

# Care as a shared practice

*Exploring how healthcare systems can move from fragmentation  
toward unified understanding*



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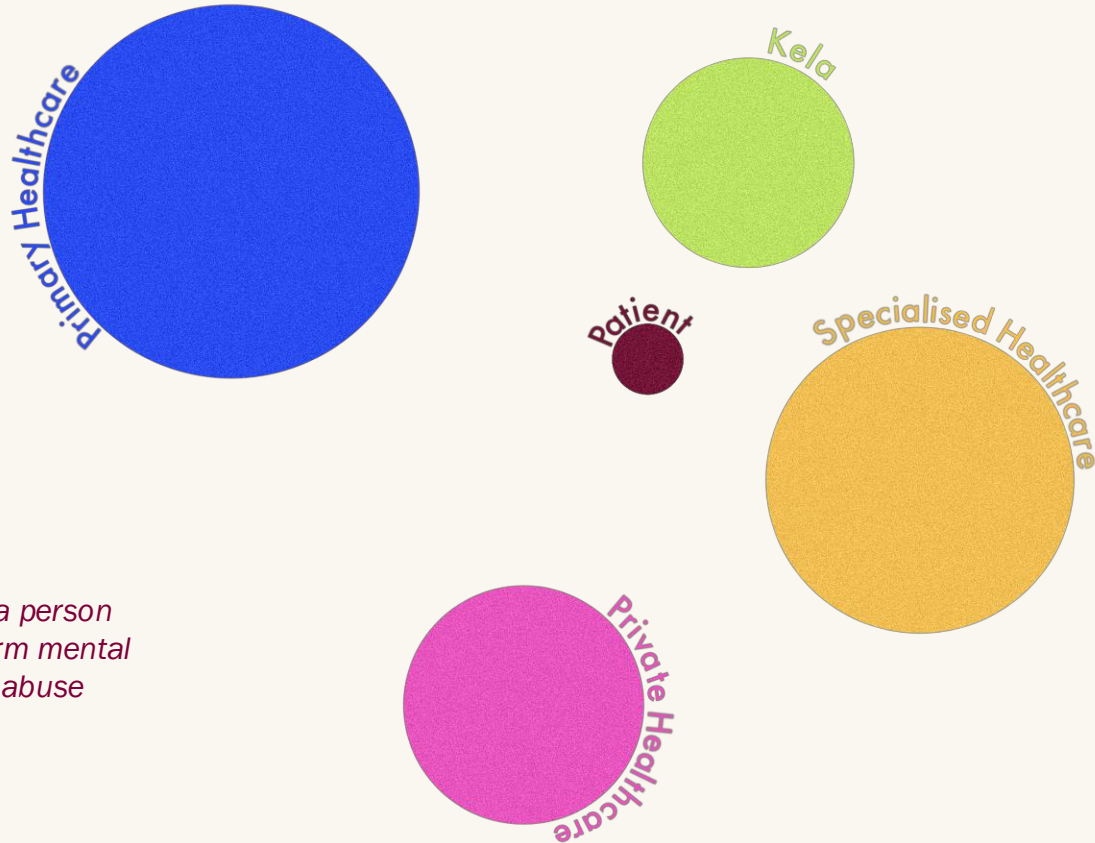
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*Creative Sustainability CHEM*



**Vulnerable patient** = a person suffering from long-term mental health and substance abuse problems



Definition of care:

