Management of chronic patients in Sweden

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Outline

1. Health care in Sweden
2. Management of chronic patients
3. Example: Hypertension
4. Example: Diabetes
5. Reflextions

Primary heath care in Sweden

- All primary care tax financed
- Low patient fees
- 60% of health centres public, 40 % private
- Patients are free to chose any health care centre
- Reimbursement
  - differ between regions, generally based number on registered patients
  - by law same for privately and publicly produced health care
- 3,8 doctors/1000 inhabitants
- 16% GPs
- All disciplines: 5 years specialisation (incl GP)

Primary care in Sweden

- Appointments booked in advance
  - Telephone: visit or advice by telephone?
  - Patients invited for checkups
  - Seldom drop-in
- Gate keeping (not formally)
- 1,5 consultations with GPs/person/year
- 20 min/visit average
- 70 % of registered population visit their GP/year

Typical Health Care Centre

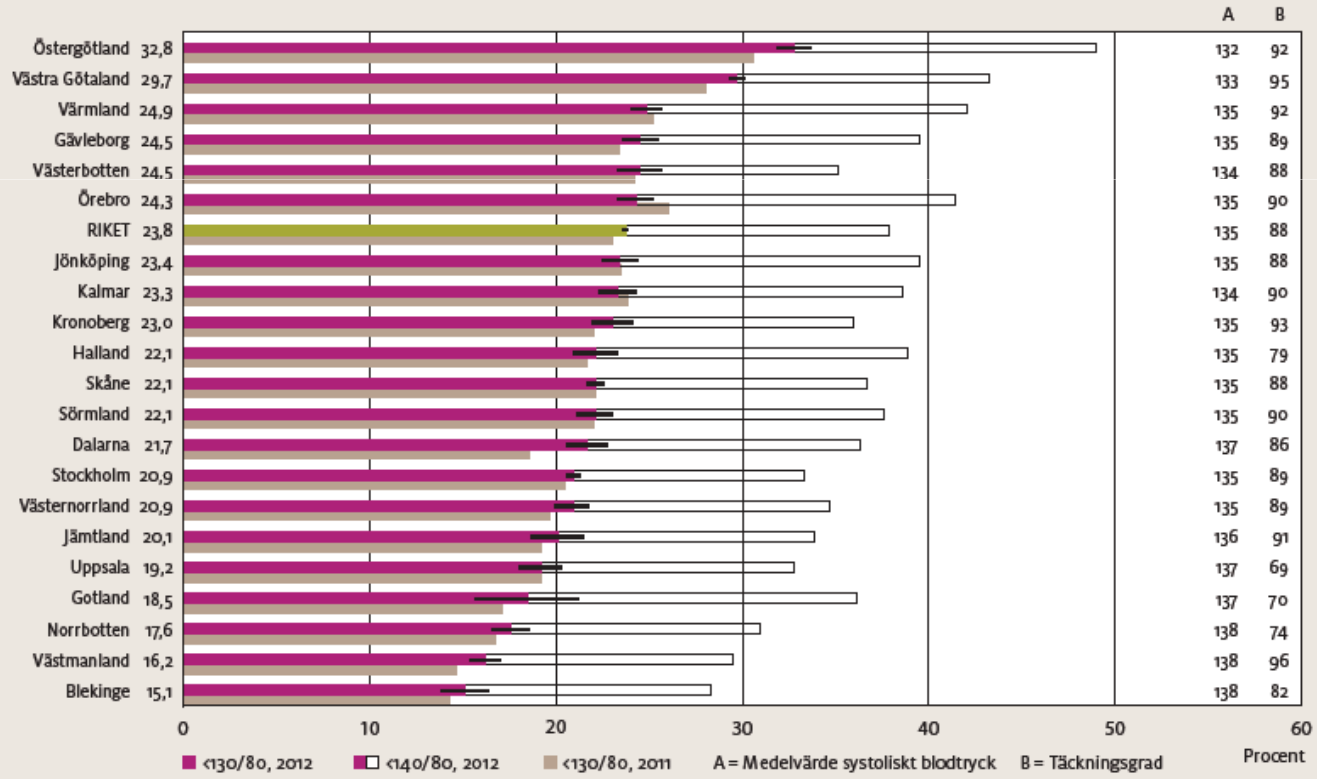
- Different occupational groups
  - Nurses
  - GPs
  - Physiotherapists
  - Psychologist(s)
  - Occupational Therapist(s)
  - Secretaries
- Well equipped
- Small Laboratory
- Digital medical records

