CONFERENCE ABSTRACT

An Integrated Healthcare System in the Middle of Denmark - the successes, barriers and the influence on Healthcare utilization

17th International Conference on Integrated Care, Dublin, 08-10 May 2017

Margrethe Smidth1,2

1: Department of Clinical Medicine, Aarhus University, Denmark;
2: Department of Emergency Medicine, HE Midt, the Central Denmark Region, Denmark

Introduction: Patients recover fastest and best at home or in municipality-care-facility in care of general-practitioners(GPs). They risk fewer complications and many admissions could be avoided thus leaving the Emergency Department’s beds free for those patients who do need specialist treatment. Acute-care initiatives in municipalities seem to be used scarcely. There is a need for investigations into how municipality initiatives could be used more in collaboration with other stakeholders in the healthcare system and the influence on healthcare-utilization.

Thus, our aim was to reduce societal healthcare-utilization while enhancing GPs’ knowledge and use of municipalities’ initiatives.

Theory/Methods: To provide GPs up-to-date information of the initiatives in Viborg, Silkeborg, and Skive municipalities and discuss which care-pathway would benefit patients most a Callcenter was established in the Emergency-Department’s pre-evaluation-unit. To speed up collaborative care “practice-packages” were developed by Emergency Physicians, enhanced by GP-advisor and adjusted by municipalities’ GPs and staff to fit with offers available in each municipality.

GPs prescribe a “practice-package” when patients present with well-defined symptoms, care and treatment is provided by municipalities’ healthcare-staff with Emergency Physicians as backup. If patients worsen when the GP-office is closed they can get admitted without use of out-of-hours services.

Healthcare-utilization-data will be collected on use-of-services at the GP and the hospital as well as data on use of home-help or/and community-nurse and patient-attribution. Successes and barriers of “practice-packages” was evaluated after a year.

Results: We hope to improve the collaborative-culture and expect “practice-packages” to increase knowledge and use of municipality-initiatives thereby improving population-health with more use of GP-services and fewer admissions and readmissions within three and 30 days.

In this study patients admitted with dysregulated VKA-treatment will be examined.

Data is being evaluated and will be ready for presentation in Dublin.
Discussions: When different healthcare providers increase knowledge of each other’s initiatives and work together to provide healthcare patients receive care in the most appropriate place and for less cost. The Callcenter is a collaborative initiative as are “practice-packages” stakeholders ownership of the project might have been one reason for the success of “practice-packages”. Barriers for use could be GP’s distrust of the municipality’s competences; another can be the time of the day and then lack of available semi-acute outpatient-appointments can be a reason for admissions.

Conclusions: Preliminary results suggest that “practice-packages” can reduce societal cost up to 30%. The experiences can be implemented across Denmark and in similar healthcare systems with care provided from different sectors.

Lessons learned: It seems to be cost-effective to plan for the acute care when patients present with well-defined symptoms. “Practice-packages” can be developed for more well-defined symptoms.

Limitations: Limitations of the study was that the Callcenter was open only during the daytime. It was difficult to collect data and especially similar data in the three municipalities.

Suggestions for future research: Research into collecting data in the municipalities would enable an easier comparison and sharing of data between the three stakeholders. It would be interesting to see if an open around-the-clock Callcenter would increase the use of “practice-packages”.

Keywords: integrated care; dysregulated vka; practice-packages