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Conference proceedings

Lost in transition—meeting the challenge through integrated care. Highlights from the 9th International Conference on Integrated Care in Vienna

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Key data

The 9th International Conference on Integrated Care (INIC09) brought over 160 researchers, policy-makers, managers and practitioners from 22 countries to Vienna, Austria, on the 5th and 6th of November 2009. The INIC09 provided a platform to exchange experiences, share knowledge and discuss ideas during the sessions as well as in the leisure time. Overall, the conference offered three key note speeches and four parallel sessions with 54 paper presentations and 19 posters discussed in five different streams and three themes.

Background

The Medical University Vienna was first asked by representatives of the International Network of Integrated Care (INIC) during the INIC08 in Gothenburg whether they would be interested in organising the next conference. After some discussions and further clarifications on the timeframe and resources they happily accepted the invitation. The annual conferences of INIC are unique in the sense that they bring together theory and practice from all over the world to discuss and develop integrated care. With the first decade of the conferences closing in, the International Network of Integrated Care, together with the local organisers, is starting to bring more acuity into the topics and continuity into the timeline. From INIC09 onwards, it is intended to already find host countries two years in advance to give the organisers and the network more time to plan and promote the events. In addition, the idea is also to provide the host country with an opportunity to promote the concept in their own country as well as show the world their understanding of integrated care (see Table 1).

Table 1. INIC annual conferences, 2000 to 2010

Year	Location
2000	Almere, Netherlands
2001	Maastricht, Netherlands
2002	Strasbourg, France
2003	Barcelona, Spain
2004	Birmingham, UK
2005	Dublin, Ireland
2006	London, UK
2008	Gothenburg, Sweden
2009	Vienna, Austria
2010	Tampere, Finland

Conference aims

Integrated care has become a wide-spread concept across health systems and countries in response to the common challenges of the 21st century: an ageing society, chronic disease and multi-morbidity. Countless projects and a great variety of models have been developed over the past years to overcome systemic, professional and cultural barriers in order to smooth out patient pathways and information flow. 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. While transitions of patients (and their data) between intra- and extramural care as well as between health professions have been the focus of many projects, transitions between health and social services, from acute/chronic care to pal-

liative care or between the 'traditional' health system and an integrated care model have been neglected so far. Hence, the theme of the INIC09 has made an effort to evaluate the status quo of successful transitions, highlight challenges in the transition process and underline the necessity of active management of transition(s).

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,
- 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 must be paid to the needs of these vulnerable groups.

Conference organisation

The conference was organized by the *Institute of Social Medicine at the Center for Public Health of the Medical University Vienna* together with the *Julius Centre for Health Sciences and Primary Care of the University Medical Center Utrecht* and the *International Network of Integrated Care*.

The Organising Committee and its duties were split between Vienna and Utrecht. While Utrecht was providing the homepage, taking care of the registration process and communication with participants, Vienna was responsible for the conference location, local sponsoring, communication with chairs and the contents of promotional mails, brochures, etc. as well as programme development. The people involved included:

- *Anita Rieder*, Medical University Vienna, President of INIC09
- *A.J.P. Schrijvers*, University Medical Center Utrecht, IJIC editor-in-chief, Advisor
- *Clarine Sies*, University Medical Center Utrecht, Administration, Communication and Registration
- *K. Viktoria Stein*, Medical University Vienna, Organisor and Scientific Programme Coordinator

To oversee the development of the scientific content and themes of the conference programme, including the identification of keynote speakers and the invitation and selection of abstracts and papers, a scientific committee was established a year in advance of the conference. This comprised:

- Volker Amelung, Professor of International Health Systems Research, Medical University Hanover and CEO Bundesverband Managed Care e.V.
- Nick Goodwin, PhD—Chair, International Network of Integrated Care and Senior Fellow, King's Fund, London
- Esko Hänninen, Director National Institute for Health and Welfare (THL), Finland
- Dennis L. Kodner, PhD, Director and Professor of Medicine and Gerontology, NYIT Center for Gerontology and Geriatrics, New York College of Osteopathic Medicine of New York Institute of Technology (NYIT)
- Anita Rieder, Professor of Social Medicine, Institute of Social Medicine, Center for Public Health, Medical University Vienna, Chair of the Scientific Committee
- Clarine Sies, Julius Centre for Health Sciences and Primary Care, University Medical Center Utrecht
- K. Viktoria Stein, Research Assistant, Institute of Social Medicine, Center for Public Health, Medical University Vienna

Conference programme

In order to give an insight into the different aspects of transition management and introduce the core topics of the conference, the scientific committee invited three distinguished keynote speakers to talk about the various aspects of transition management in integrated care. The scientific committee also invited open submissions by abstracts for both oral and poster presentations related to the issues and themes of the conference, which were specified as follows:

