

Scaling-up of integrated care for multimorbid patients in the Basque Country

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ACT@Scale project

- **Starts:** March 2016
- **Duration:** 36 months
- **Coordinator:** Philips Healthcare

OBJECTIVE: Basque Country aims to scale up the integrated care for multimorbid patients to all local organizations.

Integrate care for multimorbid patients

**Target group:
18.000 patients**



1. Define a common integrated care pathway

2. Standardize and systematize the process of empowering patients

Working group

Profiles involve

1. General Directors
2. Medical managers
3. Nursing managers
4. Healthcare Integration managers
5. Heads of Internal medicine
6. Liaison hospital nurses
7. Advanced practice nurses
8. eHealth Centre representative
9. SIAC members
10. Researchers

Organizations involved

13 ICOs
2 Sub-acute Hospitals
SIAC (Integrated care and chronicity services)
eHealth Centre
Kronikgune



Implementation of the integrated care pathway

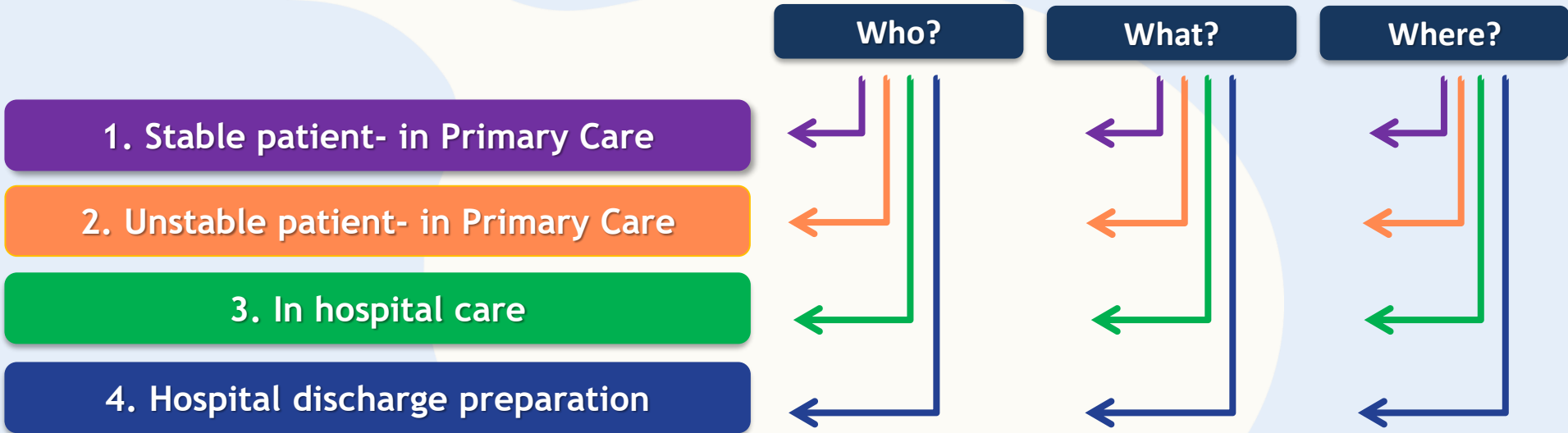
Steps

Care pathway
definition

Current situation
analysis

Common care
pathway

Patient's journey into the health system



Design of a Common care pathway

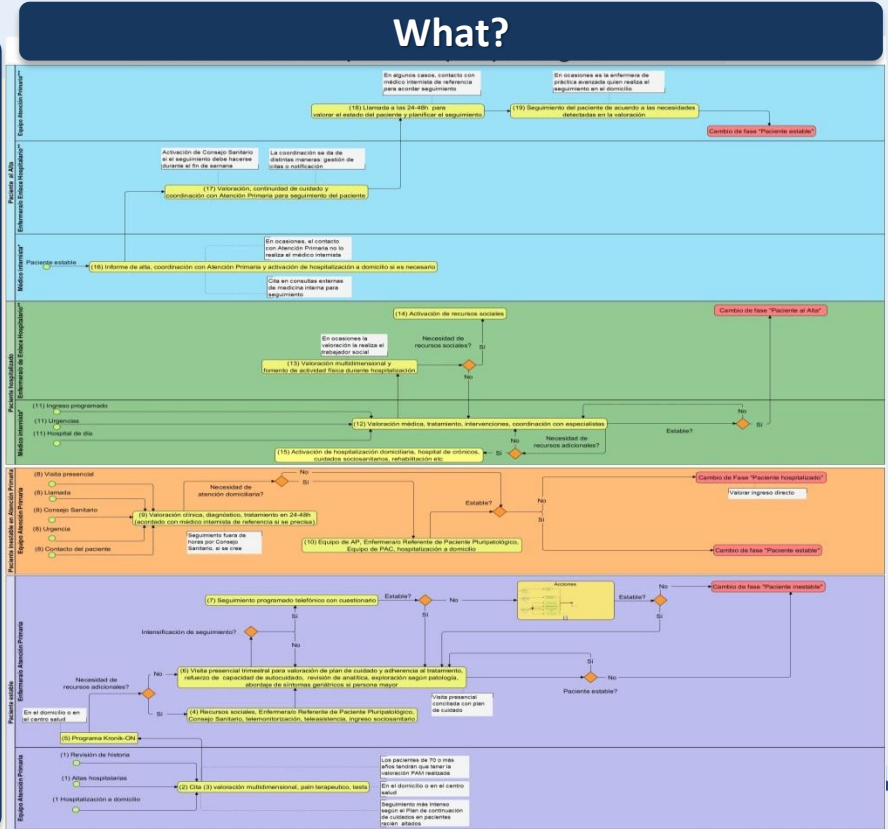
4. Hospital discharge preparation

3. In hospital care

2. Unstable patient In Primary Care

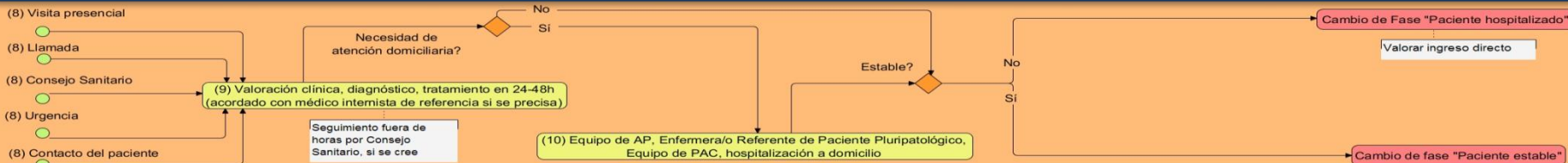
1. Stable patient in Primary Care

Who?



Example: Unstable patient in Primary Care

What is done in time order?



Starting point



Description of activities



NOTE on a specific activity



Decision point: YES or NO



Patient transition to another phase

Empowerment of patients and caregivers

Steps

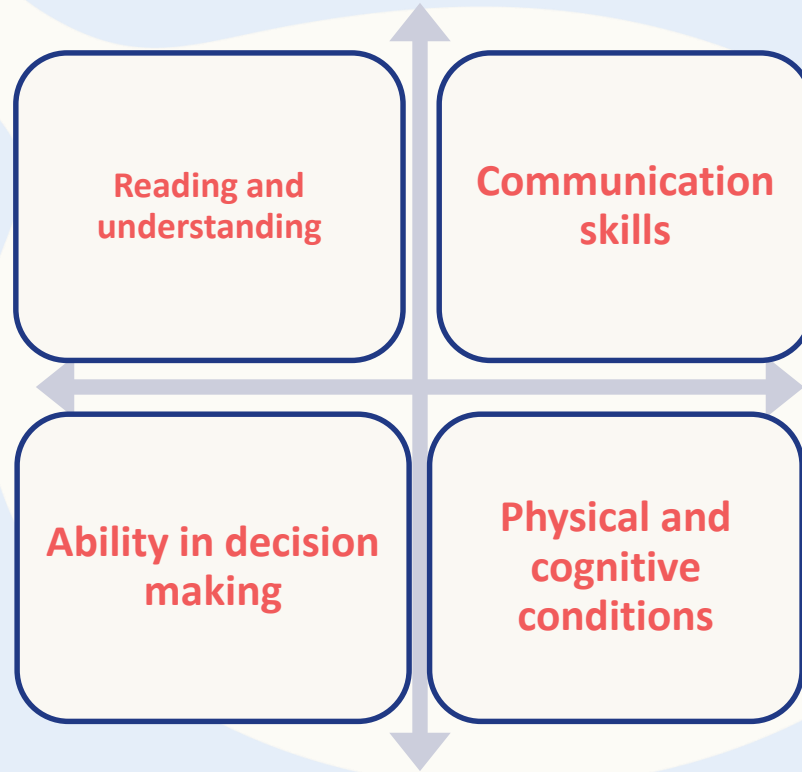
Classification of
patients
according to
health literacy

Provision of
appropriate
services

Empowerment
evaluation

VACS questionnaire

What does it check?



VACS questionnaire

- YES = 1 point; NO= 0 point
