
POSTER ABSTRACT

Integrated Health Care for frail elderly people with complex needs.

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Background: Demographic changes will lead to an increase in older, frail and complex patients. This place a high demand on health care systems and requires the care system to work more preventively, user-driven and coherent. For the most efficient use of resources, it becomes important to identify patients with the greatest potential to benefit. Digital aids may help to identify such patients.

Design, implementation and monitoring of the initiative: In this pilot project the patient group is frail elderly people with complex long-term needs who face multiple care providers. These patients are especially vulnerable to care fragmentation. This group also dominates the 5-10% top spenders who account for 2/3 of high-level health care spending both in Norway and internationally.

Intervention: Akershus University Hospital (Ahus), a 1098 beds hospital has with 6 associated municipalities developed a model for closer interdisciplinary collaboration around the frail elderly with complex needs and high consumption of health care services. This model is called Integrated Health Care (IHT).

We designed a computer application that uses deidentified health care data to identify risk patients based on age (>65) and number of emergency admissions the last six months (>3) spread over two or more different specialist departments. When a patient is included in IHT a multidisciplinary team (IHT-team) across primary and secondary care visit the patient at home. The IHT-team consists of a nurse and geriatrician from the hospital and a nurse and general practitioner from the municipality. In the conversation during the home visit, emphasis is placed on what is important to the patient. The team map risk areas and need for assistance. An individual treatment plan is created based on this conversation. The patient gets a contact person in the hospital and one in the municipality. If the patient is admitted to hospital, the IHT-team will receive an automatic notification and thus follow the patient during the hospital stay. Every 6 months there will be a follow-up conversation and opportunity to adjust the treatment plan.

Results: The first patient was included in 2020 and so far 63 patients have been included (40 of these have been followed for longer than 12 months) and the feedback is good. The patients and relatives highlight the importance of a patient-centered approach. They feel that the IHT-project provides increased security and predictability. We have seen a dramatic decrease in acute hospital admission for those patients included in the program; from on average 3 acute admissions the 6 months prior to inclusion, and 1,25 acute admission the 6 months following inclusion in IHT. There has also been a decrease in use of short-term stays in the municipalities.

Conclusion: Our IHT method is effective in identifying patients at risk of frequent hospital admissions. Offering targeted and multidisciplinary services to frail patients seems to be effective in reducing acute admissions and use of health care services in the municipalities.

Next steps: We are now about to expand our project to more municipalities, and aim to calculate health care costs.