Integrated Services in Rehabilitation - on Coordination of Organisation and Finance

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1. Introduction

In December 2001, the European Parliament and the Council agreed on a Community Action Programme to encourage cooperation between Member States to combat social exclusion. The objective of the Programme is threefold:

- first, to improve the understanding of social exclusion and poverty with the help in particular of comparable indicators;
- second, to organise the exchange of good practice and promote mutual learning in the context of NAPs/inclusion; and,
- Third, to help key social actors active in fighting poverty and social exclusion to build up their capacity and to promote innovative approaches.

One of the instruments applied in this programme are Peer Reviews, a series of multilateral evaluations of different social inclusion policies. Peer reviews should encourage mutual learning and transferability of the most effective policies from one Member State to the others.

One of the projects which are subject of peer reviewing in 2006 is the Swedish programme on "*Integrated Services in Rehabilitation – on coordination of organisation and financing"*. In this approach various stakeholders on local or regional level, operating in the field of social insurance, health care, social welfare and labour market/employment, provide funds and create an infrastructure for better cooperation and service provision to disadvantaged groups. A major aim is to improve (early) rehabilitation of persons on long term sick leave or unemployment. One project in this coordination programme that actually will be reviewed is the Delta Project in Gothenburg/Hisingen.

This discussion paper aims to give a summary of the Delta project, as well as a preliminary assessment of this policy. We will sketch main features of the project and present issues related to the basic policy, implementation and results. Subsequently, we will discuss (European) comparative aspects, including experiences and insights from other countries. Finally, a list of key questions will be presented for the meeting early December 2007, in which experts from other Member States will discuss and exchange experiences with the Swedish experts or participants in the Delta project. This list further may provide suggestions to experts from other member states when describing and evaluating similar programmes or policies in their own country.

2. The Delta project: main dimensions, experiences and evaluations

2.1. Main dimensions of the Delta project

From the Swedish documentation including the "host country paper" we extracted some information on major features of the project.

Aim

The Delta project was launched in 1997 as one of six projects within the framework of the 'Soc-sam' legislation. Aim was to see whether collaboration would be more effective in helping people who have been ill or unemployed for a long time. Many people in these groups need support from different authorities and thus risk falling between two chairs. The purpose of Delta is to give them a better reception, treatment and quality of life.

The project deals with (overcoming) demarcation problems and improving cooperation among the actors concerned. As is the case in many countries the responsibility for rehabilitation is divided among various sectors and stakeholders. Consequently, rehabilitation may be hampered by con-flicting priorities, lack of coordination or communication and inadequate planning. Improved coor-dination is necessary to meet the rehabilitation needs more efficiently and effectively and in order to restore the ability to engage in gainful employment. Furthermore, coordination should reduce duration and costs of sickness absence.

Participants and funding

Stakeholders participating in this collaboration project are:
- local social insurance offices,
- the health and medical care services,
- the municipal social services,
- the county labour board and local public employment service offices.

Delta's budget consists of funds made available by these participating authorities. The funds have been pooled in a joint budget and then distributed by a coordinating body, the so-called "Coordi-nation Association". This is a legal person in public law with legal powers. Its task is to define goals and guidelines, and to finance measures in accordance with the aims set for the coordina-tion. It also financially supports the coordination activities between the collaborating institutions. The association does not make decisions on benefits or rehabilitation measures.

Organisation

The association is supported by a secretariat as well as (currently) 1.5 "process facilitator". Each Delta based activity or project further has a project coordinator, some project assistants and a steering committee (comprising -where possible – local line managers from participating authori-ties). This staff retains its contract and payment from its employer.

Financial coordination is considered as the structure for dealing with collaboration and coordination issues, not a model for organising the activity itself. This may be done e.g. by co-localisation (same premisses, joint reception area).

Target groups and targets

The targetgroup of Delta includes people suffering from a combination of medical, physical, social and work-related problems, so persons in need of coordinated rehabilitation interventions. Currently in Sweden this target group comprises about 280 000 persons (5% of the working age population). In Hinsingen annulally about 4000 residents make use of Delta activities.
Goals formulated for in the Delta project are:

- reduce costs and suffering due to sickness absence and unemployment,
- make the asessment and treatment process shorter and more effective,
- eliminate bottlenecks which lead to passivity (being dependent on benefits),
- combat long-term unemployment and support vulnerable groups,
- broaden skills and knowledge of relevant personnel groups.

