

The POTKU project (*Potilas kuljettajan paikalle, Putting the Patient in the Driver's Seat*), Finland

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Currently, an estimated 50 million people in the European Union live with multiple chronic diseases (1) (multimorbidity), and this number is expected to increase further in the near future. As multimorbidity deeply impacts on people's quality of life – physically, but also mentally and socially –, there is a growing demand for multidisciplinary care that is tailored to the specific health and social needs of these people. Integrated care programmes have the potential adequately to respond to the comprehensive needs of people with multimorbidity by taking a holistic approach while making efficient use of resources. Such programmes are characterised by providing patient-centred, proactive and coordinated multidisciplinary care, using new technologies to support patients' self-management and improve collaboration between caregivers.

In order to inform policymakers, managers and professionals working in health and social care as well as patients' and informal carers' representatives throughout Europe about promising initiatives providing integrated care for people with multimorbidity, a series of case reports describing these initiatives was written as part of the ICARE4EU project (see Colophon). This case report describes an innovative approach to providing integrated care for people with multimorbidity in Finland.



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Summary of the POTKU project

- The Finnish POTKU project (2010–2014) aimed at improving patient-centred care by developing care for people with chronic illnesses.
- The POTKU project was targeted at all people with a chronic disease seeking care from the local primary care health centres in the regions covered by the project. A considerable part of them were people with multimorbidity.
- The POTKU project consisted of several sub-programmes in five hospital districts in Middle Finland, covering 61 municipalities and about one million inhabitants. 420 health care professionals in local health centres were involved in care development activities during the project. A slightly modified version of the Chronic Care Model was used as a theoretical framework for development.
- A key development tool for patient-centredness was a personal health and care plan (HCP), which were developed for 16 000 patients during the project. Clientship profiles were used to assess a patient’s self-management skills and the support they need.
- A pathway for people with multimorbidity was developed to integrate care services and improve patient-centred cooperation among care professionals.
- The patient-centred approach using a HCP suits the comprehensive non-disease specific needs of people with multimorbidity well. However, while these people may also need specialist care and non-medical support, the relationship with secondary care and social care needs to be improved further in the future.
- Although funding for the four-year programme has finished, some elements of the programme are now structurally embedded in the care processes in the health centres (such as the involvement and collaboration with the third care sector). Some elements, however, are hindered by a lack of resources, lack of support from management or the lack of integration with regard to IC

1. Relevant developments in health and social care for people with multimorbidity in Finland

In 2014, 19.4% of the Finnish population (5.5 million in 2014) were aged 65 years and older, and 5.0% were 80 years and older (2). Of the population aged 16 to 64 years, an estimated 39.6% had at least one (self-reported) long-standing illness or health problem in 2013 (2). In order to respond to the increasing number of chronically ill citizens, Finland has formulated policies to adapt the health care system and care practices to meet these people’s needs. However, the implementation of these policies and practices is still ongoing and the focus has not yet been on people with multimorbidity. A general description of the health and social care systems in Finland can be found in Annex I.

Currently Finland is preparing a comprehensive reform at national level, which aims to integrate health and social care systems as well as primary and secondary care (3). It is expected that people with a chronic illness, particularly people with multimorbidity, will benefit from this reform, as fragmentation of the care process will be reduced.

2. Introduction to the programme: POTKU project (‘Patient on the Driver’s Seat)

The POTKU project (*Patient on the Driver’s Seat*) was financed by the Finnish Ministry of Social Affairs and Health from its national KASTE development programme¹. The first POTKU project lasted from 2010 until 2012; the second phase from 2012 until 2014. The administrator of the project was the Etelä-Pohjanmaa Hospital District. The Ministry of Social Affairs and Health played an active role during the initiation of the project. The project was a continuation of the Toimiva Terveyskeskus (Functioning Health Centre) programme, which was also funded by the KASTE development programme. The POTKU project consisted of several sub-projects in five hospital districts in Middle Finland, covering 61 municipalities and about one million inhabitants. Altogether 420 health care professionals were involved with care development activities.

This report describes both the POTKU project and some details of one of the sub-projects, Pirkka-POTKU. Pirkka-POTKU was chosen because it involved a care pathway specifically for multimorbidity, which was implemented in the Pirkanmaa region in cooperation with the Centre of General Practice in Pirkanmaa Hospital District.

Main characteristics of the programme

The overall aim of the POTKU project was to improve the patient-centredness of chronic illness care by developing and implementing patient-centred care services for people with chronic illness in the local primary care health centres in the participating regions. The Finnish *Health Gain Model* (7), a slightly modified version of *the Chronic Care Model* (4), was taken as the theoretical basis of the project (see Figure 1). This model was considered as a framework for developing care – together with patients – towards more patient-centredness. Changes were planned in all six components of the model.

¹ The KASTE Development Programme, the National Development Plan for Social Welfare and Health Care, is a strategic steering tool of the Finnish Ministry of Social Affairs and Health to manage and reform social and health policy. For more information, see: http://www.stm.fi/en/strategies_and_programmes/kaste).