- The management of transitions between services, provider organisations, and systems for complex, multi-problems;
- Patients/clients and the challenges involved from an integrated care point of view;
- The definition and analysis of integrated care concepts and frameworks;
- 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, networking, etc.);
- The implementation of integrated care models and strategies in practice, including challenges and lessons learned;
- The unique challenges and issues related to the financing, organisation, delivery, and management of integrated services for the frail elderly and other patients/clients with chronic care or long-term care needs;

- The outcomes related to integrated care approaches on the clinical, service delivery, patient, and financial levels;
- Macro-level barriers to adopting and implementing the integrated care policies and approaches (e.g. political, economic, etc.).

The submission deadline was 22nd May 2009 and three types of papers were encouraged to correspond to the themes outlined above:

- *Research*: These presentations would provide the results, completed or in-progress, of original research projects. The material should not have been published elsewhere, except in preliminary form, and it should be ready for publication as a journal article. Papers related to PhD projects, either completed or in-progress, were especially encouraged.
- *Policy*: These papers could describe any development in policy (whether governmental, organizational, or any other) that affected the integration of care associated with the themes of the conference. Policy papers that made international comparisons were especially welcomed.
- *Practice*: These papers included projects and developments focusing on practice-oriented questions and reporting on recent experiences and innovations in integrated care. These papers required the presentation of case descriptions of integrated care on the national, regional or local level.

Those submitting abstracts could elect to present either an oral or poster presentation. Abstracts needed to be structured according to a set format, be ~200 words in length, and accompanied by the author's preference for the type of presentation. Two members of the scientific committee reviewed and rated each abstract using a standard proforma. Selection of abstracts for oral and poster presentations, as well as rejections, were then agreed by the committee. Of the 87 abstracts submitted, 57 were accepted for oral presentations (counting grouped submissions as one presentation), 20 abstracts for poster presentations and 10 abstracts were rejected. Of those invited to present oral papers, three subsequently withdrew their presentations, as did one poster submission. At this point, the scientific committee would like to thank Ingrid Mur-Veeman and Wynand Ros for their support and contributions during the review process.

Unlike the previous year [1], the submissions showed a preference for project papers but again the lack of true methodological papers was apparent. After the final selection was made, five streams were formulated to which the papers were allotted. In addition, three themes emerged to which entries had been made but which did not fit into any of the other streams. Since they were discussing important topics, such as integrating financial structures and designing adequate IT solutions, extra sessions were designated for them.

In order to give the poster presenters a more prominent role within the programme, they were also assigned to corresponding sessions, to be included in the discussions where they fit best. Staying true to the aim that the INIC conferences should also try to push integrated care to the next level, an Integrated Care Workshop was organised alongside the sessions, in order to give more room to conceptual and methodological discussions of integrated care.

The streams and themes were:

- *Stream 1*: In the Spotlight: Success Stories of Integrated Care Models in North America and Europe
- *Stream 2*: Shifting Perspectives—Who cares? Asking patients, care givers and professionals about their needs and challenges
- *Stream 3*: Untangling the Gordic Knot—Managing Transitions
- *Stream 4*: When policy meets challenge—Designing frameworks for integrated care
- *Stream 5*: Projects and Developments: Presenting international experiences
- *Theme 6*: Form follows function—Finance follows form?
- *Theme 7*: Information systems and technology—-using them as a cure not as a curse
- *Theme 8*: Physical Medicine and Rehabilitation—An entire discipline probes integrated care
- *Integrated Care Workshop*: Defining key concepts, identifying success factors, standardising the analysis of outcomes.

Revised abstracts and power-point presentations were collated after the conference to be included on the website of INIC[1] and to form the basis for the electronic publication of conference proceedings in this supplement.

Training for integration—Report from the 1st Integrated Care University "Integrated care: from theory to practice", November 3rd 2009

The concept

The idea started in discussions at various meetings of INIC and manifested itself when Vienna was asked to organise the INIC09. The organisers and the scien-

[1] www.integratedcare.org

tific committee quickly agreed to launch a pilot project entitled 'Integrated Care University' and what started out as a PhD course soon evolved into a training programme for young researchers and distinguished professionals alike with the main aim to give a comprehensive introduction into the theories, concepts and methodologies of integrated care. Nick Goodwin, Dennis Kodner and Bert Vrijhoef were asked to act as chairs and coordinate the modules. After a first revision of this concept the idea of inviting more experts and speakers to the course was dropped due to time restrictions. Since the pilot was planned as a 'one day comprehensive introductory course', Goodwin, Kodner and Vrijhoef decided to execute the lectures themselves as well. The participants were to apply to the course with a short overview of their CV, professional background and motivation, the target group being 'government decision-makers, planners, managers, practitioners, researchers, and graduate students'. Overall 24 people applied representing the whole array of experience, training and cultural backgrounds—an exciting variety not expected by the organisers and which proved to be a vital asset to the course.

