Health care for people with most needs

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Health care in Norway in brief

Ministry of Health and Care Services

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Four Regional Health Authorities

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Hospital trust

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- Hospitals
- Ambulances
- Other specialist care and services
- Private specialist care

Municipal Council

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- Regular GP scheme
- Out of hours
- Home Care services
- Long term care
- Rehabilitation
- Preventive services
- Public Health
- Economic social support and housing

} Primary health care

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Most of health care, research and education build on the paradigm «one person – one disease»

Barnett K, et al. Volume 380, Issue 9836, 7–13 July 2012, Pages 37–43

- At age 65 and higher 2/3 got two or more chronic conditions
- In absolute numbers most people with multimorbidity are below 65
- Approximately 2/3 of the health budget goes to healthcare for people with multimorbidity

Persons with multimorbidity accounts for

52% (-70%) of the consultations in general practice

over 90% of persons enrolled in home care

60% of persons hospitalised

- Persons with multimorbidity are systematically excluded from clinical guideline research

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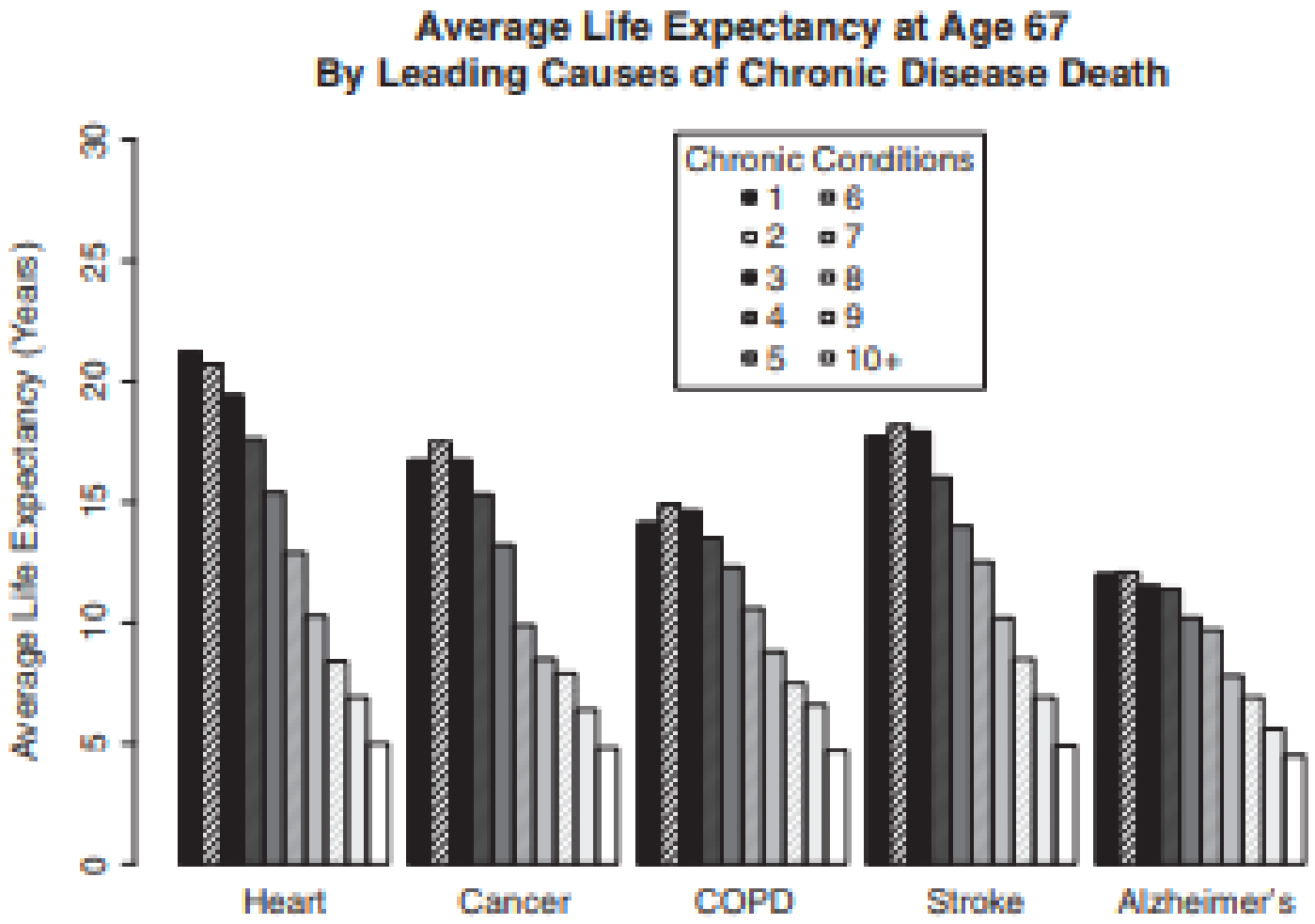

