

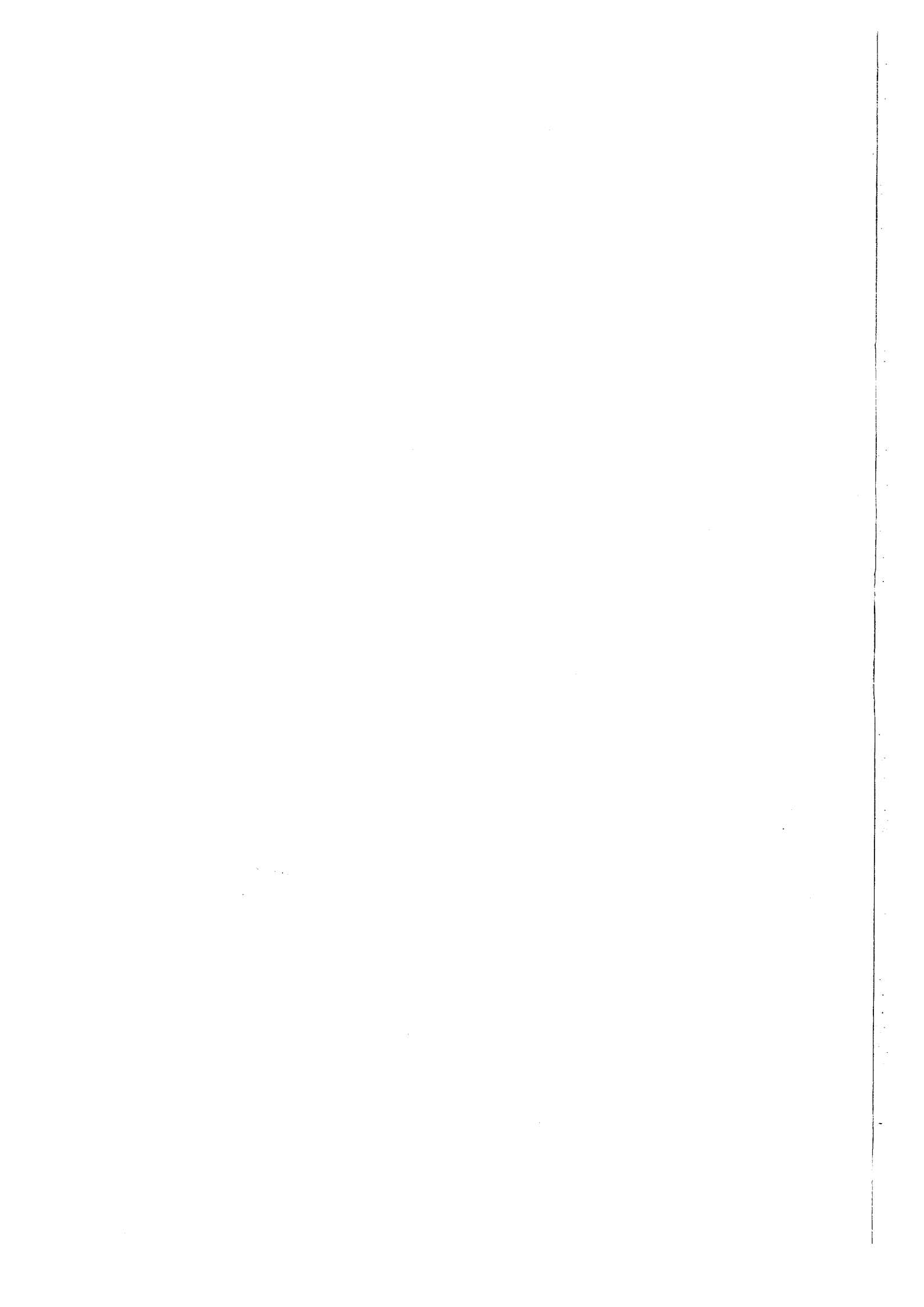
14th INTERNATIONAL CONFERENCE ON HEALTH PROMOTING HOSPITALS

May 24-26, 2006, Palanga, Lithuania

**Integrating health promotion, prevention, treatment and
care for chronic diseases across the health system**

Conference Web Site

<http://www.univie.ac.at/hph/palanga2006/htm/home.htm>



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LETTERS OF WELCOME

LETTER OF WELCOME FROM WHO

More than a decade ago the WHO Health Promoting Hospitals project was initiated in order to support hospitals towards placing greater emphasis on health promotion and disease prevention, rather than on diagnostic and curative services alone. One of the first conference took place in Kaunas in 1996 showing the interest in Lithuania on the possibilities of the concept for improving health of the population by reforming the hospitals with a new service culture. Since then, the Lithuanian HPH network has been growing and has been one of the pillars of the development of the HPH international Network. Since the beginning of the International Network of Health Promoting Hospitals it has steadily expanded and now covers 25 Member States, 36 national or regional networks and more than 650 partner hospitals. Now the focus is not to convince the management of the hospitals of the network on the effectiveness of the project but to develop evidence to convince other hospitals and prepare tools to support the work on the ones already working. The self-assessment tool has been prepared as being used by many hospitals. Also discussions are on the way to introduce some of the standards and indicators in the most assessment and accreditation tools. At the same time the book Health promotion in hospitals: evidence and quality management, the Health promotion in hospitals: evidence and quality management have been selected for the exhibition on the WHO World Health Assembly this year, where the Ministers of Health or their representatives from 192 will be present, which gives recognition to the work done during all these years.

I want to take the opportunity to thank all the persons in the Lithuanian network that have worked very hard and sometimes even against the normal hospital trends focussing more on efficiency and cost than in patients or health outcomes, and very specially its coordinator dr. Irena Miseviciene who has participated in workshops and discussions since the beginning of the network, without her we will not be here today.

Dr. Mila Garcia-Barbero
World Health Organization Regional Office for Europe,
Division of Country health Systems,
Head of Barcelona Office

LETTER OF WELCOME BY CHAIRS OF SCIENTIFIC COMMITTEE

Dear colleagues and friends,

On behalf of the Scientific Committee we warmly welcome you to the 14th International Conference on Health Promoting Hospitals.

"Integrating health promotion, prevention, treatment and care for chronic diseases across the health system" is the title of our conference. Why has the Scientific Committee chosen to address this topic in a conference in Lithuania?

Firstly, because epidemiological data clearly show the need for action in this field. Following WHO data, 400 million people worldwide will die from chronic diseases over the next 10 years. In the WHO European region, 86% of deaths are due to chronic diseases, the most important diagnoses being cardio-vascular diseases (responsible for ~50% of deaths in the region), cancer (responsible for ~20% of deaths in Europe), respiratory disorders, digestive disorders and neuropsychiatric disorders. **Plenary 1** of the conference will provide us with more in-depth information about epidemiological data and possible action to react.

The second reason why we chose this topic is that, because of the importance of the topic, WHO is currently developing a strategy on chronic diseases, and the host country of this conference, Lithuania, has a strong tradition of cooperation in international projects of WHO in the field.

And, thirdly, of course Health Promoting Hospitals can play a significant role in tackling chronic diseases, by developing models of improving the hospital's role in addressing chronic diseases. Into which direction can this go?

Let us start with the role of the hospital: Since hospitals usually see patients with chronic diseases only in times of acute crises, and since the length of stay in the hospital is continuously reduced due to medical and technological developments, hospitals have to act within a framework of cooperation with other healthcare services, taking up concepts of integrated and continuous care, case and disease management.

Now, what has health promotion got to do with it? There are numerous aspects which are also mirrored in the conference program.

Plenary 2 will address the relevance of internal hospital organisation for tackling chronic diseases: There are at least two aspects that need to be considered from a health promotion perspective: Firstly, the fact that optimum health outcomes can only be achieved if the patients are empowered to comply to and cooperate in treatment and care, so as to co-produce the best possible results. For health care professionals, this provides the challenge of empowering patients to become experts for their chronic condition. Secondly, when addressing chronic diseases, aspects of mental and social health become much more relevant than in acute and rather short-term disease. Thus, for an optimum outcome, patients also need to be supported emotionally and socially.

Plenary 3 is about the cooperation of hospitals with other health care services. We will learn what role hospitals should ideally have in the health care chain in order to provide optimum support for patients with chronic diseases – and of course different models will have to be developed for different diseases.

Plenary 4 will finally address the importance of settings conditions for the management and prevention of chronic diseases and how hospitals can cooperate with other settings like schools and enterprises to both prevent the development of chronic conditions, and to support healthy living for people who are already affected.

All these issues will further be discussed also in the parallel and poster sessions of this conference.

We thank everybody who contributed to the preparation and organisation of this conference.

The local host organisations and the local organising committee for excellent preparation and cooperation;

The Scientific Committee who supported the program development and provided the screening of the abstracts;

And all speakers, presenters and chairs in plenary, parallel and poster sessions who made it possible to offer such a full and diversified program.

We wish all delegates fruitful professional discussions, exchange of experiences and knowledge, and personal networking, and a good time in Palanga.

Prof. Jürgen M. Pelikan
(Chair, Scientific Committee)

Prof. Irena Miseviciene
(Vice-Chair, Scientific Committee)

SCOPE AND PURPOSE OF THE CONFERENCE

There are at least three reasons why the Scientific Committee has decided to choose chronic diseases as the main topic of the 14th International Conference on Health Promoting Hospitals (HPH): Firstly, because epidemiological data clearly show the need for action in this field, which is on the agenda of main European and international players. Secondly, because HPH can play a significant role in tackling this problem, since chronic diseases are – apart from genetic predispositions – strongly influenced by personal behaviour, physical and social environments. Thus, the settings approach of health promotion as well as the concept of empowering education and training can specifically contribute to prevention, but also to improving the quality of health care provision and the quality of life for those who are affected. Finally, the host country Lithuania has a strong tradition of cooperation in international projects of WHO in the field.

THE NEED FOR ACTION ON CHRONIC DISEASES

Following WHO data, 400 million people worldwide will die from chronic diseases over the next 10 years. In the WHO European region, 86% of deaths are due to chronic diseases, the most important diagnoses being cardio-vascular diseases (responsible for ~50% of deaths in the region), cancer (responsible for ~20% of deaths in Europe), respiratory disorders, digestive disorders and neuropsychiatric disorders. Still, following recent OECD data, there is a considerable mismatch between resources which are spent on curative services, and those which are spent on prevention.

Against this background, the conference will look not only at the generally growing importance of chronic diseases, but also into differences in epidemiology between new and old EU member states, into new epidemiological trends, and on the impact of chronic diseases on the quality of life and the development of QALYs and DALYs.

INTEGRATING TREATMENT, CARE, PREVENTION AND HEALTH PROMOTION FOR CHRONIC DISEASES WITHIN HOSPITAL SERVICES IN ORDER TO ACHIEVE AN OPTIMUM OUTCOME

How can hospitals organise their services in order to improve the health outcomes for patients at risk or suffering from chronic diseases? Especially for chronic patients who stay more often and longer in hospital than acute patients, the quality of the physical hospital setting (e.g. patient safety, hotel services), and the quality of general patient orientation and communication have an important impact on their health. But a hospital stay also represents a window of opportunity to train patients for better self management of disease like coronary heart disease, stroke, diabetes, COPD, cancer, and for interventions towards healthy lifestyles.

The conference will discuss how prevention, treatment and care can be developed and combined, using principles of health promotion, so as to achieve an optimum health outcome for patients suffering from chronic diseases.

INTEGRATING HEALTH CARE INTERVENTIONS ON CHRONIC DISEASES ACROSS LEVELS OF SERVICES

Patients with chronic conditions often fluctuate between different providers of health and social services, which can result in considerable discomfort for them but also in a reduction of effectiveness and efficiency of services. Cooperation between the hospital and other services is therefore vital for achieving an optimum health gain. The conference will discuss how models of integrated care, including palliative care, managed care and disease management approaches can be developed using HP principles.

Another topic will be how hospitals can contribute to improving patients' literacy for adequate use of the health care system, and how patients as experts for their health care needs can be involved in the designing and planning of adequate services.

INTEGRATING ACTION ON WIDER DETERMINANTS OF CHRONIC DISEASES ACROSS SETTINGS

Chronic diseases are influenced by numerous determinants. Action on these determinants needs to involve many players across settings, including health care systems, families, schools, workplaces, etc. The conference will discuss especially those effective interventions where hospitals can play an active role hospitals in cooperating with other sectors in tackling health determinants.

CONFERENCE PARTNERS

ORGANISERS

World Health Organization, Regional Office for Europe (<http://www.euro.who.int/eprise/main/WHO/Progs/HPH/Home>)
WHO Network of Health Promoting Hospitals (HPH) (<http://www.univie.ac.at/hph/palanga2006/hph/hph.htm>)
Lithuanian Health Promoting Hospitals (<http://www.kmu.lt/SSL>)
WHO Collaborating Centre for Health Promotion in Hospitals and Health Care (<http://www.hph-hc.cc>)
Ludwig Boltzmann Institute for the Sociology of Health and Medicine (<http://www.univie.ac.at/lbimg>)

CO-ORGANISERS

European Commission (http://europa.eu.int/comm/index_en.htm)
Ministry of Health of Republic Lithuania (<http://www.sam.lt>)
Kaunas University of Medicine (<http://www.kmu.lt>)
Kaunas University, Institute for Biomedical Research (<http://www.kmu.lt>)
Kaunas University Hospital (<http://www.kmuk.lt>)
European Hospital and Healthcare Federation (HOPE) (<http://www.hope.be>)
European Federation of Nurses Associations (EFN)
International Union for Health Promotion and Education (IUHPE) (<http://www.iuhpe.nyu.edu>)
International Alliance of Patients' Organisations (IAPO) (<http://www.patientsorganizations.org>)
European Association of Hospital Managers (EAHM) (<http://www.eahm.eu.org/index.php>)
Permanent Working Group of European Junior Doctors (PWG) (<http://66.197.129.117/~pwgeurop/site>)
European Network on Workplace Health Promotion (WHP) (<http://www.enwhp.org>)
European Network of Smoke-Free Hospitals (<http://ensh.free.fr>)
Austrian Federal Ministry of Health and Women (<http://www.bmgf.gv.at>)

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PROGRAM OVERVIEW

Wednesday, May 24, 2006

09.00 – 17.00	12th WHO Workshop of National/Regional network Coordinators <i>Venue: Dubysa</i>
17.00 – 19.30	Onsite registration <i>Venue: Vanagupe Hotel</i>
17.15 – 18.45	Meeting on Task forces on Health Promotion in Psychiatric services <i>Venue: Dubysa</i> <i>Moderator: Hartmut Berger (Germany)</i>
19.30	Welcome Reception <i>Venue: Art and recreation club "Kupeta"</i> <i>Official welcome: Remigijus Kirstukas (Mayor of Palanga)</i>

Thursday, May 25, 2006

08.00 – 09.00	Registration <i>Venue: Vanagupe Hotel</i>
09.00 – 09.30	OPENING CEREMONY <i>Venue: Dubysa</i> <i>Chairs: Jürgen M. Pelikan (Austria), Irena Miseviciene (Lithuania)</i> Welcome speeches: <i>Zilvinas Padaiga (Professor, Minister of Health, Lithuania)</i> <i>Mila Garcia-Barbero (WHO-European Office for Integrated health care Services, Barcelona)</i> <i>Jürgen M. Pelikan (Chair, Scientific Committee, LBI Vienna)</i> <i>Irena Miseviciene (Co-chair, Scientific Committee, Kaunas University of Medicine, Kaunas)</i>
09.30 – 10.30	PLENARY I: The need for action on chronic disease <i>Venue: Dubysa</i> <i>Chairs: Jürgen M. Pelikan (Austria), Irena Miseviciene (Lithuania)</i> The burden of chronic diseases in Europe and the most urgent areas for action – an overview <i>Anders Foldspang (Professor, President ASPHER, Aarhus University, Denmark)</i> Public health action on chronic diseases: European strategy to empower health systems <i>Vilius Grabauskas (Professor, Chancellor Kaunas University of Medicine, Chair Countrywide Integrated Noncommunicable Disease Intervention management committee, Lithuania)</i>
10.30-11.00	Coffee Break <i>Venue: Vanagupe Hotel</i>
11.00-12.30	PARALLEL SESSIONS I: 1.1 Examples for organising health systems to meet the challenge of chronic diseases <i>Venue: Dubysa</i> <i>Chair: Jacques Dumont (Belgium)</i> I-1.1. Chronic diseases as an increasing challenge to the public health sector: the German answer: Interdisciplinary centre as a problem solution strategy <i>Bernhard Ferdinand Henning (Germany)</i> I-1.2. Chronic diseases control policy in Lithuania: from population based to hospital based preventive programs <i>Irena Miseviciene, Zemya Milasauskiene (Lithuania)</i> I-1.3. The definition of the most appropriate and feasible clinical and organizational methods for managing chronic patients <i>Mariella Martini, Rosanna Carbognani, Giuseppe Noto, Cristina Pedroni, M. Giulia Calzari, M. Beatrice Bassi (Italy)</i>

I-1.4. Hub & Spoke networks for rare /chronic disabling diseases

Stefano Liverani (Italy)

I-1.5. Difficult hospital discharges in internal medicine wards: shared pathways for a sheltered fate as a tool for the comprehensive complex frail patient's needs, reducing inappropriate hospital use

Roberto Nardi, Antonella Tragnone, Antonella Lolli, Patrizia Kalfus, Giovanna Corsini, Luisa Diana, Teresa Ghedini, Stefano Bombarda, Saverio Di Ciommo (Italy)

I-1.6. A Model of Integrated Primary Care for Chronic Physical and Psychological Health

Susan Frampton (United States)

I-1.7. Conducting a Consumer panel for Cancer Services

Breen A, Harnett A, Hand C, Ryan C. (Ireland)

I-2. Migrant friendly and culturally competent healthcare -1

Venue: Minija

Chairs: Antonio Chiarenza (Italy), Gurwinder Gill (Canada)

I-2.1. Migrant-friendly and culturally competent communication. The development of an integrated language and intercultural mediation service for hospital and primary care services

Antonio Chiarenza (Italy)

I-2.2. Towards Sustainability and Integration of Cultural Competency in Healthcare

Gurwinder Gill (Canada)

I-2.3. Improving ethno-cultural competence of hospital staff by training - Experiences from the European Migrant Friendly Hospitals project

Karl Krajic, Christa Straßmayr, Ursula Karl-Trummer, Sonja Novak-Zezula, Juergen M. Pelikan (Austria)

I-2.4. Migrant friendly hospitals in piedmont - experience and reflections

Luigi Resegott, Mario Carzana (Italy)

I-2.5. Improving patient and community empowerment: the participatory action research/learning as an alternative approach

Lai Fong Chiu (United Kingdom)

I-2.6. Information and reception in first aid and emergency medicine

Mario Luppi, Ida Breviglieri, Ivano Giacomino (Italy)

I-2.7. Cultural Competence in Highly Specialized Health Care

Manuel Fernandez (Sweden)

I-3. Smoke-Free Hospitals

Venue: Sventoji

Chairs: Sybille Fleitmann (Germany), Simone Tasso (Italy)

I-3.1. Development of the German Network of Smoke-free Hospitals using the code and the tools of the European Network for Smoke-free Hospitals

Christa Rustler, Manja Nehrkorn, Daniela Piontek (Germany)

I-3.2. Evaluation of the Plan of Action for a Smoke-free Hospital

David Chalom (Sweden)

I-3.3. "Has Irish tobacco legislation impacted on the attitudes, beliefs and smoking habits of hospital health care workers and, if so, how?"

Rose Byrne, Nuala Mc Keown (Ireland)

I-3.4. Smoking cessation strategies for hospital patients

Gary Bickerstaffe (England)

I-3.5. Introduction of daily Carbon Monoxide testing on in-patient smokers in an acute hospital setting

Mary Smyth, Rachael Gannon (Ireland)

I-3.6. The smoke free hospital- a troublesome implementation

Ib Søggaard (Denmark)

I-4. Mental health promotion in the health care system

Venue: Dane

Chair: Hartmut Berger (Germany), Alina Stigienė (Lithuania)

I-4.1. Patients Rights in Lithuanian Psychiatric Hospitals

Danguole Survilaite (Lithuania)

I-4.2. Early recognition and intervention, a key component in the success in the treatment of schizophrenia

Inge Joa (Norway)

I-4.3. Changes in the Lithuanian psychiatry

Ona Davidoniene (Lithuania)

I-4.4. Nurse Case Management in severe psychiatric disorders in a Community Mental Health Centre of Bologna (Italy)

Rossella Capelli (Italy)

I-4.5. Reducing the medicos' tension

Lolita Cemnaliaskiene (Lithuania)

I-4.6. Psychological care of women in pregnancy and the puerperium

Margaret Sheridan (Ireland)

I-5. Health promotion for children and adolescents in hospitals

Venue: Jura

Chair: Fabrizio Simonelli (Italy)

I-5.1. - Health promotion for children and adolescents in hospitals (HPH-CA): up-date: Overview presentation for the parallel session

Katalin Majer, Maria José Caldes Pinilla, Fabrizio Simonelli (Italy)

I-5.2. The rights of children in hospital: present situation and prospects in the European hospitals

Giuliana Filippazzi, Katalin Majer, Maria José Caldes Pinilla, Fabrizio Simonelli, Caterina Teodori (Italy)

I-5.3. Implementation of the Project "For Mother and Newborn"

E. Markuniene, N. Skorobogatova, E. Krakauskiene, L. Gailiunaite, D. Stoniene, J. Ribeliene (Lithuania)

I-5.4. The "Pain-free hospital model" applied to pediatric oncohaematology: play therapy as a non-pharmacological support to painful procedures

Dorella Scarponi, Elena Marri, Simonetta Baroncini, Stefano Liverani, Andrea Pession (Italy)

I-5.5. Playing and taking care - the young chronic patient

Fabia Franchi, Sabrina Predieri, Leana Bichecchi, Cinzia Badiali (Italy)

I-5.6. Working Group on HPH-CA: the experience of the use of the online Community of practice like a tool for a European network

Marco Luvisi, Fabrizio Simonelli, Katalin Majer, Maria José Caldes Pinilla (Italy)

12.30-13.30

Lunch

Venue: Vanagupe Hotel

13.30 – 15.00

PLENARY II: Integrating treatment, care, prevention and health promotion for chronic disease within hospital services in order to achieve an optimum outcome

Venue: Dubysa Room

Chairs: Zora Bruchacova (Slovakia), Yannis Tountas (Greek)

Chronic diseases from the patient's perspective

Klaus-Diethart Hüllemann (Professor, Cardiologist, retired medical director of the St. Irmingard rehabilitation, Germany)

Health Promotion and Disease Management: view from country in transition

Vilnis Dzerve (Professor, Director of Latvian Institute of Cardiology, Latvia)

15.00-15.45

POSTER SESSIONS I

Venue: Vanagupe Hotel

I-1. The need for action on chronic diseases: Models and examples for tackling diabetes

Chair: Jacques Dumont (Belgium)

I-2. The need for action on chronic diseases: Models for tackling cancer and respiratory diseases

Chair: Luis Cote (Canada)

I-3 The need for action on chronic diseases: Models and examples for tackling diverse conditions – 1

Chair: Lillian Møller (Denmark)

I-4 Health promotion for children and adolescents in hospitals- 1

Chair: Egle Tamuleviciene (Lithuania)

I-5 Migrant friendly and culturally competent hospitals

Chair: Karl Krajic (Austria)

I-6 Health promoting psychiatric health care services and mental health promotion in the health care system - 1

Chair: Valentinas Maciulis (Lithuania)

I-7 Cooperation with other health care services in order to achieve optimum health outcomes for patients with chronic conditions

Chair: Aurelijus Veryga (Lithuania)

I-8 Smoke-Free Hospitals

Chair: Bertrand Dautzenberg (Germany)

I-9 Monitoring, evaluation, reporting and research on HPH interventions- 1

Chair: Maria Hallman Keiskoski (Finland)

15.45-16.15

Coffee Break

Venue: Vanagupe Hotel

16.15-17.45

PARALLEL SESSIONS II:

II-1. Health promoting psychiatric health care services

Venue: Dubysa

Chair: Jürgen Pelikan (Austria)

II-1.1. The task forces on health promotion in psychiatric services: What is it good for?

Hartmut Berger (Germany)

II-1.2. Prevention and Management of Chronic Courses in Psychiatric Disturbances

Hartmut Berger, Rainer Paul, Eva Heiath (Germany)

II-1.3. Glasgow Forensic Services 'Have a brave heart'

Thomas Harrison, Barbara Wilson, Janice Turnbull (Scotland)

II-1.4. The integration of the mental health service and primary care. From the local experiences to the Emilia-Romagna region project

Maria Bologna, Rosanna Carbognani, Tiziano Ferretti, Gaddomaria Grassi (Italy)

II-1.5. Health promotion in mental health nursing: opportunities, barriers and challenges: a qualitative study.

Christine Deasy (Ireland)

II-1.6. Health Promotion Activities at Republican Vilnius Psychiatric Hospital

Alina Stigiene, Valentinas Maciulis (Lithuania)

II-1.7. Effects of a late life depression education program on primary care nurses knowledge, attitudes and use of a brief screening protocol in practice

Mary Pat Butler (Ireland)

II-2. Models and examples for action on chronic diseases (II): Cardio-vascular diseases, kidney-disease and renal problems

Venue: Minija

Chair: Nils Undritz (Switzerland)

II-2.1. CardioVision 2020: Preventing Heart Disease in the Community and the Clinic

Thomas Kottke (USA)

II-2.2. Integrating health promotion into hospital routine: a set of educational program in a Cardiac rehabilitation unit

Stefano Boni, Bettinelli Antonia, Gallifuoco Maria Pia, Mariani Paola, Sarzi Braga Simona, Pedretti Roberto (Italy)

II-2.3. New home care management model for chronic cardiopathies in the elderly referred to Pieve di Coriano hospital: telecardiography and tele consultancy

Maria Cristiana Brunazzi, Pier Vincenzo Storti, Mario Pasqualini, Camelia Gaby Tiron, Raffaele Mazzucco, Maurizio Nagrelli, Marina Bellaz, Rita Sandrini, Cristina Grigoli, D. Monopoli, R. Teoli, D. Pozzetti, D. Padovani, E. Ceccarelli, E. Venturelli, A. Filippi, V. Fontanesi (Italy)

II-2.4. "Stroke care": the Emilia-Romagna integrated management project for stroke patients

Salvatore Ferro, Augusto Cavina, Francesco Nonino, Alessandro Liberati, Piera Pallazoni, Stefano Liverani (Italy)

II-2.5. Patients undergoing Oral Anticoagulant Therapy: dedicated pathway and self-management methods

Mauro Silingardi, Anna Maria Casali, Galimberti Daniela (Italy)

II-2.6. A different approach to preventing life threatening kidney disease in later life

Sue Vernon (United Kingdom)

II-3. Health promotion for hospital staff + developing the health promotion quality of hospital management systems

Venue: Sventoji

Chairs: Elimar Brandt (Germany), Tiiu Harm (Estonia)

II-3.1. Health promoting ageing for hospital staff – sults of a literature review

Dietscher Christina, Hübel Ursula, Nowak Peter (Austria)

II-3.2. Health promotion and the EFQM model: society results

Danilo Orlandini, Lorena Franchini, Silvia Candela, Giovanni Morini, Sara Baruzzo, Dorella Costi, Sandra Venero, Paolo De Pieri, Ulrich Wienand (Italy)

II-3.3. Professional accreditation standards promote health care interventions integration and quality of care

Danilo Orlandini, Gualtiero De Bigontina, Danila Fava, Nino Cimino, Illidio Meloncelli (Italy)

II-3.4. Development of Guidelines for a Gender Friendly hospital

Anna Utermann, Anna Maria Dieplinger (Austria)

II-3.5. Management of clinic and assistance practice security in the emergency area

Enrico Burato, Camelia Gaby Tiron, Graziella Borsatti, Alberto Rigo, Mario Luppi, Angela Saccardi, Mentore Carra, Simonetta Chiarucci, Ida Breviglieri (Italy)

II-4. Workshop to promote practical implementation of the smoke free hospital concept of the European Network of Smoke free Hospitals : a "hands on workshop"

Venue: Dane

Moderators: Sibylle Fleitmann, Ariadni Ouranou, Anne-Marie Schoelcher, Ann O'Riordan, Bertrand Dautzenberg (Germany)

II-5. Models and examples for action on chronic diseases (I): Diabetes, metabolic disorders and respiratory problems

Venue: Jura

Chairs: Mariella Martini (Italy)

II-5.1. Diabetes mellitus and patients' emotions

E. Danyte, E. Danieliute, J. Janusauskaitė, R. Zalinkevicius (Lithuania)

II-5.2. Integration between hospital and general practitioner in the clinical pathway of the diabetic patient

Ezio Bosi, Liliana Rabitti, Giuseppina Chierici, Dario Gaiti, Danilo Orlandini (Italy)

II-5.3. Aerosol respiratory hygiene as a main part of prevention of chronic obstructive pulmonary diseases and health promotion for patients in hospitals

Alina V. Chervinskaya (Russia), Virginijus Biskys (Lithuania)

II-5.4. HPH Strategies in The Chilean Health Reform: a Model of Care for Chronic Respiratory Patients and a Diabetic Foot Prevention Program

Jaime Acevedo, José Luis Rocabado, Luis Barrueto, Christian Yáñez (Chile)

II-5.5. Weaning centre: a sustainability path to deal with the increasing number of chronic pulmonary diseases

Ulli Weisz, Willi Haas (Austria)

II-5.6. Effect of structured education on the follow up results of metabolic syndrome patients

Laszlo Kautzky (Hungary)

15.00 – 17.45 **Meeting of TF “of Children and adolescents”**

Palanga Rehabilitation Hospital Small hall

Participation upon invitation

15.00 - 18.00 **Meeting of TF “Migrant Friendly Hospitals”**

Palanga Rehabilitation Hospital Main Hall

Participation upon invitation

19.30 **Conference Dinner**

Venue: Restaurant Vienkiemis

Friday May 26, 2006

09.00 – 10.30 **PLENARY III: Integrating treatment, care, prevention and health promotion for chronic disease across levels of services for patient empowerment, including palliative care, case management and disease management approaches**

Venue: Dubysa

Chairs: Hanne Tonnesen (Denmark), Carlo Favaretti (Italy)

Cooperation and partnerships across the health system for improving health promotion, prevention, treatment and care to address the chronic disease challenge

Sylvie Stachenko (Professor, Deputy Chief, Public Health Agency, Canada)

Harmonizing the health care system for meeting the needs of children with type 1 diabetes

Zilvinas Padaiga (Professor, Minister of Health, Lithuania)

10.30-11.15 **POSTER SESSIONS II**

Venue: Vanagupe Hotel

II-1 The need for action on chronic diseases: Models for tackling Coronary and cardio-vascular problems

Chair: Zemyna Milasauskiene (Lithuania)

II-2 The need for action on chronic diseases: Models and examples for tackling diverse conditions – 2

Chair: Evalda Danyte (Lithuania)

II-3 Health promotion for children and adolescents in hospitals- 2

Chair: Peter Nowak (Austria)

II-4 Health promotion for the disabled and for the elderly

Chair: Jurate Macijauskiene (Lithuania)

II-5 Health promoting psychiatric health care services and mental health promotion in the health care system - 2

Chair: Danguole Survilaite (Lithuania)

II-6 Health promotion for hospital staff

Chair: Mary Pat Butler (Ireland)

II-7 Improving the health promoting quality of hospital services

Chair: Thomas Kottke (USA)

II-8 Monitoring, evaluation, reporting and research on HPH interventions- 2

Chair: Jutta Skau (Denmark)

II-9 Networking for health and cooperation with other settings

Chair: James Robinson (Scotland)

11.15-11.45	<p>Coffee Break <i>Venue: Vanagupe Hotel</i></p>
11.45-13.15	<p>PARALLEL SESSIONS III:</p> <p>III-1. Improving lifestyles as important determinants for the prevention of chronic diseases <i>Venue: Dubysa</i> <i>Chair: Margareta Kristenson (Sweden)</i></p> <p>III-1.1. Motivational counselling among smokers and harmful drinkers acutely admitted to a department of neurology <i>Hanne Tønnesen, Bente Munkholm Nelbom, Bente Wind, Vibeke Olsen, Trine Larsen, Vibeke Backer (Denmark)</i></p> <p>III-1.2. Counseling and treating smokers in family practice <i>Madis Veskimagi (Estonia)</i></p> <p>III-1.3. Effect of multifaceted intervention promoting preoperative smoking and alcohol cessation: Controlled, prospective, before and after study <i>Hanne Tønnesen, Pernille Faurschou, Ditte Mølgaard-nielsen, Grete Thomas, Vibeke Backer, Helge Ralov (Denmark)</i></p> <p>III-1.4. Working together for health - partnership and networking <i>Tiiu Harm (Estonia)</i></p> <p>III-1.5. Fresh fruit & vegetables in a Scottish hospital? <i>Claire Goodheir, Paul Macintyre (Scotland)</i></p> <p>III-1.6. Promoting active living for persons with chronic disabilities <i>Michael Spivock, Lise Gauvin, Jean-Marc Brodeur (Canada)</i></p> <p>III-2. Migrant friendly and culturally competent healthcare -2 <i>Venue: Minija</i> <i>Chairs: Lai Fong Chiu (United Kingdom)</i></p> <p>III-2.1. The Migrant Friendly Hospital project in Aosta Valley – Italy <i>Giorgio Galli, Patrizia Petey (Italy)</i></p> <p>III-2.2. The intercultural mediation programme Hospital del Mar. Barcelona. Spain: Activity indicators and results of the perception and satisfaction survey of the professionals. <i>Cristina Iniesta Blasco, Ana Sancho Gomes de Travesedo, Maribel Perez Piñero, Montserrat Antonin (Spain)</i></p> <p>III-2.3. 'Fair for All' - Improving Health Care for Minority Ethnic Communities in Scotland <i>James Robinson (Scotland – UK)</i></p> <p>III-2.4. Inter-cultural Hospital in the Lombardia Region: actions and results <i>Scrabbi Lucia, Tersalvi Carlo Alberto, Avisani Rosaria (Italy)</i></p> <p>III-2.5. Securing of efficient, culturally differential nursing care for Vietnamese and Chinese minority in the Czech Republic <i>Valérie Tóthová, Gabriela Sedláková, Miloš Velemínský, Adéla Mojžíšová (CzechRepublic)</i></p> <p>I-2.6. Recent achievements of a mobile team specialized in transcultural psychiatry <i>Richard Simon (Switzerland)</i></p> <p>III-2.7. "The union makes the strength" - "Intercultural" plans comfort and welcome near the emergency and acceptance of Pieve di Coriano and Mantova hospital department <i>Pierpaolo Parogni, Mario Luppi, Carlo Calamari (Italy)</i></p> <p>III-2.8. International Healthcare Garden in Taiwan <i>Ivy Shiue (Taiwan)</i></p> <p>III-3. Monitoring, evaluation and reporting on HPH interventions <i>Venue: Sventoji</i> <i>Chairs: Maria Hallman-Keiskoski (Finland), Elimar Brandt (Germany)</i></p>

III-3.1. Towards sustainability for HPH- monitoring and evaluation of the 'Hub' hospital approach

Ann Kerr, James Robinson, Thomas Harrison, Audrey Miller, Sarah Bush (Scotland)

III-3.2. Pilot study of developing a patient safety model within the frame of reference of a health promoting hospital

Maria Hallman-Keiskoski (Finland)

III-3.3. Task Force for Quality-based Reimbursement regarding " Handling Health Promotion in Hospitals in the DRGs- Evaluation of the registration of the health promoting activities

Mette Enevold Christensen, Hanne Tønnesen, Oliver Gröne, Ann O'Riordan, Fabrizio Simonelli, Tiiu Härm, Denise Morris, Peder Vibe, Susan Himel, Poul Erik Hansen (Denmark)

III-3.4. Implementation of the HPHs Policy in the Immanuel Diakonie Groups TQM System

Werner Schmidt, Elimar Brandt (Germany)

III-3.5. The physiognomy of the HPH Network of Tuscany: the evaluation of the first five years of adhesion

Paolo Morello Marchese, Caterina Teodori, Maria José Caldes Pinilla, Katalin Majer, Fabrizio Simonelli (Italy)

III-4. Improving health promotion, prevention, treatment and care for diverse chronic conditions

Venue: Dane

Chairs: Peter Nowak (Austria)

III-4.1. Elderly patients benefit from the complexities of the comprehensive geriatric assessment

Helle Maeltseemes, Katrin Olo –Laansoo (Estonia)

III-4.2. Management of intervention integration in the Maria Teresa Chiantore Seragnoli hospice in Bologna

Elena Marri, Danila Valenti, Stefano Liverani (Italy)

III-4.3. Health gain and coping with chronic pain and major handicaps - moaning does not help

Klaus Hüllemann, Brigitte Hüllemann (Germany)

III-4.4. The "BERLINER RHEUMA-HAUS"- a HPH-concept for efficiency Treatment of Rheumatism

Elimar Brandt, Andreas Krause (Germany)

III-4.5. An Epilepsy Telephone Advice Line: A Review

Cora Flynn, Norman Delanty (Ireland)

11.45 - 14.00

III-5. Meeting of European Network Smoke Free Hospitals

Venue: Jura

Chair Ann O'Riordan.