The modules

The programme consisted of four modules starting with 'A Comprehensive Introduction to Integrated Care', led by Dennis Kodner. It aimed at providing a comprehensive overview of the background and concept of integrated care spanning from the definitions and perceptions, to the drivers, key features and potential benefits of integrated care for patients and managers. These insights were complemented by a presentation of some of the (lack of) evidence and building blocks for integrated care. Not surprisingly, this expansive array of topics also led to many questions and discussions with participants, especially on the effectiveness and appropriateness of integrated care measures in different settings. Given the amount of information presented, this module could probably fill a whole day on its own.

Module 2, 'Integrated Care: Teams and Organisational Structures' led by Nick Goodwin gave an insight into how integrated care can be delivered through multi-disciplinary teams and new forms of organisation. In the first half of the module, participants examined the theory and practice of multi-disciplinary partnership and team working to uncover the problems of creating 'clinical' and 'service' integration on the ground. A specific focus was put on the role of 'networks' as infrastructures to encourage integrated care. The second half of the module looked into the 'continuum' of organisational forms that can exist and provided case examples to illustrate these differences. Based on these findings, examples of which integrated care models best fit certain forms of patient care were discussed.

After the lunch break, the discussions continued around the topic 'Integrated Care: Clinical Tools and Their Application'. After providing an overview of the various approaches that are commonly used, the module focused on three key applications: protocol-based guidelines and/or pathways of care; case/care management; and chronic care management. It provided a practical insight into integrated care routines and allowed for a discussion of the pros and cons of the different tools.

Bert Vrijhoef concluded the intensive programme with Module 4, 'Integrated Care: Planning, Evaluating and Promoting Successful Programmes'. It revolved around the hot topic of how integrated care can be evaluated to understand its impact and benefit. The module began with an overview of selected evaluation studies on integrated care followed by a discussion on the quality of applied methods. The theoretical basis was then illustrated by a case study presentation on the DISMEVAL study, a study which was financed by the European Union and which assessed the evaluation of disease management.

The aftermath

The feedback from the participants was very positive and it was concluded unanimously that this course, and every module therein, was too short and a training structure for integrated care needs to be devised. It was also found that similar courses should be offered at future INIC conferences as well as on a university level. An extension of the programme would also allow for more discussion time and case study/good practice presentations. The interest in and feedback to the programme clearly demonstrates the necessity for comprehensive and structured training programmes within the field of integrated care. This would also assist in developing a common language and building awareness for the common challenges faced by the integrated care community. Hence, the initiators of the 1st Integrated Care University see the success of the pilot as a mandate to develop the idea further. Input and suggestions concerning topics, lecturers, design, locations, etc. are very welcome. A regular update on the progress is planned via the newsletter and the International Journal for Integrated Care.

Site visit day, November 4th 2009

As is tradition with the INIC conferences, they are preluded by a day of site visits. This year's focus was laid

on care for frail elderly, especially dementia patients and the challenges facing institutions and service providers concerning adequate structures and transitional management. Two different programmes were offered with two of the biggest service providers in Vienna: Option 1 was a day with Caritas Vienna, one of the biggest NPOs providing home care, integrated mobile care teams and specialised LTC for frail elderly. They are very innovative in their concepts and are currently trying different alternatives of housing for dementia patients (e.g. dementia shared apartment). Option 2 was a day with the Viennese Hospital Association, which is the umbrella organisation of all publicly owned hospitals, public health centres and LTC facilities in Vienna.

A day with Caritas Vienna

During the day with the Caritas Vienna, the group got an overview of the scale and scope of the services provided, from day care and long-term care centres to mobile, multi-disciplinary palliative and hospice teams. Caritas also served as an example of how to combine social and health services and how important a combination of both is when dealing with the vulnerable groups in society. Another aspect that was highlighted was the integration of the family and other caregivers, with their mobile teams also giving support to family physicians and community workers, if necessary and requested. A highly utilised service is the anonymous caregivers' hotline, where relatives and informal caregivers can call to ask for support, advice or merely some time to talk. In their service provision to frail elderly and people with dementia, Caritas Vienna has implemented various alternative methods, such as the Montessori concept of care and activating care, to improve the situation of their clients.

