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IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

Work Package 6 – Pilot Implementation of Integrated Care Model for multimorbid patients VULSK pilot site

Governing Board meeting, Malta, Jun 4th

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WHAT is work package implementing CHRODIS Multimorbidity Care Model

Expert Consensus Meeting

16 components identified

For each component:

- Description and aims
- Key characteristics
- Relevance to multimorbidity patients

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ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

Palmer K et al. Health Policy 2018

It‘s applicability should be tested in pilot actions

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Implementing sites WP6

IMPLEMENTATION PROJECTS OF THE WP

1

SITE: Andalucia, SP
SETTING: Primary Care
SCALE: Regional
FOCUS: Individualized Care Plans

2

SITE: Aragon, SP
SETTING: Primary Care
SCALE: Regional
FOCUS: Education, Continuity of Care

3

SITE: Rome, IT
SETTING: Hospital
SCALE: Local
FOCUS: Patients' education, Case Management, Technology, CGA

4

SITE: Vilnius, LT
SETTING: Primary Care/Hospital
SCALE: Regional
FOCUS: CGA, Case Manager, Individualized Care Plans, Patients' education

5

SITE: Kaunas, LT
SETTING: Primary Care/Hospital
SCALE: Regional
FOCUS: CGA, Case Manager, Individualized Care Plans

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Summary of ICMM components targeted by each implementing site

	Target components	Andalusia	Aragon	Kaunas	Rome	Vilnius
Delivery of the care model system	**60%**					
Regular comprehensive assessment of patients			Yes	Yes	Yes	Yes
Multidisciplinary, coordinated team			Yes	Yes	Yes	Yes
Professional appointed as coordinator of the individualized care plan ("case manager")			Yes	Yes	Yes	Yes
Individualized care plans		Yes	Yes	Yes		Yes
Decision support	**60%**					
Implementation of evidence based practice				Yes	Yes	Yes
Training members of the multidisciplinary team			Yes	Yes		Yes
Developing a consultation system to consult professional experts			Yes	Yes		Yes
Self-management support	**53%**					
Training of care providers to self-management support			Yes			
Providing options for patients and families to improve their self-management				Yes	Yes	Yes
Shared decision making (care provider and patients)			Yes	Yes	Yes	Yes
Information systems and technology	**35%**					
Electronic patient records and computerized clinical charts			Yes	Yes		Yes
Exchange of information between care providers and sectors by clinical information systems			Yes	Yes		
Uniform coding of patients´ health problems where possible					Yes	
Patient-operated technology allowing patients to send information to their care providers					Yes	
Social and community resources	**40%**					
Supporting access to community- and social- resources				Yes		Yes
Involvement of social network (informal), including friends, patient associations, family, neighbours				Yes	Yes	
Target components		**1/16 (6.25%)**	**10/16 (62.50%)**	**13/16 (81.25%)**	**9/16 (56.25%)**	**11/16 (68.75%)**

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Results.
Facilitators and barriers for implementation

	Barriers to the assessment	Facilitators to the assessment
Andalusia	Resistance to change of health professionals	Integrated information systems Accesible electronic health records Population health database as information source
Aragon	Linking specific intervention actions to specific outcomes	Pre/post comparable implementation indicators Accesible electronic health records
Kaunas	Limited implementation time Limited number of patients Scarcity of human resources	Pre/post comparable implementation indicators
Rome	Non-integrated information systems	Strong implementation team motivation
Vilnius	Limited implementation time Limited number of patients Scarcity of human resources Lack of qualified information technology personnel Non-integrated information systems	Pre/post comparable implementation indicators Global optimization assessment possible through health resource consumption evaluation

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Implementation in Lithuania

PILOT SITES:
Vilnius, LT
Kaunas, LT
SETTING:
Primary Care/Hospital
FOCUS:
Delivery of Care for multimorbid patients (heavy users of healthcare cost)
TOTAL SAMPLE SIZE :
400 patients

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Description of the implementation

Based on local experience and knowledge determined country specific model version. This model mainly concentrates on:

Delivery of Care

- Comprehensive assessment
- Coordinated team
- Individualized care plans
- Case manager

