AND CHALLENGE

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Context: The processes of population ageing are typical for the countries of the EU and particularly typical for Bulgaria. In 1950 the group of the young people amounted to 27% of the whole population; the group of 15-59 aged–63%; and 60+ aged–10%. Fifty years later the proportions are: 17%(15-15);58%(15-59);25(60+). Their incomes are very low to assure their health and social well-being. This is one of the most important challenges in Bulgaria.

Methods: Authors study the dynamics of population changes in the six Bulgarian regions during a 5 years period (2004 - 2009) as well as the growth and the decrease of the GDP. They explore the access of the population over working age to care. The organization of social and economic care for elderly people is also analyzed. Methods: documental analysis, statistical analysis, comparative analysis.

Results: Bulgaria is divided into 6 regions: northwestern, north central, northeastern, southwestern, south central and southeastern. The share of people aged over 60 years in Bulgaria is 24,27%, 65+ are 17.53%. For a five year period we notice an increase of their absolute number as well as the relative share. Special attention should be paid to people aged over 80, since they significantly increase the degree of dependence, the need of health and social care.

The distribution of the GDP and the population is unequal in the six regions of Bulgaria. Interdependence between life standard, level of education and health status is found out. The ageing process is most manifested in the Northwestern region.

Discussion: The ageing of population is seen as one of the major challenges to the Bulgarian society and economy. Bulgaria converts into the group of countries with demographic model “old population”. The natural growth is negative. The consequences of ageing are multiple, and include economic and social aspects. The social results affect family structures, living arrangements, behaviour and attitudes, relations between generations, health and other. The economic consequences of ageing are associated with the higher cost to society of supporting the elderly. The aging population phenomenon is offering us a new setting in which we have to realise and benefit from the full potential of older people.
THE MANAGEMENT OF MULTICULTURAL TEAMS – OPPORTUNITIES AND CHALLENGES IN RETIREMENT HOMES

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Context:
Demographic and socioeconomic changes in developed countries have increased the demand for nurses in health-care institutions. As it is important to maintain a high nurse/population ratio in order to cater towards the provision of decent health care, and based on the fact that the increasing demand cannot be met through the decreasing local supply, it is necessary to hire nurses from abroad. The consequence is a cultural diversification of the nursing workforce and results in the formation of multicultural teams.

Methods:
A theoretical discussion within the field was conducted in order to set up specific hypotheses pertaining to the functioning of multicultural nursing teams. Following variables - that have been identified as challenges that multicultural teams need to overcome - are tested by well-established measurement scales: communication, cohesion, commitment, conflict, trust and discrimination. An online-based survey of 71 nurses working in Austria, Germany and Switzerland was used testing the hypotheses.

Results:
Most hypotheses proposed were rejected, only few were accepted. Results show that when commitment to the team is high, increasing levels of diversity induce decreasing levels of commitment. Furthermore, increasing team diversity is associated with increasing levels of both process and delegation conflict. When relationship conflict was low, increasing levels of team diversity were associated with increasing levels of relationship conflict. Results also indicate that when communication is effective and misunderstandings are low, increasing levels of diversity are in negative association with the overall communication outcome.

Discussion:
Utilizing the cultural difference in an organization means to see diversity as an opportunity for competitive advantage. In order to strategically prioritize diversity management initiatives in health-care institutions, it seems sensible to offer a proactive strategic approach for a systematic implementation. For a successful management of diverse human resources following competencies are needed to be developed: LEADERSHIP acting as an engine in order to foster STRUCTURAL and CULTURAL CHANGE within the organization.
WHY INNOVATION FAILS? SOCIAL IDENTITY AS BARRIER FOR INNOVATION IN THE CARE OF OLD PEOPLE

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Context:
In the industrialized countries societies are confronted with problems associated with increased expectation of life. A central challenge is to guarantee excellent and affordable eldercare. A discussion is needed how innovative applications and new services in the day-to-day care of old people may be implemented. Often, innovation itself derives from individuals who work in encouraging environments. How to attract and keep people innovative and improve their skills, are key questions of leaders.

Methods:
We asked 35 nurses, leaders and followers, of different residential homes for the elderly in the region Tyrol, Austria, in form of oral interviews about their experiences, attitudes, wishes and needs concerning the care of elderly. The answers of the interviewed persons were analyzed by the qualitative method GABEK. It is a tool for analyzing textual qualitative data and based on the Theory of Wahrnehmungsgestalten (perceptive appearances).

