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

1. Stable patient - in Primary Care
2. Unstable patient - in Primary Care
3. In hospital care
4. Hospital discharge preparation

Who?  What?  Where?
Design of a Common care pathway

1. Stable patient in Primary Care
2. Unstable patient In Primary Care
3. In hospital care
4. Hospital discharge preparation
Example:
Unstable patient in Primary Care

What is done in time order?

- (8) Visita presencial
- (7) Llamada
- (6) Consejo Sanitario
- (5) Urgencia
- (4) Contacto del paciente

Decision point: YES or NO

Patient transition to another phase

Starting point
Description of activities
NOTE on a specific activity
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?

- Reading and understanding
- Communication skills
- Ability in decision making
- Physical and cognitive conditions
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
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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