The more chronic diseases, the less relevant clinical guidelines become

DuGoff, E. H. et al. (2014). Multiple Chronic Conditions and Life Expectancy: A Life Table Analysis. *Med Care, 52*(8), 688-694

Primary care opposed the description of patients given by the pathway supervisors from the hospital

- *"We have to take care of the whole patient and all conditions, not only the reason for the hospitalisation"* (Case B)
- *"Older patients have many additional problems that the clinical pathways don't take into consideration"* (Case A)

Hip fracture

- Dementia 30 %
- Diabetes 20 %
- Heart failure 10%
- COPD 7 %
- Delirium 50 %
- etc.
- Frail 25 %
- Polypharmacy 50 %

Living home alone

- Functional ability:
  - physically
  - cognitive
- Nutrition
- Social network
- Living condition
- Safety
- Goals and preferences

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Large usergrups in hospitals “disappear” when discharged to primary health care

Standardised rate discharges per year home care patiens per 10,000 inhabitants per year			
COPD	Heart failure	Stroke	Hip fracture
22	13	11	12

If patients discharged are spread randomly into home care services, every nurse will experience:

- O,5 per year discharged for COPD
- 0,3 per year for heart failure
- 0,2 per year for stroke
- 0,4 per year for hip fracure

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Pathways and transfer of tasks to primary health care

- Disease-specific clinical guidelines hardly support the transfer and follow-up of people with multimorbidity and in need of care coordination
- The infrequent reception of patients in home care with important chronic diseases restricts the transfer of tasks to primary care
- Specialization of nurses in primary care for the follow-up of selected chronic diagnoses is neither feasible nor sustainable

Grimsmo A et al. Disease-specific clinical pathways – are they feasible in primary care? A mixed-methods study. Scand J Prim Health Care. 2018;36:1-9

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Or[illegible]ctive in[illegible]n and prevention

Shared decision making

Eg. depression, early dementia, heart failure, diabetes, side effects, more

← Shared decision making →

Early id[illegible]	[illegible]nation/va[illegible]uation	Planning intervention	Information, follow-up
• Case finding • Preventive home visits • Checklists • Predictive risk stratification	The patient's goals and preferences Home visit/living situation • [illegible]ssessment of functions • Medical assessment of underlying causes of functional decline • Medication review/deprescribing		

