Viljandi Hospital and Integrated Services

Building a connected health and social care ecosystem in Viljandi County

Krista Valdvee | Viljandi Hospital

Viljandi County: the operating environment

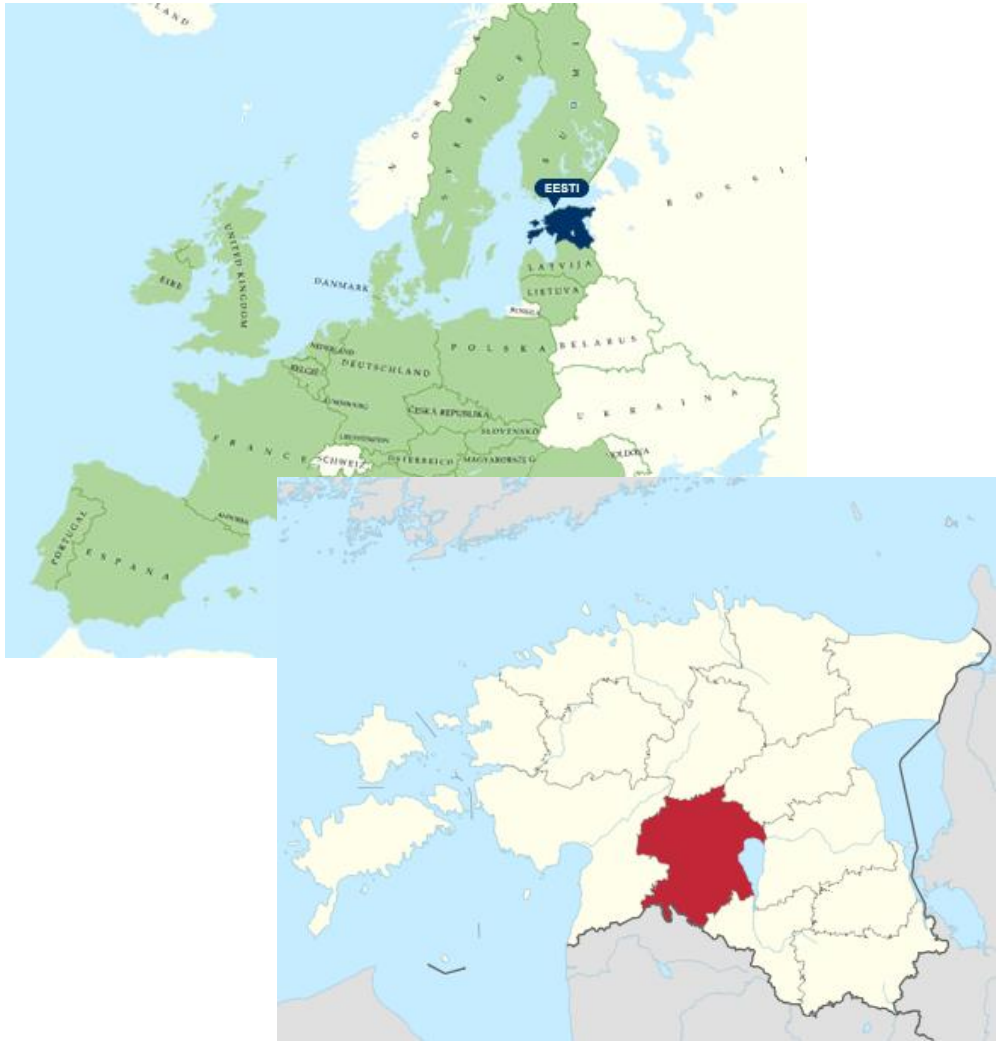
4 local municipalities

44,390 residents (1 January 2026)

25 family physician patient lists and

2 primary health centres

1 county hospital and 11 care institutions



Viljandi Hospital at a glance

Established in 2001 by merging Viljandi County Hospital and Jämejala Psychiatric Hospital

24/7 on-call coverage: emergency physician, internist, surgeon, anesthesiologist, psychiatrist and gynecologist

