SJÚKRAHÚSIÐ Á AKUREYRI
AKUREYRI HOSPITAL
A TEACHING HOSPITAL AFFILIATED WITH THE UNIVERSITY OF ICELAND AND THE UNIVERSITY OF AKUREYRI

Alþingi
Erindi nr. Þ 139/955
komudagur 14. 12. 2010

Nefndasvið Alþingis,
Austurstræti 8-10,
150 Reykjavík.

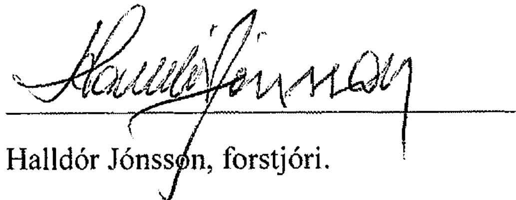
Akureyri 14. desember 2010.

Efni: Umsögn um þingsályktunartillögu um heimsóknir til eldri borgara í forvarnarskyni, 8. mál.

Framkvæmdastjórn Sjúkrahússins á Akureyri hefur fjallað um framangreinda þingsályktunartillögu og óskað eftir umsögn yfirlæknis öldrunarlækningadeildar Sjúkrahússins á Akureyri.

Meðfylgjandi er umsögn yfirlæknisins og sendist hún sem umsögn Sjúkrahússins á Akureyri um framangreinda þingsályktunartillögu.

Virðingarfyllst,



Halldór Jónsson, forstjóri.

Meðfylgjandi: Umsögn um tillögu til þingsályktunar um heimsóknir til eldri borgara í forvarnarskyni, 8. mál.

HJ2010032

Heimilisfang / address
Eyrarlandsvegi,
IS 600 Akureyri
Ísland / Iceland

Sími / Telephone 463 0100 / +354 463 0100
Póstfax / Telefax 462 4621 / +354 462 4621
www.fsa.is
fsa@fsa.is
Kennitala / ID: 580269-2229

Viðskiptabanki / Bank
Byr - sparisjóður
Reikningur / Account number 1145-26-3100
IBAN IS97 1145 2600 3100 5802 6922 29
SWIFT (BIC): LSICISRE

139. löggjafarþing 2010-2011.

Þskj. 8 -- 8.mál.

Umsögn um tillögu til þingsályktunar um reglubundnar árlegar heimsóknir til eldri borgara í forvarnarskyni.

Undirrituð er hlynnt reglubundnum heimsóknum til eldri borgara og telur þær hafa visst forvarnargildi en metur það jafnframt svo að beina ætti einstaklingum þar sem grunur er um heilsubrest til mats fagaðila innan heilbrigðiskerfisins.

Heimsóknir af þessu tagi henta vel til könnunar á þörfum aldraðra fyrir félagslega þjónustu af ýmsu tagi og auðvelda skipulag þjónustunnar. Fái einstaklingur í þörf fyrir slík þjónustuúrræði notið þeirra í kjölfar heimsóknar getur hann líklega dvalið lengur á eigin heimili og utan öldrunarstofnunar. Á Íslandi er stuðningur fjölskyldu við aldraða einstaklinga oft umtalsverður. Telja má að gagnsemi reglubundinna heimsókna öldunarþjónustufulltrúa muni nýtast sérlega vel þeim einstaklingum er ekki njóta slíks stuðnings.

Heimsóknum er ætlað að hafa forvarnargildi. Í greinargerð með þingsályktunartillögunni er rætt um að öllum íbúum 75 ára og eldri bjóðist heimsókn x1-2 á ári af öldrunarþjónustufulltrúa í Sveitarfélaginu Kaupmannahöfn. Í heimsókninni er farið yfir alla þætti sem varða heilsu og aðstæður þess aldraða og metið hvort viðkomandi þurfi á einhverri aðstoð að halda eða ekki. Að mati undirritaðrar er slíkt mat býsna víðtækt þegar kemur að heilsufarslegum þáttum og kallar á viðhlítandi menntun og reynslu öldrunarþjónustufulltrúans. Um það er ekki rætt í greinargerðinni. Það gerir kröfu til glöggskyggni nefnds öldunarþjónustufullrúa að koma auga á smávægilegan heilsubrest sem getur undið upp á sig þannig að hinn aldraði þurfi stofnanavist eins og segir í téðri greinargerð. Aldraðir einstaklingar með vitræna skerðingu eru viðkvæmur hópur og finna sökum sinna veikinda ekki alltaf sjálfir að þeir þurfi aðstoð. Mikilvægt er að finna þessa einstaklinga svo þeir eigi möguleika á viðeigandi greiningu og meðferð. Mat á heilsufari aldraðs einstaklings í þeim tilgangi að finna einkenni um heilsubrest á byrjunarstigi ætti að fara fram innan heilbrigðiskerfisins. Því þarf að tryggja samstarf milli skipuleggjenda heimsókna af þessu tagi og heilbrigðiskerfisins þannig að öldruðum einstaklingum þar sem grunur vaknar um heilsubrest standi til boða faglegt mat á heilsufari innan heilsugæslunnar.

Virðingarfyllst,

Arna Rún Óskarsdóttir

Yfirlæknir öldrunarlækningadeildar Sjúkrahússins á Akureyri.

Alþingi
Erindi nr. Þ 139/723
komudagur 7.12.2010

hjúkrunarráð FSA

13. des, 2010

Til
Nefndarsviðs Alþingis,
skrifstofu Alþingis,
Austurstræti 8-10,
150 Reykjavík

Meðfylgjandi eru frumrit af tveimur umsögnum sem þegar hafa verið sendar í tölvupósti.

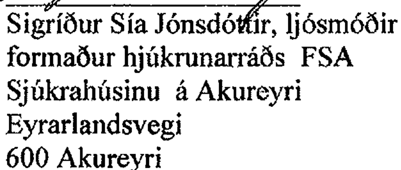
Þetta eru:

1) **Umsögun um þingsályktunartillögu um beina þátttöku fulltrúa sveitarfélaga og starfsmanna heilbrigðisstofnana í skipulagningu og stjórnun heilbrigðisþjónustu í heimabyggð.**
Þingskjal nr: 42 — 41. Lag fram á 139. löggjafarþingi.

X 2) **Umsögn um þingsályktunartillögu um reglubundnar árlegar heimsóknir til eldri borgara í forvarnaskyni. Þingskjal nr: ~~42 — 41.~~ 8. mál Lag fram á 139. löggjafarþingi.**

Virðingarfyllst,

F.h. stjórnar hjúkrunarráðs FSA



Sigríður Sía Jónsdóttir, ljósmóðir
formaður hjúkrunarráðs FSA
Sjúkrahúsinu á Akureyri
Eyrarlandsvegi
600 Akureyri

hjúkrunarráð FSA

6. des, 2010

Til
Heilbrigðisnefndar Alþingis,
skrifstofu Alþingis,
Austurstræti 8-10,
150 Reykjavík

Efni: Tillaga til þingsályktunar um reglubundnar árlegar heimsóknir til eldri borgara í forvarnaskyni. ~~Þingskjal nr: 42 — 41:~~ Lag fram á 139. löggjafarþingi.

8. mál

Stjórn hjúkrunarráðs FSA hefur fjallað um þingsályktunartillöguna og styður hana. Af reynslu frá Danmörku má sjá að heimsóknirnar hafa skilað árangri. Það sama er að segja hér á Akureyri en heimsóknir sem þessar, að danskri fyrirmynd, hafa í 10 ár verið hluti af starfsemi búsetudeildar Akureyrabæjar í samvinnum við Heilsugæslustöðina á Akureyri.

Í tillögunni er talað um að „öldrunarþjónustufulltrúa" sinni þessum heimsóknum en nánari skilgreining á menntun þeirra og reynslu kemur ekki fram. Heimsóknir hér á Akureyri eru í höndum hjúkrunarfræðinga og iðjuþjálfa og leyfum við okkur að benda á þær stéttir hafa sterkasta grunnmenntun á þessu sviði og tryggja þarf að fagaðilar munu sinna þessum heimsóknum. Einnig er mikilvægt að öllum landsmönnum yfir 75 ára aldri verði boðnar þessar heimsóknir, hvar á landi sem þeir búa.

Virðingarfyllst,

F.h. stjórnar hjúkrunarráðs FSA

Sigríður Sía Jónsdóttir, ljósmóðir
formaður hjúkrunarráðs FSA
Sjúkrahúsinu á Akureyri
v/ Eyrarlandsveg
600 Akureyri

Alþingi
Erindi nr. Þ 139/684
komudagur 6.12.2010

Guðný Bogadóttir

From: "Guðný Bogadóttir" <gbhiv@eyjar.is>
To: <nefndasvid@althingi.is>
Sent: 5. desember 2010 19:59
Attach: Feasible Model for Prevention of Functional Decline in Older People.pdf; Preventive home visits to older people in Denmark, Why,how,by whom, and when.pdf
Subject: umsögn um þingsályktun um heimsóknir til eldri borgara , 8. mál

Nefndasvið Alþingis
Sigrún Helga Sigurjónsdóttir, ritari nefndarsviðs Alþings.

Efni, umsögn um frumvarp,
139. löggjafarþing 2010–2011.
Þskj. 8 — 8. mál. Um reglubundnar árlegar heimsóknir til eldri borgara í forvarnarskyni.

Flm.: Siv Friðleifsdóttir, Sigríður Ingibjörg Ingadóttir, Þór Saari, Þráinn Bertelsson, Guðlaugur Þór Þórðarson, Þuríður Backman.