Figure 1 The Health Gain Model (4, 7)



A condition, set by the Ministry for financing, was that the POTKU project had to address all the components of the Health Gain model, meaning that innovations should be developed and implemented for all key components. However, in practice the emphasis was on improving *the delivery system* and *self-management support* for patients. Changes in the other components of the model (*decision support, clinical information system, health system and community resources*) were considered to be supportive to the innovations/changes made in the first two components.

The POTKU project addressed all people with a chronic disease seeking care from the local primary care health centres in the regions covered by the project. Although there was no specific focus on multimorbid patients, multimorbidity is very prevalent especially among older people with multiple chronic conditions.

3. Patient-centredness

Vision and involvement of patients in development processes

Although patient-centredness was at the heart of the POTKU project, a vision of patient-centredness was not laid down in the project plan or another document. However, the POTKU's project manager as well as a GP/unit manager and a nurse/sub-project manager all stated that there is a common vision on patient-centredness, which is reflected and operationalized in the development of the procedures for care delivery and the tools that have been developed to support patients and care providers. The Head of the Centre of General Practice at the Pirkanmaa Hospital District (PETE), who initiated the development of a care pathway for patients with multimorbidity (see below), said, "*patient-centredness means that the experience and the everyday life of an ill person are connected with their medicine and treatment*".

To ensure a patient-centred approach, (representatives of) chronically ill patients or their family members/informal carers were involved in several ways in the development of the POTKU project. Patients participated for example in developing the self-care assessment tool and in planning 'self-care information desks' in health centres.

Innovations to improve patient-centredness

Within the POTKU project, patient-centredness was addressed by tailoring the provided care according to the needs of chronically ill patients at two levels. At the institutional (meso) level of the delivery process, the provision of support and care is guided by a framework based on certain patient profiles or 'clientships' (see Box 1).

Box 1 Clientship profiles

Patient profiles of individuals with chronic illness are based on the assessment of the three characteristics, i.e. (1) the complexity of their medical condition(s), (2) the type of treatment (complex/not complex), and (3) finally the resources they have at their disposal to cope with their condition and treatment (good/poor). Combining these three dimensions results in four clientships:

1. Self-management clientship (medical problem not complex, good resources)
2. Co-operation clientship (medical problem complex, good resources)
3. Community clientship (medical problem not complex, poor resources)
4. Network clientship (medical problem complex, poor resources).

The profile is drafted by the care professional in cooperation with the patient. Identifying the clientship of a patient guides the care professional in specifying how the care is arranged: e.g. who is responsible for the coordination of care and what kind of supportive tools can be offered to patients.

For instance, in the case of self-management clientship these tools could be health coaching, a health library and/or electronic contact; in case of co-operation clientship these tools could be a joint consultation (with multiple disciplines) and/or an electronic consultation; in case of community clientship these could be a visit to a nurse and/or peer support group; and in case of network clientship these tools could be input from a multiprofessional care team and/or involving next-of-kin as informal carers. The clientship model that is currently used has been developed in another project (5); the supportive tools that were offered have been developed within the POTKU project and in other projects as well.

At the level of providing care to the individual patient in daily practice (micro level), the Health Gain Model was translated into the so-called 'Heart model' (see Figure 2), explaining the individual patient's care trajectory in five phases: 1) the patient contacts the care professional at the health centre, 2) preparation of the appointment, 3) the appointment with the nurse, 4) the development of a personal health and care plan (HCP; see Box 2) by the patient, nurse and doctor together, and finally, 5) self-management by the patient as a goal of the whole process.

Figure 2 The 'Heart model' (7)



Box 2 Health and Care Plan (HCP)

Individuals diagnosed with a chronic disease who contact the health centre are scheduled for an appointment with a nurse in order to develop an individualized Health and Care Plan (HCP). This HCP has been defined as *'a tool designed to be used at the national level with the focus on developing the treatment of patients suffering from long-term diseases and multiple conditions. It aims at giving patients the strength to take care of their own health'* (6).

Moreover, these patients receive a self-management assessment form, which will be discussed later together with the nurse. Guided by this self-management form, the patient's health status and need for self-management support are assessed during the appointment with the nurse. Based on this, the patient and the nurse jointly develop a HCP, which is finally decided upon by the physician in charge cooperating with the nurse. Thereupon the patient receives the HCP, which will be continuously evaluated and adapted according to the patient's needs.

The HCP is structured according to the following themes: 1. My needs (health-related problems identified by the patient with the support of a health professional), 2. My goals (what change in health status is strived for; which is the goal of the jointly agreed treatment?), 3. My measures (which health services and measures of the patient planned related to these goals), 4. Follow-up and assessment (follow-up appointments to evaluate the implementation of the HCP and its results), 5. Medication, diagnoses and contact person.

To check the quality of the HCPs developed with patients, an auditing tool was developed (see reference list): healthcare professionals read anonymous HCPs (187) in order to assess their quality and completeness. This resulted in a checklist that could be used for the development of HCPs in practice.

