# Empowering Patients and Offering Better Connected Healthcare Services
# 27th January 2015

## Good Practice Examples from the Region of Southern Denmark

Region Syddanmark

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# Subjects of today

- On a Regional Level
  - Shared Care Portal
  - Example of Integrated care and patient empowerment
- On a Local Level
  - Life Long Living
  - Example of independent living, everyday rehabilitation and citizen empowerment





Region Syddanmark

# The Region of Southern Denmark – facts

- **Structural Reform in 2007**:
  - 14 counties were changed into 5 regions
  - 271 local authorities were merged into 98
  - RSD is a merger of 4 counties and has now 22 municipalities
- **Responsibilities and competences**
  - **The state**; Sets the overall strategic frame for the society
  - **The local authorities**; Have the responsibility for assignments close to the citizen (education, labour market, rehabilitation, culture etc)
  - **The regions,** Have the responsibility for primary care and overall development plans for the entire region.



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# The Region of Southern Denmark – facts

- The region is managed by the regional council
- The region has approx 1.2 million residents
- The region manages
  - 4 hospitals
  - 800 general practitioners
  - Health agreements with 22 municipalities


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**Health Agreements between 22 municipalities and the Region**

**Important ”building block” for collaboration and empowerment**

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# Principles for the division of labour

– between GPs, the municipality and the hospitals

## Division (stratification) of patients

| | |
|---|---|
| **I. Patients**<br>- Suffering from an uncomplicated disease<br>- With good self-care ability<br>▶ **own GP** + patient | **II. Patients**<br>- Suffering from a complex disease<br>- With good self-care ability<br>▶ **own GP** + patient + hospital coordinator |
| **III. Patients**<br>- Suffering from an uncomplicated disease<br>- With poor self-care ability<br>▶ **own GP** + patient + municipal coordinator | **IV. Particularly vulnerable patients**<br>- Suffering from a complex disease<br>- With poor self-care ability<br>▶ **own GP** + patient + both coordinators depending on the course of the disease |

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# SAM:BO – purpose and contents

- The agreement describes guidelines concerning cooperation, communication, information to the patients and monitoring of the quality and is supported by electronic communication

- What do we achieve:
  - Continuity of care
  - Discharging starts as soon as you are hospitalized
  - Continuity and flexibility through dialogue
  - Patient involvement

- Flow charts describes what each sector is expected to do before, during and after hospitalization.

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# SHARED CARE

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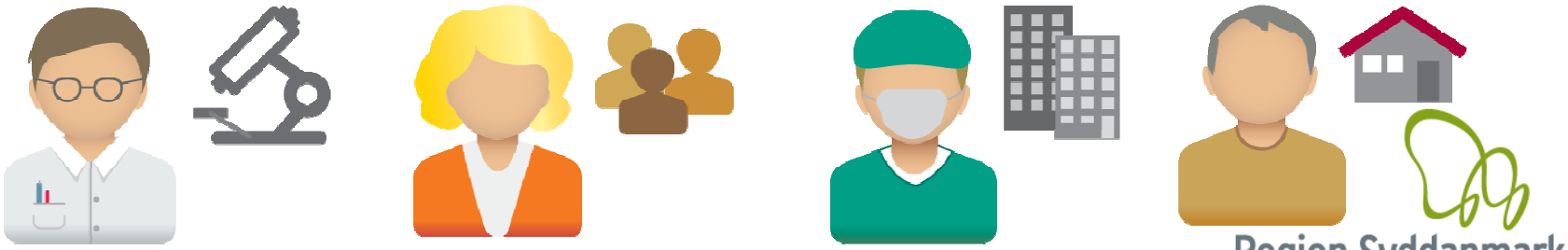
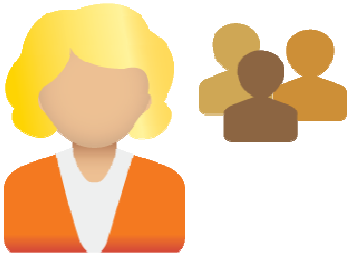
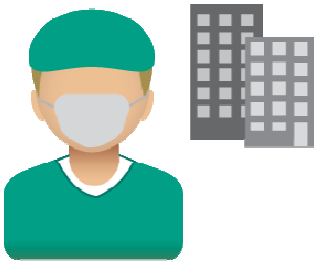
- **One care plan**, enabling all the different caregivers to work towards the same goals and support those in their services
- **One tool,** where caregivers and patients can set-up shared goals
- **One platform**, that every participant in the course of treatment uses and be orientated in
- **One platform**, making it possible to keep caregivers – and the patient – updated all the time
- **One possibility** for the patient to enter their own measurements, answer questionnaires and be informed about their treatments and goals