Alþingi ályktar að fela heilbrigðisráðherra og félags- og tryggingamálaráðherra í samvinnu við Samband íslenskra sveitarfélaga að koma á reglulegum árlegum heimsóknum í forvarnaskyni sem bjóðist öllum sem eru 75 ára og eldri til að hægt verði að veita þeim þjónustu strax og þurfa þykir svo að þeir geti búið sem lengst heima.

Sendandi;
Guðný Bogadóttir
Hjúkrunarfræðingur, Master of Europian Public Health
Hjúkrunarstjóri heilsugæslu
Heilbrigðisstofnunarinnar í Vestmannaeyjum

Umsögn um frumvarp.

Heimsóknir til eldrai borgara í forvarnarskyni er þjónusta sem boðið hefur verið uppá í Danmörku, Ástralíu, Svíþjóð og á Íslandi og er eins og fram kemur í frumvarpinu lögbundin í Danmörku. Heilsueflandi heimsóknir virkar áhugaverður kostur og í meistaraverkefni mitt fjallar um hvort heilsuefnlandi heimsóknir geti stuðlað að því að hærra hlutfall fólks 80 ára og eldra á Íslandi geti búið lengur sjálfstæðri búsetu með viðeigandi þjónustu. Ég lauk meistaranámi 2009 frá Sheffield University , Englandi og Háskólanum í Kaupmannahöfn. En þess má geta að faglegur leiðbeinandi minn í Kaupmannahöfn var einn af frumkvöðlum heilsueflandi heimsókna í Danmörku.

Til útskýringar vann ég verkefnið í 2 stigum, í byrjun safnaði ég upplýsingum um forvarnir ætluðu eldra fólki á heilsugæslustöðvum á Íslandi, með sérstakri áherslu á heilsueflandi heimsóknir. Út frá þeim niðurstöðum ákvað ég í samráði við leiðbeinendur leitarorð og leitaði að rannsóknum sem fjölluðu um árangur heilsueflandi heimsókna í forvarnarskyni, mest rannsóknir frá Norðurlöndum, Þýskalandi og Ástralíu, leitin var umfangsmikil að lokum voru fáar rannsóknir sem uppfylltu leitarskilyrði. Rannsóknarspurningin var í raun hvort það væri ráðlagt fyrir íslensk heilbrigðisyfirvöld að innleiða heilsueflandi heimsóknir á landsvísu. Niðurstaðan var í stuttu máli sú að það væri ekki ráðlegt þar sem árangur þessara heimsókna væri óljós og misvísandi. Hvort dragi úr stofnanavistun, hvort það hægi á líkamlegri og andlegri getu og bæti lífsgæði. Hins vegur voru niðurstöður rannsókna ekki það afgerandi að ráðlagt væri að hætta heilsueflandi heimsóknum þar sem þær eru byrjaðar.

Í Danmörku hafa sveitarfélög útfært heimsóknir á mismunandi máta og mörgum sveitarfélögum hefur reynst erfitt að halda úti heimsóknum. Það eru vísbendingar um að heimsóknir gagnist betur yngra eldra fólki, að fræðsla til starfsfólks heilbrigðis - og félagsþjónustu sé gagnleg og þáttaka heimilislæknis skipti máli. Þar er einnig umræða um hvort ein af ástæðum fyrir því að nýlegar rannsóknir sýna ekki jafn afgerandi árangur og var í byrjun sé sú að heilbrigðisþjónusta við eldra fólk sé almennt betri en var fyrir 15 - 20 árum og einnig að heilsufar eldra fólks sé betra. Það er að sumu leyti erfitt að bera saman Danmörku og Ísland varðandi hlutfall þeirra sem vistast á stofnunum. Ísland er dreifbýlt og það er auðveldara að skipuleggja heimaþjónustu á fjölmennari, þéttbýlum svæðum. Einnig má nefna að það hefur dregið úr hlutfalli eldra fólks á stofnunum á Íslandi.

Til að það sé á hreinu tel ég forvarnarstarf til eldra fólks mikilvægt og tel að við getum gert margt hér á Íslandi, varðandi fræðslu til fagfólks og almennings, endurhæfingu á stofnunum og í heimahúsum, samvinnu milli mismunandi þjónustu og faghópa og ég tel heilsueflandi heimsóknir eigi að vera hluti af almennum forvörnum. En í samræmi við heimildir og niðurstöður úr meistararitgerð minni tel ég að það verði að skilgreina hverju heilsueflandi heimsóknir eigi að skila, og hvers konar skipulag sé hentugast. Nú þegar er komin reynsla á heilsueflandi heimsóknir á Akureyri, mælingar á árangri hafa að mestu verið lýsandi, það er fólk hefur verið spurt um reynslu sína og hvort það muni þiggja slíka heimsókn aftur.

Ég tel það mjög áhugavert að þróa skipulag heimsókna og meta árangur áður en innleiðing á landsvísu er ákveðin. Breyta heimsóknir lífsgæðum fólks, auka þær félagslega virkni eða hreyfingu? En ítreka að ég tel að heilsueflandi heimsóknir geti orðið mikilvægur hluti af forvörnum ætlaðar eldra fólki og leið til að nálgast ákveðna hópa einstaklinga.

Set með 2 greinar um forvarnir og heilsueflandi heimsóknir frá Danmörku.

Ég hef reynt að vera stuttorð í þessari umsögn og koma meginatriðum til skila. En er fús til að veita frekari upplýsingar sé þess óskað.

Virðingarfyllst

Guðný Bogadóttir
gmail; gbhiv@eyjar.is
Sími; 4811955, 8919644

Feasible Model for Prevention of Functional Decline in Older People: Municipality-Randomized, Controlled Trial

Mikkel Vass, MD, Kirsten Avlund, DMed Sci,† Jørgen Lauridsen, PhD,‡ and Carsten Hendriksen, DMed Sci†*

(See editorial comments by Dr. Thomas Gill on pp 724–726)

OBJECTIVES: To investigate the effect of an educational program for preventive healthcare professionals in routine primary care on functional ability, nursing home admissions, and mortality in older adults.

DESIGN: A prospective, controlled 3-year follow-up study (1999–2001) in primary care with randomization and intervention at the municipality level and outcomes measured at the individual level in two age cohorts.

SETTING: Primary care.

PARTICIPANTS: Of 81 eligible municipalities in four counties, 34 agreed to participate. A total study population of 5,788 home-dwelling subjects aged 75 and 80 were asked to participate. Written consent was obtained from 4,060 persons (70.1%), of whom 2,104 were living in 17 intervention municipalities and 1,956 were living in 17 matched control municipalities.

INTERVENTION: Intervention municipality visitors received ongoing education, and local general practitioners were introduced to a short geriatric assessment program early in the study period. Control municipalities visitors and general practitioners received no education.

MEASUREMENTS: At the 3-year follow-up, the outcome measures of mortality and nursing home admissions were obtained from all, and the outcome measure of functional ability was obtained from 3,383 (95.6%) of 3,540 surviving participants.

RESULTS: Education improved functional ability (odds ratio = 1.20, 95% confidence interval (CI) = 1.01–1.42, $P = .04$) in intervention municipality participants, notably in the 80-year-olds. There were no differences in mortality (relative risk (RR) = 1.06, 95% CI = 0.87–1.28, $P = .59$) or rates of nursing home admissions after 3 years (RR = 0.74, 95% CI = 0.50–1.09, $P = .13$). Subjects aged 80 benefited from accepting and receiving in-home assessment with regular follow-ups.

CONCLUSION: A brief, feasible educational program for primary care professionals helps preserve older people's functional ability. J Am Geriatr Soc 53:563–568, 2005.

Key words: older people; preventive home visits; assessment; functional ability; community intervention

Preventive home visits to older people have been studied in several controlled trials over the past 20 years. Results are promising,[1–4] but data currently available provide few clues as to which part of the assessment process holds most information value. Some trials indicate that, to achieve benefit, preventive home visit programs must adopt a multidimensional assessment approach and be conducted by committed and skilled professionals.[4–6] Visits must be followed up, but data on how best to manage follow-up in terms of number of visits, intervals between visits, and types of contact (visit/telephone calls) are lacking. Nor is it known which age groups benefit most. Several studies have targeted people aged 75 and older, but the general rise in active life expectancy in rich welfare states invites the hypothesis that it may be more effective to target a relatively more vulnerable group (e.g., ≥80). However, it is not known whether patients' functional ability levels shape the effect of interventions. Finally, it is unknown whether these scientific programs will be cost-effective in routine primary care. Controlled feasibility trials with high numbers of participants in different communities have not been conducted.

Preventive home visitation programs are part of national policy in the United Kingdom, Australia, and Denmark, but their effects have been questioned. The introduction of the "75-years-and-over checks" in the Unit-

From the *Department of General Practice and Central Research Unit for General Practice, and †Department of Social Medicine, Institute of Public Health, University of Copenhagen, Copenhagen, Denmark; and ‡Department of Economics, University of Southern Denmark, Odense, Denmark.

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Address correspondence to M. Vass, MD, Institute of Public Health, University of Copenhagen, Blegdamsvej 3, DK-2200 Copenhagen, Denmark. E-mail: m.vass@dadlnet.dk

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0002-8614/05/$15.00

ed Kingdom in 1990, which was anchored in general practice, triggered a fierce debate because of the lack of conclusive evidence.[7] The results of a long-awaited evaluation study have just been published,[8] and since April 2004, the preventive assessment program in the United Kingdom is no longer a part of the general practitioner (GP) contract.