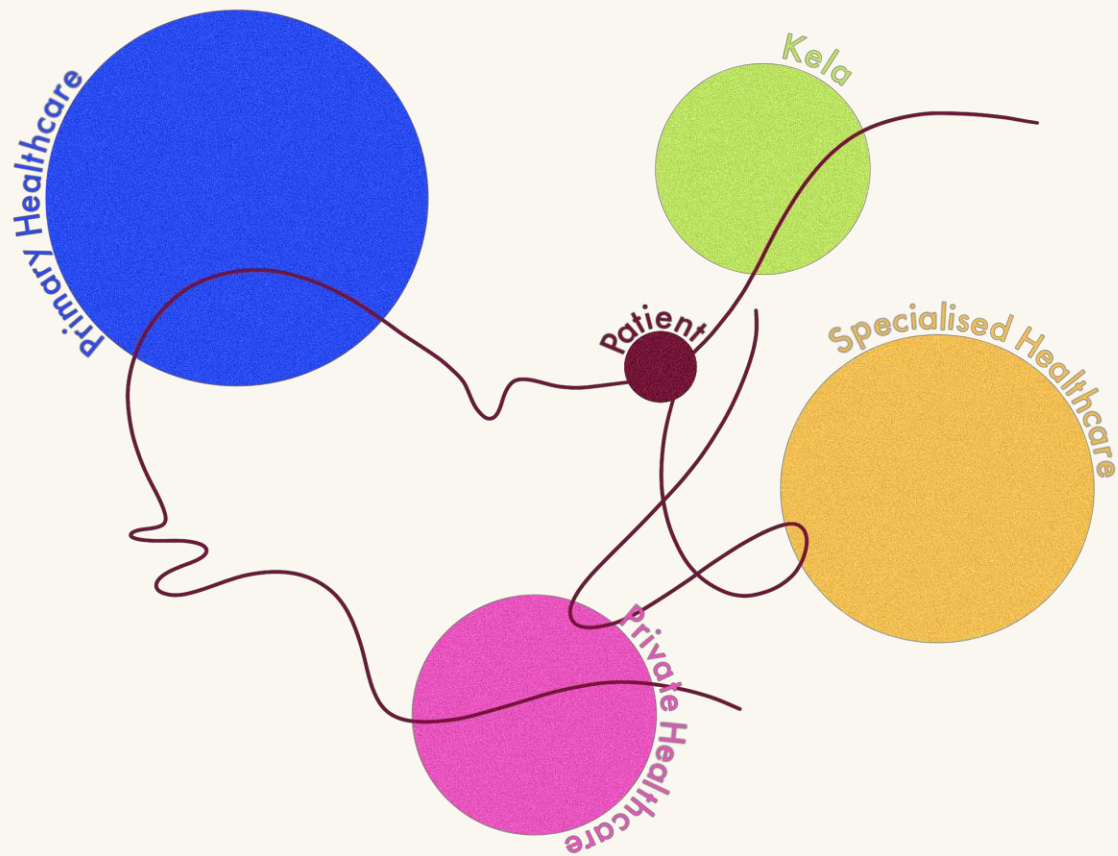
**“The process of protecting someone or something and providing what that person or thing needs.”**

*Synonym = responsibility, guidance*

(Cambridge Dictionary)



Current issue:





## Yhteisen asiakastietojärjestelmän käyttö alkaa 17.3.

12.3.2026 10.38 Päivitetty:13.3.2026 15.06



KUUNTELE



TRANSLATE

Länsi-Uudenmaan hyvinvointialue ottaa käyttöön yhteisen asiakastietojärjestelmän. Ensimmäisenä järjestelmä otetaan käyttöön 17. maaliskuuta Espoossa ja Kauniiaisissa mm. sosiaalipalveluissa, kotihoidossa ja asumispalveluissa. Käyttöönotto saattaa aiheuttaa tilapäistä hitautta palveluissa.