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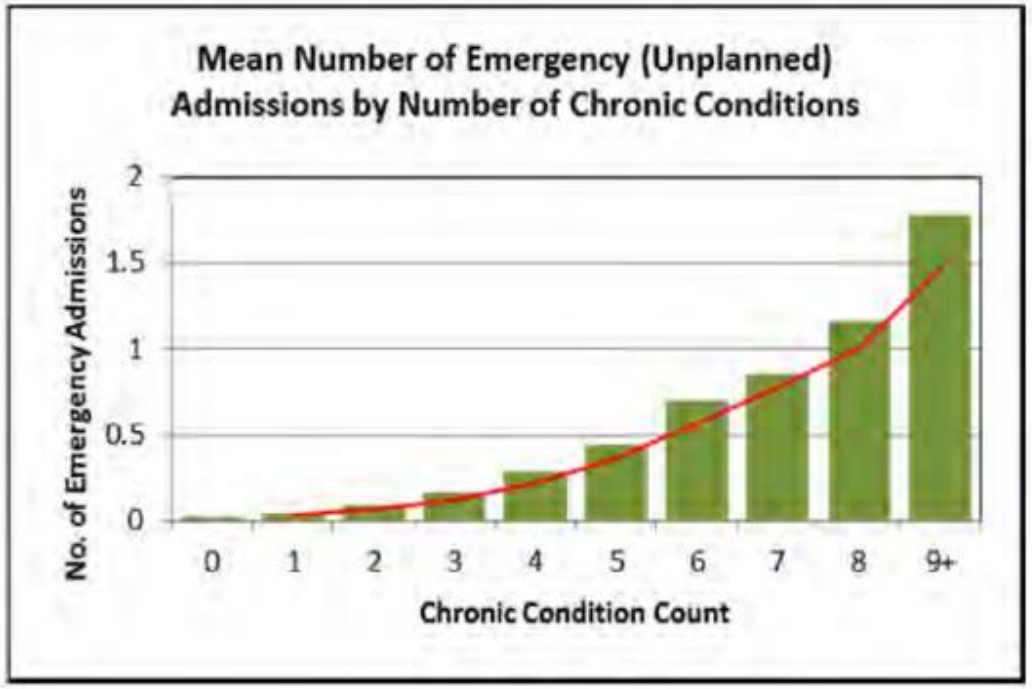
Number om chronic condtions is a good indicator of needs, risk of hospitalisation and life expectancy



Source: Central Southern Commissioning Support unit, NHS[119]

Average reduced life expectancy at 67 years of age compared to no chronic disease :

5 chronic conditions	8 år
10 chronic conditions	18 år

DuGoff, E. H. et al. (2014). Multiple Chronic Conditions and Life Expectancy: A Life Table Analysis. *Med Care, 52*(8), 688-694

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Functioning: 4 meter gate speed

Valid, reliable, easy to do, no costs, and with high predictivity:

- 5 to 10 years survival (generally from 65 years old)
- Early death and serious condition (< 0,6 m/s)
- Risk for falling, hospitalisation and long term institutional care

Litteratur: Cesari M. Role of gait speed in the assessment of older patients. JAMA. 2011;305(1):93-4

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Organising proactive intervention and prevention

	← Shared decision making →		
Early identification	**Examination/validation**	**Planning intervention**	**Information, follow-up**
• Case finding • Preventive home visits • Checklists • Predictive risk stratification	• The patient's goals and preferences • Home visit/living situation • Assessment of functions • Medical assessment of underlying causes of functional decline • Medication review/deprescribing	• Multidisciplinary planning a broad asessment • Increase functional ability: rehabilitation, muscle strengthening, and training skills • Risk reduction: e.g. prevent loneliness, malnutrition, falls, fire, isolation, etc.	• Self efficacy • Strengthening self care • Involve next of kin • Follow-up by telephone, home visits, or by volunteers • Day-care • Welfare services and welfare technology