Activities

Since it's inception in 1997 over 25 activities have been undertaken in Delta. Ongoing activities can be divided into three categories:

a. *Preventive and promotional activities,* which aim at sickness absence prevention and combatting social exclusion. Instruments applied are: interviews and discussions, theme-based sessions, group activities as wel as dissemination of information and education;

b. *Socio-medical activities,* included in the so-called "Early and Coordinated Rehabilitation Programme", have as objectives:
   - reduce waiting times and shorten treatment periods;
   - speed up RTW (Return to Work);
   - enhance professional knowledge (and thereby increase effectiveness of interventions) by inter-professional and cross-sectoral assessments.

These activites are carried out by inter-professional teams in (currently) six primary health care centres. The expert added to the team comes from the social security agency, and – in some cases, from the social services. The teams use clearly defined formats for inter-authority collaboration; team compositions and working methods vary according to local conditions.

c. *Occupational activities:* they aim to get people back into work more quickly, or into the right rehabilitation programme with less delay. Activities must reduce passivity and contribute to increased self–confidence and self–awareness of the client.

   Uncoordinated reception/intake, or lack of rehabilitation planning were addressed by the creation of the "Labour Market Plaza". This means co-locating activities in inter-authority teams, as well as conduct joint surveys, guidance activities and follow ups. The Labour Market Plaza is run by the social services and the local Public Employmet Service office; they share the same premisses and have a joint reception area.

2.2. Evaluations

From the peer review proposal we quote:

"Delta has been evaluated by Gothenburg and Karlstad Universities. According to the evaluation, collaboration has worked well both for the residents of Hisingen and the staff, as well as benefiting the economy. The great majority of the participants were satisfied with the Delta projects and felt better. Many of them have returned to work or have embarked on studies that they finance themselves. Social assistance costs have been reduced more in Hisingen than the rest of Gothenburg. The cost of the Delta collaboration programme in 2002 was SEK 73.3 million, which should be compared with the savings made in social welfare systems. The main injection of funds came from the owners. All in all, the period 1999-2003 showed a positive accumulated net outcome".

Early evaluations mainly regard Delta's effect on personnel (a common approach emerged, knowledge and skills increased, new communication pathways used) and a tentative estimate of impact on cost developments.

Effects on users (patients/clients) have been systematically explored by Hultberg[1], who had the opportunity to compare Delta centres with non Delta centres as to processes and outcomes. The main *aim* of her study was to assess if co-financed collaboration between primary health care, the social (sickness) insurance offices and social services contributed to improved care and rehabilitation for people with musculoskeletal disorders. Patients (N=136) with musculoskeletal disorders attending three health centres with co-financed collaboration (Delta health centres) were compared to similar patients attending four control health centres not practicing collaboration. The project also involved a comparative qualitative study on staff-perceptions of the collaborative structure in Delta and control health centres.

Results show that staff in both Delta and control health centres reported fairly well functioning internal collaboration. But only staff at Delta health centres reported well-functioning collaboration with social insurance offices. However, working methods seem to have changed only marginally, and the social insurance officer, although present at the centre, was not significantly more involved in preventing sick leave, than in the non-Delta centres. The author suggests that the model led to a new interdisciplinary team structure, but not to new team work.

No significant differences between patients in the Delta centres and the controls were found as to change in health status or mean number of sick leave days. The placing of social insurance staff (expected to affect the handling of sick leave certificates) did not show any reduction of sick leave days compared to controls. Patients in the Delta health centres had more contacts with physiotherapists than the controls, which received more of some types of occupational therapy. Contacts with the social insurance office, social services or hospital did not differ significantly between the groups. The type of treatment the patient received only differed slightly between the groups.

The author *concludes* that staff involved in the Delta centres perceived that the model was important for the collaborative process and that it had stimulated new interdisciplinary team structures. However, the follow-up studies of patients indicated that there were no major differences in the care and rehabilitation approaches, or treatments received, between Delta

[1] See: http://www.ub.gu.se/sok/dissdatabas/detaljvy.xml?id=6480 and http://www.fou.nu/is/sverige/document/lpr/397

and control patients. The only clear difference was that Delta patients received more physiotherapy than controls. The study faces some methodological limitations (sample size, observational design), so the data should be interpreted with caution (and may not be generalized beyond rehabilitation of people with musculoskeletal disorders).