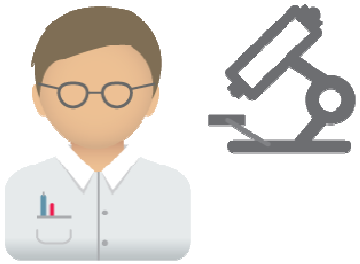
# Perspectives



The entire lifesituation for the citizen

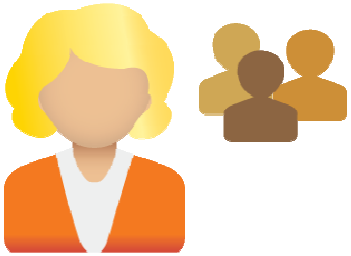


The acute disease of the patient



The overall health of the patient

# Benefits



Less effort in finding relevant information

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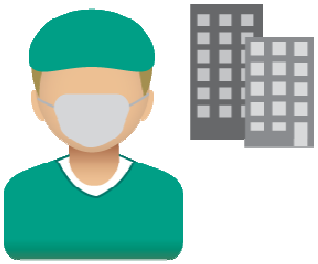
Freed up time



More information on the patient

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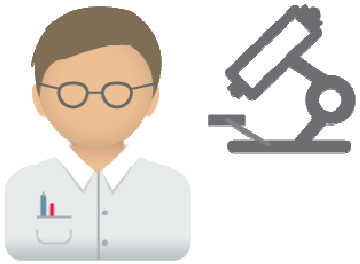
More quality of care



Insight into partners work

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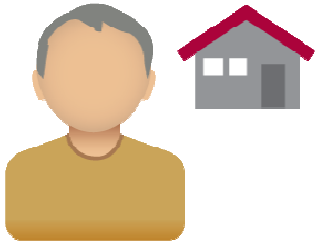
Increased collaboration