2. Management of chronic patients

National initiatives

- Follow up of results “Open comparisons”

DIAGRAM 79 – TOTALT: Andel patienter med diabetes i primärvård som når mål för blodtryck (<130/80 mmHg), 2012.
Avser patienter yngre än 80 år.



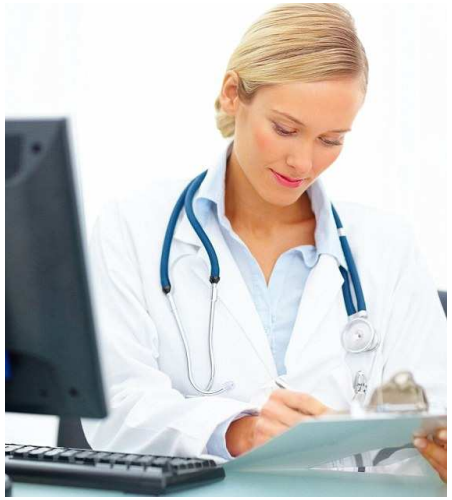
Källa: NDR – Nationella Diabetesregistret.

National initiatives

- Follow up of results “Open comparisons”
- 450 miljon SEK (50 miljon €) during 4 years
  - Improve on chronic care
  - Teamwork, focus on patients medical results and systematic quality improvement

Diseases in team care

GP

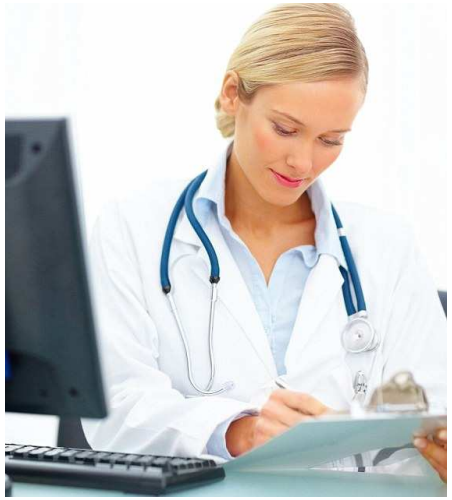


- Diabetes
- Asthma, COPD
- Hypertension
- Heart failure
- Dementia
- Life style interventions
- Depression
- Old patients, multimorbidity

Nurse

Diseases in team care

GP



- Diabetes
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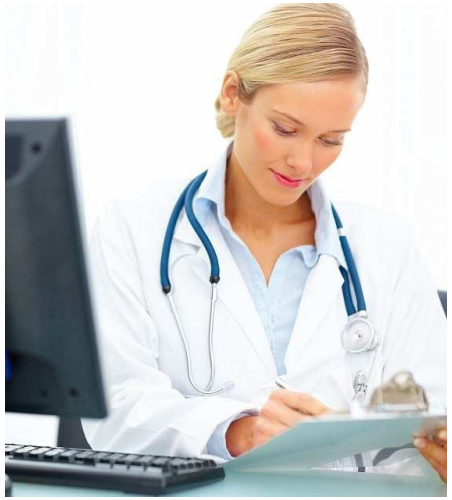
”Sub-specialist”
Nurses

Responsibities

GP



- Diagnosis
- First decisions on treatment
- Yearly checkups
  - What's new?
  - Goals for treatment
  - Change of treatment?
  - Complications?
- Patients agenda?
- Comorbidity?

Individual patient

Nurse

- Initial treatment
- Yearly checkups
- Routine examinations and lab tests
  Follow up medication and life style
  Help to start new medication
- THIS disease

Protocol

	Nurse
Diabetes	Feet examination, need foot specialist? Referred to ophthalmologist? Insulin, technique, find right dose
Asthma, COPD	Yearly checkups, spirometry Tobacco cessation
Dementia	Home visit for help with diagnose Regular follow up medication and situation
Life style interventions	Advice and support for life style change
Depression	(Support)
Old multi-disease patients	Home visit (with and without GP) Side effects from medication?