3. A provisional comparison with policies and practices in other countries

3.1. EU policy perspective

Employment is considered as the most critical factor for social inclusion of people with disabilities. The European Employment Strategy aims – among other things - to contribute to more personalised tailored policies, as well as a shift from long term benefit dependency to active labour market measures.

In the Disability Action Plan the commission aims to reinforce the involvement of stakeholders and key players.[2] In the first phase of the implementation of this plan (2004 and 2005), the employment related priority actions contain as a (first) topic: access to and retention in employment, including the fight against discrimination. Also the open method of co-ordination stresses adequate participation of stakeholders.

In the light of these objectives and policies the Delta model can be considered as an effort to remove barriers to the integration and participation of people with disabilities in the labour market. More specifically: barriers related to programme implementation and service provision. The Delta model is an innovative approach in increasing the integration into the labour market of disadvantaged groups. The model also aims to meet specific elements of revised European Employment Strategy, namely:

- better access to active labour market measures;
- Improve the offer of personal assistance and guidance when necessary.

As far as we can see no more specific objectives or recommendations have been expressed in EU policy regarding involvement or cooperation of stakeholders.

3.2. Coordination and cooperation: problems and "solutions" examined in literature.

Also in some other EU countries the past decade pilot projects and experiments have been started to address coordination and collaboration problems in the service delivery to persons with disabilities or on long term sickness or unemployment benefit.

This is a relatively recent tendency, at least in the area of policies to reduce sickness absence levels and expenditures. Until a few years ago the core research on sickness absence and RTW (Return to Work) measures focussed on the type and timing of interventions (medical, social, work related, benefit related).[3 & 4] Incidentally attention was paid to the role of waiting periods in health care, or the impact of inadequate medical treatment ("iatrogenous sickness absence").

[2] Equal opportunities for people with disabilities: an European action plan (Commission, 2003).

[3] Bloch, F.S. & R. Prins (Eds.) *Who Returns to Work and Why? A Six-Country Study on Work Incapacity and Reintegration*, International Social Security Series , Volume 5, Transaction Publishers, New Brunswick/London, 2001.

Problems in the area of cooperation between professionals and agencies dealing with employment, rehabilitation and RTW recently have received a more prominent place in literature. Initially recommendations regarded the need for (better) communication between agencies involved, or better knowledge of the competencies of other professionals involved. As an illustration the (in the Dutch and UK literature well known) recommendation can be mentioned, stating that health care professionals should no longer neglect the importance of work for their patients well-being[5]: work is "generally therapeutic and an essential *part* of the rehabilitation"[6] Recently rehabilitation experts from the USA and Canada reviewed literature and identified various lessons on stakeholder involvement in rehabilitation (including questions like "is involvement from all stakeholders necessary?").[7]

The need for coordinated stakeholder involvement seems particularly to be discussed regarding RTW for persons with *mental health problems*, a category of clients which is increasing in most EU member states. Regarding the range of measures applied there still is few evidence based information on impact and effectiveness.[8] Coordination problems are prominently mentioned in one of the few available literature reviews. In their report "Job retention and mental health: a review of the literature" Thomas et al. compare models and services that are relevant for job retention services, namely:[9]

1. *Employee assistance programmes*, provided by the employer, which include counseling and allowing employees free and confidential access to mental health professionals. Originating from the USA these programmes are relatively new in the UK and primarily are a form of easily accessible stress intervention. They provide help to employees while working and are a source of advice for the management of health problems within the workplace;

2. *Social process models*, in which a "job retention worker" has four roles: source of information to the work place (about the nature of the disability), interpreter (of work place policies and procedures to persons with disabilities), negotiator (helping to secure adjustments in tasks and work site) and trainer (to supervisors and others, how to accommodate persons with disabilities);

3. *Case management approach* to both vocational rehabilitation and job retention which involves having a central worker who facilitates and maximizes communication between health services, employment services, employers and other relevant agencies. The case manager needs training in vocational, rehabilitation and employment issues.