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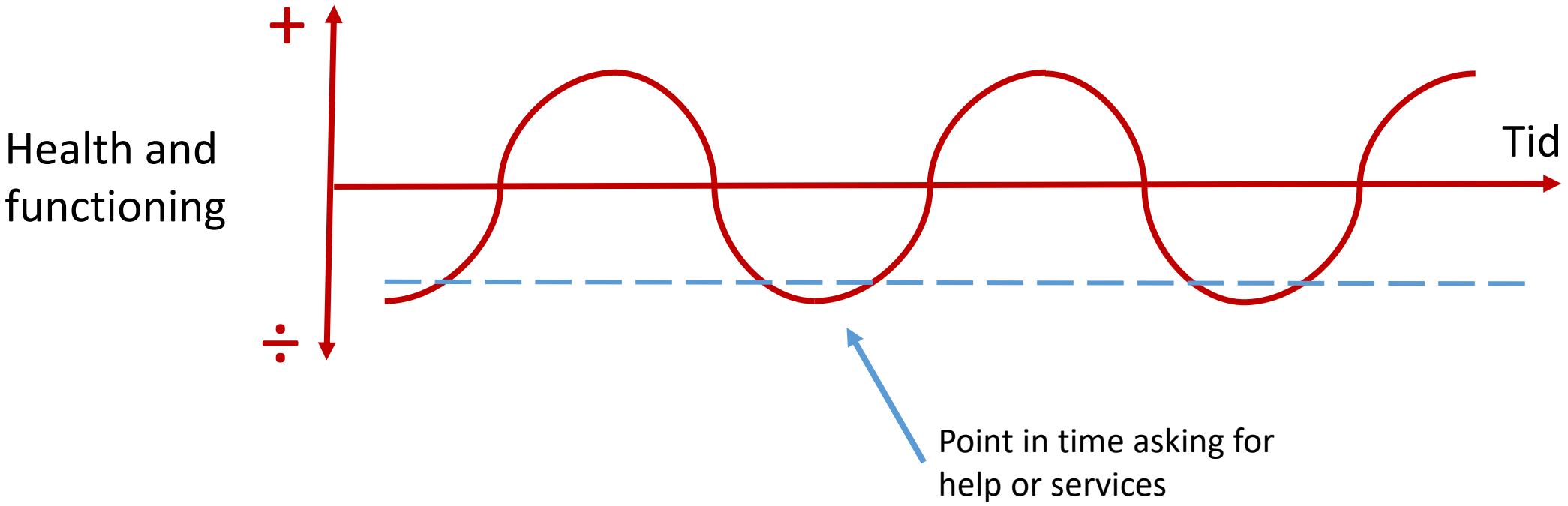
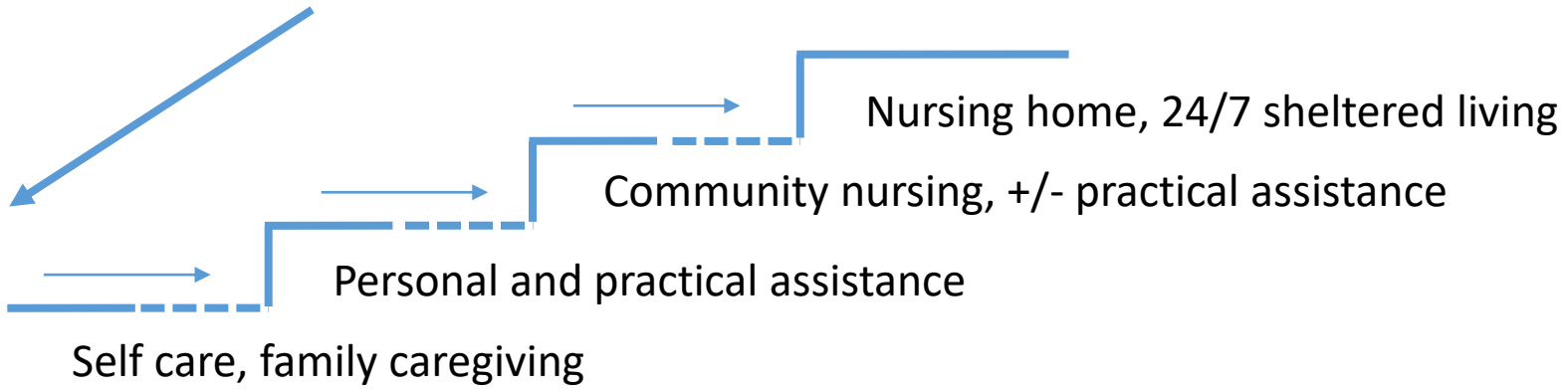
«Migration to the mean»