*“The Western Uusimaa Wellbeing Services County will gradually transition to using the Lifecare Client and Patient Information Systems by the end of May 2026.”*

(Länsi-Uudenmaan hyvinvointialue, 2026)



Tiedotteet ja uutiset

Kolumnit

Päätökset

Tapahtumat

Ohjeet, suositukset ja yleistiedoksiannot

Tilaa aineistoja

Uutiskirjeet

STM sosiaalisessa mediassa

Avoimet työpaikat

suomi [svenska](#)

## Omalääkäri, omahoitaja, omatiimi vai ammatinharjoittaja? – Hoidon jatkuvuuden monet mallit

sosiaali- ja terveysministeriö  
1.10.2025 10:59 TIEDOTE

Tällä hetkellä kaikilla hyvinvointialueella on jo käytössä tai vähintään kehitteillä malli, jolla pyritään parantamaan hoidon jatkuvuutta perusterveydenhuollossa. Vaihtoehtoja ja yhdistelmiä on useita: hoidon jatkuvuutta on tuettu esimerkiksi osoittamalla paljon palveluita tarvitseville omahoitaja-

*“At the moment, all Wellbeing Services Counties either already have in use, or are at least developing, a model aimed at improving continuity of care in primary healthcare. [...] The purpose of the “omalääkäri” programme launched in spring 2025 is to encourage wellbeing services counties to develop and implement models that meet regional needs.”*

(Ministry of Social Affairs and Health, 2025)

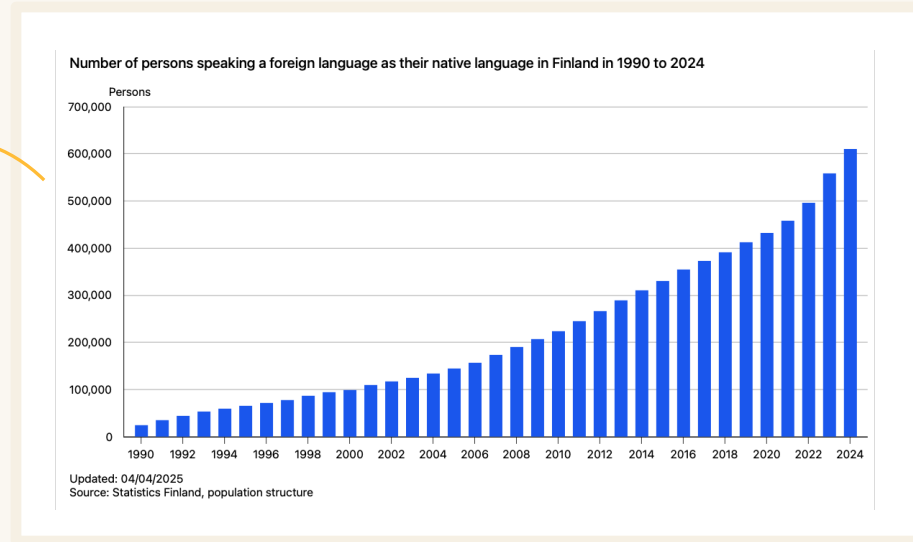


- Increasing linguistic diversity in Finland is exposing gaps in communication



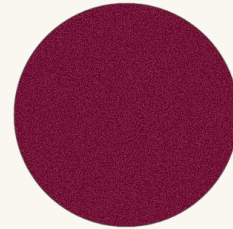
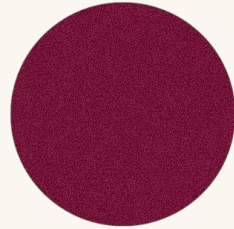
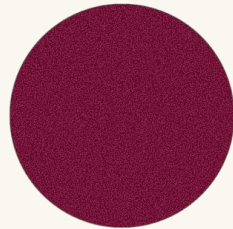
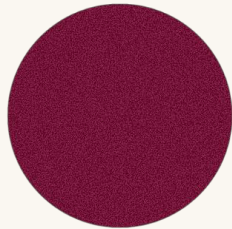
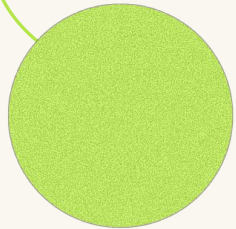
***“The number of foreign-language speakers exceeded 600,000 during 2024.”***

(Statistics Finland, 2025a)