Since 1998, all Danish municipalities have been required by law to offer two annual preventive home visits to all citizens aged 75 and older. Their main purpose is to support personal resources and networking and to offer social support aimed at preserving functional ability. How to organize and implement the program is at the discretion of each municipality, which receives no detailed guidelines. This is in agreement with the Danish policy of decentralization. District nurses or physiotherapists/occupational therapists primarily conduct visits, and the GPs are rarely directly involved. Lay workers are not a part of the program. National evaluations report that about 60% of those aged 75 and older accept and receive the preventive home visits.

After the law had been in force for a few years, many municipalities came to recognize a need for more knowledge about home visitor qualifications, the best way to conduct the visits, and how to organize the program in the best way, which included targeting clients most in need of the services offered. However, because the legislation had already been introduced, a controlled feasibility study could not be conducted.

It seems relevant to argue that good health and independence, measured as functional ability, is a robust outcome, because it embraces the individual and the medical/administrative discourse.[9,10] Many geriatric and gerontological primary care problems are associated with professional skills. Furthermore, many clinical and social problems due to functional disability can be improved through flexible interdisciplinary linkage. It was therefore hypothesized that active life expectancy could be improved through education of home visitors and their local GPs by introducing a simple tool, promoting the use of a common professional language, and underlining the importance of avoiding ageism.[11]

The main purpose of the present study was to investigate the effect of an educational program for preventive healthcare professionals in routine primary care on functional ability, nursing home admissions, and mortality in older adults. In addition, the goal was to investigate whether the effects differed by age and baseline functional ability and whether regularity or number of visits was of importance for the possible beneficial effects.

METHODS

Design

A prospective, controlled 3-year follow-up study (1999–2001) with randomization and intervention at the municipality level and outcomes measured at the individual level was designed. Municipalities were included if they offered preventive home visits as prescribed by law and were able to facilitate fair or good rehabilitation and if GPs were able to participate by contract. Fifty of 81 municipalities in four counties met these criteria and were invited, and 34 municipalities agreed to participate. No demographic differences were seen between the participating 34 and the remaining 16 eligible municipalities.[11] None of the municipalities discontinued participation, and none were lost to follow-up.

For sample size and power calculation, a variance component model for capturing the expected intracommunity correlation in the necessary cluster-sampling scheme was postulated. Calculations were conservative in that an unpaired design was envisaged, indicating a need for at least 15 municipalities in each group (intervention and control) and at least 100 older persons in each municipality.[11] A matched randomization design was chosen to allow for the considerable variations in management and organization of preventive home visits among the municipalities. Randomization was performed independently of the investigators after paired matching of intracounty municipalities, urban/rural type, size, and geriatric services. After randomization, there were no differences in baseline characteristics between intervention and control municipalities (municipality size, population density, expenses per 75 inhabitants, total number/staffing of preventive home workers, and general collaboration between general practice and the home care systems).[11]

The Intervention

Based on updated geriatric and gerontological documentation, all intervention municipality visitors received education, and local GPs working in the same intervention municipalities were introduced to a short geriatric assessment program.[12] Twice a year, two key persons from each of the 17 intervention municipalities were entrusted with the task of introducing a standard assessment tool and of promoting training in its use and interpretation. Assessment of functional ability at every visit was recommended.[13,14] Tiredness in daily activities of the visited older people was interpreted as an early sign of disability, and the visitors were asked to search for the reason for such tiredness in the health, mental, or social domain.[15–17] If any suspicion of a health problem emerged, the visitors were asked to consider and discuss contact with the GP, who was urged to avoid ageism and take any encounter seriously. GPs were encouraged to incorporate a short geriatric assessment (the mnemonic 5 D's: delirium, depression, dementia, drugs, drinks) in his/her usual clinical practice.[18] In nine of the 17 intervention municipalities, at the beginning of the study period, local GPs also accepted and participated in a 2-hour small-group educational session.

Control municipalities received no education and conducted the national preventive program in their own way. Effects of the intervention were measured as a dichotomized variable (intervention versus control) and as a derived intervention-dose variable (high (education to visitors and GPs), medium (intervention only to visitors), control (no education)).

Study Population

The study population has been described in detail elsewhere.[11] Briefly, two cohorts of people aged 75 to 80 living in the 34 municipalities were drawn from the Civil Registration Office. Four thousand three home-dwelling 75-year-olds and 1,785 home-dwelling 80-year-olds were asked to

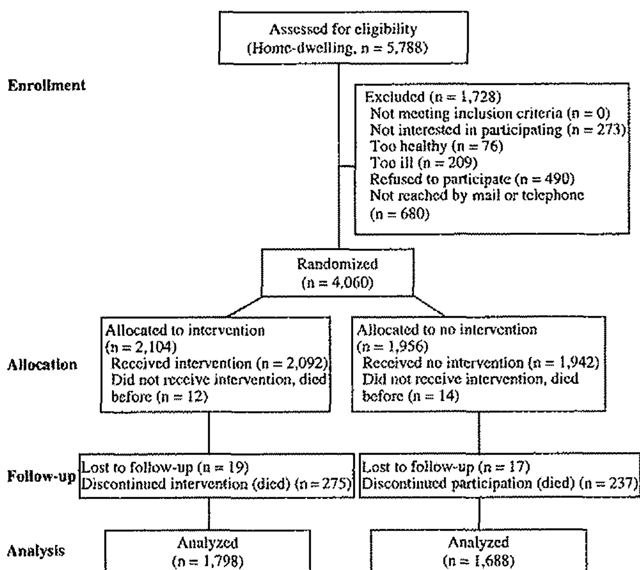

Figure 1. Derivation of the study population.

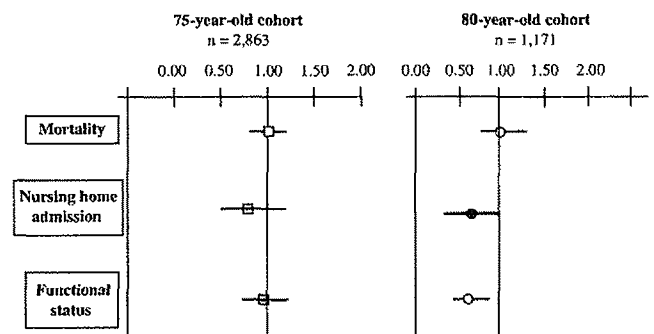

Figure 2. Mortality and nursing home admission risk ratios and functional ability odds ratios between intervention and control participants (95% confidence intervals) 1999–2001 in the two age cohorts. (All analyses adjusted for sex, functional status and living alone at baseline, and municipality pairs). Odds ratio less than 1 is associated with lower mortality, lower risk of admission to nursing home in the study period, and better functional ability on the Mobility-Help scale.

participate by letter. Written consent was obtained from 2,876 (participation rate 71.8%) of the former and 1,184 (participation rate 66.3%) of the latter. At the 3-year follow-up, the main outcome measure was obtained from 2,529 of the 2,559 75-year-old survivors (98.8%) and from 957 of the 963 80-year-old survivors (99.3%). Twenty-two persons died and four were institutionalized before the intervention started, leaving 2,863 75-years-olds and 1,171 80-years-olds in the study population. There were no major differences in baseline characteristics between intervention and control participants.[11] The derivation of the total study population is shown in Figure 1.[19]

Outcomes

Functional ability was measured at baseline using questionnaires and after 3 years using a validated mobility scale included as a dichotomized variable: able to manage all activities without help versus need of help for one or more activities.[20,21] Mortality and nursing home admissions specified by the Civil Registration Office were measured after 3 and 5 years.

Covariates

The following covariates were used: number of home visits during the 3 years (0, 1–4, ≥5), regularity of preventive contacts (home visits and telephone calls) during the 3 years (regular yearly contacts, any contact, no contact), and sex. The 17 pairs of municipalities were based on the matched randomization, and live alone was measured as "yes" or "no" at baseline.

Statistical Methodology

Mortality and nursing home admissions were analyzed using Cox regression and functional ability with logistic regression with and without the dead. All analyses were intention-to-treat analyses. When analyses were stratified by sex, results were in the same direction for men and women. Consequently, analyses were combined for men and women including sex as a covariate, thus retaining sufficient statistical power.

Ethics

The study complies with the Declaration of Helsinki and was approved by the relevant regional research ethical committees.

RESULTS

The results of the 3-year follow-up analyses in the total study population showed that educational intervention was associated with improved functional ability in persons living in the intervention municipalities (adjusted odds ratio (OR) = 1.20, 95% confidence interval (CI) = 1.01–1.42, $P = .04$). Intervention was not associated with mortality (adjusted relative risk (RR) = 1.06, 95% CI = 0.87–1.28, $P = .59$) and rates of nursing home admissions (adjusted RR = 0.74, 95% CI = 0.50–1.09, $P = .13$).

The age-stratified analyses showed that intervention was associated with beneficial effects on functional ability in the 80-year-olds but not in the 75-year-olds (Figure 2), with the largest effect in those with a high intervention dose ($P = .003$) (Table 1). No effects on mortality or rates of nursing home admissions were seen, although nursing home rates were insignificantly higher in participants living in the control municipalities in both age cohorts. This tendency became clearer after the study ended and the cumulated risk of nursing home admissions reached significance in the 80-year-old group (Figure 3). Days "saved" in nursing homes were 3,450 per 1,000 75-year-olds and 820 per 1,000 80-year-olds over 5 years (Table 2). When analyses were restricted to participants managing all activities without help at baseline, similar dose-response effects of intervention were seen (Table 1). No effects were seen in persons in need of help at baseline for one or more activities in either age group.