The community care trap

(Long term) assistant and nursing services



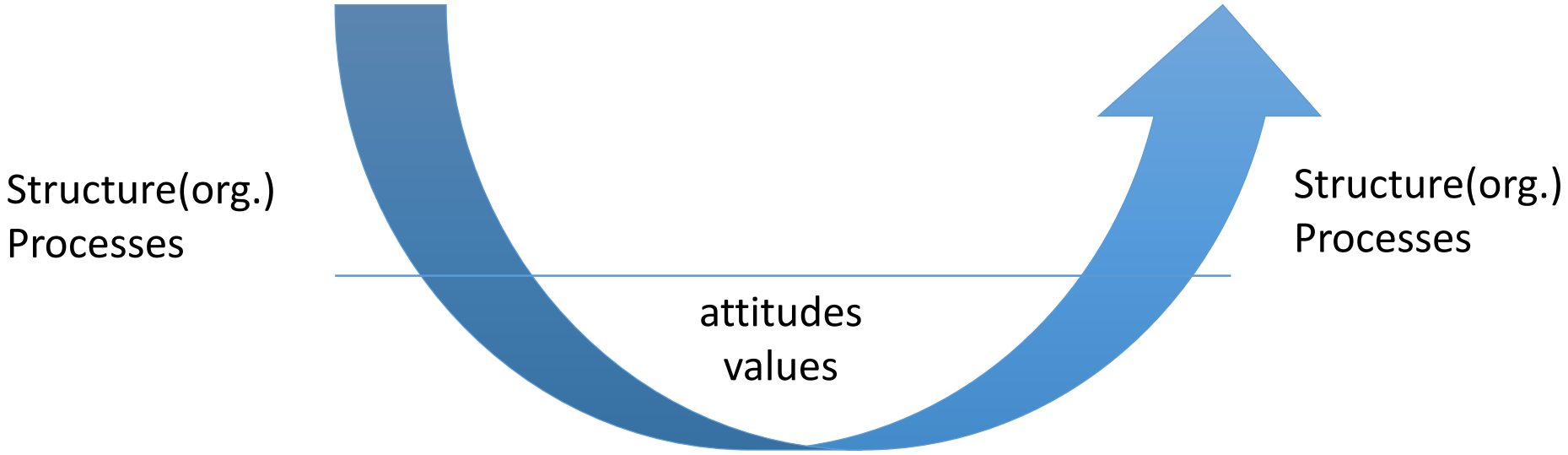
Short time limited interventions

Reablement
Risk reduction
Training
Prevention
Day-care
Transport
Welfare technology
others.

Mind shift

”What’s the matter?”

”What matters to you?”



From reactive pathway today

to proactive pathway tomorrow

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‘What matters to you?’ day - 6th June 2018

KS sent out 53,000 buttons to 191 municipalities and 40 hospitals.

