Preface

Dear participants,

Welcome to Vienna, the world capital of integrated care from 3 to 6 November 2009. During this 9th Annual Conference on Integrated Care we discuss the theme: Lost in Transition: Meeting the challenge through Integrated Care. Many aspects are on the agenda: the patients' view on integrated care and their improvement in health; the management and financing of integrated care; the definitions used in policy and scientific papers; the approaches, methods and tools used in integrated care and their efficacy (e.g. clinical guidelines and other decision support tools, case/care management, chronic illness management, e-health; the implementation of integrated care models and strategies in practice, including challenges and lessons learned;

The aim of the conference is the same as in the previous eight conferences: to bring together researchers, policy makers and practitioners interested in transmural cooperation and coordination between different providers of health and social care in order to exchange knowledge and experiences and to generate new ideas, new research and new projects on integrated care.

Integrated care has become a widespread concept across health systems and countries in response to the common challenges of the 21st century: an ageing society, chronic disease and multi-morbidity. Countless projects and a great variety of models have been developed over the past years to overcome systemic, professional and cultural barriers in order to smooth out patient pathways and information flow. Of course this does not come without frictions and abrasions and even when integration projects have proven to be a success obstacles remain to be solved, such as managing the change and sustaining innovations.

One aspect has especially been as much in the centre of attention as left on the sidelines of the model: the question of transition. Transitional care can be thought of in at least two important ways: the actions of service providers designed to provide coordination and continuity as the patient/client moves between different levels and types of acute and post-acute care, including the hospital, nursing home, and in-home care; and two gap-bridging services provided to patients and families as they transition from illness to wellness and from dependence to self-care. Hence, the management of transitions is a building block without which sustainable integrated care models are not feasible. As these topics are of paramount importance when organising care for the frail elderly and terminally ill, special attention shall be paid to the needs of these vulnerable groups.

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