During the visit at a hospice, the group was introduced to the mobile palliative teams and mobile hospice teams. Eighty-two percent of their clients were end-stage cancer patients who receive pain management, social, psychological and emotional support from specialised doctors, nurses and trained volunteers. If the patients asked for it, the teams also included religious attendance. When care at home was not an option or at the express wish of the patients, they would be transferred to the hospice. On average, the age of these patients was 72 and the average support lasted for 70 days[2].

The final stop was at a dementia ward of a long-term care facility, where a tour was taken in two smaller groups. The ward had been newly designed, on the ground floor and separated from the rest of the inhabitants, to accommodate only stage 3 and 4 dementia patients. This measure had been taken after the management had realised that those patients needed much more specialised and extra care than could be offered in the regular LTC setting. Two common rooms were used for day time activities, one offering action such as painting, singing or therapeutic sessions; the other offered a place for those preferring more peace and quiet, with dimmed lights and music. Even though each inhabitant has an assigned room and bed, this is not abided by strictly since there is an open door policy and the inhabitants are free to walk around and lie down wherever they want. This is only one detail which had changed and one of the nurses explained that it had been a challenge to convince relatives of this concept. So far, the conclusion is that inhabitants and staff are more relaxed than before the redesign[3].

Overall, this day impressed all the guests with its many facets of mobile care and specialised care and the energy the professionals and volunteers demonstrated and left everyone with new ideas and insights to bring back home.

Viennese strategies for health and social care

Meanwhile, in a different part of town, the second group of INIC09 participants was visiting the facilities of the so-called 'Sozialmedizinisches Zentrum Süd', a universal care provider with geriatrics centre and nursing home. In Vienna, all community-held hospitals and nursing homes are brought together under the roof of the Viennese Hospital Association which is managed by the City Council. All over the city, some hospitals have been reorganised to meet the health needs of their specific neighbourhoods and renamed 'social-medical centres'. At this first location, near the main train station of Vienna, the participants got a full tour of the day care centre, nursing home, emergency unit and geriatrics ward. The different services and processes were explained and there was ample time for discussion.

In the afternoon, a similar institution was visited in another part of town. There, the participants were introduced to the integrated patient e-record which was developed to accommodate all health and social ser-

[2]Hospice care—A service of Caritas Vienna. Caritas Vienna presentation during the site visit day of the 9th International Conference on Integrated Care; 2009 November 3–6; Vienna, Austria. Available via the corresponding author.

[3]Caritas of the archdiocese of Vienna; One part of our home care services: psychosocial counselling for carers; Nursing homes. Caritas Vienna presentations during the site visit day of the 9th International Conference on Integrated Care; 2009 November 3–6; Vienna, Austria. Available via the corresponding author.

vices in the City of Vienna. Hospitals, nursing homes, mobile care providers, social workers as well as doctors have the possibility to access the e-record and fill in their parts of the patients' history. Unfortunately, this system still meets a lot of resistance from the various service providers and is not yet fully implemented. A demonstration in the geriatrics ward illustrated how the system works in practice.

As in many other systems, one of the main challenges especially with elderly patients is the revolving door effect, which in the community facilities of Vienna was solved by a stringent discharge management. The person responsible is a nurse who makes sure the patients and relatives know well in advance what will be needed back at home. As necessary, social workers, the family physician and mobile care providers are involved to ensure the adequate services and support are organised.

The last stop of this tour was the basement of the nursing home where the participants encountered the newest editions to the staff: robots which are designed to assist in delivering carts with meals, medication and similar to their designated destinations.

Conference proceedings, INIC09, November 5th–6th 2009

The official opening ceremony of the INIC09 took place in the Austria Trend Hotel Savoyen, with representatives of important stakeholders in the health and social care systems, led by the Austrian Federal Minister of Health, the President of the Austrian and Viennese Chamber of Physicians, the Vice-Chairman of the Main Association of Austrian Social Security Institutions and the CEO of VAMED AG. The panel stressed the fact that the challenges of the ageing society and the ever more complex care systems demanded new concepts and bold decisions. For Austria, the conference presented a unique opportunity to discuss these issues with international experts and receive first hand knowledge from projects and programmes around the world. The panel unanimously agreed that integrated care poses a viable concept for the Austrian health system.

Nick Goodwin inspired the audience with a short introductory speech on the international imperative of integrated care, once more underlining the potentials of the concept while at the same time pointing out the weaknesses which have to be overcome in order to realise a break through: a common understanding, sound evaluation methods and closer international cooperation are paramount to establish integrated care as a full-grown research and practice field with impact on national and international levels.

