A CASE MANAGER APPROACH IN MANAGING MULTIMORBIDITY

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CHRODIS+ IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

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Introduction

The aim is to evaluate the Integrated Care Model for patients with multiple morbidities. The newly presented model with the key element – a case manager, i.e. an advanced nurse practitioner, in primary health care will be assessed in Lithuanian pilot sites.

Methods and materials

The Lithuanian Bioethics Committee provided the permission for the project. The pilot survey started with the primary health care team training: roles and functions delegation for the team members, long lasting patient's care planning including individual approach to patient continues care needs.

Patients' inclusion criteria:

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):

E11 + n J44/J45 + n I50 + I48 + n	n	I. I11 ; I20 ; I25 ; I50 ; I48 II. E11 E06.3 ; E89 III. J44; J45 IV. M05; M15-M19; M80; M81; M54 G54; G55

206 patients were randomly selected in Kauno Klinikos and Kaltinenai sites. A control group of 50 patients was formed. Control group will undergo usual care without interventions.

Results

1. A case manager invites patient to participate in the pilot survey – signed patient agreement to participate in the study.
2. 1st patient's visit, performed by a case manager:

Chronic conditions status, frailty and severity of chronic conditions measurement.

Medication use: interactions testing, and compliance.

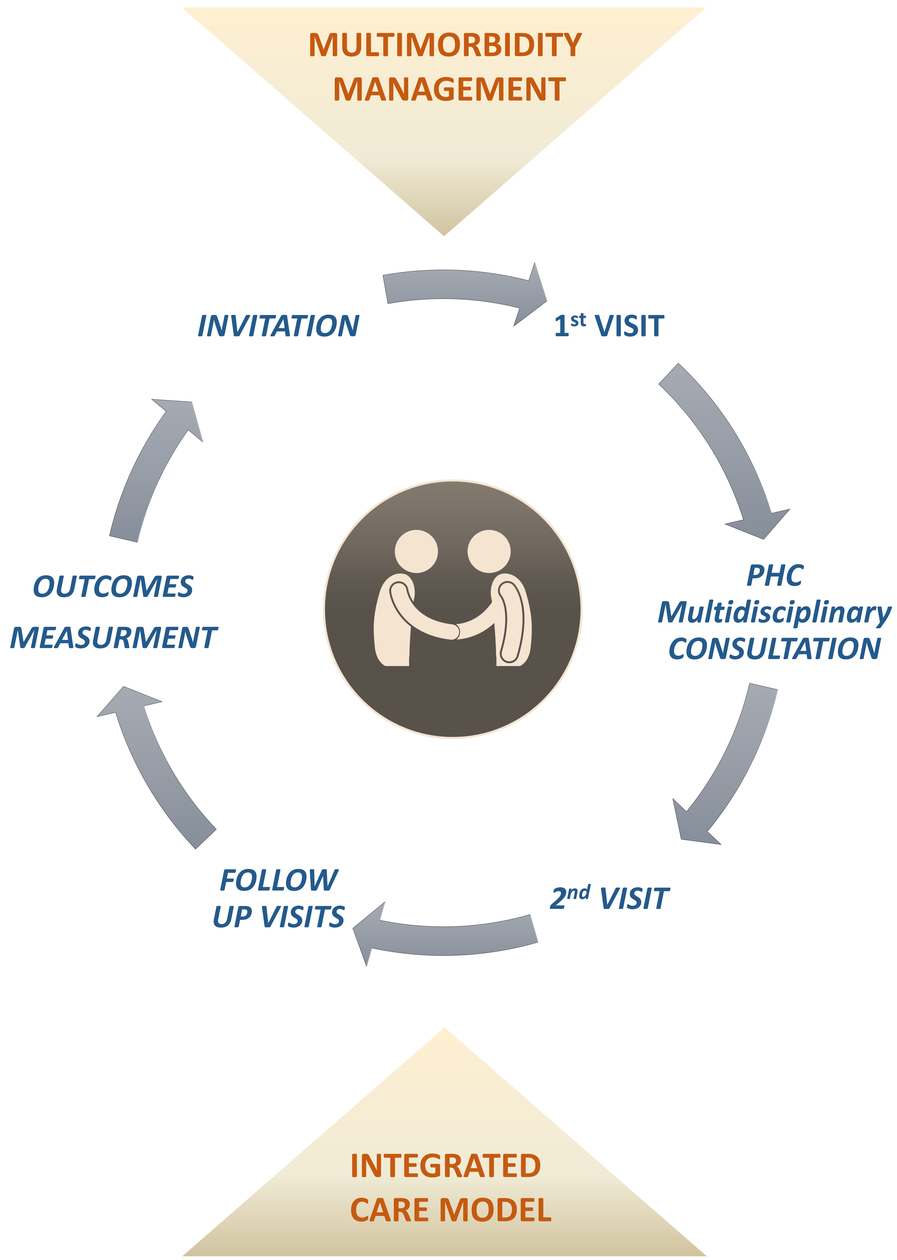
The highlighting of main health problems from patient point of view.

Prevention status: immunization, prevention screenings

Check-up performances:

- Screening for mental health care conditions: mini mental status and anxiety and depression scale (Minimental and HAD scale).
- Social status (IPA questionnaire).
- Health quality assessment, health care assessment (EQ-5D and PACIC+), frailty index measurement.
- Telemedicine services initiation.

3. PHC multidisciplinary consultation (personal family physician, Chrodis+ experts /family physicians and advanced nurse): construction of individualized patient's health care plan.
4. 2nd visit: consensus on health care plan with a patient.
5. Follow up visits .
6. Last patient visit: outcomes measurement.



Conclusion

The effectiveness of new model for multimorbid patients care (presenting a key element – a case manager) in primary health care - will be assessed through following outcomes:

1. Patients' quality of life (EQ-5D).
2. Quality of health care: The Patient Assessment of Care for Chronic Conditions (PACIC+).
3. Patients needs for social and mental health care: screening using Minimental, HAD scale, IPA questionnaire.
4. Process indicators:

- Number of patients' consultations during pilot: total, in primary health care level (GP nurse i.e. case manager), secondary/tertiary level.
- Number of polypharmacy and number of incompatible drugs combinations (drug interaction rate).
- Assessment of the utilization of health care resources .
- The number and duration of hospitalizations.
- Admissions to emergency departments due to exacerbation of the chronic condition in 12 months.

Acknowledgements

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