Deliverable 8.2 Report on Learning Session I

Work package 8: Citizen empowerment

ACT@Scale

Advancing Care Coordination and Telehealth @ Scale

This publication arises from the ACT@Scale (Advancing Care Coordination and Telehealth deployment at Scale) Programme which has received funding from the European Union, in the framework of the Health Programme under grant agreement 709770. The ACT@Scale programme is fully aligned with the European Innovation Partnership in Active and Healthy Ageing objectives to deploy integrated care for chronically ill patients.

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Short description of the Deliverable:
Work package 8 of the Advancing Care Coordination and Telehealth deployment at Scale (ACT@Scale) project, which strives for obtaining commitment and support from interest groups related to care coordination and telehealth, intends also to apply a collaborative methodology (PDSA – Plan, Do, Study, Act) to improve performance of four key drivers of change (Stakeholder and Change Management, Service selection, Sustainability and business models, and Citizen empowerment).
This deliverable presents the results of the baseline phase from the programs that have selected citizen empowerment as one of their driver to facilitate their scaling-up.

REVISION HISTORY			
REVISION	DATE	COMMENTS	AUTHOR (NAME AND ORGANISATION)
V1.0	19/12/2016	First version including all program	Claire Buchner

Executive Summary

The aim of ACT@Scale is to scale up good practices within a given region by implementing collaborative approaches. ACT@Scale methodology, based on Plan-Do-Study-Act (PDSA) cycles, applies multi-organizational structured collaborative quality improvement procedures and adapts them to scale up integrated care experiences.

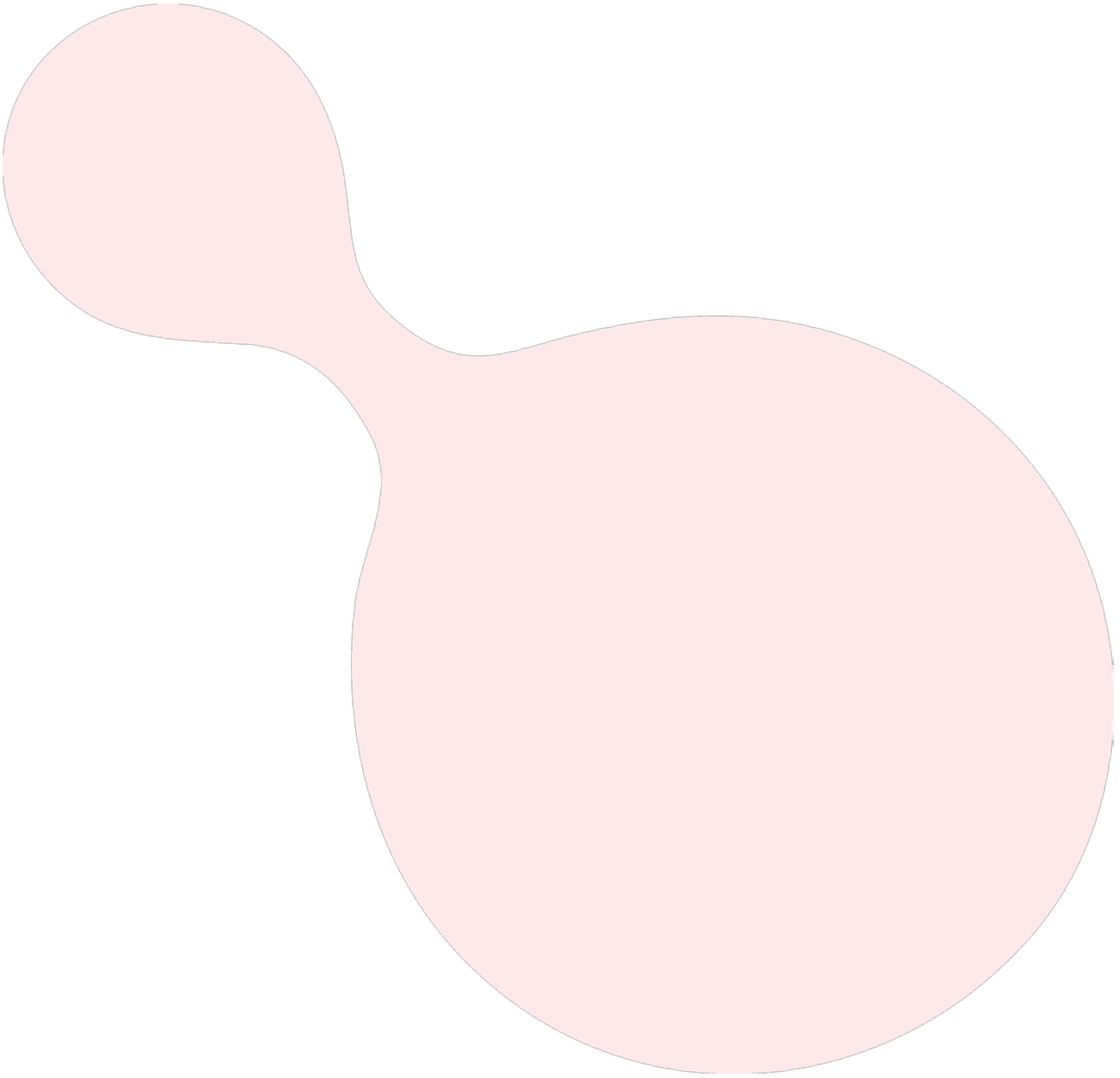
The different phases of the collaborative methodology of ACT@Scale are:

