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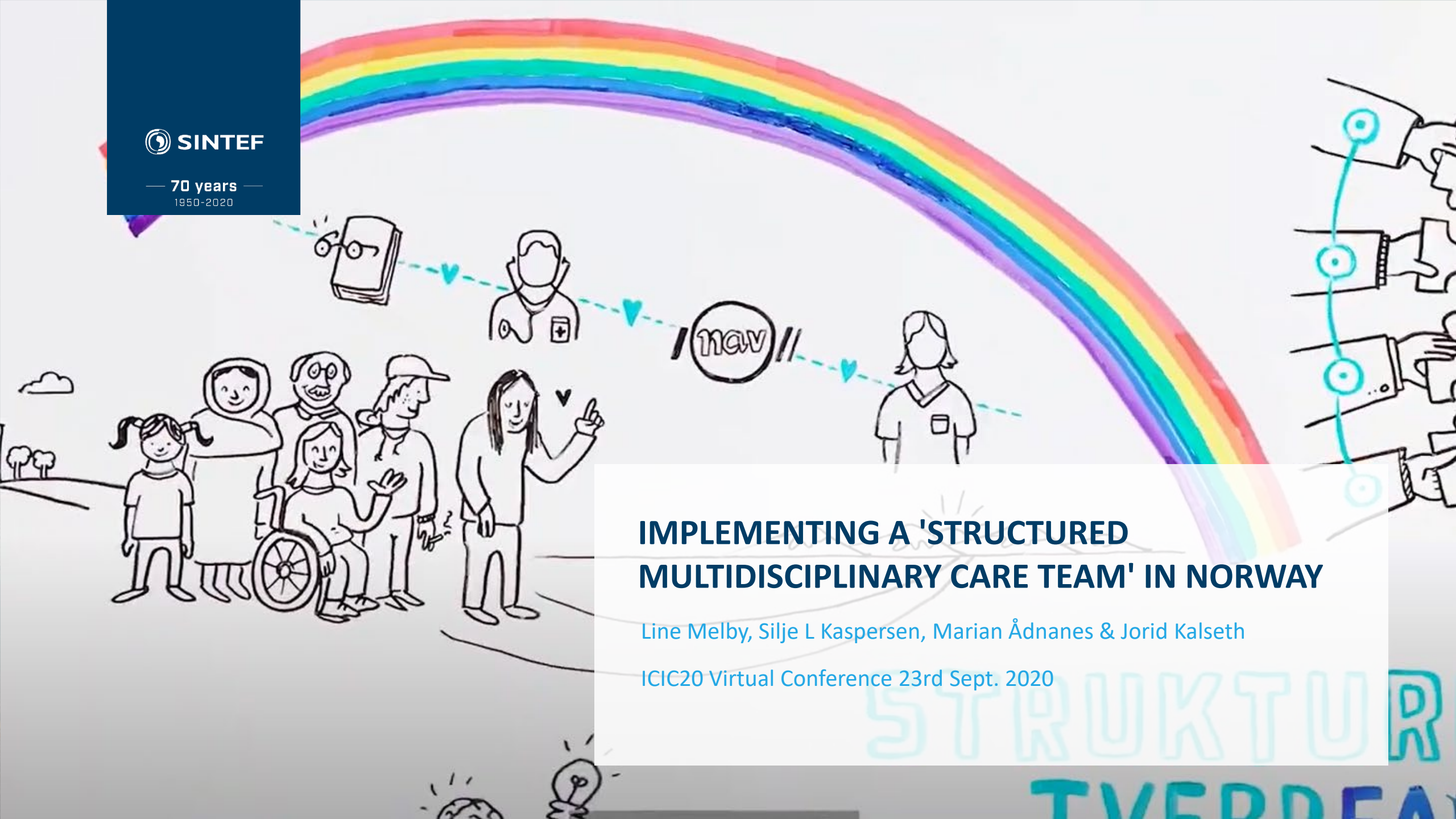

