Chapter 13

Conference papers for theme 4

National learning network for good patient care pathways

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ABSTRACT

Care pathways are required to effectively transfer the care of elderly and chronically ill patients from the tertiary or secondary care establishments to the community environment. The deployment of excellent care requires pathways that enables a seamless transition of care and needs communication, an appreciation of the limitations of care practices, logistic and infrastructural issues that might arise at the patients final destination of care.

This requires closely involving community, district or municipality healthcare professionals who understand the patients care needs to ensure that the patient is receiving ongoing support to aid their continuing recovery. Unfortunately for the SARS-CoV-2 cases where discharging the recovering patient meant placing them back into an environment of isolation even for healthcare professions, robust care pathway models became necessary. This was necessary for those with additional care and rehabilitation needs who were then impacted by the concern of transmission to other vulnerable groups.

The lack of robust frameworks for good patient care pathway was studied by the Norwegian institute of public health who present a national best practice case study to show how this could be achieved.

INTRODUCTION

The Association of Local and Regional Authorities (KS) is implementing an initiative called "National Learning Network for Good Patient Care Pathways" in collaboration with the Norwegian Institute of Public Health (NIPH). [1-3] The work is funded by the Ministry of Health and Care Services (HOD), which also heads the steering committee. The purpose is to support municipalities and health trusts in improving transfer of care and to safeguard users' needs for comprehensive, safe and coordinated services. Good Patient Care Pathways for the elderly and chronically ill began with two learning networks in 2014–2015. Since 2016, eight more learning networks have been established. These regions included almost half of the country.

A decision was made to continue Good Patient Care Pathways in the period 2020–2023 so that all the country's municipalities and health trusts have the opportunity to participate in learning networks. While separate learning networks have previously been implemented for the elderly and the chronically ill, and for mental health and substance abuse, the work in the period 2020–2023 will include all adult users who receive municipal services. The duration of the learning networks is 18 months. Before start-up, there is a preparation phase of three months. There are four meetings during the network period. A meeting where participants can exchange experiences is held about one year after the fourth network meeting. In addition, there is an annual national meeting where participants can exchange experiences.

DESCRIPTION OF GOOD PRACTICE

The learning networks for Good Patient Care Pathways aim to improve the transfer of care, both internally in municipalities and hospitals and between hospitals and municipalities. The tools and methods used for improvement work are research-based and built on knowledge of what works in practice.[1] The foundation of Good Patient Care Pathways is twofold. The work must result in users experiencing equality in the preparation of their continuity of care plan. That's why the question "What matters to you?" is so central. An important tool for strengthening the user role is the form entitled "What matters to you?". The purpose of this form is to acknowledge that patients are experts on their own lives, to assign services based on what is important to each patient, and to allow patients (together with service providers) to

assess the usefulness of the services provided. The "What matters to you?" form is based on the Patient- Specific Functional Scale (PSFS) and translated into Norwegian and validated by Professor Ingvild Kjeken. However, it is of little help to ask patients these questions if the person asking does not listen to the answers and take action accordingly. In addition, it also does not help to ask if the interdisciplinary team does not plan and systematise patient care pathways in a way that makes it clear who is responsible for what; users must experience integrated, coordinated and safe patient care pathways.

The second part of Good Patient Care Pathways is a generic care pathway (Patient Trajectory for Home-dwelling elders – PaTH), a general pathway with a structured discharge process that can be used for all patient groups, regardless of diagnosis.[2 3] PaTH started as an interdisciplinary development pro ject in Central Norway in 2009. Anders Grimsmo, professor emeritus of the Norwegian University of Science and Technology (Norges teknisk-naturvitenskapelige universitet, NTNU), played a key role in this development work and participates in all network meetings. Procedures and checklists adapted to local conditions have been prepared for each element in the chain of cooperation. The patient is reported as ready for discharge and information is exchanged, either in a physical meeting or by telephone. Home care services are established, the primary nurse is appointed, and needs are mapped within three days, possibly only after an intermediate/short-term stay.[3] After 14 days, everyone who is offered municipal home care services must visit or receive a visit from their GP. Everything is evaluated by the primary nurse and adjusted as needed after four weeks. A municipality will only in exceptional cases be the one to initiate a patient care pathway following discharge from hospital. Most often, the patient care pathway is initiated after individual users experience a decline in health and functional ability, and – on their own initiative or with the help of relatives – ask for help. Other municipal services may also detect a need for assistance. Patient care pathways that start following discharge from hospital comprise such a small proportion of all patient care pathways that it would not be expedient to have special procedures for this group. Municipalities that have succeeded with integrated patient care pathways use the same framework for all patient care pathways for users in need of municipal care and treatment services. The same scheme can be used for new patients and annual reviews.

EVIDENCE OF IMPACT AND SUSTAINABILITY OF GOOD PRACTICE

A Challenging Year

The COVID-19 pandemic greatly affected work with Good Patient Care Pathways. After 12 March 2020, it was not possible to hold physical network meetings, and considerable work therefore went into adapting the meetings to an online format. Among other things, this included shortening presentations and using new tools for collaborating and sharing experiences. Efforts were made to make the meetings more interactive, and guidance from improvement teams had to be implemented in new ways.

This approach is also in-line with the practice of shared medical appointments and combined medical reviews for diseases with comparable requirements in multiple patients.

We have now returned to physical learning collaborative meetings, but coaching has continued to be virtual. We also try to motivate health services to reflect on, learn by and grow through the best experiences from the time of the pandemic.

Keywords: national learning networks, good patient care, care pathways, generic care pathways

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