# Benefits



Possibility to track their treatment

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Feeling safe

Possibility to see goals and status

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Motivation

Possibility to enter information

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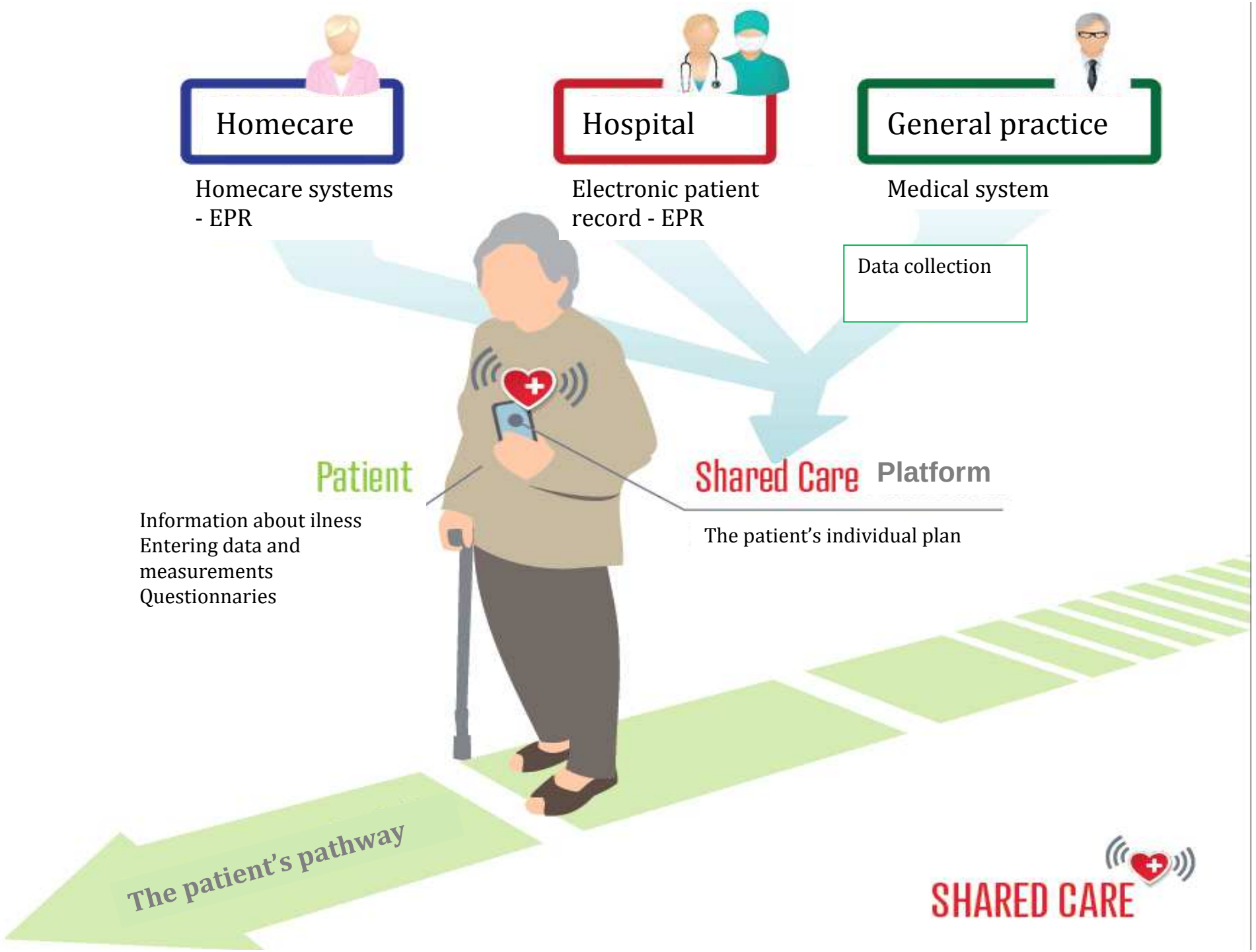
Involvement


Homecare
Hospital
General practice
Homecare systems - EPR
Electronic patient record - EPR
Medical system
Data collection
Patient
Shared Care Platform
Information about ilness
Entering data and measurements
Questionnaries
The patient's individual plan
The patient's pathway
SHARED CARE

# An example from one of our municipalities

# Fredericia Shapes the Future

## Life Long Living

Maintaining Everyday Life
as Long as Possible

**A way to ensure future welfare**

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# Life Long Living

- ”I handle most things myself. Yesterday I did all my laundry”