IMPLEMENTING A 'STRUCTURED MULTIDISCIPLINARY CARE TEAM' IN NORWAY

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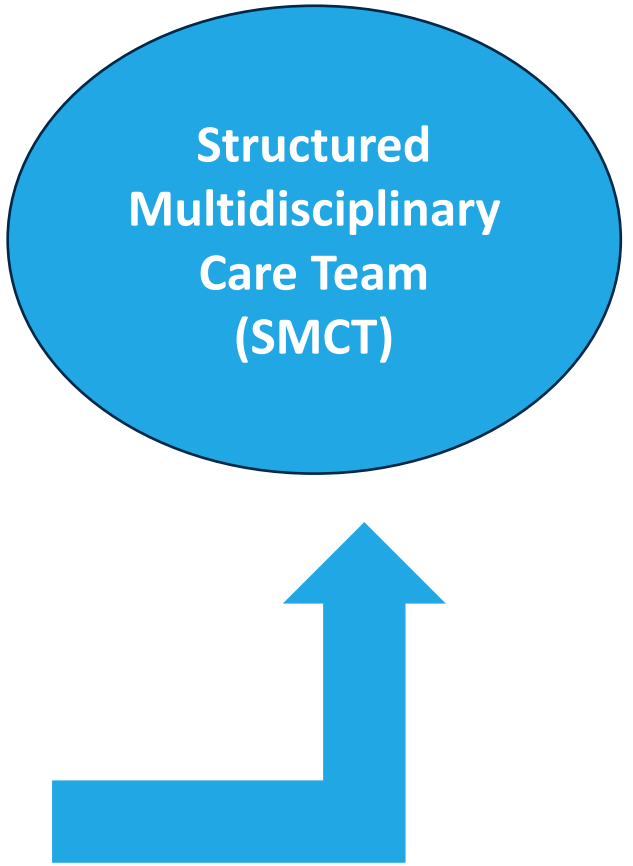
Introduction

- In Norway, several measures have been implemented to create integrated care. Examples are Individual care plans, various teams, as well as coordinators for specific diseases/conditions
- BUT: Persons with long term, complex needs still experience a lack of coordination and fragmented services
- On this background, Norwegian health authorities have issued new recommendations for how to follow up persons with long term complex care needs



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Who and how?

- **Who?** The target group comprise persons with comprehensive and complex needs (healthcare, welfare/labour services, child welfare etc.), *independent of age and diagnoses.* They are among the 3-5 % of the population who has the highest need and risk for services.
- **How?** Through systematic assessment of care needs and establishment of a dynamic, small, multidisciplinary care team led by a coordinator. User involvement is emphasised, and users should be surveyed by the instrument PSFS (Patient Specific Functional Scale)

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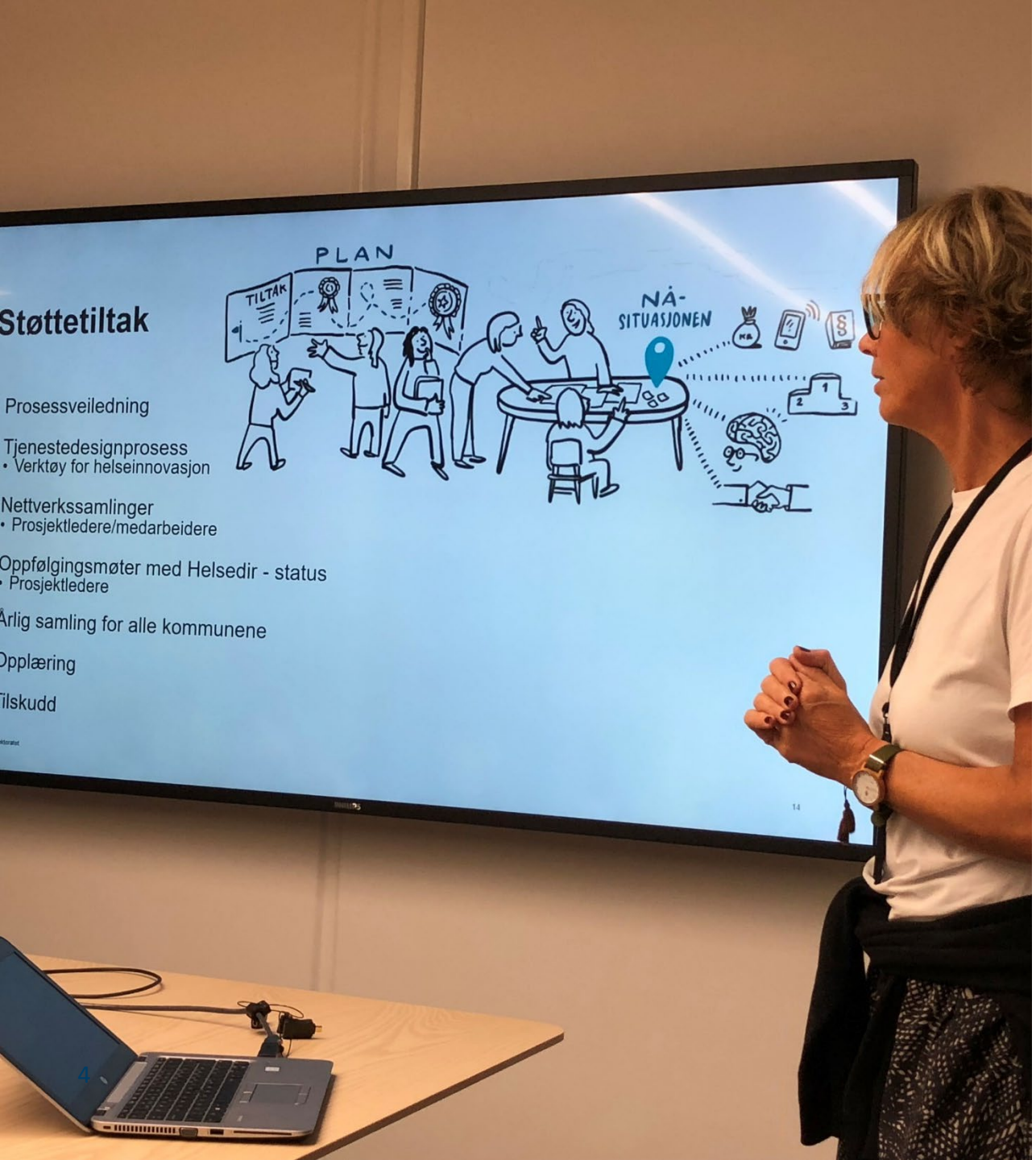

