Chronic disease

• Nearly half of the population will have a chronic disease

• Measurements shows that patients with heart disease is the single biggest gro
Goal

• **Effective goal**
  - Cost effective care

• **Project goal**
  - Decrease unnecessary registration in hospital
  - Decrease unnecessary readmission
  - Decrease unnecessary polypharmacy

• **Quality goal**
  - People with chronic disease get the service they need from primary care to be able to live with a high quality of life
The mission

• To develop a model that is generalized to other chronic disease

• Test the model at some pilots in primary care

• Is it possible? Patients with heart failure are the largest group. Can we create nurse-lead visits for each diagnosis in primary care??
Heart failure – process map

Patient med dyspné

DL på VC

Svikt ssk. VC

Hemsjukvård

UKG Klin. Fys.

Ssk. hjärtsviktsmott.

Läkare sviktmott.

Medicin vårdavdelning

ME/kardiologen vårdavdelning

Akuten

Invasiva utredningar? Sviktpacemaker

Hjärtdagvård? 10%

Fysioterapi

Mobilt Hjärtsviktsteam? 1 miljon
Together for the best possible health and equal care

1177 Patient-medverkan/anhörig-medverkan
Samhällsaktiviteter/Vardagsliv

Lärcafé Patientföreningar Anhörig-medverkan

Primary care

Transparency

Specialist care
Pilot for heart failure

- Cooperation between primary care doctors and heart failure nurse and a cardiologist and heart failure nurse from the hospital
- Heart failure team is expanded with:
  - district nurse in homecare
  - physiotherapist
  - counselor / psychologist if necessary
  - Dietician if necessary
15/11 2016
Start Pilot
primary care
Hälsan 1

Autumn 2017
Start of
5 - 6 primary care
units in the region

2018
Generalization
of this work in
primary care 2018

Continued work on the basis of experiences in the pilot