Results:
The results identify a connection between the social identity of nurses and their level of innovative thinking and behavior. The lack of professionalism with regard to innovation in the eldercare bases on their defined roles and activities that are characterized by a narrow set of responsibilities and tasks.

Discussion:
Social Identity Theory supports the process to understand the impact of group identification on personal behavior and confirms that certain behavior of nurses affect the quality of patient care. Changes and improvements in the care of old people can only be guaranteed if the nurses start to redefine their role models as nurses to overcome old traditions and role models. Furthermore, the profession is characterized by unattractive working conditions (e.g. working hours, payment, reputation). As consequence human resources in the care of elderly are rare. This is a further challenge in the implementation of an innovative driven culture that encourage employees to improve the quality of patient care.
LOGISTICS MANAGEMENT OF THE INTEGRATED HOME CARE SERVICE: WHICH IS THE MOST EFFICIENT DISTRIBUTIVE MODEL?

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Context:
The shift of the healthcare focus from the hospital towards the local and domicile levels (Integrated Home Care Service) can be mentioned as one of the most relevant evolutionary trends in the world healthcare sector (Longo, 1999; Profili and Sammara, 1999; Jacobs, 2001). The shift of the disease treatment focus towards the local and domicile levels has not been considered yet in an independent research stream. Objective of the project herein presented is to identify the most efficient managerial-distributive model for medical equipment, pharmaceuticals, oxygen therapy and parenteral nutrition.

Methods:
An analysis of the delivery models used within the Italian health care system was performed through an extended literature review and structured interviews with professionals working within institutions placed at different levels of the distribution chain in two Italian regions (5 LHAs, 3 intermediate distributors, 3 Pharmacies, 3 product/services provider companies).

Results:
Eleven managerial-distribution models were identified. Strengths and weaknesses were assessed for each model. The analysis performed led to the identification of the best practice: distribution through pharmacies with different suppliers - DPDS (implemented within the LHA Vallecamonica Sebino). It proves to be accessible, it is territorial capillary, it allows a strong and effective logistics organisation and it led to a reduction of costs for the Regional Healthcare Service of 31,70% (6 months observation period).

Discussion:
The application of the logistics model of DPDS would grant a high level of flexibility within the whole system, leading to the possibility for patients/users to choose the most efficient product taking into consideration their willingness to pay. This model would be profitable to all the actors of the logistic chain and for the Regional Healthcare Service, granting a good quality of the service and savings for the payer.
IMPROVING INNOVATION CAPABILITY THROUGH EDUCATION: A STUDY OF HEALTHCARE LEADERS

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Context:
The health care sector in Sweden, as in many other countries, is facing the challenge to meet new and increasing demands, with resources that do not grow equally to the needs. To meet this challenge it is necessary to reinvent the ways of working. Previous studies show that current improvement models are contributing to short-term operational benefits, but are not developing long-term innovation capability in the organization. The purpose of this study is to investigate the possibility for leaders within a Swedish public healthcare organization to improve their personal innovation capability, as a way of finding new paths for integration.

Methods:
As part of a university course in innovation and the profound knowledge of improvement, a group of Swedish healthcare leaders carried out innovation projects. In parallel the participants reflected on their practical experiences and the development of their innovation capability in relation to the course literature. Reflections were submitted at three occasions. A content analysis was conducted on the participants’ reflections seeking to identify trends of learning outcomes over time.

Results:
The results show that the participants’ reflections develop over time. Initially their focus is mainly on gaining knowledge of the problem domain and how to implement their pet solutions, regardless of the value for the patients or the organization. Over time the approach becomes more critical and reframing of the problem is not uncommon. Participants actively seek to test their ideas and some ideas are even rejected or put on hold. Furthermore, the value of involving patients and different stakeholders in testing and execution becomes more obvious for many of the participants. In the last report some of the participants are experiencing organizational resistance.

Discussion:
The shift from a focus on pet solutions to a more critical approach towards ideas and problem framing, indicate that the leaders develop their innovation capability. The upcoming organizational resistance suggests that the possibility to utilize the personal innovation capability is dependent on the organizational context and the climate for embracing new and innovative ways of working. For the purpose of reinventing the system it is not enough to develop the personal innovation capability.
THE MISSING LINK. PROMOTING SECTOR-INTEGRATION BY COOPERATIVE FUNDING IN AUSTRIA’S HEALTH CARE

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Context:
Austria’s health care shows high fragmentation and constraint of innovations with organizational boundaries. During the health system reform 2005, federal health platforms with so-called reform pools were established as the first step to cooperative funding of health care. These pooled budgets aim at enhancing innovative projects, especially health care integration, which should lead to higher system efficiency and effectiveness.