1. Baseline phase
2. Learning cycle
3. Coaching cycle
4. Dissemination phase

This deliverable documents the information gathered at the end of the baseline phase, starting the learning cycle in those programs that have selected the citizen empowerment driver. This information is organized as a route map and follows the structure below:

- Selection of the driver to work on based on scientific evidence
- Set up the multidisciplinary team
- Identification of improvement areas
- Definition of collaborative objectives
- Development of specific interventions for changes that lead to scaling-up ("change package")
- Definition of key performance indicators

Content



Introduction

The first phase of the collaborative methodology in ACT@Scale project is that of the baseline concluded with the maps of the current situation in the different research area. Starting the learning phase, a first workshop was organized to define the work for the collaborative methodologies.

Within each partner region, multidisciplinary working teams have defined several improvement areas that included for example, some resistance to change, lack of time of professionals to fully engage in use of tools and personalised education material, as well as, lack of engagement of key stakeholders in using the service due to a number of barriers and financial sustainability.

The information within this deliverable outlines and describes the output of initial collaborative methodology group work from each partner in relation to citizen empowerment. Each program has outlined the specific improvement areas, objectives and related interventions to be carried out as part of the PDSA cycles within collaborative methodology work.

The process of identifying the specific improvement areas, objectives and related interventions to be carried out is outlined below

Topic selection

Programs selecting citizen empowerment as one of the drivers for scaling up are:

- Diabetes Telemonitoring (NIRE)
- COPD Telemonitoring (NIRE)
- Weigh to healthy pregnancy (NIRE)
- Congested Heart Failure Telemonitoring (BAS)
- Multimorbid integrated intervention (BAS)
- Chronic Patient program (CAT)
- HC Support for Nursing Home (CAT)
- Integrated Care Sub Acute (CAT)

Multidisciplinary team (number and profile)

The multidisciplinary team is composed by different members, the functions and roles are:

- Organizer
  - Plan, prepare, chair and run the collaborative
- Experts
  - Provide knowledge on specific matters depending on the topic selected
- Decision makers
  - Support and sponsorship of the implementation process
  - Capacity to eliminate bottlenecks during the implementation process

- Project Manager/Representatives of organizations
    - Choose the right type of subject to improve
    - Define clear objectives, target and indicators
    - Ensure team building
    - Ensure mutual learning rather than teaching during the collaborative
    - Motivate and empower implementers
    - Equip and support implementers to deal with data collection and analysis
    - Learn and plan for sustaining improvement
- Implementers/Representatives of organizations
    - Implement the improvement changes
    - Continuous assessment and learning cycles within their organization
    - Provide input and feedback to the team
    - Ensure sustainability of the implementation

Improvement Areas

Selection by team members of the issues within citizen empowerment to work on to facilitate scaling-up of the good practice.

Objectives

Teams agree and describe the progress they want to achieve on each improvement area.

Change package (interventions)

Define the interventions/changes to be carried out: develop specific ideas for changes that lead to scaling up within citizen empowerment in each good practice; agree on interventions; and document the "change package". These will be further refined once the first PDSA cycle starts.

Citizen Empowerment Improvement Areas

The following section outlines the selected improvement areas identified by each region for improvement during the PDSA cycles are for selected program

Diabetes Telemonitoring (NIRE); COPD Telemonitoring (NIRE); Weigh to healthy pregnancy (NIRE)

- Underuse of existing tools to measure patients' capacity to self-care
- Underuse of existing tools to improve patients' involvement in their own care i.e. portal technology
- Lack of personalisation of health information

Congested Heart Failure Telemonitoring (BAS)

- The information and the training sessions provided to the healthcare professionals is not uniform
- The training for patients and caregivers is not adapted to the disease phase and the tools available are underused
- Computer tools to facilitate patients´ and informal caregivers´ empowerment are not adapted to users´ capacities

Multimorbid integrated intervention (BAS)