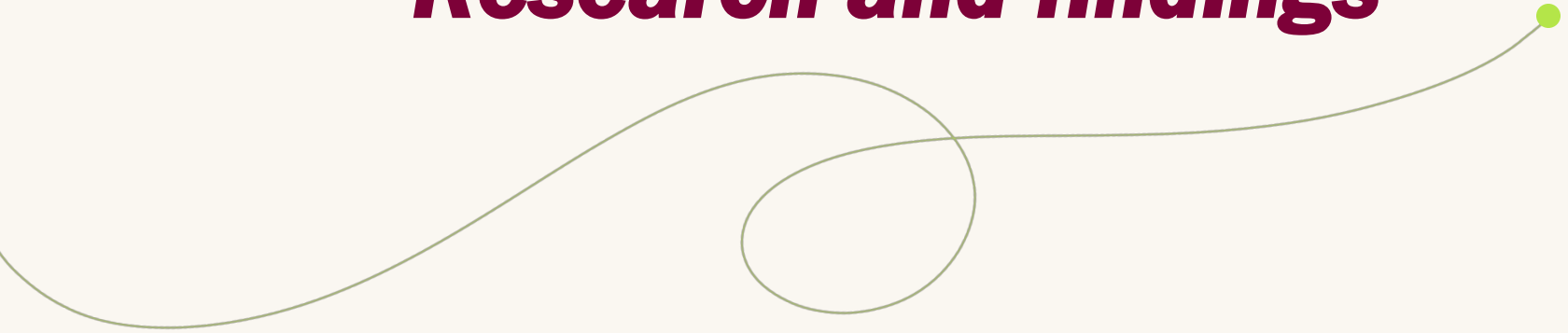
One in six people in Finland speak another native language than Finnish



(Statistics Finland, 2025b)



# ***Research and findings***





**Understand internal  
languages of care  
institutions**



Continuity of  
Understanding  
2026

***better care  
for all***

Continuity of  
Knowledge  
2025

Continuity of Care  
2024



*Desktop research: Three different perspectives*



**Patient**



**Provider**



**Administrative**

### Collaborative work with partners



### Interviews and fieldwork



#### Round Table Discussions

- **5 professionals** from Kela, HUS, and the Uusimaa Wellbeing Services Counties

#### Ideation Session

- **8 participants** from Kela, HUS, and the Uusimaa Wellbeing Services Counties

#### Early conversations

- **10 meetings** with healthcare professionals and representatives from Kela

#### Semi-Structured Interviews & Fieldwork

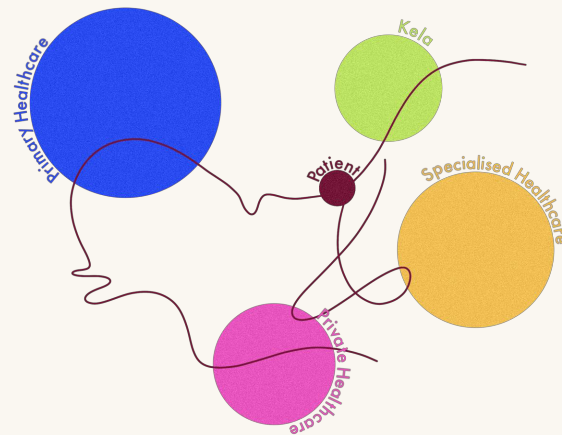
- **9 interviews** with healthcare professionals, experience experts, clients, and foundations