The pilot project

- Duration: 2018-2021
- The Norwegian Directorate of Health owns the project
- Six municipalities across Norway ('pilot municipalities') received financial- and process support to implement the new recommendations

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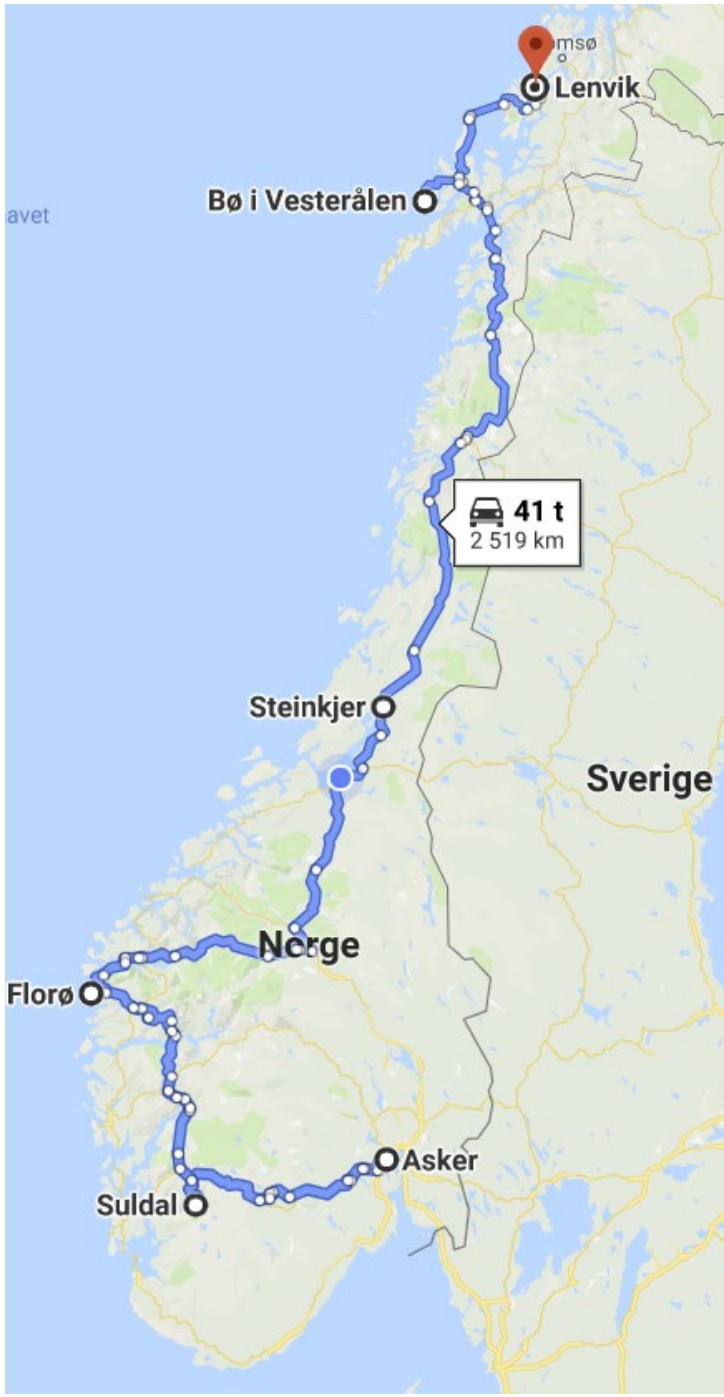
The research study: objectives