The number of home visits and regularity of contacts did not attenuate the associations between intervention and functional ability, but in the 80-year-old cohort, a dose-

Table 1. Odds Ratios (ORs) of Having Better Functional Mobility After 3 Years in Two Age Cohorts

	Age at Baseline					
	75 (n = 2,863)			80 (n = 1,171)		
Groups Compared	OR (95% Confidence Interval) *P*-value					
Intervention vs control*	1.03	(0.83–1.28)	0.77	1.53†	(1.12–2.09)	0.008
Intervention dose (vs control)*						
Only municipality intervention	1.27	(0.93–1.73)	0.13	1.22	(0.81–1.84)	0.34
Municipality and GP intervention	0.85	(0.64–1.15)	0.31	2.10†	(1.29–3.44)	0.003
Number of preventive home visits (vs no visits)‡						
1–4	0.76	(0.60–0.96)	0.02	0.10	(0.71–1.40)	0.98
≥5	0.88	(0.57–1.37)	0.58	2.03†	(1.14–3.62)	0.02
Contacts (vs no contacts) (visits and telephone calls)‡						
Preventive contacts	0.80	(0.61–1.05)	0.11	0.99	(0.67–1.44)	0.97
Regular yearly contacts	0.91	(0.69–1.12)	0.49	1.62†	(1.09–2.40)	0.02
No disability at baseline (manage all activities without help)§						
Only municipality intervention vs control	1.14	(0.80–1.62)	0.48	1.33	(0.84–2.11)	0.23
Municipality and GP intervention vs control	0.97	(0.70–1.34)	0.83	2.04†	(1.15–3.62)	0.02
Preventive contacts vs no contacts	0.80	(0.61–1.05)	0.11	1.09	(0.71–1.67)	0.69
Regular yearly contacts vs no contacts	0.91	(0.69–1.12)	0.49	1.94†	(1.23–3.05)	0.004

Note: Odds ratio > 1 is associated with better functional ability on the Mobility-Help scale.
* Analyses adjusted for sex, municipality pairs, functional status, and living alone at baseline.
† Statistically significant.
‡ Analyses adjusted for intervention dose, sex, municipality pairs, functional status, and living alone at baseline.
§ Analyses adjusted for sex, municipality pairs, and living alone at baseline; n = 2,863 age 75, n = 503 age 80.
GP = general practitioner.

response effect of the number of home visits ($P = .02$) and regularity of contacts ($P = .02$) on functional ability was observed, although it was not in the 75-year-old cohort.

DISCUSSION

The main claim is that a brief, manageable, and ongoing educational intervention for professionals working with preventive home visits was feasible and improved older people's functional mobility. Effects were stronger in 80-year-old home-dwelling people than in 75-year-olds, and the difference in cumulated risk of nursing home admissions reached significance in the former cohort. Increased effects were seen when GPs in the community participated in the education. Accepting and receiving regular preventive home visits was associated with better functional mobility in 80-year-olds.

The premises for this proactive assessment model must be kept in mind. First, it must be seen in the context of the Danish healthcare system. The current Danish population is 5.3 million inhabitants, of whom 15% are aged 65 and older. The counties are responsible for hospital and specialized geriatric and psychogeriatric treatment and rehabilitation, the municipalities for home and institutional care and long-term rehabilitation. GPs are responsible for health problems in the primary care sector, where they are organized in independent, private practices contractually funded by the counties, but they have no community service authority. Hospital, general practice, and community services are all fully tax financed. Second, district nurses, who focused on establishing a trustful relationship and who were encouraged to raise issues of everyday life relevance and to offer general health-promoting advice and guidance, usually conducted the national in-home preventive assessment programs. If appropriate, identified relevant health or social problems revealed during the home visit could result in practical or personal support. Follow-up visits were able to identify changes over time. Third, all the participating study municipalities were motivated and had at least fair possibilities for promoting rehabilitation. They had all agreed to uphold the legislation and to join a scientific study and had claimed political support to act on discovered relevant needs and the will to solve identified problems identified during the visits. Finally, academics also working in primary care delivered the educational study intervention.

Limitations

Noninstitutionalized individuals were targeted, and the 30% overall refusal rate among eligible subjects may represent a weakness. However, analysis of the nonparticipants revealed no major differences in mortality between intervention and control municipalities at follow-up (data not shown).

At baseline, 81% of the 75-year-olds and 69% of the 80-year-olds were nondisabled.[11] The mortality rates in both age cohorts over the 3 years were low, which is reported to favor the achievement of beneficial effects of in-home assessment.[4] Because death is associated with functional decline, and there was an insignificantly higher mortality

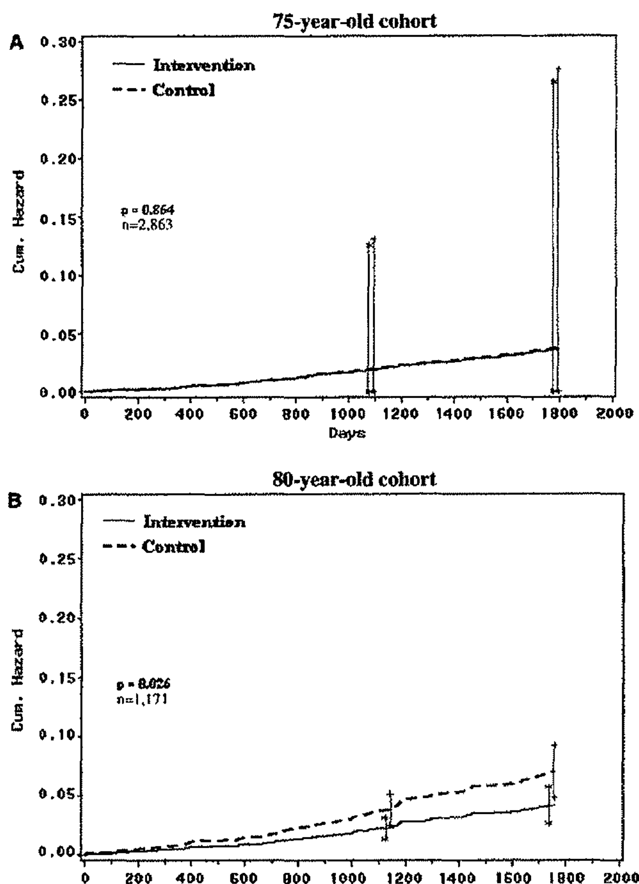

Figure 3. Cumulated risk function for nursing home admissions from baseline to 5-year follow-up; intervention compared with control participants in two age cohorts. Analyses adjusted for sex, municipality pairs, home visits, and living alone and functional status at baseline.

rate in both intervention cohorts, the theoretical possibility of a survivor selection phenomenon could account for some of the effects, but when the dead were included in the analysis as disabled, all effects were similar (data not shown), and there was no difference in mortality after 5 years.

Blinding may represent a problem because the study was mentioned in the invitation letter and in local newspapers to obtain a high response rate for the questionnaire surveys. Consequently, all participants knew that their municipality took part in a project, but they did not know whether they belonged to an intervention or a control municipality. No overall differences in participant response rates were observed between intervention and control municipalities,[11] and during the 3 study years, fewer persons accepted and received at least one preventive home visit in the intervention municipalities than in the control municipalities,[12] which supports that most participants were blinded to the intervention.

The results did not change when adjusted for municipality variation, which justifies the matched design. The municipalities could not be blinded to the intervention, but data collection from the municipalities varied in both directions.[12] It may therefore be argued that there was no systematic overreporting from intervention municipalities, although it was impossible to avoid communication between home visitors working in intervention and control municipalities, even if no educational intervention took place in the latter. During the study period, county meetings took place (not a part of the study) during which preventive home workers from intervention and control municipalities exchanged experiences. This could have diluted some of the intervention, but all these "control interventions" would tend to underestimate positive effects.

Strengths

Study strengths were the absence of major baseline municipality differences, the high number of municipalities from several geographic regions, the high number of participants with an extremely low drop-out rate, and the incorporation of a detailed cost-effectiveness analysis, the promising results of which will be published elsewhere. The findings have widespread generalizability, also because of the highly feasible nature of the intervention design and the use of structured guidelines, which paved the way for easy implementation in regional education. A further strength is the ongoing possibility of follow-up. It is remarkable that effects on nursing home admissions continued after the intervention ended. The study questions whether 3 years in general is an optimal follow-up period, and it points to sustainable effects of the intervention.

Implications

It is noticeable that the educational efforts (indirect intervention) were measurable at the individual level, even if only 60% of the home-dwelling participant population accepted and received the core home-visit service. It underlines the educational potential in primary care and implies that preventive home visiting demands skill. It is tempting to state that general spin-off effects of the education to other professionals of the home care systems could be a contributory cause.

Table 2. Mean Nursing Home Days in Intervention and Control Groups After 3 and 5 Years

Age	1999–2001	1999–2003
75		
Intervention (n = 1,460)	6.78 (n = 30)	22.55 (n = 63)
Control (n = 1,403)	10.97 (n = 37) P = .13	26.00 (n = 62) P = .53
80		
Intervention (n = 632)	14.34 (n = 23)	39.41 (n = 38)
Control (n = 539)	14.67 (n = 26) P = .95	40.23 (n = 46) P = .94

The intervention effect was clearly stronger in the 80-year-old group when home visitors and GPs were presented to the assessment tools and instructed on how to interpret and use them. This underlines the often-claimed need for qualified interdisciplinary education and is fully in agreement with the intention of testing a simple tool for managing problems often occurring in older people. Being alert to tiredness in daily living seems, in addition to promoting notice of functional decline in the individual assessment situation, to catalyze and promote a common language for primary care professionals.