13.15-14.15

Lunch

Venue: Vanagupe Hotel

14.15-15.45

PARALLEL SESSIONS IV:

IV-1. Patient empowerment + intersectoral cooperation for tackling chronic diseases

Venue: Dubysa

Chairs: Luigi Resegotti (Italy)

IV-1.1. The "Art of empowerment" in doctor-patient-interaction - a first meta-study on qualitative linguistic research

Peter Nowak (Austria)

IV-1.2. Informed consent as a means for health integration and promotion

Pietro Ragni, Daniela Riccò, Antonia Nini, Franco Prandi, Antonio Chiarenza (Italy)

IV-1.3. A partnership between a health care system and the regional school system

Matthew Masiello (US)

IV-1.4. A Health Promoting Health Care System in Rural America

Matthew Masiello (US)

IV-1.5. Hospital and school together for the management of chronic disease and quality of life of children and families

Guarnaccia Sebastiano, Valseriati Daniela, Battaglia Silvia, Bresciani Antonella, Micheletti Serena, Pluda Ada, Riviera Emma, Polsini Italo, Consonni Anna, Di domenicantonio Paolo, Farella Giuseppe, Buzi Fabio, Macca Claudio, Prandi Elena, Pagliaini Lucia, Battaglia Marcella, Valseriati Laura, Cornella Chiara, Salucci Mariangela, Domenighini Serena Giulia, Manfredi Daniela, D'agata Emanuele, Gnaccarini Giuseppina, Chiarini Maria Teresa, Pellegrino Patrizia, Gastaldi Stefania, Silini Antonietta, Cicchelli Roberta, Castellani Alfonso, Avisani Rosaria, Pini Francesco, Notarangelo Luigi Daniele, Tiberti Alessandra, Spiazzi Raffaele, Ferretti Giovanna, Conti Adelaid (Italy)

IV-2. Monitoring, evaluation and reporting on HPH interventions

Venue: Minija

Chair: Louis Cote (Canada)

IV-2.1. Annual use of National Indicators in the Swedish Network for HPH, lessons learned

Mats Hellstrand, Margareta Kristenson (Sweden)

IV-2.2. Health and Social Services Centres in Quebec: An example of collaboration between hospitals and other health and social agencies in the community

Nicole Dedobbeleer, André-Pierre Contandriopoulos, Hung Nguyen, Louise Rousseau, Lise Lamothe, Robert Bilteys, Zahra Elmmala (Canada)

IV-2.3. Estimating the Benefit of Interventions Across the Spectrum of Heart Disease

Thomas Kottke (USA)

IV-2.4. A descriptive study of the perceptions of a sample of health care workers of the processes of person centered planning in a residential centre for people with Intellectual Disabilities in the Mid-Western region of Ireland

Eileen Carey (Ireland)

IV-2.5. Middle term (1 year) evaluation of the impact of a training provided to charge nurses to develop patient education strategies

Jacques Dumont, Thomas Genevieve (Belgium)

IV-3. Workshop Mental Health Promotion in Health Promoting Hospitals

Venue: Sventoji

Moderators: Jürgen M. Pelikan, Christina Dietscher (Austria)

IV-4. Integrating health care interventions on chronic diseases across levels of services

Venue: Dane

Chair: Zora Bruchacova (Slovakia)

IV-4.1. The autonomy of the patient with outcome of lesion of the upper motor neuron also depends on the preservation of muscle length: efficacy of the self treatment in chronic patients and hypothesis about a program of prevention since the acute phase

Isabella Campanini, Francesco Lombardi, Andrea Merlo, Guido Vezzosi (Italy)

IV-4.2. Inclusion of Palliative Care for Motor Neurone Disease Patients

Bernie Corr (Ireland)

IV-4.3. Serving the Community - Secondary and Primary Care Together - A Shared Health Promotion Initiative

Suzie Loader, Don Sinclair (United Kingdom)

IV-4.4. Role of primary care physicians in a model of integrated out-patient care for dementia

Guido Federzoni, Gaetano Feltri, Susanna Casari, Carlo Alberto Goldoni, Andera Spanò (Italy)

	<p>IV-4.5. Bringing professionals to the same table: a participatory approach for continuity of care across different levels of service Alessandro Campani, Manuela Furlan, Francesco Niccolai (Italy)</p>
	<p>IV-5. Interactive seminar: Policy and service quality for migrant Venue: Jura Moderators: Werner Schmidt (Germany), Karl Krajcic (Austria)</p>
14.15-15.45	<p>Open meeting on International Cooperation for Children's Health Promotion Venue: Palanga Rehabilitation hospital Small hall Chair: Maria José Caldés Pinilla (Italy)</p>
15.45-16.15	<p>Coffee Break Venue: Vanagupe Hotel</p>
16.15 – 17.15	<p>PLENARY IV: Action on wider determinants of chronic disease: Cooperation between the hospital and other settings Venue: Dubysa Chairs: Ann O'Riordan (Ireland), Juozas Pundzius (Lithuania)</p> <p>What are the wider determinants of health, and how can the hospital cooperate with other settings in order to tackle them? John Ashton (Professor, North West Regional Director of Public Health NHS Executive, United Kingdom)</p> <p>Use of hospital settings to address social determinants of health: Value of international collaboration to reduce the burden of chronic disease Mikko Vienonen (Coordinator for Expert Group "Social Inclusion, Healthy Lifestyle and Work ability", Finland)</p>
17.15-17.30	<p>FORMAL CONFERENCE CLOSING Venue: Vanagupe Hotel</p> <p>Announcement of the best poster winners Announcement of 15th International Conference on health Promoting Hospitals in Vienna, Austria Jürgen M.Pelikan (LBI Vienna, Austria)</p> <p>Closing on behalf of the WHO Oliver Grone (WHO Regional Office for Integrated Health Care services) Chair: Irena Miseviciene (Lithuania), Jürgen M.Pelikan (Austria)</p>
17.30-18.00	<p>FAREWELL COCKTAIL Venue: Vanagupe Hotel</p>

POSTER SESSIONS IN DETAIL

POSTER SESSIONS I

Thursday, May 25, 2006

15:00 – 15:45	<p>I-1. The need for action on chronic diseases: Models and examples for tackling diabetes Chair: Jacques Dumont (Belgium)</p> <p>I-1.1 The glycemic control during pregnancy and the physical and psychomotor development of offspring of diabetic mothers Jūratė Buinauskienė, Evelina Buinauskaitė, Vitalija Marmienė (Lithuania)</p> <p>I-1.2 The puzzle of diabetes quality management in Belgium: a good example of a chronic disease multi disciplinary and multi strategies approach. Jacques Dumont (Belgium)</p> <p>I-1.3 Healthy School Environment Project and Prevention of Type 2 Diabetes Merja Ihanainen, Leena Pohjamo, Hely Muikkula (Finland)</p>
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I-1.4 The importance of effective communication in chronic diseases. An study about type 2 Diabetes.

Maria Sandin, Antonio Sarria, Eva Bolaños (Spain)

I-1.5 Comparison of Group and Individual Education regarding Medical Nutrition Therapy in Patients with Type 2 Diabetes Mellitus

Helena Scanlan, Linda Killeen, Sandra Mcateer, Seamus Sreenan (Ireland)

I-1.6 An intensive Nurse-led, Multi-interventional clinic is more successful in achieving vascular risk reduction targets than conventional diabetes care

Jacqueline Mac Mahon (Ireland)

I-1.7 Health promotion in patients with Type 2 diabetes at Odense University Hospital (OUH), Denmark.

Lisbeth Minet, Else-Marie Lønvig, Lisa Korsbek, Lene Sjöberg (Denmark)

I-1.8 FIN-D2D group counseling process in Raahe area

Matti Honkala, Merja Ihanainen, Liisa Rasi, Eija Karsikko, Riitta Vainionpää, Sara Hakala, Heli Havia, Riitta Heikka, Auli Saario, Maarit Katainen, Erja Karhunen (Finland)

I-1.9 Empowerment Approach in Diabetes Care- from Hospital to Primary Care.

Victoria Oladimeji (UK)

I-2. The need for action on chronic diseases: Models for tackling cancer and respiratory diseases

Chair: Luis Cote (Canada)

I-2.1 Need for adjusting therapy-methods in the treatment of Cancer patients

Brigie Hüllemann, Klaus Hüllemann (Germany)

I-2.2 Promoting integration in nursing practice in hospital and home care, for cancer patients.

Anne Marie Pietrantonio, Patrizia Guidetti, Angela Righi, Vilma Culpo, Lorella Rossi, Davide Milani, Barbara Lugli, Paola Liotti, Rita Franchetto (Italia)

I-2.3 COPD - cut out peoples' dangers

Alexander Bock, Arno Schmidt-Trucksass, Martin Halle (Germany)

I-2.4 Let's take a breath. Health Promotion Project to improve respiratory health and physical activity in asthmatic subjects

F Falcone, P Beltrami, F Riboldi, G Ghedini, D Draghetti, S Aristei, P Farruggia, F Raggi, C Cinti (Italy)

I-2.5 Integrated hospital – home care programme for advanced respiratory insufficiency of patients assisted with home long-term mechanical ventilation

Marina Galetti, Giuseppe Dedonno, Vincenzo Galavotti, Elena Politano, Carlo Sturani (Italy)

I-3 The need for action on chronic diseases: Models and examples for tackling diverse conditions – 1

Chair: Lilian Møller (Denmark)

I-3.1 Improvement of quality of life of the patients with chronic diseases in East-Viru Central Hospital

Alevtina Uustalu, Tiina Nappa, Igor Muhhin (Estonia)

I-3.2 Improvement of quality of life of the patients with chronic diseases in East-Viru Central Hospital

Alevtina Uustalu, Tiina Nappa, Igor Muhhin (Estonia)

I-3.3 The role of the CKD Nurse Specialist in the treatment and education of patients with Chronic Kidney Disease in Mayo General Hospital

Carmel Mcdermott (Ireland)

I-3.4 The Liaison MS Specialist Nurse

Debbie Mcardle, Orla Hardiman, Jane Roche (Ireland)

I-3.5 Supporting patients with Chronic Fatigue Syndrome - Myalgic Encephalopathy (ME) in Lothian

Diane Loughlin (Scotland)

I-3.6 Multiple sclerosis an integrated therapeutic pathway from the hospital to home care

Massimo Albuzza, Giorgio Reggiani, Gabriele Greco, Eros Forghieri, Mario Santangelo (Italy)

I-3.7 Epilepsy and pregnancy a multidisciplinary pathway for patient's education and empowerment

Giuseppe Masellis, Anne Marie Pietrantonio, Mario Santangelo, Laura Sgarbi, Gabriele Greco (Italy)

I-4 Health promotion for children and adolescents in hospitals- 1

Chair: Egle Tamuleviciene (Lithuania)

I-4.1 Protecting the hospitalised child "The Hospital Made for Children" Project is born in the University of Siena Hospital

Anna Grasso, Lucia Rappuoli, Gianluca Tornese, Claudio Amato, Mariano Vincenzo Giacchi (Italy)

I-4.2 Organization Of Medical Care For Children With Perinatal Nervous System Disorder

Artamonova Galina, Belikova Darya, Artamonova Anna (Russia)

I-4.3 The Italian Ministry Project of " Hospital without Pain" .Measuring pain in children

Valeria Bachiocco, Simonetta Baroncini, Mario Lima (Italy)

I-4.4 Identification of adolescents alcohol users in paediatric practice

Lagle Suurorg, Inna Tur (Estonia)

I-4.5 Exploratory survey on health promotion activities carried out in children's hospitals and Pediatric Departments in Vienna

Irmgard Eichler, Peter Nowak (Austria)

I-4.6 The extension of natural babies' feeding in Taurage County

Iveta Pauliene (Lithuania)

I-4.7 WHO CINDI children's programme in Estonia

Lagle Suurorg, Inna Tur (Estonia)

I-4.8 Study on childhood illness attitude

Lagle Suurorg, Inna Kramer (Estonia)

I-4.9 Concept analysis of failure-to-thrive or proposed new term 'faltering growth'.

Doris Corkin (Northern Ireland)

I-5 Migrant friendly and culturally competent hospitals

Chair: Karl Krajic (Austria)

I-5.1 Evolution towards migrant friendly Health centers

Elvira Méndez Méndez, Mariana Isla Viale (Spain)

I-5.2 The death in the hospital: equal and culturally interventions.

Patrizia Sironi, Rosario Canino, Ermanna Derelli (Italy)

I-5.3 "Telephone hugs" Long distance mothers: The experience of "long-distance" parenting for women from Eastern Europe employed in family care roles in our city.

Piera Bevolo, Deliana Bertani, L. Gualdi, Antonio Chiarenza (Italy)

I-5.4 Continuity of care programme "Improving coordination and communication between levels of care": Hospital - Primary Health Care.

Rosa Suñer, Dolors Juvinyà, Carme Farré, Isabel Fernández, Montserrat Figuerola, Carme Bertran (Spain)

I-5.5 Promoting a Migrant Friendly and Culturally Competent Hospital-Beaumont Hospital

Orla Daly (Ireland)

I-6 Health promoting psychiatric health care services and mental health promotion in the health care system - 1

Chair: Valentinas Maciulis (Lithuania)

I-6.1 Social rehabilitation complex for mental patients at RVPH

Alma Buginyte (Lithuania)

I-6.2 Scotland HPH Mental Health Hub

Thomas Harrison, Mark Richards (Scotland)

I-6.3 Significance of functional brain studies to the health promotion in Republican Vilnius Psychiatric Hospital

Kastytis Dapsys, Milena Korostenskaja, Dalia Rusteikiene, Alina Stigiene (Lithuania)

I-6.4 Using the Physical Health Check tool in an acute Psychiatric Unit

Tricia Keogh – Hodgett (Northern Ireland)

I-6.5 Health Promoting Mental Health Service

Lina Toleikyte, Stuart Eales (United Kingdom)

I-6.6 The people speak - Service User Views On Mental Health Services

Lorcan Martin, Gerard Farrell, Patrick Harkins, Carol Harrington, Richard Keogh, Denise Mccarthy, Marie Murphy, Regina Reynolds, Stephen Sibley (Ireland)

I-6.7 An Integrated Rehabilitation Programme for Patients suffering from Schizophrenia

Bodil Nørregaard Thomsen, Susan Allan (Denmark)

I-6.8 Twelve steps faith teaching program for the patients with chronic psychiatric disorders

Valius Sruoga (Lithuania)

I-7 Cooperation with other health care services in order to achieve optimum health outcomes for patients with chronic conditions

Chair: Aurelijus Veryga (Lithuania)

I-7.1 The integrated territorial data sheet as a tool needed to create the assistance network of the AUSL Health Board of Reggio Emilia

Rosanna Carbognani, Pietro Penna, Adriana Costi, Giulia Calzari (Italy)

I-7.2 From diagnosis to integrated planning in the area of at-risk parenting: a model for collaboration between Health and Social Services

Deliana Bertani, Maria Lorena Ficarelli, Graziella Fornaciari, Gabriella Ghidoni, Rosaria Ruta (Italy)

I-7.3 In selected chronic diseases, "Home Care" may reduce hospitalisation

Federico Ruggeri, Barbara Clima, Luca Fruggeri, Alessandro Ingardia, Alessandro Gatta, Andrea Tognù (Italy)

I-7.4 The attitude of the citizens' of Siauliai towards the prevention of chronic noncommunicable diseases on the level of GP's institution

Rezgiene Loreta Rasute, Mazeika Remigijus (Lithuania)

I-7.5 Primary care centres: providers of preventive and promotive care

Misra Preeti H. (India)

I-7.6 The self-help/mutual aid as a social labour instrument and on health promotion: the experience on the Health Project

Patrizia Beltrami, Michele Filippi, Maria Rosa Degli Esposti, Paola Furlini, Monica Marchesini (Italy)

I-7.7 GRACER: A regional network of coordinated rehabilitation services for the severely Brain-Injured persons

Salvatore Ferro, Alessandra Maietti, Paolo Boldrini, Piera Pallazzoni, Stefano Liverani (Italy)

I-7.8 Population's assessment of the quality of outpatient health services in Lithuania

Liudmila Dregval, Irena Miseviciene (Lithuania)

I-8 Smoke-Free Hospitals

Chair: Bertrand Dautzenberg (Germany)

I-8.1 Belgium French Community: Integration of Health promotion strategies in Smoke free hospital network

Jacques Dumont (Belgium)

I-8.2 Self audit of smoke free policies in 1157 European hospitals

Dautzenberg Bertrand (France)

I-8.3 The Protection of the non-smokers

Dalibor Petras, Stefan Petricek, Zora Bruchacova (Slovak Republik)

I-8.4 Implementation of the ENSH smoke free hospital concept in Central and Eastern European countries

Sibylle Fleitmann, Ariadni Ouranou, Anne-Marie Schoelcher, Ann O'riordan, Bertrand Dautzenberg (Germany)

I-8.5 Healthcare staff, education and counselling, setting a good example. The Smoke-Free Hospital project

Stella Boaretto, Elisabetta Poli, Ester Delsante, Sandra Bosi, Angela Accardo, Eletta Bellocchio, Anna Maria Ferrari, Danilo Orlandini (Italy)

I-8.6 Smoke-free hospitals project in Lithuanian HPH network

Aurelijus Veryga, Daiva Vainauskaite (Lithuania)

I-8.7 Smoking Cessation - an Important Part of Treatment

Leena Järvi, Maritta Kilpeläinen, Päivi Grönroos, Eeva Nordman (Finland)

I-9 Monitoring, evaluation, reporting and research on HPH interventions- 1

Chair: Maria Hallman Keiskoski (Finland)

I-9.1 Benefits of a Sharps Awareness Education Programme in a Dublin Teaching Hospital

Maura Cagney, Blanaid Hayes, Monica Donnelly, Ciara McGowan (Ireland)

I-9.2 HPH Balanced Scorecard

Brigitte Bergmann-Liese, Hans Alsen, Babette Dietrich, Werner Schmidt, Hans-jochim Standke (Germany)

I-9.3 The clinical pathway in the promotion of quality health care to patients suffering from thoracic pain

Gianpaolo Gambarati, Duilio Braglia, Lorena Franchini, Gabriele Desimoni, Enrichetta Bianchi, Paola Nasi, Danilo Orlandini (Italy)

I-9.4 Identification of Legionella in the Hot Water Supply of a General Hospital in Isfahan, Iran

Ali Asghar Neshat, M.R. Shahmansouri (Iran)

POSTER SESIONS II

Friday, May 26, 2006

10:30 – 11:15

II-1 The need for action on chronic diseases: Models for tackling Coronary and cardiovascular problems

Chair: Zemyna Milasauskiene (Lithuania)

II-1.1 Initial effects after a first-ever stroke

Daina Kranciukaite, Diana Sopagiene, Daiva Rastenyte, Egle Milinaviciene (Lithuania)

II-1.2 Stroke care assessment in two Kaunas hospitals

Diana Sopagiene, Daiva Rastenyte, Egle Milinaviciene, Daina Kranciukaite (Lithuania)

II-1.3 Effective interventions for promoting cardiovascular health in Kaunas University Hospital Clinic of Cardiology

Remigijus Zaliunas, Lina Jancaityte (Lithuania)

II-1.4 Morbidity of acute myocardial infarction in Kaunas (Lithuania) population from 1983 to 2002

Ricardas Radisauskas, Gailute Bernotiene, Daiva Rastenyte, Lina Jancaityte, Domininka Sidlauskienė (Lithuania)

II-1.5 Integrating action on physicians' of the Intensive Care departments cardiovascular risk including their workplaces

Vidas Pilvinis, Kazimieras Viezelis, Egle Kalinauskienė (Lithuania)

II-1.6 Mortality from ischemic heart disease in Kaunas (Lithuania) population from 1983 to 2002

Gailute Bernotiene, Ricardas Radisauskas, Lina Jancaityte, Domininka Sidlauskienė (Lithuania)

II-1.7 Introduction for CVD prevention in Rapla County Hospital (Estonia)

Mari Põld, Liis-Mail Moora, Aili Laasner (Estonia)

II-1.8 The clinical and care path for patients suffering from chronic cardiac decompensation

Rosanna Carbognani, Maria Giulia Calzari, Stefano Bendinelli, Paolo Pietranera (Italy)

II-1.9 Investigating of coronary angiography complications in patients of medical university centers

Rezvan Zarkeshan, Ghلامreza Khademi (Iran)

II-1.10 A risk health behaviour modification programme targeting hypertensive outpatient population in a general hospital setting in Athens

Yannis Tountas, Berk Aristeia, Chondroleou Anna, Mentziou Irini, Schoretsaniti Sotiria, Thanasa Georgia, Andreadis Emmanuel, Diamantopoulos Emmanue (Greece)

II-2 The need for action on chronic diseases: Models and examples for tackling diverse conditions – 2

Chair: Evalda Danyte (Lithuania)

II-2.1 Empowering patients for chronic disease in the NSGD hospital Nephrology and Dialysis department

Pier Luigi Tosi, Cristina Grimaldi, Giorgio Monzani, Vania Corti, Serena Del Puglia, Laura Graziani, Gabriela Kuhn, Marco Quercioli, Alberto Appicciafuoco, Vincenza Fusari (Italy)

II-2.2 Epilepsy and pregnancy a multidisciplinary pathway for patient's education and empowerment

Giuseppe Masellis, Anne Marie Pietrantonio, Mario Santangelo, Laura Sgarbi, Gabriele Greco (Italy)

II-2.3 Chronic pain treatment in ambulatories outside the hospital

Sandro Sottili, Fabio Rubino, Piergiacomo Puccio (Italy)

II-2.4 Redesign of HIV Services in Tayside, Scotland

Wendy Peacock (Scotland)

II-2.5 Rapid Access Service for Patients with Inflammatory Bowel Disease

Kelley Ryan (Ireland)

II-2.6 Not just cheese and chocolate! Identification of migraine trigger factors - An educational study

Esther Tomkins (Ireland)

II-2.7 The needs of patients suffering from rheumatoid arthritis. The impact of the disease on patient quality of life.

Pasqualina Sottilotta (Italy)

II-2.8 Brain Attack - Pilot initiative

Tricia Keogh – Hodgett (Northern Ireland)

II-3 Health promotion for children and adolescents in hospitals- 2

Chair: Peter Nowak (Austria)

II-3.1 Integrated home care (IHC) for children with serious chronic pathologies in the Reggio Emilia Health District (Italy)

Mara Manghi, Cristina Marchesi, Enrica Bianchi (Italy)

II-3.2 Family - Centered Newborn Care: Present and Future in KMH

Rita Balciuniene, Dalia Stoniene (Lithuania)

II-3.3 Educational needs of adult patients and meeting these needs of these needs in Tartu University Hospital

Tiina Freimann (Estonia)

II-3.4 The Italian Ministry Project of "Hospital without Pain". A pain educational program for paediatric health professionals

Valeria Bachiocco, Simonetta Baroncini, Elena Marri, Teresa Matarasso, Francesco Nonnino, Chiara Bagnoli, Carolina Guerrieri (Italy)

II-3.5 Pain-Free Hospitals "Invasive procedures in the paediatric age group": A project on oncohaematology

Simonetta Baroncini (Italy)

II-3.6 Living with diabetes – an adolescent perspective

Helen Burke (Ireland)

II-3.7 Education of parents about children infectious diseases, care, prevention and health promotion

Egle Tamuleviciene, Giedra Leviniene, Rita Baneviciene (Lithuania)

II-3.8 GRIEF-SUPPORT to children and youth after losing parents or siblings.

Inger Bårtvedt (Norway)

II-4 Health promotion for the disabled and for the elderly

Chair: Jurate Macijauskienė (Lithuania)

II-4.1 A staff dedicated to special care dentistry for handicapped people

Christian Bacci, Ettore Valesi-Penso (Italy)

II-4.2 “Dolphin” project “The hospital mesh for the disability: protected ways for the serious disabled people.

Storti Pier Vincenzo, Borsatti Graziella, Luppi Mario, Mezzadrelli Giovanna, Sturani Carlo, Tiron Camelia Gaby (Italy)

II-4.3 The acute elderly: Hospital-territory integration model

Anna Burattin, Maria Tonni, Maurizio Poli, Paolo Marzollo (Italia)

II-4.4 Assistance and accompaniment to the death in R.S.A.

Roberto Caprioli, Teresa Ricciardi, Angela Monese, Ivana Pisoni, Anna Lisa Mazzoleni (Italy)

II-4.5 Care For Elderly People: Optimum Score Realized By Clinical And Organisation Models

Fernando Anzivino, Chiara Delli Gatti (Italia)

II-4.6 Health promotion of the elderly in the community: prevention of the falls, urinary incontinence and promotion of oral hygiene

Jurgita Knasiene, Rita Baneviciene, Jurate Macijauskiene, Gyte Damuleviciene (Lithuania)

II-4.7 Audit of a Rehabilitation Unit for Older People

Emma Bartlett, Fiona Keogan, Alan Moore, Ciaran Donegan (Ireland)

II-5 Health promoting psychiatric health care services and mental health promotion in the health care system - 2

Chair: Danguole Survilaite (Lithuania)

II-5.1 The Work In Network: Raise The Mental Health

Elena Bruni, Dr Francesca Cigala (Italia)

II-5.2 “Health Professionals with a Psychiatric Diagnosis”

Karen Strangaard Poulsen, Karl Mathisen (Denmark)

II-5.3 Theatrical Integrated Laboratory to support children’s and adolescents’ mental disease.

Luigina Cenci, Maria Antonietta Tavoni, Andrea Bartola, Claudia Pasqualini, Cesare Cardinali (Italy)

II-5.4 Mental Health Promotion: an experience with school.

Matteo Vezzoli, Giovanni Lutteri, Claudio Moser, Francesca Girardelli, Deborah Pomiatto, Maria Grazia Buso, Mauro Motter (Italy)

II-6 Health promotion for hospital staff

Chair: Mary Pat Butler (Ireland)

II-6.1 Clinical training of student nurses in a health promoting hospital

Neus Brugada, Dolors Juvinyà, David Ballester, Carme Bertran, Alicia Baltasar, Margarita Gou (Spain)

II-6.2 Taking care of who takes care of us. Organizational health through the integrated use of psycho-corporal techniques

Gioacchino Pagliaro, Daniela Buriola, Rosa Costantino (Italia)

II-6.3 Monitoring working conditions of staff suffering from (loco)motorium chronic diseases due to manual actuation of laden and patients in Hospital Company of Pavia Province from year 2002 to year 2005

Arch Gian carlo Scarpini, Luca Abatangelo, Stefano Salvadori (Italy)

II-6.4 Action on the physicians’ chronic burnout involving all administering levels of a hospital

Egle Kalinauskiene, Rita Baneviciene, Tautvydas Jankauskas, Albinas Naudziunas, Laima Jankauskiene, Leone Cepinskiene, Kazimieras Viezelis, Ausra Bernotiene (Lithuania)

II-6.5 Staff Matters

Kathleen Cooper, Sarah Bush (Scotland)

II-6.6 An assessment of the validity of the SF-36 questionnaire among the employees in the Kaunas hospital

Rita Baneviciene (Lithuania)

II-6.7 Promoting children’s dental health - developing good practice guidance for hospitals.

James Robinson, Kathryn Bailey, Nicole Bauwens, Wendy Doorghen, Alison Fenwick, Alana Ingram, Elizabeth Roebuck (UK)

II-6.8 Stay Healthy at Work --Staff Program

Rose Byrne, Martin Smith (Ireland)

II-6.9 Stress and mood disorders among intensive care unit nurses'

Zemyna Milasauskiene, Irena Miseviciene (Lithuania)

II-6.10 Relationship between nurses health complaints, risk profile and self-rated health

Zemyna Milasauskiene, Irena Miseviciene, Daiva Zagurskiene (Lithuania)

II-6.11 The interdependence between health condition of the nursing staff and the ergonomic work conditions

Vidmantas Januskevicius, Audrius Spirgys, Paulius Vasilavicius (Lithuania)

II-6.12 The influence of hospital work environment to the quality of service

Laimute Radziunaite, Stasys Gendvilis, Loreta Treigyte, Virginija Juciuviene (Lithuania)

II-6.13 A Survey of First Year Nursing Students' Perception of the HIV/AIDS phenomenon

Joseph Adepoju, Mary Watkins, Agnes Richardson (U.S.A.)

II-6.14 Farmamico project

Daria Bettoni, Roberto Del Bono, Giuliana Martini, Roberta Volpi (Italy)

II-7 Improving the health promoting quality of hospital services

Chair: Thomas Kottke (USA)

II-7.1 Planning a dental team for latex-free treatments

Christian Bacci, Ettore Valesi-Penso (Italy)

II-7.2 Feeding and nutritional counselling

Daniela Mazzotta, Alberto Appicciafuoco, Barbara Niccoli, Rita Marianelli, Mariangela Manfredi, Vincenza Fusari, Isabella Frati (Italy)

II-7.3 The Role of teamwork during the treatment with radioisotopes

Eve Kelk, Eve Palotu, Galina Shamarina (Estonia)

II-7.4 Obligation to promote best practice: enteral feeding

Doris Corkin, Julie Chambers ((Northern Ireland)

II-7.5 Volunteers in hospitals in the Czech Republic – Tool for the health promotion of the long-term and serious ill patients

Ivana Korinkova (Czech Republic)

II-7.6 The development of a Bi-level Positive Airway Pressure (BIPAP) service

Geraldine Mcvey (Ireland)

II-7.7 The main reasons of the development and prophylaxis of bedsores

Laimute Radziunaite (Lithuania)

II-7.8 A formative project planning for health promotion in hospital welcome process

Michele Cristofano, Fabrizio Simonelli, Angela Simonelli, Laura Iia Bruschi, Rosalba Becherini, Rina Torrioli, Alberto Appicciafuoco, Vincenza Fusari, Giuseppe Remedi, Margherita Aliboni, Angela Brandi, Paolo Maria Ursino, Flora Coscetti (Italy)

II-7.9 Participation of dialysis patients in assessing and improving the treatment received

P. Borgatti, M. Ravelli, M. Manini, L. Cerullo (Italy)

II-7.10 Developing empowering counselling in hospital

Leena Liimatainen, Tarja Kettunen, Ulla Perko, Jari Villberg (Finland)

II-8 Monitoring, evaluation, reporting and research on HPH interventions- 2

Chair: Jutta Skau (Denmark)

II-8.1 Is diagnoses related morbidity applicable for monitoring of chronic diseases?

A.Gaižauskiene, R. Gaidelyte. R. Senkuviene, (Lithuania)

II-8.2 Audit of health promotion activities within a UK hospital

Gary Cook, Charlotte Haynes (England)

II-8.3 Post operative telephone service for day case patients

Noreen Smyth (Ireland)

II-8.4 Development of a useful evaluation method of short-term post-education courses for health professionals

Jutta Skau, Ditte Mølgaard-Nielsen, Louise Stage (Denmark)

II-8.5 Educational intervention promoting awareness of pregnancy at work

Maura Cagney, Blanaid Hayes, Monica Donnelly, Eimear Burke (Ireland)

II-8.6 Experience of clinical and economic research in Russian hospitals

George N. Golukhov, Izolda S. Cherepanova (Russia)

II-8.7 Men's perspectives of health promotion booklet and the Implications from a Health Literacy Perspective.

Jacinta Mc Aree-Murphy (Ireland)

II-9 Networking for health and cooperation with other settings

Chair: James Robinson (Scotland)

II-9.1 New settings for health promotion: the use of the local press as instrument to improve citizens' information. The experience of Modena Local Health Service

Paola Artoni, Maria Monica Daghigh, Simona Adalgisa Anna Giuliano, Loredana Luisi, Anne Marie Pietrantonio, Pina Lalli, Giuseppe Fattori (Italy)

II-9.2 From health education to social marketing: the health promotion strategies in the different settings of everyday life. "The Health Promotion Programme" carried out by Modena Local Health Service

Fattori, G., Artoni, P., Daghigh, M., Giuliano, S., Luisi, L., Pietrantonio, A. (Italy)

II-9.3 A network strategy to produce effective communication tools for Local Community: the experience of the Italian Laboratory for Citizen Empowerment

Maria Monica Daghigh, Anne Marie Pietrantonio, Anna Vittoria Ciardullo, Giuseppe Fattori (Italy)

II-9.4 Health promotion and empowering of the local population in municipalities of fast changes

Pia Ahonen, Vappu Syrjälä (Finland)

II-9.5 HPH interregional project "Allergy at School": the four years experience integrating Hospital Services and Territory for health promotion on allergic diseases in children

Mariangela Manfredi, Alberto Appicciafuoco, Paola Minale, Giuseppe Ermini, Paolo Campi, Emanuela Cammelli, Isabella Frati, Daniela Mazzotta, Rina Brunetti, Roberto Predonzani, Fabrizio Simonelli, Paolo Morello marchese (Italy)

II-9.6 Developing a local Network, supporting Health Promoting organisations/ settings

Lina Toleikyte, Cathy Warlow (United Kingdom)

II-9.7 GUESS WHO'S COMING FOR DINNER? Socio-Sanitary research on free food services and attitudes of indigent Italian and foreign users in Bologna

Debora Previti, Augusta Albertini, Francesca Celenza, Marika Sardo Cardalano, Stefania Ricci, Giovanna Vittoria Dallari, Franco Riboldi (Italy)

II-9.8 Aspects of Health of Kaunas Sport Veterans

Juozas Skirmantas Paukstys, Lolita Sileikiene (Lithuania)

PLENARY SPEAKERS

PLENARY I: THE NEED FOR ACTION ON CHRONIC DISEASE

Anders Foldspang



Anders Foldspang
Professor, MD, PhD, DMSc
SHORT CURRICULUM VITAE

Anders Foldspang, born 21.10.1945

1974 MD, University of Aarhus, Denmark.

1979-97 Associate professor in medical sociology, University of Aarhus.

Since 1995 Director, MPH programme, University of Aarhus.

Since 1997 Professor in health services research, University of Aarhus.

Since 2004 Head, Department of Health Services Research, Institute of Public Health, University of Aarhus.

2004 President Elect and since 2005 President, Association of Schools of Public Health in the European Region (ASPHER).

1979 Ph.D. (theme of thesis: disability and vocational rehabilitation), University of Aarhus.

1983 DMSc (theme of thesis: social, vocational and medical rehabilitation), University of Aarhus.

Research generally based on epidemiologic methods supported by multivariate statistical analysis. Research interests have over the years covered a series of public health themes, including e.g. vocational and social rehabilitation; rehabilitation of tortured refugees; schoolchildren's health; occupational health; etiology of urinary incontinence in adult women; evaluation of the effect and cost-effectiveness of acute pre-hospital intervention; dementia in old age; primary prevention of osteoporotic fracture. –At present building up a database following a 10% systematic population sample in a Danish region, 170,000-180,000 inhabitants, through 1990-2003; individual information include, e.g. mortality; hospital stays, visits to GPs and other health service consumption; socio-economic background.