- Score 0 to 4



0-2 points “Low”: patients or caregivers with low health literacy

3 points “Medium”: patients or caregivers with intermediate health literacy

4 points “High”: patients and caregivers with high health literacy

Osakidetza 's empowerment services

Red

Care givers and patients with low health literacy

- Kronik-On program

Orange

Care givers and patients with intermediate health literacy.

- Kronik-On program
- Active Patient program (as participant)

Green

Care givers and patients with high health literacy

- Kronik-On program
- Osasun Eskola session (on line materials)
- Patient health folder (mobile or computer access)
- Active Patient program (as participant or coach)
- Osakidetza mobil app
- Programs available locally

Empowerment Evaluation

- All data registered are encoded with NANDA, NIC and NOC taxonomies
- Evaluation is done according to nursing taxonomies

osanaia

osa (OSAKIDETZA) **naia** (Nursing Advanced Information Assistant)

Empowerment indicators

1. Does the patient know the disease signs or symptoms?

2. Does the patient avoid behavior that can promote disease progression?

3. Does the patient follow the recommended treatment?

4. Does the patient know who to call in case of needs?

Summary

All 13 Integrated Care Organizations agreed on a **common integrated care** for multimorbid patients

The integrated care is sufficiently **flexible** to be adapted to the different local necessities and diversities

The **new technological tool** (Integrated programs Management - GIP) will facilitate its implementation

The **empowerment process** will be homogeneous and systematic

Patients will be classified based on their **health literacy**

Based on this classification, the patients will be offered **different empowerment tools**

The patient's **empowerment** will be **evaluated**

Thank you

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