Targeting the older population lies at the heart of proactive health-promotion programs. An "optimal preventive period" in old age may be related to a susceptible phase in every individual's functional pattern. Patterns of functional decline vary for men and women.[22,23] Older men in general have better functional abilities than women in the same age group. Beneficial effects of home assessments have previously been found in favor of women.[12] Hence, the influence of home visits on functional decline may have an age and sex bias.

Proactive prevention programs would only play a limited role once elderly people have passed "a point of no return" in a functional decline pattern. The possible reversibility in earlier stages of decline is fully in agreement with what some trials report.[4,5] Moreover, these analyses established that all positive effects were seen when intervention effects were measured in those who were nondisabled at baseline.

These results suggest that, in a rich welfare state context, where a national, proactive, municipality-based in-home assessment program is being implemented, professional skill and interdisciplinary education should be given priority and greater attention should be paid to early triggers of functional decline. It is not possible from this study to conclude which authority in primary care can best manage a preventive program, but it seems justified to target the group of "not considerably disabled," and not to start at too early an age because the beneficial effects are most obvious for 80-year-olds. Other preventive, sex-based strategies for "the younger old" may facilitate health promotion in old age.

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CONTRIBUTION TO THE MAIN TOPIC

M. Vass
K. Avlund
C. Hendriksen
L. Philipson
P. Riis

Preventive home visits to older people in Denmark

Why, how, by whom, and when?

Vorbeugende Hausbesuche bei älteren Menschen in Dänemark – warum, wie, von wem und wann?

Abstract In Denmark, political decisions improved the implementation of 'preventative thinking' into every-day clinical work. The potential benefits of preventive efforts have been supported by legislative and administrative incentives, and an ongoing effort to remain focused on the benefits of these initiatives towards older people is politically formulated and underlined as part of the new structured municipality reform.

Evidence of beneficial effects of health promotion and prevention of disease in old age is well documented. In-home visits with individualised assessments make it possible to reach older persons not normally seen in the health care system. In-home assessment is not just a health check, but also an opportunity to meet individual needs that may be of importance for older people to stay independent. Preventive home visits may be part of an overall culture and strategy to avoid or prevent functional decline. There is an urgent need of an interdisciplinary teamwork and management for such programmes, incorporating flexible cooperation between the primary and secondary health care sector. The value and importance of geriatric and gerontological education is evidence based.

Key words older people – functional decline – home visits – community health care – municipality organisation – eduction

Zusammenfassung Politische Entscheidungen haben in Dänemark die Verankerung präventiven Denkens in der alltäglichen Praxis erleichtert. Der mögliche Nutzen präventiver Maßnahmen wurde durch die Gesetzgebung und administrative Anreize unterstützt. Der politische Wille zur weiteren Förderung dieser Initiativen für alte Menschen findet seinen Ausdruck in Teilen der neuen Gemeindereform.

Die Evidenz günstiger Effekte durch Gesundheitsförderung und Krankheitsprävention im höheren Lebensalter ist gut dokumentiert. Hausbesuche unter Verwendung individueller Assessments erreichen ältere Menschen, die normaler Weise nicht im Gesundheitssystem erreicht werden. Häusliches Assessment ist nicht nur ein Gesundheitscheck, sondern bietet die Möglichkeit, sich mit individuellen Bedürfnissen zu beschäftigen, die für die Selbstständigkeit älterer Menschen von Bedeutung sind. Präventive Hausbesuche könnten Teil einer Gesamtstrategie sein, die zum Ziel hat, die Entwicklung von funktionellen Einbußen zu verhindern. Es gibt einen dringenden Bedarf für interdisziplinäre Teamarbeit in derartigen Programmen, die flexible Zusammenarbeit zwischen dem primären und sekundären Gesundheitssektor einschließt. Der

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Mikkel Vass (✉)
Institute of Public Health
University of Copenhagen
Øster Farimagsgade 5
1014 Copenhagen K
Denmark
Tel.: +45-3532/7960
Fax: +45-3532/7946
E-Mail: m.vass@daldnet.dk

Kirsten Avlund
Department of Social Medicine
Institute of Public Health, University of Copenhagen

Carsten Hendriksen
Department of Social Medicine
Institute of Public Health
University of Copenhagen and Bispebjerg University Hospital
Copenhagen, Denmark

Lotte Philipson · Povl Riis
AgeForum
The Danish Ministry of Social Affairs
Skibhusvej 52A, 3
5000 Odense C, Denmark
E-Mail: aef@aeldreforum.dk
Internet: www.aeldreforum.dk

Nutzen und die Bedeutung geriatrischer und gerontologischer Ausbildung ist evident.

▷ **Schlüsselwörter**
ältere Menschen – funktionaler Abbau – Hausbesuche – gemeinschaftliche Gesundheitspflege – Gemeindeorganisation – Ausbildung

Introduction

Most nations in the world face a considerable demographic challenge caused by the steeply rising number of older people. The idea of setting up preventive home visits to older people – rooted in legislation and delegated to local authorities – originated in Denmark and arises from a long tradition of Danish social and health policy. The Danish initiative of preventive home visits and the scientific testing of the method have met widespread interest.

Preventive home visits to older people are not a new idea. As early as the 1950s, the Danish Medical Association debated whether functional decline was preventable. In the 1960s district nurses were assigned to visit older people and offer help. Later, outreach activities were included in the district nurses' work descriptions, and the 1970s saw a project realised in a local authority where district nurses visited people aged 75 or over in their homes. Up through the 1990s, several Danish municipalities introduced preventive home visits at their own initiative. Schemes were designed very differently, performed at vastly differing intervals and had highly different contents.

Nevertheless, with attention on early signs of functional decline and the corresponding early and coordinated follow-up activities, preventive home intervention had proved a suitable instrument for activities aimed at maintaining older people's autonomy, independence, and functional ability allowing them to continue caring for themselves.

What is a preventive home visit?

Preventive home visits constitute a *dynamic* process aiming at establishing *relations* that – within the framework of the community and senior citizen policies – allow the older person and the visitor to preserve or improve the older person's long-term possibilities of leading a good, independent life, i.e. a life without disability and with postponement of need for help [14]. A preventive home visit is not just a health check, but an assessment in a broader perspective, leaving the possibility of primary, secondary, and tertiary prevention of disease, as well as life style advices and general health promotion.

Comprehensive international research has proved that preventive home visits are beneficial and that particularly the privileged older people benefit from such activities. Assessments must be multidimensional and must not focus solely on health, but instead on an overall picture [15]. Physical fitness impacts significantly on feelings of being able to manage. Therefore, preventive home visits must comprise all aspects of the individual's well-being, i.e. functional ability, welfare, life content, home conditions and possibilities of self-determination, etc. but also include review of medication, rehabilitative support, visitation and referral to specialist or other health care professionals if needed.

What may be the cause of beneficial effects?

Data currently available provide little evidence for which elements are most valuable, and it is not clear whether the outcome differs by what is assessed, or whether it is the process and interaction that is effective. It is tempting to speculate that the main reasons for benefit are due to both optimising the 'system' through interdisciplinary and coordinated follow-up and management of identified problems, as well as optimising the recipient 'person'. Highly developed self-care, strong social networks, and improved coping as well as a positive experience of one's own health status appear to provide a better life situation.

In 1995 Hendriksen hypothesised the possible causality of the favourable effects of preventive home visits: Preserved functional ability with a reduced need for use of hospital admissions and institutions are caused by improved self-care and coping strategies within the older people involved. In case of stress or illness, improved confidence, higher self-esteem and self-efficacy leads to a better possibility of utilizing one's own resources and support from family and friends. Public community care and preventive offers support this, especially when older persons are taken seriously, and they are involved in the decisions. The optimal situation is achieved if shared responsibility is obtained and the older persons become familiar and confident with how the health and social care systems are functioning. This makes it easier to use the system and thus to stay in control [8].

The Danish law on preventive home visits

In 1996 the Danish Ministry of Social Affairs introduced municipality organised preventive home visits to older people as a state law. The legislation did not command specific guidelines on how to carry out the visits, but delegated how to organise a scheme aimed at supporting personal resources, networking and offering social support. The social discourse was underlined despite that most evidence and literature at that time were rooted and elaborated by the health care culture.

Excerpt from the Danish law

(Act 1117 of Dec. 20th 1995 with the amendments of 2005 and 2006)

1. *The local council shall offer preventive home visits to all citizens having reached the age of 75 and living in the municipality.*
(2) *The local council shall organise the visits according to needs. A citizen shall always be entitled to an offer of at least two annual preventive home visits.*
(3) *The local council may opt to except citizens from the scheme who are receiving both personal and practical help under S. 83 of the Act on Social Services.*
2. The Minister for Social Affairs may, in cooperation with the Minister for Health, lay down regulations on local obligations under this Act, including on coordination with other general local authority preventive and activating measures.

