Danish Ministry
of Social Affairs and Inclusion

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International Workshop

Service Delivery Systems for Assistive Technology in Europe

Copenhagen, May 21-22, 2012

Findings of the Working Groups and of the Plenary Discussion

(not revised)

WORKING GROUP 1: "ORGANIZATIONAL MODELS"

Facilitator: Tuula Hurnasti (Finnish National Institute for Health and Welfare)

Rapporteur: Peter Cudd (Barnsley Hospital NHS Foundation Trust, UK)

Research Questions

- How should the ideal system be designed so as to promote innovation, AT market and to meet the citizens' needs?

Main findings

- Users and innovators can meet\communicate (see 'Sophisticated system…') – e.g. face to face meetings or 'placements in real life provision\support'.
- Users are empowered and get enough information to make informed choices
- Free choice of solutions that meet the individuals needs – remove barriers to innovation (e.g. sanctioned lists)
- Getting the needs out there : use a reality channel to advertise needs and reward innovation (Dragon's Den); Internet; a person seeking innovations by visiting end users (possibly happening in Sweden) AND connected to 'what is available'
- Sophisticated system to support communication between users and stakeholders, experiences and needs capture, and, help users identify solutions' – semantic search, natural language processing, expert system (e.g. combine EASTIN + AskSara + Realise, www.reaisepotential.org)
- Linking AT to the public procurement of innovation, industrial innovation programme – Pre-commercial procurement.
- Users and innovators can meet\communicate (see 'Sophisticated system…') – e.g. face to face meetings or 'placements in real life provision\support'.

Unabridged notes from the discussion

- Preliminary remarks
  - Service providers are between 'end users' and inventors\manufacturers
  - Is the end user in control of their life or are they purely in receipt of the professionals choice of AT ?
- Users' point of view
  - They do not know what is available, possible
  - Bad experiences are strongly demotivating
  - They should be involved, lead even. It takes time, they need to share their needs\knowledge
  - Inclusive – single channel to meet their needs = life needs not separated health from social, etc.

- User panels to drive innovation but linked with stakeholders
- Empowerment through direct communication with peers; caution about possible difficult
- Technology and 'people' based services
- Local postbox for ideas
- AT Innovation Facebook
- Periodical questionnaires
- Getting the needs out there: use a reality channel to advertise needs and reward innovation (Dragon's Den); Internet; a person seeking innovations by visiting end users (possibly happening in Sweden)
- Connect the above to EASTIN

- Researchers'\innovators' point of view
  - Don't want to disclose their ideas
  - Identify the real need – be lead by user requirements
  - Knowledge of the market – economically and user acceptability and effectiveness
  - Innovate use of existing solutions, innovate service (provision) – ecological
  - Fast tracks to market – supported process
  - Independent researchers test the innovation to certify it is suitable
  - Sharing experiences

WORKING GROUP 2: "EXPERTISE"

Facilitator: Evert-Jan Hoogerwerf (AIAS Bologna Onlus, Italy)

Rapporteur: Dominique Archambault (Université Paris 8, France)

Research Questions

- How to ensure the user influence in selecting AT?
- What are the appropriate professional roles within an ideal system?
- What should be the appropriate educational standards?

Main findings

- The service delivery system should be able to provide appropriate services for different needs
- level of complexity of the problem of the user
- level of knowledge, awareness and decision making ability of the user
- expected level of complexity of the solution
- More flexibility in the AT delivery system to cope with competence of end users (for instance avoid costly evaluations for simple needs expressed by users)
- The rehabilitation process should empower the user to make him/herself a specialist
- Specialists should have the attitude to make themselves as much as possible unnecessary, nevertheless making sure that high level expertise is available when needed.
- The role of people with disabilities in AT service delivery should be enhanced, e.g.: peer support in the selection process
- AT service delivery should start with individual rehab plan. Technology should be functional to the plan and never be a goal in itself.
- User must have a more active role in the whole process. E.g. integration of self assessment reports and user evaluation reports in the service delivery process, in order to take better into account environmental factors and personal goals.
- Need for independent advisory centers to address more complex needs

- People who are delivering AT service have different backgrounds, they can develop their AT skills. Part of the AT skills is to be aware of their knowledge limitation and able to ask for advice when needed, and be aware that ICT and AT does not solve all problems and that used improperly they can lead to aggravating a situation (e.g. frustration).
- AT should be included in initial education of professionals, e.g. medical doctors
- In order to facilitate harmonization across Europe, good practices should be identified and codified (minimum standards of good service delivery?).
- To avoid fragmentation of the knowledge base, we should create resources and tools for gathering and dissemination of knowledge, that can be as well used and contributed by users, administrations and stakeholders.