- Low capacity of healthcare professionals to provide with proper educational sessions to patients and caregivers and assess its impact on their health and quality of life
- Poor awareness and willingness in healthcare professionals to give patients more prominence in the decision making process
- Unstructured and unequal empowerment programs for patients and caregivers among the organizations
- Underuse of existing empowerment tools such as online Health School, Active Patient program or Personal Health Folder
- Incoherence between the patient´s or caregiver´s capacity to be empowered and the education (materials, tools) or services provided
- Absence of empowerment interventions in early stages of the disease

Chronic Patient program (CAT)

- Communication between patient/relatives and health/care professionals
- Awareness of self chronic conditions and ways to better manage them
- Communication among healthcare professionals and the nursing homes about patient needs and adherence to treatment

HC Support for Nursing Home (CAT)

- To improve understanding of different cultural needs in end of life care
- **Training:**
- To improve communication between healthcare professionals and patients/users by means of providing training to the healthcare team.
- **Resources:**
- To improve time allocation to healthcare professionals to attend the needs of users, patients and families.
- **Information:**
- To improve information between nursing homes and patients, users and families.

Integrated Care Sub Acute (CAT)

- Communication between patient/relatives and health/care professionals
- Awareness of self chronic conditions and ways to better manage them
- Communication among healthcare professionals and the nursing homes about patient needs and adherence to treatment
- Level of the empowerment of patients and caregivers is not monitored or assessed.

Citizen Empowerment Objectives

The following objectives for the improvement area of citizen empowerment have been identified:

Diabetes Telemonitoring (NIRE); COPD Telemonitoring (NIRE); Weigh to healthy pregnancy (NIRE)

- Expand professionals´ awareness on the relevance of the empowerment and their skills to performed activities related
- Reflect on the possibility of agreeing decisions jointly with patients and caregivers
- Assess the level of empowerment of patients and caregivers
- Consolidate and deploy the use of patient portal technology to facilitate personalized data collection and health messages
- Perform the evaluation of patients´ and caregivers´ empowerment level

Congested Heart Failure Telemonitoring (BAS)

- Promote and improve empowerment skills of both healthcare professionals and patients/caregivers
- Provide patients and caregivers with online applications (Osakidetza´s apps) or corporative technological platforms (Personal Health Folder) to enhance their self-management capacity
- Perform the evaluation of patients´ and caregivers´ empowerment level

Multimorbid integrated intervention (BAS)

- Augment healthcare professionals´ awareness on the relevance of the empowerment and their skills to performed activities related
- Reflect on the possibility of agreeing decisions jointly with patients and caregivers
- Assess the level of empowerment of patients and caregivers
- Provide patients and caregivers with training programs adapted to their specific needs and capacities
- Coordinate health and social care procedures to respond to the needs of patients with poor resources
- Consolidate and deploy a corporative “Active Program” for multimorbid patients
- Focus on training in early stages of the diseases
- Increase proactive attitude among patient and caregivers to develop self-management skills

Chronic Patient program (CAT)

- Provide both the patients/relatives and health/care professionals with an online tool to ensure the communication without the need of a visit to the Primary Care Centre or the patient's home
- Provide both the patients/relatives with an app to rise awareness about the chronic conditions and the ways to better manage them
- Deliver training courses at the Primary Care Centres for both the patients and relatives about the chronic conditions and the ways to better manage them
- Structure/formalize the training information and hold it within a single repository
- Design a better communication process between the healthcare professionals working at BSA and the nursing homes (private ones)

HC Support for Nursing Home (CAT)

- To improve healthcare delivered to patients with advanced chronic conditions
- To identify patients with advanced chronic conditions
- To formalize healthcare delivered to patients with advanced chronic conditions
- To prepare training on the Advanced Care Planning for healthcare professionals and patients with advanced chronic conditions

Integrated Care Sub Acute (CAT)

- To implement a program based on a specific multi-component intervention to improve the quality of care transitions (based on medication management, promotion of resuming a healthy lifestyle, and improved care coordination after discharge), lead by Transitional Coaches, and shared with patients/caregivers and with primary care.
- To empower patients and caregivers by providing them with guides and tools to make a successful transition process (based on medication adherence, healthy lifestyle and other possible risks).
- To follow-up the results of this intervention.
- In this sense, we plan to implement and evaluate an innovative intervention based on the quoted elements, and, as a parallel action, to promote a research study to compare the results of this intervention with usual care in other wards of the institution.

Citizen Empowerment Change Package (interventions)

The following proposed interventions will be carried out and will be further refined once the first PDSA cycle starts.