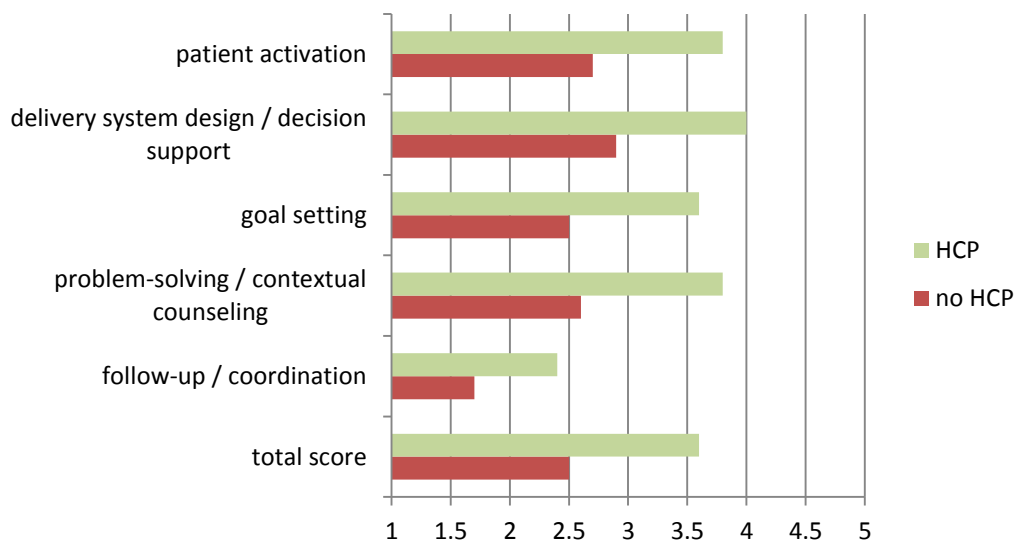
Results and experiences related to patient-centredness

One of the original objectives of the POTKU project was that all participating chronic disease patients would receive an HCP. At the end of the POTKU project in 2014, the number of HCPs was estimated at about 16 000 (7). There were several reasons for this relatively low number of developed HCPs. First of all, changes in chronic illness care delivery are difficult to make within a limited period of time. This also applies to the implementation of HCPs, which proved to take more time for nurses and doctors than expected. The interviewed GP/unit manager and nurse also mentioned the problem of integrating the HCP's in the patient's Electronic Medical Record, as the information system used in the health centres is not compatible. Consequently, nurses and doctors had to enter patient data twice (in the patient's EMR and his/her HCP) and did not have a real-time overview of all patient information available at any moment. This substantially hindered the implementation of HCPs in daily clinical practice. In addition,

unit managers of health centres did not always support the implementation of the new approach to chronic illness care in practice e.g. by providing sufficient staff.

Despite the low implementation level, the HCP proved to be a workable and efficient tool for improving patient-centredness in daily practice. Data from the POTKU project show that the use of HCPs is related to a better quality of chronic illness care as perceived by both patients and healthcare professionals and a reduction in service utilization and costs (see the section on Financing). Figure 2 shows that at the end of the POTKU project in 2014 chronically ill patients who had an HCP perceived the care they received as significantly better on all dimensions of the PACIC questionnaire² than patients who did not have an HCP. During the project doctors and nurses in health centres gathered feedback from the patients about their experiences with the HCP. Positive reactions of patients were, for example, as follows: *“This is exactly what should have been done all along”*, *“For once someone is listening to me”* and *“Now I know myself what I am doing and when”* (7).

Figure 2 Perceived quality of chronic illness care (PACIC mean scores: theoretical range: 1–5) of chronically ill patients who received care from a health centre participating in the POTKU project with or without an HCP in 2014 (7)

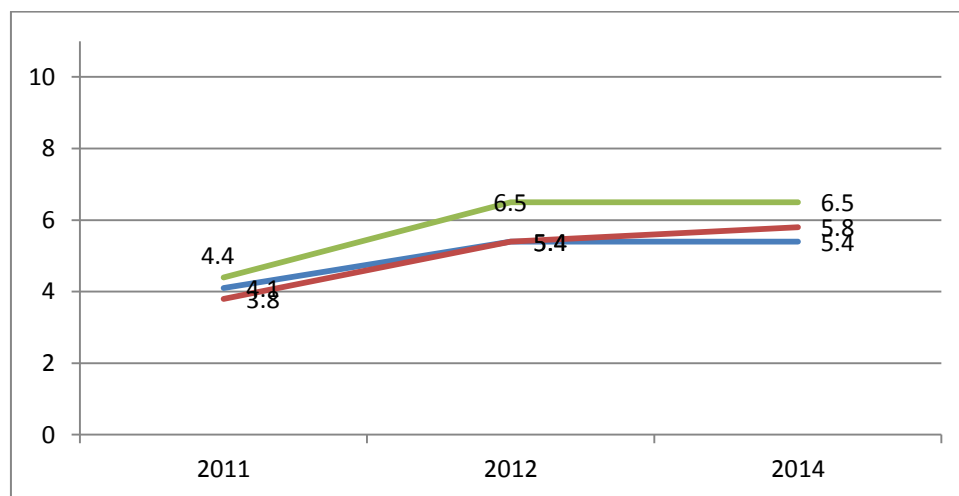


In the external assessment of the project, the healthcare professionals of the participating health centres were asked how they experienced the new approach. Some quotes from these professionals were *“The*

