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POSTER ABSTRACT

Clinic for Multimorbidity

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Introduction: Every fourth person suffers from more than one long-term disease multimorbidity, rising with increasing age. Everyday-life of multimorbid patients is influenced by difficulties in managing their conditions, complex drug regimes and attending multiple appointments in a fragmented health system. Thus, multimorbid patients experience lack of coordination and interdisciplinary care management. Typically, GPs have coordinated the patient's treatment. An expressed need exists for more cooperation and continuity.

Practice change implemented: By establishing Clinic for Multimorbidity at a regional hospital, we enabled joint-assessments of multimorbid patients. Patients are referred by their GP. Prior to the patient's appointment, a physician reviews previous records and plan relevant medical investigation. At arrival, the nurse collects information, a pharmacist reviews the medication, followed by physiotherapy and occupational therapy assessments. The physician then has a collating consultation. Afterwards, a multidisciplinary conference involves relevant specialties, providing a joint treatment plan. The GP can participate by videoconference. The final treatment plan is agreed, the patient referred back to general practice and the nurse ensures necessary homecare. The consultations are gathered same weekday and schedules are coordinated by the nurse.

Aim: To offer a holistic overview of multimorbid patients with complex problems, and to support GPs in care coordinating.

Population and stakeholders: Multimorbid patients constitute the target population. Stakeholders include GPs and hospital healthcare professionals.

Timeline: Clinic for Multimorbidity was established May 2012 and since then, data has been collected.

Highlights: Clinic for Multimorbidity involves healthcare collaboration, knowledge sharing and shared treatment plan. In total, 141 patients have visited the clinic. Females constitute 60% and median age is 70 years IQR=63:77. Circulatory 20%, endocrine 10% and respiratory diseases 9% are most frequent. In median, patients has a usage of 11 drugs IQR=7:15. General health, physical and mental wellbeing is low compared to other groups, scoring 25, 26 and 42

on SF-12, respectively. Patients wait 31 days IQR=20:50 from referral to final assessment. Before the consultation, a median of four examinations IQR=3:5 are conducted and four medical specialties IQR=3:5 are represented at the conference.

Sustainability: The clinic delivers a comprehensive status on the patient and coordinates different treatments giving an ideal onset for future treatment plans. However, diseases change over time making it difficult to sustain.

Transferability: Practicalities of organizing the clinic are manageable and can be transferred to other hospital settings. This demands close collaboration between healthcare professionals and prioritizing of a resource-consuming intervention.

Conclusions: It is feasible to establish an organization and collaboration targeting patients with multimorbidity. The novel approach focus on patient's needs instead of mono-targeting diseases and support the GPs in coordinating comprehensive trajectory for this patient group. These complex patients require involvement of several disciplines and professions and the hospital-based approach with all specialties in one place ensure few contacts for the patient and would not be achieved by outgoing teams.

Discussions and lessons learned: Multidisciplinary approaches are called for and initiatives should consider setting aside fast-track care when handling multimorbid patients, due to disease complexity. Future effect evaluation on ex. healthcare use is planed.

Keywords: multimorbidity; general practitioners; collaboration; multidisciplinary; outpatient clinic