Services delivered in Viljandi and in several other Estonian locations

~82,000
specialist-care patients / year

~5,350
inpatients / year

~50
emergency patients / day

~1,200
employees

A broad continuum of care

Outpatient care and diagnostics

Emergency medicine and internal medicine

Surgery, intensive care

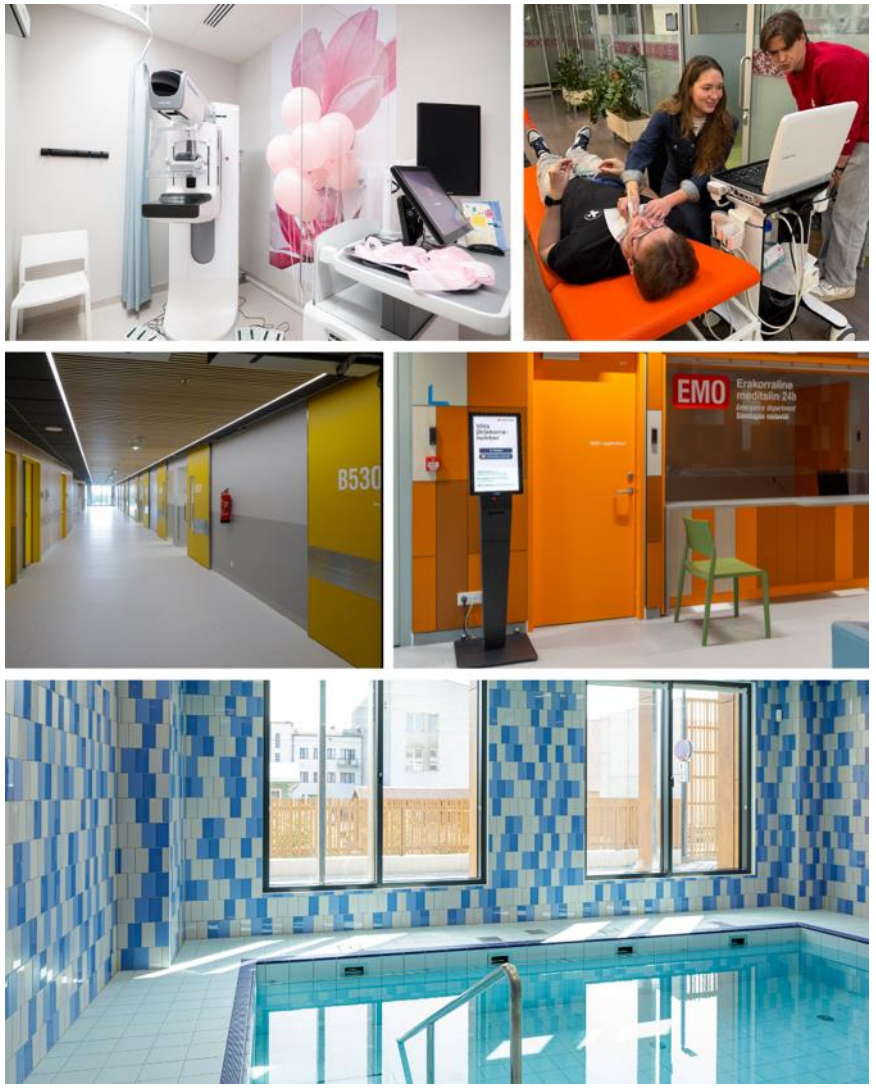
Maternity ward and gynaecology

Rehabilitation, nursing care and home services

24/7 psychiatric services

Special care services for people with mental health support needs

Addiction treatment and rehabilitation



Innovation is our mindset

Integrated Healthcare and Social Services – PAIK

Hospital at Home and Other Home-Based Services

Mobile Services

Collaboration with Cleveron – Parcel Locker Services

Tervikum: infrastructure designed for integration

- Family physicians and hospital services under one roof
- Healthcare services closer to the patient and easier to navigate
- New infrastructure for developing integrated services
- Shared bed-capacity principle
- Major improvement in functional logistics
- Modern patient service environment
- Opportunity to connect social services more closely with healthcare

The journey towards integrated services

2016–2017
Design of integrated health and social care

2018–2021
PAIK project Phase 1

2022–2026
Impact study of the integrated service

2026
County-level TERVIK collaboration

What do we mean by an integrated service?

Purpose: support people with chronic conditions and social challenges to cope at home

Target group: people aged 65+ with one or more chronic conditions and one or more social challenges

Health manager: a nurse or social worker who coordinates the network

Health plan: an agreed plan developed with the person and the professional network

The operating model: one person, one coordinated network

Family physician

Hospital specialists

PERSON + agreed health plan

Social services

Health manager = connector, coordinator and contact person

Home-based services

Collaboration with municipalities and family physicians

The health manager acts as the link and named contact person

Operational base: Viljandi Hospital’s home-services team

Presence in family physician practices: approximately one day per week or month

A shared information-exchange platform is still missing

Integration requires

shared responsibility

regular contact

clear coordination roles

information that follows the person

Thank You!
viljandihaigla.ee