Ten years with the law

After 10 years with the law approximately 60% of the targeted population accept and receive the offered preventive home visits – a percentage increasing with increasing age. In December 2002 the Ministry of Social Affairs published a report in Danish of how the preventive programme was organised in Denmark; 99% of all Danish municipalities answered the questionnaire. This survey confirmed the great variation of how the law was managed and implemented. Some conclusions are mentioned here:

- The programme was a part of the home care system in 40% of the municipalities, and in another 40% a separate section under the social municipality department.
- 14% had chosen to let the programme be a separate section in relation to different grouping of older persons based on frailty.
- Less than 50% of the municipalities had made specific guidelines and quality assurance indicators, and more than the half had systematically used the visits to collect information on community needs and wishes from the old persons to be used for administrative and political purposes.
- Almost all municipalities contacted the targeted group of older people by letter, and continued to inform regularly about the possibility of a home visit. For 80%, this was done in such a way that the older person must actively renounce the visit, if they do not wish to be visited.
- Not all municipalities offered visits twice a year as prescribed by the law, and many municipalities did not offer preventive home visits to very frail older people, in accordance with the amendment of the Act from 2005, whereby home visits are no longer compulsory for recipients of both personal and practical help.
- Some municipalities combined the preventive visits with assessment visits related to allotment of home help.

Lay workers were not a part of the programme but cooperation with private organisations for older people is often built in to local schemes in order to integrate preventive 'thinking' in the community. In January 2007 a new structural reform fused 271 Danish municipalities into 98, and the home visit scheme was adjusted to this new municipal organisation, with respect to community variations. The Act on Preventive Home visits is planned to be revised in 2008.

At present, visits are primarily carried out by district nurses, but several other primary care professional, e.g. occupational therapists, physiotherapists, and social workers are also engaged in the scheme. An obligatory health check is not included, and general practitioners are rarely directly involved.

Assessment of older people in the community – the role of preventive home visits

Prevention should not focus solely on health, but on an overall picture of old peoples life, because physical fitness also significantly impacts mood, emotions, and ability to manage. Therefore, prevention must comprise all aspects of an individual's well-being, i.e. functional ability, welfare, life content, home conditions and possibilities of self-determination, etc.

Besides attaining concrete offers of assistance and support, *individual older people* visited by preventive staff are gaining confidence in a public sector's ability to assist if specific needs should later arise – and thus it creates a sense of security in daily life. If older people live alone and only have a modest or no network of family or friends, the visit also gives

them the important message that they are not "forgotten". The approach to each individual citizen also enables local authorities to establish contact to people with whom, they would otherwise not be in touch. But the scheme also carries perspectives for others than the immediate target group.

Older people's *network of family and friends* can use the scheme to develop a valuable, non-official supplement: "community health and social services".

Based on its observations of older family members and friends, the network can, for instance, urge individuals to accept the offer of a visit and ensure that special issues are addressed – perhaps with a view to paving the way for visits to general practitioners, local social administrations, local centres for rehabilitation, or for other types of assistance. The close personal ties further allow visitors to register any needs for ad hoc visits – e.g. in relation to serious, social events, which completely changes the life of a citizen, such as the death of a spouse . This aspect encompasses especially preventive efforts aimed at older men's high suicide rate.

In the past decade, life expectancy and health of the older population have improved markedly, a trend that apparently will continue. In ten years, 75-year-olds are consequently expected to manage even better than 75-year-olds today. This development will pose major challenges throughout the field of preventive activities, and will require considerations in legislation as well as in the organisation of preventive home visits.

The development also presents major challenges to *professional staff members* throughout the old-age care sector, including staff groups involved in preventive home visits. The preventive home visit scheme in this way offers a possibility to show how preventive and health promoting activities can be joined to ensure that attention is focused both on risk situations and on an individual's total resources.

The Danish longitudinal intervention study on preventive home visits for older people

Since many municipalities needed more knowledge about the best way to organise and carry out the preventive home visits a feasibility trial was launched in 1998. The study was designed to evaluate how sociomedical research was translated into practice – a study of effectiveness in contrast to efficacy. In *efficacy* studies the intervention is highly standardised, often intensive and implemented by well-trained research staff usually in a single setting. The *effectiveness* studies include a broad, heterogeneous sample that is intended to be representative of a defined target population. The intervention within the study was designed to be adaptable and implemented by staffs with varying levels of expertise in the primary care setting [6].

Many geriatric and gerontological problems are associated with professional skills. Furthermore, many clinical and social problems due to functional disability can be improved through flexible *interdisciplinary linkages*. We therefore hypothesised that active life expectancy could be improved through *education* of home visitors *and* their local general practitioners by introduction of a simple tool, by promoting the use of a common professional language, and by underlining the importance of avoiding ageism [17].

In a three years prospective randomised controlled follow-up study design 34 municipalities in four Danish counties participated. Over 4000 older people in two age cohorts (75 years and 80 years at baseline) were followed through survey questionnaires and detailed register information on their use of health care [17].

The effectiveness of the educational intervention among the professionals was associated with a small but consistent reduction in functional mobility disability for all citizens living in the municipalities randomised to intervention [2, 18, 19]. These beneficial results seemed so be intensified if the amount of educational intervention was high; i.e. based on education of home visitors *as well as* general practitioners, indicating the importance of linkages, follow-up, and interdisciplinary cooperation. The details and process of the intervention to the home visitors have been described elsewhere [17].

The main conclusion of the Danish feasibility study on preventive home visits:

- Education of home visitors was associated to improved functional ability of home dwelling older people
- Education of home visitors was cost-neutral [10]
- Offering preventive home visits as part of the daily work in the communities was associated with improved functional ability among persons accepting the visits
- Numbers and regularity of visits were of importance
- Women benefited more than men
- 80 year-olds benefited more than 75-year-olds
- The same home visitor from visit to visit, and the establishment of a good contact were important
- Interdisciplinary collaboration with general practitioners was very important

These results, combined with experiences from earlier international efficacy studies on in-home assessment, point clearly at beneficial outcomes. Active assessment is not a substitute for high quality medical care of older people, but a supplement that can reduce the need

for institutional care and increase the possibility of their staying active and living an independent life. The interdisciplinary collaboration with general practitioners and geriatric expertise is however also very important. The studies make clear that comprehensive assessment in the homes of older persons can be a valuable preventive strategy as for avoiding functional impairment [4, 5, 7, 12, 15]. It is cost-neutral [10] but it is important, however, to emphasise that beneficial effects of preventive home visits presuppose that home care and early reactions to functional decline constantly be adjusted to the needs, and that staff and leadership of the programme are engaged and seriously prioritise interdiciplinarity [8, 13, 15].

Involving general practice

The highly positive scientific documentation of preventive home visits related cooperation between general practitioners and the home care system, resulted in a new general practitioner contract service in Denmark from April 2006. Practitioners are now compensated for outreach home visits to frail older people, normally over the age of 75. The objective of the doctor's visit is to gain understanding of the older person's resources and functional ability, to comprehensively review, to assess, and possibly to revise the patient's use of drugs, and to obtain knowledge on the older person's daily life situation, all of which will enable the general practitioner to act as a competent partner in the interdisciplinary primary health care team. Thus, the visit is *not* a house call in the conventional sense of the word. To assist this new initiative, a visitor's guide has been prepared, containing suggestions for what general practitioners should focus particular attention on and weigh during the visit. The general practitioner preventive home visit must be set up in advance and take place in understanding with the older person, and is only paid for once annually per older person. Despite the short existence of the scheme, it has already gained a solid foothold in the general practitioners' working routines.

The content of preventive home visit

Based on scientific studies and experiences from municipalities in Denmark, the content of preventive home visits should encompass:

- Trustful contact
- Structured interview
- Overall assessment
- Concrete agreements or management plans and
- Follow-up

Trustful contact

Trust and confidence are necessary if useful information is to be exchanged. Professionals working in the scheme must have positive attitudes towards older people since ageism is probably the most important blocking for initiatives aiming at older citizen's well functioning.

It is crucial, both in speaking and acting, that respect is shown for the visitee, to listen and to allow the person time to talk. At the same time, the professional can ask in-depth questions to demonstrate interest in the person and indicate that the person is taken seriously.

The initial and following visits should not run along the same lines. At the first visit, the purpose of the visit should be explained. And subsequently, the visitee's desires should determine the contents of the visit. Expectations often become clearer during later visits. If trustful contact has been achieved, the older person will automatically provide more and more bits of information on how everyday life works and on aspects that could perhaps not be discussed during the first visit.

Generally, new questions arise that can be debated or that pose requirements to the preventive worker's other competences.

If the visit succeeds in establishing a friendly atmosphere of mutual trust, confidence and empathy for the visitee's daily life, the foundation has be laid for building a relation [11].

The relationship of trust shall not be used to manipulate the visitee in certain directions, thus intervening in his or her right to self-determination, just as the visitor cannot in his or her communication indicate that the visitee will be divested of responsibility. Thus, a successful result presupposes that the visitor is professionally competent and able to communicate his or her knowledge in a manner appropriate to each individual, i.e. with empathy and qualified tuition skills.

The structured interview

Once the contact has been forged, the most important aspect is to structure the interview. For the professional, that involves planning the framework for the visit, including the timeframe, and controlling it during the interview by means of conscious methods that can be individualised from person to person – and from visit to visit [8].

The main element is to review the daily routines and ask relevant and specific questions on social, mental and health aspects, including reviewing med-

ication administered. As to the individual topics of conversation, the visitor can, of course, offer both general and individual information, guidance and advice. Thus, the aim is to cover all important aspects of the person's life during the interview.