Diabetes Telemonitoring (NIRE); COPD Telemonitoring (NIRE); Weigh to healthy pregnancy (NIRE)

1. Prepare, organise and provide training sessions focused on empowerment methodologies, techniques and tools for professional
2. Define, agree and implement methodologies (questionnaires, scales etc.) to measure the empowerment level of patients and caregivers in the routine practice
3. Define the criteria to stratify patients/caregivers according to their capacity to be empowered and determine the service to be offered (type of training, material, tools, activation of social resources etc)
4. Motivate and train patients in the use of portal technology
5. Adapt the content of portal in partnership with patients

Congested Heart Failure Telemonitoring (BAS)

1. Create and implement a structured empowerment program (sessions, content, material and ICT tools) for patients with congestive heart failure for all the organizations of Osakidetza
2. Periodically revise and validate standardized training material for both healthcare professionals and patients/caregivers
3. Develop a Specific “Active patient” program for congestive heart failure
4. Develop and set up a training program (clinical knowledge, techniques and assessment skills) for all professionals (clinicians and nurses) to provide capacity in empowerment methodologies.
5. Agree and share standardized questionnaires, scales and forms between primary care and hospital to monitor patient´s and caregiver´s empowerment

Multimorbid integrated intervention (BAS)

1. Prepare, organize and provide training sessions focused on empowerment methodologies, techniques and tools for professional
2. Explore, qualitatively analyze, and document the possibility and capacity of including systematically patients and caregivers in the decision-making process
3. Define, agree and implement methodologies (questionnaires, scales etc.) to measure the empowerment level of patients and caregivers in the routine practice

4. Define the criteria to stratify patients/caregivers according to their capacity to be empowered and determine the service to be offered (type of training, material, tools, activation of social resources etc)
5. Recruit, motivate and train multimorbid patient to be leaders of the "Active Patient" program and organize sessions with other patients and caregivers
6. Adapt the content of the Kronik ON program to address empowerment in early stages of the disease and publish it in the online Health School
7. Prepare, plan and set up activities for the informal caregivers to solve frequent questions and support them in promoting self-management skills of patients
8. Launch informative actions for patients and caregivers to enhance their proactivity

Chronic Patient program (CAT)

1. Foster the access of the users in the different chronic care programmes to "La Meva Salut" (the Catalonian patient portal) and the usage of the e-consultation tool to establish a communication channel among the healthcare professionals and the patients/relatives
2. Prepare an app meant to rise awareness about the main chronic conditions giving advise on how to better manage them
3. Ensure that the patients and relatives within the chronic care programmes attend the training courses delivered at Primary Care
4. Better structure and formalize in the same format all the training information for patients and relatives and make it accessible online through a single point of access
5. Think about and formalize a process for better communication between the healthcare professionals from BSA that are serving the nursing homes and the personnel (mainly nurse assistants) that are working in there. The process may include the usage of telemedicine solutions/videoconferencing facilities, etc.

HC Support for Nursing Home (CAT)

1. Create and implement a structured program for the Advanced Care Planning dissemination through sessions, content and online training.
2. To develop and set up workshops and sessions on the Advanced Care Planning for users and families.

Integrated Care Sub Acute (CAT)

1. Support identification of patients at risk we will start planning the discharge process and implement the following interventions;
   - Medication; Ensure correct understanding of treatment, and adherence.
   - Health habits; Provide guides and tools to promote resuming healthy lifestyle habits.
   - Transition care levels.
2. Ensure proper communication with the primary care nurse or physician.

All these interventions will be carried out by a "transition coach", which will be a nurse with 40-50 hours training, and who will work in collaboration with the physicians, social workers and physical therapists.

Key Performance Indicators

Using WP04 indicators as a reference the following KPIs relating to scaling up, programme and process will be collected during the project.

SCALIN-UP OUTCOME INDICATORS

Citizen empowerment

Data input	Topic	Type	Target for surveys
Citizen empowerment	Psycho social	PAM survey (included in MAY)	Patients

PROCESS INDICATORS

Citizen empowerment

Data input	Topic	Type	Target for surveys
Citizen empowerment	Psycho social	Rest or MAY survey	Patients
	Psycho social	CSPAM survey	Frontline staff

Collaborative Methodology: Baseline Regional Report – Telepsychiatry (RSD MH TH)

During the first six months of ACT@Scale, RSD has experienced certain challenges in the involvement of the identified telepsychiatric service and professionals. These challenges have emerged as the identified service is more mature than what was intended for ACT@Scale. Furthermore, the organisational set up required to participate in ACT@Scale does not exist in the current telepsychiatric service as the service has already moved beyond this stage. The challenges have resulted in a delay in the planned project activities, primarily the Collaborative Methodology.

Currently, RSD is working to engage a different telepsychiatric service and a new set of professionals to be part of ACT@Scale. The new service focuses on the use of telemedicine in diagnosing, treating and monitoring citizens suffering from depression. The involvement of this service will ensure a more coherent contribution to ACT@Scale. However, the schedule for the data collection and the collaborative methodology will be delayed as the new constellation and engagement have to be properly established. If the engagement of the new service is secured, the activities are expected to be initiated in January 2017 and the aim is to be in line with the rest of the consortium by March 2017.