² The PACIC (Patient Assessment of Chronic Illness Care; MacColl Center for Health Care Innovation, Group Health Cooperative, 2004) questionnaire is an international validated instrument that covers several dimensions (from the patient perspective) of what is considered high-quality chronic illness care according to the Chronic Care Model (4).

jointly drafted plan creates security and continuity in patient care and clarifies the role of professionals”, “The content of the work has totally changed. I work in a more holistic manner, I see the patient as a whole” and “I don’t think on behalf of the patient; we think and plan together”. When asking our interviewees what they considered to be the merits of the project, all answered that the project has resulted in more awareness among healthcare professionals regarding the value of a patient-centredness approach to chronic illness care. As a result of the project, the healthcare professionals involved in the project experienced a more patient-centred attitude among healthcare professionals. Figure 3 shows the results of a survey in 2011, 2012 and 2014 among healthcare professionals of health centres participating in the POTKU project. The figure shows that the quality of chronic illness care as perceived by the healthcare professionals involved (as measured by the ACIC questionnaire³) has increased between 2011 and 2012, and remained at this improved level in the second phase of the POTKU project.

Figure 3 Perceived quality of chronic illness care (ACIC mean scores) of healthcare professionals working in a health centre participating in the POTKU project in 2011, 2012 and 2014 (7)



Green line: POTKU sub-project Kuusiokunnat; red line: POTKU sub-project Hämeenlinna; blue line: total POTKU project

Range: between “0” and “2” = limited support for chronic illness care; between “3” and “5” = basic support for chronic illness care; between “6” and “8” = reasonably good support for chronic illness care; between “9” and “11” = fully developed chronic illness care

³ The ACIC (Assessment of Chronic Illness Care) questionnaire (MacColl Center for Health Innovation, Group Health Cooperative, 2000) is an international validated instrument that covers several dimensions (from the perspective of healthcare professionals) of what is considered high-quality chronic illness care according to the Chronic Care Model (4).

4. Integration, management, competencies

Ways and tools for integration in practice

The main organizations involved in the POTKU project were public primary care health centres. According to the aims of the project, patient-centredness, multi-professional cooperation and cooperation between diverse health centres were promoted during the project. In addition, cooperation between (public) health care and the third sector (e.g. patient associations) was enhanced. However, cooperation between primary care and secondary care, and cooperation between health and social care played a smaller role in the POTKU project, although these were mentioned as aims in the original project plan. Below we present some main results and experiences of POTKU from the perspective of integration.

In health centres the collaboration between doctors and nurses changed substantially. Instead of working separately, they now work together as a team (The Finnish Doctor-Nurse Pair Model, (8)). The nurse takes care of the coordination of care and always have a consultation with the chronic disease patient to work together on an HCP, which has to be approved by the GP. In addition, the project also made visible ‘the invisible ways to work separately’, such as doctors having their own meetings, own coffee breaks etc. In some of the health centres these evolved into mutual events for both doctors and nurses. A great deal of work was done to change the attitudes of both doctors and nurses⁴ towards more patient-centredness and co-operation. As confirmed by the project manager: *“The way professionals had looked at the patients through their own narrow lenses changed indeed”*. Evaluated by the interviewees, one of the main successes of POTKU was the change in attitudes towards more patient-centredness and willingness to develop one’s own work.

Collaboration between health centres during the project was ongoing. In the sub-project Pirkka-POTKU, the Centre of General Practice in Pirkanmaa Hospital District arranged meetings for health care centres every other month. During these meetings close relationships with the professionals in neighbouring health care centres were established, mutual brainstorming and knowledge exchange took place, best practices discussed etc. This cooperation resulted in e.g. the exchange of different models of the health care plan, on which the final model of HCP was then developed. The continuation of this kind of collaboration after the project varies regionally depending on the resources targeted to it.

⁴ Nurses refer here both to registered nurses and primary nurses.

Health centres' cooperation with the third sector (patient associations) was rare before the POTKU project. During the project a continuing cooperation was established. For example, in the health centres in the Pirkka-POTKU region patient associations come once a month to present themselves to patients and staff at an information desk. Cooperation with patient associations and "client panels" were established in all POTKU sub-projects. In addition, many patient group activities first led by professionals were continued under the leadership of patient associations. A coordinator for third-sector collaboration has been appointed in every health care centre, which seemed to work well in practice and therefore also continued after the project finished in 2014. Care providers are altogether now more aware of the support these patient associations can offer the patients. GPs, for example, can guide patients to contact local patient associations by giving them precise contact information. According to the interviewed GP/unit manager, the cooperation with the third sector *"was zero before the project"* (GP/unit manager). The change was confirmed by a social worker from a patients' family member association: *"Now there is a clear structured way to work, good routines, easy to cooperate."*

As mentioned earlier, cooperation between primary and secondary care was not in the main focus of the project. A noteworthy attempt to increase coordination was the care path for multimorbidity (Box 5), which was developed by the Pirkanmaa Hospital District, partly together with Pirkka-POTKU sub-project. However, the cooperation mostly followed the established practices existing in health care, as in the exchange of patient information. For example, the traditional way of GPs asking for a consultation through written enquiries was continued: GPs do not get feedback information on how patient's care has continued after the consultation. Due to the separate patient record systems, a large part of the information flow between primary care and secondary care still takes place in paper format, which hampers effective cooperation.