The first keynote speaker was Prof. Eric Coleman, Director of the Care Transitions Program at the University of Colorado Denver who talked about the Care Transitions Programme™. His key message was "Listen to your patients". They are the ones who know best what they need and what they lack. As examples of the current weaknesses in the system, he gave the poor preparedness of patients when transitioning between services and sectors, the inability to find the right practitioner or the conflicting advice they receive for their illness management. All in all, this leads to the very descriptive image of the 'no care zone', where patients frequently experience medication errors or medication changes [2, 3], and readmissions cause a revolving door effect [4]. For example, '[I]n the 12 months following hospitalization, two out of three patients have either been readmitted or have died [within the US Medicare system]' [4, p. 1421]. As a powerful illustration of the necessity of better care coordination he showed an enlightening figure (Figure 1) depicting the various pathways, interfaces and crossroads a patient faces after discharge from hospital [5].

However, Prof. Coleman pointed out the need for pause before praising care coordination and case management as the ultimate solution to these problems. As described in the article of Peikes et al. (2009) [6], who compared the outcomes of 15 randomised trials, so far there is little evidence or even negative results on disease management/case management and care coordination measures. Prof. Coleman also unveiled the myth that case managers were doing the bulk of care coordination—it's the family caregivers and patients themselves who do most of the work. In order to enable them to perform these tasks as best they can, the Care Transitions Intervention™ was developed by Prof. Coleman and his team. The key elements are [6]:

- Low-cost, low-intensity, adapt to different settings
- One home visit, three phone calls over 30 days
- 'Transition Coach' is the vehicle to build skills, confidence and provide tools to support self-care
  - Model behaviour for how to handle common problems
  - Reconcile pre- and post-hospital medications
  - Practice or 'role-play' next encounter or visit

It is a self care model, where "medication self management, a patient-centered record, a follow-up with the primary care physician/specialist and knowledge of red flags or warning signs and how to respond to them" [6] form the pillars of the training. The coaching programme starts in the hospital where a transition coach schedules a home visit within 30 days of release. During the personal encounters, health goals are formulated, patients are asked to formulate key

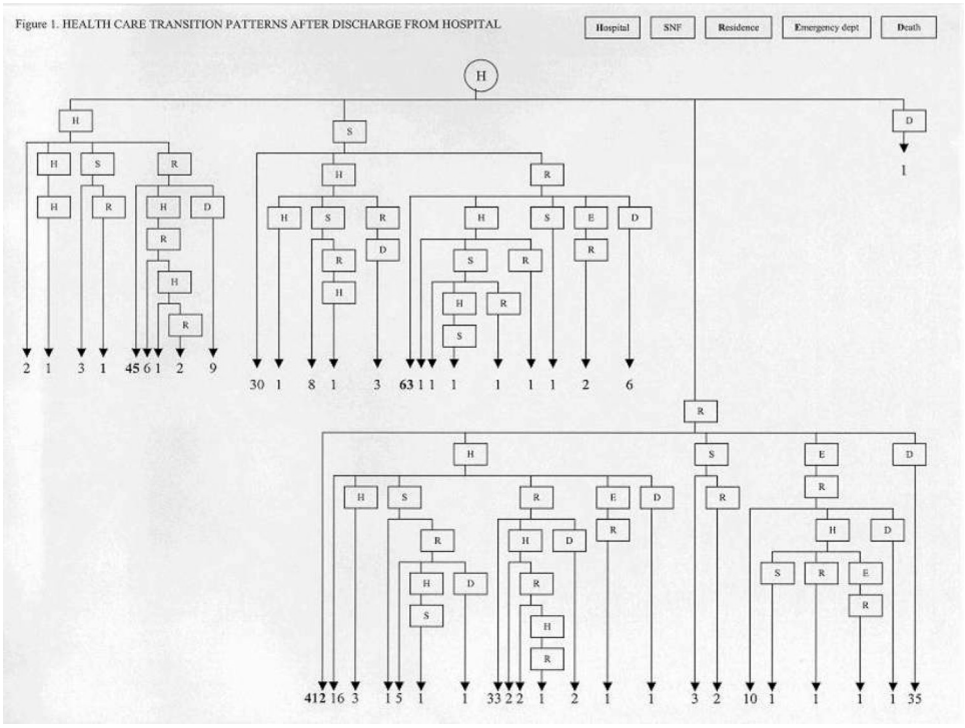

Figure 1. Health care patterns after discharge from hospital.

questions and the patient record is filled in. The home visits are supplemented by three phone calls and the whole coaching process takes six months. In a randomised trial of community-dwelling 65+ citizens with a non-elective hospital admission, the Care Transitions Intervention™ helped save U$300,000 over a 12-month period (n=350 older adults). Further results showed [6]:

- Significant reduction in 30-day hospital readmits (time period in which transition coach involved)
- Significant reduction in 90-day and 180-day readmits (sustained effect of coaching)
- Net cost savings USD $300,000 for 350 patients/ 12 months
- Adopted by over 170 leading health care organizations nationwide

All of these results would not have been possible if it weren't for a consistent engagement of physicians. In conclusion, the patients' preferences have to come to the fore and we have to start not only talking *about* them but *with* them.