Methods:
Reform pools enhance structural changes or projects with macro-economic benefits for the health care system. Projects of service “out- or insourcing”, cooperative funding of outpatient care, and integrated health care aim at shifting care between the in- and the outpatient health sector in order to enhance system effectiveness and efficiency. Implemented projects correlate with main target fields of health system performance: accessibility, effectiveness, efficiency, equity and patient focus. The authors rate the integration potential of reform pool projects by setting up an assessment framework of their impact on health system target fields and their level of innovation.

Results:
Results show that radical innovations have the highest impact on performance and thus the integration of sectors. Evaluation of one of the biggest projects implemented gives certain validation of the results drawn from the framework, but for other reform pool projects faces restrictions in information value, concentrating on care quality, cooperation and cost savings merely. No correlation was found between the amount of financial resources approved and the level of innovation, so radical innovations seem to be feasible with lower funds, too.

Discussion:
Reform pool budgets could enable extensive improvements of the Austrian health care system, but as funds are virtual, they illustrate upper limits with no utilization obligations. Budgets have to be reserved from health care spending, so that federal states and social health insurance lack of funds for the usual health care delivery. Although radical projects enable sector integration, pilot phases tend to be prolonged rather than long-term financing negotiated. Results of the framework could contribute to long-term pooled budgets, but have to be confirmed with further evaluations in practice.
THE CHEUAL BREAST CANCER MODEL: INTERACTIVE COST-UTILITY ANALYSIS TO SUPPORT DECISION MAKING

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Context:
The CHEUAL Breast Cancer (BC) Model is an interactive cost-utility analysis simulation model that allows the calculation of direct costs, long-term health outcomes for patients, incremental cost-utility rate and budget impact analysis of new therapeutically interventions in BC, in real time. This model can be used in clinical, hospital’s formulary drug inclusion and reimbursement decision-making, turning easier the work of these professionals.

Methods:
We focus on secondary data collection from clinical, epidemiological, and health economic research studies, of scientific journals (through B-On database); as well as from demographical and economic Portuguese data, provided by the National Institute of Statistics and Ministry of Health Reports, to construct and validate the model (empirical study). It was internally validated by univariate and probabilistic sensitivity analysis (Monte Carlo Simulation). External validation was also achieved.

Results:
Our model was considered valid. It is composed of 5 input variables (patient number, new treatment patterns, clinical data (history of disease, patient age, tumor and size, lymphatic nodes affected, and diagnosis related group), country heath or BC budget and study perspective (Ministry of Health or Hospital)); and of 7 data processor variables (currently used treatment patterns; transition probabilities to the next disease level (disease and therapy adverse complication probabilities, dying probability related or not to BC), CU data (direct costs, utilities, country discount rate), BC incidence and prevalence data and female population number, model cycle length and time horizon of the study)). A Markov Cohort Simulation Model was used to compute the variables and reach the overall algorithm.

Discussion:
Our goals had been achieved. However we have considerable study limitations due to data scarcity in Portugal. Our major contribution is the construct and validation of a model that allows a more efficient management of BC treatment strategies that are good value for money in a transparent, credible and efficient way. On the other hand, we present a model that can be easily worldwide adapted, providing a useful tool in the allocation of an increasingly scarce health resources decision-making and thought, supplying an easy way to reduce the global burden with BC.
DEVELOPING LEADERSHIP IN HEALTHCARE BY EXPERIENTIAL LEARNING

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Context:
The healthcare sector is known for constant and rapid change, highlighting the need for strong leadership skills. As leadership can hardly be developed by theoretical input, a scenario close to a real life simulation was developed where students could practically experience a leading role in healthcare. In experiential learning (Kolb, 1984) immediate personal experience is the focal point for learning. It is described as a cyclic process that integrates immediate experience, reflection, abstract conceptualization and action.