A small-scale example of cooperation between primary care and secondary care took place in one of the health centres participating in the POTKU project, located next to a district hospital. Financed by the POTKU project, peer groups for CVA/MI patients had been established (moderated by professional care providers or representatives of the patient association) by a team consisting of a nurse and physiotherapist from the health centre together with a nurse from the hospital specialized in cardiovascular diseases. The meetings were highly appreciated by the patients, and collaboration between the coordinators was considered to be working well. But this may have to do with the fact that the two nurses already knew each other well. Since financing has stopped, no new support groups have been initiated. *"In the collaboration between two different organizations, the role of the managers (their support) is very important. The actual collaboration then depends on individuals and their attitudes"* (nurse manager).

Box 5 Care pathway for people with multimorbidity

The care pathway for people with multimorbidity has been developed to integrate care services and improve the patient-centred cooperation between care professionals and care providers. It guides the selection of professional services and support that are offered to patients with multimorbidity, the information flow between professionals, and the type of self-management support that could be offered based on the phase of the illness and coping process of the patient. Improving patient-centredness is the core idea behind the care pathway. Care and support are organized differently for different clientships (see Box 1).

The care pathway for people with multimorbidity was developed by the Centre of General Practice of the Pirkanmaa Hospital District (PETE), which is responsible for the development of many other care pathways as well. The pathway was developed in cooperation with healthcare professionals of various disciplines and with patient representatives.

The care pathway is constructed on the basis of the patient's care process. It gathers different elements, including a self-care form for the patient, the above-mentioned profiling of clientships (see Box 1), health care plan (see Box 2), key contact information links etc. Together, they target a continuous and versatile delivery of care services to the patient. When the key items are included in a care pathway, every professional knows exactly what needs to be done (e.g. which care providers to contact, with whom to cooperate while planning, arranging and controlling the care and support for the patient, about which patient associations to give information etc.).

The care pathway for people with multimorbidity is a relatively new tool and was not yet implemented fully in the POTKU project. All care pathways developed by PETE are publicly available online in an open portal Terveysportti (9), so that all care professionals have access to them. All citizens can access this website too, but in the current form the care pathways are mainly guides and tools for care professionals and are not adapted for use by patients themselves. The significance of the care pathway for professionals was summarized as follows: *"The care pathway is a systematic way to make visible what services are available, to share knowledge about what to offer to patients."* (The head of PETE)

The role of management

The management of the health centres participating in POTKU played an important role in how the goals of the project were reached. The commitment of the managers of the health centres involved was seen as one of the most important factors affecting the success of the project. The unit manager in a health centre is usually a general practitioner, who is in charge of the administrative issues. In addition, s/he sometimes also still practices as a doctor among other GPs in the health centre. In some areas where the managers were especially committed, the project showed better results (e.g. amount of personal health care plans). The commitment of the managers was visible e.g. in how often they participated in

multiprofessional care team meetings (focusing on care) and in multiprofessional development group meetings (focusing on development of the organization and new ways to work); the latter being an important part of the project. In addition, the commitment of managers was reflected in how they allocated staff resources for development during and after the project. *“The managers who prioritized the development of chronic care and who saw the POTKU programme as a chance to develop their work, were committed and this was seen in the results.”* (Project manager)

During the project, poor commitment by doctors to patient-centredness and support for self-care was identified in the inter-evaluation of the project. Therefore, the steering group of the project decided to appoint from the project budget two part-time doctors (GPs) to work on the project. It turned out that officially involving a doctor in the project was needed to ensure other doctors’ commitment. Also the support of senior management was acknowledged to be of crucial importance.

Multiprofessional development groups in the health centres turned out to be success factors from the perspective of commitment and achievement of the goals of the project. These groups consisted of various actors such as manager-doctor, nurse, health centre assistant, office staff member and public health nurse (e.g. diabetes nurse or a nurse doing health promotion work with patients). Groups were led by e.g. head nurses or expert nurses. The groups discussed organizational problems and tried to find ways to solve them together. The groups served as an efficient commitment tool for the staff and resulted in the further developments of everyday practices. For example, the enrolment procedure of patients at the health centres was changed as a result of the multiprofessional development groups’ work. A GP/unit manager stated *“The main thing in the discussions of this kind of group is to ponder together how to make the process better”*. It seems that in some organizations (those with committed managers) this type of development work will continue after the project.

Competencies

The development of competencies of care staff in POTKU included e.g. training in motivational interviewing (aiming to enhance patient-centred communication), change management training, project management training and different kinds of workshops to develop care processes, e.g. care pathway. A Lean thinking (10) training was arranged, too, being one of the training schemes related most clearly with developing care processes related to multimorbidity and high needs patients.

The POTKU project also cooperated with the ASVA 2013–2014 project, which aimed to develop and implement a Case Management Model into the Finnish health care system. ASVA included a Case Manager continuous training course, which is still organized by Helsinki Metropolia University of Applied

Sciences. The aim of this training course is to increase specialized knowledge of the care of people with chronic illness, including people with multimorbidity or other patients or clients needing and using a lot of services. The Finnish Ministry of Social Affairs and Health has formulated a framework for Case Manager training, based on the Chronic Care Model (11). Successful completion of ASVA training allows the use of the title Case Manager (Asiakasvastaava in Finnish) and is usually rewarded as part of the nurse's salary.