	Nurse	Other team members
Diabetes	Feet examination, need foot specialist? Referred to ophthalmologist? Insulin, technique, find right dose	(foot specialist)
Asthma, COPD	Yearly checkups, spirometry Tobacco cessation	Physiotherapist if severe COPD
Dementia	Home visit for help with diagnose Regular follow up medication and situation	
Life style interventions	Advice and support for life style change	
Depression	(Support)	Psychologist: Short psychotherapy
Old multi-disease patients	Home visit (with and without GP) Side effects from medication?	

3. Example:
Nurse and GP team for Hypertension

Kvarnholmen's Health Care Centre

The idea!

- Blood pressure and heart failure requires many contacts until targets are achieved
- Need for physician time seems infinite
- Why not use nurses' competence?

Before

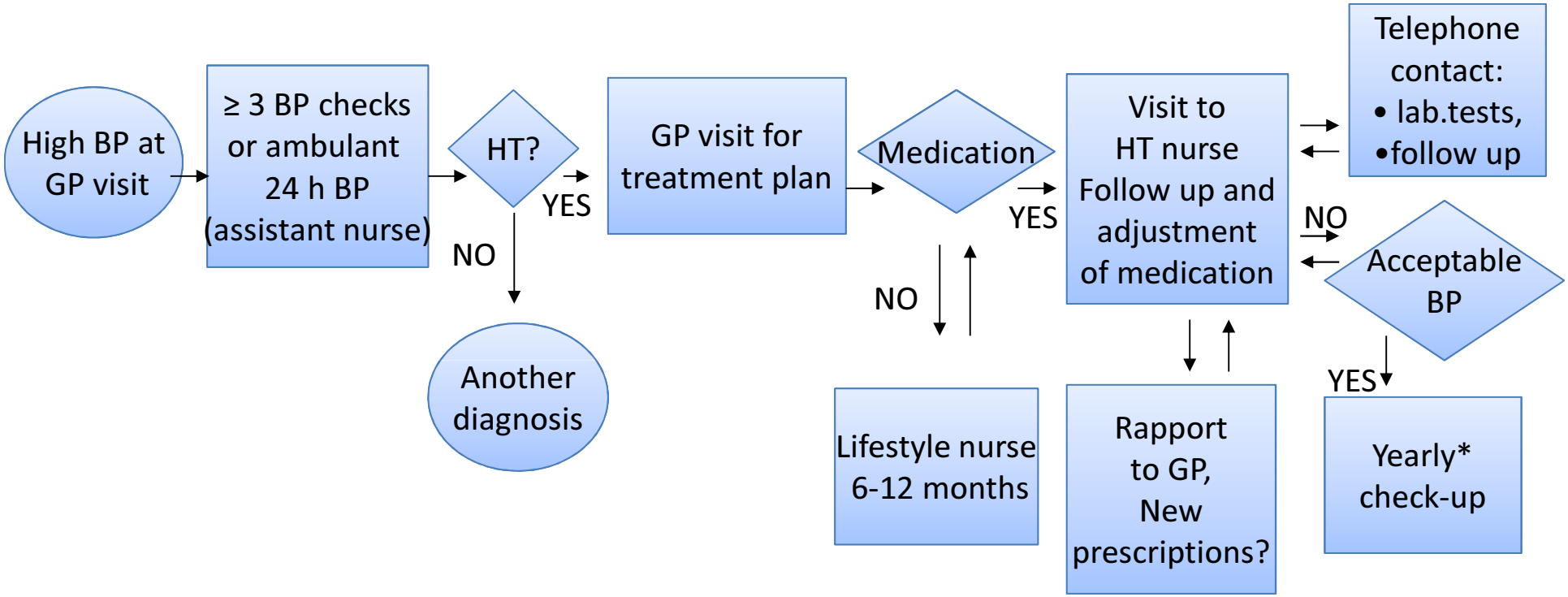
- GPs constantly lack of time
- Nurse helped to check blood pressure and to take blood samples, but
- GP had to contact (call) patient to initiate it
- GP's call → other discussions initiated by patient → slow process to reach goals for treatment