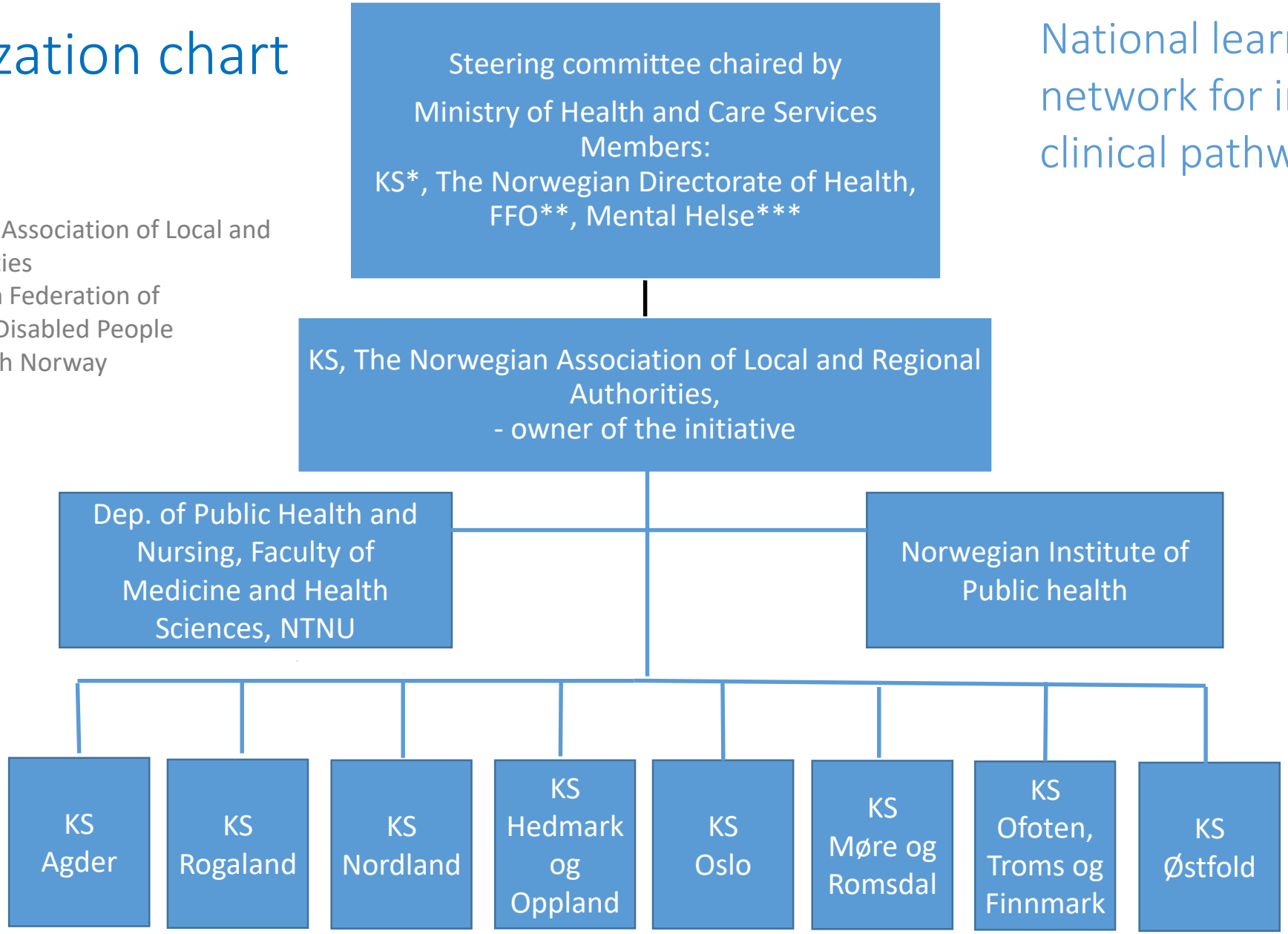
Many shared information in our Facebook group: Gode pasientforløp.

The initiative was supported by
- The Ministry of Health and Care Services
- The Directorate of Health
- Minister of Health, Bent Høie
- Minister for the Elderly and Public Health, Åse Michaelsen

Organization chart

National learning network for integrated clinical pathways

* The Norwegian Association of Local and Regional Authorities
**The Norwegian Federation of Organizations of Disabled People
*** Mental Health Norway