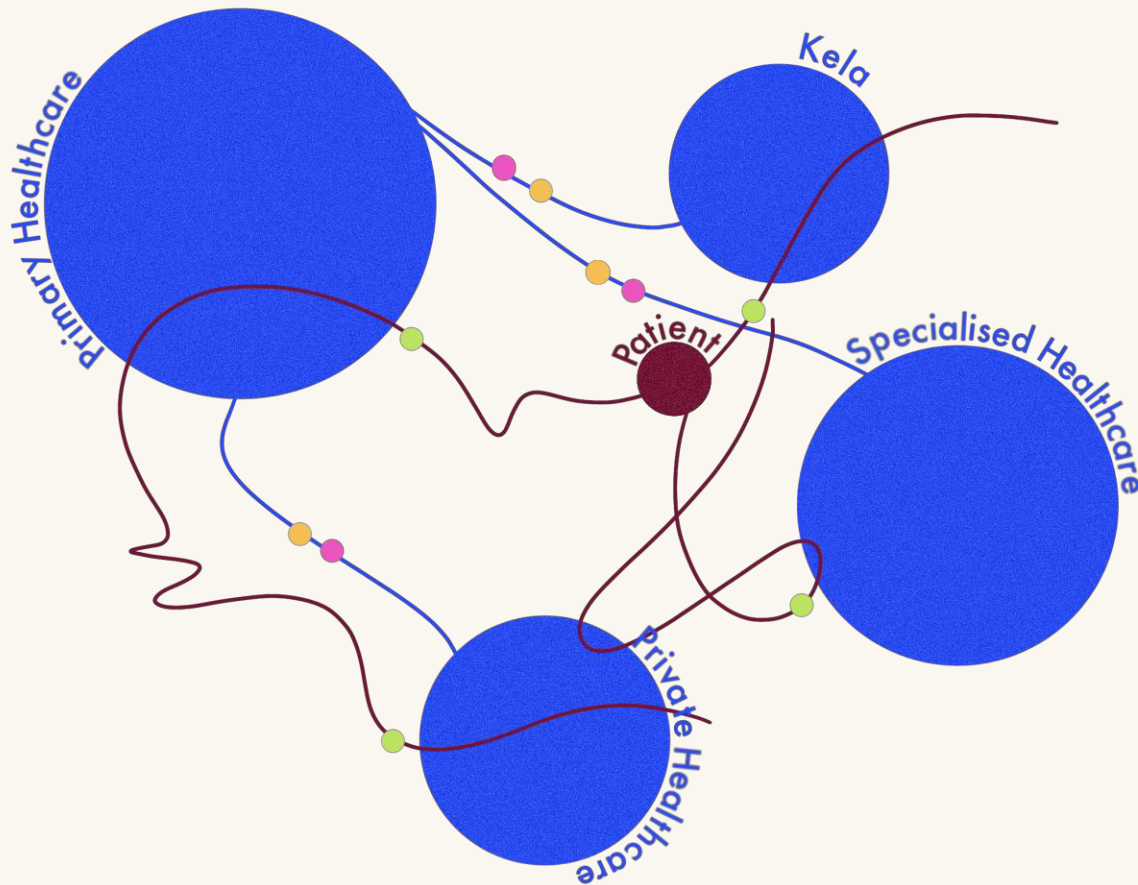
#### Mid-Term Presentation

- Presenting interim findings and meeting project partners



*Mapping patient journeys with professionals*





*Bottlenecks*

- *Multiple Systems*
- *Documentation Style*
- *Assessment Criteria*



## Insights from fieldwork

### 1. Multiple Information Systems:

Healthcare still uses many separate data systems due to its previously decentralized structure. Even after the creation of Wellbeing Service Counties this fragmentation remains and makes it harder to access patient information.

### 2. Different Ways of Communicating:

Miscommunications arise when patients receive care in multiple services because institutions have individual understandings of care and their own way of communicating with patients and other institutions.

### 3. Inconsistent Digital Services:

Digital services are working well in Finnish, but are still underdeveloped in other languages. This highlights how Swedish speakers have a clear disadvantage when seeking information.