Methods:
During a whole semester each of the 26 students took over the role of a relevant stakeholder in a project on cross-border care. The members of the consulting team had the task to develop a concept on a new cross-border health care system for a European cross-border region including details on financial structure, hospital structure, process of implementation and more. Besides intermediate presentation at certain dates, social media (Facebook, Twitter, Blogs) was used to influence opinion making. To assess a potential change in students’ self-assessment of leadership skills, the Revised Self-leadership Questionnaire (RSLQ; Houghton, 2002) was administered before the start and at the end of the real life simulation.

Results:
At the end of the semester, students presented the final results of the project in a final symposium to key stakeholders in the field of health care. The final report stated that special attention needs to be allocated to the interaction of different financing systems, language differences and the safe exchange of patient information. In the leadership evaluation students’ overall scores in the RSLQ were significantly higher at the end of the project compared to the start. Analyzing the results on the single dimensions showed a significant increase in behavior-focused strategies at the project end compared to the kick-off.

Discussion:
The real life simulation on cross-border care has shown how concepts of experience-based and blended learning can be successfully integrated into health care education. Although the results of the leadership evaluation suggest that students’ experiences in the project may have positively influenced their self-leadership, further research will be conducted to strengthen the results.
CALL CENTRE CLINIC: AN INNOVATIVE MODEL FOR THE INTEGRATION OF TREATMENT IN THE HOSPITAL/TERRITORY

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Context:
The progressive aging of the population and the growing incidence of chronic degenerative diseases produce the necessity to design organisational models to ensure continuity of treatments and care (Scaccabarozzi et al., Lombardia Region, 2007), protected resignations and a true Hospital/Territory integration. This resulted in the implementation of a Call Centre Clinic (CCC) of continual multi-specialist care for Internal Medicine by the Hospital Authority Ospedale Civile Legnano.

Methods:
The principal objectives of the clinic are to support the protected resignation of patients with chronic degenerative diseases, to ensure continuity of treatment, reduction of repeated hospital admissions, improvement of patient satisfaction, increased sharing of care planning and reduction of costs. Between September and December 2010 there were 759 health services provided and 93 evaluations of patients.

Results:
The study demonstrates the advantage of outpatient and telephone management which, by not increasing management costs, ensures a direct assessment of the patient. The efficacy results obtained from the tests of the CCC have proved significantly higher with respect to similar data derived from analyses relating to heart failure and other referenced diseases, showing a percentage of re-admissions within 30 days, for the same diagnosis on the total patients taken in care, equal to 11%, (for heart failure 15% in Valley et al. 2004, 17.4% in Anselmino et al. 2005, 18% in Reitsma et al. 1996, 49% in Feldman et al. 2001).

Discussion:
The testing of the CCC is an important attempt to validate for the Neurological and Internal Medicine areas, permitting over and above improvements in terms of effectiveness, and also the rating of the service. In a rating scale of 1 to 7, it is shown a mean score of overall rating equal to 6.31 with a patients/ family members/care givers satisfaction level equal to 6.50 for the information received and the ability to involve family members.
ECONOMIC ASPECTS OF NURSING IN INPATIENT NATUROPATHY – EVIDENCE FROM GERMANY

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Context:
The aim of the present study is to present the general situation of inpatient naturopathy in Germany and to analyse from an economic point of view the nursing costs incurred by naturopathy in an acute inpatient setting in comparison with the costs incurred by conservative care. This was done by means of a randomised, controlled study.
The DRG “F62C Heart failure and shock without severe co-morbidity or complications (CC) in multi-morbid patients” was analysed.

Methods:
A total of 106 patients were selected at random. An extensive costs analysis was performed for these patients in order to determine the costs of the nursing. These costs (measured in euros) and the duration of the patients’ hospitalisation were compared with data from over 250 hospitals in the entire Federal Republic which offer only conventional medical treatment.

Results:
The aim of the present study is an analysis of the nursing costs for inpatient care of multi-morbid patients, with particular focus on a holistic, comprehensive treatment.
It is found that the nursing costs in an inpatient acute hospital with naturopathic focus are significantly higher than the nursing costs in hospitals operating exclusively according to conventional medicine.