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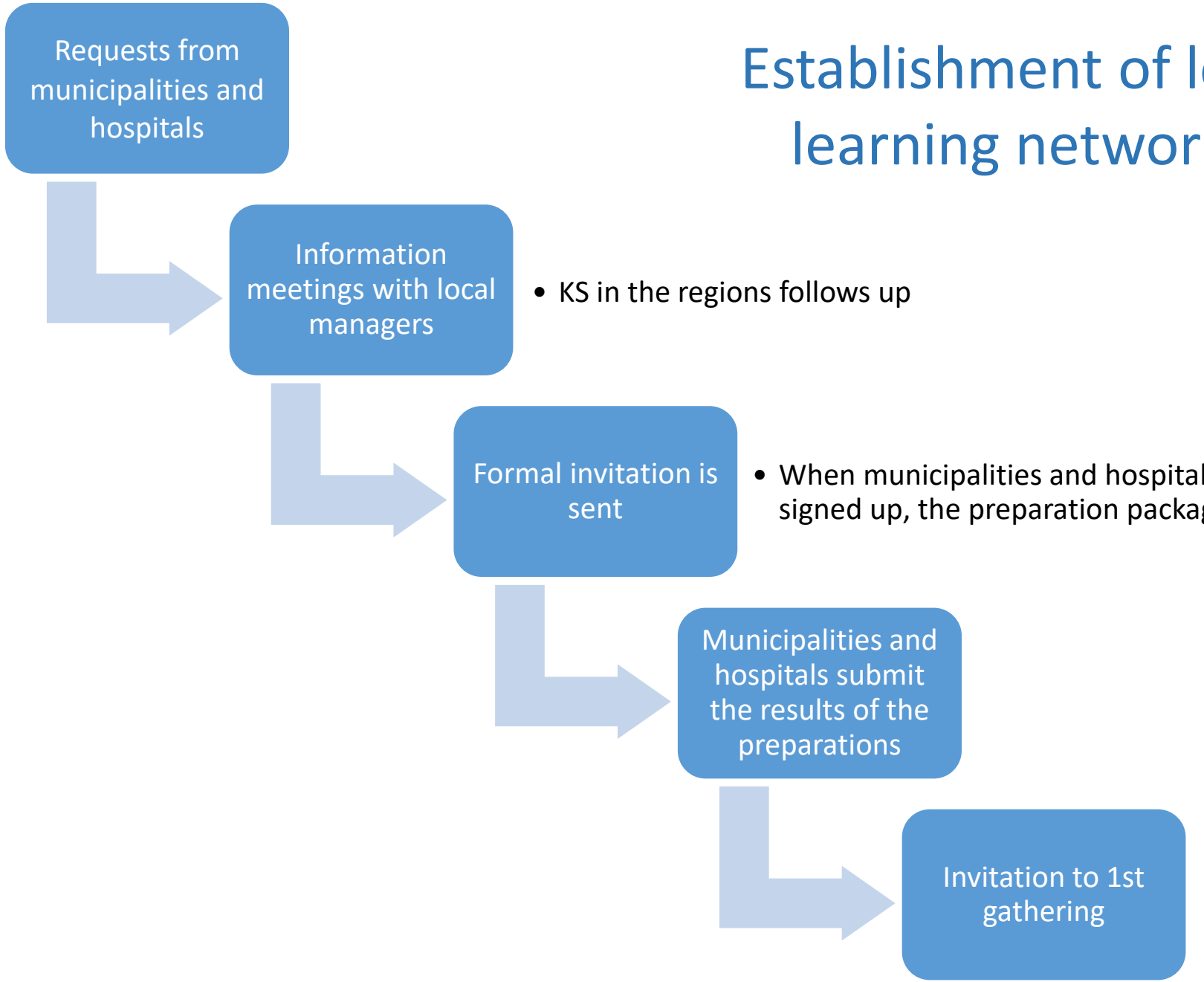
Establishment of local learning networks



- KS in the regions follows up
- When municipalities and hospitals have signed up, the preparation package is sent