Vilius Grabauskas



SHORT CURRICULUM VITAE

Professor Vilius GRABAUSKAS born and educated in Kaunas, Lithuania. His Medical degree he received in 1966 from Kaunas University of Medicine where after graduation continued to work as a research fellow, lecturer, associate professor and full professor in cardiology and public health. Between 1978 and 1986 he was working for the World Health Organization starting as a Medical Officer and completing his assignment as Director, Division of Noncommunicable Diseases (NCD), Geneva, Switzerland. Under his leadership the WHO Programme for Community Health in Noncommunicable Diseases based on integrated approaches to NCD prevention was developed (INTERHEALTH at global level and CINDI at European level). Upon return from WHO he continued his research in NCD prevention (Director, CINDI-Lithuania), was actively involved in the formulation of national health policy in Lithuania, served as a chair of newly established National Board of Health. Internationally he continued active collaboration with and through WHO in different capacities, including chairmanship of CINDI Management Committee, chairmanship of Standing Committee of the WHO Regional Committee for Europe, Executive President of the WHO Regional Committee for Europe, membership of WHO Executive Board. Institutionally he was actively involved in the academic activities serving for more than eleven years as Rector, Kaunas University of Medicine and currently continuing as Chancellor of same University. Altogether he has close to 300 research publications majority of which is devoted to epidemiology, NCD prevention and public health.

PLENARY II: INTEGRATING TREATMENT, CARE, PREVENTION AND HEALTH PROMOTION FOR CHRONIC DISEASE WITHIN HOSPITAL SERVICES IN ORDER TO ACHIEVE AN OPTIMUM OUTCOME

Klaus-Diethart Hüllemann



SHORT CURRICULUM VITAE

Hüllemann, Klaus, internist, psychotherapist, sports, social and rehabilitation physician; b. Apr.5, 1938, m., 3 children.; past dir. of the first German Health Promoting Hospital, dir., prof.Dr.med. Klaus-D. Hüllemann GmbH; hon. pres. German Network Health Promoting Hospitals and chairman sci, coun., acting dir. lifestyles, health promotion and medicine Akademie Kloster Heilig-kreuztal; prof. internal medicine,1975-, Munich University; contr. more than 280 articles to prof. journals. Mem. AAAS, N.Y. Acad. Scis., German Chinese Med. Ass., Internistenverband, German Milton Erickson Soc. Clin. Hypnosis (sci. coun.).

Vilnis Dzerve



Prof., Director of the Latvian Institute of Cardiology, Riga, Latvia

Birthdate and place: May 5, 1941 Liepaja, Latvia

Marital status: married, two children

Personal code: 040541 - 10 634

Office Address:

Latvian Institute of Cardiology

13 Pilsonu Str.

LV-1002, Riga

Latvia

Education and training:

1959-1965: M.D., Riga Medical Institute

1966-1971: Ph.D. (Dr.med.), Latvian Institute of Experimental and Clinical Medicine, Riga Dipl. MMD No 031351

1983-1990: Certificates. Public Health Care, Moscow

1992: Clinical Physiology, dipl. H-D No.000005, 17.06.1992.

1993: Certificate. Public Health Care. Stockholm

1999: Certificate, CVH Practitioner's Institute, Virginia, USA

2000, 2002: Certificates, WHO CINDI Programme Winter schools, Helsinki, Finland

Professional experience:

1971-1977: Research Physiologist, Latvian Institute of Experimental and Clinical Medicine, Riga

1977-1990: Chief, Department of Physiology, Latvian Institute of Cardiology, Riga

1981-1991: Deputy Chief, Council of Science, Ministry of Health Care of Latvia

1992-1993: Chief, Department Science and Education, Ministry of Welfare of Latvia

1990-present: Director, Latvian Institute of Cardiology

1998-2001: Scientific Coordinator, Finnish-Latvian CVD Project

1999-present: Director, WHO CINDI-Latvia Programme

1995-present: Coordinator and Investigator, Clinical Trial "Mildronate efficacy in the case of cardiac insufficiency", 1995;
Coordinator of 8 Evaluations of bioavailability 1995-2002.

Chief, Steering Committee, Clinical Trial "Mildronate + ACE inhibitor (lisinopril) 2002 - 2004;

Author, Protocols of Clinical Trials MILSS I, MILSS II (Mildronate and stable angina) 2003; "MI&CI" (Mildronate and Claudicatio Intermittens) 2005.

Teaching experience:

1969-1975: Assistant Professor at Riga Medical Institute

1988- 2006: Invited speaker, Seminars organised by Latvian Society of Cardiology, Latvian Institute of Cardiology, Heart Foundation of Latvia, different International organisations.

Memberships, awards, foundations, editorial boards:

1982: Latvian State Award in Science

1970-present: Member, Latvian Society of Physiology

1975-present: Member, Latvian Society of Pharmacology

1985-present: Member, Latvian Society of Cardiology

1985-1992: Member. "International Physicians against Nuclear War"

1988-1992: Vice-Chief, "Latvian Division of International Physicians against Nuclear War"

1989-present: Member, Latvian Physicians Association

1991-2000: Vice-president, Latvian Society of Cardiology

1991-2005: President, Heart Foundation of Latvia

1993-present: Member, Section on Epidemiology and Prevention International Society and Federation of Cardiology

1995-present: Fellow, European Society of Cardiology

1996-present: Member, Latvian Hypertension Society

1996-2000: Vice-president, Latvian Hypertension Society

2000-present: Executive Secretary, Latvian Society of Cardiology

2003-present: Member, Editorial Board "Seminars in Cardiology"

Publications, author certificates:

168 scientific publications

5 author's certificates (USSR)

Invited conferences, symposia, seminars:

Till 1990: 22 scientific meetings in USSR

1991-2005: 77 scientific meetings in 23 countries

PLENARY III: INTEGRATING TREATMENT, CARE, PREVENTION AND HEALTH PROMOTION FOR CHRONIC DISEASE ACROSS LEVELS OF SERVICES FOR PATIENT EMPOWERMENT, INCLUDING PALLIATIVE CARE, CASE MANAGEMENT AND DISEASE MANAGEMENT APPROACHES

Sylvie Stachenko



MD, Msc., F.C.F.P.

Telephone (work): (613) 946-3537

Facsimile (work): (613) 954-8529

E-mail: sylvie_stachenko@phac-aspc.gc.ca

EXECUTIVE PROFILE

Public health expert in the field of health promotion and chronic disease prevention with over 20 years experience in academic, community and government organizations at international, national and local levels. Led chronic disease policies at national level e.g. cancer control, diabetes, cardiovascular, breast cancer, AIDS. Led international policy efforts in the field of cardiovascular and other non-communicable diseases such as the joint WHO/Public Health Agency of Canada Policy observatory on chronic disease and participated in the development of a number of international policy documents eg the International Heart Health Declarations, WHO Global Strategy for Non-Communicable Diseases, European Health for All Policy (Health 21). Led primary care research initiatives in Quebec, implementation research efforts at the national level and policy research initiatives at the international level. Managed multidisciplinary team of health professionals ranging from 30 to 170 employees and budget of \$25 million.

MOST RECENT PROFESSIONAL EXPERIENCE

Public Health Agency of Canada, Ottawa Deputy Chief Public Health Officer, Health Promotion and Chronic Disease Prevention Branch, and Director, WHO Collaborating Centre on Chronic Disease Policy	2004-present
Health Canada, Ottawa Director General, Centre for Chronic Disease Prevention and Control	2002-2004
World Health Organization, Denmark Director, Non-Communicable Diseases and Mental Health	2000-2002
Director, Health Policy and Services	1997-2000

EDUCATION

Harvard School of Public Health, Boston, (USA) Masters in Epidemiology and Health Services Administration	1985
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London School of Hygiene and Tropical Medicine, England Diploma in Industrial Hygiene	1980
Kellogg Fellowship in Advanced Studies in Primary Care, Kellogg Centre, McGill University, Montreal	1979-1981
University of Montreal, Montreal, Residency in Family Medicine	1975-1977
McGill University, Montreal, Medicine M.D.C.M.	1975
McGill University, Montreal, B.Sc., Honours Biophysics	1971
Université De Caen, France, Baccalauréat, Sciences	1968

Zilvinas Padaiga



Curriculum Vitae

Zilvinas Padaiga

Date of Birth: 4 December 1962
Place of Birth Kaunas, Lithuania
Civil Status: Married, two children
Education

1980-1986 Kaunas Medical Academy, Kaunas, Lithuania, Medical doctor, specialized in pediatrics;
1993-1994 Kuopio University, Finland, Master in Public Health;
1994-1995 Kuopio University, Finland, Ph D. in Public Health;
1999 Kaunas University of Medicine, Habilitation thesis.

Professional Experience:

2004 – to present Minister of Health, Lithuania;
2002-2004 Kaunas University of Medicine, Lithuania, Vice-Rector for Studies;
2000- to present Kaunas University Medicine, Lithuania, Faculty of Public Health, Department of Preventive Medicine, Professor;
1998-2003 Parliament of Lithuania, National Health Board, Advisor;
1994-2000 Kaunas University of Medicine, Faculty of Public Health, Department of Preventive Medicine, Associate Professor;
1996 Lithuanian Health Care Reform Bureau, Ministry of Health, National Task Force for "National Health Program", Expert
1991-1996 Kaunas Medical Academy, Department for Coordination of International Programs, Senior Coordinator;
1990-2001 Kaunas University of Medicine, Institute of Endocrinology, Researcher;

1986-1990 Kaunas medical Academy, Department of Pediatrics, Assistant Professor

Foreign Languages: English, Russian, Polish

Additional Information: Member of the Lithuanian Association of Medical Doctors; Expert of the World Health Organization

PLENARY IV: ACTION ON WIDER DETERMINANTS OF CHRONIC DISEASE: COOPERATION BETWEEN THE HOSPITAL AND OTHER SETTINGS

John Ashton



Prof., North West Regional Director of Public Health NHS Executive, Manchester, UK-England

Professor John Ashton CBE, North West Regional Director of Public Health and Regional Medical Officer was born in Liverpool in 1947. Educated at Quarry Bank High School in Liverpool, the University of Newcastle-upon-Tyne Medical School and the London School of Hygiene and Tropical Medicine, he has specialised in psychiatry, general practice, family planning and reproductive medicine and finally public health.

He worked in Newcastle and Northumberland, Hampshire and London before returning to Liverpool in 1983. For two years he was a Councillor on Hampshire County Council.

John Ashton is well known for his work on planned parenthood and healthy cities and for his personal advocacy for public health. He was a member of the British delegation to Macedonia during the Kosovo emergency and played a prominent role in resolving the fuel dispute.

John holds chairs in the Liverpool Medical School, Liverpool John Moores University, the Liverpool School of Tropical Medicine, Manchester Medical School and the Valencia Institute of Public Health in Spain.

He is the author of many scientific papers; articles and chapters in books and of several books including "The New Public Health" which is a standard textbook on public health.

Since 1993 he has held his regional position and has played an active part in developing government policies for public health. He was awarded the CBE in the Millennium New Year's honours list for service to the NHS.

John Ashton lives in Liverpool and has four sons and two stepsons.

Mikko Antero Vienonen



CURRICULUM VITAE

VIENONEN, Mikko Antero (190146)
Consultant in International Public Health
M.D., Ph.D.
Specialty in General Practice,
Specialty in Health Administration,
Specialty in International Health

Address: Sysimiehenkuja 1, 00670 Helsinki, Finland
e-mail: m.vienonen@kolumbus.fi
Tel. Mobile: +358-50-4421877
Tel. home: +358-9-7248621
Fax: (none)

By basic training Specialist in General Practice (Family Medicine). After ten years of field work in rural Finland in the 1970s was invited to be responsible for the development of primary health care, especially maternal and child care, school health and family planning in National board of Health/ Finland. In the late 1980s transferred to international development cooperation in the health sector working for several projects in Africa, Asia and Latin America.

In 1993 was invited to join the WHO Regional Office for Europe, the Department of Health Policy and Services, to work in the field of health care management, especially focusing on the on-going health care reforms in Europe. In particular dealt with issues on patients' rights and citizens' views on health care, decentralization of health services, health care financing, and setting priorities in health care. More in depth was involved with countries like Armenia, Belarus, the Czech Republic, Estonia, Georgia, Latvia, Lithuania, Hungary, Moldova, the Russian Federation, and Ukraine. The preparation for the WHO Conference on European Health Care Reforms, which was held in 1996 in Slovenia, took most of time in 1996. Creating networks among countries in the area of health care reform, health care financing patients' rights and health care management was the strategy of the Health Services Management Programme in 1997-1999.

In 1999 I started working as Special Representative of the Director General of WHO in Russia, with the permanent duty station in Moscow. This assignment entailed a broad range of coordination and assistance to the Russian Federation in humanitarian and developmental assistance for the whole health sector. Also cosponsorship in the UNAIDS team was an important role for WHO in a country with a fastest growing HIV epidemic in the world.

Retired from WHO in February 2006 at age of 60, after which was contracted by the Ministry of Social Affairs & Health / Finland to act under the Northern Dimension Partnership in Public Health and Social Well Being (NDPHS) as Coordinator for new expert group SIHLWA ["Social Inclusion, Healthy Lifestyles & Work Ability" consisting of sub-groups namely 1) Alcohol, 2) Adolescent health & social inclusion, 3) Workplace health & safety].

PLENARY ABSTRACTS

PLENARY I:

Thursday, May 25, 2006, 09.30 – 10.30

THE NEED FOR ACTION ON CHRONIC DISEASE

THE BURDEN OF CHRONIC DISEASES IN EUROPE AND THE MOST URGENT AREAS FOR ACTION – AN OVERVIEW

Anders Foldspang

Over the last 10-15 years, the epidemiological situation in the European Region has included dramatic change as well as more steady development. In the western part of the region, there have been increases in life expectancy, whereas in the early 1990s life expectancy decreased relatively fast in the eastern part of the region. Mortality from cardiovascular disease in Western Europe decreased since the early 1970s, contrasting the repeated, and increasingly high, maxima in Eastern Europe. In the region as a whole the top ten list of burden of non-communicable diseases (NCDs) is headed by cardiovascular disease, neuropsychiatric disorders, injuries, and neoplasms, together being estimated to account for more than 2/3 of Disability Adjusted Life Years (DALYs). New epidemics of NCDs are emerging or can be forecasted, e.g. the increase in the overweight and obesity prevalence, which in turn will produce more diabetes mellitus, hypertension, and other cardiovascular disease. Mental health problems – e.g., depression, alcohol dependence, schizophrenia - are increasing and, besides their role as background for suicide, represent major sources of unsatisfactory quality of life.

Like in other regions, health and life expectancy depend heavily on socio-economic background, conditions of living, and individual behaviour. This leaves the health system – primary as well as secondary and tertiary services - with the potential of not only striving to cure the patients but also to seek to promote health and prevent disease and other unwanted outcome.

The lecture will present an overview of the population NCDs situation in Europe and discuss proposed priorities as concerns the focus for health promotion and prevention based on health systems settings. Furthermore, it will discuss the role of the hospital in possible actions, the evidence basis for such action, and possible recommendations for the Health Promoting Hospitals.

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PUBLIC HEALTH ACTION ON CHRONIC DISEASES: EUROPEAN STRATEGY TO EMPOWER HEALTH SYSTEMS

Vilius Grabauskas

BACKGROUND

European Region of the World Health Organization (WHO) with its 52 Member States represents a very diverse entity in terms of chronic disease (CD) morbidity, mortality and their determinants. The variation in capacities of national health systems supposed to respond to the needs of populations in CD prevention and control in different countries is large. The need for sharing experiences in addressing the CD problem throughout Europe is obvious, especially using hospital settings to support public health actions in CD.

RATIONALE

Although evidence enough exists that many CD result from unhealthy life styles and unfavourable social conditions, meaning that roots of major CD are common, still, the prevailing actions against this group of CD follows vertical approaches. WHO/EURO coordinated CINDI programme (Countrywide Integrated Noncommunicable Disease Intervention) continues to be the only effort based on integration of actions across continuum in health promotion, disease prevention and care. Actions that are tested and implemented by CINDI network involving 33 European countries and Canada are aimed at improved health and reduction of CD through adoption of healthier life styles, simultaneous reduction of common risk factors (RF) and improved health care. Since CINDI concepts for integrated actions have been generated by the health profession, hospital settings are important players in CD risk reduction process.

CINDI VISION FOR PUBLIC HEALTH ACTION IN CHRONIC DISEASES IN EUROPE

The strategic framework aimed at reduction of CD, targets four major conditions: cardiovascular disease, cancer, chronic obstructive pulmonary disease and diabetes. It focuses on four lifestyle-related factors: tobacco, diet, physical activity, and alcohol. In turn, this should lead to the improvement of individual risk profile by affecting four biological risk factors: overweight, hypertension, abnormalities in lipid and in carbohydrate metabolism. To achieve this, four integrated approaches are to be applied: individual risk reduction (aimed at high-risk individuals), population risk reduction (aimed at social determinants), rational use of health services (by empowering primary health care), and appropriate referral system support. These efforts should be guided by four major strategies: policy development, capacity building, surveillance, and dissemination. All the above should be related to the improved functioning of socioeconomic environment by focusing on four major social determinants of NCD: poverty, education, employment, and balancing social inequalities.

The strategy should be developed and implemented by partnerships on several levels. The international level would involve WHO, Member States, European Union, Professional health associations and nongovernmental organizations. The national level would involve governments, all societal sectors affecting health, academic and health care communities, and nongovernmental organizations. The local level would involve communities and their settings, institutions, interest groups. However, in the European situation, the WHO Regional Office for Europe has a unique authority and clear mandate to lead the development and implementation of the European chronic disease strategy and thereby to help create a better health environment throughout the Region.

CONCLUSIONS AND RECOMMENDATIONS

The network of Health Promoting Hospitals is well suited to contribute to CD risk reduction first of all by innovatively implementing high risk strategy in CD prevention as well as through provision of improved health care for CD patients. However, hospital settings and hospital staff can also be a powerful instrument in educational activities thus considerably contributing to the implementation of population strategy as demonstrated by CINDI experience.

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PLENARY II:

Thursday, May 25, 2006, 13.30 – 15.00

INTEGRATING TREATMENT, CARE, PREVENTION AND HEALTH PROMOTION FOR CHRONIC DISEASE WITHIN HOSPITAL SERVICES IN ORDER TO ACHIEVE AN OPTIMUM OUTCOME

CHRONIC DISEASES FROM THE PATIENT'S PERSPECTIVE.

Klaus-Diethart Hüllemann

Most diseases in the developed countries and in many developing countries are chronic diseases.

Chronic patients have many comprehensible expectations toward the health system and towards health professionals. Some results of the International Study Care About Women with Cancer: Fears (negative influence on partnership-relations, 66%; diminished self-esteem, 35%), 73% wanted to be involved in treatment decisions. Source of support: 1. Partner, 2. Children, 3. Other family members, friends, 4. Senior physicians, 5. Social workers, psychologists.

Many chronic patients learn self management and self care. Out of our case studies of patients with chronic pain and major handicaps the prerequisites of coping and health gain are: Humor, stable human relations, curiosity and play instinct, observational skills, good cheer, zest for life, indomitable will, stamina, love, gratitude.

As possible consequences for hospital services and the different professional groups in the hospital some principles are suggested for better communication and better motivation: Goal (what to communicate?), Tailoring (what is the position the patient takes?), Gift Wrapping (how to communicate the goal?), Processing (how to create a drama?). In this respect Health Promoting Hospitals are asked to implement „The Standards“, especially Standard 4 „Promoting Healthy Workplace“ and Standard 5 „Continuity and Cooperative.“

For chronic pain patients two main goals should be taken to heart: Be for the patient a compassionate partner and be for the disease an up to date scientist .

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HEALTH PROMOTION AND DISEASE MANAGEMENT: VIEW FROM COUNTRY IN TRANSITION

Vilnis Dzerve

BACKGROUND

86% of deaths and 77% of disease burden in Europe are caused by noncommunicable disease (NCD), mainly cardiovascular disease, cancer, mental disorders, diabetes mellitus, and chronic pulmonary disease. Gaining better health for the people of Europe is both feasible and achievable. It is already possible to significantly reduce the burden of premature death, disease and disability in Europe through comprehensive action on the leading causes and conditions.

HEALTH PROMOTION APPROACHES

Health promotion and the prevention of NCD have a relatively small share of the health system budget. According to Organization for Economic Cooperation and Development (OECD), on average, only 3% of total health expenditure goes toward population-wide prevention and public health programs, while most of the spending is focused on "sick care." From observation of countries, a typology of NCD policy might be categorised as follows:

Category A: Limited, single prevention approach;

Category B: Expanded, multiple prevention approach;

Category C: Integrated, multifactorial approach to prevention;

Category D: Integration of prevention with health service and broader health system efforts;
Category E: Integration with broader societal efforts on determinants of health and health protection.
Most of East European countries where health care system is in transition, belongs to first three Categories. Reasons will be discussed.

REALITY AND VISIONS

As an example the Latvian Health Promotion System is presented. The investment in the Programme „Healthy life style 2007-2009” is 0.2% of investments in Health Care Programme. The place and role of hospitals in the HP system is theoretically accepted but not supported by Programme documents and investments. Nevertheless, the specialized centres in the hospitals are very active in development of case management systems. The Case management experience in Latvian Centre of Cardiology is presented.

Many of the problems connected with NCD do not respect national borders, nor are they the exclusive responsibility of the health sector. Solutions often have to be transnational and cross-sectional in nature or require international solidarity to achieve success on the national level. Main actions in this context are:

Strengthening international, bilateral and multilateral cooperation;
Information exchange, technical cooperation and capacity building;
Research and monitoring.

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PLENARY III:

Friday, May 26, 2006, 09.00 – 10.30

INTEGRATING TREATMENT, CARE, PREVENTION AND HEALTH PROMOTION FOR CHRONIC DISEASE ACROSS LEVELS OF SERVICES FOR PATIENT EMPOWERMENT, INCLUDING PALLIATIVE CARE, CASE MANAGEMENT AND DISEASE MANAGEMENT APPROACHES

COOPERATION AND PARTNERSHIPS ACROSS THE HEALTH SYSTEM FOR IMPROVING HEALTH PROMOTION, PREVENTION, TREATMENT AND CARE TO ADDRESS THE CHRONIC DISEASE CHALLENGE

Sylvie Stachenko

There is substantial agreement internationally about the need for multisectoral action for improving chronic disease prevention and management. However, no clear consensus exists about integration and how best to achieve it. As a result, the relationships between the public health and health care systems are still evolving but their potential is far from being fully exploited. During this presentation, we will discuss how hospitals can organize cooperation with other levels of care in order not only to improve the treatment and care components but also to tackle chronic diseases upstream. We will also explore how public health principles can transcend the traditional boundaries across the health system and levels of care, and discuss the implications for hospitals and the Health Promoting Hospitals Network.

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HARMONIZING THE HEALTH CARE SYSTEM FOR MEETING THE NEEDS OF CHILDREN WITH TYPE 1 DIABETES

Zilvinas Padaiga

This presentation focuses on the necessity of the harmonization of health services in diabetes control among children. It is based on more than twenty years of experience in research- and practice-based diabetes control in Lithuania.

Type 1 diabetes accounts for 5 to 10 percent of all diagnosed cases of diabetes, but is the leading cause of diabetes and the most often chronic disease in children. Incidence and prevalence of type 1 diabetes in Lithuanian children until 14 years of age has been steadily rising during the period of last twenty years. It is most frequently diagnosed in boys and girls in 10-14 years age group. However, within European context, Lithuania still belongs to the countries with low incidence of childhood diabetes (8.3 per 100 000 population per year).

Presentation stresses the necessity of harmonizing and strengthening the link between health care services, which are delivered at primary level and hospital level, emphasizing the importance of patient-oriented health care system. It also puts special emphasis on the role of health professionals and patients in health education. People with diabetes, including children, play central role in managing their disease. As children with type 1 diabetes are at risk for long-term complications, it is essential for health professionals to support their efforts to understand the nature of their illness and its treatment; to identify emergency health problems at early, reversible stages; to adhere to self-care practices; and to make necessary changes to their health habits. Due to low technical complexity, low capital requirements, and cultural acceptability diabetes education should be not only an integral part of diabetes care, but also a high-priority intervention for all countries.

The National Diabetes Program for 2006-2010 will be approved this year. It establishes prevention, diagnostics and treatment aims, goals and their fulfillment for the diabetic patients in Lithuania.

In 2005 the project e-health, which is financed by World Bank and EU Structural Funds, was launched. The main aims of this patient-oriented project are to improve citizens and health professionals access to reliable and comprehensive information, to ensure better quality of health care services, and to develop information exchange system between health care institutions.

Health Promoting Hospitals are a very important integral part of patient-oriented health care systems, especially in case of chronic patients. Evidence-based treatment, which is delivered together with health education, and tight links with other providers of health care services, will ensure that needs of patients living with chronic diseases are adequately met.

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PLENARY IV:

Friday, May 26, 2006, 16.15 – 17.15

ACTION ON WIDER DETERMINANTS OF CHRONIC DISEASE: COOPERATION BETWEEN THE HOSPITAL AND OTHER SETTINGS

HOW CAN THE HOSPITAL COOPERATE WITH OTHER SETTINGS TO TACKLE THE WIDER DETERMINANTS OF HEALTH

John Ashton

It is many years since the distinguished London Academic Bryan Abel-Smith wrote his seminal work on Hospitals in which he demonstrated over time the history of hospitals that had been established to meet the needs of the poor, which was that they would inevitably be hijacked by the middle classes. Equally vexing is the question as to whether hospitals can ever provide Public Health leadership when all of the premises on which they are established seem to collude with a reductionism that is fundamentally downstream. For example, in the UK at the present time, policy rhetoric is about Out of Hospital Care with one of the main levers, namely Payment By Results, set up to reward hospitals for increased activity.

For more than 30 years, the World Health Organisation position has encouraged us to think of Health and Health Care systems which are built from the bottom up with Public Health Orientated Primary Care as the foundation of the total system, yet few countries, notably, Finland and Cuba have really managed to achieve this.

This paper will seek to bring together several strands of development over the past 20 years. Firstly, that relating to the hospital as a setting and as such its role in health, providing healthy conditions as well as the delivery of health care, secondly, the issue of whether Primary Care led systems are still possible and thirdly, it begs the question as to whether hospitals can truly embrace a Public Health model in which they see themselves as a resource to Health rather than as the end in themselves.

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USE OF HOSPITAL SETTINGS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH: VALUE OF INTERNATIONAL COLLABORATION TO REDUCE THE BURDEN OF CHRONIC DISEASE

Mikko Viononen

The biggest health challenge facing Europe is that of NCDs causing 86% of deaths and 77% of disease burden in Europe. Only with integrated action on risk factors and determinants, and strengthening health systems it is possible to prevent, or modify risk factors, prevent onset of disease, prevent recurrence of disease, prevent progression of disease, prevent disability and prevent painful or premature death. International collaboration is a valuable asset when searching for efficient evidence based methods, and when outside back-up aiming towards right decisions and direction is needed. Find the right partners!

The foundations of adult health are laid in early life. Therefore, those hospitals providing services for pregnant women, children and adolescents are in a key position. Practice guidelines, standards, and monitoring of care is still far from optimal. Hospitals have not been in the forefront when it comes to health promoting settings and environment. The movement of smoke-free hospitals is proceeding. Most progressive hospitals have totally prohibited smoking during working hours. Canteens are not allowed to sell tobacco products. The food in hospitals should be exemplary. BMI should be measured for every patient. Doctors are criticized of writing prescriptions too freely. Instead of a prescription one can order: "brisk walk 45 minutes four times per week".

Hospitals can become more active in discussing harmful lifestyles, leading into chronic diseases. Although it is avoidable, 30,000 women die each year from cervical cancer in Europe. Tobacco and alcohol related deaths are counted in millions. Have we been too busy doing things right rather than right things?

In moving forward, hospitals together with international partners could start by:
Bringing together key stakeholders from the health system and broader society;
Carrying out situation analysis on the size of the problem priorities for action;
Evaluating what is already in place, strengths and weaknesses, and identifying current gaps;
Strengthening international, bilateral and multilateral cooperation by developing an alliance for advocacy and action on NCDs which unites major international players.

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ABSTRACTS FOR PARALLEL PAPER SESSIONS AND CONFERENCE WORKSHOPS

PARALLEL SESSIONS I:

Thursday, May 25, 11.00-12.30

SESSION I-1. EXAMPLES FOR ORGANISING HEALTH SYSTEMS TO MEET THE CHALLENGE OF CHRONIC DISEASES

CHRONIC DISEASES AS AN INCREASING CHALLENGE TO THE PUBLIC HEALTH SECTOR: THE GERMAN ANSWER: INTERDISCIPLINARY CENTRE AS A PROBLEM SOLUTION STRATEGY

Bernhard Ferdinand Henning

INTRODUCTION

In Western countries, chronic diseases constitute an increasing challenge facing the public health sector. This situation is aggravated by a population growing older and older, and by additional psychic impairments frequently observed in case of chronic diseases.

OBJECTIVE

To avoid consultation of various physicians, as often practised by persons suffering from chronic diseases, as well as consultation of specialists in different disciplines, and the double examinations often carried out in such cases, interdisciplinary treatment centres are being established, in which suited specialists of various disciplines jointly co-ordinate diagnostics and treatment. Psychologists and social workers are integrated as well as medical treatment partners in the non-stationary sector.

METHOD

At the Marienhospital, Herne (Ruhr area, Germany, 170,000 inhabitants, rate of migrants 12,1%, rate of unemployment 16,3%, 25% of the population being older than 60, 6 denominational hospitals, university clinic of Bochum, 16 wards, 618 beds, 1,000 employees, 23,000 patients per year), the following centres have been established: interdisciplinary abdominal centre (under the leadership of the departments of gastroenterology and -visceral surgery; in addition: psychologist, gynaecologist, urologist, oncologist, radiologist, anaesthesiologist, surgeon, physiotherapist, social worker); tumour centre (departments of haematooncology, -gastroenterology, -visceral and general surgery, radiologist, radiotherapist, specialist in internal medicine, anaesthesiologist, psychologist); vascular centre (cardioangiologist, specialist in internal medicine, vascular surgeon, radiologist, psychologist); continence centre (urologist/neurourologist, visceral surgeon, gynaecologist, gastroenterologist, psychologist, social worker, physiotherapist, neurologist).

In addition an interdisciplinary reception unit has been established, where the course is set for the correct allocation of patients, and the way may already be paved for clinical pathways.

RESULTS

It could be proved, that owing to the establishment of centres, the period of time needed for making a diagnosis, and -during which a hospital treatment is required could be reduced, while improving patient contentment. At the same time, a cost reduction could be achieved.

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CHRONIC DISEASES CONTROL POLICY IN LITHUANIA: FROM POPULATION BASED TO HOSPITAL BASED PREVENTIVE PROGRAMS

Irena Miseviciene, Zemyrna Milasauskiene

ISSUE

Noncommunicable chronic diseases (NCD) - are the major causes of death over the world and in Lithuania also. Increasing morbidity and disability due to the cardiovascular diseases, cancers, diabetes and chronic obstructive lung diseases obligate to implement more effective diseases control methods, including health promotion and disease prevention.

BACKGROUND

Lithuania is one of several countries in Europe which 25 years ago started to elaborate and implement integrated prevention for NCD's control at population level. The conception of integrated NCD control was born in Lithuania in 1981, when the first WHO meeting took part in Kaunas. Lithuanian WHO experts prof. Z.Januskevicius, prof. V.Grabauskas and Prof. A.Baubiniene on the basis of international Kaunas-Rotterdam intervention study (KRIS) presented the evidence based data of effective control of cardiovascular diseases risk factors. The experience of effective multifactorial cardiovascular diseases risk factors control at population level in one city (1977-1981) among males, stimulated the development of Country Wide Integrated NCD's prevention programme (CINDI) in urban (Kaunas) and rural (5 rural regions of Lithuania) male and female population.

WHO expanded the preventive programmes across different settings - schools, kindergartens, worksites and hospitals - were implemented very efficiently in Lithuania. Ten year experience of Health Promoting Hospitals (HPH) project gave a lot of good practice examples of NCD risk factors control among patients and hospital staff.

CONCLUSION

Collaboration of Kaunas University of Medicine staff with governmental bodies (Ministry of Health and Education, municipalities, etc.), nongovernmental organizations (National Health Board, patient's organizations, etc.) influenced the National Health Policy. Health Promotion and disease prevention became one of priority areas of National Health policy. Close relations and collaboration with WHO and participation in international networks (CINDI programme and International HPH network) is a dimensionless value for Lithuanian health professionals and overall population.

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THE DEFINITION OF THE MOST APPROPRIATE AND FEASIBLE CLINICAL AND ORGANIZATIONAL METHODS FOR MANAGING CHRONIC PATIENTS

Mariella Martini, Rosanna Carbognani, Giuseppe Noto, Cristina Pedroni, M.Giulia Calzari, M.Beatrice Bassi

BRIEF DESCRIPTION OF THE PROJECT

In the field of chronic patient management, the most recurrent problems are linked to:

- The definition of appropriate diagnostic and therapeutic and care;
- The concretisation of the patient-involvement logic, placing the "patient-expert" at the centre of his disease management;
- The redesign and re-orientation of a care system faced with new economic challenges;

The targeted objective is the increased centrality of the chronic patient, able to collaborate with health staff who are increasingly taking on the role of "companion" within the care path; and the creation of an integrated model, which guarantees continuity of care.

METHODS/ACTIONS

- The identification of a selected target of chronic patients (cancer, cardiac decompensation, BPCO)
- The definition of a specific care path for each target, identifying the relevant caregivers, tasks and roles according to an evidence-based follow-up defined and co-constructed.

- The comparison of the hypothetical path with the existing one, highlighting organisational, operational and behavioural problems.
- The project considered all aspects linked to the management of targeted patients: patient records, protocols, non-clinical problems, performance and monitoring systems.

CONCLUSION AND EVALUATION STRATEGY

The project, started in 2004, has been developed in various steps and is still underway. The first step included the set up of multi-professional project groups. These groups developed a theoretical pathway formalised in a flow chart, a follow up form, and a set of indicators. At the end of this first phase the overall project was presented to all departments in order to start the implementation of the new model throughout the whole province.

This new model will be tested through the use of 3 sets of indicators described below:

1. for cancer patients

- No of deceased cancer patients treated with palliative care at home / Total number of deceased cancer patients
- No deceased cancer patients treated in Hospices / Total number of deceased cancer patients under the local health authority

2. for chronic cardiac decompensation patients

- No. of complete diagnoses carried out according to the EBM protocol / total number of diagnoses carried out in the year.
- No. of home care nurses activated for class NYHA IV decompensation or for patients with high social and care complexity/ total number of cases with class III/IV stratification

3. for chronic respiratory insufficiency patients:

- No. of complete diagnoses carried out according to the established protocol/total number of new cases of chronic respiratory insufficiency entering the care path.
- No. of home care nurses activated for global chronic respiratory insufficiency or for patient with high social and care complexity/ total number of new cases of global chronic respiratory insufficiency.

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HUB & SPOKE NETWORKS FOR RARE /CHRONIC DISABLING DISEASES

Stefano Liverani

The ministerial decree 279 of 2001 provided that the Regions would identify a network for the prevention, surveillance, diagnosis and therapy of rare diseases.

Emilia-Romagna identified the centres that constitute a regional network by Council Resolution no. 160 of 2004.

A Technical Group for rare diseases was subsequently created: amongst other tasks, it has the aim of proposing the assignment (to be charged to the Regional Sanitary Service) of services and/or medicines not included in the LEA, as well as suggesting the integration of the list of accredited medical units.

Furthermore, various specific work teams have been activated for each pathology and small groups of pathologies. These teams, including specialists and representatives of patient's associations aim at creating networks in which the Hospital Services (Spoke) can send the patients to highly-specialised centres (Hub) for treatments that are particularly complex and that require highly-specialised professionalism and technology.

The centres included in the Hub & Spoke network ensure an overall taking care of the patient via diagnostic and treatment protocols shared at regional level and guarantee effective and homogenous treatment.

The first network of this type in the field of rare diseases was dedicated to haemophilia and congenital hemorrhagic diseases.

The Hub Centre has been identified in the Hospital-University of Parma and there are seven Spoke Centres in the regional territory. The Technical Group for Haemophilia has promoted the creation of a Regional register collecting the patient's data: an instrument of great usefulness for assistance, epidemiological and statistical purposes.

The network is centred around a dynamic system of relations between various centres to guarantee quick diagnosis, appropriate therapy and assistance to the ill persons in all phases of their diagnostic-therapeutic path, according to various levels of assistance complexity.

