South Karelian social and healthcare district (EKSOITE)

HOMEREHABILITATION

Rehabilitation supporting the elderly in every stage of the service path

Riikka Lehmus, Unit supervisor 31.1.2018
COSTS, PRODUCTIVITY AND AGEING

HEALTHCARE HAS BEEN LOSING PRODUCTIVITY
SERVICE SECTOR PRODUCTIVITY DECLINING SINCE 1980S, ESPECIALLY IN HEALTHCARE

Productivity by selected sectors
Retail
Information
Manufacturing
Finance
Services
Hospital/long-term care

— Average annual rate of change 1987-2014 —

3X
Gap between most & least productive companies

Normal aging specific prognosis and costs
Effective home rehabilitation and other early interventions
THE SERVICE USAGE PROFILE AND COSTS IN SOUTH KARELIA 2016

Part of these costs and visits are preventable by using AI and anticipatory analytics.

Pushing customers, visits and costs occur later.
From Volumes to Values

Value outcomes:

– Reduced long term care in facilities and long term care
– Care delivered in remote versus acute settings
– New emergency models and surgical interventions avoided
– Effective home rehabilitation interventions
– Real world data analyses and clear view of the patient journey
– Measuring outcomes instead of volumes

Value will be a standard of care and cure
From centralized to distributed services

- Hospitals
- Invested in decentralized services
- Coordination of resources and knowhow 24/7
- Home based models
- Cost-effectiveness
- Flexible use of resources
- fixed resources
Restructure – Beds
EKSOTE ORGANISATION

CEO

Family and social welfare services
Health and elderly services
Rehabilitation
Strategic support services

Processes

Promotion of health and welfare
Service needs assessment
Rehabilitation and discharging
We have developed homerehabilitation in Eksote since 2010. At the beginning we didn´t have much staff to work on the field and that´s why we started to support home care workers to sustain customers functional ability. This is very important also today though we have much more resources and our interventions provided by rehabilitation professionals are very intensive.

Strategically the main point has been brave change from institution based models to home based models. We have moved our nurses duties to physio- and occupational therapists duties. We have integrated our processies and put the effort to early stage. We have decided to work multidiciplinary in all our processies.

Now we want to discharge very rapidly and straight to home if possible and support them. We want to develop wide customer management solutions in the future to improve our processies.
Early interventions

- Multiciplinary service needs assessment
- Family care givers early support and coaching
- Early support for people with memory impairments
- Home visits that enhance well-being
- Low threshold receptions (Isoapu-service center)
- Enhancing health in collaboration with organizations and volunteer workers
- Service guidance and internet advice, chat-services
MEMORY IMPAIRMENTS – Rehabilitation path after diagnosis

Memory impairment

Reception of a physiotherapist

Home visits (physiotherapist) 1-5 times

Physiotherapy groups
Municipal exercise groups
3. sectors and organisations groups

Eksote memory impairment rehabilitation groups

Eksote memory impairment and their next of kin rehabilitation

Eksote multidisciplinary homerehabilitation

Memory impairment coordinators
EASY-ACCSES MODEL TO ELDERLY SERVICES

Discharge from hospital

Service needs assessments and service guidance teams

CUSTOMER MANAGEMENT SOLUTIONS (SBM)

Multidisciplinary service needs assessment

Centralized discharge

Multidisciplinary home-rehabilitation

Family care givers assessments - process

 regularization home-care?

No need for services

Support interventions

Homecare rehab. intervention

Private / 3. sector
# CENTRALIZED DISCHARGE

<table>
<thead>
<tr>
<th><strong>What?</strong></th>
<th>Centralized discharge-model: Multidisciplinary service and rehabilitation needs assessment and support interventions.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why?</strong></td>
<td>The goal is a unified service model to all citizens. The action seeks more knowledge and process monitoring.</td>
</tr>
<tr>
<td><strong>To whom?</strong></td>
<td>To all discharged patients who has no regular homecare but the need for services.</td>
</tr>
<tr>
<td><strong>How?</strong></td>
<td>Discharging unit orders a service needs assessment to the customer. Nurse and a pt / ot makes the assessment at customers home at the same day when discharged. They also will start the necessary interventions to support daily living and rehabilitation. They also evaluate the need of home care and start the process if needed. Home care rehabilitation-intervention will last 4-6 weeks before the decision of regular homecare. The team follows all the time the progress of rehabilitation and need of services.</td>
</tr>
<tr>
<td><strong>Resources?</strong></td>
<td>Lappeenranta Four nurses + three physiotherapist + occupational therapist + three practical nurses = 11 person-years &lt;br&gt; Imatra Two nurses + physiotherapist + occupational therapist + two practical nurses</td>
</tr>
<tr>
<td><strong>Duration?</strong></td>
<td>0-6 weeks</td>
</tr>
<tr>
<td><strong>Goal?</strong></td>
<td>Less than 50% of customers end up regular home care customers</td>
</tr>
</tbody>
</table>
4. **Homecare evaluation intervention** will always begin for new customers who need homecare support.