Now

- The GP
  - sets goals for treatment
  - prescribes medications
- The nurse
  - Maintains contact with the patient
  - See patient to monitor blood pressure, take blood test when needed, until goals are reached
  - Lowers or raises dose on prescribed medications
  - Discuss life style changes with patient
  - Report and discuss with GP before next patient contact

Process chart Hypertension

Kvarnholmens hälsocentral



* Patients only diagnosed with HT and no comorbidity may have yearly heck up with HT nurse every second year and GP every second year
All check ups preceded by blood tests

”Results”

Average BP for all patients with HT
(last measured BP value for the year)

2009: 164/87

2010: 156/85

2011: 158/85

2012: 146/83

4. Example:
Team for Diabetes

Lindsdals's Health Care Centre

Structure

- Defined responsibilities
- Check lists
- Systems for report

GP's responisbility: newly diagnosed patient

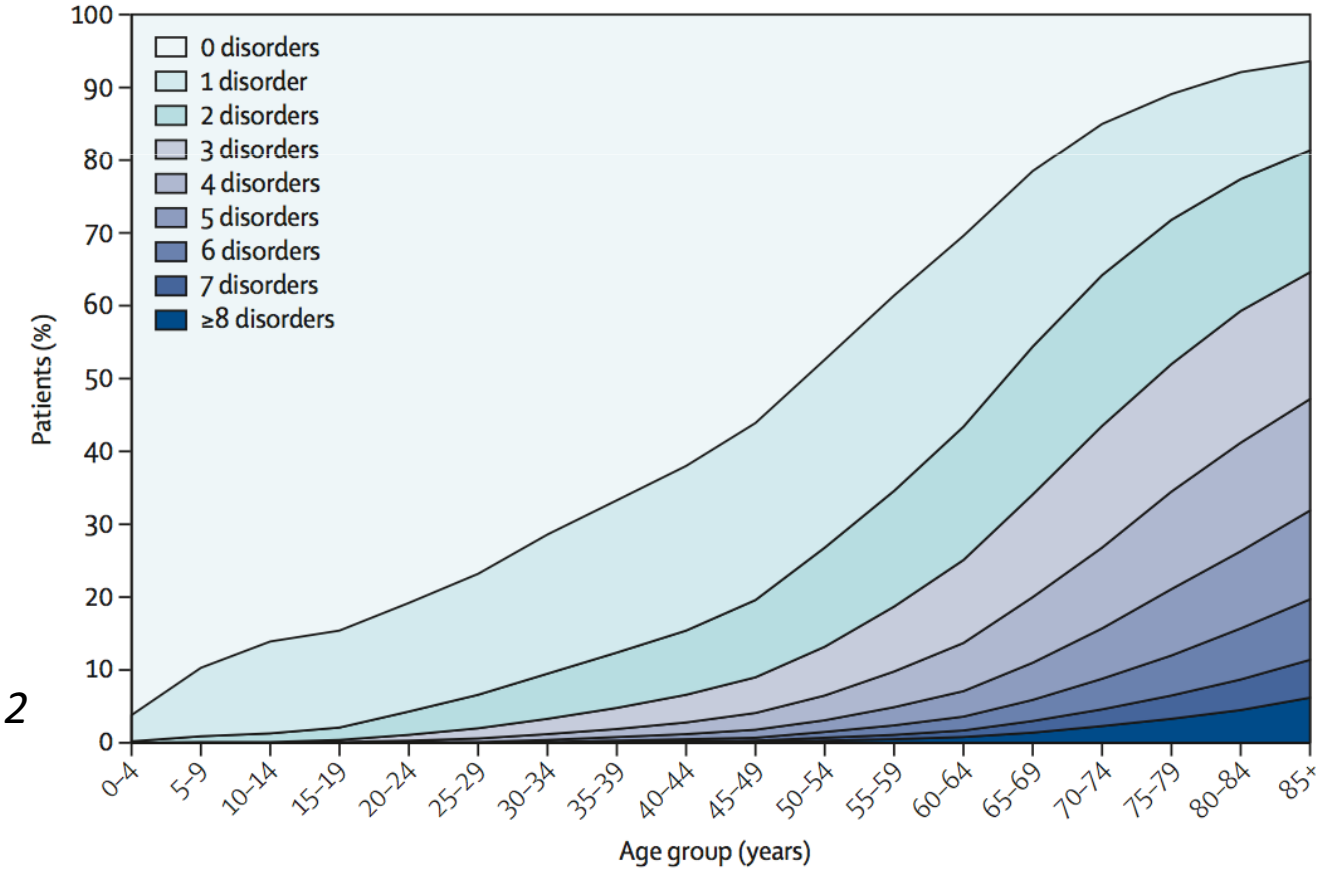
- Diagnosis incl current symptoms, comlications?
- Blood samples: Lipids, HbA1c, blood status, B-glucose, p-sodium, p-potassium, creatinine, microalbuminuria (albumin-creatinine ratio)
- Check GAD antibodies and C-peptide if LADA is suspected
- ECG, blood pressure
- Basic information about the disease incl advice concering diet, exercise, alcohol intake and tobacco.
- Treatment plan: Lifestyle changes, medication
- Discuss targets, responsibilities
- Plan follow-up at Diabetses nurse visit