- In the overall study we investigate
  - Providers' and patients'/users' experiences with the team organisation
  - Patient outcome
  - Economic consequences for the municipalities and for the specialist healthcare

- In this presentation, we focus on the first phase of the implementation: **how do municipal service providers work and reshape work processes to detect and enrol all their inhabitants with long term complex care needs into SMCTs?**

Data collection

- Methods: semi-structured interviews with employees in the six pilot municipalities (N= 175), as well as with users/patients. Here we only use data from interviews with employees.
  - Participants: staff working in healthcare, social work, child welfare, schools, kindergardens, and the Norwegian Labour and Welfare Administration, and clerical staff in the municipal administration, as well as health and social top managers



Results

✓Working according to the structured multidisciplinary team- way of thinking is not radically new, but has nevertheless been experienced as quite challenging

The most frequent challenges when implementing the team, demanding reorganisation of work processes and new routines:

1. How to systematically identify *all* persons in the target group
2. Recruiting and training coordinators for the teams
3. Involvement of users in their own care team

1. Identification of *all* persons with long term complex needs

I am preoccupied with our municipality having one system for identification, so we can say that "we do it like this!" We should not have one system for detecting children in need and one for adults. We need to have a common understanding, a common policy

Project manager in one of the pilot municpalities

- It is managers' responsibility to ensure that inhabitants are screened, assessed and identified
- GPs are assigned a crucial role in identification through a digital risk assessment tool
- The municipalities need an easy channel where one can refer potential patients to the team (their own specific team)

2. Recruiting and training team coordinators

- Coordinators need training and access to support
- They also need *time* to do the coordinator job
- The coordinator position should be divided between more staff

My employees think it is all right to be a coordinator, but if you ask others in the organisation, I guess they would say it is a pain in the neck. So you have to 'sell it' as a task that will make you grow as a professional. And that it will make our inhabitants in better health, so we can focus more on those that really needs us

Manager

3. Patient involvement in the team

- Digital tools for individual care plans may strengthen user involvement but may be too advanced for many users. Also many providers' find it hard to use
- All pilot municipalities should use The PFSF instrument (What matters to you?)
- The most important opportunity for securing patient involvement is in the face to face meetings between providers and patients (according to providers)

Buttons with the slogan "What matters to you?"

Summarised

- We found large variations between the pilot municipalities concerning their 'readiness' for implementing the 'structured multidisciplinary care team' model
- Many challenges arose as they started to work on preparing for implementation. However, many of the challenges were common. We have presented three of the most important

Discussion


Implement the team!
Competence and skills: Ensuring that staff receives proper training and support so they can act as team coordinators, assess patients needs etc.
Organisational commitment: securing mangerial support, establish routines for referring potenial patients to the team
Municpal preparedness: informing about the new team, establishing arenas for collaboration and communication across the muncipality,

Conclusion

- SMCTs can be useful arrangements for persons with long term complex care needs. However, providing all potential users with such teams requires work on many levels; e.g. new collaboration routines, systems for identifying users, and increased competence among providers
- SMCTs should be considered a complex intervention, implying that it is time consuming and complicated to implement them, and difficult to foresee all the effects

THANK YOU FOR YOUR ATTENTION!

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