Chronically ill patients were invited to participate in peer groups and lifestyle groups to develop self-management competencies. None of these types of support were specifically targeting patients with multimorbidity, but often these groups consisted of people who had more than one chronic condition. In patient training, cooperation with diverse patient associations was of importance. In Pirkka-POTKU sub-project, the local Family Association for Mental Health gave training not only for patients but also for care professionals working in health centres.

5. Use of e-Health technology

In the POTKU project there was no special focus on e-Health issues. However, a considerable effort was made in promoting the collection of patient information by care professionals into electronic patient records to enable the efficient use and exchange of information. In addition, some e-health tools developed by other projects were implemented in the POTKU project (see Box 6).

Box 6 E-Health tools developed and/or implemented in the POTKU project

Navigator, Suuntima (in Finnish) (12), was developed in the Kurkiaura project (13) but also implemented in the POTKU project. Navigator is a tool for a patient to assess her/his coping behaviour in everyday life and a tool for a professional to evaluate patient's situation from a care perspective.

eOwnHealth tool is an electronic service through which patients have access to their laboratory tests and can communicate with care professionals without face-to-face meetings.

EBMeDS decision support e-tool (Evidence-Based Medicine electronic Decision Support) was used by GPs (developed by the Finnish Medical Society Duodecim). It connects evidence based medical information (such as care recommendations) with the patient records and provides individually customized care guidance, reminders and warnings and links to support doctors' decision making.

The clinical information system of the health centres cannot integrate the HCP format in the patient records. Health care providers need to provide the personal HCP separately from the information in the patient records, and each time they wish to adapt the HCP, they need to make a new one. This restricts to a great extent the usefulness of the HCP, in particular when the patient visits different care providers. The template of HCP is missing also in the Internet versions of care pathways. This is a national problem, as the GP/unit manager stated: *“This is a national-level thing – everyone is waiting for a place for the HCP in the information system!”*

Moreover, individual health centres and hospitals use various information systems. The patient can only inform his secondary care providers by bringing her/his HCP on paper to the hospital (medical specialist). This is a considerable shortcoming of the system and substantially reduces the usability of the HCP.

Another problem resulting from separate health records is that it was almost impossible to systematically identify patients who are ‘high users’ of services provided by diverse providers. This made it difficult to contact these patients and offer individually customized care services and support to them. Different clinical systems among care organizations also caused a problem regarding the evaluation of the project. The POTKU project aimed to gather information of all patients for whom the personal health care plan had been prepared, but this appeared to be impossible due to the fragmented clinical record systems. The evaluation was then carried out manually by choosing the patients randomly from different regions.

The use of the eHealth tools is still relatively limited in Finland. For example, according to the interviewed GP/unit manager, the decision support tool was not used widely in the Pirkka-POTKU sub-project, due to a few mistakes and problems with the tool. In addition, the GP/unit manager commented: *“If we allow people to send questions [by using eHealth tools], we [doctors] have to have more time to answer them.”*

6. Financing of the programme and outcomes related to costs

Financing of the POTKU project

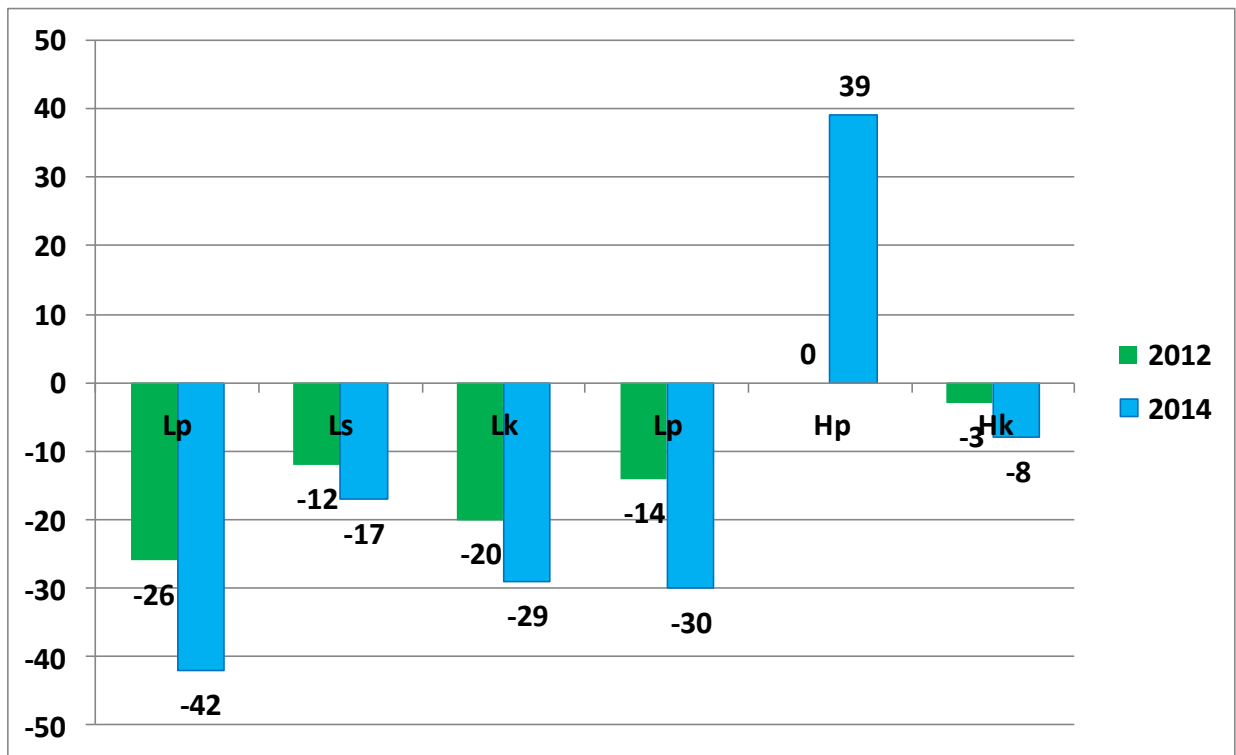
Two separate grants, 2010–2012 and 2013–2014 from the KASTE development project (see section 2) of the Ministry of Health and Social Affairs provided funding. The total budget of POTKU I (2010–2012) was 6.6 million euros with a grant of 5 million euros from the Ministry while the remainder was funded from municipalities involved in the project. The total budget of POTKU II (2012–2014) amounted to 4.4 million euros with a grant of 3.3 million euros.

