

Specific approaches to integrating care in Austria - The cases of psycho-geriatric coordination and palliative care (SUSTAIN project sites)

Abstract

Introduction

Integrated care has gained importance over the past decade in Austria with a strong focus on integration and coordination within the health care system, e.g. by implementing discharge management in hospitals and sporadic disease management initiatives. Alongside these developments, long-term care (LTC) has progressively been shaped as a sector, with distinct funding mechanisms and by creating new links with the health system, e.g. by new types of job profiles. Still, generally fragmented structures have been identified as barriers to person-centred care, continuity and systemic prevention. These difficulties culminate when it comes to care at the end of life as palliative care was 'delegated' to specific wards or hospices, rather than being integrated across sectors to extend possibilities for dying at home. There is growing awareness that improvements to current practice are necessary, in particular in view of the rising number of older people suffering from multimorbidity and dementia. In response to these challenges, many local initiatives have evolved, two out of which will be presented in this contribution. The 'Palliative Care Coordination' (PCC) in Styria and the 'Geropsychiatric Centre' (GPZ) in Vienna were chosen as sites for further organisational development in the context of the EU Horizon 2020 Project SUSTAIN. The following description refers to the baseline assessments at these sites between September 2015 and April 2016.

Changing practice

Both the PCC and the GPZ have changed mainstream practice of health and social care delivery in Austria over the past 10-15 years by integrating palliative care and addressing the specific challenges of dementia care.

1) The PPC in Styria was established in 1998 to coordinate the extension of palliative services across care pathways and to disseminate the rationale of person-centred care at the end of life. Based on funding from the regional Health Fund, the aim was in the first place to provide mobile palliative care to cancer patients free of charge, in cooperation with hospitals and local non-profit organisations providing home care. The multi-professional mobile teams took some time to get acknowledged and to improve cooperation across Styria between relevant facilities specialised on palliative care, primary care and LTC services. An important strategy for gaining trust and mutual understanding consisted in the provision of consultancy and training in this field. Furthermore, the organisation trains and involves volunteers, in cooperation with the 'Hospice Association'. A wide range of partners across the entire region is supporting the small team of professionals in the central office.

2) People suffering from dementia and their carers encounter difficulties when it comes to detect and assess dementia and to cope with consequences. The GPZ was therefore established in 2002 in Vienna as a unique

centre for community-based consultancy (clinical-psychiatry and neurology). It is also conceived as a diagnostic 'clearing' centre with a 'Memory Clinic' and offers counselling, by phone and face-to-face, to GPs, health and social care services, to hospitals and family carers. The multi-professional team (7.5 FTE) of psychiatrists, psychologists, nurses and a social worker is networking with a wide range of stakeholders and provides all services free of charge.

Key findings

To date, the PCC in Styria counts about 60 professionals (FTE), organised in nine teams by three community care organisations. The initiative serves the Styrian population of about 1.2 million inhabitants. The original aim to reach 40% of all cancer-patients was eventually reached by 2014. This target group represents 70-80% of the total of about 2,000 clients per year. In the future, the group of non-cancer patients should be given major importance because of the growing need expressed by older people with multimorbidity to receive integrated palliative care at the end of life in residential settings and at home.

The GPZ serves about 1,800 clients each year and reports high rates of user satisfaction. However, the small scale and persisting difficulties to get systematically acknowledged by GPs and hospitals opens space for further quantitative and qualitative development.

The baseline assessment to identify potential areas of further organisational improvement of both models will be finalised by April 2016 so that it will be possible to present more highlights, results and lessons learned at the conference.

Conclusion

The two distinct approaches have shown to be sustainable models of integrated care over more than a decade by now. Following a longer pioneer phase, they have reached organisational consolidation and have a high potential for being transferred within Austrian and other national contexts. However, there remain a number of contingencies (e.g. specific leadership, political support, staffing) that call for further investigation.

Location

Austria

Year

2016

Related Integrated Care keywords

- SERVICE, FUNCTION AND CARE INTEGRATION / COORDINATION – TRANSITIONS

Pervasiveness

Small scale in a jurisdiction

Status



Completed

Links

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