Mobile teams – Mobile Esther teams
Care coordination - Care planning
What is best for you, Esther?
Who need to cooperate to make that happen?
What improvements needs to be done?
New legislations January 2018

- Improved cooperation between region health care and community care; the care continuum
- More efficient use of our combined resources in health care and community care = better care for the patients
- From Hospital care to Health care provided timely and close to Esther in her familiar home environment
- Primary care as the base of health care
- No one in hospital unnecessarily
- Care coordinator
- Coordinated individual plan - SIP

Requirement to develop common guidelines for better cooperation
Secure and safe health care and community care
Global aims

• Esther feels safe at home and can say "I get the care I need when I need it and where I need it"
• Less avoidable hospitalizations
• If hospitalization is needed: Esther is involved and secure during the process
• All Esthers get good and safe care on equal terms throughout the county
Project Mobila teams

• Understand and develop new approaches to care when Esther is at home

• Improve cooperation, quality and competence to create value for Esther at home

• Esther Mobile Teams strengthen the care at home
Care situations

Non ending

Ending

One unit

Several units

Leading Health Care
Project Mobile teams

Esther Mobile Team aims to strengthen the care when Esther is at home

For patients with comprehensive and/or complex needs

*Keywords: Person Centered, Proactive, Secure, Planning, Coordinated, Mobile*
Mobile Estherteams Test w 3-14

Team collaboration in existing primary care centers and community care where the patient is listed
Project Care coordination

Improvements started:

• New coordinated individual care planning process
• Coordinated Individual Plans, SIP
• New IT-support, LINK, Messenger
• Care coordinators in Primary care centers
New coordinated care planning process

**Target group**
Care planning process for patients of all ages, who after discharge from hospital care need efforts from social services, the community care and / or the county-funded primary care

**Admission to hospital**
Information to primary care and community care

**Planning length of stay**
Information to primary care and community care. Planning starts

**Discharge message**
Patient will be able to come home in 24 hours

**Care planning at home**
Coordinated care planning is done, SIP

IT system: Link and Messenger
Coordinated individual plan, SIP
Care coordinator at primary care centers

- Phone number for direct access
- Regular contact
- Improving care for patient with comprehensive and/or complex needs
- Prevent avoidable hospitalizations
- Coordination with community care
- Coordinate home visits
- Take part in care planning and individual care plans

http://plus.rjl.se/infopage.jsf?childId=20292&nodeId=43149
The Microsystem Festival 2017
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