*Uncovering underlying fragmentation...*

**Multiple information systems** ●  ● Fragmented **informational** continuity

**Different ways of communicating** ●  ● Fragmented **interpretive** continuity

**Inconsistent digital services** ●  ● Fragmented **accessibility** continuity



# ***Our proposal***





*Finland is striving towards "a sustainable and safe welfare society" where everyone can have faith in the future."*

(Ministry of Social Affairs and Health, 2026)



*Finland is striving toward **an equitable society** based on trust.*

*Achieving this requires a healthcare system that emphasizes seamless communication across institutions through standardized patient care summaries, transparent patient assessment criteria, and inter-institutional collaborations.*

*Together, these practices foster a culture of care grounded in **shared responsibility** and **holistic support** for every patient.*



Our proposal

# ***Intervention points***





## ***Standardization***

***“Patients feel that they often need to repeat themselves during the process”***

*(Social worker at primary healthcare - 2026)*



## ***Standardization***

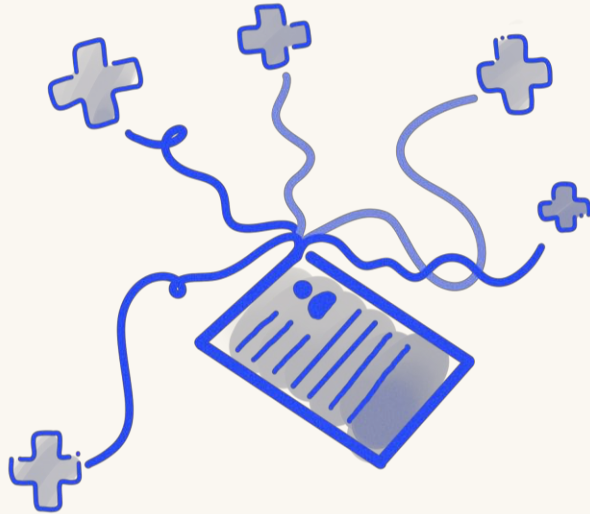
***“I get bounced around between healthcare providers,  
and I am told you cannot be here”***

*(Experience expert - 2026)*



## *Standardization*

# Unified patient information



Enabling more responsible and continuous care through a shared patient history overview.



## **Standardization**

### **Omalääkäri [personal doctor]**



Patient has a designated personal  
doctor from local healthcare service  
Provides long-term and holistic care

(Ministry of Social Affairs and Health, 2025)



## **Standardization**

### *Omalääkäri [personal doctor]*

Patient has a designated personal doctor from local healthcare service  
Provides long-term and holistic care

(Ministry of Social Affairs and Health, 2025)

### **Omapotilas [personal patient]**

Healthcare providers share responsibility across care path with a long-term vision of patient's history



## Standardization

# Standard patient information summary

Name: \_\_\_\_\_

Social security: \_\_\_\_\_

**Social:**

Housing status \_\_\_\_\_

Employment status \_\_\_\_\_

**Current care pathway:**

On-going treatments \_\_\_\_\_

Up-coming transition \_\_\_\_\_

**Last appointment:**

\_\_\_\_\_

\_\_\_\_\_

**Tests:**

\_\_\_\_\_

\_\_\_\_\_

**Diagnosis:**

\_\_\_\_\_

**Doctors note:**

\_\_\_\_\_

\_\_\_\_\_

Active institutions involved:

HUS IU LUVN KELA



## *Integration*

*“We don’t know based on what criteria other institutions make certain decisions for patients”*

*(Expert at a healthcare institution - 2026)*



## *Integration*

*“We do not get trainings for the patient assessment criteria.  
New employees are often thrown into work immediately”*

*(Senior expert at primary healthcare – 2026)*



## *Integration*

# Onboarding frameworks



Establishing frameworks that familiarize new employees with care pathways and assessment criteria that affect patients' long-term care.