Discussion:
This could be because the care in naturopathic hospitals fulfills the task of co-treating accompanying diseases efficiently and considers the multi-morbid patient with his/her complex ailment in a holistic way. Therapeutic methods from different therapeutic areas are used as appropriate for the indication. It is found that, measured in therapy time, the therapeutic nursing efforts are also reflected in higher costs. The period of hospitalisation for heart failure patients receiving naturopathic treatment is also significantly longer than that for those treated using purely conventional methods. Further studies are intended to investigate the effectiveness of inpatient naturopathic procedures on the patient’s state of health.
BUILDING INTEGRATED SERVICES DELIVERY (ISD) IN FRANCE REQUIRED A HIGH LEVEL OF INSTITUTIONAL PARTNERSHIP

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Context:
The implementation of ISD PRISMA model for older people was investigated in France during the 2006-2010 period. One of the principle components of the model is to implement advisory boards at institutional, organisational and professional levels to implement a new co-responsible decision-making framework.
The French public authorities’ fragmentation represented one of the first barriers identified in the implementation study. We have characterized the modalities of institutional partnerships and analyzed the influence of these modalities on the ISD implementation.

Methods:
The PRISMA France study followed 3 pilot-projects deliberately contrasted in terms of the local health and social care services organization and demography. This contrast was aimed to make a comparative and overall analysis. We used a qualitative method approach. It relied on semi-structured interviews with all actors at all level, observations during meetings and official documentation collection. The analytical framework of the sociology of public action was used.

Results:
Whatever the pilot-project, the ISD implementation was incomplete. Building of an institutional partnership was complex.
The different modalities of institutional partnerships documented allowed us to draw 5 essential conditions for its implementation:
1. The necessity of moving from an external or experimental framework to a common project framework.
2. The balance institutional decision-making power between State administrations and local authorities.
3. The institutional partnership has to communicate explicitly and establish incentives for the collaboration at the organizational level.
4. A person dedicated over time to make the link between the institutional and organizational advisory boards.
5. A long run perspective.

Discussion:
Literature on ISD insists on taking into account the local context. Our study documents that whatever the much contrasted local context, building ISD in France required firstly common conditions that rely on institutional partnership. In view of the PRISMA-France results, a larger experimentation was launched as part of the 2008-2012 French Alzheimer Plan, using the same ISD model: the Homes for Autonomy and Integration of Alzheimer Patients.
TREATMENT COSTS AND PRODUCTIVITY LOSSES CAUSED BY TRAUMATIC BRAIN INJURIES

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Context:  
Brain injuries require tertiary level hospital treatment. Brain injuries are often followed by early retirement. The aim of this study was to estimate the direct tertiary hospital treatment costs, and the productivity losses due to early retirement caused by traumatic brain injuries.

Methods:  
A random sample of 155 patients admitted to Turku University Hospital due to traumatic brain injury was sent a questionnaire to determine any resulting early retirement and detailed treatment history and clinical data were obtained from patient records. The cost estimates for the treatment procedures, hospitalization days and visits to outpatient clinics were based on the actual costs incurred. Loss of productivity estimates were based on two schemes: 1) patients were assumed to have worked until age 65 years without brain injury, and the productivity losses due to early retirement were calculated for patients who left the workforce early, and 2) same as scheme 1) but retirement probability was adjusted by age- and sex-specific probability of early retirement among Finnish employees.

Results:  
Average treatment costs per patient in a tertiary hospital were €9,295, (surgery €1,610 and other costs €7,685). Treatment costs for severe brain injuries were significantly (p < 0.001) higher (€16,021) than for less severe cases (€7,060). Length of follow-up time was not correlated with treatment costs. Based on the incidence of new traumatic brain injuries in Finland, annual tertiary hospital treatment costs are approximately €50 million. Production losses due to early retirement were estimated to be €810,482, varying between €560,381 and €849,604, per retired depending on the severity of brain injury and estimation scheme. Annual nationwide productivity loss estimates varied between €470 and 760 million, depending on the estimation scheme.

Discussion:  
The cost of lost productivity arising from early retirement due to traumatic brain injury far outweighs the direct medical costs of treatment. The cost estimates presented here are conservative as they do not include the cost of reduced productivity in patients who remain in the active workforce or care from providers not in a tertiary hospital setting.
INTEGRATING CLINICAL LEADERSHIP DEVELOPMENT WITH SERVICE IMPROVEMENT: A CASE STUDY OF AN ENGLISH NHS TRUST

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Context:
In the UK improving clinical leadership is at the heart of the NHS Next Stage Review. This research project focused on creating a structured leadership development programme for senior clinicians at a large teaching hospital in the North of England. The aim was to upskill Clinical Directors and embed their learning by supporting them in planning and leading a local service improvement project.