The second keynote was delivered by Dr. Jack Hutten, of the Public Health Department of the Dutch Ministry for Health, Welfare and Sports. With him, perspective shifted to a top-down approach and the administrator's viewpoint of the health care system as he explained the Dutch solution of implementing the "health by all" strategy. Facing the same problems of demographic ageing and increase of chronic conditions as all the other industrialised countries, the Dutch designed a new integrated financial structure for the intramural and extramural sectors of the health care system. The main goals of the federal Ministry for Health were to:

- Reduce the increasing number of people with a chronic condition
- Delay the age at which chronic conditions firstly manifest
- Prevent or delay the onset of complications
- Enable patients to cope with their condition in order to improve quality of life

A vital aspect of the design was to include ALL of the population, healthy, high-risk and patient groups, and prevention is defined as an integrated part of care. This ambition is implemented in the national strategy "being healthy, staying healthy" which includes national life style campaigns, regulation measures and the better coordination of public health and curative care. They are supplemented by integrated (regional) health policies.

Starting from 2006, the new integrated care delivery for chronic conditions was implemented by providing:

- More room and responsibility for relevant parties
  - Citizens/patients
  - Care providers
  - Health insurers

- Less government interference (more competition and negotiations)
- Government supervises affordability, quality, access to care

One of the key elements of the reform was the privatisation of health insurers. A basic care package is defined by the Ministry of Health and insurers have an acceptance duty. Moreover, clients are able to change their insurance every year. Additional services and coverage lies at the discretion of the insurers and their clients and is not regulated by the government. The measures were accompanied by strict quality and transparency obligations.

An instrument to guide the stakeholders is the 'Integrated Health Care Standard' which is formulated by all relevant parties (patients and all care providers) and describes the terms of good health care and care organisation. It is planned to have a standard for every chronic condition, currently one for diabetes (Figure 2) and one for cardio-vascular risk management are available.

Maybe the most important element of the reform is the design of an integrated financial structure which will go into its pilot phase in 2010. The question was not 'who' has to be financed but 'what' and hence, the aim was to define one price for a given integrated care package. The risk compensation will be carried out as a mix of ex-ante and ex-post measures (for the details, please see Dr. Hutten's presentation [7]).

The first results of the reform include an activation of patient groups who see their chance to actually influence their care and treatment, as well as a surge in the numbers of 'primary care teams' for chronic care. Moreover, health insurers have developed special offers and packages for patients with chronic conditions. While this undertaking is impressive and could become a showcase system reform, Dr. Hutten did not fail to mention the potential risks and draw-backs associated with the redesign. These include the risk of double payments, the problem of how to mirror co-/multi-morbidity, a possible reduction of choices for patients along with an inequality in the market. Also, a connection with the long-term care sector and the social support act are still pending.

In summary however, this presentation proved those wrong who maintain that a comprehensive and incisive reform of a grown and complex system is not possible and that top-down approaches are prone to fail. The Netherlands demonstrate once again their leading role in the development of innovative and integrated care, which reaches all levels and players.

In the afternoon, the participants were asked to go into the first and second parts of the parallel sessions. In Stream 1 – "In the Spotlight: Success Stories of Integrated Care Models in North America and Europe"—four successful models of integrated care from North America (NORC_SSP from USA and PRISMA from Canada) and Europe (Healthy Kinzigtal from Germany and SGE Eindhoven from the Netherlands) were presented in depth, from the planning, organisation, financing to the evaluation and implementation of the programmes. Stream 2 – "Shifting Perspectives—Who cares? Asking patients, care givers and professionals about their needs and challenges."—continued and deepened the discussions on patient preferences and how to involve caregivers more actively, while Stream 3 – "Untangling the Gordic Knot—Managing Transitions"—took a closer look at the organisational challenges of transition management. In Stream 4 –