Diabetses nurse's responisbility: newly diagnosed patient

- See patient within 1-4 v
- Patient education (and information to family members), based on the individual care plan
  - What is diabetes?
  - Reinforce about life style changes: diet, exercise, tobacco, alcohol
  - Ensure that prescriptions are understood
  - Realistic target values?
  - Self Control (especially if insulin therapy)
- Establish individualized care plan (targets, actions and responsibilities, follow-up)
- Referral to ophthalmologist
- Exam feet, consider referral to foot specialist
- Registration in the NDR.
- BMI and waist size

5. Reflections:

- Shared responsibilites > teamwork?
- Young multi morbidity patients → many nurses



Barnett K et al, Lancet 2012

5. Reflections:

- Shared responsibilites > teamwork?
- Young multi morbidity patients → many nurses
- Time with patient

Advantages:

- ”Routine stuff” is not forgotten
- Extended continuity
- Goals clearer


Thank you!

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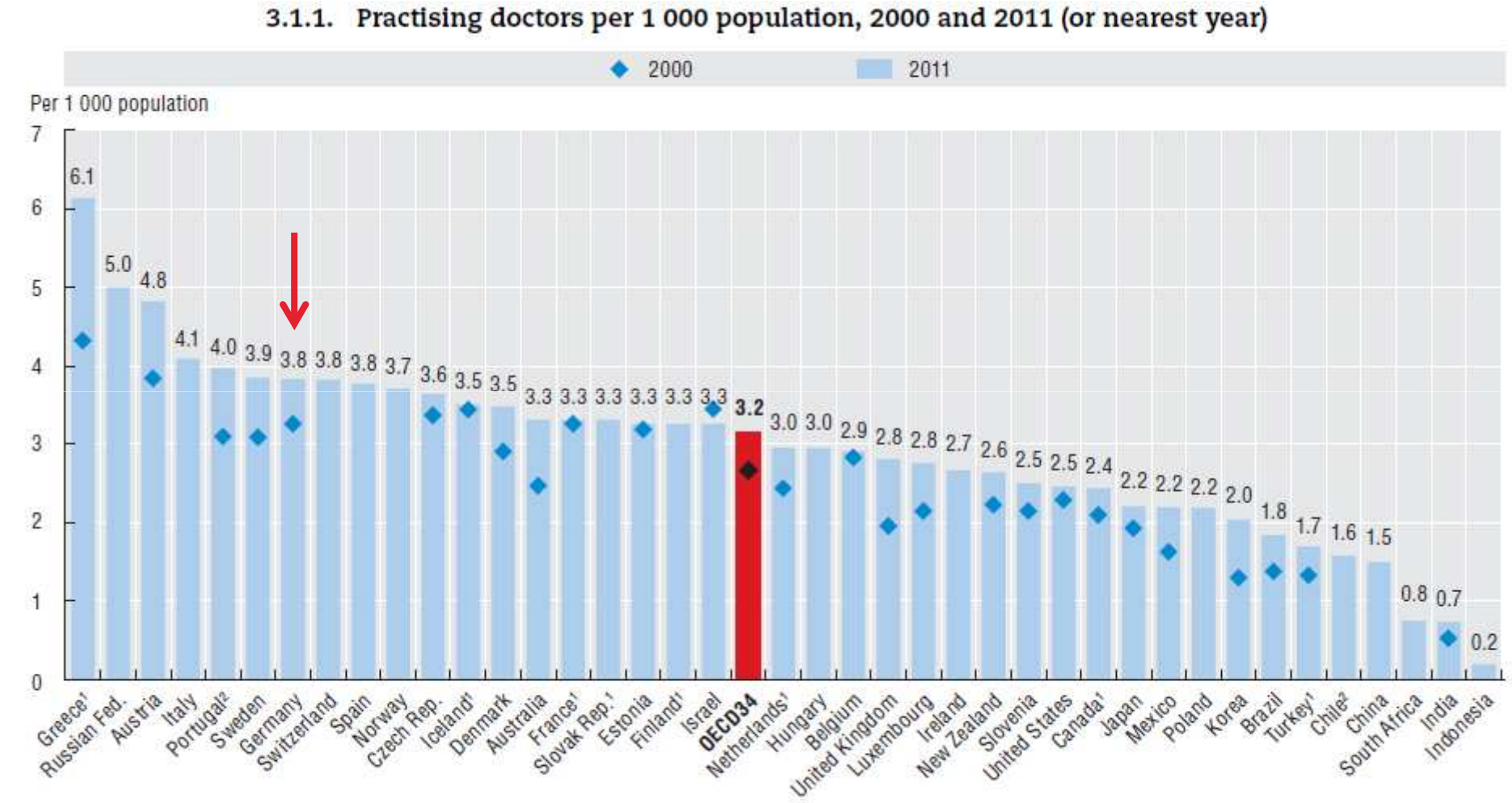
Dr Eva Arvidsson