Methods:
Fieldwork was conducted in two stages with both quantitative and qualitative methods employed. Initially self-assessment questionnaires were completed by a sample of Clinical Directors and case study visits to other NHS Trusts were undertaken. The data and information collected was used to design a bespoke leadership development programme for Clinical Directors. On completion of the programme Clinical Directors and Directorate Managers were interviewed to assess the impact of the intervention.

Results:
This research suggests that a well-planned leadership development programme can deliver positive benefits for both individual clinicians and healthcare organisations. Clinical Directors and Directorate Managers report that the programme has: enhanced leadership skills and capabilities; promoted more effective partnership working between doctors and managers; and generated enthusiasm and commitment for service improvement projects.

Discussion:
This case shows that focused clinical leadership programmes can yield results. Evidence suggests that participating Clinical Directors are now more empowered, better informed, and increasingly accountable members of the directorate management team. Furthermore, linking leadership training with the planning of service improvement projects represents a deliberate attempt to embed Clinical Directors’ learning, to foster partnership working, and to encourage entrepreneurialism and innovation. However, in times of austerity a key challenge for organisations will be to find the resources to sustain this type of training and development initiative. It is also clear that to increase clinical interest in leadership activity, decision-making powers and processes in healthcare organisations need to be devolved and made even more inclusive.
DEVELOPING AN ENGAGEMENT THEORY FOR BOARDS IN THE NON PROFIT SECTOR

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Context:
This study seeks to understand the relevance of corporate governance theories to the non-profit sector and to relate this to a case study of board governance in hospices in the UK, a sector with an annual turnover of 800 million euros. The study is predicated on the need, at an organisation level, for board leadership skills and behaviours which are conducive to the integration of nonprofit organisations with their communities and their local health economies.

Methods:
Three methods were used: a selective literature review, an emailed survey questionnaire, and focus groups/depth interviews. Quantitative data (n = 232) from the questionnaires was analysed by examining frequency and cross-tabulation tables, together with bivariate correlations. Qualitative material was subjected to content analysis, and coding and categorising of themes.

Results:
The selective literature review identified a lack of clarity about which aspects of the main governance theories and frameworks have the most utility for the non-profit sector. The empirical study provided evidence of the existence in the UK hospice movement of a range of levels of organisation maturity, structures, processes and behaviours. It confirms findings that effective corporate governance is highly context dependent. Self-reported focus on board tasks relating to setting organisation direction and promulgation of organisation values was strong, and was relatively weaker in the areas of strategy development and in monitoring of clinical performance.

Discussion:
The findings indicate board focus & board behaviours which are related more closely to stewardship and stakeholder theories of corporate governance than to agency theory, although, paradoxically, the board composition of these non-profit bodies reflects an agency model. The boards in this case study all indicate an orientation to integration with local communities and with local health and social care economies. The findings point to the desirability of a re-conceptualisation of corporate governance theory in non-profit organisations, provisionally named ‘engagement theory’, which can embed a triadic proposition of high engagement within a climate of high trust & high challenge. This has implications for how trustees on the boards of non-profit organisations may wish to enact their role.
THE REFORM OF OUT-PATIENT HEALTH CARE DELIVERY IN BULGARIA – DOES IT PROVIDE FOR INTEGRATION OF CARE FOR CARDIOVASCULAR CONDITIONS?


Context:
One of the main scopes of the health reform in Bulgaria was the restructuring of the out-patient health care delivery system, in order to improve effectiveness, enhance quality and performance. The general practitioner (GP) figure was introduced to provide primary care for chronic patients (e.g. cardiovascular diseases) and the polyclinics were restructured in specialized diagnostic consultative centers. Standards for inpatient management of cardiovascular diseases were implemented, but outpatient guidelines are still lacking.

Methods:
The aim is to explore whether the change of the out-patient health delivery structure in Bulgaria supports the integration of care for chronic cardiovascular diseases. We performed a meta-analysis of previous own researches of the therapeutic treatment of 723 197 cardiovascular patients, in order to assess the quality and continuity of care, patient satisfaction and access to care.