WORKING GROUP 3: "EFFECTIVENESS"

Facilitator: Gert Jan Gelderblom (Zuyd University, The Netherlands)

Rapporteur: Terje Sund (NAV, Norway)

Other participants: Renzo Andrich Italy; Alena Galadova, Slovakia; Ase Brandt, Denmark; Erland Winterberg, Sweden; Nina Lindqvist, Sweden; Kaija Jotela, Finland; Heidi Antilla, Finland; Zoltan Nagy, Hungary; Jan Spooren, Belgium; Eero Kyllonen, Finland

Research questions

- what are the appropriate outcome indicators for an ideal system?
- What are the appropriate cost indicators ?
- How should cost-control/containment methods be appropriately implemented, such as public procurement procedures, recycling processes, etc.?

Main findings

- Steps in a service delivery system (from the Heart Study): initiative, indication, typology, selection, authorization, delivery, use, service / after sales
- Service delivery system effectiveness: combined effect (black box) of effectiveness of AT device and effectiveness of service
- Effectiveness: maximise outcomes of use; optimise outcome of service; minimise costs
- Notes on Research Question 1 (What are the appropriate outcome indicators for an ideal system?)
- Indicators should be based on participation/ICF indicators
- Objective: achievement of objectives (e.g rehabilitation targets, waiting times)
- Subjective: User perception. Satisfaction (e.g user perception of the services received)
- Examples of instruments: Quest 2.0 (satisfaction), Nomo 1.0 (effectiviness), FABS/M (effectiviness of mobility devices in term of participation), IPPA (problem solving)
- Notes on Research Question 2 (What are the appropriate cost indicators ?)
- Cost analyses are related to resource allocation and not to individual decisions
- Cost of the individual solutions (e.g.Social costs over time)
- Cost of the process of service delivery (efficiency of the service delivery)
- Notes on Research Question 3 (How should cost-control/containment methods be appropriately implemented, such as public procurement procedures, recycling processes, etc.?)
- Recycling of assistive devices (measured as % of total number of provided devices)
- Framework contracts
- Lean methods (to optimize the service delivery process)

PLENARY DISCUSSION

Facilitator: Renzo Andrich (Don Gnocchi Foundation, Italy)

Research questions

- Roadmaps for improvement and sustainability (vision 2015): what should be implemented and what should be avoided ?

Main findings: what should be implemented

- Evidence based AT services – research-based information
- Sharing Knowledge/ contents (eg. good practices and case studies)
- Basic AT education in medical professions
- Authorities must be open (very complex area, no single method would solve problems); it is difficult to get evidence in all areas of this field
- Similar practices in all areas of a Country
- in system with decentralization knowledge may not be present where needed. Central knowledge bases would be useful to prevent fragmentation.
- AT evaluation based on ICF
- Build the individual project in relation to what the user wants to do
- Life user needs should be addressed not separately from the AT programme
- EU wide disability ACT that defines basic standards in service provision and cross-country evaluation
- AT service provision is a profession: there should be education, the labour market is asking for it
- Easily accessible Info system (brochures, protocols etc)
- Need to join international expertise
- Training and education at all levels (from AT for dummies to high qualification)
- Quality assurance schemes
- Infrasctructure of independent information centres to support change
- Budgets established based on needs and not on AT categories
- European indicator systems of the situations in the various Countries
- Harmonisations of the various systems

Main findings: what should be avoided

- Changes not based on knowledge
- Leave the user out of the process
- Reinventing the wheel
- Tendency to go back to strict medical model
- Increase the gap between those who can afford AT and those who cannot
- Dependency on political changes
- Unrealistic attempts to make a single EU system