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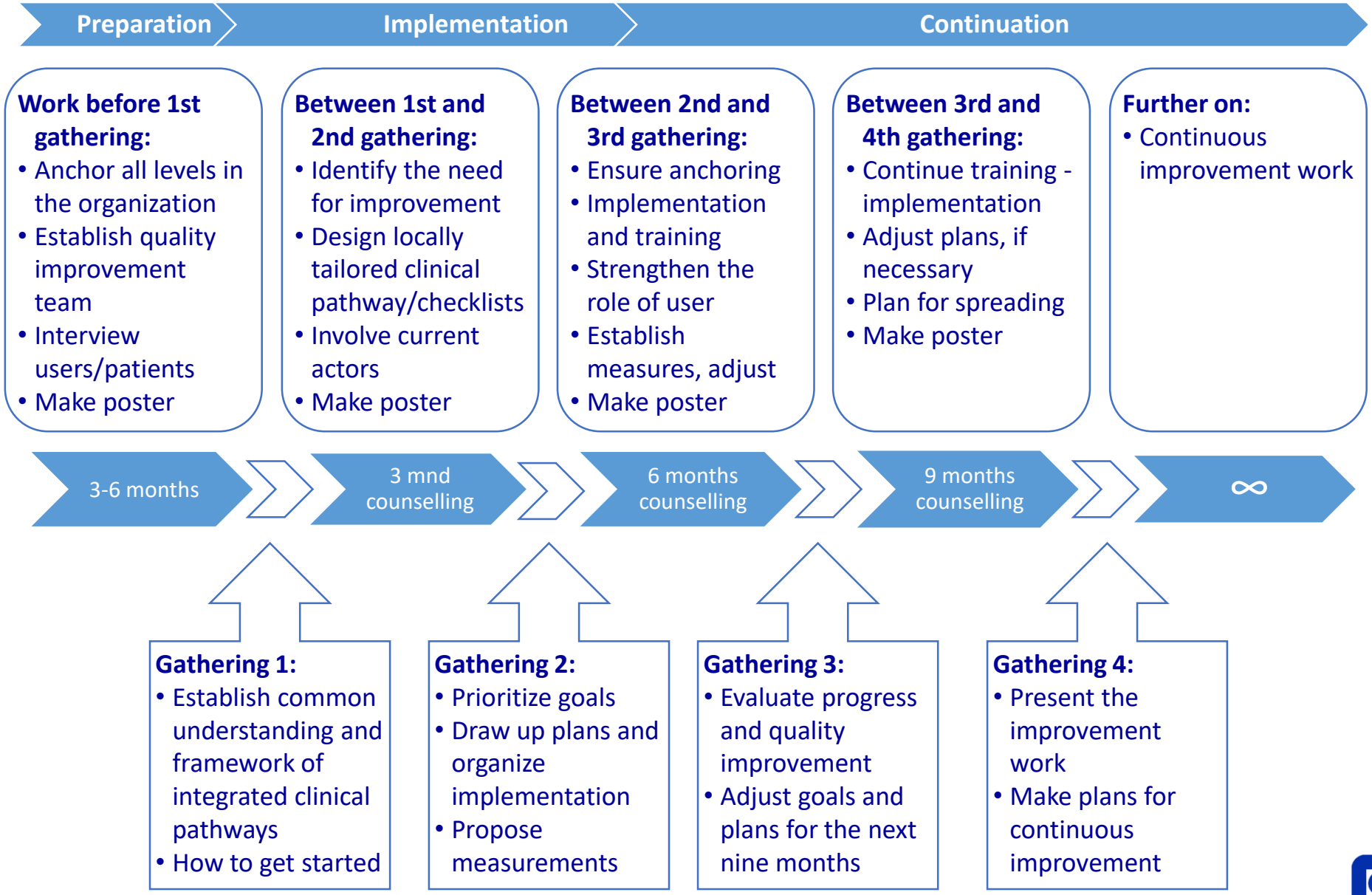
Program for learning networks for integrated clinical pathways



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Thank you for listening

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