Søren Madsen, 92 years old,
has been trained in the project

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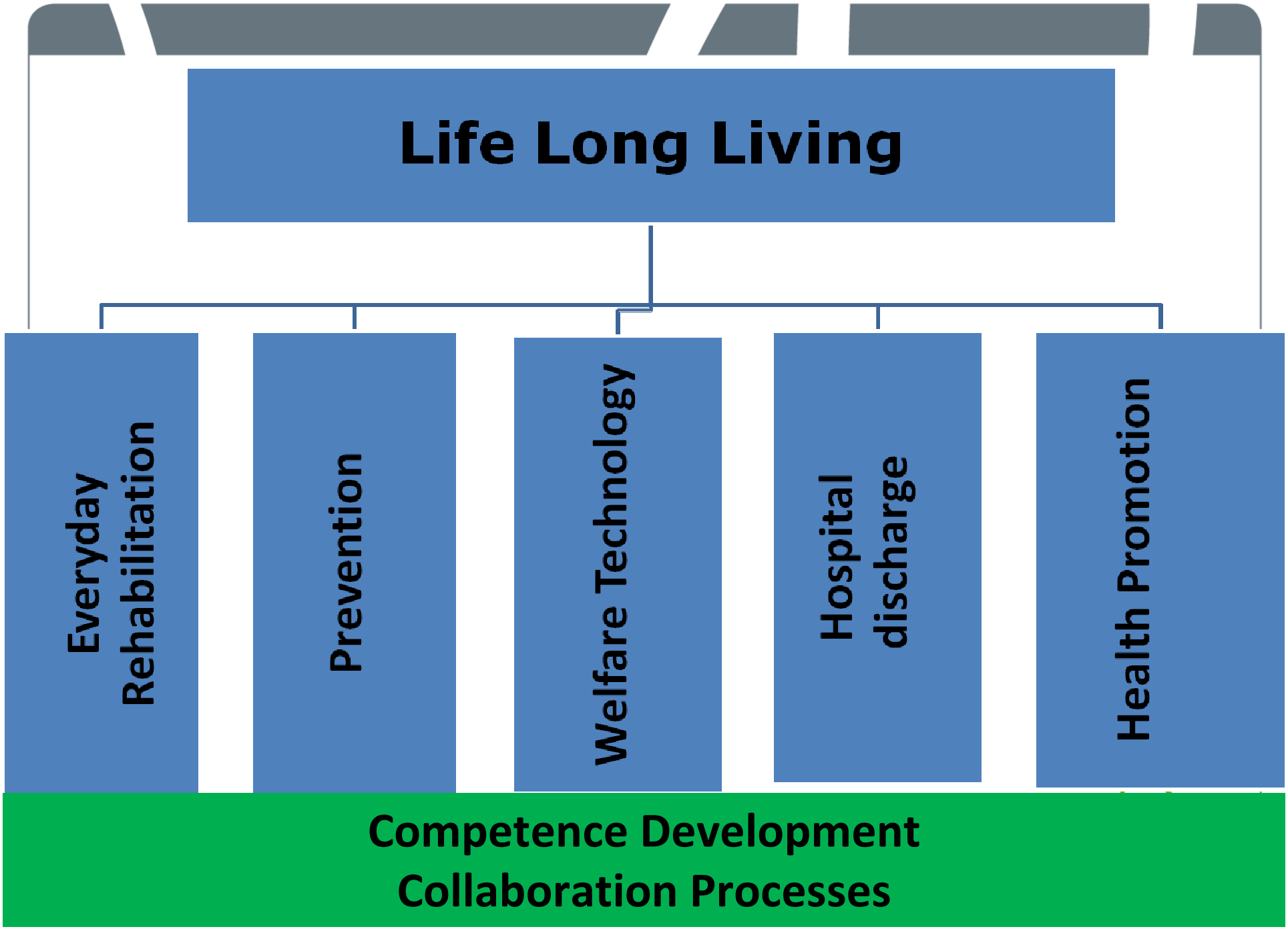
Life Long Living
Everyday Rehabilitation
Prevention
Welfare Technology
Hospital discharge
Health Promotion
Competence Development
Collaboration Processes

# Life Long Living

**The vision**

A municipality with active and resourceful elderly, who through prevention, rehabilitation, technology and social networking maintain everyday life as long as possible.

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# Life Long Living

## Change of paradigm

Change the way we look at our senior citizens from "helpless" patients to citizens with resources.

Change the assumptions for future care by looking at the individual's resources and by providing self-help instead of providing compensatory – and pacifying care.

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# Change of paradigm in practice

- From re-active to pro-active intervention
- From late to early intervention
- From dependence to independence
- From compensation to rehabilitation
- From care to prevention
- From treatment to early detection
- From limits to resources
- From senior burden to senior strength

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# Every Day Rehabilitation

Help to self-help

Staff has to put their hands in their pocket

Focus on activities in every day life

Look at resources – make a plan for the citizen

Care in a ”training way”

Intensive help in the beginning

- A Service shock…….