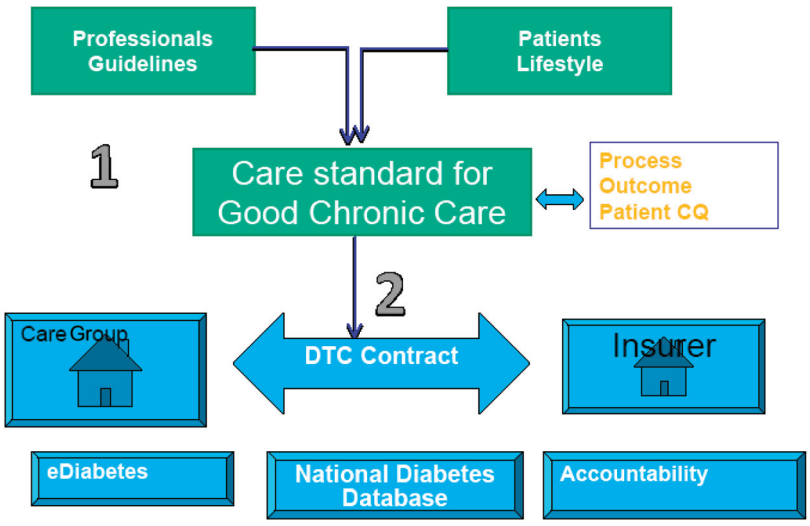

Figure 2. The Dutch Chronic Care Model [7].

"When policy meets challenge—Designing frameworks for integrated care"—pros and cons of top-down approaches and government programmes were considered and Stream 5 – "Projects and Developments: Presenting international experiences"—illustrated the variety and flexibility of integrated care.

At the conclusions of the first day, delegates were invited to the award ceremony of the Medical Scientific Fund of the Mayor of the City of Vienna and a subsequent Gala Buffet in the beautiful premises of the Vienna City Hall. After the intensive first day, this was the perfect possibility to relax in an inspiring atmosphere.

Day 2 of the conference started with the third keynote speech by Dr. Richard Antonelli, Medical Director, Children's Integrated Care Organization, Children's Hospital Boston, Harvard Medical School. Dr. Antonelli brought a hitherto underrepresented topic into the focus of the plenary: transitioning from paediatric to adult care services. With Paul Valery's citation "the trouble with our times is that the future is not what it used to be", he highlighted the facts that families and patients nowadays have easy access to multiple sources of information, they know what they want and they want to be involved in the decision-making process. Similar to Prof. Coleman, he warned the audience to see care coordination per se as a life saver. He introduced the Medical Home concept as a solution with an extension for family-centered care when transitioning from paediatric to adult care services. Care provided in a Medical Home is [8]:

- Accessible
- Family-centered
- Comprehensive
- Continuous
- Coordinated
- Compassionate
- Culturally-effective
- And for which the primary care provider shares responsibility with the family.

According to the National Partnership for Women and Families a Medical Home "is a medical office or clinic where a team of health professionals work together to provide a new, expanded type of care to patients. Having a medical home feels like having an old style family doctor, but with a team of professionals, using modern knowledge and technology, to provide the best possible care for you in their office" [8, p. 11]. This concept bares special potential for the management of children and youth with chronic conditions. Figures show that nearly 40% cannot identify a primary care physician, and 20% consider their paediatrician as their primary care doctor. Also, children and youth with chronic conditions have fewer job opportunities, lower high school graduation rates and higher college drop out rates than their healthy peers. In order to counteract this situation, the paediatric practice in a Medical Home setting will:

- provide care coordination for youth with complex conditions
- create an individualized health transition plan before age 14
- refer youth to specific primary care physicians
- provide support and confers with adult providers post transfer
- actively recruit adult primary care/specialty providers for referral

Based on Wagner's Chronic Care Model, Antonelli illustrated his idea of a Medical Home for children in a figure "The concept of the Medical Home in the paediatric setting" (Figure 3) [8, p. 33].

Since this model aims at activating and empowering the families and their young patients, there are also tasks and skills defined that they will have to develop and accept:

- Entering in a discussion process with the practice to define transition after diagnosis. Planning with families/youth begins early (paediatric practice) or when youth are transferred to the practice (adult practice).
- Practice provides educational packet or handouts on expectations and information about transition.
- Youth participate in shared care management and self care (e.g. call for appointment/refills).
- Practice assists families/youth to develop an emergency plan (health crisis and weather or other environmental disasters).

A key message of Antonelli's presentation was that in paediatric care health only constitutes one piece of the puzzle, and one always has to consider the family situation, social and emotional background as well as the educational system. A special emphasis is hence laid on dedicating more time and open ears to the families. This is also reflected in a study by Antonelli et al. (2008) [9] who analysed the primary focus of encounters in medical homes. While 67% still deal with clinical/medical management, 13% take care of referral management; at least 7% of encounters social services and 4% consider educational and school issues. Thirty-two percent of a total of 3855 care coordination encounters had reported the prevention of some event as an outcome: of those 58% prevented a visit to the paediatric office or clinic, 26% prevented an emergency department visit and 10% made a visit to the subspecialist unnecessary.

