Symposium: Innovating care for people with multiple chronic conditions in Europe (ICARE4EU)

UNIVERSITY OF EASTERN FINLAND

Caring For People With Multiple Chronic Conditions in Finland: Policy And Practices

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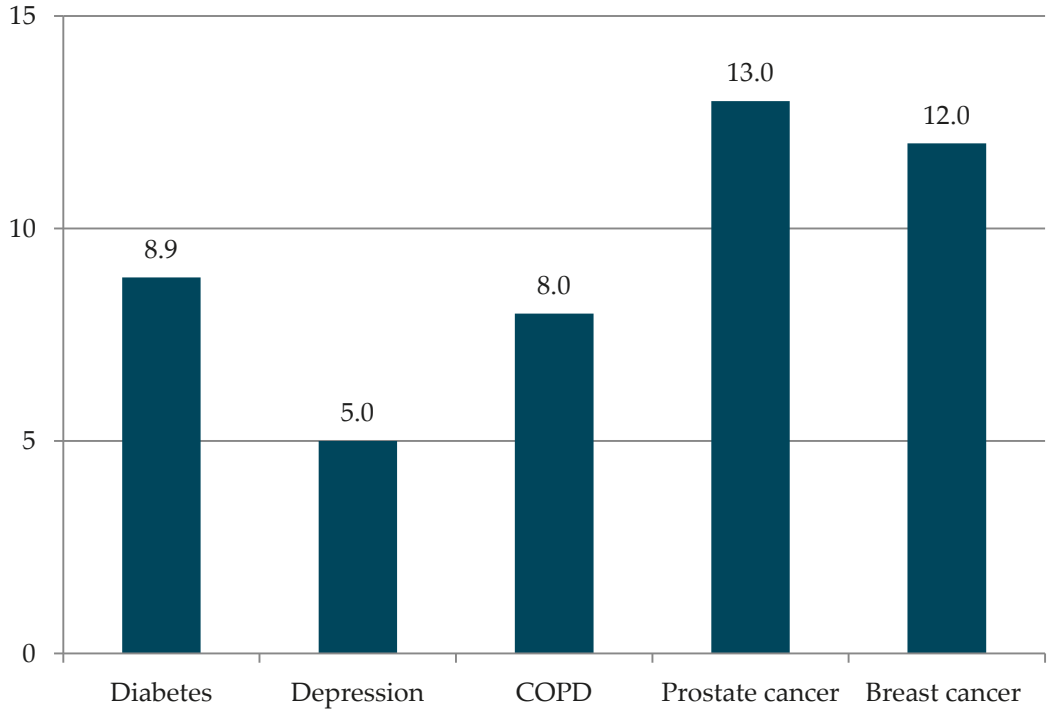
The challenge of multimorbidity in Finland

- Chronic diseases have been on the political health agenda in Finland for many years.
- Recently, also multimorbidity has been addressed as a policy and management issue, for example in the hospital districts.
  - Especially so called expensive clients, heavy users, high needs patients
- Joint provision and budgeting of health and social care in Finland create possibilities to integration of care, both at a local and national level.
  - Towards centralization and mergers of health and social organizations and primary and specialized care
- Some care development programmes have addressed the importance of integration of services and collaboration between diverse actors regarding the care of multimorbidity patients.

Some figures:

- In 2011, among a total population of almost 5.4 million inhabitants, 17.0% was aged 65 years and older, and 4.8% 80 years and older.
- Among the population aged 16 to 64 years, an estimated 37.2% reported to have at least one long-standing illness or health problem (Eurostat 2011)

Figure 1. Prevalence of some major chronic diseases in Finland in 2011-2013



Putting the Patient on Driver's Seat (POTKU) programme 2010–2012

- Actors: public primary care organizations (health centres) in 62 municipalities
- Aim: to develop care for people with chronic conditions, people with multi-morbidity as part of the target patient group
- The project design: Chronic Care Model
  - Aim to improve all functions included in the model, setting the patient in the centre of the care; including also multi-discipline cooperation between health care professionals.
  - Definition of multimorbidity:
    1. Patients with multimorbidity and/or patients who use a lot of services of many organizations or clinics, who need special support or to whom it is important to outline a holistic plan of care,
    2. Patients who are heavy users of services, but whose services do not meet the needs,
    3. Long term patients or patients who have dropped out of the service system, patients who need proactive planning of care.

Strengths

1. The traditional **organisation-centred model** of care pathways **has reformed into a patient-centred model**. The pathway describes a service system that is tailored to clients' needs while at same time being clear, effective and cost-efficient.
2. A **mutual culture** of staff development has been created.

Weaknesses

1. The **current system**, in which one patient is treated by different organisations, does not facilitate management of the patient's overall process.
2. Lack of **management skills**
3. Lack of **quality and impact indicators**

Programme was financed by the Ministry of Health and Social Affairs through the national development programme http://www.potkuhanke.fi/fi/potku-i-etusivu

Developing Case Manager Model for Patients with Multimorbidity 2013–2014 (ESF project)

Aim: to develop and implement the Care Manager Model for patients with multimorbidity in (public) health care organizations through increasing the competencies of care staff

Based on: Chronic Care Model

People with multimorbidity was explicitly addressed in the aims, but they are an indirect target group; the actual target group are the nurses attending the course (education project) and the organizations in which they are working

See more: http://www.metropolia.fi/tutkimus-ja-kehitys/hankkeet/terveys-ja-hoitoala/esr-asva/

Care Path for Patient with Multimorbidity

- A care chain for patients with multimorbidity
- Developed by Pirkanmaa hospital district (see POTKU programme)
- It has been developed by a multi-disciplinary team, coordinated by one of the hospital districts in Finland

Care Model for Patient with Multiple Diseases in Primary Care

- Developed by City of Helsinki, development group of non-clinical healthcare

- These both are tools for care professionals, include guidelines, check-lists for professionals and other basic information materials, patient information and self-care in a same place
- Both are available in Finnish on the Web http://www.terveysportti.fi/

To conclude

- There are many initiatives to integrate care services
- Not clear/main focus on multimorbidity (yet), but multimorbidity mentioned in the aims
  - Is inter-organizational cooperation between organizations emphasized clearly enough?
  - The role of the social care in integration processes?
  - The role of the informal care, patient organizations, relatives etc?

- Patient-centredness (e.g. care paths) emphasized quite well
- The outputs? –From whose perspective? Financial?
- Attempts to start experiments on the area of 'heavy users' of care

Thank you!

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