WP6
Pilot action Plan Report for Country

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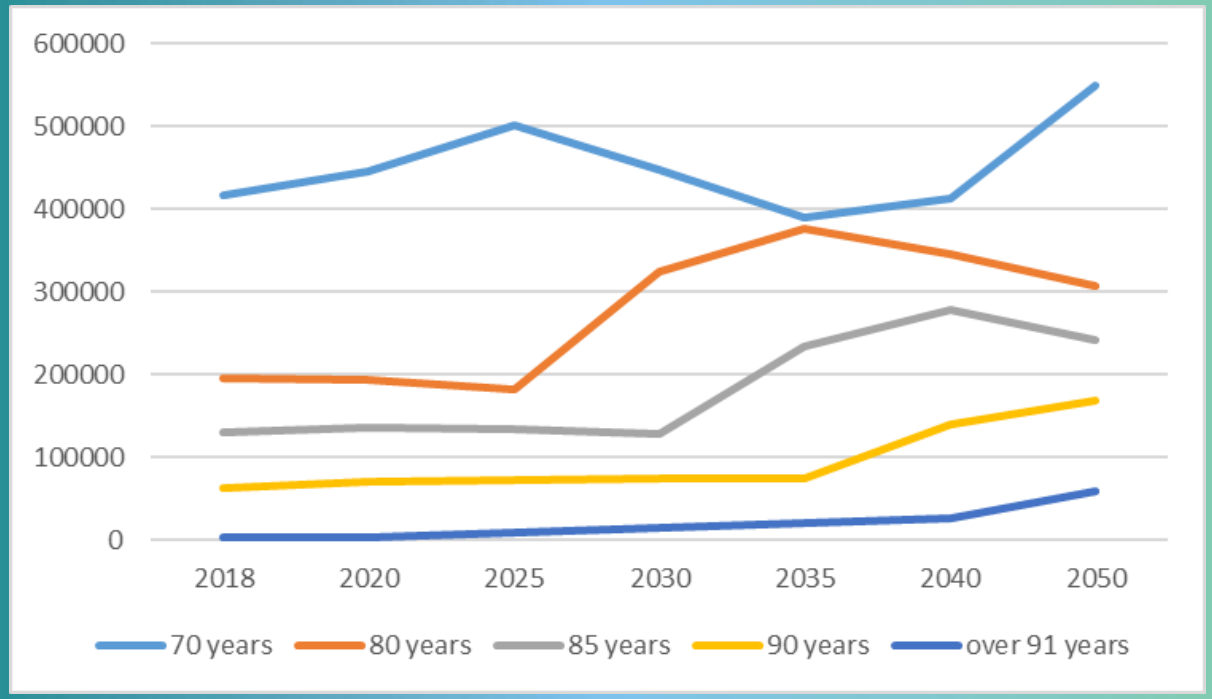
General conditions



Ageing in the Polish society

General conditions

1. Polish society is one of the fastest-ageing European societies.
2. Patients aged at least 65 often suffer from health problems resulting from chronic diseases, accompanied by mental and social issues, additionally complicated by problems with patient mobility and locomotion, impairment of sense organs functions, cognitive functions, motivation, balance and gait, and risk of falls
3. The elderlies often suffer from more than 3 medical conditions that require varied therapeutic approach and therapeutic priorities focused on prognosis, chances of survival and possible specialist treatment
4. The primary health care, outpatient specialist care or hospital care are usually provided in a traditional clinical settings oriented at a disease instead of a patient in line with specific expert recommendations (single condition services adopting single condition guidelines)
5. Health care providers usually work individually, without communication with each other, not exchanging necessary information about a patient and not looking at patient's problems as a whole

Target population

- Patients age 65+ with multimorbidity and polypharmacy

Models of care considered

- The intervention is based on Chrodis Model of Integrated Care (the Integrated Care Model for Multimorbidity developed in the JA CHRODIS).
- WHO Model of Integrated Care for Older People, Kaiser Permanente Model and House of Care Framework - *seem to be convincing among the described models of care focused on the efficiency of the system of health care and elderly people`satisfaction as a recipients of services.*