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DIFFICULT HOSPITAL DISCHARGES IN INTERNAL MEDICINE WARDS: SHARED PATHWAYS FOR A SHELTERED FATE AS A TOOL FOR THE COMPREHENSIVE COMPLEX FRAIL PATIENT'S NEEDS, REDUCING INAPPROPRIATE HOSPITAL USE

Roberto Nardi, Antonella Tragnone, Antonella Lolli, Patrizia Kalfus, Giovanna Corsini, Luisa Diana, Teresa Ghedini, Stefano Bombarda, Saverio Di Ciommo

BACKGROUND

Internal Medicine patients (pts) are mostly elderly, complex, with progressive and chronic co-morbidities. The "difficult hospital discharges" (DHD), in addition to the nature and severity of the diseases, are conceived as situations involving an economic, human and organizational burden exceeding pts' and their families' capacities, inducing an hospital discharge delay and requiring an involvement of primary care services.

AIMS

To investigate the prevalence of DHD, to describe clinical and social patient's characteristics, to explore the reasons for discharge delays at an Internal Medicine ward, to implement the best post-discharge care.

MATERIAL AND METHODS

During the year 2005 we analysed, in a middle-sized country hospital, all the pts for which, just at admission, some delay for discharge, owing to their whole complexity, was presumable.

INSTRUMENTS AND MEASURES

Comprehensive multidimensional assessment, clinical-social risk score, specific needs of care, mean of stay, outcomes (i.e., fate after discharge, in hospital mortality) were evaluated.

PRELIMINARY RESULTS

We reviewed 99 pts initially judged as potential DHD (mean age: 81.6, range: 61-100), corresponding to 5.4% of all pts admitted in our ward. On the basis of the initial clinical-social prognostic score three groups of pts were found, with low (40.4%), moderate (37.3%) and high risk (22.6%), each of one itself not significantly related to the level of dependency. The most frequent causes of hospital admission were stroke (16%), cognitive impairment-dementia (15%), cardiovascular (14%), fractures (13%), cancer (12%). At discharge ≥ 5 drugs were prescribed in 56.5% of pts. (mean for each pt: 5.7; range: 1-11). 5.5 days (range 0-20) was the mean time from the hospital flag to the sheltered primary care management implementation. 52% of pts were discharged home (an assisted discharge was performed in 41% of these, with some nurse and/or social support), 30% were admitted to a long-term care facility, 1% to hospice, 17% died during hospital stay.

CONCLUSIONS

Our findings suggest the need to improve the systematic case finding of frail, complex, very old pts admitted to Internal Medicine wards with potential DHD. More than 80% of DHDs may be discharged from hospital, with some satisfactory solutions for pts and their families. Planning discharge just at admission, inter-professional patient centred communication and cooperation between hospital and primary care services can be thought of as three simple rules that inspire desirable behaviours in a shared delivery care. The basic value of the management of these patients is the acceptance of a *comprehensive collaborative medicine* in the larger macrocosm of health care system.

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A MODEL OF INTEGRATED PRIMARY CARE FOR CHRONIC PHYSICAL AND PSYCHOLOGICAL HEALTH

Susan Frampton

Research has shown that between 70-80% of all visits to primary care sites, whether hospital or community based, result from problems related to psychological distress (Kroenke et al., 1989, 1990). Across a wide variety of medical conditions, untreated co-morbid psychiatric disorders are associated with a dramatic increase in medical complications and poorer patient outcomes. For example, patients with severe COPD (Chronic Obstructive Pulmonary Disease) are 2.5 times more likely to be depressed than patients without COPD or mild COPD (van Manen, Bindels, et al., 2002). The prevalence of panic disorder in cardiology outpatients and patients with CAD (Coronary Artery Disease) ranges from 10-50% (Fleet, Lavoie & Beitman, 2000).

In CAD patients, co-morbid depression is the best single predictor of cardiac events during the 12 months following diagnosis (Sheps & Sheffield, 2001).

Given the overwhelming evidence of the significant link between psychological and physical health problems, and the current stigma in most societies that accompanies a "mental illness", a model has been developed that combines assessment of both physical and psychological health issues in primary care settings successfully. This model is being used extensively throughout the veterans health system in the United States, where uniquely high rates of PTSD (Post Traumatic Stress Disorder) further complicate the health status of patients treated in hospitals and clinics designated for military veterans. This model is characterized by the inclusion of behavioral health professionals as members of the primary care team. Patient care is viewed as continuous over time rather than as involving discrete treatment episodes, and mental and physical health standards are viewed as equivalent in importance.

In this session, we will present this integrated model, providing examples of how hospitals and clinics can develop culturally sensitive approaches to treatment of chronic psychological issues in primary care settings. We will discuss the many potential benefits of an integrated approach to care of chronic health issues, including reduction in costs. The literature demonstrates that behavioral interventions can substantially reduce medical utilization in primary care settings and thus associated costs (Levant, 2002). Even greater reduction of utilization occurs when specific chronic disorders such as asthma or arthritis are targeted (Sobel, 1994). Patient outcomes improve (Katon, 1995; Callahan et al., 1994), patient compliance increases (Blount, 1998), medical costs are reduced in the range of 20%-40% (Cummings, et al; 1991; Stroshal et al., 1996), and staff and patient satisfaction increases (Blount, 1998).

Finally, lessons learned and continuing obstacles to an integrated approach to treating chronic disease will be shared.

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CONDUCTING A CONSUMER PANEL FOR CANCER SERVICES

Breen A, Harnett A, Hand C, Ryan C

OBJECTIVE

As part of the planning process in developing services for patients with a malignancy and in particular the Patient Support Centre in the Mid-Western Regional Hospital Limerick a consumer panel was organised to invite patients to share their ideas and suggestions on the planning, management and daily operational running of services.

METHOD

The Irish Cancer Society recommended that patients who are in clinical remission i.e. 2 years after treatment be selected for inclusion in the consumer panel. Ten patients were randomly selected from the hospital database of cancer patients eight of the ten were women. The general practitioners caring for these patients were contacted to ask advice regarding the suitability of their patient for inclusion in the panel. The consumer panel that convened on Daffodil Day the 19th March 2004 consisted of 14 cancer patients, eight individual female patients, one male patient and five representatives from the cancer support group. A second panel was conducted Sept 2005 to coincide with the opening of the patient support centre. The final consumer panel for this group of cancer patients was conducted April 15th in the support centre.

RESULTS

The themes that emerged from the March 2004 consumer panel were as follows, access to the service, information, breaking the news of the diagnosis, informed choice, service availability, support at the time of diagnosis, counselling support, the potential for support groups, the cancer support centre, the service within the hospital and Oncology, support after discharge from hospital and the oncology service, the different needs of men, support for families, Radiology service. The panel conducted in September 2004 focused on the cancer support centre and what services it could provide for cancer patients in the region. The final panel for this group took place April 2005 and explored the use of the centre in relation to conducting patient support group meetings.

DISCUSSION

The findings of the March 2004 consumer panel verified that there were no problems in relation to gaining access to the hospital system for surgery. It was recognised that breaking the news of a cancer diagnosis would be difficult for everyone concerned, the staff and clearly the patient and their family. It was evident from the focus group participants that there is no standardisation of information received in relation to diagnosis, surgery and prognosis as well as treatment options. It was felt that there should be someone available to talk to patients and answer questions immediately after the diagnosis is given and it was also felt important that a family member should be present at time of being given a diagnosis although one patient had not wish any family member to be with her. The potential for support groups was emphasised by many consumer group participants as a valuable resource that was not being utilised. It was felt by the members of the group that men have different needs in relation to support when they get a cancer diagnosis. The care provided within the oncology service in the hospital itself was considered very positive. In relation to aftercare patients reflected that they often felt isolated and alone once treatment regimes are finished. The panel conducted in April 2005 further explored the provision of patient support groups and what format the meetings might take. There are two groups in operation a womens support group and a mens support group they both meet monthly.

CONCLUSIONS

It was clear that the consumer panel felt that the panel had been worthwhile and they felt reassured that their opinions were important in informing future cancer services in the region.

Many of the suggestions from the group have already been put in place. It will be important when the next panel is set up to explore what the particular needs of men might be and it might even be useful to convene a panel of men only to ensure that their particular needs are provide for in cancer services in the region.

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SESSION I-2. MIGRANT FRIENDLY AND CULTURALLY COMPETENT HEALTHCARE -1

MIGRANT-FRIENDLY AND CULTURALLY COMPETENT COMMUNICATION. THE DEVELOPMENT OF AN INTEGRATED LANGUAGE AND INTERCULTURAL MEDIATION SERVICE FOR HOSPITAL AND PRIMARY CARE SERVICES

Antonio Chiarenza

Language discordance between patients and health care staff can lead to communication problems and misunderstandings. Patients who do not share the language of the professionals caring for them are doubly at risk: they risk receiving less than optimal care because they are part of a migrant or minority community, and they face the additional risk posed by language barriers. This is particularly true when communication is part of diagnosis and treatment. Here, it is of utmost importance that relevant clinical information is elicited from and conveyed to the patient in a correct and appropriate manner. Effective communication of medically relevant information is a prerequisite for both clinical decision-making and client-provider trust, and hence for the patients' successful treatment and co-operation in reproducing his/her own health. Therefore language barriers have adverse effects not only on the accessibility of care but also on the quality of care, patient satisfaction and health outcomes.

In order to overcome language and cultural barriers the health authority of Reggio Emilia has initiated a significant process of re-orientation of its services in order to become a culturally competent organisation. Following the two and half year experience of the EU project MFH, the Health Authority of Reggio Emilia has implemented a far reaching and innovative language and intercultural mediation service aimed at improving the communication and the relationship between health staff and migrant populations in the whole province of Reggio Emilia, including both hospitals and district services.

Within the framework of the MFH approach the AUSL di Reggio Emilia set up a specific development plan which had to achieve four main objectives for all health care services of the Authority:

Professional interpreter services should be made available whenever necessary to ensure good communication between non-local language speakers and clinical staff.

Patients should be informed about language services available and how to obtain these services.

Clinical staff need to be empowered on how to work competently with interpreters to overcome language barriers and obtain better outcomes.

In addition patients' education materials should be made available in non-local languages to assist with communication.

Given the characteristics of our health authority which covers urban as well as rural areas with hospital and primary care services, we decided to set up a community-based interpreting service, using intercultural mediators with interpreting competencies and connecting needs and resources of various services. We also encouraged the development of partnerships with other local authorities who were tackling the specific needs of migrant and ethnic groups. In doing this we also tried to integrate the local health plans with the local social plan. We therefore established coordination of the service at a central level with links to each health district (there is quite a distance between the north and the south part of the province).

The service covers the Arabic, Chinese, Hindi, Urdu, Punjabi, Albanian, Russian, Turkish and Romanian languages and offers the following types of intervention for clinical encounters and health promotion activities:

On-site presence of the intercultural mediator

Weekly scheduled intervention

Urgent intervention (within 2/3 hours)

Over-the-phone intervention

Interpreting and translation

Patient information and education

Community information and education

Written information material

Training for staff on how to work with intercultural mediators and for intercultural mediators on how to work in clinical encounters.

The goal of this communication is to present the approach adopted to improve effective communication and to develop a sensitive relationship with migrants and ethnic minority groups; and to discuss data and experiences of the initial year of activities of this new language and intercultural mediation service.

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TOWARDS SUSTAINABILITY AND INTEGRATION OF CULTURAL COMPETENCY IN HEALTHCARE

Gurwinder Gill

Trillium Health Centre is an acute-care hospital with two sites, and has one of the busiest Emergency Services in Canada. It is situated in the Greater Toronto Area where over 43% of the population was born abroad, and there is a higher % of recent immigrants & individuals whose spoken language is one other than English or French (39.5%).

Cultural Competency in healthcare can be defined as "a set of integrated attitudes, knowledge and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups and communities". This indeed is a challenge for hospitals such as Trillium Health Centre, given the demographics of its patient and staff population.

THIS SESSION WILL

Outline the recent journey that Trillium Health Centre, Canada, has been on to being more patient-centred and culturally competent

Include a basic culturally competent framework that the hospital has been focusing on towards its goal of creating a healthy environment that promotes respect, equity, access and diversity

Outline some key diversity strategies, practices and processes that Trillium Health Centre has been focussing on systemically that will result in everyone taking on responsibility for the commitment towards respecting diversity versus Diversity Services being a 'stand-alone' program.

Staff will be accountable for incorporating and integrating diversity practices, looking at planning and problem-solving through a diversity lens.

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IMPROVING ETHNO-CULTURAL COMPETENCE OF HOSPITAL STAFF BY TRAINING - EXPERIENCES FROM THE EUROPEAN MIGRANT FRIENDLY HOSPITALS PROJECT

Karl Krajic, Christa Straßmayr, Ursula Karl-Trummer, Sonja Novak-Zezula, Jürgen M. Pelikan

Cultural competence training (CCT) for staff in health care seems one of the most widespread measures to deal with ethno-cultural diversity, especially in North America. Most of the documented studies and experiences on cultural competence training originate from the US, whereas European contributions still are rare - at least from continental Europe. The paper presents experiences from hospitals from 8 EU member states. Within the European Migrant Friendly Hospitals project 2003-2005, sponsored by the European Commission, DG Sanco, training for hospital staff was implemented in seven European hospitals, aiming primarily at the support of staff. Evaluation criteria were feasibility/acceptability, quality, effectiveness, cost-effectiveness and sustainability. Data were collected by a staff questionnaire in a before - after design, by documentation sheets, telephone interviews with project co-ordinators and group discussions at project meetings. Key findings: 7 of 8 pilot hospitals managed to implement CCT, with (a) wide variations of acceptance among staff as measured by participation (b) considerable variations in quality as measured by concordance with a training "Pathway" agreed upon (c) generally good impact on staffs' self-perceived knowledge, skills and comfort level in trans-cultural situations (d) good cost-effectiveness concerning external costs and (e) good sustainability as far as the general acceptance of the issue as part of Continuous Professional Education for hospitals is concerned.

The presentation will outline basic concepts, present an overview on outcomes and summarize critical points relevant for hospitals willing to improve quality and promote health of an increasingly diverse clientele by implementing CCT for their staff.

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MIGRANT FRIENDLY HOSPITALS IN PIEDMONT - EXPERIENCE AND REFLECTIONS

Luigi Resegott, Mario Carzana

When analysing the situation of the hospitals in our country the question arises: could they operate without taking into account the migrants both as a charge (when sick) and as a resource (when healthy)? The point is whether hospitals should be a setting where people from other countries are simply welcomed, or rather a settings where everybody feels at home no matter of his origin, race and social condition. Starting from his family story and the Italian history, the first author states that many Italians could have been considered as "migrants" within their own Country in the past. The present wellbeing of the society has been built through a reciprocal friendly attitude. The authors analyze the number of hospital admissions of non European Union citizens in Piedmont in 2004 that were 35553 (4.4% of total admissions), whereas in the same time period more than 30% of the hospital staff and 60% of people supplying private health care to Italian patients in hospitals, old people houses and at home were non European Union citizens. Many of them lack adequate formation and legal tutelage. The action of Piedmont Region in this field follows the Chart of Ottawa's principles:

- To enable: Education of the migrants on health care principles, Italian language and regulations Education and training of the hospital staff on the needs of migrants and the way to help them
- To mediate: ISI (Health Information for Migrants) service; cultural mediation through NGOs
- To advocate. Street Lawyers Organisation giving legal tutelage against abuse and violence

The "Migrant Friendly Hospital" task force of the Piedmont HPH network coordinates all these actions for promoting equity and quality of services.

It is too early for assessing the results of these actions, but the satisfaction of both patients and migrant is steadily increasing

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IMPROVING PATIENT AND COMMUNITY EMPOWERMENT: THE PARTICIPATORY ACTION RESEARCH/ LEARNING AS AN ALTERNATIVE APPROACH

Lai Fong Chiu

The goal of the Migrant Friendly Hospital initiative is to improve the delivery of hospital services in Europe for migrants through the identification, development and evaluation of effective practice. In Biscoff's (2003) literature review undertaken on behalf of the MFH initiative, of the four main areas of concern i.e. communication, socio-cultural responsiveness, patient and community empowerment, and the monitoring of migrant health and health care, evidence to support the effectiveness of patient and community empowerment is the most nebulous and conceptually least developed in relation to MFH. While the benefits of patient and community empowerment have been reported in academic publications, the exact mechanisms of empowerment are seldom delineated. Therefore, models of good practice gleaned from this literature are of little value to practitioners who wish to adopt empowering practice and to policy makers who are keen to evaluate what works. Based on practice of the Community Health Educator model, a community empowerment model in health promotion developed iteratively in the U.K. over the past 15 years through five consecutive participatory action research projects, the author suggests that the present conceptual and practical difficulties of implementing patient and community empowerment is by and large an epistemological problem brought about by the dominance of the conventional mode of knowledge production. The quest for knowledge generalisation through conventional research and publications blinds us to the importance of development in participatory praxis based on local knowledge. This paper outlines the problems of conventional research in understanding and developing empowerment practice, and proposes that the participatory action research (PAR) and action learning approach should be adopted to improve knowledge and practice in this area.

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INFORMATION AND RECEPTION IN FIRST AID AND EMERGENCY MEDICINE

Mario Luppi, Ida Breviglieri, Ivano Giacomino

ANALYSIS OF THE CONTEXT

Mantova district became only recently ground of immigration, at the beginning mainly male than, gradually also female; this matter brought to light a new reality in sanitary field.

The complex structure of First aid and Emergency Medicine, delegated, because of its own specificity to reception of people with sanitary problems, became a privileged observation centre at the top position for the comprehension and the treatment of the "foreign" sanitary demand deriving from the social changes.

40.000 citizens addressed to the complex structure of Carlo Poma First Aid and Emergency Medicine during the first 6 months of 2005. 11% of these represent a sample coming from North Africa area, America, South Africa, Mid East, Far East, North-Equator Africa, South Equator Africa.

The presented clinical situation were quite different even if car accidents, and work accidents definitely are the most common causes of sanitary demand, followed by surgery problems, gynaecological and obstetrics problems.

During the allocation of sanitary services lots of linguistic, social and cultural inconveniences came out and this phenomenon generated the activation of translation and social intervention channels which refined with the progressive increase of the migration phenomenon.

ADDRESSEES

Tourists, extra European immigrated population, cultural mediator pools, first information services.

DEFINITION OF THE PROBLEM AND GENERAL AIM

Possible and effective communication and information represent a vital joint for the allocation of first aid services and the continuity of the care process.

SPECIFIC AIMS

Translations in English, French, German, Spanish, Arabian, Russian, Polish, Chinese of an extract of the company service book, service brochure, triage evaluation.

Preparation of first aid cultural mediators pools with a specific course regarding Service matters.

Preparation of janitor's lodge operators to transmission of informations

Use of anamnestic multicultural test suggested by Lombardia Region

Continuity of the cooperation with Green Cross regarding cultural mediators matter

Prevalence studies on sanitary demand of immigrated population for possible researches with University Institutes

PRINCIPLES AND EVALUATION METHODS

Information documents at anyone's disposal translated in multilanguages and adoption of these documents in First Aid Service and Emergency Medicine.

Activation of formation courses for mediators, janitor's lodge operators, sanitary staff.

Use of the questionnaire of operators of First Aid.

Detailed analysis of sanitary data and comparison of them with those of the provincial context.

Project and implementation in cooperation with the Formation Service.

Prevalence studies on the sanitary demand of the immigrated population.

CONCLUSIONS

Communication of the interventions must be institutional and social.

The first one (institutional) must inform all operators of the Carlo Poma Hospital Company about the planning and the realization of intercultural projects through internet.

The second one helps the addressees of the communication to become the Adoption communities of the immigrated, The social research and formation Institutions.

For this last case the adopted means are: local and regional mass media, radio, t.v. through poster, questionnaires, cd rom, brochures, detailed reports about the project, study, research, inquiries.

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CULTURAL COMPETENCE IN HIGHLY SPECIALIZED HEALTH CARE

Manuel Fernandez

Since decades ago the Swedish health care system has been transformed by the immigration of many refugee groups with different racial, ethnic, and cultural backgrounds. Since many physicians and nurses receive no formal training in cultural issues in health care they are poorly prepared to handle the special concerns raised by migrant patients.

Culturally competent care can include an understanding of the importance of addressing patients from different backgrounds with respect to their culture, the identification of culturally based patient mistrust for healthcare, and a knowledge of religious and cultural customs.

A project based within the framework of the "Task Force on Migrant Friendly Culturally Competent Health Care" (TF on MF-CCHC) and in association with a local workgroup of health care professionals, has been developed in the somatic wards of the Uppsala University Hospital. These wards provide highly specialized care to a region containing 6 counties with a total of 165 000 immigrant inhabitants and a county with 35 000 immigrant inhabitants.

THE AIM of the project is to facilitate the provision of high quality, culturally sensitive care by: (1) A survey that examines utilization of the somatic departments by migrant patients (2) Delivering education and training in cultural competence to the hospital at large and by (3) providing culturally appropriate information to the patients.

RESULTS

The survey showed the lack of routines regarding the care of migrant patient. The use of relatives, including children, as interpreters was common. The staff had limited knowledge on cultural competence, especially in the domains of patients perceptions of health, illness and death rituals. They had not adequate knowledge of the local migrant groups in the City and

COUNTY

The Staff of two Departments at Uppsala University Hospital participated in an educational and training program. The contents of the educational program included cultural awareness, knowledge concerning cultural issues effecting health care, religious issues and development of skills. In both educational groups, changes in self-rated levels of awareness, knowledge and skills occurred in the expected direction. 86 % of participants in the course were very satisfied

CONCLUSIONS

The need of education and training of the staff was evident and the participants well motivated.

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SESSION I-3. SMOKE-FREE HOSPITALS

DEVELOPMENT OF THE GERMAN NETWORK OF SMOKE-FREE HOSPITALS USING THE CODE AND THE TOOLS OF THE EUROPEAN NETWORK FOR SMOKE-FREE HOSPITALS

Christa Rustler, Manja Nehrkorn, Daniela Piontek

OBJECTIVE

With 3.600 hospitals employing approx. 1,2 Mio. Workers, treating 17,4 Mio. patients a year and very few measures to implement an effective tobacco control policy, establishing a national network of smoke free hospitals in Germany is a major challenge which will take time and effort. The code and the standards of the European Network for Smoke-free Hospitals ENSH are the basis of the implementation. Members of the network can achieve European certificates depending to their score of the self audit, one of the basic tools of the ENSH. The result of a nationwide survey based on this self audit showed, that non smoker protection is basically implemented. But there are major areas of improvement in building up a systematically and sustainable approach for an overall smoke-free policy in hospitals, for staff training, smoking cessation programmes, health promotion and monitoring the development. The standards and tools of the ENSH and the European exchange of experience are very helpful aspects to implement a smoke-free policy in hospitals and a national network.

METHODS

Distribution of the code, standards and the tools of the European Network for Smoke-free Hospitals, motivating hospitals to become members, implement a process of a smoke-free hospital and to achieve the levels of certification, evaluation of the implementation by conducting an annual retry of the ENSH-self audit for all members and interested hospitals, organising meetings and workshops on regional level to support the exchange of experience and share good practice.

RESULTS

From the start at July 1st 2005 to February 2006 nearly 30 hospitals become registered members of the network. More than 50 hospitals are interested in becoming a member of the network. The member hospitals show better results in their self audit than non-members and improvement in the categories commitment, training, smoking cessation, health promotion for staff and monitoring.

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EVALUATION OF THE PLAN OF ACTION FOR A SMOKE-FREE HOSPITAL

David Chalom

The plan of action for a smoke-free hospital in Hässleholm was presented at the 13th International Conference for HPH in Dublin, 2005.

The first yearly evaluation shows that the hospital has successfully attained a smoke-free profile by meticulously carrying out the myriad of measures and partial goals that the plan of action consisted of. Adjustments were made, such as empowering department heads and section leaders, in order to enable a thorough and effective completion of tasks. Some departments have created their own plans of action to implement the measures that will ensure the attainment of the goals of a smoke-free hospital.

The reporting, by physicians, of patients' nicotine addictions and diagnoses in the patients' digital journals, has not yet been evaluated. Appropriate methods are demanded and are presently being designed.

Cooperation with other organizations, such as the municipality and its department of youth and education, has resulted in more extensive tobacco prevention measures than expected.

The media have given significant coverage of the events, spokespersons, set-backs and progress of the plan of action. This has resulted in an increased public awareness of nicotine as a drug as addictive as heroin, and for which help can be received.

The evaluation shows that a prerequisite for successfully carrying out all the measures and partial goals is to appoint persons responsible for each, with deadlines for implementation. The evaluation also shows that regardless of how ambitious and meticulous, or how multi-strategic and inter-sectoral the plan of action is, there are always new arenas into which tobacco prevention work can be launched with the hospital's cooperation. Examples of such arenas are presented.

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HAS IRISH TOBACCO LEGISLATION IMPACTED ON THE ATTITUDES, BELIEFS AND SMOKING HABITS OF HOSPITAL HEALTH CARE WORKERS AND, IF SO, HOW?

Rose Byrne, Nuala Mc Keown

A hospital is a workplace where a large diverse group of workers are employed and live in the community it serves. As such hospitals should continually promote positive lifestyle changes such as smoking cessation interventions (Naidoo and Wills, 2000). In 1998 a survey of the beliefs and attitudes towards smoking and smoking habits of all staff was carried out in the Louth County Hospital, following the introduction of pioneering tobacco legislation it can be stated anecdotally that these findings have changed in a positive way. However there is a dearth of valid research to justify this assumption. The purpose of this study was to compare data from before and after the legislation.

THE OBJECTIVES OF THE STUDY

To re-assess the attitudes, beliefs and smoking behaviour of hospital staff following tobacco legislation
To ascertain if the legislation has had any influence on the attitudes and beliefs of hospital staff to smoking and passive smoking
To establish if hospital smoking cessation interventions are appropriate to their current needs.

METHODS

A self completed questionnaire was the research tool used in this study. Both quantitative and qualitative data analyses were carried out. The reason for choosing self completed questionnaires was to reduce bias, to facilitate comparisons between respondents and to guarantee confidentiality.

OUTCOMES

Data analysis is currently in progress, however initial indications show a reduction in the number of staff who smoke. More staff stated that they wanted to quit smoking while fewer were contented smokers. Tobacco legislation was cited by most staff as the catalyst for their increased awareness of the hazards of passive smoking. However there are emerging differences between smokers and non-smokers on this issue.

PRELIMINARY CONCLUSIONS

Initial findings indicate some change in attitudes, beliefs and smoking behaviour among staff following tobacco legislation. It appears that a wider choice in smoking cessation interventions would be welcomed by respondents and some interesting suggestions were made by staff.

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SMOKING CESSATION STRATEGIES FOR HOSPITAL PATIENTS

Gary Bickerstaffe

Level 1 and Level II smoking cessation pathways were developed to intervene in hospital patients who smoke. A programme of systematic identification, advice, referral to support services and when appropriate, immediate instigation of evidence-based smoking cessation treatment.

Two levels were developed to close gaps in service to hospital patients who smoke, who were not being offered advice or treatment in a systematic way. Also developed to integrate the activity of hospitals and primary care in interventions and management of smoking related diseases.

Also, momentum is gathering to achieve smoke free hospitals. This requires an appropriate and sustainable intervention, which provides education and intervention, alongside prohibition. Staff are trained in two levels of intervention. The second level was a joint development between the hospital and Primary Care.

Level I identifies patients that smoke and offers advice on benefits of quitting. Patient given information leaflet on local and national services, with options to arrange support. They can, if desired be referred directly to local specialist service who then contact them to offer options for support. A sticker was designed for patient notes acting as a cue and record of the intervention. Level 1 has been particularly successful in intervening in assessment of pre-operative patients, resulting in large amounts of referrals.

Level II interventions are designed to offer inpatients support to stop smoking whilst in hospital. Two Trust teams jointly developed an assessment form. This form documents a risk/benefit assessment for an inpatient to use nicotine replacement therapy (necessary for certain patient groups who should only be prescribed NRT under caution).

The form enables prescribers and non-prescribers to initiate NRT. If assessor is qualified prescriber, they dispense prescription themselves. If assessor is not qualified, the form becomes a recommendation to prescribe; qualified prescribers can view assessment information and add their signature. Inpatients given a Level II assessment are 'discharged' to local Smoking Cessation service by detachable part of assessment form. Patients are then monitored after discharge.

No inpatient receives NRT unless Level II assessment completed by trained Assessors. Ensuring patients are offered motivational and behavioural support alongside medication. Evidence supports this as most efficacious use of NRT.

DATA

As the Level II inpatient scheme was initially limited to priority areas of cardiology, respiratory, diabetes, stroke and maternity as part of the pilot, the number of assessments has been limited. The scheme is now being extended to other departments within the hospital

To date (Feb 2006) there has been 270 inpatient assessments completed.

Approximately 90% of these patients opted to continue to receive motivational support after discharge. About 10 –15 % were lost to follow up as they had moved or telephone contact details had changed. A follow up letter is sent to these patients but only approximately 2% of these responded and gave additional contact details to maintain their support.

The four week quit rate within these patients is similar to that seen in the general public at about 47%. The 12 month quit rate is expected to at least be in line with national success rates at about 18% probably slightly higher, although no specific 12 month follow up has been instigated to date. This is now in the planning stage.

Patients from cardiology and respiratory departments comprise approximately 85% of the referrals. There have been no adverse events reported associated with the use of NRT in any of the inpatient groups.

There is high patient satisfaction with the scheme. This is recorded from the patient/advisor discussion support sessions.

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INTRODUCTION OF DAILY CARBON MONOXIDE TESTING ON IN-PATIENT SMOKERS IN AN ACUTE HOSPITAL SETTING

Mary Smyth, Rachael Gannon

AIMS

To increase smoker awareness of the effects of Carbon Monoxide inhalation.
To assess the impact of daily Carbon Monoxide testing on referral rates to the Stop Smoking Support Service in the hospital.

OBJECTIVES

Update staff on the effects of Carbon Monoxide inhalation
Educate staff on use of Carbon Monoxide monitor
Ensure staff are aware of how to refer to the Stop Smoking Support Service
Educate patients on the effects of Carbon Monoxide inhalation

METHODOLOGY

Following consultation with Clinical Nurse Managers and staff in a 15-bed cardiology ward regarding daily Carbon Monoxide testing, agreement to participate in the project was sought and obtained.

The following tools were developed / provided:

care plan for smokers
carbon monoxide recording chart
carbon monoxide monitor
information leaflets on quitting

The Health Promotion Officer for Tobacco Management developed brief education sessions for staff including the following:

update on effects of Carbon Monoxide inhalation
the value of regular Carbon Monoxide testing especially in the early stages of quitting smoking
use of the Carbon Monoxide monitor and chart for recording progress
use of a care plan for smokers

It was agreed that, following identification of smokers on admission, and advice to quit, the smokers care plan would be initiated and daily Carbon Monoxide levels recorded.

Staff provided a brief explanation to patients regarding effects of Carbon Monoxide inhalation and offered daily Carbon Monoxide monitoring as part of general care plan.

Information leaflets were provided by staff to support this initiative.

All smokers were assured of support to quit during time in hospital and follow up after discharge.

Exclusion criteria were agreed and a timeframe of 3 months was agreed.

EVALUATION

Patient and Staff perception questionnaires will be used for evaluation purposes and will be presented at conference.

The number of referrals and quit attempts made during first 8 weeks of project will be compared with numbers in previous 8 weeks.

Staff and patients will be asked to evaluate this project and preliminary results will be available in May

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THE SMOKE FREE HOSPITAL - A TROUBLESOME IMPLEMENTATION

Ib Søgaard

Four years ago our hospital decided to be a smokefree institution to a start for all staff members.

The start was not easy.

One staff member smoke in his private office and started a fire alarm and a following fire-brigade-turnout.

One year ago we included in-patients and their visitors and relatives.

A lot of angry letters from heavy smokers appeared in the local newspapers. Patients were seen just outside the entrance to the hospital in their thin hospital clothes and drip racks. It was not possible for political reasons to make the hospital grounds smokefree. As we had removed all ashtrays the hospital was nearly burned down due to a cigarette in a plastic bag. In the end we have been forced to install a smoke cabin for patients which appeared as a cartoon in many newspapers. All employees have received new conditions of employment saying that they could be out of job if they violated the new rules. So far we have not tried this.

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SESSION I-4. MENTAL HEALTH PROMOTION IN THE HEALTH CARE SYSTEM

PATIENTS RIGHTS IN LITHUANIAN PSYCHIATRIC HOSPITALS

Danguole Survilaite

Patients' advocacy workgroup, established at Club 13&Co. (National Organization of Persons with Psychiatric Disorders and Their Friends) initiated an investigation on status of patients' rights in psychiatric hospitals in 2004. The workgroup prepared a questionnaire of 21 questions on various patients' rights in psychiatric hospital. 38 % of inpatients of Republican Vilnius Psychiatric Hospital, 76 % of inpatients of Sveksna, 58% of inpatients of Siauliai and a small part of inpatients of Klaipeda and Rokiskis were questioned during the period of 2004-2005. The administration of Kaunas and Ziegdriai psychiatric hospitals refused the investigation of their inpatients.

After the data analysis it has been found out that status of patients' rights in Lithuanian psychiatric hospitals is satisfactory enough, but not excellent yet. Some failures were found:

6-8% of patients are physically abused by lower medical staff; ~10% - by other patients.

~30% of patients complain about the lack of information from doctors about diagnosis of illness, medical condition, and treatment.

~30% of patients complain about not satisfactory conditions in hospitals (too many patients in a room, a lack of security of personal goods, the occupational and work therapy is applied involuntarily, etc.).

~5% of patients complain about breach of their confidentiality.

The outcomes of the investigation were reported to the administration of all the hospitals and published in the magazines Psychiatry News and Club 13 & Co. News.

The comparison of investigation results are presented in the article. Investigations are planned to be performed regularly.

CONCLUSIONS:

Research on violation of patients' rights in hospitals, performed by the patients themselves, enhances to evaluate the situation in the most impartial way.

It may be presumed, these institutions which patients advocacy group was not let in, may cover the most patients rights violations;

It is worth to involve patients in the administration (treatment) boards of hospitals;

It is necessary to put more efforts in human rights education of junior staff;

To turn attention of professionals to pay more human attention to patients, especially informing them.

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EARLY RECOGNITION AND INTERVENTION, A KEY COMPONENT IN THE SUCCESS IN THE TREATMENT OF SCHIZOPHRENIA

Inge Joa

In recent years, literature highlights the correlation between short duration of untreated psychosis (DUP) and good outcome in schizophrenia. Two recent meta-analyses 1, 2 concluded that long DUP appears to be an important risk factor for poorer outcome, such as longer time to remission, less remission, more psychotic relapse. Only one study, the TIPS project (Early Identification and treatment of Psychosis) 1997-2000, has quasi-experimentally reduced DUP and demonstrated the effect of Early Detection on outcome. 301 first episode patients are included in the project. The Early Detection (ED) program in Rogaland County, Norway, (population 390 000) consisted of two components. The first was intensive Information Campaigns (IC). The public mass media campaigns had three aims, the first was to teach the general public about early signs of first episode psychosis, the second aim was informing the public about the importance of getting help early, and the third aim was informing about the existence of a low threshold psychiatric detection and assessment team. The use of media included ads in local newspapers, brochures, posters and commercials at the cinema and on local TV and radio stations. The IC also had an aim of providing targeted education programmes towards teachers and GP's about the signs of early psychosis and the establishment of a new first episode treatment program. The second component was low threshold early Detection Teams (DT's) which could be contacted directly by everyone. They were located within the county public psychiatric system in order to facilitate case finding, evaluation and triage. The presentation will describe in details the antistigma work and secondary preventive strategies within the TIPS project. Further on patient data in the ED sector for baseline and follow up will be presented.

REFERENCES

- Perkins DO, Gu H, Boteva K, Lieberman JA. Relationship between duration of untreated psychosis and outcome in first-episode schizophrenia: a critical review and meta-analysis. *Am J Psychiatry* 2005 October;162(10):1785-804.
- Marshall M, Lewis S, Lockwood A, Drake R, Jones P, Croudace T. Association between duration of untreated psychosis and outcome in cohorts of first-episode patients: a systematic review. *Arch Gen Psychiatry* 2005 September;62(9):975-83.
- Melle I, Larsen TK, Haahr U et al. Reducing the duration of untreated first-episode psychosis: effects on clinical presentation. *Arch Gen Psychiatry* 2004 February;61(2):143-50.