Health centres used this funding for appointing staff to develop project activities and tools. Care providers working in the health centres did not receive additional fees or incentives for their activities. Although patients did not receive any incentives either, they were invited to a free consultation with a nurse at the start of the project, in order to develop their HCP. The funding of the project was temporary, which is in line with standard procedures for these kinds of grants in Finland. After the project ended the new activities in health centres were supposed to be continued with usual care funding.

Results related to costs

Although direct cost savings were not the aim of the project, indirect cost savings were expected due to the development of a more efficient care delivery process. One of the interesting outcomes in this respect was a reduction in the use of healthcare services after the introduction of HCPs. Figure 4 shows that the use of HCPs within the POTKU project resulted in a lower use of services by chronically ill patients. This result was even more evident for patients who had more than ten visits per year (e.g. their unplanned visit at doctor's practice decreased by 50 %) (7). In parallel phone call consultations with nurses increased because they replaced the consultations with doctors. This lower use of services has the potential of achieving cost savings in the long run.

Figure 4 The reduction in the use of services one year before and after the HCP (2012–2014) (7)



N 2012=239; N 2014=242

Lp=Urgent visits at GP's practice; Ls=Planned visits at GP's practice; Lk=All visits at GP's practice (total); Lp=Phone call consultations with doctors; Hp=Phone call consultations with nurses; Hk=Visits to nurse's practice

7. Reflections on the case

The POTKU project holds valuable lessons and experiences for other integrated care projects. First, a common theoretical framework, in this case the Health Gain model, was considered to be extremely important for the successful development and implementation of POTKU. As the project manager of POTKU summarized: *"In the management of the project you can always lean on the common framework; it helps in coordinating and focusing the development work. The framework steered common goals and reporting and helped in the administration of an extensive programme with lots of actors in a large geographical area"*.

Second, improving patient-centredness, one of the main aims of the project, was quite successfully achieved using a multifaceted strategy involving (1) support for healthcare providers and patients, (2) establishing productive collaborations and (3) adapting the care delivery process. To this end,

development work was targeted on everyday tools to improve patient-centredness, most notably the HCP, which was considered the most significant output of the project. As the interviewed GP/unit manager stated: *“The care plan is a big thing! Although it has to be developed further in future... Lots of practical tools were developed... awareness and knowledge to do things in an alternative way, e.g. by utilizing third sector services, are already there. This knowledge has to be integrated in usual care and everyday practices more closely in future.”* Collaboration between different health centres, multiprofessional development groups, commitment of management as well as staff’s willingness to change attitudes and develop new work routines were seen as key success factors towards more patient-centredness.

Third, the POTKU project was integrated in ‘usual care’. The key actors of the project, for example the managers of sub-projects, were partly working at and paid by local health centres. Thus the development of care took place at the level of daily practice, which increased acceptability and willingness to change, and could be implemented in everyday operations.

Fourth, according to the interviewees, it took time to establish the structures for development in the health centres: concerning e.g. who is responsible of the development of work practices, what kind of development team supports this ‘change agent’, what kind of collaborating, meetings and reporting to the management is needed. These development structures and practices evolved during the project, though this was not stated as an aim in the beginning.

Fifth, sustaining a large project beyond the duration of the grant has proven to be difficult in various cases and is greatly dependent on leadership and enthusiasm of managers and staff. Now that the POTKU project has finished, several activities, such as preparing health care plans or collaborating with the staff in other health centres, will not continue on a similar scale. It remains to be seen what happens to activities such as the collaboration with the third sector, which were expected to continue.