Integrated Care Model Components implemented

Regular comprehensive assessment of patients

(Comprehensive Geriatric Assessment -set of the standard tools- and frailty detection using Prisma-7 scale (primary health care) and Fried`s Scale and Edmonton Scale (hospitals),

Training members of the multidisciplinary team (hospitals` multidisciplinary teams including doctors – different specializations, nurses, physiotherapists, psychologists, dieticians, carers) focused on multimorbidity, polypharmacy and patient- centred, patient-oriented, anticipatory and pro-active care,

Training of care providers to tailor self-management support based on patient preferences and competencies (home carers, informal carers, neighbours, others)

Methods

Comprehensive Geriatric Assessment:

•performed at least once a year, oriented towards early detection of change/disorders and intervention to prevent escalation of change/disorders in declining physical and mental capacities: mobility loss, malnutrition, visual impairment, hearing loss, cognitive impairment (including delirium and dementia, AD), depressive symptoms, geriatric syndromes: urinary incontinence, risk of falls, fractures, frailty syndrome. Tests performed: ADL, Activities of Daily Living, IADL, Instrumental Activities of Daily Living, Barthel; Assessment of orthostatic hypotension, assessment of urinary incontinence; anthropometric measurements, Assessment of nutritional status NRS 2002, Mini Nutritional Assessment, Assessment of balance and gait and risk of falls according to Tinetti and Time Up and Go (TUG) scales.

Methods

Comprehensive Geriatric Assessment:

•extended to include studies on detection of heart and respiratory failure (Nt pro BNP laboratory test and spirometry) and for detecting frailty (Primary Health Care - screening Prisma-7 scale, ambulatory specialistic health care diagnostic tests: Fried`s Scale, Edmonton Scale),

•using useful tools such as: set of diagnostic tools, new technology tablets and information systems (specialized software), telecare, telemedicine devices to improve the diagnostics,

•and creation of the possibility of data transmission and communication between patients and TM members, members among each other, external cooperation with specialists, hospitals, institutions, personal data protection, security systems

Methods

Training members of the multidisciplinary team

(hospitals` multidisciplinary teams including doctors – different specializations, nurses, physiotherapists, psychologists, dieticians, carers)

•focused on multimorbidity, polypharmacy and patient- centred, patient- oriented, anticipatory and pro-active care. The role of interdisciplinary team members in the care of elderly patients with multiple diseases, the tasks of individual team members, understanding their tasks in the care of a specific patient, documentation and information flow, the importance of communication between team members, models of communication and tools, creation of a single care plan and evaluation, using case studies as examples.

•(3 days courses 20 didactic hours, including lecutres, workshops, case studies)

Methods

Caregiver support

•Training of care providers to tailor self-management support based on patient preferences and competencies (home carers, informal carers, neighbours, others)

•support in the community (relatives, neighbours), psychological intervention, training and support offered to family members and other informal caregivers of care-dependent older people, particularly but not exclusively when the need for care is complex and extensive and/or there is significant caregiver strain.

•support in the use of government programmes addressed to seniors (informational, instrumental support for implementing programmes such as: POZ PLUS, Social Policy for the elderly people 2030. SAFETY - PARTICIPATION - SOLIDARITY), support in the use of local government initiatives and initiatives of patient organisations (information campaigns, workshops, forms of care), volunteering,

•(3 days courses 20 didactic hours including lecutres, workshops, case studies)

*This presentation arises from the Joint Action addressing chronic diseases and healthy ageing across the life cycle (JA-CHRODIS+), which has received funding from the European Union.

Identified threats

- Fragmented, scattered, insufficient care offered to the elderly,
- High cost of health care does not ensure patients` safety,
- In many cases health care completely differs from the patients' needs and expectations,
- Insufficient interventions, increases the level of stress and causes other negative consequences, such as: polypharmacy, unnecessary hospitalisations, frequent use of emergency aid, re-admission or institutionalisation in long-term care centres.

Specific aims

- Improved coordination of activities between the hospital, primary health care and secondary health care (social services), ensuring continuity and regularity of care, adequate to the health and psychosocial problems of patients co-existing in the multimorbidity.
- Actions targeting the patient and his or her ability to care for himself or herself and remain in his or her own living environment, at home for as long as possible while being independent and as sufficient as possible.