15 care trainers

3 therapeuts, 2 visitation staff and nurses

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# Prevention

Home visits from nurses looking at:

- Correct medication
- Signs of lonelyness / social exclusion
- Every day risks in home
- Changes in behaviour

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# Hospital Discharge

**New ways of collaboration**

- Smooth process from hospital care to home care followed by ambient life
- The citizen has to feel safe and taken care of, even though that there is no staff around him

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# Welfare Technology

**Philosophy:**

- Welfare technology is a tool to support the creation of every day rehabilitation, but overall focus is still on people, relations and self-help
- Welfare technology is not an objective in itself
- Too much technology can create passivity

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# Health Promotion

- Starts at 65
- Objective is to inform about how to live an active and healthy life as senior citizens
- ”senior training”
  - Not only health, but also economy, social networking, senior sexlife, physical activity and new technology

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# Competence Development and Collaboration Processes

- Staff has to be trained to coach and provide self-help
- Should be able to spot early signs of sickness and social exclusion
- Create new and transparent collaboration processes between hospitals and local care centers.
- Establishment of home visits immediately after hospital discharge

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# A few examples …

Every day rehabilitation

and

training to become independent

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# From ”patient” to indepenent

- Mrs Hansen apply for personal care and practical help + wound care
- Receives intensive training for 31 days
  - In total 72,3 hours
- Would normally receive 9,3 hours per week (483 hours per year)
- Gets independent and happy
- The investment pays back after app. 2 months.
- Yearly savings: 20.000 EUR / 822 hours

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# An active daily life

- Mr. Jensen applys for cleaning assistance
- Receives training for 3 weeks (15 hours)
- Would normally receive assistance for 25 minutes per week but becomes independent (and happy?) instead
- Savings 25 min./week =21,7 hours/year
- The investment is paied back after app ¾ year.
- Yearly savings: 900 EUR and 17 man hours

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# How long time does the effect lasts?

- Mr. Madsen applys for personal and practical assistance + + help with medication dosage after hospitalisation.

- Receives intensiv training for 12 weeks, 190 hours
- Would normally receive 12,1 hours per week.

- Gets independent in relation to personal care but receives clearning assistance each 14 day (50 min)
- Follow up after 9 months. Mr. Madsen is happy and gets on very well, only receiving cleaning assistance.

- The investment is paid back after app. 2 months
- Yearly saving = app. 22.000 EUR

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# Doing her shopping alone

- Mrs Olsen is 80 years old and has COPD
- **Assistance in traditional system:** 290 minutes per week for personal and practical assistance. Cannot walk without breathing apparatus
- **Assistance in new system:** 35 minutes per week support stockings and cleaning assistance
- Mrs Olsen can now walk a little without breathing apparatus, is more independent, and makes her shopping, takes her bath and does some of the cleaning herself.

**Difference in assistance before and after:**

255 min. pr. week – yearly saving: 221 hours per year

**Yearly savings: ca. 10.000 EUR**

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# European Year for Active Ageing and Intergenerational Solidarity

## Life Long Living;
## Maintaining Everyday Life as Long Possible

## Won the first price for Age Friendly Environments

http://ec.europa.eu/social/main.jsp?catId=1002&langId=da&videosId=2609&vl=en&furtherVideos=yes

- 2010 Local Gorvernment Denmarks Great Innovation Award
- 2011 the European Public Sector Award (EPSA ) – Best Practice Certificate
- 2012 The model has been integrated in the Danish national budget as model for the overall Danish municipalities on how to conduct the services within elderly and care in a rehabilitative and empowering manner.

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# European Projects

**Shared Care is being upscaled in SMART CARE project**
**http://pilotsmartcare.eu/norm/home/**

**MAST (Model for Assessment of Telemedicine)**

**Renewing Health**
**http://www.renewinghealth.eu/en/assessment-method**

**United for Health**
**http://united4health.eu/**

**Mastermind** MAnagement of mental health diSorders Through advancEd technology and seRvices – telehealth for the MIND
**http://mastermind-project.eu/**

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**Thank you for your attention**

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