It is important that the conversation veer towards positive aspects of the interviewee's everyday life and not concentrates only on risk and frailty. The visitor should therefore not only endeavour to uncover problems or track risks, but also function as a 'talent scout' who can support the visitee's resources. At the same time, the visitor should, however, apply a professional view to risk situations and use appropriate tools to find early signs of functional limitations that can be remedied. Experience shows that it may be critical to discover and respond to fatigue as a central symptom connected with daily activities [1].

An actual screening, i.e. early diagnosing of selected diseases (e.g. dementia and osteoporosis) should not be the focus, and the interview should not follow a fixed, predetermined template or a fixed comprehensive questionnaire. Conversely, it appears advantageous to lay down the structure of an interview and control it within a flexible framework that opens up possibilities for individual adjustments [16]. These professional skills must be trained and followed up continuously in small group based education to ensure the implementation of an engaged and a skilled staff. Good literature on the art of holding professional motivational interviews may prove helpful.

Overall assessment

Through gentle and empathetic motivational interviewing based on professional competence, the visitor records an individual's functional abilities by evaluating the person in his or her daily settings compared to the surrounding network and environment. The citizen's wishes and expectations should be included in discussions on specific needs for changes, and actual agreements and management plans may be concluded. Health-promoting and preventive advice and guidance should be touched upon but not necessarily initiated. The ability to 'keep an ear to the ground' remains a key aspect. The visitor must professionally be able to handle the dilemma between professional knowledge that may benefit the citizen and his or her own attitudes to, for instance, life styles – and the citizen's right of self-determination without transferring a sense of guilt to the visitee or making him or her feel ill.

Concrete agreements or management plans

Based on professional competence, the visitor records an individual person's performance by evaluating the person in his or her daily settings compared to the surrounding network and environment. The citizen's wishes and expectations should be included in discussions on specific needs for changes, and actual agreements and management plans may be concluded.

During the visits, visitors may advantageously note on a standardised form how life has been since the last visit, what was agreed upon and initiated, and when the next visit is scheduled. To foster excellent, interdisciplinary cooperation, a copy of the form – of course with the citizen's consent – can be forwarded to any relevant partners, including the general practitioner.

Follow-up

The primary objectives of follow-up visits are to maintain contact and trust and also to evaluate whether changes according to agreements and management plans have occurred since the last visit.

Discussions from previous visits must also be repeated to confirm wishes and expectations previously voiced. Finally, the interview should discuss whether initiated support from or contact to others is functioning satisfactorily. If not, this could be an item to follow-up.

Organisation and target group

There is scarce evidence on how visitation programmes are best organised and managed. Feasibility may depend on local and national health and social care cultures. Considerable differences in structures make it difficult to know which part of the management process and medical assessment that is most valuable. It is evident that the follow-up element is of crucial importance, but strictly how many visits to be offered per year are not really known. It seems relevant to individualise according to differences in personalities, and functional and social status, although at least once a year after the age of 80 may catch an increasing rate of geriatric problems. Most studies have focused on people aged 75+, but ethnic minorities may still have unidentified problems and needs that should be addressed at a much earlier age. Additionally, group activities and self-administered questionnaires for health risk appraisals targeted at the 'young' old, i.e. the 75–80 age group, might well prove a more efficient offer of preventive initiatives [3, 16]. Flexible interpretation of the age criterion would therefore be preferable.

Cooperation

Preventive home visits should be embedded as a coordinated part of the overall public offer to older people. Cooperation with general practitioners and the secondary health sector should also be prioritised.

Which citizens should be visited?

As stated earlier, preventive and health-promoting home visits aim basically to preserve or postpone functional decline. Unsurprisingly, research can now document that the best-functioning part of the older population most benefits from the visits, because they have a potential for improvement [4, 5, 12, 15]. Aiding in maintaining functional ability while also responding quickly to early signs of disability seems to be the right strategy. Thus, the target group is non-infirm older people.

Preventive home visits as integrated or independent part of the home care service?

Better effects will presumably be achieved, if the preventive staff is well-integrated and professionally rooted in home care service units. The visitors must be empowered to launch concrete relief arrangements based on individual assessments. Thus, various types of local authority organisations will offer various procedures for executing visits. Municipalities using rigid rule-governed procedures lose flexibility, whereas more innovative and project-governed administrations may more quickly lose the overview necessary to make daily routines work [9, 20]. Municipalities building their home visit management on a framework may enjoy the advantage of being able to provide individualised flexible services even in complex situations. However, the disadvantage may then be that not all citizens can expect the same service and that this type of organisation requires a very high level of skill and competence. This underlines the need for education, training and professionalism [9, 13, 15, 20].

Preventive visitors

Competences

International as well as the Danish studies clearly demonstrate the significance of preventive workers' professional competence. Therefore, training levels should aim to encompass wide professional knowledge of the social and health areas alike.

Motivation

In addition to social and health competences, visitors must also be motivated and committed to working with older people. Personal maturity is another competence needed in order to understand and perceive when and how to deliver balanced counselling and guidance to older people. Preventive visitors must therefore also be able to recognise and master existential problems that will always be needed as an aspect of visits to older people.

Empathy

All preventive professionals state almost uniformly that establishing good contact is a key condition for successful visits. Preliminary analyses in the Danish project support this statement, because results were primarily being visible in the group where good relations were established between citizen and preventive visitor. This is another way of urging local authorities to ensure that the same professionals render the service and that they master the assignment by receiving relevant supplementary training comprising professional knowledge as well as communication competence. There are many indications that preventive visitors' competence and ability to show empathy contribute decisively to enabling citizens to master their lives better.

In this light, preventive home visits constitute a process in which an individualised public service extended in an atmosphere of professional knowledge and empathy with the individual person will in time translate into helping citizens to help themselves.

Perspectives

Despite the burgeoning evidence base supporting home- and centre-based programmes for the prevention of functional decline and disability, significant financial and organisational barriers have precluded implementation of these programmes in most settings. However, in Denmark we have experienced political decisions to improve the implementation of 'preventative thinking' into every-day clinical work. The potential benefit of preventive efforts has been supported by legislation and administrative incentives, and an ongoing effort to remain focused of the benefits of these initiatives towards older people is

politically formulated and underlined as part of the new structural municipality reform.

However, ageism in all parts of health and social culture may be the one most challenging issue to address. Many years of health care with a predominantly medical gaze on older peoples' needs must be changed to a more balanced view of achieving autonomy and successful ageing even with ailments. Much more focus on how older people manage everyday life will force care systems to use multidimensional interventions with focus on functional outcomes rather than diagnoses is needed. And finally, the challenge of ageing societies may be most efficiently met through coordinated and skilled primary care team building. Good leadership and competent facilitation of interdisciplinary linkages are the prerequisites to efficient management of care for the older population.

Conclusions

- Evidence of beneficial effects of health promotion and prevention of disease in old age is well documented.
- In-home visits with individualised assessments make it is possible to reach older persons not normally seen in the health care system.
- In-home assessment is not just a health check, but also an opportunity to meet individual needs that may be of importance for older people to stay independent.
- Preventive home visits may be a part of an overall culture and strategy to avoid or prevent functional decline.
- There is an urgent need of an interdisciplinary teamwork and management for such programmes, incorporating flexible cooperation between the primary and secondary health care sector.
- The value and importance of geriatric and gerontological education is evidence based.

Conflict of interest There is no conflict of interest. The corresponding author assures that there is no association with a company whose product is named in the article or a company that markets a competitive product. The presentation of the topic is impartial and the representation of the contents are product neutral.

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Heilbrigðisstofnun Suðurlands
sjúkrahús og heilsugæsla
v/Árveg · 800 Selfoss
sími 480 5100 · fax 480 5101

Alþingi
Erindi nr. Þ 139/438
komudagur 29.11.2010

Selfossi, 25.11. 2010.

Nefndasvið Alþingis,
Austurstræti 8 -10,
150 Reykjavík.

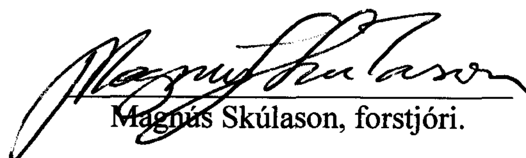
Efni: Umsögn um tillögu til þingsályktunar, þskj. 8, 8. mál.

Framkvæmdastjórn Heilbrigðisstofnunar Suðurlands hefur fjallað um þingsályktunina og greinargerð, sem henni fylgir.

Framkvæmdastjórnin fagnar tillögunni og lýsir yfir stuðningi við hana. Framkvæmdastjórnin bendir jafnframt á, að víðast í umdæmi Heilbrigðisstofnunar Suðurlands hefur íbúum 80 ára og eldri verið boðin fyrirbyggjandi heimsókn. Sumstaðar fara bæði hjúkrunarfræðingur heilsugæslunnar og aðili frá sveitafélaginu – heimaþjónustu. Við teljum afar mikilvægt að hjúkrunarfræðingur komi að þeim þáttum er varða heilsu og mati á heilsu.

Aukin þjónusta á þessu sviði krefst aukins vinnuframlags viðkomandi þjónustuaðila og þar með aukins kostnaðar. Huga þarf að þeim þætti við ákvörðun um að auka þessa þjónustu.

F.h. Heilbrigðisstofnunar Suðurlands,



Magnús Skúlason, forstjóri.