Friday 9 May 15.00-15.20

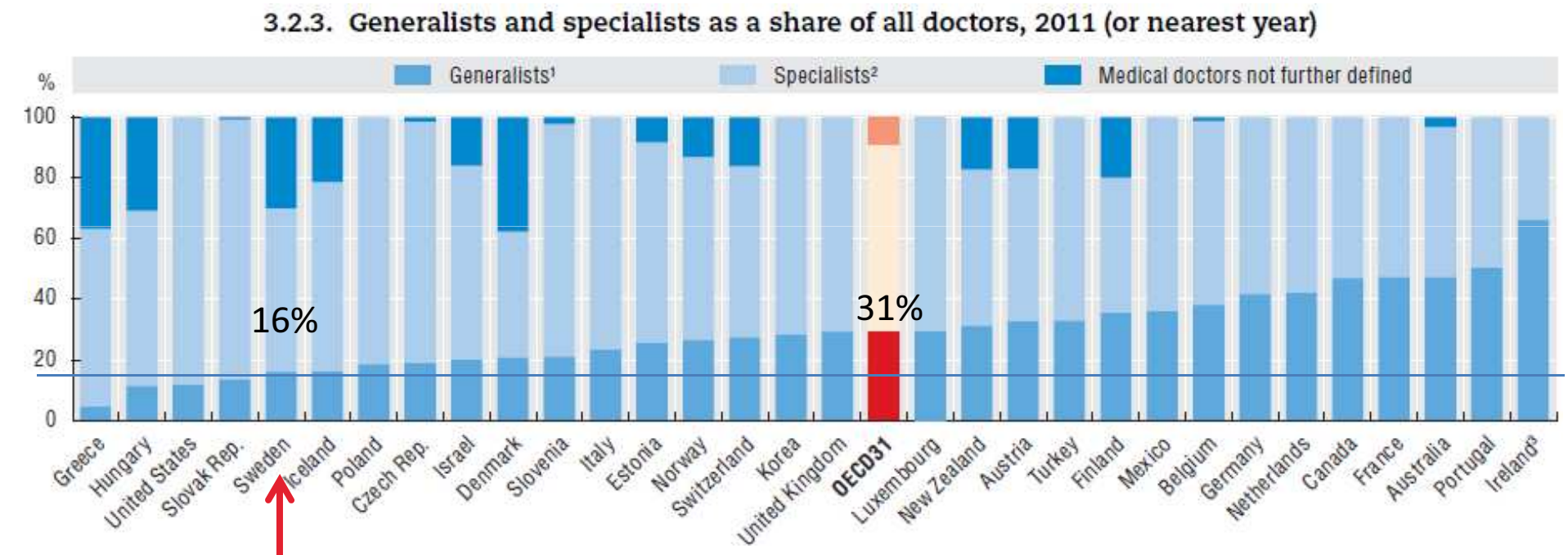
Doctors/1000 inh



1. Data include not only doctors providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).
2. Data refer to all doctors licensed to practice (resulting in a large over-estimation of the number of practising doctors in Portugal).

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

GPs as a share of all doctors

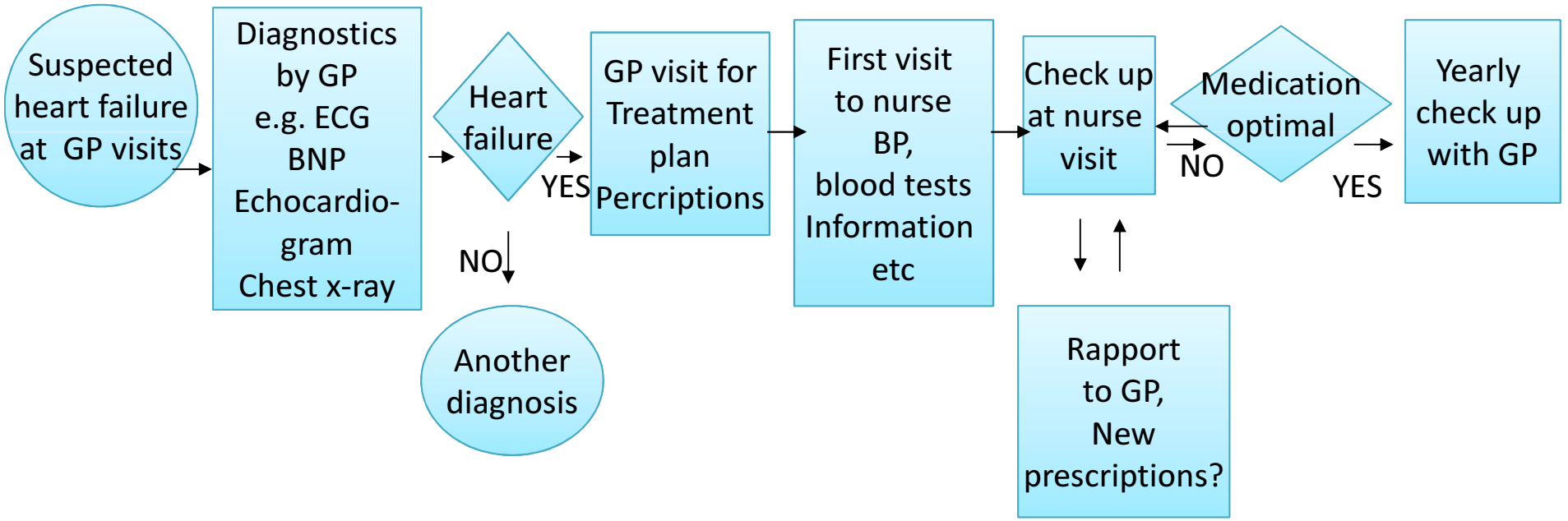


1. Generalists include general practitioners/family doctors and other generalist (non-specialist) medical practitioners.
2. Specialists include paediatricians, obstetricians/gynaecologists, psychiatrists, medical, surgical and other specialists.
3. In Ireland, most generalists are not GPs ("family doctors"), but rather non-specialist doctors working in hospitals or other settings.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

Process chart Heart Failure

Kvarnholmens hälsocentral



Doctor consultations/capita