However, the Medical Home demands a redesign of the health system since primary care physicians cannot

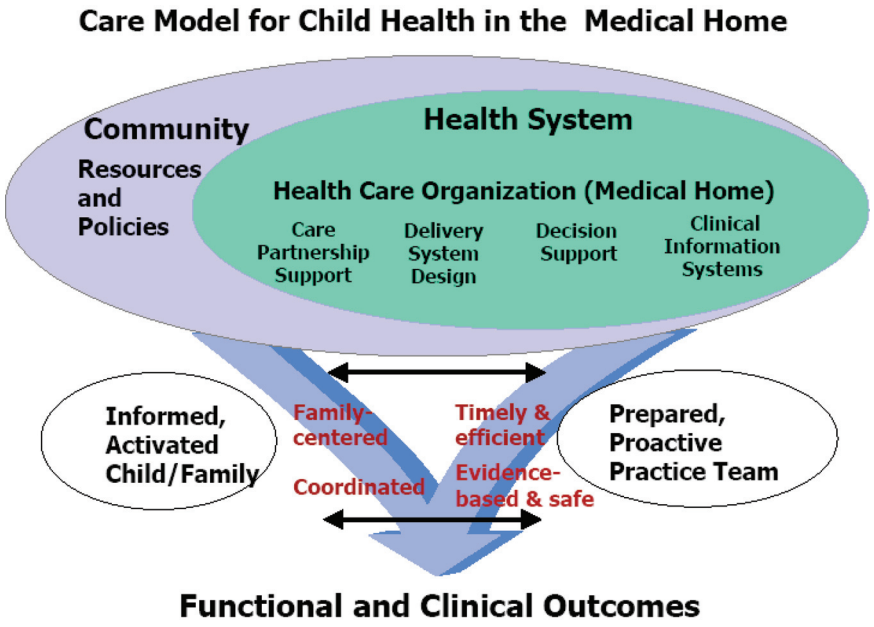

Figure 3. The concept of the Medical Home in the paediatric setting.

be expected to "do it all". As with other reorganisation measures; those would include the financial structures, quality measurements, public administration and regulatory support. In an effort to model, describe and measure care coordination in the paediatric setting, Antonelli et al. (2009) [10] developed a framework and put it into practice in the Children's Hospital Boston Integrated Care Organization. The presentation certainly demonstrated a well-structured approach for the complex management challenges of children and youth with chronic conditions.

After a short break, the parallel sessions continued with the wrap up of Streams 2–5. In the fourth and final round of the parallel sessions, three new topics were introduced: Theme 6 dealt with "Form follows function—Finance follows form?" and brought examples of how to integrate financial structures according to organisational needs. Theme 7 focused on "Information systems and technology—using them as a cure not as a curse" and Theme 8 "Physical Medicine and Rehabilitation—An entire discipline probes integrated care." highlighted the potentials of health care measures at the workplace and reactivation and rehabilitation of disabled employees.

Even though it has already been remarked in earlier conferences [1] and discussion papers on the future challenges of integrated care [11, 12], that a lot more attention has to be paid to financial and technical developments and structures for integrated care, there still seems to be a lack of interest or experience and knowledge in those fields. Hopefully, at the INIC10 in Tampere we will finally encounter more entries on these topics.

Concluding remarks

The conference concluded with closing remarks from Guus Schrijvers, who promoted the upcoming INIC events and gave first impressions of the INIC10, taking place in Tampere, Finland from June 16th–18th 2010. Esko Hänninen and Ilmo Keskimäki from the Finnish organising committee then indulged the audience in picturesque images of the city, port and convention centre of Tampere and its surroundings making it really difficult not wanting to sign up immediately for a trip to the Southwest of Finland (details for all events can be found on the newly designed homepage www.integratedcare.org).

The final feedback round revealed that participants had found the variety and diversity of presentations and topics both an asset and a downside to the conference. Since this scope and scale are the very blessing and curse of integrated care, the authors believe that we have to come to terms with it. INIC09 has demonstrated how adeptly and innovatively the integrated care community is operating and implementing the concept, but it has also illustrated that the efforts in conceptualising and evaluating integrated care should be intensified in order to enhance the viability and effectiveness of integrated care—as Lech Walesa, Polish Politician and Founder of Solidarność, already said "A fragmentary solution is none at all."

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Information on the details of conference speeches and study tour visits in this article of proceedings represent entirely the views and understanding of the authors and may not represent the views of the speakers themselves. The authors apologise for any misrepresentation of facts and/or mistakes in interpretation that may be presented.

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