Decision Support

- Team training
- Consultation system

Self Management Support

- Options for self management
- Shared decision making

Social and Community Resources

- Tailor Self-management
- Options for self management
- Shared decision making

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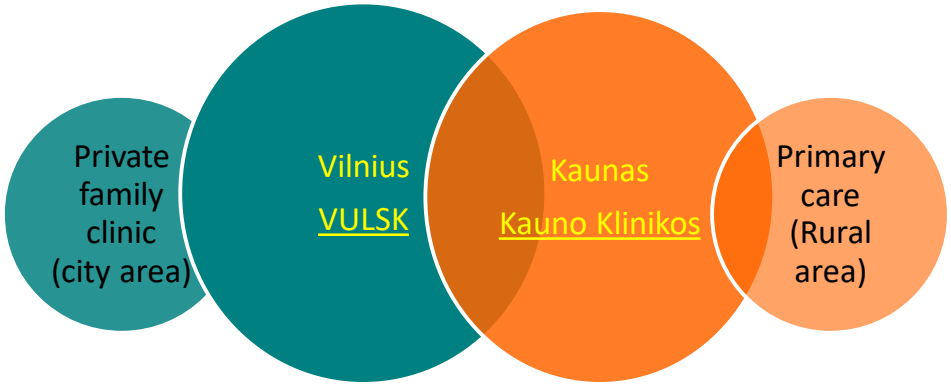
Implementation in Lithuania

Vilnius University Hospital
SANTAROS KLINIKOS

HOSPITAL OF LITHUANIAN UNIVERSITY OF HEALTH SCIENCES
KAUNAS CLINICS



Pilot sites in Lithuania had a the kick off with all members of LIWG from Kaunas and Vilnius:

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Target patients

- Age range: between 40 and 75 years old
- Clinical characteristics: list of patients having more than one chronic condition from at least two different systems (according to ICD-coding)
- Stratification: Frailty index

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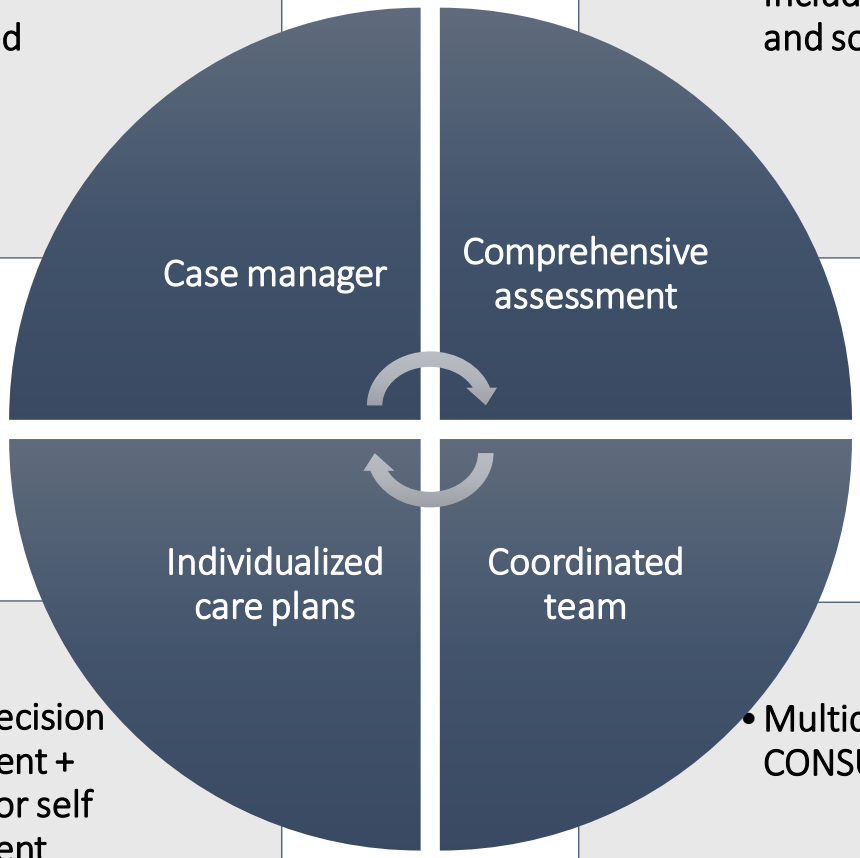
How we do it ?