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CHANGES IN THE LITHUANIAN PSYCHIATRY

Ona Davidoniene

At the beginning of independence hospital care was prevailing in Lithuania like in most post-soviet countries. Out-patient structures were rather weak and usually limited to supporting treatment and referring to hospital in case of worsening of patient's state or relapse. A decision was made to reorganize the network of mental health care. First of all Seimas (that is the Parliament of Republic of Lithuania) approved the basic laws and programmes for regulation of mental health care. The Seimas passed Mental Health Care Act (in 1995), Narcotic and Psychotropic Substances Control Act (in 1998), State Programme on Mental Diseases Prevention (approved in 1999), National Drug Control and Drug Use Prevention Programme (approved in 1999), State Alcohol Control Programme (in 1999), Suicide prevention programme for 2003-2005 (approved in 2003). Project of State Mental Health Strategy is ready and are send to Government for approval.

It was established that the mainstream of the reform is to pass from the existing prevalence of in-patient care to much more developed out-patient care which will to dominate in future. Mental health centres were to be set up at primary care level in all municipal areas. Every centre is to form a team of specialists, that is a psychiatrist for adults, a child and adolescent psychiatrist, a psychiatrist for dependences, two social workers, two or three nurses and one or two psychologists. Much concern is given to social problems, home visits, psychological help, family assistance, and occupational activities. Mental health centres start patients' clubs, occupational rooms, where patients are taught various skills, train themselves in arts and music, go on outings and excursions, arrange their own poetry matinees, exhibitions, etc.

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NURSE CASE MANAGEMENT IN SEVERE PSYCHIATRIC DISORDERS IN A COMMUNITY MENTAL HEALTH CENTRE OF BOLOGNA (ITALY)

Rossella Capelli

Nurse Case Management in "Borgo-Reno "CMHC" (a psychiatric unit for outpatients that deserves 56.000 inhabitants) was introduced in 1998. At the beginning, an operative model was settled in order to take care of patients with severe and persistent mental disorders that required complex integrated assistance. In a second phase, a further subdivision was introduced between chronic cases, with prevalence of residual clinical features and high levels of disability, and new cases with severe disorders, who could still be treated successfully, in order to reach a better outcome and to prevent impairment.

According to these two groups, two different operative model were applied; patients' allocation was based on clinical, social and family-related factors.

- In MNC (Maintenance Nurse Care) nurse personnel plays an important role as referring provider of non-specific care.
- Nurse Case Management (CM) is founded on operational and relational responsibility of nurse personnel in order to achieve clinical and social condition patients' improvement by means of coordinating the whole sociomedical and rehabilitative net, with the essential involvement of patient's families. The complexity of personalized care projects required by case management (user's need evaluation; services' plan development, organization, provision, monitoring, inspection, assessment and follow-up) is feasible and effective by use of specific work instruments (nurse clinical chart, home visits, peer review, work-load calculation and subdivision, liaison with medical personnel) and requires appropriate personnel training and education.

The ratio between MNC and Nurse CM cases has been greater than three in the last five years. Nurse CM cases have been approximately 40 out of about 900 currently in-charge outpatients. Nurse CM institution caused a three-fold increase in the number of nurse home visits to patients, but resulted in a 50% decrease of both emergency cases and hospitalization days in nurse CM patients.

The clinical and welfare impact of nurse CM was appreciated by the staff members, thus the operative model was accordingly validated. The moderate number of operators in the equipe and their usual flexibility to get engaged in research and development projects were valuable factors to the project's growth and to its achievements.

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REDUCING THE MEDICOS' TENSION

Lolita Cemnalienskiene

THE PURPOSE of the work: to help the employees of the hospital to reduce the tension with the help of mental assistance

THE METHODS

Conversational groups: taking part in such activities enable you to pay more attention to your problems and the other participants' problems, and you improve your providence, empathy, tolerance, decrease stress and develop your communicative skills.

Relaxing activities: during the activities you can rebuild the relation between tension and relax, work and comfort. You improve yourself inwardly and the opportunities of your self-regulation.

The character of the work: the carried on survey of the employees has shown that they need some psychological assistance. The main point of the survey was to know if a staff member would participate in conversational and relaxing activities. 105 nurses and 20 doctors have answered to the questions of the survey. 85 % of the nurses told they would like to start relaxing activities, 34% of them would take part in conversational groups, 27% - would choose both of them and 6% of the nurses gave a negative answer. 60 % of the doctors told they would like to start relaxing activities, 10% of them would take part in conversational groups, 5% - would choose both of them and 35% of the doctors gave a negative answer.

There were two groups for relaxing activities with 8 people in each one. 2 months later they were joined together because of participants' moderation. Relaxing activities were held once a week from December, 2004 to June, 2005.

At the beginning of the course the participants were asked if stress at work was usual and what its level was. In addition they had to express their expectations of coming here and the time they had planned to spend in the course. 14% of the people said that they were under pressure all the time and 50% of participants felt tension only sometimes. The average score has been 6.6 using points from 1 to 10. 78% of them hoped to learn some exercises of auto training, 28% of participants came only to relax, 42% wanted to have such activities constantly, 21% wished to communicate for one month and after it they wanted to come only sometimes and 21% of them told they would keep going only for one month.

THE RESULTS

17% of the nurses and 8% of the doctors, who registered with the activities, took part in them. Each time they had 30 minutes of relaxing exercises and the rest time was spent on discussion. They learnt and practiced the auto training exercises. About a half of them practiced the exercises very actively only at the beginning of the course and the other part of them started practicing more after they had improved their skills and saw the advantage of such activities.

Those who had attended the course all the time told they had the use of the activities after 8 months had passed. They felt themselves more peaceful, could help others and managed with stress and conflicts easier. In addition they felt and regulated physical and emotional shape, could rest better and had a less need to take medicines. We discovered that patients needed more mental help to themselves. Participants become more tolerant and we started to understand them more. There appeared a common sense between the patients which allowed them to be more satisfied and safe.

The participants who attended the course quite long wanted to share their psychological competence and its use at work. We intend to continue the activities and adjust their format.

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PSYCHOLOGICAL CARE OF WOMEN IN PREGNANCY AND THE PUERPERIUM

Margaret Sheridan

Postnatal Depression (PND) affects 10 -15% of women following the birth of a baby (Cooper et al. 1988). It affects the quality of a woman's life and her experience of mothering, and can affect the whole family. The importance of detecting and responding to these cases is underlined by the growing knowledge of the potential adverse effects that postnatal depression can and does have on the social, emotional, cognitive and intellectual development of children (Murray and Cooper, 1997, Hay et al., 2001).

Women who experience a low mood and /or raised anxiety levels during pregnancy and following delivery benefit from extra professional support. Most women express a preference for counseling and 'talking therapies' rather than medication

(Morrow and Chappel, 1999; Copt, 2004). By accessing counseling at an earlier stage in the stress cycle, exacerbation of mother's emotional and mental distress can be prevented.

Research conducted in the Rotunda Hospital in Dublin in the year 2000 found that 77% of women who subsequently developed PND could be identified prior to discharge from hospital. This was achieved by eliciting a history of depression, combined with a positive score on the Edinburgh Postnatal Depression Scale (EPDS) (Crotty and Sheehan, 2004). The EPDS is a self-report ten-item scale designed by Cox et al (1987).

ACTION

As a result of the Rotunda research a Support Midwife for Mental Health was appointed to promote the psychological well-being of women in pregnancy and the puerperium and to provide extra support.

SUPPORT SERVICE

The role of the mental health support service is to develop a strategy for the prevention, early detection and management of postnatal depression and other perinatal mental health problems.

This includes identifying a population at risk, facilitating appropriate support and accessing a range of services for them. To act as an advocate for vulnerable women to ensure that their needs are addressed, beginning at the first antenatal visit.

BENEFITS

Through education and support there is now an increased awareness both for patients and the health care team of how negative emotions and/or anxiety impact on the pregnancy and the puerperium.

The introduction of support and routine screening has benefits for mothers, their relationships, maternal attachment and children's social, emotional, cognitive and intellectual development.

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SESSION I-5. HEALTH PROMOTION FOR CHILDREN AND ADOLESCENTS IN HOSPITALS

HEALTH PROMOTION FOR CHILDREN AND ADOLESCENTS IN HOSPITALS (HPH-CA): UP-DATE: OVERVIEW PRESENTATION FOR THE PARALLEL SESSION

Katalin Majer, Maria José Caldes Pinilla, Fabrizio Simonelli

SHORT INTRODUCTION

Since April 2004, within the international HPH network, there is a specific Task force and related international Working group active on the theme of Health promotion for children and adolescents in hospitals, which has focused its attention on the following priority thematic areas: definition of a specific conceptual and operational background; promotion of the respect of children's rights in hospitals; mapping and evaluation of current practices of health promotion addressed to children and adolescents in hospitals; realisation of an HPH-CA Community of practice. The yearly international HPH conferences represent an important occasion to inform the international scientific community about the actual development level of the work carried out and about the new perspectives of action. As last important milestone, the 3rd Meeting on Health promotion for children and adolescents in hospitals (HPH-CA), held in Florence between the 2-3 of December, 2005, is to be mentioned, since important decisions on the new perspectives of action have been taken.

The most significant developments of action related to the priority thematic areas: as mentioned before, the activities carried out in the last year by the Task force and related Working group can be divided into different thematic areas, as follows:

- HPH-CA Background: recently, a Background document on Health promotion for children and adolescents by hospitals (HPH-CA) has been elaborated and shared, which should constitute the reference point for the future actions of the

Task force and Working group, and for the international HPH-CA Community of practice; also the Final report on the HPH-CA Background Survey on Health promotion for children and adolescents in hospitals, carried out in the year 2004, has been distributed within the HPH network.

- Children's rights in hospitals: an action plan for increase the awareness on the necessity of the adoption of the charters on children's rights in hospitals has been prepared with the corresponding first actions.
- Current practices: a plan for mapping and evaluation of the current practices has been elaborated.
- HPH-CA Community of practice: as an experimentation, an online platform has been started up, as a discussion forum restricted at this moment to the Task force and Working group members, and in the general part of it some relevant documents has been examined and validated.

In addition, the Task force and the Working group is also continuing to establish links with another networks, associations and bodies, at an international level, in order to evaluate and realise common pathways on relevant issues related to the area of health promotion for children and adolescents in hospitals.

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THE RIGHTS OF CHILDREN IN HOSPITAL: PRESENT SITUATION AND PROSPECTS IN THE EUROPEAN HOSPITALS

Giuliana Filippazzi, Katalin Majer, Maria José Caldes Pinilla, Fabrizio Simonelli, Caterina Teodori

Hospitalisation can be a trauma for children and adolescents, due to the unfamiliar environment and unknown procedures by unknown people, and its negative psychological consequences may last for years.

This risk can be prevented or at least reduced by

- providing children and families with correct and exhaustive information on hospital, as well as healthcare professionals (doctors and nurses) with adequate training about the psychosocial needs of children/adolescents in hospital and about communication techniques; and
- involving community services (schools, consulting rooms, family advice bureaus, etc.) in the promotion of health among children and adolescents in cooperation with the local hospital.

The Working Group on Health Promotion for Children and Adolescents in Hospitals (HPH-CA) of the HPH Network has recently carried out an exploratory survey on the promotion of the child's health in hospital involving 114 hospitals and paediatric departments of the European Region.

This survey focused on various aspects related with activities of health promotion, such as the legal context, the kind of training and the standards adopted, the current practices and in particular the actions aiming at assuring the respect of the rights of children in hospital, listed in various Charters.

The survey revealed that 56% of the interviewed hospitals has not adopted any Charter as well as a lack of tools to assess the respect of the rights where a Charter was adopted.

How can we convince hospitals to be more aware of the rights of children in hospital and to prove their commitment in this sense? How can the HPH Network promote and support the information about the Charter of the rights of children in hospital and its implementation? The Working Group HPH-CA of the HPH Network is developing specific actions to be carried out in and by hospitals in this area and trying to enlarge the number of co-operators. This commitment in the specific hospital setting is in line with the philosophy of the recent WHO European Strategy for child and adolescent health and development, where the protection and promotion of the rights of children and adolescents is cited as a moral and legal obligation.

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IMPLEMENTATION OF THE PROJECT "FOR MOTHER AND NEWBORN"

E. Markuniene, N. Skorobogatova, E. Krakauskiene, L. Gailiunaite, D. Stoniene, J. Ribeliene

OBJECTIVE OF THE PROJECT

To encourage cooperation among public and medical institutions in order to decrease number of abandoned children, reduce violence against children, and to develop responsible parenthood.

TASKS OF THE PROJECT

- Present newborn period of life to Kaunas schools' pupils.
- Prepare and deliver lectures and video material about newborn development during the first days of life.
- Present preterm babies' problems, needs, reasons why babies are born before term, and how to avoid that.
- Encourage schoolchildren to make handicrafts for newborn departments' patients.
- Arrange a conference, an exhibition, and an excursion for schoolchildren in the Neonatology Clinic on the occasion of Mother Day.

Newborns being treated at Neonatology Clinic of Kaunas Medical University Hospital (KMUH) stay in the hospital together with their mothers up to 2 - 3 months. Often a mother of such newborn is very young, a person that was a schoolchild not so long ago. One might question: Is she responsible enough for a fragile life? Is she able to take care of it and feel motherly love? Therefore motherhood, responsibility for a life needs to be developed from young age. Representatives of the Neonatology Clinic approached Kaunas Municipality Education Department and heads of Kaunas schools with a proposal to present lectures about term and preterm babies, tell about babies' problems, further development. Especially pointing out, that healthy lifestyle, responsible attitude to parenthood is necessary in order to have healthy, term babies born. Even in the case when babies are born preterm or sick, if surrounded by care and love of parents and medical staff, they grow up cheerfully, the same as other children. To strengthen such responsible and caring attitude to the newborns schoolchildren were invited to knit clothes, bed covers during their works (technologies) lessons. 15 schools responded to the invitation. Lectures were delivered in all the 15 schools. Schoolchildren got very interested in development of newborns, their adaptation, and peculiarities of their growth. They asked how girls and boys shall live, so that when they are parents they have healthy babies. During the conference that was arranged representatives of schools, mothers of preterm babies delivered speeches. During the conference excursion in the Neonatology Clinic was arranged. Schoolchildren and their teachers could observe the smallest preterm babies, weighing less than 1 kilo. At the exhibition all the knitwear of schoolchildren: socks, caps, sweaters were presented. Other institutions, like family centres, women's clubs, and disabled people associations joined the handicraft initiative. Members of patchwork clubs from all over of Lithuania made covers for incubators that facilitate dark and cosy environment for the babies, imitating mother's womb. Beautiful and cosy environment influenced the staff themselves, positively impacting communication with parents of the little patients. Exhibition was on for a week, it was visited by KMUH staff and other guests.

RESULTS OF THE PROJECT

- Heads of the schools got interested in the new form of education and plan to continue cooperation and lessons of knitting for newborn babies at the schools.
- Neonatology Clinic and its little patients received beautiful handicrafts from schoolchildren and their mothers.
- Public opinion was focused on birth-rate reduction issue.

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THE "PAIN-FREE HOSPITAL MODEL" APPLIED TO PEDIATRIC ONCOHAEMATOLOGY: PLAY THERAPY AS A NON-PHARMACOLOGICAL SUPPORT TO PAINFUL PROCEDURES

Dorella Scarponi, Elena Marri, Simonetta Baroncini, Stefano Liverani, Andrea Pession

The application of the principles of pain therapy in paediatrics is a significant step in the regional "Pain-free Hospitals" programme.

In order to improve the quality of life of the child and his/her family the aim is to treat the child suffering from any kind of pain and to minimise stress and fear.

Pain-free Hospital Committees (COSD) have shared the definition of the International Association for the Study of Pain (IASP, 1979) and have agreed on the approach that oncological pain must be treated as "Total pain".

GOAL AND OBJECTIVES

Programmes carried out in Emilia-Romagna are based on the integration of pharmacological and non-pharmacological methods, in order to minimise the acute pain induced by any medical procedure. Oncological pain is not solely linked to the pathology in itself, or to the side-effects of therapy, but, especially in paediatric oncology patients, to diagnostic-therapeutic procedures.

METHODS/ACTIONS

The Paediatric Oncohaematology Unit in Bologna has carried out an intervention programme on oncological pain, using Play Therapy as a non-pharmacological support for painful procedures in paediatric oncohaematology, in co-ordination with the Baroncini Anaesthesia and Intensive Care Unit at the S. Orsola-Malpighi University Hospital in Bologna.

Within the multidisciplinary group specific psycho-pedagogic support is provided for the family aimed at facilitating a trust relationship between patient and staff allowing the patient, parents and staff to work together in the treatment of pain in the child and adolescent.

Supplying the parents and the patient with adequate information in order to rationally understand the phenomenon of pain, whether or not associated to procedures, within a wider communication context surrounding the disease experience, it is possible to apply a precise psycho-diagnostic strategy. Understanding of the factors which contribute to the onset of pain in each patient assesses: the level of psychophysical development of the child, his cognitive and emotional ability, his fundamental personality characteristics and his past experiences, both individual and family, which have informed his personal awareness of the symptom of pain.

In the play therapy session, the presence of another person values the background, needs and emotions, demonstrating a genuine desire to accept. The relationship with the therapist accompanies the child to that imaginary place where made-up stories and the things in them, even the most frightening ones, can have a place. The most frequently observed kinds of games were: direct medical games, imaginary medical games, indirect medical games, drawing and groups.

PRIMARY TARGET: children, adolescents and family members.

EVALUATION OF RESULTS

Psychological intervention makes the experience of the patients under care less dramatic, with the benefit of more relaxed participation during procedures and with a reduction in the perception of pain measured according to validated evaluation scales.

The adults, parents and staff involved agree on a significant reduction in the perception of pain, measurable with appropriate instruments, which is felt by the child followed by a psychologist before the procedure.

It is interesting to observe how greater attention to pain promoted by health care staff, but also by the voluntary workers in the COSD, has given rise to similar projects throughout all the paediatric oncology units in Emilia-Romagna.

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PLAYING AND TAKING CARE - THE YOUNG CHRONIC PATIENT

Fabia Franchi, Sabrina Predieri, Leana Bichecchi, Cinzia Badiali

During last years the treatment's demand for diabetic children has increased, and so it has been organized an answer based on the synergy between the community paediatrics and the domiciliary nurses. It was necessary to organize a different way of planning, considering the entry into the primary school, the kindergarten and the summer amusement places.

Now is starting the necessity of:

- a multiprofessional evaluation of the demand and the taking up of the task, involving family and institutions in the treatment process, in order to fix common aims, each in the contest of their own competences;
- the definition of the Personalized Assistance's Plan considering the level of child's awareness;
- the guarantee of specific competence and continuity of the reference nursing figure.

The key point of cronicity requires an intense effort to the Healthy Staff conscious of necessity to assist many years along the chronic patients, researching their conditions stability and the preservation of the best life quality. In this way the illness may become a "meeting point" between different figures that actively contribute and cooperate for the same target.

The approach is very important: and for the children it is based on an educational finality and on the research of a deep therapeutics cooperation between child, family and adults, with the help of the empathic attention, the communication and the use of an understandable language. It is also important to try to create an equilibrium between illness and effective therapeutical means.

Mainly through the play the nurse can fix a mutual acquaintance, a relationship, stimulating the child's capacity to communicate all that he isn't able to say.

The assistance of a young chronic patient requires sensibility, method, professional awareness, continuity, integration and the patient's empowerment.

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WORKING GROUP ON HPH-CA: THE EXPERIENCE OF THE USE OF THE ONLINE COMMUNITY OF PRACTICE LIKE A TOOL FOR A EUROPEAN NETWORK

Marco Luvisi, Fabrizio Simonelli, Katalin Majer, Maria José Caldés Pinilla

BACKGROUND

Since April 2004, within the international HPH network, there is a specific Task force and related international Working group active on the theme of Health promotion for children and adolescents in hospitals, focusing on different priority thematic areas. One of these is the realisation of an online HPH-CA Community of practice. As last important milestone, the 3rd Meeting on Health promotion for children and adolescents in hospitals (HPH-CA), held in Florence between the 2-3 of December, 2005, is to be mentioned. During this meeting, important issues related to the realisation of an online HPH-CA Community of Practice have been presented and discussed, and the next steps of work have been identified.

The most significant developments in the thematic area:

the experimentation conducted by the HPH-CA Working Group on the use of the new tool (Community of practices on-line) has pointed out that it is very useful for foster knowledge creation within the members of this group.

The Working Group has select this tool because it was suitable for create a community of practice to promote the 'network culture' around the concept of health promotion in this specific field, which is one of the main objectives of the Task Force and the Working Group.

From a wider point of view, communities of practice make it possible to:

- network relevant players of the international context (i.e. universities, research centres, hospitals, etc.) so to improve the quality of the service delivered;
- reduce the time spent for solving problems;
- support and facilitate communication among professionals.

The HPH-CA Task Force and Working Group has been supported in this experimentation by the European Federation for the Quality in eLearning (<http://www.qualityfoundation.org>), and within it, by the European Co-ordination of the Special Interest Group of Healthcare sector, with regard to the issues of knowledge creation and management, and the value of community of practices on-line.

The results of the first phase of experimentation (until May, 2006):
are mainly related to the discussion and sharing of the following documents using this new method:

- HPH-CA Background document;
- HPH-CA Good Practices (Template and List of criteria);
- Memo on Children's Rights by the HPH-CA Working Group (Knowing and respecting the rights of children in hospital).

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PARALLEL SESSIONS II:

Thursday, May 25, 16.15-17.45

SESSION II-1. HEALTH PROMOTING PSYCHIATRIC HEALTH CARE SERVICES

PREVENTION AND MANAGEMENT OF CHRONIC COURSES IN PSYCHIATRIC DISTURBANCES

Hartmut Berger, Rainer Paul, Eva Heiath

There is a high risk to become a chronic ill patient if one has a first onset of a psychiatric disorder. This workshop informs on European initiatives for mental health promotion and focuses on theoretical, epidemiological and practical data to prevent chronic courses in psychiatric illness. Additionally it will show the work of the colleagues from Lithuania on Health Promoting Mental Health Services and of the Taskforce on Health Promoting Psychiatric Services in Europe.

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GLASGOW FORENSIC SERVICES 'HAVE A BRAVE HEART'

Thomas Harrison, Barbara Wilson, Janice Turnbull

The Forensic Directorate at Leverdale Hospital in Glasgow Scotland provides a low secure forensic rehabilitation facility providing an area wide tertiary service for mentally disordered offenders. We became a hub for health improvement within Mental Health In-Patient Facilities in Glasgow with our three-year involvement as an impact evaluation site for the Health Promotion Health Service Framework designed by HealthScotland.

The seeds of good team working were planted early on when staff realised that the patient group following on from the results of their Service User Questionnaire wanted more structured activities within the wards.

The impetus for action began when interested staff brought their own enthusiasm, knowledge and equipment into the unit- the safe use of free weights fishing hillwalking to name a few initially financed by staff fundraising. We now have various projects which allow patients to be involved with all aspects of health. This year they have grown their own vegetables and the patients are including them in their supper groups etc and have developed allotments for patients own use..

Those early seeds fed by a vast amount of team work and learning on the part of staff and patients have grown over a number of years to provide a wide range of health promotion activities throughout the Directorate such as

1.Smoking Cessation 2.Work it Out Project. 3.Healthy Eating 4. Cycling. 5. Walking
6.Literacy 7.Carers Group 8.Staff Health 9.Blood Monitoring Clinic 10.Men's Health Clinic 11.Swimming 12. Football. 13 Bowling 14 Acorn Project 15 Patient Council

Emphasis has been given throughout the development of project activities to respond to and engage with those patients who participate least- to find out what would meet their individual needs. This led to the development of the Acorn Project (Horticultural) and we are currently involved with the National Pathways to Health and JogScotland Initiatives.

OUTCOMES

Increased physical activity was observed by our patient group, improvements in mood and behaviour re positive mental health and well-being, educational, re-integration, reducing evidence of stigma and creating equality, healthier menus, increased consumption of fruit, monitoring of medication concordance, greater awareness of a range of health issues, health screening checks for patients and skill development.

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THE INTEGRATION OF THE MENTAL HEALTH SERVICE AND PRIMARY CARE. FROM THE LOCAL EXPERIENCES TO THE EMILIA-ROMAGNA REGION PROJECT

Maria Bologna, Rosanna Carbognani, Tiziano Ferretti, Gaddomaria Grassi

BRIEF DESCRIPTION OF THE PROJECT

Over the last few decades in Italy, some factors have shifted the question regarding mental health towards the area of primary care:

- the overcoming of the mental institution that has contributed to give back, also to the seriously ill patient, the right to be treated by his/her General Practitioner.
- the increasing prevalence of common emotional disorders (CED)
- the redefinition of the health concept meant as bio-psycho-social wellbeing, of which the individual is actively responsible.
- health policies that have supported the passage of the treatment context from the hospital to the territory

The reply to these new, complex scenarios lies in the necessary integration between services such as mental health and primary care, that have adjoining intervention areas, but above all share an approach based on the person and the problem. Local collaboration experiences, born at the end of the 1980s in urban areas particularly exposed to pressing assistance questions (such as Reggio Emilia and Bologna where psychiatric hospitals have been quickly overcome and communal services have been active since the 1970s), progressively organising themselves and awakening other realities, have come together in the "Basic Psychiatry and Medicine" project promoted by the Emilia-Romagna Region in 2000 and successively in the "G. Leggeri" Integration Programme 2004 - 2006 between primary care and mental health.

GOAL AND OBJECTIVES

The general objective of the "G. Leggeri" Programme (cured by Curcetti et al, 2005) is the improvement of the integration between the psychiatric service and primary care in all Districts of the Region, by promoting appropriate interventions for the protection of the population mental health.

METHOD/ACTIONS

- Support by the MHS (Mental Health Service) of the capabilities of the GP (General Practitioner) to recognise, handle directly, send (when necessary) the CED patient to the specialist service

- Improvement of the management of somatic pathologies in the patient with serious mental disorders
- Shared promotion of recognition programmes and early intervention

SPECIFIC ACTIONS

The consequent actions regarding above all:

- shared definition of assistance paths
- structuring of dedicated consultancy services
- integrated training programmes between psychiatrists and General Practitioners

CONCLUSIONS

In this perspective, the District of Reggio Emilia activated for the first time in the Region already in 1992, the Consultancy Service for CED patients sent from the General Practitioners (Moscara and Bologna, 2002) and dedicated to the integration of various shared training programmes. During 2005, in coherence with the objectives of the Regional Programme, it started the first integration project on site between the Mental Health Centre (MHC) and the Primary Care Centre (PCC).

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HEALTH PROMOTION IN MENTAL HEALTH NURSING: OPPORTUNITIES, BARRIERS AND CHALLENGES: A QUALITATIVE STUDY

Christine Deasy

Much has been published in recent years regarding the nurses' role in health promotion generally. However, there remains a paucity of research, which considers this in the context of mental health nursing. Specifically, opportunities and challenges for mental health nurses in the promotion of health among service users have not previously been investigated in Ireland.

This qualitative study explored mental health nurses understanding of, and engagement in, health promotion within their professional practice. A core objective of the study was to identify the barriers and enabling factors to promoting health in mental health nursing practice. A stratified random sample of nurses employed by the Mental Health Service in one Irish county participated in the study. Data collection involved two phases, which comprised of a focus group and nine interviews.

The findings suggest that the participants were positively orientated towards health promotion and their role as health promoters. However, their understanding of health promotion was limited and many used an educational rather than a health promotion approach. Empowerment, advocacy and educating clients about their lifestyle behaviours were regarded as central to their practice. While many opportunities to promote health existed, barriers in the work environment prevented them from developing their health promotion role. These included lack of time, staff shortages, stigma, difficulty accessing information and lack of motivation. Challenges, to promoting health included mental illness, institutionalisation and staff education.

The conclusions drawn from this study are that while mental health nurses perceive that they have a role in health promotion the identified barriers and challenges must be addressed to ensure that health promotion is central to their professional practice.

RECOMMENDATIONS

- Mental health nurses must engage in more multidisciplinary and collaborative working.
- Nurses must use their collective power to positively influence the wider determinants of health.

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HEALTH PROMOTION ACTIVITIES AT REPUBLICAN VILNIUS PSYCHIATRIC HOSPITAL

Alina Stigiene, Valentinas Maciulis

Mental patients' care in Lithuania can be traced from XVI century. The hospital in Vilnius opened in 1903 as one of the four modern facilities built before WW1 according to Tsar's plan to provide Russia with 10 modern regional hospitals each 1000 beds. With its present 666 beds and 61 psychiatrists (total staff 750) it remains the largest mental hospital in Lithuania. In addition to its 16 in-patient wards (7 for specialised treatment) it has a day-time ward, social aid department, psychotherapeutic, out patient counselling centres. We offer up-to-date pharmacotherapy, psychotherapy, psychosocial rehabilitation, refer for professional rehabilitation and housing. Our hospital is equipped with modern medical devices to accomplish CT, CEEG, neurophysiological examination of cognitive functions, ECT with Thymatron DGx.

Our hospital as the only of the 9 mental hospital has joined HPH network in 2001 and got its international group certificate. Since 2001 we took part in all 4 national and 5 international HPH conferences. In 2004 we hosted the IX national conference with representatives from the international network, and prof. Hartmut Berger delivered his communication on the significance of health promotion in psychiatry. We publish papers about HPH, take part in NGO events, forums, RTV programs, drawing into cooperation more institutions and organizations. Projects are being implemented at the hospital since 2001:

- Social rehabilitation complex for mental patients
- Social reintegration of long term mental patients in the club 13&Co.
- Instruction of Alzheimer disease patients and their relatives
- Instruction of patients with symptomatic mental disorders and their relatives.

Patients' families are reached and consulted, relapses prevented. Followed reintegration into society appears to be more successful.

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EFFECTS OF A LATE LIFE DEPRESSION EDUCATION PROGRAM ON PRIMARY CARE NURSES KNOWLEDGE, ATTITUDES AND USE OF A BRIEF SCREENING PROTOCOL IN PRACTICE

Mary Pat Butler

Depression is particularly common among the elderly and is associated with functional impairment comparable or worse than chronic medical conditions, increased health service utilisation and suicide. In a rapidly growing older society primary care nurses have an important contribution to make in the detection of late life depression, yet few studies have reported on the training of primary care nurses to recognise depression in the elderly.

The aim of this study was to describe and evaluate the effects of a two day late life depression training programme on primary care nurses knowledge, attitudes, and use of a brief screening protocol in practice at one and three months following training. An uncontrolled repeated measure design was used. The total population of primary care nurses in one geographical region in Ireland (n=253) were invited to participate, 73 of which commenced training and 66 completed the programme. Data collection instruments included the Late Life Depression Quiz, Depression Attitude Questionnaire and a practice measure specifically developed to evaluate the uptake of a screening tool. Data was analysed using SPSS (Version 11.0) to produce descriptive and inferential statistics.

Statistically significant differences were found between pre and post training for knowledge about late life depression ($p < 0.0005$), attitudes to depression which was significant for 9 of the 20 attitudes statements ($p < 0.05$) and confidence in ability to assess for depression ($p < 0.0005$). Subjects began to use the screening protocol in practice and had screened 20% of older patients for depression at one month and 16% at three months after training. This short training programme was effective in producing both knowledge and attitude change, but issues related to using screening instruments require further study.

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SESSION II-2. MODELS AND EXAMPLES FOR ACTION ON CHRONIC DISEASES (II): CARDIO-VASCULAR DISEASES, KIDNEY-DISEASE AND RENAL PROBLEMS

CARDIOVISION 2020: PREVENTING HEART DISEASE IN THE COMMUNITY AND THE CLINIC

Thomas Kottke

BACKGROUND

CardioVision 2020 is a community and clinical initiative in the United States launched in 1999 by a team that includes Mayo Clinic Rochester. The program promotes a smoke-free environment, availability of healthy foods and opportunities for physical activity. CardioVision 2020 also promotes five personal goals: Tobacco-free and zero exposure to tobacco smoke; five servings of fruits and vegetables a day, only lean/extra lean meats and low fat/fat-free dairy products; total serum cholesterol <5.2 mmol/L (LDL <2.6 mmol/L for individuals with heart disease); systolic blood pressure <130 mm Hg and diastolic blood pressure <85 mm Hg; and, 30 minutes of physical activity on most, if not all, days of the week.

CardioVision 2020 is organized around the supposition that sustained behavior change requires both stimulating individuals to attempt behavior change and changing the physical and social environment to support the individuals who are trying to change. To raise public awareness that Olmsted County residents are adopting the CardioVision 2020 personal goals, CardioVision 2020 produces television programs, radio interviews, and newspaper feature articles in the model of "behavioral journalism", an intervention technique that publicizes the healthy behavior of real people who live in the community. Because contests and competitions have been shown to help people change their diets, increase physical activity, and lose weight, CardioVision 2020 sponsors short-term contests for smoking cessation, physical activity, and weight control. These contests stimulate the people who live or work in Olmsted County to sample lifestyle change. To help people sustain their new lifestyles, CardioVision 2020 promotes and produces environmental improvement programs. These include a smoke-free restaurant ordinance and a menu-labeling program for restaurants, cafeterias, and other suppliers of ready-to-eat food. The menu-labeling program identifies entrees that contain less than 1,000 mg of sodium and 500 or fewer calories of which fewer than 7% come from saturated fat. CardioVision 2020 also advocates the construction of multi-use trails as a way to increase public opportunities for daily physical activity. Behavior change competitions in a particular area (e.g., the Quit-and-Win competition for smoking cessation) are conducted simultaneously with environmental change campaigns (e.g., the campaign for smoke-free restaurants and bars) because they support and reinforce each other.

Evaluation: Analysis of program effectiveness was based on independent population-based telephone interview samples from 1999, 2000, 2001, and 2003; a mailed dietary questionnaire; blood pressure and cholesterol data from medical records of consenting Olmsted County residents; and, national, state, and county comparisons when data were available.

RESULTS

More than 90% of the population considers CardioVision 2020 to be a good, very good, or excellent idea and nearly 9% of the population reports making a behavior change because of CardioVision 2020. The program is associated with a 25% reduction in the number of people exposed to environmental tobacco smoke and small but significant increases in fruit consumption and daily physical activity. Serum cholesterol goal achievement increased (52.0% in 1999; 57.5% in 2003) as did blood pressure control (53.7% in 1999; 59.9% in 2003). Attempts to quit smoking and the amount of time spent in physical activity did not increase. Compared to Minnesota and national trends, fruit and vegetable consumption increased significantly in Olmsted County.

CONCLUSIONS

CardioVision 2020 is viewed favorably and is associated with positive changes in several personal behaviors and risk factor levels.

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INTEGRATING HEALTH PROMOTION INTO HOSPITAL ROUTINE: A SET OF EDUCATIONAL PROGRAM IN A CARDIAC REHABILITATION UNIT

Stefano Boni, Bettinelli Antonia, Gallifuoco Maria Pia, Mariani Paola, Sarzi Braga Simona, Pedretti Roberto

Educational programs are recommended at both national and international level for the prevention of cardiovascular diseases and are essential to achieve effective results in various rehabilitation programs. However it is often unclear how to translate preventive recommendations into practice, keeping them readily understandable and effective. Our intervention aims at the patients' empowerment, transferring skills and knowledge to individuals entering the programs and making easier for them to self manage secondary prevention at home in the long term.

In line with these principles, we have developed a series of educational programs for patients admitted to our rehabilitation Institute (about 680 patients/year). The overall approach is multidisciplinary, aiming at giving patients a comprehensive and integrated set of knowledge about their own disease. Family members are also strongly encouraged to participate and to take an active role in the whole process.

Different programs are tailored for patients with coronary artery disease (CAD) and with chronic heart failure (CHF).

The educational sessions, supervised by the consultant cardiologists, approach the following:

- Approach to the disease, its aetiology, pathogenesis and risk factors, with particular relevance for smoking (performed by nurses)
- Nutritional risk factors, diet and weight reduction (dieticians)
- Therapy management and compliance. A specific session is focused on anticoagulant therapy, given its importance (physicians and nurses)
- Practical behavioural suggestions for everyday's life (nurses)
- Stress management (psychologists)
- Physical activity (physiotherapists)

After all sessions, patients' satisfaction for the programs will be tested through a simple questionnaire. Furthermore we are developing a new questionnaire, at the end of the program, to evaluate the effective gain in terms of knowledge and skills for the individuals.