Purpose of this intervention is to evaluate customers functional ability and real need of services or care. **Duration 4-6 weeks**. The goal is to restore functional ability. This team supports homecare with different interventions (below).

At the end of intervention team will discuss together with home care workers and other specialists to make a decision about regular homecare.

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**Service needs assessment request**

- Discharging customer who is not a regular home care customer but has a need of services.
- Request from discharging unit

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**Centralized discharge – unit**

**MULTIDISCIPLINARY SERVICE NEEDS ASSESSMENT**

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**1. No need for homecare evaluation intervention or other interventions** (no daily need of care), service needs guidance

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**2. Intensive multidisciplinary home rehabilitation intervention** 6-8 weeks (2-3 x / week)

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**3. Supportive intervention**

- Practical nurse or nurse 1-2 x weeks max. 6 weeks.

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**Regular homecare will begin**

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**No need for homecare anymore**

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**Further actions** (Friend to help going outdoors, municipal exercise services, 3. sector, private sector etc.)
<table>
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<tr>
<th><strong>What?</strong></th>
<th>Multidisciplinary homerehabilitation intervention at customers’ home by physio- and occupational therapists.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Why?</strong></td>
<td>To recover functional ability in acute situations. To support discharging. To prevent useless need of services. To extend the living environment.</td>
</tr>
<tr>
<td><strong>To whom?</strong></td>
<td>Discharged patients, customers who lost suddenly their functional ability. Uhka toimintakyvyn alentumisesta ja palvelutarpeen kasvamisesta. Kotihoidon asiakkaat. Palvelutarpeen arviöinnin kautta tulevat.</td>
</tr>
<tr>
<td><strong>How?</strong></td>
<td>Multidisciplinary evaluation and rehabilitation plan. Physiotherapy and occupational therapy, focused on functional daily practising and extending the living environment.</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td>27 therapists (physiotherapists and occupational therapists)</td>
</tr>
<tr>
<td><strong>Kesto</strong></td>
<td>Approx. 6-8 wk, 3 x week, about 60 min at the time.</td>
</tr>
<tr>
<td><strong>Tavoite</strong></td>
<td>More value and quality of life to customers. Reduce the need for services.</td>
</tr>
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DATA-BASED DECISION MAKING AND RESULTS

Transparency in all actions.

Value and information-based management, high quality efficiency and performance.
21000 homerehabilitation visits in 2017
# Over 75-year old living at home in Finland and in South-Karelia 2010 ja 2015

<table>
<thead>
<tr>
<th>Väestö +75-vuotiaat, vertailua</th>
<th>Etelä-Karjala</th>
<th>Koko maa</th>
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</thead>
<tbody>
<tr>
<td>People, over 75 year old, %</td>
<td>10,2</td>
<td>11,8</td>
</tr>
<tr>
<td>Living at home, %</td>
<td>90,1</td>
<td>93</td>
</tr>
<tr>
<td>Regular homecare customers,%</td>
<td>10,5</td>
<td>13,1</td>
</tr>
<tr>
<td>At nursing homes, %</td>
<td>4,1</td>
<td>5,2</td>
</tr>
<tr>
<td>Long term care in wards, %</td>
<td>4,9</td>
<td>1,7</td>
</tr>
<tr>
<td>Cared by family care keepers, %</td>
<td>4,1</td>
<td>5,5</td>
</tr>
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Eksote 2017 95,2%
Rehabilitation intervention and integrated services for new customers before regular homecare

-56%
Cost-effectiveness – Homerehabilitation and new discharging model

- 2014: 23000€ / person
- New models: 15000€ / person

= -8000€ / person

= SAVINGS  3M€ = 30%
Operating costs per customer (rehabilitation)

Toimintakulut per asiakas (Kuntoutus)

- **Nursing home**
- **Home care customers**
- **Family care giver customers**
Thank You!

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