- Patient orientated
- Including mental and social issues



- Shared decision with patient + options for self managment
- Multidisciplinary CONSULTATION

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CASE MANAGER

- REVIEW OF PATIENTS‘ HEALTH CARE (WHAT IS MISSING?)
- EVALUATION OF THE CONTROL OF CHRONIC CONDITION
- PRIMARY CONTACT FOR THE PATIENT, CARE PLAN COORDINATION, CARE MANAGEMENT, ARRANGEMENT OF THE SOCIAL SUPPORT
- FEEDBACK CONTROL FROM SPECIALISTS AND PATIENTS
- **CLOSE CONTACT WITH THE PATIENT**

**CASE MANAGER IN KAUNAS CLINICS*

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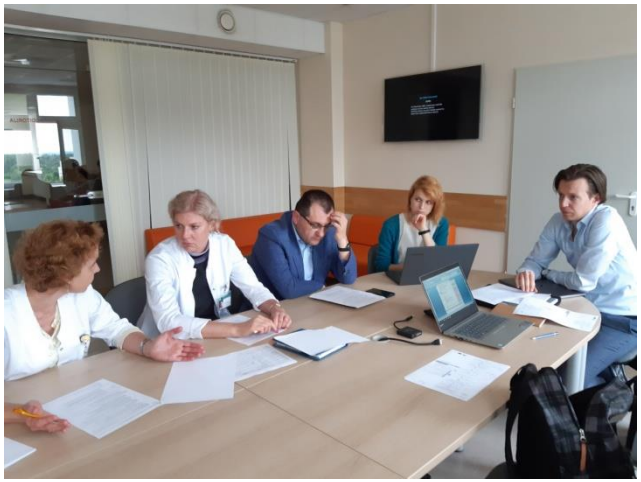
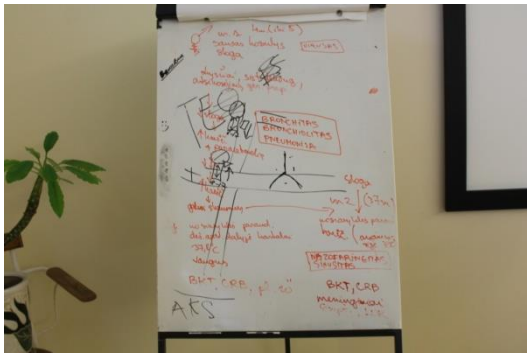
COORDINATED TEAM



-Coordinated meetings once a month to discuss special cases or frailty patients

-Team is composed of GB + case manager + several specialists in the relevant diseases

-Nominated clinician and case manager responsible for patient's treatment presents the case to multidisciplinary team members'



-Coordination between all relevant team members must be maximized.

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Possible benefit

Policy makers

- Provide evidence on effective interventions that can represent the basis to inform policy

Stakeholders

- Provide a cost-effective effective intervention to be applied in different contexts

Patients

- Receive comprehensive care centered on needs

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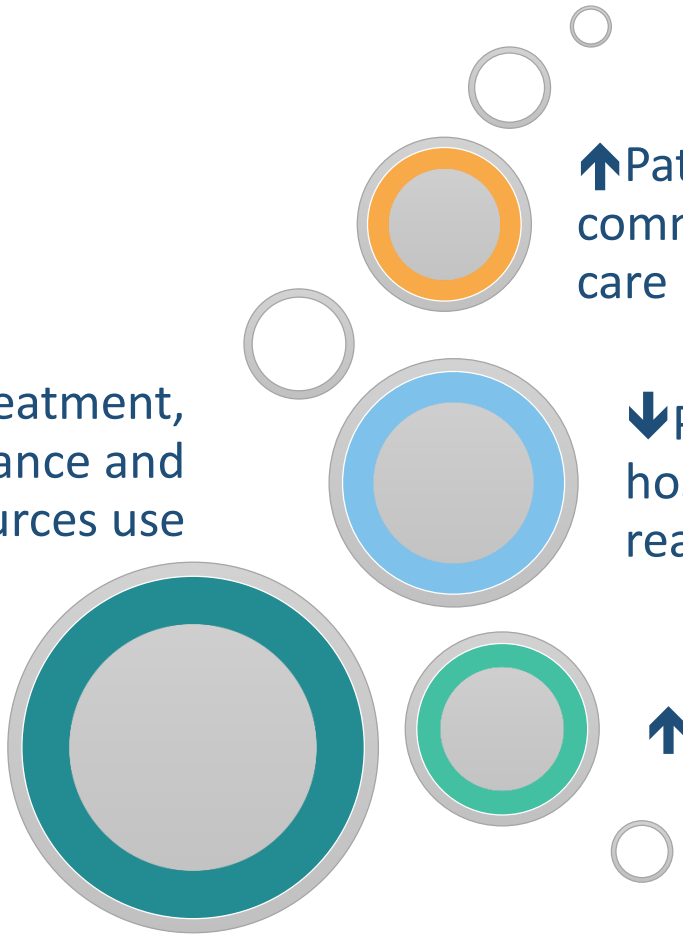
Desirable goals….