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NEW HOME CARE MANAGEMENT MODEL FOR CHRONIC CARDIOPATHIES IN THE ELDERLY REFERRED TO PIEVE DI CORIANO HOSPITAL: TELECARDIOGRAPHY AND TELE CONSULTANCY

Maria Cristiana Brunazzi, Pier Vincenzo Storti, Mario Pasqualini, Camelia Gaby Tiron, Raffaele Mazzucco, Maurizio Nagrelli, Marina Bellaz, Rita Sandrini, Cristina Grigoli, D. Monopoli, R. Teoli, D. Pozzetti, D. Padovani, E. Ceccarelli, E. Venturelli, A. Filippi, V. Fontanesi

INTRODUCTION

Acute cardiovascular mortality has been significantly reduced thanks to scientific and technological advancements; this has led simultaneously, to a higher average age, and an increase in the number of elderly people with chronic cardiovascular diseases. Such major health, social and economic consequences call for new management strategies. Health assistance in the elderly mainly regards chronic heart failure, untreatable chronic heart ischemia and arrhythmias.

SCENARIO ANALYSIS

Pieve di Coriano Hospital's tele-electrocardiography and consultancy service at present serves a population of 43,000 of whom 12,000 over 65 years, 3,070 over 75 years and about 1,000 over 90; about 40% of this population is affected by chronic cardiovascular diseases and heart failure is the main reason for hospitalization.

AIMS

The new management model aims to:

- Improve patient home care by involving family doctors in assisting the elderly with chronic cardiovascular diseases requiring frequent monitoring and/or sudden relapses, especially for housebound patients.
- Better integrate Hospital/Community care with hospital promoted two-way counselling (H.P.H).
- Best fit hospital admittance and specialist examinations.

MATERIALS AND METHODS

The above hospital has been operating a telecardiology and teleconsulting service since February 2004. Eighteen family doctors in the catchment area were supplied with 12 lead portable electrocardiographs connected by phone line to the terminal service in the cardiology department.

RESULTS

388 telecardiology ECGs and teleconsultancies were carried out between February 2004 and December 2005 in patients over 65 years, 220 females (56.7%) and 168 males (43.3%), average age 82 +/- 5 years.

Patients may be divided into two groups:

- patient follow-up for chronic heart failure with/without atrial fibrillation (199 pts. ; 51.2%)
- relapse assessment of chronic cardiopathies: pre-cordial pain, lipothymia, non-specific symptoms (189 pts ; 48.8%)

pag.1

In the first group of 199 pts, 134 pts. (67.3%) were found to be stable and on-going therapy was confirmed, in 32 pts. (16.1%) treatment was modified on-line and only 33 pts (16.6%) required further hospital investigation.

In the second group of 189 pts, only 58 pts. (30.6%) required emergency hospital treatment, 23 pts. (12.3%) required further non-urgent tests and in 158 pts (57.1%) no cardiac emergency was detected.

CONCLUSIONS

Preliminary results of this new model H.P.H. for dealing with chronic cardiopathies in the elderly, confirm the validity of tele-medicine in managing home-care for the chronically ill, thus significantly reducing the need for further investigations and/or hospitalization .

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"STROKE CARE": THE EMILIA-ROMAGNA INTEGRATED MANAGEMENT PROJECT FOR STROKE PATIENTS

Salvatore Ferro, Augusto Cavina, Francesco Nonino, Alessandro Liberati, Piera Pallazzoni, Stefano Liverani

Stroke has been acknowledged as a health care priority in Italy. Evidence suggests that dedicated care provided by hospital-based multidisciplinary specialist stroke services and early supported discharge with rehabilitation and support in the community setting can improve survival and reduce disability.

The National Stroke Project: Since 2005 the Health Authority of the Emilia-Romagna Region (ERR) (northern Italy, 4-million inhabitants) is coordinating a national project funded by the Italian National Health Service called "How to guarantee effective health care in stroke". The project involves 15 Italian regions, and is aimed at improving health care standards for stroke patients according to the recommendations of an evidence-based National Reference Statement on stroke management. The Emilia-Romagna Region Stroke Project : The ERR "Stroke Care" project, paralleling the aforementioned national project, is aimed at defining hospital-community integrated management pathways for patients with stroke in the Local Health Care Units (LHCUs) of ERR. The project goals are: Integrating stroke care at all stages (before admission, during hospital stay, and after discharge); Creating in-hospital dedicated clinical and rehabilitation care pathways; Creating hospital-community integrated health care pathways; Structuring educational programmes for implementing effective multidisciplinary and multiprofessional care.

The ERR "Stroke Care" project develops through the following initiatives:

A survey on the models of care provided to stroke patients by the LHCUs;

An evidence-based Regional Reference Statement produced by a multidisciplinary panel on the optimal integrated management of patients with stroke;

The commitment to all the LHCUs of producing stroke management programmes based on the indications of the Regional Reference Statement;

The analysis and comparison of the programmes produced by the LHCUs to identify potential barriers and facilitating factors before implementation;

A set of clinical and organisational indicators for monitoring the implementation of the "Stroke Care" project in the LHCUs;

The analysis of the educational programmes for health care professionals implemented in the LHCUs.

RESULTS of the survey on the models of care provided to stroke patients by the LHCUs show that on only 7 of the 44 total acute hospitals have a comprehensive Stroke Unit (16%), 1 a mobile stroke team (2%) and 36 do not have any organized care for stroke (82%). The multidisciplinary panel have completed the Regional Reference Statement of the optimal integrated management of patients with stroke and the analysis of the programmes produced by the LHCUs show several crucial aspects related to the implementation phase.

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PATIENTS UNDERGOING ORAL ANTICOAGULANT THERAPY: DEDICATED PATHWAY AND SELF-MANAGEMENT METHODS

Mauro Silingardi, Anna Maria Casali, Galimberti Daniela

BRIEF DESCRIPTION OF THE PROJECT

There are many indications of Oral Anticoagulant Therapy (OAT) and these are transversal to all hospital wards; the first 3 months of therapy are those with the highest risk of complications. It is known that self-medication is associated to an unacceptable risk of complication. The complexity of OAT management makes it necessary to be controlled to certain degrees within the community. Optimum management in terms of indications and monitoring is fundamental.

PRE-INTERVENTION PHASE

Our data show that self-medication was present in about 15% of OAT patients; there were no educational meetings, it was not possible to verify the appropriateness of clinical indications and monitoring the quality of OAT was impossible.

GOAL AND OBJECTIVES

OAT patients are managed through a dedicated hospital department, the Haemostasis and Thrombosis Centre. The purpose is to provide a uniform methodology to access, treatment and care path in order to promote a process of cultural growth and organisational change.

METHODS/ ACTIONS

Development of specific procedures concerning:

- patient access and care path;
- correct instruction in OAT management;
- management of haemorrhagic complications during OAT;
- management of surgical interventions during OAT.

Computerised OAT management.

SPECIFIC ACTIONS

Training the patient through periodical three-monthly meetings.

Informing the patient about OAT through the preparation of a guidebook.

OAT training courses.

Periodical review of the procedures in compliance with international guidelines.

PRIMARY TARGET

OAT patients; specialist medical staff in the hospital and community managing patients with concurrent medical problems (e.g. programmed surgery).

EVALUATION OF RESULTS

Control indicators:

Structure indicators (no. of users , no. of samples)

Results indicators linked to product standards concerning user attention, effective practice and treatment precision.

CONCLUSIONS

An encrypted OAT management pathway assures the monitoring of a high number of patients, minimising the phenomenon of self-medication. Uniformity of management procedures assures clinical quality, user satisfaction and the cultural growth of the operators.

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A DIFFERENT APPROACH TO PREVENTING LIFE THREATENING KIDNEY DISEASE IN LATER LIFE

Sue Vernon

Renal damage sustained in Childhood and caused by urinary tract infection, may cause long term morbidity for some individuals. The Nurses led Urinary tract infection(UTI) direct access service for children was deliberately set up (following a comprehensive research project published in the British medical journal in 2004) to improve the early detection of childhood UTI by combining teaching, improvement in awareness and understanding of Childhood UTI with prompt referral , continual support and investigation of UTI via a nurse led service, across primary secondary health care services and by working to improve community understanding about the importance of Childhood UTI .This paper will provide a practical outline to working in an a new way.

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SESSION II-3. HEALTH PROMOTION FOR HOSPITAL STAFF + DEVELOPING THE HEALTH PROMOTION QUALITY OF HOSPITAL MANAGEMENT SYSTEMS

HEALTH PROMOTING AGEING FOR HOSPITAL STAFF - RESULTS OF A LITERATURE REVIEW

Dietscher Christina, Hübel Ursula, Nowak Peter

The ageing of populations has been a topic of concern for the WHO and the European union for long. Throughout Europe, one of the consequences of this demographic development is the raising of retirement ages, aiming at securing pension systems. For the working population, this results in longer working life spans and related higher health risks.

Why should Health Promoting Hospitals care?

Hospitals are considered as one of the most health-endangering workplaces anyway, characterised by multiple somato-psycho-social risks, heavy work loads and comparably low levels of control over work. This affects especially ageing staff members: The heavier the burden is staff have to cope with throughout their working life, and the less they can control their work environment, the earlier age-related problems will become apparent in a work force.

That's why the Viennese information network "health promotion in hospitals and nursing homes" (www.gspwien-info.net) decided to focus its annual theme 2005 on "healthy ageing of staff - contributions of hospitals and nursing homes".

A comprehensive literature review was carried out in order to better understand the situation in the European health care sector and to identify international measures and recommendations for age-friendly workplaces especially in the health care field. Findings were summarised in a fact sheet, and discussed and further developed together with 280 staff members from Viennese hospitals and nursing homes during an Open Space workshop in November 2005.

The presentation will

- outline the specific demands and opportunities of an ageing workforce
- focus on suggestions for improvement like
 1. Consider ageing-friendliness as a goal in organisational development
 2. Provide and develop supportive leadership
 3. Consider the needs of an ageing workforce in personnel development
 4. Support health promoting self management of hospital staff
 5. Lobby for political support
- describe the resonance and some results of the Open Space workshop

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HEALTH PROMOTION AND THE EFQM MODEL: SOCIETY RESULTS

Danilo Orlandini, Lorena Franchini, Silvia Candela, Giovanni Morini, Sara Baruzzo, Dorella Costi, Sandra Venero, Paolo De Pieri, Ulrich Wienand

BRIEF DESCRIPTION OF THE PROJECT

Population health is influenced by individual, health and socio-economic determinants. Social conditions affect health more than genetic factors and habits; social policies, distribution of income and knowledge, as well as equity affect the chances of benefiting from the health service activities .

The Italian network of the health service organisations applying the EFQM model (European Foundation for Quality Management), coordinated by the Reggio Emilia Health Authority, has promoted a study on the subject discussing the areas related to the criterion of the Society

GOAL AND OBJECTIVES

If the mission of a health service organisation is improving well-being in society, all the results end up in the chapter on Performance Results; for EFQM, the impact of the organisation's activities on society must also be defined.

The EFQM model allows to compare organisations and urges self-evaluation: by applying EFQM, we compare strategies and actions and improve the system transparency.

METHODS/ACTIONS

The organisation must monitor internal policies to verify adhesion to the declared values using instruments capable of evaluating its own intervention. The values must be set on the basis of the community development, because the health authority is a partner in a social health project, for example equal opportunities, impact on local economy, social responsibility, the culture within the health authority and environmental impact.

SPECIFIC ACTIONS

The first phase of the comparison involves the choice of several matters for verification. For each matter, the rationale must be written, the target population must be identified, the services involved in the activities affecting the results on the population in question must be identified, the measurable elements and indicators must be defined, the data at the disposal of the different authorities and their comparability must be evaluated.

PRIMARY TARGET

The Society Results define or come from the relationship with the community. They contribute to defining the implications the choices made by the health authorities have on the community and how they can achieve changes and with which instruments.

EVALUATION OF RESULTS

The indicators used can be either objective or subjective, but the application of the instrument is an indicator in itself. The objectives must be confirmed in actions carried out in the health authority processes, which may be able to achieve or influence the Society Results, even if not the expected outcome.

CONCLUSIONS

The cultural development of the community creates an environment receptive towards the possibilities for change. Identifying the activities with a direct or indirect influence on the population health and recognising the connections between them, which can affect the very determinant of health, facilitate the implementation of mechanisms for health promotion.

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PROFESSIONAL ACCREDITATION STANDARDS PROMOTE HEALTH CARE INTERVENTIONS INTEGRATION AND QUALITY OF CARE

Danilo Orlandini, Gualtiero De Bigontina, Danila Fava, Nino Cimino, Illidio Meloncelli

BRIEF DESCRIPTION OF THE PROJECT

The Italian Association of Diabetes Specialists (AMD) is a scientific society whose objective is to promote the diffusion of suitable structures for the prevention, diagnoses and treatment of diabetes mellitus across the whole country. The Association has 1800 members and is organised in 17 regional branches. For more than ten years AMD has been promoting professional accreditation as an instrument for assessing the service quality. The standards of the accreditation model (3rd release) direct quality towards clinical pathways which integrate all health care interventions.

GOAL AND OBJECTIVES

AMD promotes the integrated governance of the health care system and peer review to evaluate the achieved quality level and to promote continuous improvement. The long-term objective of achieving a reduction in the chronic complications of diabetes and of increasing patient participation in treatments and patient empowerment, suggests an important cultural change with the questioning of skills and abilities.

METHODS/ACTIONS

The standards of the AMD accreditation model deal with organisational (eg. Policy and Planning) and professional topics (eg. Evidence Based Medicine and Clinical Pathways) and suggest a training and educational model in relation to the characteristics of the Italian Health Care System. At national level, a panel of indicators for good quality in the process and in the outcomes of the diabetes care has been defined and this must be applied to the services which require accreditation.

SPECIFIC ACTIONS

The diabetes services to be accredited carry out self-assessment on the standards check list, then for the adaptation of the service characteristics to the standards, they are supported by a doctor who is an expert in both diabetes and quality management systems. The inspection by peer review is carried out by expert auditors, trained in line with the ISO 19011, who evaluate the conformity to the standards; a national committee decides on the service accreditation level. The certificate has a duration of three years, after which a control inspection is carried out.

PRIMARY TARGET

The diabetes services participate voluntarily in professional accreditation.

EVALUTATION OF RESULTS

The procedure has been implemented for several years now, since 1999 when the second edition of the standards manual was published. Tens of services have been accredited, some of which have also carried out the control inspection. The first professional accreditation was awarded to the Guastalla Hospital Diabetes Center of the Reggio Emilia Health Authority, in 2000.

CONCLUSIONS

Professional accreditation allows us to see the organisation through its processes, those sequences of interfaced activities aimed at the achievement of health, carried out by professionals using technology and resources, whether hard (machinery) or soft (guidelines, clinical pathways), and appropriate working methods. The integrated governance suggested by the standards is fundamental to the continuous improvement of the quality of actions, tasks, professional levels, interfaces, methods and technologies.

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DEVELOPMENT OF GUIDELINES FOR A GENDER FRIENDLY HOSPITAL

Anna Utermann, Anna Maria Dieplinger

Gender Health is a topic not commonly known in hospital settings. As gender health can be considered as a quality factor as well as a socioeconomic factor for a health providing organization, there seems to be a need for appropriate and scientifically based guidelines.

A literature research showed that no general guidelines for the implementation of gender health in a hospital have been defined so far. The three major papers found scrutinize either gynecological / obstetric departments or the health care system in general.

Based on these papers a working group in the General Hospital of Linz (AKh) defined eleven guidelines for gender health in a general hospital. During half a year of work the group of interdisciplinary health care professionals discussed gender

specific topics in a hospital setting and tried to establish the needs and the resources. The guidelines developed include medical, nursing, social, organizational and psychological aspects and each guideline is further defined by aims and strategies to reach these aims.

The objective is to promote a more patient oriented, individual, gender sensitive view and behavior in a health care system. Further steps not only aim at implementing these guidelines in the General Hospital of Linz but also to collaborate with hospitals all over Europe.

Gender health can bring a major input to a health promoting hospital.

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MANAGEMENT OF CLINIC AND ASSISTANCE PRACTICE SECURITY IN THE EMERGENCY AREA

Enrico Burato, Camelia Gaby Tiron, Graziella Borsatti, Alberto Rigo, Mario Luppi, Angela Saccardi, Mentore Carra, Simonetta Chiarucci, Ida Breviglieri

INTRODUCTION TO THE CONTEXT

It's estimated that error in medicine involves something like 8.000.000 people admitted every year to Italian hospitals and among them 320.000 are victims of errors or unfortunate events during the admission to the hospital and 35.000 the ones who lose their life. This fact determines the absolute need to get more efficient the operations aimed at the prevention and decrease of clinic risk thanks to the competence of a department full time dedicated to the analysis of adverse events and able to create an integrated system between figures and fields which are involved in different ways.

For all these reasons, this company decided the institution of an Appropriation and Epidemiology Service and an office for the management of Clinic risk with the aim to support Sanitary Direction during the actions for the continues improvement of the appropriation of cares in the context of clinic governance. Priorities of the service are: improvement of patient's security (clinical risk management), reduction of insurance costs, organizational congruence of work that might respond in an efficient way to the requires of operators and customers. From this sprang the activity plan regarding the function of clinical risk management with deliberation of General Director nr. 457 of 16.06.04 and subsequently confirmed in the deliberation nr. 127 dated 3rd March 2005

ADDRESSEES

All consumers who use the emergency service and sanitary staff who operates in emergency areas (P.S. of Matova, Asola, Pieve, and U.o. Emergeny Medicine)

GENERAL AIM

General aim regards the promotion of health and of consumer's safety with a point at the improvement of quality of clinical assistance operations following the prevision, the management and the reduction of the risk which is related to adverse facts connected to the clinical and assistance performance and reducing, where possible, insurance and management costs, organizing the activity in a more congruent manner with operators' and consumers' needs. The purpose is to create an alliance between consumers citizens and sanitary operators for to dialog about error and sanitary safety which represents the most serious reason of conflict in the relationship between doctor and patient.

ACTIONS AND FIRST RESULTS

The operation is divided in 5 steps:

First step. Establishment of coordination team "board" for risk management

Second step. Applicable test of analysis instruments (FMEA, root cause analysis, audit) with 2 lab days for board group which has been constituted for the practical test of instruments indicated in literature (EMEA schedules and root cause analysis°) and individuation of UU.OO and services on which applying the pilot project.

Third step. Construction of a retrospective - prospective data base for analysis of accidents which took part in the committee for the evaluation of sinister created between Appropriation and Epidemiology and Legal Service.

Fourth step. Pilot project for identification of principle risks connected to principle recovered pathologies and to care and assistance processes through:

- Constitution of a work team for "clinical risk" on the individuated UU.OO.
- Formation/training of the "clinical risk" work team for 300 operators within the 31.12.06
- Elaboration of specific individuated risk prevention activities and actuation of program
- Actuation of overseeing program regarding adverse events to medicines and medical tools
- Elaboration and sharing of a minimal set of data useful for the monitoring of individuated risks with definition of result indicators

Fifth step. Security card for clinical practice and company assistance and annual report, at drafting time.

CONCLUSIONS

First results of Pilot project obtained from the above described actions have also brought following improvement actions:

- Evaluation of patients who do not present themselves after the visit to the Operative Unit and patients who do not present themselves to visit in PS after having done the triage evaluation and the opening of the PS schedule through the involvement of the Volunteer Hospital Association operators
- Traceability of First Aid patient through the bracelet with barcode lecture.
- Security process for management of medicines in PS

In future undertaken actions will be followed and improvement new actions will be defined with the drafting of security card of clinical and assistance practice shared with Active Citizen Association and Court of Sick persons' rights.

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SESSION II-4. WORKSHOP TO PROMOTE PRACTICAL IMPLEMENTATION OF THE SMOKE FREE HOSPITAL CONCEPT OF THE EUROPEAN NETWORK OF SMOKE FREE HOSPITALS: A "HANDS ON WORKSHOP"

Moderators: Sibylle Fleitmann, Ariadni Ouranou, Anne-Marie Schoelcher, Ann O'Riordan, Bertrand Dautzenberg

Created in 1998, the European Network Smoke Free Hospitals is present in 19 countries counting more than a thousand member hospitals. The aim of the network is to adopt and implement a common strategy for the establishment of a smoke free environment for staff, visitors and patients within and around the hospital setting. The concept is laid down in a 10 point European Code. A series of tools have been developed in order to facilitate implementation of the smoke-free Hospital concept. These tools were piloted in several countries and are undergoing a continuous process of adaptation and improvement based on cultural specificities.

THE AIM of the workshop is the transfer of knowledge on practical implementation including following topics:

How to involve management and staff in building a smoke free hospital

How to carry out a self assessment of the smoke free hospital situation and how to use the results to promote political and financial support for the implantation of a smoke free policy

How to carry out an assessment of the smoking status of hospital staff and how to use the results to bring forward smoking cessation in the hospital

How to implement and develop tools for a smoke free maternity project including CO Measurements and development of question

The workshop will be organised as a round table discussion with experts offering their practical knowledge on implementation to the participants. Experts will be chosen from different countries in Europe to offer a wide array of experiences in different cultures.

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SESSION II-5. MODELS AND EXAMPLES FOR ACTION ON CHRONIC DISEASES (I): DIABETES, METABOLIC DISORDERS AND RESPIRATORY PROBLEMS

DIABETES MELLITUS AND PATIENTS' EMOTIONS

E. Danyte, E. Danieliute, J. Janusauskaite, R.Zalinkevicius

The ability of patients with diabetes to cope with the regular and troublesome treatment and self-control is strongly influenced by psychosocial factors affecting self-control, complication risk and quality of life. Negative emotions might be an obstacle in patients' coping with treatment, learning self-care skills. The aim of our study was to evaluate diabetes related negative emotions and their relation with the type of diabetes and complications. 62 patients with diabetes hospitalized during one month period in Kaunas Medical University Hospital were interviewed. 28 (45.16 %) males and 34 (54.84 %) females filled the questionnaire. 24 (38.71 %) patient had type 1 diabetes and 38 (61.29 %) type 2 diabetes. 56 patients (90.32 %) expressed one or several negative emotions related with their diabetes. The most frequent negative motions related with diabetes were sadness (69.4 %), anger (67.7 %) and anxiety (62.9 %). The evaluation of sadness, fear and anxiety was higher in females ($p < 0.05$). Almost all the disease related emotions (except guilt) were expressed stronger in patients with type 1 diabetes, when compared to type 2 diabetes. For analysis of the impact of complications on diabetes related emotions we grouped patients according treatment with laser photocoagulation in anamnesis. The evaluation of anger, sadness, frustration and resignation was higher in treated with laser photocoagulation group. Conclusions: Disease related emotions (except guilt) were expressed stronger in patients with type 1 diabetes, when compared to type 2 diabetes. Feelings of anger, sadness, frustration and resignation were higher in patients with chronic diabetes complications (treated with laser photocoagulation).

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INTEGRATION BETWEEN HOSPITAL AND GENERAL PRACTITIONER IN THE CLINICAL PATHWAY OF THE DIABETIC PATIENT

Ezio Bosi, Liliana Rabitti, Giuseppina Chierici, Dario Gaiti, Danilo Orlandini

BRIEF DESCRIPTION OF THE PROJECT

The primary prevention for diabetes, early diagnosis, correct therapy which comprises the education and empowerment of the diabetic, prevention of the acute and chronic complications of the disease, must involve the hospital specialists and general practitioners in a coordinated and integrated manner.

GOAL AND OBJECTIVES

To apply to the diabetic an integrated care management model which involves hospital specialists and general practitioners in a coordinated and motivated manner, standardising care and improving the service quality through the application of guidelines and shared clinical pathways and through easier, simpler access.

METHODS/ACTIONS

The organisation management has approved a programme of collaboration between hospital specialists and general practitioners for health care to the diabetic. Using the Balanced Scorecard method, the strategic objectives of the clinical pathway of the diabetic within the health care system and the sequence of necessary activities have been identified. Collaboration and integration have been made possible by the common continuous training of the general practitioners and hospital specialists, by the definition of tasks, responsibilities and activities, and in particular by the definition and application of guidelines for out-patient follow-up of the diabetic.

SPECIFIC ACTIONS

Newly diagnosed patients are sent by the general practitioner to the hospital specialist for the assessment and staging of the disease, then they are cared for by the general practitioner for continuation of the metabolic compensation and for the follow-up care.

Communication is ensured by medical records and integrated patient diaries which will shortly be in digital format. Compilation of the clinical and epidemiological data allows an evaluation of the effectiveness of the integrated management model.

PRIMARY TARGET

The project provides for the involvement of type 2 diabetics without insulin, both newly diagnosed and further progressed.

EVALUATION OF RESULTS

The programme has been implemented for several years in the districts in the north of the province of Reggio Emilia which have a population of 100,000 inhabitants with about 6,000 diabetics, of whom 5,500 were being treated by the hospital services. So far 1,600 diabetics have taken advantage of the programme which has involved a total of 50 general practitioners. Evaluation of care quality with the data for the metabolic compensation and for the incidence of complications, which were already good to start with, have not shown any significant variations, whilst the perception of quality has improved.

CONCLUSIONS

The transition from specialist to general care often encounters resistance, but if the patient affected by a chronic disease is offered integrated, easily accessible, quality care, then the change in the care method is willingly accepted.

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AEROSOL RESPIRATORY HYGIENE AS A MAIN PART OF PREVENTION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASES AND HEALTH PROMOTION FOR PATIENTS IN HOSPITALS

Alina V. Chervinskaya, Virginijus Biskys

The experts of WHO forecast the subsequent increase of COPD and asthma on worldwide. Mainly it has been related to deteriorative ecologic situation. To stop this tendency aerosol methods with physical factors are preferable because of physiological action without system side effects. Dry salt inhalation therapy has a long history in Europe since 19-th century. Nowadays there are a number of resorts are exploiting salt caves for patients with pulmonary diseases. Halotherapy (HT) is the result of adapting natural salt aerosol from salt caves to flexible usage in other locations. In addition to availability the ability to deliver a specified varied dose of dry rack salt represents a major advantage of HT over the treatment in natural salt caves. Over 15 years, numerous expert groups have worked on standardization of halochambers based on exact understanding of condition in salt caves. HT was sanctioned by Ministry of Public Health in Russia and Lithuania.

The efficiency of HT for care of respiratory and allergic diseases, ENT-pathologies was proved by many scientists in controlled studies. The inclusion of HT into the rehabilitation course of pulmonary pathology patients (with asthma, COPD, bronchitis, pneumonia and others) allows achieving therapeutic effect by 82 -95% of cases along with the most optimal use of pharmacotherapy. It has shown that the application of the HT assured 1,5-2 times reduction of morbidity level in long term observation.

Dry sodium chloride aerosol has positive effect on the defense system of the respiratory tracts. It enhances mucociliary clearance in conjunction with normalization of bronchial microflora and immunological benefits. Data from prevention studies showed strong efficacy of dry salt aerosol in reducing the risk of common cold during cold season. HT may be recommended to healthy persons and patients with chronic respiratory diseases prior to or during every cold season. Evaluation of respiratory symptoms, functional parameters, local immunity in persons with risk factor of lung diseases, confirmed their significant changes under the action of HT. It can use as a sanitary method for respiratory airways.

We look at positioning of dry sodium chloride aerosol with HT as a main component of respiratory hygiene for prevention of respiratory diseases, relief of environment hazards and rehabilitation of chronic patients. As a consequence of clinical and mechanism acting understanding of HT, the concept of "maintaining bronchial health" appears to be helpful in health promotion activity of hospitals.

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HPH STRATEGIES IN THE CHILEAN HEALTH REFORM: A MODEL OF CARE FOR CHRONIC RESPIRATORY PATIENTS AND A DIABETIC FOOT PREVENTION PROGRAM

Jaime Acevedo, José Luis Rocabado, Luis Barrueto, Christian Yáñez

Since our last communication to the International Conference on HPH, in Moscow 2004, we have explored a way for implementing the HPH Model at North Hospital Complex of Santiago of Chile. During 2005, we generated an Initiative Team integrated by clinical and administrative chiefs of that institution plus some external ad honorem collaborators with expertise in Cultural Change. We learned that, without a formal structure supporting our HPH Initiative at the local level, it's very likely to lose the effort.

The Chilean Health System Reform separated the Sanitary Authority' functions: those relative to Public Health were assigned to the Regional Ministry of Health Secretaries, while those relative to the management of Assistance Networks were attributed to Health Services. Inside the new structure of these Health Services we discovered a key office able to connect both visions: the Model of Care unit, whose mission is implementing the new 'Model of Integral Care with Family Approach' in all facilities of each Assistance Network. North Metropolitan Health Service accepted to incorporate the strategies developed by HPH into the three levels of care of the North Metropolitan Assistance Network, as a tool for promoting participatory research and development, and is also considering our proposal about funding a Centre for Patient Education and Health Promotion in Hospitals (tertiary), Diagnosis and Therapy Centers (secondary) and Family Health Centers (primary care) for further consolidation of our local experiences and evidences.

Our HPH Chile & Latin America Initiative prides on presenting two inaugural projects: a model of integral care with family approach for chronic respiratory diseases patients whose design was born from the field observation at a specialist ambulatory care unit, and a Diabetic Foot Prevention Program based on the high occupation of Surgery beds at San Jose Hospital by income patients with this hard preventable Diabetes complication.

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WEANING CENTRE: A SUSTAINABILITY PATH TO DEAL WITH THE INCREASING NUMBER OF CHRONIC PULMOLOGICAL DISEASES

Ulli Weisz, Willi Haas

The increase in chronic diseases puts additional stress on the service provision of hospitals. Within our concept "sustainable hospital" we want to face this challenge with a sustainable service and capacity planning that on the one hand can respond to changing health service requirements of society and on the other hand provides information on work load, health gain, empowerment, financial and ecological costs for different response options.

Sustainable development requires health services and patient treatment systems that are viable for the future, systems whose own functioning must meet the criteria of sustainability. Hospitals play a central role in the health services system and make a significant contribution to public health. This makes them major players in ensuring a fundamental building block for the sustainable development of society as a whole. For this reason we research the possibilities existing to introduce the concept of sustainable development and to implement it in a Health Promoting Hospital, an issue which until now had practically never been closely examined.

As a result of a feasibility-study ("The sustainable hospital. A feasibility-study" Weisz et al. 2005, funded by the Austrian Technology-Ministry) three central areas of intervention were defined as key to a sustainable hospital. One of these is "Planning of sustainable services" using the example "Weaning-Center" (a competence center for artificial respiration patients) which focuses on empowering, education and training in order to achieve an optimum health gain. It shows how hospitals can react to the increasing number of chronic pulmonary diseases by organising their services according to the criteria of sustainability.

In a follow-up project ("Proving the sustainable hospital"), which we have submitted to the Austrian Technology-Ministry and which should start in May 2006), we are demonstrating the social, economic and ecological improvement potentials of this new integrated treatment system.

The "planning of sustainable services" in particular aims for the following results

Demand for a "Weaning Center" by Viennese patients with chronic pulmonary diseases.

Tested accounting model for planning sustainable services, covering economic, ecological and social aspects.

Comparison of the conventional treatment system and „Weaning Center“ considering information on their economic, ecological and social impacts.

The upcoming project is a cooperation of an interdisciplinary team of researchers with an Austrian Health Promoting Hospital, the Viennese Otto-Wagner-Hospital, the Vienna Hospital-Association and the Berlin Immanuel Diakonie Group. The concept „Weaning-Centre“ is an approved health promoting measure.

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EFFECT OF STRUCTURED EDUCATION ON THE FOLLOW UP RESULTS OF METABOLIC SYNDROME PATIENTS

Laszlo Kautzky

BACKGROUND

The metabolic syndrome is the nightmare of the XXI century. Different metabolic and vascular disorders increase the prevalence of fatal cardiac events. Patients are unaware of the risk factors therefore they need structured education to increase their cooperation.. In the background there are genetic, environmental and socio-psycho-pedagogic determinant factors.

AIMS: to evaluate knowledge level of patients, to investigate the changes of metabolic and vascular parameters, and to evaluate their attitude towards the disease.

Patients:n=73, (58 male, 15 female) mean age: 53+/-11,3y, BMI:32,6+/-4,2 kg/m², HgbA1c: 8,9+/- 1,8%, RR: 162/104, Chol:6,38+/-1,32mmol/l, TG:4,38+/-1,84mmol/l, fasting glucose:10,2+/-4,3, mmol/l, postprandial glucose:15,5+6-4,75mmol/l. As a control group we observed 15 patients who were nor willing to participate structured training course. Folloe up period: 12 months. Methods: to check metabolic and vascular parameters before and after education and treatment. To evalu-

ate the knowledge levels using questionnaires(scores), to measure the attitude and satisfaction (ATT39, DQOL) Education was based on the topics of Assal's Teaching Letters.

MAIN RESULTS

Objective parameters (lipids, blood sugar, HgBA1C, body weight, blood pressure) improved significantly, $p < 0,001-0,005$, except uneducated people, whose same parameters didn't improve appropriately. Patients' awareness was highest towards diabetes and hypertension, whilst towards other risk factors, like lipids, body weight etc. was less intensive. Change of behaviour of patients was highest in drug-taking, much less in diet regulation and least in exercise. Knowledge level post training increased double of basic level, but after one year decreased again by 15%. Knowledge of uneducated people presented insignificant change. DQL and ATT 39, (patient satisfaction level) showed significant improvement.

CONCLUSION

Significant improvement could be observed in parameters, which are influenced by drug taking. Life-style and diet habits changed less. Patients were mainly aware of diabetes, hypertension, less frequently to obesity, ischaemic heart disease, and lipid disorders as well. Radical change of life-style and diet in adult age is terribly difficult, but successful prevention of the metabolic syndrome can be carried out only by education, starting at a very young age. Main task of health professionals is continuous education of endangered population.

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PARALLEL SESSIONS III:

Friday, May 26, 11.45-13.15

SESSION III-1. IMPROVING LIFESTYLES AS IMPORTANT DETERMINANTS FOR THE PREVENTION OF CHRONIC DISEASES

MOTIVATIONAL COUNSELING AMONG SMOKERS AND HARMFUL DRINKERS ACUTELY ADMITTED TO A DEPARTMENT OF NEUROLOGY

Hanne Tønnesen, Bente Munkholm Nelbom, Bente Wind, Vibeke Olsen, Trine Larsen, Vibeke Backer

BACKGROUND

Smoking is the most important risk factor for morbidity and mortality and in general, all contacts to the health care system should include stop smoking counselling. Emergency patients seldom have this opportunity, though the information of increased risk for smokers at surgery is - in principle - mandatory, due to their high incidence of postoperative complications. The aim of the study has been to illustrate the convenience in a department of acute surgery and the acceptance of motivational counselling by a nurse trained in health promotion.

METHODS

From May 2003 to January 2004, 200 patients, admitted due to acute surgical and current daily smokers, were offered behavioural counselling before discharge, undergoing surgery or referred to the wards as in-patients. After counselling the patients were offered a 6 weeks stop smoking program. Follow-up was planned after 3 and 6 months.

RESULTS

121 (61%) patients accepted a motivational counselling. Age was found to be the single factor of importance, as ages increase from 45 years with highest motivation for change, to 64 years with lowest degree of motivation. Fagerstrom, pack-years, gender, illness, work or alcohol consumption did not influence the outcome. Ten patients wanted to be referred to the Stop Smoking Program, immediately after the motivational counselling. Among the 57 patients who allowed us to follow up, 10% had quit smoking, and 17% among the continuing smokers wanted admission to the Stop Smoking Program,

CONCLUSION

Nearly two of three smoking patients acutely admitted to an orthopaedic department accepted motivational counselling against smoking when offered counselling by a nurse especially designated and trained to that purpose. Age was the only factor to influence the motivational level, with the youngest being most motivated. Interestingly, the sex, smoking habits and harmful drinking were not relevant. It is relevant to consider how and to which groups of acutely admitted patients the smoking intervention should be integrated in the clinical routine.

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COUNSELLING AND TREATING SMOKERS IN FAMILY PRACTICE

Madis Veskimägi

Prevention is important part of physician's work. In real work it is quite frustrating activity because of its comprehensiveness. Tobacco stands out as the agent most responsible for avoidable illness and death. 70 percent of smokers report wanting to quit. With 70 percent of smokers seeing a physician each year, clinicians are uniquely poised to intervene with patients who use tobacco. Most accessible medical institution is primary care and family physician.

SCOPE OF STUDY

Analysis of effectiveness of intervention and treating tobacco use based rural Family Physician Centre of Tõstamaa, Estonia. Overview of patients, treating plan and results.