## *Integration*

*Critical information training programs for new employees*



## *Exchanging perspectives*

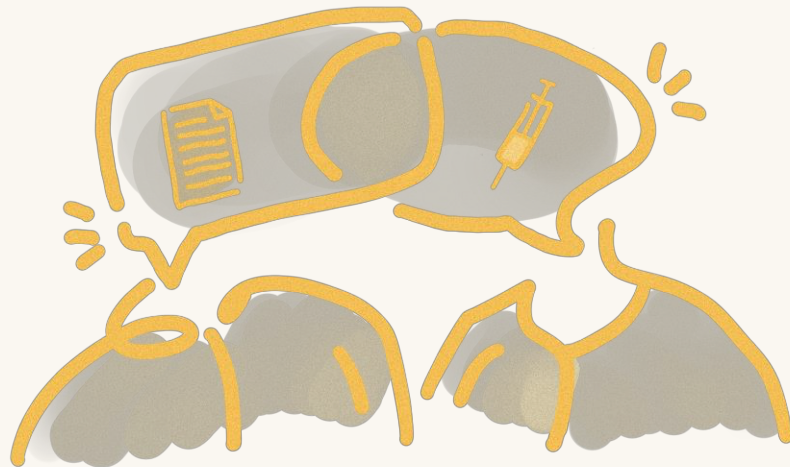
*“I work with the other care institution the best because  
I understand their criteria the most.”*

*(Social worker at primary healthcare – 2026)*



## *Exchanging perspectives*

# Knowledge sharing practices



Bridge institutional silos at the employee level through collaborative knowledge-sharing practices.



## *Exchanging perspectives*

*Exchange programmes such as shadowing or workshops across healthcare institutions.*



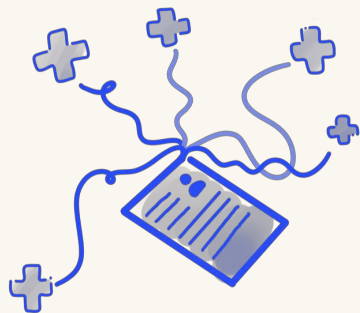
Our proposal

# ***Opportunities***





### **Unified patient information**



- **Earlier support** instead of waiting for problems to escalate
- **Quicker recognition** of patients who may be at risk
- **Reduced repetition of assessments** and administrative work
- **Greater shared accountability** in institutions, leading to consideration of **holistic wellbeing**

### **Shared responsibility**



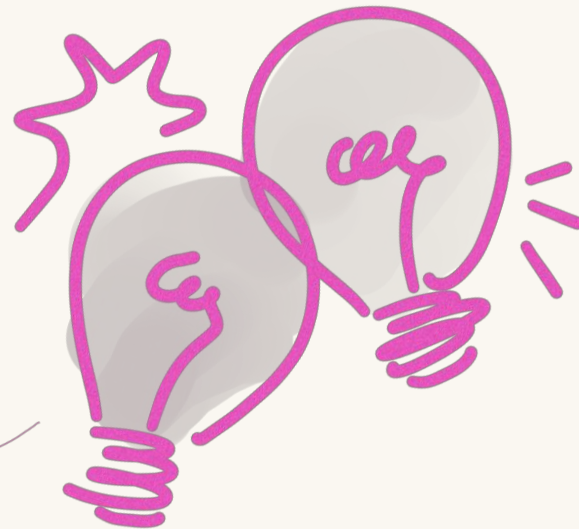


### *Onboarding frameworks*



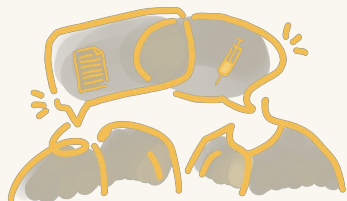
- **Professionals are trained to understand different care systems from onboarding**
- **More complete understanding** of patient pathways across time and place
- **Greater understanding** of each other's roles for the patient
- **Reduced misunderstandings** about assessment criteria