Sixth, attempts to develop integrated patient-centred care were mostly limited to primary care. Although cooperation with third sector services, such as support from patient organizations, was enhanced, the links between primary health care, social care and secondary care remained sparse. Financial and structural reforms in health and social care as well as effective and compatible eHealth tools and information systems are needed to enable better integration and support patient-centred care.

To conclude, the POTKU project, with its holistic view on chronic care and linkages to and collaborations with other Finnish development projects, has been quite effective in fostering patient-centredness. It forms a promising base to develop better care for people with multimorbidity in the future. The ideas and principles of the POTKU project will be continued in a new project called *A Better Everyday Life (Parempi arki)*, which will also receive funding from the national Finnish KASTE Development Programme). This project will focus on ‘complex needs’ patients – many of them suffering from multimorbidity – with a high demand for care services and particularly aims to improve cooperation between primary and secondary care and between health and social care.

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Colophon The ICARE4EU project and the selection of ‘high potential’ programmes

The ICARE4EU project aims to identify, describe, and analyse innovative integrated care practices for people with multimorbidity in European countries, and to disseminate knowledge and experiences from these practices to all European countries in order to support further implementation of effective and sustainable care approaches for European citizens with multimorbidity (www.icare4eu.org).

Multimorbidity is defined in this project as *the presence of two or more medically (somatic or psychiatric) diagnosed chronic (not fully curable) or long lasting (at least six months) diseases, of which at least one is of a primarily somatic nature.*

In 2014, country experts in 31 European countries identified programmes at a national, regional or local level that focus(ed) on providing care for adult (or older) people with multimorbidity, or contain(ed) specific elements for this target group. Programmes had to comprise a formalized cooperation between two or more services, of which at least one medical service; and they had to be evaluated – or had an evaluation planned – in some way. Detailed information about these programmes was collected via a survey to be completed by the programme coordinator. In this way, country experts identified 178 programmes, of which 101 (from 24 countries) were considered eligible for analysis by the project team.

As a next step in the project, these 101 programmes were evaluated by the project team based on quantitative and qualitative criteria. For each programme, five quantitative scores were computed, a general score (assessing general aspects such as its evaluation design, perceived sustainability and transferability) and four scores that provided an indication of its level of 1) patient-centredness, 2) integration of care, 3) use of eHealth technologies and 4) its innovativeness in financing integrated care services. Subsequently, members of the project team qualitatively assessed these four aspects again for a selection of programmes that had high quantitative scores. The qualitative evaluation was based on the available descriptive information gathered by the survey (e.g. description of the aims of the programme, the reported strengths and weaknesses) and already published evaluation reports. This resulted in a short list of so called ‘high potential’ programmes. To decide whether or not to select a programme of this list for further study, the project team checked with the country expert and/or verified information by contacting the programme coordinator. In this way, eight programmes were selected for a site visit; all programmes positively responded. The eight programmes that were visited were operational in Belgium, Bulgaria, Cyprus, Denmark, Germany, Finland, the Netherlands and Spain.

This case report is based on information about the programme POTKU (Potilas kuljettajan paikalle – Väli-Suomen KASTE-hanke, Putting the Patient on the Driver’s Seat), Finland. For this case report, the previously collected survey data were verified and enriched by data from internal or external documents and qualitative interviews with the project managers, representatives of care providers and a representative of a patient family association. All interviews were conducted by two members of the ICARE4EU project team, and were recorded. Interviewees received the draft text of the case report for validation, and approved the final report. All interviewees signed a written agreement to publish this case report.

Appendix 1 Some characteristics of the health and social care system in Finland (14, 15)

Health and social care

The Parliament of Finland together with the Finnish Government set the objectives for health and social security at the national level, and municipal parliaments at the local level. The Ministry of Social Affairs and Care directs and guides health and social services at the national level. Health and social care is primarily funded through taxation. The parliament nationally and municipal parliaments locally set the total budget for public health and social funds. Thus, typical for Finland is a strong integration of health and social care nationally and locally, both in provision and financing. Municipalities (over 300) are responsible for organising social welfare and health care. They can provide basic social welfare and health care services alone, or form joint municipal authorities with other municipalities. Municipalities may also purchase social welfare and health care services from other municipalities, organisations or private service providers.

Health care

Health care in Finland has been traditionally divided into primary care and specialized care. The Finnish health care system has been quite decentralized; municipalities have played a large role in organising and producing health care. Every municipality must have a health centre which provides primary health services. Hospital districts (20) organise specialized medical care, but it is financed by municipalities. In addition, hospital districts are responsible for planning and developing specialized medical care so that primary care and specialized care form a functioning whole. In addition to public municipal health care and private health care, there is an occupational health care system, which obliges employers to provide free preventive health care services for employees. As in many other European countries, the total population of Finland is covered for healthcare costs (through the National Health Insurance (KELA). Benefits are comprehensive, though clients' fees have increased in recent years.

Social care, home care and care for the elderly

In Finland, municipalities have the responsibility for social care, home care and long-term care for the elderly, although those services can be provided by both the public and private sector. In Finland, as in many other countries, care at home, self-care and continuity of care have been political and managerial targets for care provision. This has increased the need to find new ways to provide care in home settings, like new technologies and mobile services. In addition, the need to increase support for family/informal carers has been put on the political agenda.

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