Alþingi
Erindi nr. Þ 139/439
komudagur 29.11. 2010

LEB
Landssamband eldri borgara

Langholtsvegur 111, 104 Reykjavík
KT: 600989-4059; Fax:+3545515835
Símar: +3545677111/ +3546986250
Netfang: leb@leb.is
Heimasíða: www.leb.is

Umsögn um þingskjal 8- 8. mál

Tillaga til þingsályktunar um reglubundnar heimsóknir til eldri borgara í forvarnaskyni

Landssamband eldri borgara hefur tekið til umfjöllunar ofnagreinda þingsályktunartillögu og telur hana getað stuðlað að því að eldra fólk geti búið sem lengst í heimahúsum ef það óskar þess og fær þá aðstoð sem það þarf. LEB leggur því til að tillagan verði samþykkt.

Fyrir hönd LEB

Helgi K. Hjálmsson, formaður.

Valgerður K. Jónsdóttir, framkv.stjóri

LÆKNAFÉLAG ÍSLANDS

ICELANDIC MEDICAL ASSOCIATION

Alþingi
Erindi nr. Þ 139/319
komudagur 22.11.2010

Nefndasvið Alþingis
Austurstræti 8-10
150 Reykjavík

Kópavogi, 19. nóvember 2010

Efni: Umsögn um tillögu til þingsályktunar um heimsóknir til eldri borgara í forvarnarskyni, 8. mál

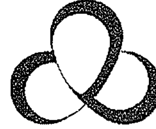
Læknafélag Íslands hefur fengið ofangreinda tillögu til umsagnar. Félagið gefur ekki umsögn um efni tillögunnar.

Virðingarfyllst,
f.h. Læknafélags Íslands

Birna Jónsdóttir
formaður

Hlíðasmára 8 | IS-201 Kópavogur | Sími/Tel.: +354 564 4100 | Fax: +354 564 4106 | Kt.: 450269-2639 | lis@lis.is | www.lis.is

Alþingi
Erindi nr. Þ 139/302
komudagur 19.11.2010



SAMTÖK FYRIRTÆKJA
Í HEILBRIGÐISÞJÓNUSTU

Reykjavík 19. nóvember 2010

Varðar: Umsögn um þingsályktunartillögu

Stjórn Samtaka fyrirtækja í heilbrigðisþjónustu lýsir ánægju sinni með þingsályktunartillögu flutta á 139. löggjafarþingi 2010 – 2011, þingskjal 8. – 8. mál, um reglubundnar árlegar heimsóknir til eldri borgara í forvarnaskyni. Stjórnin telur víst að slíkar heimsóknir muni stuðla að því að eldri borgarar geti búið lengur í eigin húsnæði og þurfi þar með síðar á stofnanaþjónustu að halda. Slíkt eykur lífsgæði eldri borgara og sparar fjármuni vegna rekstrar dvalar- og hjúkrunarrýma.

Virðingarfyllst,
Gísli Páll Pálsson formaður SFH

HVERAHLÍÐ 20 - 810 HVERAGERÐI
KT. 560502 6720 - WWW.SAMTOK.IS

SAMTÖK SUNNLENSKRA SVEITARFÉLAGA

Alþingi
Erindi nr. Þ 139/1007
komudagur 16.12.2010

Selfossi, 13. desember 2010
1010005SA ÞH

Nefndasvið Alþingis
Austurstræti 8 - 10
150 Reykjavík

Efni: Umsögn SASS um tillögu til þingsályktunar um heimsóknir til eldri borgara í forvarnarskyni, 8.mál.

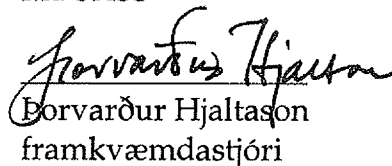
Á fundi stjórnar Samtaka sunnlenskra sveitarfélaga, sem haldinn var 10. desember sl., var tekið fyrir erindi frá heilbrigðisnefnd Alþingis þar sem óskað var umsagnar um tillögu til þingsályktunar um heimsóknir til eldri borhara í forvarnarskyni.

Eftirfarandi umögn var samþykkt:

„Stjórn SASS leggur áherslu á að ekki er hægt að leggja á sveitarfélögin auknar lagalegar skyldur sem leiða til mikils kostnaðar án þess tryggja þeim um leið aukna tekjustofna."

Umsögninni er hér með komið á framfæri.

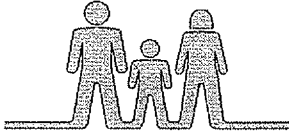
Virðingarfyllst,
f.h. SASS



Þorvarður Hjaltason
framkvæmdastjóri

Aðsetur - Address:	Símar - Telephone:	Myndsendir - Fax:	Netfang - E-mail:	Kennitala - Id.no.:
Austurvegur 56 800 Selfoss Iceland	480 8200	480 8201	sass@sudurland.is	480775-0159

Alþingi
Erindi nr. Þ 139/813
komudagur 8.12.2010



HEILSUGÆSLUSTÖÐIN Á AKUREYRI

Nefndasvið skrifstofu Alþingis
Austurstræti 8-10
150 Reykjavík

Akureyri, 7. desember 2010

Tillaga til þingsályktunar um reglubundnar árlegar heimsóknir til eldri borgara í forvarnarskyni.
139. löggjafarþing 2010–2011.
Þskj. 8 - 8. mál.

Umsögn frá stýrihópi um heilsueflandi heimsóknir á Akureyri og nágrenni.

Stýrihópur um heilsueflandi heimsóknir á starfssvæði Heilsugæslustöðvarinnar á Akureyri (HAK) frétti fyrir tilviljun af þessari þingsályktunartillögu en hún var hvorki send Akureyrarbæ né HAK til umsagnar. Þar sem heilsueflandi heimsóknir til aldraðra hafa verið hluti af þjónustu á starfssvæði HAK frá árinu 2000 teljum við ástæðu til að senda inn umsögn um áðurnefnda tillögu með upplýsingum um framkvæmd þjónustunnar hér á svæðinu.

Heilsueflandi heimsóknir hófust sem tilraunaverkefni á árunum 2000 og 2001 og voru í upphafi kostaðar af Akureyrarbæ. Reynslan á þessu tilraunatímabili var afar jákvæð og því var ákveðið að halda þjónustunni áfram. Frá árinu 2002 hafa heilsueflandi heimsóknir verið hluti af þjónustusamningi heilbrigðisráðuneytis og Akureyrarbæjar um rekstur HAK. Framkvæmdin tekur mið af reynslu og framkvæmd slíkra heimsókna í Danmörku og vel er fylgst með þróun og breytingum í þjónustunni þar. Fagfólk á þessu sviði hérlendis hefur um langt árabil horft til Akureyrar sem fyrirmyndar í fyrirbyggjandi heilsuvernd fyrir aldraða, einmitt vegna þessara heimsókna. Árið 2006 héldum við málþing á Akureyri um þessar heimsóknir og þar mættu yfir 70 manns allsstaðar af landinu; frá sveitarfélögum og úr heilsugæslu, þar sem unnið er með þessi mál. Eftir því sem við best vitum hafa verið gerðar tilraunir til að veita svipaða þjónustu í fleiri bæjarfélögum sem hafa þá sína eigin útfærslu á heimsóknunum.

Stýrihópur heilsueflandi heimsókna á Akureyri fagnar þessari þingsályktunartillögu og telur víst að þessi einfalda forvörn skili sér margfalt í betri lífsgæðum og minnki þörf fyrir stofnanavistun. Kostnaður við heimsóknirnar er tiltölulega lítill miðað við þann ávinning sem þær hafa í för með sér. Í þeim breytingum sem eiga sér stað á fjölda hjúkrunarrýma á landinu væri lag að færa til fé úr stofnanaþjónustunni í forvarnirnar, hvort sem það yrði á hendi sveitarfélaga eða heilsugæslu að útfæra þjónustuna.

Forvarnagildi þessara heimsókna virðist, samkvæmt reynslu okkar og annarra, einkum felast í því að veita aukna öryggiskennd. Í heimsóknunum er lögð áhersla á vellíðan og heilsueflandi lífsstíl frekar en sjúkdóma og færniskerðingu og þannig eflist fólk í

Heimilisfang / Adress: Hafnarstræti 99, 600 Akureyri, Iceland
Sími / Tel: 460 4600
Fax: 461 2605
Netfang / e-mail: hak@hak.ak.is

viðleitni sinni til að viðhalda og jafnvel auka sjálfsbjargargetu sína og færni. Þannig frestast þörfin fyrir dýrustu þjónustuúrræðin.

Í Danmörku var farin sú leið að láta sveitarfélögin um að útfæra hvert fyrir sig þessar heimsóknir og þar eru þær jafn misjafnar og sveitarfélögin eru mörg. Sumstaðar er mikill metnaður lagður í þær, annarstaðar er þátttaka og áhugi lítill og árangurinn eftir því rýr. Það er því mikilvægt að lagt verði af stað í þetta verkefni með það að leiðarljósi að nýta þá reynslu sem til er af slíkum heimsóknum, efla það sem virkar vel og sleppa hinu sem ljóst er orðið að ekki skilar árangri.

Allar upplýsingar um heimsóknirnar, og framkvæmd þeirra hér, eru fúslega veittar af undirrituðum.

Virðingarfyllst,

Kristín Sóley Sigursveinsdóttir
framkvæmdastjóri
Búsetudeildar Akureyrarbæjar

Margrét Guðjónsdóttir
framkvæmdastjóri
Heilsugæslustöðvarinnar á Akureyri

Heimilisfang / Adress:
Hafnarstræti 99
600 Akureyri
Iceland

Sími / Tel: 460 4600
Fax: 461 2605

Netfang / e-mail:
hak@hak.ak.is