MATERIAL AND METHODS

Material of current study is collected period between 2004-12-1 and 2005-11-30 by analysis of patient individual counselling and treating card. Retrospective assessment and statistical analysis is done.

RESULTS

The intervention and treating group consist totally 35 patient. There are 23 male, average age 38 y, and 12 female, average age 47 y. Group is collected by three main route, from everyday work due to illness 19 cases. In the health educational event 13 cases and 3 cases when patient turn directly to reception for counselling. In the male group the average Fagerstrom score is 5,0 and 21 packet-year. In the female group the average Fagerstrom score is 5,3 and 25,5 packet-year. Relative motivation for cessation is equal, 3,4 point. It is higher among patient who turn actively for counselling. In 4 cases there is done only counselling, 4 cases counselling and prescribing nicotine chewing-gum. In 27 cases there is used counselling and prescribed bupropion and chewing-gum in individual dose. On an average there is 2 reception and 3 telephone counselling for each patient. In female group 5 patient (41%) is tobacco-free an average 14 week. In male group 12 patient (51%) is tobacco-free an average 18 week.

CONCLUSION AND DISCUSSION

Intervention and treating tobacco use by family physician and family nurse is effective. Medical team know patient's individual and family risk factors. This fact is used for increasing of motivation. Smokers cite a physician's advice to quit as an important motivator for attempting to quite. There is possible to plan of intervention and combined treatment for longer period, even for years. This result as good patient-physician relationship and high rate of quite.

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EFFECT OF MULTIFACETED INTERVENTION PROMOTING PREOPERATIVE SMOKING AND ALCOHOL CESSATION: CONTROLLED, PROSPECTIVE, BEFORE AND AFTER STUDY

Hanne Tønnesen, Pernille Faurschou, Ditte Mølgaard-Nielsen, Grete Thomas, Vibeke Backer, Helge Ralov

PROBLEM

Need to improve the efficiency of preoperative lifestyle intervention by early initiation by General Practitioners (GPs).

DESIGN

Implementation of cross-sectional, evidence-based guidelines aimed at improving the number of risk patients (defined by drinking harmful and/or smoking daily) entering the preoperative hospital program of life style prevention. A controlled prospective, before-under-and-after study evaluated its impact on appropriateness and applicability.

BACKGROUND

The risk patients develop 2-4 times more complications after surgery, while 6 and 4 weeks of preoperative smoking cessation and stop drinking, respectively, reduce the postoperative morbidity significantly. However, the preoperative contact to the hospital may be too short to fulfil this. Therefore, it is important to initiate the program already by the GP at the time of admission to surgical department.

SETTING

GPs in the local area, 2 preventive interventionists, Tobacco Cessation Clinic, Alcohol Unit, and consecutive adult risk patients at admission from GPs to the surgical departments.

Key measures for improvement: Risk patients entering the preoperative program of life style intervention; GPs volunteering to use new cross-sectional guidelines.

STRATEGIES FOR IMPROVEMENT

Multifaceted and stepwise increasing interactive implementation support aimed the GPs over 1½ year, beginning with traditional information and additional reimbursement and ended up with monthly feedback. A last step was a surgical approach including the hospital, exclusively.

EFFECTS OF CHANGE

Of 199 local GPs, 47 wanted to participate positively, but they did not change the daily routines. The participating GPs admitted 301 patients for surgery during an 18 months period, 72 were risk patients and six of these had the program initiated by GPs. In contrast, 24 of 28 patients had motivational counselling when the program was initiated in the surgical outpatient clinic, exclusively, in the following period.

LESSONS LEARNT

Cross-sectional implementation of a preoperative program of life style prevention is still a challenge. New strategies for cross-sectional implementation are required to offer prevention programs in due time before surgery. In the meantime, the surgical departments should offer the programs, whenever relevant.

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WORKING TOGETHER FOR HEALTH - PARTNERSHIP AND NETWORKING

Tiiu Harm

BACKGROUND AND OBJECTIVES

Estonian Network of Health Promoting Hospitals - HPH was established in 2000 and, at the present, includes 23 hospitals (43% of total number of Estonian hospitals). 75,6% of opened hospitals' beds are connected with HPH network. HPH movement is ongoing process in all 15 counties of Estonia. Estonian HPH Network is a good base for intervention, implementation and evaluation of new trends, policies, strategies and for cooperative partnership and networking in WHO HP projects on national and international levels.

Smoking is the biggest single preventable risk factor. In the popular mind smoking is mainly associated with lung cancer or chronic obstructive pulmonary diseases (COPD). Much less is known about the harmful effect of smoking in relation to cardiovascular diseases (CVD).

According to the health behaviour study of Estonian adults (2002) 45% of men and 18% of women are daily smokers. 2000 death and 3500 new diseases per year are caused by smoking in Estonia.

Out of 100 000 people at least 250 men and 80 women under the age 65 die of heart diseases per year.

PARTNERSHIP AND NETWORKING

Estonian HPH Network joined European Network Smoke Free Hospitals (ENSH) in 2005, September. 5 representatives of Estonian hospitals visited Seinajoki Hospital (the basic hospital of Finnish Network of Smoke Free Hospitals) in Finland, 2006, January to exchange experiences and get more know-how in implementation of smoke-free hospital strategy.

Estonian HPH Network is co-partner to Estonian Network of Workplaces Health Promotion (WHP).

Estonian HP hospitals are seriously involved in the implementation of National Strategy for Prevention of CVD (2005-2020), especially in reduction of smoking prevalence and developing the tobacco free environment and smoking cessation counselling service throughout country with the help of a new Tobacco Law (05.06.05).

ACHIEVED RESULTS

The network of 20 smoking cessation counselling clinics was set up on the bases of 17 HP hospitals and 2 health centres in 2005 and it covers with counselling service all 15 counties in Estonia;

62 health professionals were trained as counsellors for smoking cessation service (2005);

3 HP hospitals started as pilot smoke-free hospitals (2006, January); 4) 3 HP hospitals are co-partners in Workplace HP project (since 2005); 5) WHO European Guiding materials on HPH and ENSH are translated into Estonian language and published (2005) for dissemination and implementation in Estonian hospitals (2006); 6) HP hospitals are developing an active cooperation with community institutions (GPs, patients' unions, local government, media etc) in organizing the World No-Tobacco Day, May 31 and World Heart Day, September 24 etc.

EFFECTIVENESS INDICATORS

By 2020 the CVD mortality of men and women under 65 should be reduced by 40% and 30 % respectively; 2) the smoking habit is diminishing among the 16-64 year old men to 40% by 2008 and to 30% by 2020; the smoking habit is diminishing among the 16-64 year old women to 16% by 2008 and to 10% by 2020.

CONCLUSIONS

The reduction of prevalence of tobacco consumption is a long-term national priority (2005-2008-2020) in Estonia. The efficient implementation of the national strategy for CVD prevention requires working as an united front at all levels. Co-ordinated cooperation between different fields (education, culture, economic, traffic, science, medicine etc) is the only way the expected results can be achieved.

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FRESH FRUIT & VEGETABLES IN A SCOTTISH HOSPITAL?

Claire Goodheir, Paul Macintyre

The mortality rate from heart disease in Scotland is the highest in Western Europe and inequalities relating to this remain prevalent. A number of national policy statements have addressed this fact with specific reference to nutrition and the Scottish diet.

Instigated by a consultant cardiologist in a busy West of Scotland hospital, the initiative, to open a fruit shop in the hospital foyer began in 2002. The shop represents a novel response to growing rates of cardiovascular disease in an area of low socio-economic status. It has since been evaluated to determine its effects on staff, patients and visitors to the hospital.

In accordance with the 'settings' concept of Health Promoting Hospitals (HPH), health promotion activities in hospital should be part of an integrated, organisational, approach that seeks to facilitate accessible health choices that are inherently beneficial. The evaluation suggests that the fruit shop has successfully addressed accessibility, although as yet it lacks the integration necessary to be a HPH initiative.

The research highlighted a positive overall impact on consumption of fruit and vegetables. Specifically, staff felt that the mere presence of the shop acted to raise awareness of the health benefits of eating more fruit and vegetables as well as an incentive to buy and consume more for themselves, patients and visitors. Results show that 41% of staff use the shop at least twice per week. The prevalence for staff purchasing fruit & vegetables to take home was analysed in comparison to deprivation rates and showed interesting results.

There were also additional unexpected outcomes identified from this research. For example, some staff interviewed showed that individual clinical practice is being influenced the availability of fruit and vegetables in the hospital.

With reference to the evaluation report, this paper will discuss the fruit shop, suggesting that it plays a significant role in the development of the conceptual understanding of the settings approach of HPH and lays the ground for informed commitment to it at organisational level.

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PROMOTING ACTIVE LIVING FOR PERSONS WITH CHRONIC DISABILITIES

Michael Spivock, Lise Gauvin, Jean-Marc Brodeur

In an effort to promote active living for persons with chronic disabilities, it is important to consider the effect of neighbourhood-level determinants on this particular population. The nature and distribution of these determinants remain largely unknown. This presentation will describe the presence of supports for active living for persons with chronic disabilities and examine the association between the presence of these supports and neighbourhood-level indicators of affluence and proportions of persons with disabilities living in the neighbourhood. These supports have been dubbed environmental buoys. An extensive review of the literature yielded three categories of buoys, namely the walking surface, signage/traffic signals, and adaptation of destinations/transport.

In the context of a larger project measuring determinants of active living for the general population, teams of trained observers were dispatched to 112 neighbourhoods (i.e. census tracts) on the island of Montreal, Canada in order to assess environmental buoys.

Results show a general lack of buoys in comparison to features supporting active living in the able-bodied population. A t-test for paired samples showed that the difference between these two means was statistically significant ($t(111) = -41.80$ $p < 0.0001$). A 3-level hierarchical linear model analysis revealed that the presence of buoys was unrelated to both neighbourhood-level indicators of wealth and the proportion of persons living with a disability in the neighbourhood.

The few environmental buoys which are present in this urban area do not relate to neighbourhood-level indicators of wealth and are not concentrated in neighbourhoods with high proportions of persons with physical disabilities. A concerted effort is needed on behalf of health-care providers, government officials, urban planners and architects in order to prevent the effects of a sedentary lifestyle from compounding what are often already fragile health conditions.

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SESSION III-2. MIGRANT FRIENDLY AND CULTURALLY COMPETENT HEALTHCARE -2

THE MIGRANT FRIENDLY HOSPITAL PROJECT IN AOSTA VALLEY – ITALY

Giorgio Galli, Patrizia Petey

Migrant Friendly Hospital project start in health service of Aosta Valley region at the beginning of 2000, to reply at the growing demand of health assistance by a large number of immigrants, often without residence permit.

In January 2000 is established a specially information counter for the health of the immigrants. I remember that Italian law allows health assistance also to the illegals immigrants (only for pressing treatments). During year 2005 we have entered more of 300 inquiries.

In December 2000 is opened a medical surgery of basically cares only for the illegal immigrants (or strangers that wait for the residence permit), people that live and work in our region. This surgery is opened one day a week. During year 2005, the doctor has visited 130 immigrants -men, women and children - from the following countries of origin: Rumania (36%), Maroc (33%), Albania (9%), Moldavia (7%), Ucraina (2%) and the others from Central Africa (Nigeria, Ivory Coast – 7%) and South America (Bolivia, Ecuador, Brazil – 6%). In 2002 the immigrants entered in the medical surgery was 185, 186 in 2003 and 140 in 2004. The principal pathologies results: obstetric-gynaecologic (30%), gastroenterologist (18%), orthopaedic (15%), odontological (9%), dermatological (5%). The doctors working in medical surgery of basically cares can prescribe clinical tests, specialist examinations and also medicinals.

I specify that Aosta Valley is a small region with 120.000 inhabitants and in the last ten years we have a progressive increase of immigrants that want to live and work. In 1993 the regular strangers extra EU was 770, while in 2003 are 3117 (3% of the total population). The number of the illegals is unknown but is not indifferent.

In 2003 are inserted inside the hospital (especially in gynaecology unit) the intercultural mediators, now extended in the whole hospital. Mediators (of different nationalities) are present 5 days a week and are called for all necessities, not only to translate the language but above all to support behaviours belonging different cultures. Intercultural mediators are also inserted in the territorial health facilities.

For the end of this year will be available a guide health services for immigrants, translated in many languages. In autumn will start a vocation training for doctors and nurses to facilitate the intercultural approach.

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THE INTERCULTURAL MEDIATION PROGRAMME HOSPITAL DEL MAR. BARCELONA. SPAIN: ACTIVITY INDICATORS AND RESULTS OF THE PERCEPTION AND SATISFACTION SURVEY OF THE PROFESSIONALS

Cristina Iniesta Blasco, Ana Sancho Gomes de Travesedo, Maribel Perez Piñero, Montserrat Antonin

OBJECTIVES

To assess the utilization of the intercultural mediation programme and to assess the perception and satisfaction among professionals.

RATIONALE

The programme started in June 2003 and it was due to the fact that Hospital del Mar from Barcelona (418 beds-teaching hospital) attends 2 neighbourhoods (Ciutat Vella and Sant Martí) with a 36,1% immigration rate.

METHODS

Monitoring, detection of needs and assessment of the programme is coordinated by the head of the helpdesk.

Weekly availability of intercultural mediators for immigrants from the following countries: Morocco 20 hours, Pakistan 12 hours, Romania 12 hours, Gipsy 3 hours covering a wide range of languages: classic Arabic and Moroccan dialects, Urdu and Punjabi, Romanian, English, French, Spanish.

Mediators take notes concerning each patient attended daily (where the mediation took place, who asked for it, the patient's profile and any relevant information about the mediation).

A survey among the professionals was designed in order to assess the degree of satisfaction. The survey includes 26 questions and it was answered to by 302 professionals (doctors and nurses).

RESULTS: year 2005

Activity

1203 uses attended the service, i.e. 100 users on average every month. 6456 mediation actions were performed, with every user receiving on average 5 mediations, which on average lasted 20 minutes. Services mostly demanded: mother-child 29%, emergencies 35%, medicine 13%, surgery 13%, others 10%).

Perception/satisfaction

95.6% of the professionals were aware of the service, 81.2% considered it useful, 64.4% were satisfied. Suggestions made: increased time for the services. Supplementary efforts made by the medical staff:

- important 32,3%
- depends on the language 37,7%
- little 25,3%

CONCLUSIONS

The monthly monitoring of the activity allows improving the programme. Better knowledge and information about the programme is required among the professionals.

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'FAIR FOR ALL' - IMPROVING HEALTH CARE FOR MINORITY ETHNIC COMMUNITIES IN SCOTLAND

James Robinson

This paper will give a picture of how Scotland is developing its health service to meet the needs of a multi-cultural, multi-ethnic society. The devolved Scottish Government, the Scottish Executive, is encouraging Scots to recognise that theirs is a multi-cultural society through its 'One Scotland - Many Cultures' Campaign.

The government recognises that a multi-cultural society needs culturally competent services able to meet the needs of all its citizens. To assess how far this was being achieved in healthcare the Scottish Health Department conducted a survey of all National Health Service providers. The conclusions were disappointing for while there were some areas of good practice it was clear that nationally health services were not meeting the needs of minority ethnic groups. The Executive therefore developed guidance on how it expects culturally competent healthcare to be developed and delivered, how in other words it expects healthcare to be 'Fair for All'.

The 'Fair for All' guidance sets out five key areas to be addressed:

- Organisational change and leadership
- Demographic surveillance
- Accessibility to culturally competent care
- Human resources
- Community development

Health Boards are required to submit annual reports showing how they are progressing.

To support health care providers in implementing the guidance the Scottish Executive established the National Resource Centre for Ethnic Minority Health. This Centre provides on-going advice and support through a multi-disciplinary steering group and a number of working groups.

Among a number of tools developed to support implementation of 'Fair for All' is a Diversity Impact Assessment Toolkit which health care providers are using to examine the potential impact of policies and practices on different communities and patient groups. The 'Fair for All' guidance has proved sufficiently effective that it has been extended to cover other areas of actual or potential discrimination.

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INTER-CULTURAL HOSPITAL IN THE LOMBARDIA REGION: ACTIONS AND RESULTS

Scrabbi Lucia, Tersalvi Carlo Alberto, Avisani Rosaria

AIM

To promote a methodological network strategy in the inter-cultural area with the staff, in order to grant an integrated approach in any possible application field.

CONTEXT INTRODUCTION

Since 2000 the Lombardia Regional Health Department (LRHD) started this project setting to work together 16 hospital staff. This steering group worked to produce a guide to assist staff in their work with patients are from different cultures. The guide was developed from this steering group after having known the Migrant Friendly Hospital Pilot Initiative.

ACTIONS AND RESULTS YEAR 2005

On March, the LRHD produced the Regional Guide and spread it in 115 Regional hospitals. The regional guide want to be a basic instrument to open an health service with people are from other cultures and to improve them.

The regional guide includes information on:

- What means Intercultural Hospital in Lombardia Region
- What are the principles in which it inspires
- What are the hospital areas needed more actions to improve welcome with immigrants.

Besides, it suggests to regional hospitals the method to organize a training course in an hospital that want to improve health services with migrants.

On May/December, the LRHD planed a training course for 40 hospital staff of 23 hospital structures that must plan an other course in their hospital.

Since April a regional database is on line on web site www.sanita.regione.lombardia.it, also in English. In this data base there are many information translated in several languages that are useful for all hospitals (p.e. a multilingual notice-board

set in all First aid Places of Lombardia Region; a multilingual anamnestic questionnaire of the emergency; the rights and duties of citizen, etc.).

The data base is necessary to monitorate and control the application of the Regional Guide in the whole regional area.

Year's end 2005 the number of hospitals that started a project to improve welcome migrant increase from 16 to 22 hospitals.

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SECURING OF EFFICIENT, CULTURALLY DIFFERENTIAL NURSING CARE FOR VIETNAMESE AND CHINESE MINORITY IN THE CZECH REPUBLIC

Valérie Tóthová, Gabriela Sedláková, Miloš Velemínský, Adéla Mojžíšová

After 1989, i.e. after changes in social, political, but also in social and health care system, the Czech Republic becomes destination of immigrants, groups and individuals, both from neighbour countries and from remote areas. The result of it is that people from different continents, members of numerous cultures, religions and colours of the skin have been settling temporarily or permanently in our country. This fact brings nurses and other health care workers to think about apparent "reduction of the world" in which they can come into contact with a big number of people of different cultural profiles in a very short time, because of migration and quick electronic communication means. Useful and effective help to clients from different cultures in health care requires good preparedness of the nurses who should be able, on the base of their trans-cultural knowledge and skills, to provide holistic nursing care at a level corresponding to the needs of the citizens from such countries. This has lead us to prepare a three-year research project called "Securing of efficient, culturally differential nursing care for Vietnamese and Chinese minority in the Czech Republic". These two minority groups were selected, on one hand, because Vietnamese constitute the biggest minority group from Asian countries living on the territory of the Czech Republic, in a number of 34 179 persons, followed by the Chinese minority group in a number of 3 421 persons, and on the other hand because a typical feature of both minorities living in our country is their separatedness and reclusiveness based on considerable cultural difference and language ignorance. The research project was submitted to the competition of the Internal Grant Agency of the Health Ministry of the Czech Republic. The project was successfully accepted by the Ministry, which means that we obtained financial support from the state budget for the project implementation. On the base of the results, a standard for provision of adequate culturally differential primary, secondary and tertiary nursing care for Vietnamese and Chinese minorities will be elaborated. At the same time, a monograph focused only on these two minority groups will be prepared in the scope of the grant. At present, the project solution has been running since two years. I would like to present the results of resarch on the conference.

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RECENT ACHIEVEMENTS OF A MOBILE TEAM SPECIALIZED IN TRANSCULTURAL PSYCHIATRY

Richard Simon

During the meetings of the task force called "migrant friendly and culturally competent hospitals" we would like to present the achievements of a team specialized in transcultural psychiatry.

We will first describe the public psychiatric health care system's organization which underlies our institution and then address the more specific questions which arise from within the field of transcultural psychiatry. Our institution has developed a particular concern for the so called "migrant patients".

Our experience with migrant patients has led us to review previously established procedures in both their practical and theoretical aspects, i.e. collaboration with translators, specific family situations (dispersion, traumatic experiences by several family members.), precarious residence situations, unfamiliar symptoms, etc.

In order to give an answer to the above-mentioned problems in our institution, we have opted for the creation of a pluridisciplinary mobile staff specializing in transcultural psychiatry.

The goal of the team is, on the one hand, to introduce the hospital staff to this type of treatment and, on the other hand, to offer an ethnopsychological support to medical staff during hospitalizations or ambulatory treatments. This is being achieved through: documentation of standard procedures, ethno-psychiatric consultation, specific training modules and clinical supervisions.

The difficulties we have encountered in creating this mobile team can be summarized as follows : institutional resistances (due to the novelty of such activities and the resulting reorganizations); theoretical resistances (on a psychodynamic level, the analysis of the therapeutic relationship with migrant patients has revealed frequent strong counter attitudes, including cultural counter-transference).

Finally we will address how this model can be applied to other medical environments, such as general hospitals, home interventions by a medical staff.

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**“THE UNION MAKES THE STRENGTH” - “INTERCULTURAL” PLANS COMFORT AND WELCOME
NEAR THE EMERGENCY AND ACCEPTANCE OF PIEVE DI CORIANO AND MANTOVA HOSPITAL
DEPARTMENT**

Pierpaolo Parogni, Mario Luppi, Carlo Calamari

CONTEXT INTRODUCTION

The growing request for urgent sanitary performances and for shelters by Italian people, elderly with chronic pathologies, regularized and not permanent extracomunitari, determines the necessity of structuring a program of local continuous check and growth of the capacities of qualitative hospital answer. So it is necessary to identify the catchment area and activate a series of services that are able to improve the answer and the effectiveness of the sanitary action towards an evolving registry view, where for evolution the future reality is represented.

OBJECTIVES

Improve the offer and expectations health service user relationship giving knowledge of that which offers himself in order to decrease gape; recognize the differences of attitudes, cultural needs and conditions between individuals and between various groups of populations. Increase self-evaluation of people-patient, reduce the improper accesses and increase the self-management capacity

ACTIONS

Evaluation of the needs of the user, taking the background social, cultural, religious and pathological into account; the hospital tries to reduce the barriers physical, linguistic, cultural and other which can obstruct the access and the grant of the services. Study and material popular-educational realization and activity of formation of the sanitary staff in order to improve the capacities of interaction and compliance with the users.

GROUP

The total population of Mantova of which comes to an agreement the 8% extracomunitari and the total population of the Secchia Destra of which the 6% extracomunitari (given in the September 2004).

EVALUATION

We intend to evaluate the degree of participation to the project by the councils, MMB and chemists' towards the realization of a true sanitary net of information and education.

CONCLUSIONS

The goal which intends to reach himself is to improve the users and hospital relationship, through a use aware of the structure offers, avoiding accesses and not correct requests, but above all setting up a confidence cooperation relationship with the sanitary staff.

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INTERNATIONAL HEALTHCARE GARDEN IN TAIWAN

Ivy Shiue

OBJECTIVES

To understand how International Healthcare Garden facilitates foreigners access to integrated medical care in Taiwan.
To investigate how International Healthcare Garden meets foreigners' demand while staying in Taiwan.
To bring all information on migrants' health in Taiwan to all coming migrants.

BACKGROUND

Nowadays, more and more internationals have come to Taiwan whether studying, working or just living here for another new life with their spouses. For example, up to date there are more than twenty thousand Canadians living in Taiwan. This is just a case of one nationality, let alone others from other parts of the world and from Southeast Asia in particular. Taiwan has been trying taking efforts on investing migrants' health including establishing International Healthcare Garden at National Tao-Yuan Hospital. They have started to offer well-trained medical personnel and nursing staff with outstanding ability in multiple languages more than 20 to service all the people from outside of Taiwan in order to create a suitable health environment for them. Since 4S advantage of Tao Yuan General Hospital has been tried to remain the quality of migrants' health, suppose International Healthcare Garden should be the model of international medical service provided within the nation for foreigners in Asia.

METHOD

A survey will be used to describe and assess the satisfaction and attitude from international migrants. A self-administered questionnaire with a combination of closed and open-ended questions will be sent via emails and/or mails by post from all Embassy and International Trade Offices in Taipei. Closed questions are used to generate some general questions. Nevertheless, open questions allow the respondents a chance to draw issues, problems and/or suggestions.

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SESSION III-3. MONITORING, EVALUATION AND REPORTING ON HPH INTERVENTIONS

TOWARDS SUSTAINABILITY FOR HPH- MONITORING AND EVALUATION OF THE 'HUB' HOSPITAL APPROACH

Ann Kerr, James Robinson, Thomas Harrison, Audrey Miller, Sarah Bush

BACKGROUND

HPH in Scotland has been re-started at the same time as a practical package of support for health promotion in health care settings (HPHS) was developed. A structure has now been set up for an early implementation phase. This structure is unique in that the co-ordinating body is the NHS Health Scotland, the national body for health improvement in Scotland, rather than a hospital. Most of the work of the network is being carried out by 'hub' hospitals.

AIMS of the early implementation phase and 'hub' hospitals

- To provide support over a 3 year period for HPH
- To review the health related outcomes
- To assess individual and organisational learning

Each 'hub' contracts to identify areas of interest for development of good practice. 6 areas have been identified to date and cover areas of healthy living in hospitals and healthy lifestyles for patients for example. The hospitals are expected to use the HPHS tools and support and to participate in local, national and international networks. A key task is to encourage participation of other hospitals and link with local community health services

METHODS

As HPH is an established initiative with a developing international evidence base, this phase of development in Scotland is not being subjected to a research evaluation. The process is one of documentation of work and activity to enable a review at 3years. The hospitals and co-ordinating centre are expected to maintain records and detailed monitoring information on agreed criteria. These will be fed into an external review along with interviews with the staff and organisations involved for evidence of impact at individual and organisational level.

The presentation will cover the range of hospitals and areas of health promotion involved, the agreements and monitoring arrangements, as well as indications of sustainability to date

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PILOT STUDY OF DEVELOPING A PATIENT SAFETY MODEL WITHIN THE FRAME OF REFERENCE OF A HEALTH PROMOTING HOSPITAL

Maria Hallman-Keiskoski

The purpose of the pilot research was to study and develop a model applicable for a health promoting hospital for analysing and preventing adverse events associated with treatment. The so called Vincent's model of investigation, developed to health care based on the system theoretical model of James Reason, was applied in the study (A Protocol 1999). A special feature of the study was the involvement of the patient and relative in the research process together with the medical staff.

The research material was gathered in 2004 at the emergency policlinic and in patient nursing units of the Central Finland Central Hospital. Three patient cases were picked from among a total of 2162 emergency patients. The material consisted of the accounts of the patients and relatives, experiences on the use of the Vincent's model of investigation and investigation reports, and common discussions and thematic interviews of the discussion participants. Accounts, common discussions and thematic interviews were recorded on audio tape and transcribed to form a part of the research material. The analysis method used was content analysis and classification.

The accounts opened a new point of view to the performance of the entire treatment chain. Application of the Vincent's model of investigation turned out to be difficult; however, it could be used to bring out the system's shortcomings constituting a safety risk and hence requiring prevention. The common discussion gave a new possibility for a constructive analysis of adverse situations and relieved the staff from the culture of guilt.

Based on the pilot study, a new patient safety model suitable for the frame of reference of a health promoting hospital was developed. The model allocates the activities simultaneously to the organisation, patients and medical staff. Also, in the results of the study, new possibilities are set forth for developing patient safety.

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TASK FORCE FOR QUALITY-BASED REIMBURSEMENT REGARDING " HANDLING HEALTH PROMOTION IN HOSPITALS IN THE DRGS- EVALUATION OF THE REGISTRATION OF THE HEALTH PROMOTING ACTIVITIES

Mette Enevold Christensen, Hanne Tønnesen, Oliver Gröne, Ann O'Riordan, Fabrizio Simonelli, Tiiu Härm, Denise Morris, Peder Vibe, Susan Himmel, Poul Erik Hansen

15 new codes has been developed for documentation in the medical records and for reimbursement og HP activities in hospitals. Hitherto the tradition for registration of HP activities has been sparing and the activities are often invisible in the budgets and balances regarding hospital services as well as regarding economy.

OBJECTIVE

To evaluate the use of standardised registration codes for HP procedures in clinical day life in HP hospitals. To compare the use of the codes in standadised materials at HP hospitals and further to evaluate if the codes were useful, applicable and sufficient.

METHODS

The project was a quality development study with participants from 20 departments/hospitals in 6 countries. The study consisted of two parts in accordance with the objectives.

A: 14 standardised medical records to be coded by all participants

B: 20 local medical records from each participating department/hospital to be coded by the local department/hospital exclusively.

RESULTS

The data collection has been completed. The resposnerate was 100%. The analyses are ongoing

CONCLUSION

The results will be presented at the HPH Conference in Palanga 2006.

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IMPLEMENTATION OF THE HPHS POLICY IN THE IMMANUEL DIAKONIE GROUPS TQM SYSTEM

Werner Schmidt, Elinar Brandt

OBJECTIVE

To describe the implementation of the HPH Core Strategies and of the Standards of Health Promotion in Hospitals as part of the overall organization quality improvement system and culture of the IMMANUEL DIAKONIE GROUP Berlin (IDG).

SETTING

Immanuel Diakonie Group (Holding)- Hospitals and Social Facilities in Berlin, Brandenburg and Thüringen with over 1000 beds and 1900 employees.

IDG is General Member of EFQM and 2 Hospitals are Member of the HPH-Network of WHO.

METHODS

WHO-Pilotproject "Implementing the HPHs Strategy and Standards through a combined application of the EFQM Excellence Model and the Balanced Scorecard (BSC)":

Since 2002

- systematic implementation of HPH policy in the process of developing vision, values and strategical basic orientations
- Development and Implementation of a HPH-focused Balanced Scorecard for IDG

RESULTS

The centre of the presentation is to demonstrate the 20 strategic objektivs in the BSC of the IDG to it connections

- to the 18 HPH Core strategies and the 5 Standards for Health Promotion in hospitals and
- to the EFQM Excellence model.

CONCLUSION

An effective way for Implementation of the HPH Policy as part of hospitals overall quality improvement system is the management instrument "Balanced Scorecard" in combination with the EFQM Excellence Model.

The Authors will inform about experiences, successes and barriers.

KEYWORDS:

HPH Policy implementation, Balanced Scorecard,EFQM Excellence Model, Hospitals quality.

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THE PHYSIOGNOMY OF THE HPH NETWORK OF TUSCANY: THE EVALUATION OF THE FIRST FIVE YEARS OF ADHESION

Paolo Morello Marchese, Caterina Teodori, Maria José Caldés Pinilla, Katalin Majer, Fabrizio Simonelli

The Health Promoting Hospitals Network of Tuscany, built in April, 2001, has represented a further concrete sign of the diffusion of a new health culture in the Region. The work carried out in this first period of adhesion has been based on the definition of a particular network physiognomy. Three strategies have been realised: elaboration of HPH standards, re-orientation of the organisational processes, improvement of the relationships through training activities.

All the activities were yearly evaluated in order to point out the achievement of the prefixed objectives. The evaluation process was based on a self-evaluation system defined by the Regional Co-ordinating Centre of the HPH Network of Tuscany. The comparative analysis of the emerged results from the evaluation process allows today to have a balance of the first five years.

OBJECTIVES

- Monitor the development level of the projects in the single Local Health and Hospital Units, of those realised in a joint way among the Units, and of the network co-ordinating activities;
- Put in evidence the excellencies and the criticisms met in the first five years of activities of the HPH Network of Tuscany;
- Programme the activities of the next period of adhesion.

Target Group

the whole HPH Network of Tuscany, the Regional Health Authority, the international HPH Network.

METHODOLOGY

the annual self-evaluation, realised together with the Managements of the Local Health and Hospital Units and the Co-ordinators of the inter-corporate projects, is based on an ad hoc self-evaluation tool aligned with the standards individuated by the international Working Group, with respect of the specificity of the Tuscany HPH network. Each year, the results are elaborated in a graphical way, and an annual report on the development level of the HPH project in Tuscany is prepared.

RESULTS

The self-evaluation system has allowed the comparison of the progress made by the single corporate and the inter-corporate projects.

In parallel with the self-evaluation process, the following actions have been carried out, with a network perspective:

- different levels of re-orientation of the organisational processes have been obtained;
- with regard to the thematic inter-corporate HPH projects (Smoke-free Hospital, Pain-free Hospital; Intercultural Hospital, Safety in Hospital, Humanisation, Acceptance) specific HPH standards have been elaborated for the Tuscan hospitals;
- specific training activities have been organised (both on transversal and thematic aspects);
- a data-base collecting the good HPH practices has been realised;
- research activities have been made and scientific articles have been published.

CONCLUSIONS

The definition of easily utilisable and suitable evaluation tools allows and facilitates both the comparison among the corporate and inter-corporate projects, and the diffusion of the results with a perspective of network, favouring the general growth of the Regional Network. Moreover, it allows to programme the actions of the next period of adhesion. This experience can be proposed as an evaluation model for other HPH Networks.

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SESSION III-4. IMPROVING HEALTH PROMOTION, PREVENTION, TREATMENT AND CARE FOR DIVERSE CHRONIC CONDITIONS

ELDERLY PATIENTS BENEFIT FROM THE COMPLEXITIES OF THE COMPREHENSIVE GERIATRIC ASSESSMENT

Helle Maeltsemees, Katrin Olo –Laansoo

The aging of the general population affects the whole of society and requires changes and reforms in the areas of health-care and social services in order to assist the elderly person (65 Elderly patients benefit from the complexities of the Comprehensive Geriatric Assessment and older) to cope with everyday life as their health and well-being declines.

The Estonian population is aging quickly. For example, in the capital of Estonia - Tallinn, the percentage of elderly people is 16,7%. At present, the main goal of our health policy is to encourage this population to retain their independence for as long as possible. Preparing people for coping in the latter stages of their lives is one of the basic principles of social

policy of the government of Estonia. The problems of the elderly are closely linked to a rise in the standard of living and a guarantee of human rights. The well-being of elderly people is mainly dependent on their social integration and its most important aspect, self-sufficiency.

In the past year at our Tallinn Central Hospital Medical Rehabilitation and Long term Care Clinic , great importance was given to the comprehensive geriatric assessment, which is based on the common assessment system in health and welfare settings. The adaptation of comprehensive geriatric assessment was carried out by a team of doctors, nurses and social workers using an international standardized instrument - RAI, and was administered by the Estonian Sick Foundation and the Estonian Association of Gerontology and Geriatrics.

In 2005, 347 geriatric assessments were carried out in our hospital.

In order to evaluate the results of our work, we performed a follow-up study where 200 cases (patients) were randomly selected. Contact was made with the families of these patients and, through that contact, the direct effects of the geriatric assessment on the patients were brought to our awareness.

RESULTS OF THIS STUDY ARE AS FOLLOWS

Of the original 200 cases, contact was made with a total of 167 patients. Out of that total, 41 patients had died, 34 patients were in a nursing home (long-term care facility), 27 patients were receiving homecare, 37 patients renewed contacts with their family doctors and were receiving treatment and medical care, 14 patients were content with their home situations and 14 patients showed renewed interest in their healthcare.

In conclusion, the abovementioned results indicate that the geriatric assessment is an important key in developing a patient's treatment plan as well as ongoing treatment. The development of a patient treatment plan should not be delayed, particularly when a patient is in critical condition. The geriatric assessment creates an active collaboration between medical personnel and social networks

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MANAGEMENT OF INTERVENTION INTEGRATION IN THE MARIA TERESA CHIANTORE SERAGNOLI HOSPICE IN BOLOGNA

Elena Marri, Danila Valenti, Stefano Liverani

BRIEF DESCRIPTION OF THE PROJECT

The Hospice is a residential health structure providing care and attention to those who are nearing the end of their lives, sharing this objective with the other links in the palliative care network.

Palliative treatment requires a global intervention model able to evaluate the interaction of physical and emotional suffering, spiritual needs and socialisation difficulty.

The complexity of the situation which patients and family live through requires an integrated multi-disciplinary and multi-professional approach, which has already been consolidated in all the 14 Hospices in Emilia-Romagna Region.

GOAL AND OBJECTIVES

The arrangement of occasions for meetings, comparisons and training of the care team is a basic element in the hospice organisational model, but is also the basis of the suggested training model, which requires substantial contact with everyday life.