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4 Alexanderson, K. & A. Norlund (Eds.), *Sickness absence – causes, consequences and physician's certification: A systematic literature review by the Swedish Council on Technology Assessment in Health* Care, Stockholm, 2004.

5 HM Government, *Health, work, wellbeing: caring for our future*, London, 2006.

6 Waddell, G. and A.K. Burton, *Concepts of rehabilitation for the management of common health problems*, DWP, 2004.

7 Franche, R-L, R. Baril, W. Shaw, M. Nicholas, P. Loisel, *Workplace-based Return-to-Work Interventions: optimizing the role of stakeholders in implementation and research*, Journal of Occupational Rehabilitation, Vol. 15, No. 4, December 2005.

8 Prins, R. & W.Heijdel, *Disability benefits due to mental health problems, an overview of figures and measures in six countries*, Beiträge zur Sozialen Sicherheit, Forschungsbericht Nr. 7/05, Bern, Bundesamt für Sozialversicherung, 2005.

9 Thomas, T., J. Secker, B. Grove, *Job retention and mental health: a review of the literature*, London, 2002.

When compared on various criteria some form of case management (#3) appears to be the most effective means of support for both employees and employers, "as they provide a holistic and integrated support system for clients".

3.3. Other reforms in the organization of rehabilitation service delivery

Not only in Sweden but also in some other EU member states the last decade initiatives have been taken and - in some cases - well documented and evaluated, which aim to tackle the same problems as the Delta model: poorly planned and fragmented rehabilitation measures or service delivery to vulnerable groups with health problems. Two examples are sketched here; the Peer Review will give the opportunity for more thorough comparisons, exchange of experiences and (common?) lessons.

United Kingdom: Pathways to Work

When considering the aims, process, outcomes and evaluations of the Delta project some parallels with the Pathways to work Pilots show up. From October 2003 in 7 Jobcentre Plus districts pilot projects were held, aiming at reducing of the number of persons claiming or receiving work incapacity benefits. Clients are offered a combination of various assessments (e.g. work focussed interviews, screening) and services to improve labour market readiness, which are provided by personal advisers. These services are given in cooperation with local health providers, with the objective to help the client in his/her management of their disability. Work resumption and employment is further supported by providing the client financial incentives, like a (Return to Work) credit. Regular statistical information on customers, tools applied, jobs entered and benefit payment completions allow a monitoring of the pilots. Special attention is paid to "how other stakeholders can help", which refers in particular to employers, insurers and general practitioners. The performances of the pilots are reported to be very encouraging in terms of outflow from the benefit rolls and entering employment.[10]

Netherlands: The client as coordinator

A somewhat different approach has been added to the repertoire of measures applied in the Netherlands. From 1998 – 2002 pilot projects have been carried out, which provided vouchers to persons receiving a (long term) disability benefit. The vouchers aimed to empower motivated benefit recipients to make a programme for return to work themselves, and acquire the services needed on their own. The regular stakeholders involved (social insurance agency, employment service) deliberately had a restricted role. The "personal reintegration budget" users showed to be relatively well educated; the services they purchased were more tailor made, compared to the services provided in the "regular" rehabilitation and employment programmes. As work resumption rates were comparatively high, in 2004 the programme (with several adaptation), has been introduced nation wide, and also for unemployed (now called "IRO: Individual Reintegration Agreement"). The budget costs are about 10-40% higher that the expenditures per client in the regular programmes, but placement rates (employment) are 20% - 80% higher than in the regular programmes.

[10] Blyth, B. *Incapacity Benefit reforms: Pathways to Work pilots performance and analysis*, DWP, Working Paper no. 26, 2006.

4. Initial assessment and some questions

Relevance

Although the size of the category of persons with multiple problems (health, social, unemployment) is comparatively small, in particular this category of clients suffers from a problem which more and more is addressed in social policy: fragmented rehabilitation and lack of cooperation in service delivery. In general several agencies and professionals are involved in the provision of health care, benefits and rehabilitation to persons with health problems, and poor planning, communication and collaboration are becoming more and more subject of discussion.

The Delta model seems to be *one of the earliest and well documented attempts* in Europe where awareness has been “translated” into addressing the problems in stakeholder involvement. Moreover, substantial evaluations were held, be it with restrictions as to design (control group design could only be applied in the Hultberg study), methodology (self assessments of staff involved), or monitoring (on client case level) of the activities of all stakeholders involved.