### **Shared understanding**





### *Knowledge sharing practices*



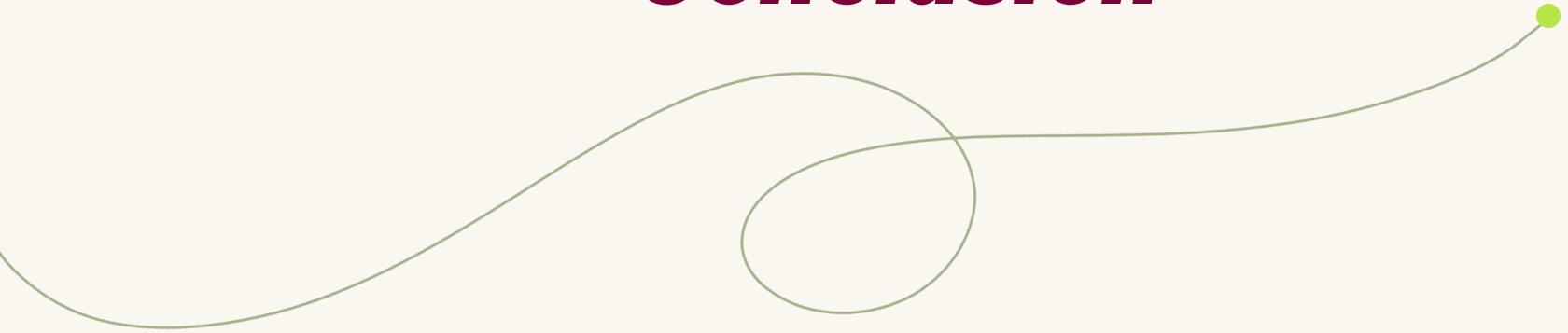
- **Continuous learning** through open conversation and reflection
- Stronger empathy between professionals
- Knowledge sharing helps **professionals learn from each other**
- Creation of a **health culture** based on listening and growing together

### **Continuous learning**



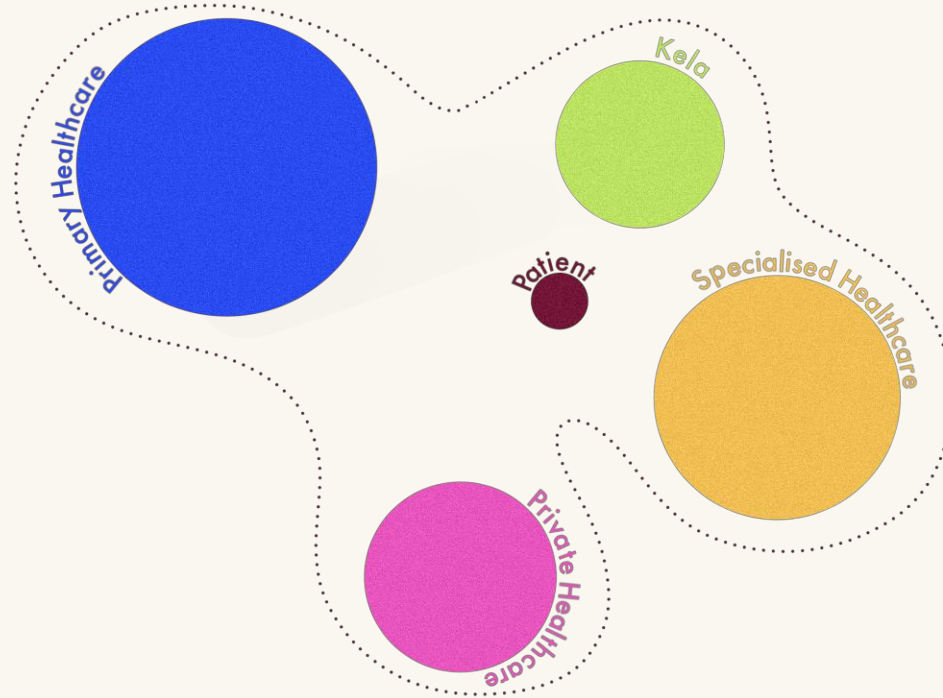


# ***Conclusion***





*When understanding is continuous, care can be continuous as well.*





***Thank you!***  
***Kiitos!***  
***Tack!***

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