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**LONG DESCRIPTION OF THE BEST PRACTICE CASE**  
**„Implementation of the Integrated Model of Health and Social Care“**

## **General description of the organisation and/or project**

Panevėžys County Governor's Administration is a public regional governmental organisation implementing the functions which are supervised by the Governor. Panevėžys County Governor's Administration (further referred to as County Administration) operates in accordance with the National Law of County Governing. The County Administration is financed by the National Budget.

The main tasks of this institution are:

1. To implement the regional state policy in the fields of social care, education, culture, health care, territorial planning, land use and protection, agriculture, civil defence, etc. Implementation of the state and interregional programmes.
2. To coordinate the activities of Governmental institutions in Panevėžys County.
3. To foresee the priorities in the County and to elaborate programmes.

Health and social care activities are coordinated *by two separate* divisions of County Administration - the Office of the County Physician and the Department of Social Affairs.

The Office of the County Physician and the Department of Social Affairs organise the state health and social care strategies and reforms approved by the National Government; analyse health and social status of the county inhabitants and provide the National Government, the Ministry of Health Care and Ministry of Labour and Social Care Affairs with the proposals concerning health and social care of the inhabitants living in Panevėžys County. The Office of the County Physician and the Department of Social Affairs are responsible for the establishment, reorganisation and elimination of health care and social care institutions which belong to the County Administration.

The Office of the County Physician and the Department of Social Affairs in cooperation with the municipalities organise the implementation of health and social care programmes in the county.

In order to promote national, regional and local inter-sectoral cooperation in 2000 Panevėžys County Governor's Administration started a project Development of the Health Program for Panevėžys County. The main goal of the project was to create the document *based on the community needs of Panevėžys region* where compulsory changes and strategy could be determined in order to improve health care on the basis of the best world, regional and national strategies.

The project contained the following tasks: 1. To make the analysis of health status of the County inhabitants. 2. To evaluate inter - sectoral cooperation possibilities on regional and local levels. 3. To determine joint aims, strategies, activities of health improvement. 4. To determine the priorities of health improvement in the County and to coordinate them with other sectors. 5. To discuss health programme with the community and to foresee further ways of communication with the public.

In order to achieve these objectives, one of the measures of the Panevėžys County's Health program is to integrate resources, inputs, distribution, management and partnership services,

connected with the health and social care. Integrated health and social care model is directed to the social risk groups in which health care inequalities show up most often.

It is a model of institution, which connects already existing human, structural, organizational and financial resources in order to achieve the program goals. This model was implemented as a demonstrative one. It should be used by all family health care services and social care services licensed for health care.

## **The main content of the case**

The model of integrated health and social care was implemented in Panevėžys city in 2003. It was the result of a joint work among Panevėžys County Governor's Administration, Panevėžys City Municipality and Community in the program of Integrated Care for Social Risk Groups. The main objectives of the project are divided into two groups. Long term objectives (until 2020) seek to improve the quality of life of social risk groups and 25 % - to reduce health care inequalities relating to social difference. Short term objectives (until 2010) seek to develop the network and a variety of non-institutional health care and social care, to improve the quality of care for social risk groups promoting the cooperation between social and health care sectors.

The project goals seek:

1. 80 % increase of the availability of non-institutional social care for the severely disabled and their family members.
2. 80 % increase of the number of the severely disabled and their family members, receiving integrated non-institutional social and health care.
3. 80 % of the severely disabled and their family members ensure pain management, symptom control and psychosocial care.

Organizational structure of the Integrated Model of Health and Social Care integrates different activities

1. Administration.
2. Family physician service.
3. Consultants.
4. Home Service.
5. Day care centre.

Family physician service and consultants provide services for all subjoined patients and also consult patients who are admitted to the home care service and day care centre. Home service provides nursing, social care, medical and psychosocial rehabilitation and physicians' consultations. The main task of home service is to keep self – sufficiency of the patient at home as long as possible. People admitted to the day care centre receive the same services as those at home care. The main task of day care centre is – psychosocial and spiritual help for the patients and their family members relieving social isolation. All services complement each other depending on the needs of the patient and his family. This structural organization of the services helps to ensure consecutive medical and psychosocial rehabilitation of the patient and his family, to reduce the loss of self – sufficiency of the patient from preventable complications and the lost number of the working days for family members.