Evaluations and prospects

The analysis by Hultberg indicates that teamwork as such was not very developed in the Delta Centres. This is intriguing, as favourable financial conditions for teamworking are there. What are the backgrounds that this opportunity has not (or only moderately) been used? Could lack of tamwork be due to organisational factors like lack of staff (vacancies), time pressures, or do external factors account for it, like long geographical distances?

Regarding the target groups defined at the start of the model project it would be interesting to know, whether some sub categories of client/patients are more fitting or “sensitive” to the Delta approach than others (e.g. persons with mental health versus clients with musculoskeletal related restrictions). What can be said about the employment/social position of clients under the new model, compared to the old situation?

Finally in the light of the research evaluations made an insight into further prospects of the model may be interesting: have the original problems, that gave rise to the (pilots and) model, been improved in a way that the authorities involved will increase the budgets for the collaboration? Currently up to 5% of the budget of each of the four authorities involved in the model is spend to this model.

Scope of collaboration

An interesting feature of the Delta model is the content and scope of the (financial) collaboration. The pooling of budgets, targeting of activities and financing of coordination and collaboration activities seem to be the core issues of the model. The Delta philosophy does not intend to direct a change *working procedures* in service delivery: it merely aims to facilitate the development of well functioning collaboration structures. It also seems not to be intended to test alternative ways of *individual case management*. The documentation indicates that quite some variation can be observed in the actual processing of rehabilitation measures. It would be interesting to know whether – after the experiences collected – the actual business processes and instruments used

on individual case level should or have been adapted (as is the case in the Pathways to Work model). Did some stakeholders get mandate from others to decide on issues that are in the province of other stakeholders?

Important stakeholder missing?

As working conditions and employers' attitude affect the success of rehabilitation programmes, cooperation with the work place representative (employer) is an important factor for work resumption. Hultberg observed that work place visits "were very rare in both the Delta and the control group". Some countries (e.g. the Netherlands, Norway) recently increased the responsibility of employers regarding sickness absence management (financial incentives, compulsory provision of RTW-plan).

The Delta model seems to pay little attention to *the involvement of the employer* (or occupational health service). Based on research more and more the viewpoint is supported that "work has the potential to be part of the recovery process"" (Thomas et al., Waddell). In a leaflet for health professionals it is recommended that "supervisors should keep in touch with employees on mental ill health sickness absence at least once every two weeks".[11] Have workplace based RTW interventions (e.g. adaptations of work site, job, working time) been applied? Although the financial structure of the Delta model would make *financial* participation of the employer complicated, the question can be stated how the employer is involved and should be involved in the RTW activities.

Professionals in a multidisciplinary team

Traditionally rehabilitation is often considered as a separate second stage process, carried out when medical treatment has been completed. It however more and more is advocated that rehabilitation should be an integral part of good clinical and occupational management (Waddell, et all). As the Hultberg study indicates, health care providers involved in the project showed some reluctance as well as time constraints regarding participation in the multidisciplinary team approach and making use of the services of the (added) non-medical professional in the centres. Moreover, the social security office expert participating in the teams, did not show a more intensive contact frequency with clients. As this study suggests participating in a one location team is one thing, working in a multidisciplinary way is still something else. Multidisciplinary collaboration and team work put some requirements on participants. Which lessons have been learned regarding what is needed in this area: is some additional training needed (e.g. on the competencies of the other participants), a cooperative attitude, enough motivation, extra time for collaboration, etc.? Which lessons have been learned to make maximal use of the presence of other professionals in the team?

[11] BOHRF, Systematic review of workplace interventions for people with common mental health problems, 2005.

Supporting facilities

Implementation of better planned and coordinated Return to Work programmes also needs some technical support. The documentation provided does not give a full insight into the experiences with facilities that may show to be supportive. Two important facilities which often are mentioned in operating rehabilitation programmes, are *information or public awareness campaigns,* focusing on the target groups and *monitoring of processes and outcomes* (data base, inter programme client monitoring, performance indicators. In particular when comparisons with less coordinated approaches are possible (as the Delta approach is voluntary) adequate data collection and reporting could be very useful. Which experiences and lessons have been learned on communication and monitoring?