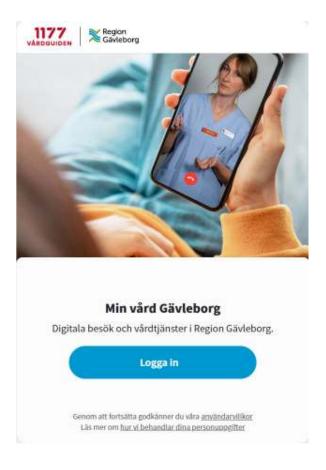
Transforming healthcare

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Gävleborg County

- > 293 000 inhabitants
- > 3 emergency hospitals
- > 43 primary care centers (18 private)
- > Funded by regional taxes and aimed aid
- > Transregional compensation
- Politically governed health care





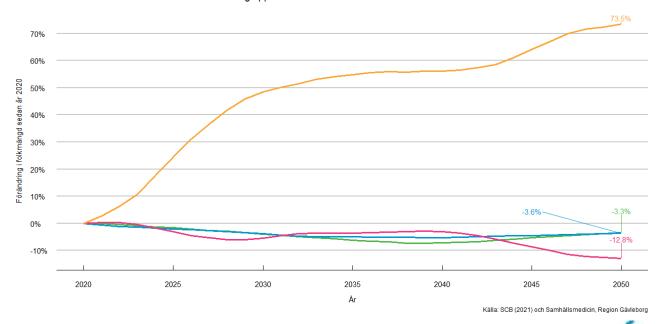
Why Min Vård Gävleborg?

- > Political decision
- "If the banks can, so should we"
- ➤ Higher access = Higher consumtion?



Procentuell förändring i olika åldersgrupper, 2020-2050 Aldersgruppernas forändring i Gävleborgs län jämfört med är 2020

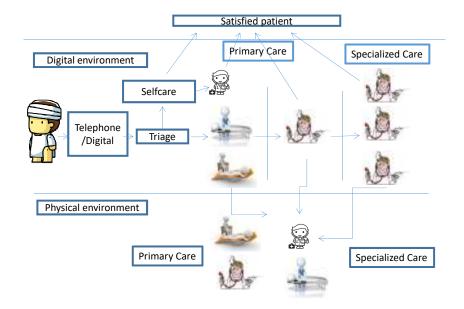




DIGITALA VÁRDMÖTEN

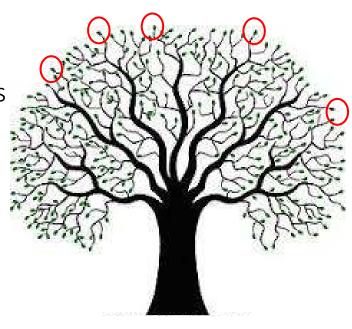
What?





Every triage exit has 5 attributes

- ➤ Profession
- ➤ Speciality Diabetes, Asthma, Cancer etc
- > Care unit
- ➤ Care form Digital, Physical, Self Care
- ➤ Urgency 12 levels





Potential recipents



Why so complex?

- > Task shifting
- > Quickly adapt "best practise", new guidelines etc
- Quality assured guiding
- ➤ Higher access ≠ Higher consumption



"Side effects"

- > Conference calls/chat
- Consulting
- Questionnaires
- > Asynchronous chat with your care giver
- ➤ Municipal care autumn -22?



Chronic diseases

- > Better surveillance
- > Higher autonomy
- > Deeper insights



Reumathoid Arthritis

- > 1800 patients
- > Self initiated checks if suspected detoriation
- > Activate questionnaire
- > Order lab test
- Composite index
 - * 0-2,8-> Self Care
 - * 2,8-4,2-> Chat with a reumathology nurse
 - * >4,2 (or siginificant trend) -> Chat with reumathologist



Disrupting the way we measure health care

- > Is an auto-triage a visit? If the patient refers herself to an X-ray?
- ➤ Is a chat a visit? When? Who is producing when we're having a 3-way chat/video?
- > Is an online chat-consultation a referral?
- > Are our patients with reumathoid arthritis on a waiting list?
- ➤ No visits-no DRG-production
- ➤ Best case scenario: Low production, high access. But how will our state aid/transregional funding be collected?



Questions?

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