↑Patient‘s access to community resources, care and services

Optimize treatment, maintenance and healthcare resources use

↓Potentially avoidable hospitalizations and readmissions

↑The quality of life

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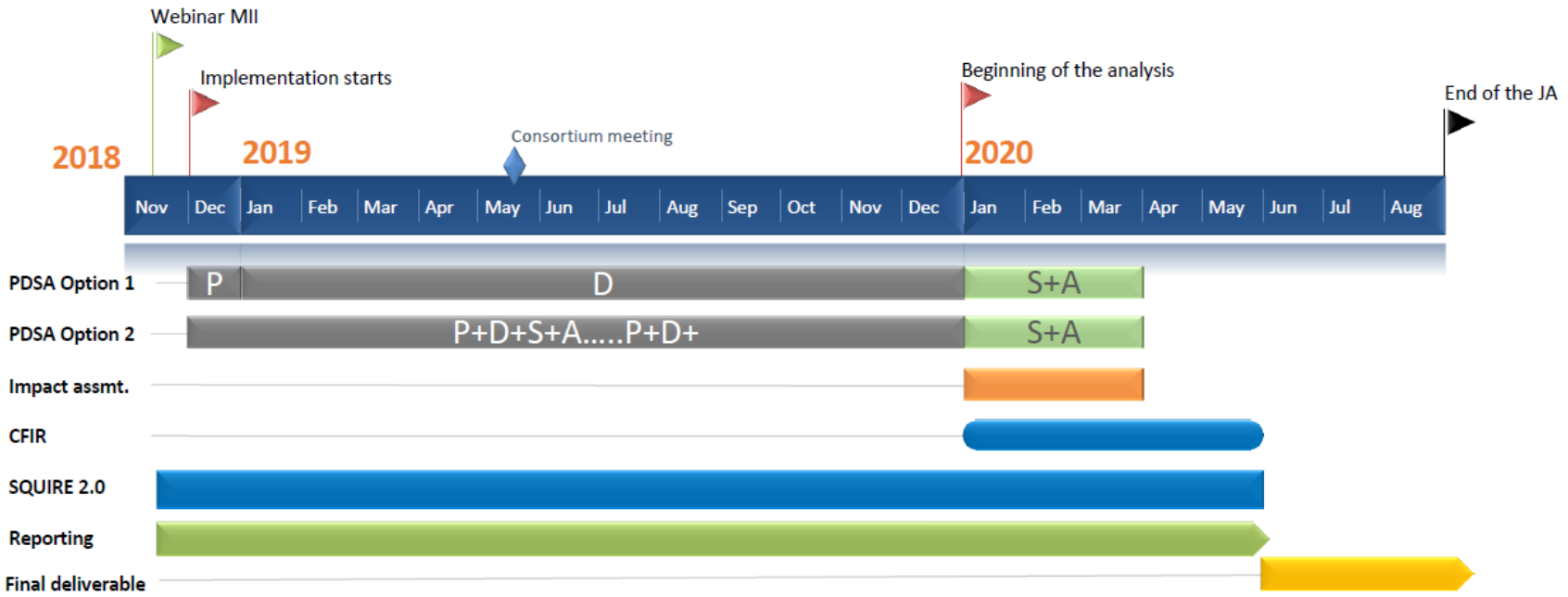
Timeline

Timeline



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CHRODISIANS IN LITHUANIA

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Thank you for your attention

The Joint Action on Implementing good practices for chronic diseases (CHRODIS PLUS)

This presentation arises from the Joint Action CHRODIS PLUS. This Joint Action is addressing chronic diseases through cross-national initiatives identified in JA-CHRODIS to reduce the burden of chronic diseases while assuring health system sustainability and responsiveness, under the framework of the Third Health Programme (2014-2020). Sole responsibility lies with the author and the Consumers, Health, Agriculture and Food Executive Agency is not responsible for any use that may be made of in the information contained therein.

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