Services are carried out by a multi-disciplinary team of medical and non-medical staff providing patients with medical and nursing help, psychosocial and spiritual support. Patients' families receive counselling and education about the illnesses. They are also supported during the period of the illness and bereavement.

All services are supervised by an administrator and each structural subdivision has its supervisor (physician, chief nurse, social care organizer). A complete team consists of the following staff:

- Doctors
- Nurses
- Clergy
- Persons specializing in psycho-social help, such as psychologists, psychotherapists, social workers
- Rehabilitation specialists
- Occupational and other therapists
- Masseur
- Dieticians
- Administrator
- Volunteers with differing skills

Additionally team is able to seek consultations with anaesthetists, oncologists, radiotherapists, surgeons, psychiatrists and other specialists.

Pre-conditions for effective care are the appropriate selection of well-qualified staff by experienced specialists and a continual process of training. Team members discuss the cases and evaluate the team work at regular meetings.

All activities of the institution are financed by the different sources of financing. The activities of family physician are financed by Patient insurance fund. Panevėžys Municipal Budget finances Palliative Care program and buys social care services. Additional activities are supported by charity funding, incomes – by fee paying services.

## **The reasons behind the case**

The disabled belonging to the social risk group face up health and social problems which can be solved by the assistance of certain institutions and services.

Different institutions like the Ministry of Social Care and Labour and the Ministry of Health Care are responsible for solving social and health problems on the state level. The arrangement and the service financing differ depending on the institution type responsible for the service provision. Health care services are funded by the Obligatory Health Care Fund and social services are covered from the state and municipal budgets. It is worth noting that social care institutions are unable to ensure social services to the people who need additional permanent health assistance. Health care institutions like nursing hospitals provide hospitalisation and they can not meet the people's demand and furthermore, hospitalisation is expensive. Notwithstanding the enhancing of out-patient nursing defined in different legal acts, we still do not have organisational and financial presumptions for that, i.e. the payment of out-patient nursing is not paid by the Obligatory Health Care Fund.

Performed investigations proved that the majority of the people with advanced disability suffer from a number of physical, psychological, spiritual, social and practical problems. Experiencing tortures and incurable symptoms some people commit suicide or choose euthanasia. Nowadays most often close relatives (most often women who are usually short of knowledge and lack physical strength) take care of the highly disabled.

When life period is becoming longer, the number of chronic diseases increases, the birth crisis and increasing emigration have effect on the decrease of the employable population. Thus, real danger arises that the highly disabled might be left without the assistance of their close relatives. This fact might have negative consequences on the social development of the state.

## **The actors behind the case**

Project coordination group consists of Panevėžys County Governor's Administration, Panevėžys City Municipality and Community representatives. The role of Panevėžys County

Governor's Administration is to coordinate the project, to provide methodological consultations, to evaluate the results of the project, to present the project and share the experience. Panevėžys City Municipality is responsible for the evaluation of quality of the integrated care services and financing it.

The role of the Community representative Public enterprise Integrated Health Care Centre is to implement the model practically. The role of the community in this project is very important for several reasons. At first, Integrated Health Care Centre took the initiated the start of the project. Later they implemented the model using their own financial and human resources and did it in a very short (half a year) time. Even being on the better start position, not a single governmental institution took risk to try to do it. It is an example that more often non-governmental institutions are more flexible, more motivated for changes and more sensitive for the people needs, and the activities of the Community should be supported.

Other acting parties are those receiving services. They are highly disabled patients with incurable progressive diseases and their family members having low incomes. The needs of this group of people were evaluated previously at the project "Development of the Health Program for Panevėžys County". The involvement of non-governmental patient organisations in this planning process and attention delivered to their needs lead to success.

## The process leading to success

**Preparatory process.** Involvement of the community representatives to the decision making and planning process helps governmental institutions to satisfy the community needs and gives good results.

Despite the fact that model was implemented in a year the process leading to success took long time and started much more ago. The project "Development of the Health Program for Panevėžys County" played the most important role. *During this project great attempts were made for creating the possibility for the people, like individuals, organisations and communities to participate in the decision making process. We sought that Panevėžys County Health Care program should represent the interests of different members of the community and should foresee the ways of satisfying them.* Representatives from different sectors and non-governmental organisations took part in this project. All municipalities of Panevėžys County were involved. Every stage of the project was discussed in public.