Results:
The analysis revealed poor control over the main risk factors for cardiovascular diseases: 43.55 % of all patients suffered from hypercholesterolemia; 26.57% of the patients demonstrated decompensated heart insufficiency. The share of the mono therapies with high medication dosages in Bulgaria was twice as high as compared to the EU practice. In 27.14% of the double-therapy and 59.46% of the triple therapy cases there was non-adherence to the ESC guidelines. The patient satisfaction survey revealed that only 31.40% found improvements in the quality of out-patient care, 34% thought that access to care was enhanced, and 41.70% - that access to out-patient specialists was improved.

Discussion:
The reform in the out-patient health care delivery did not fully achieve its priory set goals. The quality and continuity of care are poor, resulting in increased cardiovascular hospitalization levels and high mortality rates. Future reforms should be directed towards implementing national out-patient cardiovascular guidelines and replacing the capitation reimbursement with pay-for-performance models.
OVERHOSPITALIZATION – A KEY ISSUE IN HOSPITAL MANAGEMENT IN BULGARIA


Context:
Ten years after the launch of the inpatient reform, the hospital system in Bulgaria still faces many shortcomings. The existing infrastructure is outdated and highly exceeds the needs of the society. Hospital performance is still unsatisfactory with regards to quality of care, effectiveness and containing inpatient expenditures. There is a clear tendency of increasing rate of hospitalization episodes, which constitutes one of the key reasons for steady increase in hospital expenses. The aim of this study is to analyze the reasons and the trends in hospitalization patterns in Bulgaria.

Methods:
The analyses encompass performance and statistical indicators of hospitals in Bulgaria for the period 2000-2007. Data is derived from the Annual reports of the National Health Insurance Fund in Bulgaria and the Annual statistical reports of the Bulgarian Institute of Statistics.

Results:
The analysis revealed that the average hospitalization rate in Bulgaria is 22 patients/per annum per 100 inhabitants (16 pts in the EU) and there is an annual increase of 26%. The main diagnoses for hospital admission are bronchopneumonia and heart failure. In 2007, 612,103 patients were hospitalized via the emergency units without referral, which constitutes 49.3% of all hospitalization episodes for the year. Only 65.5% of all Bulgarian patients for the period 2000-2007 received treatment in primary care facilities, as compared to over 80% in other EU countries.

Discussion:
The analysis reveals that the over hospitalization trend in Bulgaria is due to induced demand from the providers, the existing incentives to increase volume by reporting inexistent activities or up-coding diagnoses, the opportunity to transfer patients among wards, the inefficiency of the referral system and the increasing rate of self-referrals from medical specialists who work in both outpatient and inpatient establishments. These shortcomings have lead to deteriorating quality of inpatient care, high rates of avoidable mortality, and increased hospital mortality. Future reforms should be directed towards applying mechanisms for performance-based competition and a hospital reimbursement system based on quality.
THE EFFECT OF PROFESSIONAL NETWORKS ON THE DIFFUSION OF A ROBOTIC SURGICAL SYSTEM: AN EMPIRICAL STUDY

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Context:
Medical technologies represent a relevant component of healthcare costs. Literature showed that organizational and professional factors play role for fully understand patterns of technologies diffusion, but there is still a scant of knowledge on how they influence the adoption. Our study attempt to understand how inter-physician relations affect the adoption of a robotic surgical system.

Methods:
We performed a systematic literature review to identify the interventions for which the system was used. We sampled potentially adopters within the Italian National Health Service. A sociometric questionnaire was submitted to medical directors, allowing us to gather data on attributional characteristics, first and current degree of utilization, perceived determinants of the adoption and professional social networks. 40 physicians provided full answers. Descriptive statistics and social network analysis techniques were used to analyze the inter-physician networks and the patterns of diffusion.

Results:
Our findings indicate that professional network plays a major role for technology adoption and diffusion. The first adoption was influenced by “word of mouth” and clinicians make wide use of scientific articles to decide about technology adoption, suggesting their attitude towards evidence-based medicine. The level of adoption is significantly correlated to the ties with both colleagues and other figures. Our analysis shows the presence of opinion leaders and the high variability for what concern the year of first adoption and patterns of diffusion.

Discussion:
Our paper provides contribution to the healthcare management literature. Firstly, we highlight that integration should enhance the diffusion of innovation within healthcare organizations, while other approaches usually consider emerging technologies as a facilitating factor in the integration of knowledge and skills. Secondly, policy makers and hospital administrators may easily identify opinion leaders, implementing strategies aimed at favoring the subsequent diffusion of certain technologies or, in sharp contrast, to hinder the adoption of those devises whose effectiveness appears questionable.