The occasions for meetings and comparisons with the team combine with the permanent, continuous, daily training based on multidisciplinary evaluation, on the description and analyses of situations encountered in everyday life and of the background of the staff different members to such situations. At the same time, the meetings also represent the main element to guarantee high-quality personalised global care and the tool for dealing with the burn-out risk in the staff, as well as the basis to open discussions on highly ethical problems.

METHODS/ACTIONS

The organisational system at the Hospice of Maria Teresa Chiantore Seràgnoli di Bentivoglio- Bologna comprises frequent meetings as follows:

- Daily briefings (14.00- 15.00) as follows: 1) comparison of the evaluations of individual professionals (Case-managers, nurses, doctors, physiotherapists, basic health care assistants, psychologists, integrated home care service nurses (ADI) and, sometimes, general practitioners) to achieve the real multi-dimensional assessment of the patient and his/her family's needs, 2) the decision is taken on the best global response (therapeutic, care, psychological) for an effective multi-disciplinary approach, and 3) the working schedule for effective inter-professional work is created. This comparison is made for each of the 30 hospitalised patients.
- Weekly staff meetings (Tuesday 15.00-18.00) during which, in the presence of the supervising psychologist, specific ethically and emotionally relevant situations are discussed, with in-depth analysis of the emotional impact of such situations on the staff and subsequent elaboration. At the same time and using the same methods, management of conflicts arising within the team is also dealt with.
- Meetings among staff from the same area for thorough specific, internal, scientific analysis : Doctors: weekly; nurses: weekly; basic health care assistants: weekly; physiotherapists: fortnightly; psychologists: weekly.

PRIMARY TARGET: patients, family members and staff

EVALUATION OF RESULTS

Permanent, continuous, daily training, based on the discussion and evaluation of situations directly experienced by the group or by individual staff members, and of reported emblematic situations, facilitates the profound modification of the approach to patient care which goes right across:

Professional training of individual staff members
Personal development of individual staff members
Specific professional training of the different professions
Integrated professional training of the care team
Development of the care team

CONCLUSIONS:

The results on the effectiveness of such an organisational model are evaluated by means of the perceived quality questionnaire, systematically handed out to patients and their families.

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HEALTH GAIN AND COPING WITH CHRONIC PAIN AND MAJOR HANDICAPS - MOANING DOES NOT HELP

Klaus Hüllemann, Brigitte Hüllemann

BACKGROUND

Human beings suffering lifelong pain and/or major handicaps often have to endure the side effects and failures of professional help. The principles of health promotion (empowering, participatory, holistic, intersectoral etc.) are not always promising in the long run.

But on the other side we all know men and women who neither give up the desperate struggle for survival nor do they persist in a permanent sad mood, in the contrary they sometimes radiate calmness and happiness.

What are the prerequisites of these superior coping strategies or better: health gain strategies?

METHODS

Medicine case studies are mostly the basis to see any causal relations and to advance or refute hypothesis. Therefore we studied selected patients of our hospital and also the medical history of some outstanding personalities, e.g. the philosopher Karl Jaspers and the founder of modern clinical hypnosis Milton H. Erickson. Biographical details are given.

RESULTS AND CONCLUSIONS

The bio-psycho-social inheritance plays a major role in some but by no means in all cases. We could not distinguish a major genetic influence nor could we exclude such an influence. The family and especially the early childhood development in some people contributes to built up a stable personality despite relapsing pain, but other people are stable without any support of the family.

Generally we found the following qualities in this selected group:

Stable human relations - self reflection - spiritualism - humor, curiosity and play instinct - zest for life and stamina.

It seems that zest for life is the younger brother of the elder one whom Blaise Pascal named "logique du coeur", that means logic of the heart which comprises cordial vigour.

Modern brain research teaches us that health gain may be learnable up to old age. Disability can serve as motivation for healthful learning, but in the end it remains a gift or a miracle that some disabled may gain more health than so-called healthy persons.

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THE "BERLINER RHEUMA-HAUS" - A HPH-CONCEPT FOR EFFICIENCY TREATMENT OF RHEUMATISM

Elimar Brandt, Andreas Krause

OBJECTIVE

Integrating health care interventions on patients with rheumatism across levels of services is in Germany a relevant problem. Cooperation between the hospital and other services therefore vital for achieving an optimum health gain and for economic results. On the basis of:

the HPH Core strategy COM 2 (Empowerment of health professionals in the community for health promoting co-production in treatment and after-care of patients) and

the Standard 5 of Health Promotion in Hospitals (To ensure collaboration with relevant providers and to initiate partnerships to optimize the integration of health promotion activities in patient pathways)

Hospitals of the Immanuel Diakonie Group Berlin developed the concept "Berliner Rheuma- Haus".

SETTING

Hospitals of the Immanuel Diakonie Group Berlin:

- Rheumaklinik Berlin- Wannsee und Zentrum für Naturheilkunde (Treatment of Rheumatism, Orthopedic Surgery, Center for Naturopathy) and
- Rheumaklinik Berlin-Buch (Treatment of Rheumatism).

RESULTS

The authors of the presentation will describe this innovative concept and the start of the implementation as the view of hospital manager and rheumatologist.

The internal strategic basis for the concept "Berliner Rheuma-Haus" is the Balanced Scorecard as management instrument of the Immanuel Diakonie Group.

The presentation will cover the special fields of the coordination of the different providers of health care services on rheumatology incl. "Self Help Groups" and "Rheuma-Liga".

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AN EPILEPSY TELEPHONE ADVICE LINE: A REVIEW

Cora Flynn, Norman Delanty

Other studies of other conditions have shown that face to face consultation is not always necessary and phone interventions may resolve the problem promptly avoiding further complications (Miller 2002). This study examines tele-nurse advice to epilepsy patients, its indirect effects on other medical services and seeks to find out what patients would do if this service was unavailable.

AIMS

To identify the reasons why patients contact the service
To categorise the advice that patients were given
To establish what patients would do if the service was unavailable to them.
To observe the effects of the service on A&E and OPD attendance by these patients.

METHOD

An audit of phone interactions was carried out retrospectively, reviewing 6 weeks of calls. During this time patients were asked to choose from a set of options what they would do in the absence of the service.

RESULTS

172 calls were reviewed. The main finding of the study is that 89% of patients said they would contact a medical doctor (51% hospital doctor 38% GP) if the service was not available. 4% of patients said they would request to have their appointment brought forward, while 3% said they would have attended A&E. This study although small, proves that this service is valuable in the care of epilepsy patients and shows positive effects on other medical services. It also highlights the epilepsy nurse as a key member of the multidisciplinary epilepsy team.

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PARALLEL SESSIONS IV:

Friday, May 26, 14.15-15.45

SESSION IV-1. PATIENT EMPOWERMENT + INTERSECTORAL COOPERATION FOR TACKLING CHRONIC DISEASES

THE "ART OF EMPOWERMENT" IN DOCTOR-PATIENT-INTERACTION - A FIRST META-STUDY ON QUALITATIVE LINGUISTIC RESEARCH

Peter Nowak

Encounters with doctors are in most cases the starting point and milestones of a more or less empowered and patient-centred carrier of self management for people with chronic illnesses. They are a gateway to adequate professional support for self management and decisive situations for the motivation of patients to care for their life and illness. Especially the opportunity to integrate prevention, treatment and care are developed or hindered through these encounters on the individual level of care. Therefore effective communication of doctors is a key area for improving health and quality of life.

Linguistic analyses of doctor-patient-interaction is an established field of research since 35 years. Numerous, mainly qualitative studies are published, but thus far have not been comprehensively analysed and synthesized. Unlike the disciplines of medicine and psychology, there is a lack of meta-studies in the area of discourse research.

For the first time this meta-study develops the methodology for the synthesis of qualitative linguistic discourse research. It categorizes (German-speaking) doctors communicative behaviour with a special focus on the question, if there is discourse-analytic evidence what could be called "empowering" or "dis-empowering" interactive processes on the part of the doctor.

First results on the basis of the synthesis of six primary studies will be presented as a comprehensive systematic of doctors communicative behaviour and the specific effects of these "interventions" on patients. Two conclusions will be drawn: 1) the need for further synthesis of discourse research with a focus on "empowering interaction" 2) the need for more theoretical exchange between the clinical, psychological, sociological and linguistic approaches to patient empowerment.

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INFORMED CONSENT AS A MEANS FOR HEALTH INTEGRATION AND PROMOTION

Pietro Ragni, Daniela Riccò, Antonia Nini, Franco Prandi, Antonio Chiarenza

BRIEF DESCRIPTION OF THE PROJECT

The theme of informed consent has acquired increasing importance, especially for legal and insurance reasons. The heart of the problem, however, is associated with ethical aspects, which today must include the empowerment of patients. Good empowerment reduces the risk of disputes and compensations, and allows the citizen to choose a treatment with greater peace of mind and to be aware of his/her own course of health treatment. This is true not only with regards to acute pathologies, but also for chronic conditions. The acquisition of consent for the treatment of a chronic pathology, makes it possible to share therapeutic choices with the patient, thereby giving him/her more information, and ensuring ongoing compliance with the treatment.

THE AIM of the project is to encourage a positive relationship and a well-informed therapeutic alliance between the citizen and the health service. Informed consent is not a series of forms but a course of action, regarding not only the hospital, which allows the patient to undergo treatments for acute or chronic diseases. We have adopted a new procedure for informed consent, using the same forms in all 5 hospitals in the AUSL of Reggio Emilia, and which are to be used by the various professionals that follow courses of treatment for chronic diseases (cardiac decompensation). We have planned training courses for doctors and nurses.

The primary target are patients for whom an invasive diagnostic or therapeutic operation is proposed; patients affected by cardiac decompensation; patients designated for anti-tumoral chemotherapy. We expect the new procedure for informed consent to help in acknowledging the citizen extensive decision-making autonomy regarding therapeutic choices affecting them. Good awareness and conviction regarding these choices favours both compliance with diagnostic and therapeutic proposals as well as greater freedom from avoidable medicalisation.

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A PARTNERSHIP BETWEEN A HEALTH CARE SYSTEM AND THE REGIONAL SCHOOL SYSTEM

Matthew Masiello

In 2004, a federal law of the US Congress mandated that schools and communities develop local wellness policies and school health councils. It was further stipulated that these wellness policies must address plans to combat childhood obesity. The Center for Disease Control recommends that these school wellness councils address eight areas in the developmental process. These areas include health education, family/community involvement, health promotion for staff, health school environment, counselling, psychological and social services, nutrition services, health services and physical education. In many instances, schools do not have the expertise to appropriately analyze these federal/state health recommendations.

In partnership with the twelve school districts of the county, the Office of Community Health of the regional health care system will formally assist the schools in the coordination, monitoring and evaluation of the programs developed and implemented by this Regional Coordinated School Health Council. This partnership will allow the school systems to comply with the federal mandate as well as allow this public health arm of the regional health care system to systematically, and in a more cumulative fashion, evaluate those health promotion/disease prevention programs developed and implemented for the schools of the region by the health care system. Such a partnership between schools and health care system may serve as a model for other communities.

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A HEALTH PROMOTING HEALTH CARE SYSTEM IN RURAL AMERICA

Matthew Masiello

At the present time the American Hospital Association does not have formal, health promotion/disease prevention standards, similar to that outlined by the World Health Organization, as part of their accreditation process. Despite significant advances in diagnostic and curative medicine significant segments of the American population lack social service and mental health services. In 1997, a large health care system in rural southwest Pennsylvania, USA developed an Office of Community Health to address the varied and concerning health issues of the region in which it serves. A paediatrician/public health professional was hired to direct this new initiative. With additional grant funding from a managed care company and the health care system Board of Directors, two additional public health and four public health nurses were hired to further develop the health promotion/disease prevention (HP/DP) programs for this rural, economically depressed region.

Since 1997, school and community, evidenced based programs have been developed and/or implemented, as well as monitored and evaluated, by the staff of this Office of Community Health. These initiatives include programs in obesity prevention and cessation, injury prevention, bullying prevention in the school setting; a preschool dental hygiene program

and tobacco prevention and cessation programs. In 2005, a formal hospital based, worksite wellness program was implemented, inclusive of a campus wide tobacco use ban. Summative reports, including evaluation data, are presented to the State Dept. of Health, the local county commissioners and the health care system Board of Directors. Considering the lack of formal, public health driven, HP/DP programmatic activity in the US health care system this rural based, health care system initiative may serve as a model for other US communities. The goals and objectives of the World Health Organization Health Promoting Hospital Initiative have been adopted by this rural health care system as a means of further addressing the health issues of this region of the United States.

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**HOSPITAL AND SCHOOL TOGETHER FOR THE MANAGEMENT OF CHRONIC DISEASE AND
QUALITY OF LIFE OF CHILDREN AND FAMILIES**

Guarnaccia Sebastiano, Valseriati Daniela, Battaglia Silvia, Bresciani Antonella, Micheletti Serena, Pluda Ada, Riviera Emma, Polsini Italo, Consonni Anna, Di Domenicantonio Paolo, Farella Giuseppe, Buzi Fabio, Macca Claudio, Prandi Elena, Pagliaini Lucia, Battaglia Marcella, Valseriati Laura, Cornella Chiara, Salucci Mariangela, Domenighini Serena giulia, Manfredi Daniela, D'agata Emanuele, Gnaccarini Giuseppina, Chiarini Maria teresa, Pellegrino Patrizia, Gastaldi Stefania, Silini Antonietta, Cicchelli Roberta, Castellani Alfonso, Avisani Rosaria, Pini Francesco, Notarangelo Luigi Daniele, Tiberti Alessandra, Spiazzi Raffaele, Ferretti Giovanna, Conti Adelaid

BACKGROUND

The chronic disease involves all the aspects of the social life of the patient. Not only is the doctor called to answer to the child's health, but all the professionals who interact with children and their families. It becomes therefore necessary to structure a plan of cooperation between hospitals and schools to promote a consistently improving quality of life for children affected from chronic disease.

METHOD

The Pedagogical Clinical Laboratory, a structure of the Children's Hospital, is the centre of reference for the child, its family and the professionals, with the scope to achieve optimal adhesion to the therapeutic-educational plan. Since the children spend a significant portion of their day at school, we have promoted three courses (fifteen hours in five sections), for teachers about the most frequent chronic diseases in childhood: asthma, diabetes and epilepsy. Particularly, we have emphasized the importance of the administration of drugs in schools. At the beginning and the end of the course the participants have completed a questionnaire regarding theoretical, practical and psychological aspects of the disease.

RESULTS

During the last few scholastic years, 134 teachers have participated in the project. The results obtained by questionnaires demonstrate an increase in the awareness of a variety of pathologies, and a greater knowledge of the role of school staff in the management of chronic diseases. The teachers tend to omit the administration of drugs as an immediate solution/reaction, however, at the end of the course (adequately instructed, also with practical exercises), this is indicated at the first intervention in an acute crisis of disease.

CONCLUSION

The collaboration between Hospital and School strives to concur the optimization of the management of the chronic disease and the improvement of the quality of life of the child and his/her family.

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SESSION IV-2. MONITORING, EVALUATION AND REPORTING ON HPH INTERVENTIONS

ANNUAL USE OF NATIONAL INDICATORS IN THE SWEDISH NETWORK FOR HPH, LESSONS LEARNED

Mats Hellstrand, Margareta Kristenson

BACKGROUND

The importance of developing indicators for HPH has increasingly been recognised. Members of the Swedish HPH network have developed a set of indicators; brief enough to be included in ordinary hospital's routine follow up. The set of indicators have, in January 2006, been included, for a third time, in member hospitals annual accounts.

OBJECTIVE

To evaluate the feasibility and perceived value of the Swedish indicators for HPH.

METHOD

The indicators cover the main domains of the HPH concept; disease prevention (three indicators) health enhancement (four indicators), supporting the health development in the catchments area (two indicators) and promotion of a positive health development for staff (four indicators). In addition, one area covers the overall management of hospitals i.e. weather health orientation is used as a strategy for a more effective health service (five indicators). The indicator structure is very similar to the one suggested on the national level for the new National Target for Health "A More Health Promoting Health Service". A detailed manual has been developed, where definitions and criteria can be found. After reporting on indicators an evaluation sheet shall also be filled in, concerning the process for doing the indicator test. The results are analysed at individual hospital and group level and each hospital can compare their results with the total. At following workshops representatives from member hospitals have met and discussed the process and the perceived value of measurements and the benchmarking process.

OUTCOME

The evaluation demonstrates a high feasibility and also a high-perceived value of the indicators. The results have been used in two ways; For the network, the synthesis of responses from these annual reports give an insight in the development of our work progress, and give one basis for the planning process in the network, which includes a yearly two-day seminar. The second, and most important use of indicators is for the local development; e.g. at the member hospitals, where the indicators are now increasingly often integrated in the annual reports from departments to the board. In this process, the results are also to be commented, e.g. clarifying what activities are fulfilled and areas for development.

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HEALTH AND SOCIAL SERVICES CENTRES IN QUEBEC: AN EXAMPLE OF COLLABORATION BETWEEN HOSPITALS AND OTHER HEALTH AND SOCIAL AGENCIES IN THE COMMUNITY

Nicole Dedobbeleer, André-Pierre Contandriopoulos, Hung Nguyen, Louise Rousseau, Lise Lamothe, Robert Bilterys, Zahra Elmala

Fifteen local health and social services network development agencies have been implemented in Quebec, in January 2004. They had the goal to develop local health and social services networks in their community. Each network is related to a local authority, a health and social services centre (CSSS), merging establishments identified by the Agency. These establishments are in most cases local hospitals, community health centers (CLSCs), residential and long-term care centres. Looking at all the challenges faced by the CSSS today and considering the evolution of the concept of "health promoting hospital" at the international level, it seems pertinent to assess how the strengthening of the intersection between public health and the health care system evolves in these CSSS. The two largely unlinked parts of the Quebec Health System, public health and health care officials have to work collaboratively to respond to public health threats but also to assure optimal care, prevention of common diseases and health promotion. The objective of this presentation will be to present preliminary results of a pilot study conducted to ascertain current and planned health promotion policies, programs and activities in three CSSS of one of Quebec regions, Montérégie. A questionnaire was developed to monitor these interventions, using as a guide the WHO self-assessment tool on standards for health promoting hospitals and indicators for the measurement of these standards. Success criteria for health promoting CSSS will be explored in relationship with success criteria for health promoting hospitals. The commitment of hospitals to the health of the population in the community will be examined in the extension of the "health promoting hospital" concept to concepts of "health promoting health and social services centres" and "health promoting networks". Lessons from the extension of the health promoting concept will be discussed.

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ESTIMATING THE BENEFIT OF INTERVENTIONS ACROSS THE SPECTRUM OF HEART DISEASE

Thomas Kottke

BACKGROUND

Because interventions to prevent and treat heart disease and congestive heart failure (CHD/CHF) are applied to different, but overlapping, segments of the population across the spectrum from primordial prevention through treatment of patients hospitalized for acute conditions and on to secondary prevention, it can be difficult to estimate the extent to which implementing a particular intervention might contribute to improving the health of a population.

METHODS

To assist in prioritizing initiatives, we conceptualized a Markov chain analysis in which a population is divided into three pools (apparently healthy, known CHD/CHF with preserved left ventricular systolic function, and known CHD/CHF with depressed left ventricular systolic function). Individuals in the population move from one pool to another over time by way of three streams (out-of-hospital cardiac arrest, acute/emergent events, or ambulatory presentation). The user is allowed to modify the demographics of the population and population risk factor levels. The user is also allowed to modify the rates at which interventions of documented efficacy for the treatment of acute events or chronic conditions are applied in the population, and the user is allowed to modify the expected efficacy of these interventions.

RESULTS

We have been able to develop a decision support tool that is based on a set of weighted, directed graphs that describe the flow of individuals as they age and develop CHD/CHF or die from non-cardiac causes. These graphs can account for all important interventions that can be applied to prevent and treat CHD/CHF.

CONCLUSIONS

It is possible to develop a decision support tool that can model the application of interventions to control risk factor and interventions that are applied before, during and after acute CHD/CHF events. This decision support tool can be used to optimize outcomes across the spectrum of intervention and can be accessed on the internet.

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A DESCRIPTIVE STUDY OF THE PERCEPTIONS OF A SAMPLE OF HEALTH CARE WORKERS OF THE PROCESSES OF PERSON CENTERED PLANNING IN A RESIDENTIAL CENTRE FOR PEOPLE WITH INTELLECTUAL DISABILITIES IN THE MID-WESTERN REGION OF IRELAND

Eileen Carey

BACKGROUND

For many years, the promotion of person centred planning for people with Intellectual Disabilities has been the core objective for every service provider. Under the guidelines of this philosophy nursing staff in a residential centre in the mid-western region of Ireland devised a unique approach to care (referred to as St. Vincent's approach to care) for people with Intellectual Disabilities.

RESEARCH AIM

The aim of this study was to describe and analyse the processes currently used to implement person-centred planning under the guidelines of St. Vincent's approach to care.

METHODOLOGY

The methodology of this study was qualitative in nature. Purposive sampling of health care workers in a residential centre of people with intellectual disabilities was employed. Data Collection involved one Focus group Interview.

FINDINGS

Findings included 4 master themes, Organisational Framework, Personal Planning, Collaboration and Spirituality.

CONCLUSIONS

Most staff nurses and clinical nurse managers had training in person centred planning whereas few other multidisciplinary team members had attended training sessions

The pivotal role of the Registered Nurse for the Intellectually Disabled was highlighted. Systematic processes are in place, which could be conducive to person centred planning. However, interdisciplinary communication appeared scarce as some professionals involved in the care of the service user rarely got together. There was a noted absence of an advocate involved in planning with service users.

RECOMMENDATIONS

A broad-based co-ordinated approach to the implementation of the processes of person-centred planning is identified and advocated.

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MIDDLE TERM (1 YEAR) EVALUATION OF THE IMPACT OF A TRAINING PROVIDED TO CHARGE NURSE TO DEVELOP PATIENT EDUCATION STRATEGIES

Jacques Dumont, Thomas Genevieve

Patient education is one main strategie in chronic disease management.

To contribute at the development of patient education programs in hospitals, the Health Promoting Hospital Network of the French community of Belgium organise in 2004-2005 a 4-days training in patient education management. 20 persons took part at this training (December 2004 - April 2005). After one year (march 2006) we will conducted a self-questionnaire evaluation to assess the impact of this training.

Target : nursing executive level in 15 different hospitals.

Evaluation tool : - self audit questionnaire

- focus group interview

EVALUATION POINTS

- development of inside patient education programs between april 2005 and march 2006
- development of inside patient education training between april 2005 and march 2006
- development of patient education structures (co-ordinator, relay,..)
- self estimation of patient education capacities

RESULTS

Will be available for the HPH conference in may 2006

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SESSION IV-3. WORKSHOP MENTAL HEALTH PROMOTION IN HEALTH PROMOTING HOSPITALS

Moderators: Jürgen M. Pelikan, Christina Dietscher

Due to the epidemiological and social relevance of mental health (at least one in five Europeans is affected by a mental disorder at any given time), this topic is high on the agenda of WHO and of the European Commission.

Hospitals are affected by this trend in several ways:

- Following WHO, one in four patients visiting a health care institution has at least one mental, neurological or behavioral disorder, and most of these conditions are neither diagnosed nor treated. But also for mentally healthy patients, the circumstances related to a hospital admission (e.g. fear, unfamiliar surroundings) represent a risk for mental ill health.
- For hospital staff, the hospital represents a risky work setting - physically, but also mentally. There is evidence that nursing and medical staff suffer from higher levels of stress than the average population. Also exposure to violence at work is an above-average problem in the health care field.
- Finally, hospitals can play an important role in mental health promotion in their communities, especially by raising attention and providing information, education and support against stigmatization.

In this situation, and following up on a workshop that was held at the 13th International HPH Conference in Dublin in 2005 (see report in HPH Newsletter 25), the workshop will provide an overview on past and current HPH activities in the field and will discuss possibilities to further develop action in the HPH network in the future. Options for setting up a task force within HPH or preparing an international project in the field will be explored.

Who should attend the workshop: The workshop addresses all health care professionals who are interested in mental health promotion in and by hospitals, and who would like to get involved in joint activities on an international level.

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SESSION IV-4. INTEGRATING HEALTH CARE INTERVENTIONS ON CHRONIC DISEASES ACROSS LEVELS OF SERVICES**THE AUTONOMY OF THE PATIENT WITH OUTCOME OF LESION OF THE UPPER MOTOR NEURON ALSO DEPENDS ON THE PRESERVATION OF MUSCLE LENGTH: EFFICACY OF THE SELF TREATMENT IN CHRONIC PATIENTS AND HYPOTHESIS ABOUT A PROGRAM OF PREVENTION SINCE THE ACUTE PHASE**

Isabella Campanini, Francesco Lombardi, Andrea Merlo, Guido Vezzosi

The upper motor neuron syndrome (stroke, traumatic brain injury and brain injury) is the first cause of chronic disease in adult population. In these patients, a pathological loop takes place between the presence of paretic, spastic and co-contraction components, the modifications of the rheological properties of the muscle and the development of altered postures. The following shortening of the muscle turn out to be one of the main factors of the reduction of the motor capacity in the everyday life. Thus, we thought that it was important to make the patient aware of the importance of preserving the muscular lengths and a method of following up and inclusion criteria in self-care project have been identified.

Instrumental investigation (gait analysis and dynamic electromyography) enabled us to select ten patients and to define their treatment. Physiotherapists performed the protocol of these stretching treatments. Results show up an improvement of the autonomy in walking.

A second project defined a protocol of self-treatment in an adult patient with cerebral palsy. After ten months of specific auto-stretching the patient recovered in the hip extension, thus reaching the capacity of standing and postural transitions. A following training led to the acquisition of the ability of walking by a rolling walker. Today this project has been extended to a group of chronic stroke, CP and TBI patients, that treat themselves according to a protocol which can put in act alone or with help of their families.

The next step to be done is the research of an actable program of prevention starting since the acute phase, made up on the interaction between patients, families and the hospital equipe (physiotherapist, nurses, doctors).

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INCLUSION OF PALLIATIVE CARE FOR MOTOR NEURONE DISEASE PATIENTS

Bernie Corr

INTRODUCTION

Motor Neurone Disease [MND] is a relentless neurological degenerative disorder affecting motor neurones for which there is no cure. The life expectancy following diagnosis with MND is 3-5 years. In Ireland one person dies from MND every five

days. The treatments are never curative so care is multidisciplinary and palliative from the time of diagnosis. Our aim is to promote autonomy, ensure dignity and enhance quality of life. Maintaining control is vital to the MND patient. The MND patient requires hospitalisation and the care of a multidisciplinary team in the acute stages. Liaison with hospital staff and the inclusion of palliative care can enable a patient to remain at home following this acute phase. Therefore, reducing the need for re-hospitalisation, maintain autonomy and enhances quality of life.

OBJECTIVES

This study was undertaken to determine the current utilisation of the liaison with hospital staff and the use of palliative care by the Irish MND population.

METHODS

Patients enrolled on the Irish Register for Motor Neurone Disease from January 2002-December 2004, were included in the study. Palliative care services were defined as those provided by a regional hospice centre, or by a recognised palliative care physician, in a general hospital keeping up the links with the hospital. Care was defined as at least one consultation with a Palliative Care Consultant, one visit by a palliative care Home Care Team, or one admission to a Hospice for respite, day care, or terminal care.

RESULTS

The number of MND patients who die at home is high at over 60%. The percentage of deceased MND patients, who accessed palliative care services, has increased from 20% in 1998 to 70% in 2004 reducing the need for re-hospitalisation. Palliative care staff also discussed specific difficulties they have in looking after MND patients.

The unpredictability of the course of the illness.

The very heavy burden of care.

The ethical issues regarding end of life decisions.

CONCLUSIONS

The management of MND requires a multidisciplinary team approach maintaining the link with the hospital however ensuring that Palliative

Care forms an integral part of the approach. Multidisciplinary management of MND can promote autonomy, enhance quality of life and increase survival.

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SERVING THE COMMUNITY - SECONDARY AND PRIMARY CARE TOGETHER - A SHARED HEALTH PROMOTION INITIATIVE

Suzie Loader, Don Sinclair

INTRODUCTION

Heatherwood & Wexham Park Hospital (HWPH) serves a diverse population including the town of Slough – one of the more deprived parts of South East England. The people of Slough, many of whom are staff in the hospital have historic high rates of heart disease, diabetes and lung cancer.

INTERVENTION

HWPH is working with its local Primary Care Trust (PCT) (who have trained members of the local population in community focused health promotion techniques) to deliver health promotion in a culturally sensitive manner to patients and staff. The Hospital identifies patients, relatives and staff for referral to 'weight management', 'healthy living' and 'smoking cessation' clinics sited at the hospital, staffed by primary care staff.

OUTCOMES

The numbers of attendees are monitored, and data is collected relating to: age groups, ethnicity, numbers of staff v patients etc. Advice is available on healthy eating and exercise or specific smoking cessation. The number who attend is monitored against the number who successfully lose weight, quit smoking, or demonstrate a qualitative change in knowledge, attitude and behaviour.

CONCLUSION

This project began in January 2006, as a collaborative venture between two organisations. We believe that it demonstrates effective joint working between two organisations who hold the same philosophy aiming to empower staff and patients to take responsibility for their own health. The outcomes of the project will be reported at the conference and on a quarterly basis to the East Berkshire Health Promotion Forum to ensure it continues to be effective.

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ROLE OF PRIMARY CARE PHYSICIANS IN A MODEL OF INTEGRATED OUT-PATIENT CARE FOR DEMENTIA

Guido Federzoni, Gaetano Feltri, Susanna Casari, Carlo Alberto Goldoni, Andera Spanò

The increasing burden of patients with dementia has prompted the local government of Emilia-Romagna to deliberate the "Regional Dementia Project" (1999). The design includes specialized out-patient clinics with competencies for diagnosis and care planning.

PROBLEMS AND GOALS

In line with the regional project, the Local Health Agency (LHA) of the Province of Modena and representative associations of primary care physicians (PCP) have established a protocol of intent to promote early assessment and diagnosis of dementia, correct referral to specialized clinics and a standardized clinical management.

The main aim of this agreement is to improve the quality of life and health of demented individuals and their carers, permitting patients to remain at home as long as possible, and to promote the governance of dementia patients by the PCP, given the long and chronic course of this disease. The PCP is often the family physician as well, and is ideally poised to evaluate the impact of the disease on family life. The specialized referral clinics offer diagnostic competencies and consult for specific problems.

METHODS

The protocol consists of two phases: in the first phase, when the PCP suspects a diagnosis of dementia, he/she administers simple, standardized screening tests, such as the Symptom of Dementia Screener (S.D.S.) to the caregiver and the Mini Mental State Examination (M.M.S.E.) to the patient to tap cognitive competencies. Somatic morbidity is evaluated by the 'Indice di Severità di Malattia' (I.S.M.) checklist. Functional status is quantified with the Activities of Daily Living and Instrumental Activities of Daily Living (ADL/IADL) scales. Lastly, the PCP prescribes blood chemistries and instrumental examination, as suggested by international diagnostic guidelines.

When the S.D.S. score is >6 and the MMSE score is <27, the PCP refers the patient to the specialist; after the diagnostic work-up the patient returns to the referring PCP with a care plan and advice for future management. As needed, the family may be referred to a psychologist, for individual or group support.

In the second phase, the PCP will track the illness with a yearly multidimensional assessment. In addition, the PCP stages the emotional and psychological distress of the carers to identify the need for psychological or social support. As needed, the PCP can enrol the patient in the "house-call" home care service.

RESULTS

A total of 288 physicians have participated (54% of all PCP in the public health service of the province). The mean age of the 2826 patients enlisted was 82 years; mean MMSE score 11.92; median somatic comorbidity was 4 diseases; mean

ADL 2.6. One third (31.2%) of the case series was not taking psychotropic agents; one half (53.5 % took one, 14.7% two, and 0,6 % three classes of psychoactive agents (neuroleptics, antidepressants, and cognitive enhancers –anticholinesterase inhibitors). A total of 72.7 % subscribed to one or more home health care services.

In order to keep patients in their home or community as long as possible, specialist services will support the PCP for the management of critical situations during the course of the disease.

A syllabus of continual education in psychogeriatrics for the PCP and service of psychological family support is in progress.

RECCOMANDATIONS

Referral to the specialist centers by the PCP has for the most part been correct. It is necessary to simplify the protocol for referral, providing greater emphasis on clinical history than standardized tests. On the other hand, follow up of the disease is best handled by standardized instruments. The exchange with the specialist services and PCP must be improved to facilitate sharing of information and redirection of the support of the specialist more towards the PCP and less directly to the family.

CONCLUSIONS

Primary care physicians have the competencies to address the problem of dementia and correctly manage the patient and family over the course of the disease. This experimental protocol permits better integration of the Primary Care Physician with the network of specialists, social workers and both in- and out- patient services for dementia.

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PROMOTING HEALTH AND MANAGING LONG-TERM CONDITIONS AT HOME. PATIENT INVOLVEMENT AND CASE MANAGEMENT

Kostakis Christodoulou, Charlie Clerke, Moira Sugden, Steve Tall

Aims and objectives

- To reduce hospital admissions by 5% by 2008.
- To immunise 70% of over 65s.
- To redefine the approach to chronic disease recognising that professionals and patients have complementary knowledge and experience.
- Care management rather than acute intervention should be the focus.
- Move away from disease and cure.
- Develop the concept of long-term conditions and support.
- Maximise independent living.

Outcomes

Set up Expert Patients Programme

Groupwork support for people with long term conditions to enable them to become key decision makers in the treatment process. Six groups run so far with 97 participants.

Community Matrons

Case management role to identify people with multiple and complex conditions and at risk of hospital admission. Carry out an holistic assessment and actively manage their care, with treatment at home wherever possible. Four Matrons newly in post currently managing 35 cases.

Flu immunization campaign in support of healthy living

An Action Plan set up to deliver immunisation to people over 65 using pharmacies, schools and GPs, with local publicity and an Advice Day event to target hard to reach groups.

Chronic Obstructive Pulmonary Disease Pathway

A multi-disciplinary pathway across primary and secondary care set up to manage patients in the community, and reduce hospital admissions. Community Spirometry Clinics to support 817 existing and an estimated 1128 un-diagnosed patients.

Practice Based Commissioning

Devolve budgets to GPs to commission services directly tailored to patient's needs, and to provide a wider variety of services. GPs forming into clusters to share specialities and develop community based services as alternatives to hospital care. Five GPs engaged in national pilot to build and spread best practice.

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BRINGING PROFESSIONALS TO THE SAME TABLE: A PARTICIPATORY APPROACH FOR CONTINUITY OF CARE ACROSS DIFFERENT LEVELS OF SERVICE

Alessandro Campani, Manuela Furlan, Francesco Niccolai

In Italy patients with severe chronic conditions are often treated, for acute events or for check-up, in a third-level Hospital; then they need to be taken in charge by a local second-level service (called Local Health Authority), in order to assure domiciliary care, diagnostics, social support.

These patients have to interact continuously with both the Hospital and the Local Authority; it's critical for different health-care providers to manage these patients, and continuity of care is seriously threatened.

The prevailing approach to address these problems is "clinical pathways", conceived as a tool to satisfy the needs of patient in an integrated way, putting together the professionals from different specialities and roles.

But up to now has been underestimated the potential conflict between different professional cultures, in particular between hospital clinicians and primary care clinicians; thus the clinical pathways are often perceived as set of bureaucratic rules imposed by management.

The University Hospital of Pisa is an acute care Hospital, serving a wide-area covering the North-West part of Tuscany. Residents in metropolitan area of Pisa refer, for primary and secondary care, to the Local Authority. Both these providers have decided to face the problem of continuity of care through a participatory approach, with the support of researcher from Healthcare Management Laboratory.

Clinicians having a different role across the path of the patient, and belonging to both the different healthcare providers, have been put together in a training setting. A precondition was that the professionals worked on communication processes. Then they have compared the as-is process of care with customer needs (originating from focus group) and they have selected and shared some improvement initiatives, following the principles of patient involvement and education. Some examples: an informative leaflet for all the inpatients given out before discharge; a toll-free number to keep a contact with healthcare staff of the Hospital; a reengineering of the process to obtain healthcare facilities.

These results have been shared with the management and the improving actions are just now tried out and implemented.

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