**Initiation of the project.** The representatives of the Public Enterprise Integrated Health Care Centre applied to Panevėžys County Governor's Administration with the problem and offered partnership. The situation was analyzed and the decision to take actions was adopted. The project coordination group was formed according to Panevėžys County Governor's order.

**Strategic planning.** A joint project was elaborated by Panevėžys County Governor's Administration and Public enterprise Integrated Health Care Centre. The problems, concerned groups, aims, goals, measures, merits and demerits, vista and dangers were identified.

**Program elaboration.** The program of Integrated Care for Social Risk Groups was elaborated. The program was approved by Panevėžys County Governor. The organizational structure and the financing mechanisms of the model were made up under the method guidance of the County Physician's Service.

**The implementation and supervision of the model.** The program was presented to Panevėžys City Municipality. Panevėžys City Council approved the program. Panevėžys City Municipality did the public purchase service inquiry as proposed in the project. The Public enterprise Integrated Health Care Centre **won the competition and** received the financing and started to provide services. The model was implemented by the Public enterprise Integrated Health Care Centre, coordinated – by Panevėžys County Governor's Administration and financed – by Panevėžys City Municipality.

**Evaluation of the program and public awareness.** Integrated social and health care is one of the national health and social policy priorities. This model was elaborated as demonstrative one, seeking to develop this kind of services. So the regular evaluation of the program and public awareness were very important. At the regional level the program was presented to public by different public communication means, conferences, round tables and so on. At the national level model was presented to the National Health Board and Health Care Ministry.

A good choice of the actors of the project, particularly community members, was one of the main reasons that lead to success.

## **Results indicating success**

Integrated health and social care model was implemented. It is a new model of the integrated services that help to achieve important goals of the program of Integrated Care for Social Risk Groups.

At first the variety of non-institutional health and social care services was enlarged. Two new kinds of services were implemented: integrated health and social care and palliative care.

Second - the network of non-institutional health and social care services, and number of care beneficiaries increased the availability of services was improved. Common number of the services recipients was – 74 in 2003 and 109 – in 2004. Among them the number of highly disabled patients was 38 in 2003 and – 60 in 2004. The number of palliative care recipients was 0 in 2003 and – 16 in 2004.

Furthermore, the quality of life for the severely disabled and their family members was improved and self – sufficiency of the patients in their living place was retained.

Additionally, the partnership and cooperation principle among governmental, municipal and community institutions avoiding the duplication of the functions was implemented. Public enterprise Integrated Health Care Centre provides services to the highly disabled patients, who need social care as well as health care, Panevėžys city municipality Social Care Centre oriented to the less disabled people who need more social care than health care.

At last, economical effect was achieved: the finances of the Patient Insurance Fund were saved because less patients needed expensive hospitalisation; the finances of the municipal budget were saved because a part of expenses necessary for the service provision were covered by Public enterprise Integrated Health Care Centre; the finances of the governmental budget were saved, because self – sufficiency of the patients in their living place has been retained and the number of the lost working days for the nursing of the highly disabled family members decreased.

## **The main obstacles of the case**

### **Risks**

1. Panevėžys City Municipality will not approve the purchase of the services. 2. Belief, point of view and way of life will preclude potential service customers from becoming customers. 4. Lack of qualified personnel.

### **Prevention of risk factors**

Panevėžys County Governor's Administration coordinated the project, provided methodical consultations and public discussions. The Municipal Council was ensured to finance the project by organizing public discussions and presenting the advantages of the project.

Public enterprise "The Centre of Integrated Health Services" performed active marketing seeking additional funding. Additional sources of finance were as follows: income for paid services, charity aid, project money, financing from the obligatory health care fund. Service expenses were decreased by voluntary work, labour exchange supported programs, service provision under the contracts with other legal entities, the training of service beneficiaries relatives.

The development of the services was stimulated all over the county, the activity results of the institution are declared in public in order to assure the demand of the service customers.

The lack of qualified personnel was negotiated by organizing educational programs.

## **Main sources of inspiration behind the case**

The internal motivation of the project coordination group members, good team work and positive evaluation by the national level governmental and political institutions and local community members were the main sources of inspiration.

## **The most important lesson learnt**

Involvement of the community representatives to the decision making and planning process helps the governmental institutions to satisfy the community needs and provides good results.