
CONFERENCE ABSTRACT

Where are the pathway patients?

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Introduction: To shorten hospital stays and thereby reduce costs, more responsibility and tasks are shifted into primary care. One action is to prolong clinical pathways for specific diagnoses beyond the hospital setting. The aim was to investigate the feasibility of this approach.

Methods: Qualitative study on the lessons learned from two cases of collaboration regarding pathway patients between specialist and primary care and a quantitative study covering a primary and specialised somatic health care use for a population of more than 200,000 people.

Results: The objectives of the two cases were the same, to ease the discharge process and improve follow up in primary care, but the progress and results were different; one had success (they changed to a generic pathway), the other not. Primary care personnel reported unfamiliarity with clinical pathways and especially the focus only on one single diseases. They said that most of their patients had several additional health problems (multimorbidity) which was not taken care of in the pathways. Furthermore, they reported to see few patients with the chronic diagnoses frequently seen in hospitals.

This was investigated in the quantitative study which confirmed that there were few persons among home healthcare nursing patients in each municipality discharged from a hospital with a diagnosis of chronic obstructive pulmonary disease (COPD), heart failure, stroke and hip fracture. One home health care nurse working in a community with 10,000 inhabitants will on average see respectively 0.5, 0.3, 0.2 and 0.4 of these patients each year. It was also confirmed that patients with these diagnoses had extensive multimorbidity, with 85 to 91% having two or more chronic diseases.

Discussion: Base on the findings in this study, in can be argued that it is not sustainable to prolong disease-specific pathways into primary care. The reason is that there will not be enough patients to give the nurses the needed experience to provide high quality disease specific care. This indicates that when implementing diagnose specific pathways beyond the hospital setting, they should be merged with a generic (not disease specific) pathway in primary care.

Conclusions: To have a more structured follow up of patients discharged to home health care, generic pathways are likely to be more efficient.

Lessons learned: There were very few patients with only one chronic disease. Integrated care for patients with multimorbidity and complex conditions might be improved by implementing a generic clinical pathway with a holistic and structured approach in primary care. A generic pathway should balance the condition specific needs and needs that go across the chronic diseases while taking into account impairments and social contexts.

Limitations: The quantitative study only included home healthcare nursing patients. The study was conducted in Norway, and the findings might not be generalizable to other health care settings.

Suggestions for future research: Studies on the appropriateness of generic pathways are needed and studies from other health care settings are needed to confirm the findings.

Keywords: care coordination; integrated care; patient-centred care; home healthcare nursing; multimorbidity
