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IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

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Pre-Conference WP6 Workshop:

Implementation of CHRODIS Integrated Care Model for Multimorbidity in Aragón, Spain

Antonio Gimeno Miguel,
on behalf of the whole Local Implementation Working Group
Aragon Health Sciences Institute (IACS)

13.05.2019

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Structure of the presentation

- Description of the implementation
- Participants enrolled so far
- Barriers to implementation and support needed to overcome barriers
- Possible deviations from PAP
- Site visits
- Timeline

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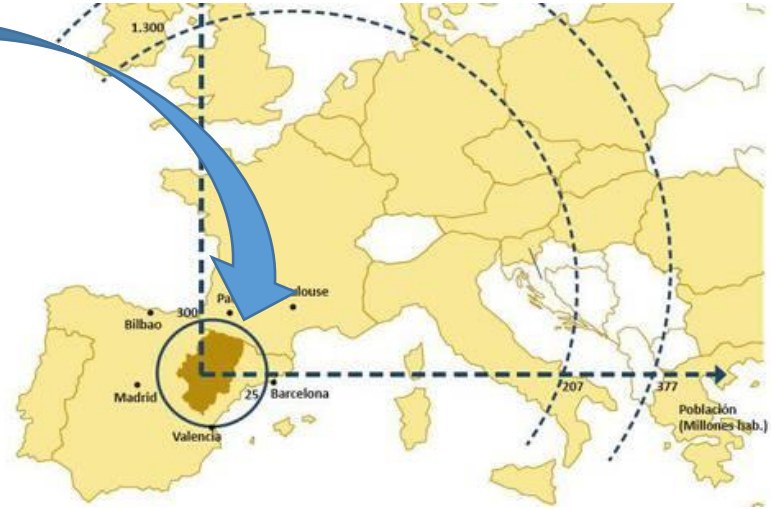
Description of the implementation



Aragón´s Public Health System

To test the feasibility
To asses the success
To develop adaptations

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Description of the implementation

Some data on Aragón´s Public Health System

- 1.3 M inhabitants approx, half of the population living in Zaragoza

- 95% users of Public Health System: universal coverage, free of charge

- Primary Care serves as gatekeeper

- Very well trained healthcare professionals, but not specifically in managing multimorbid patients

- Clinical guidelines for specific diseases

- Computerized medical records – uniform coding systems

- No official multimorbidity care models / strategies ongoing

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Description of the implementation

DELIVERY OF CARE

1. Regular comprehensive assessment of patients
2. Multidisciplinary, coordinated team
3. Case manager
4. Individualized care plans

DECISION SUPPORT

5. Implementation of evidence based practice
6. Training members of the multidisciplinary team
7. Developing a consultation system to consult professional experts

SELF-MANAGEMENT SUPPORT

8. Training of care providers to tailor self-management support
9. Providing options to patients and their families
10. Shared decision making

INFORMATION SYSTEMS AND TECHNOLOGY

11. Electronic patient records and computerized clinical charts
12. Exchange of patient information
13. Uniform coding of patients´ health problems
14. Patient-operated technology

COMMUNITY AND SOCIAL RESOURCES

15. Supporting access to community- and social- resources
16. Involvement of social network

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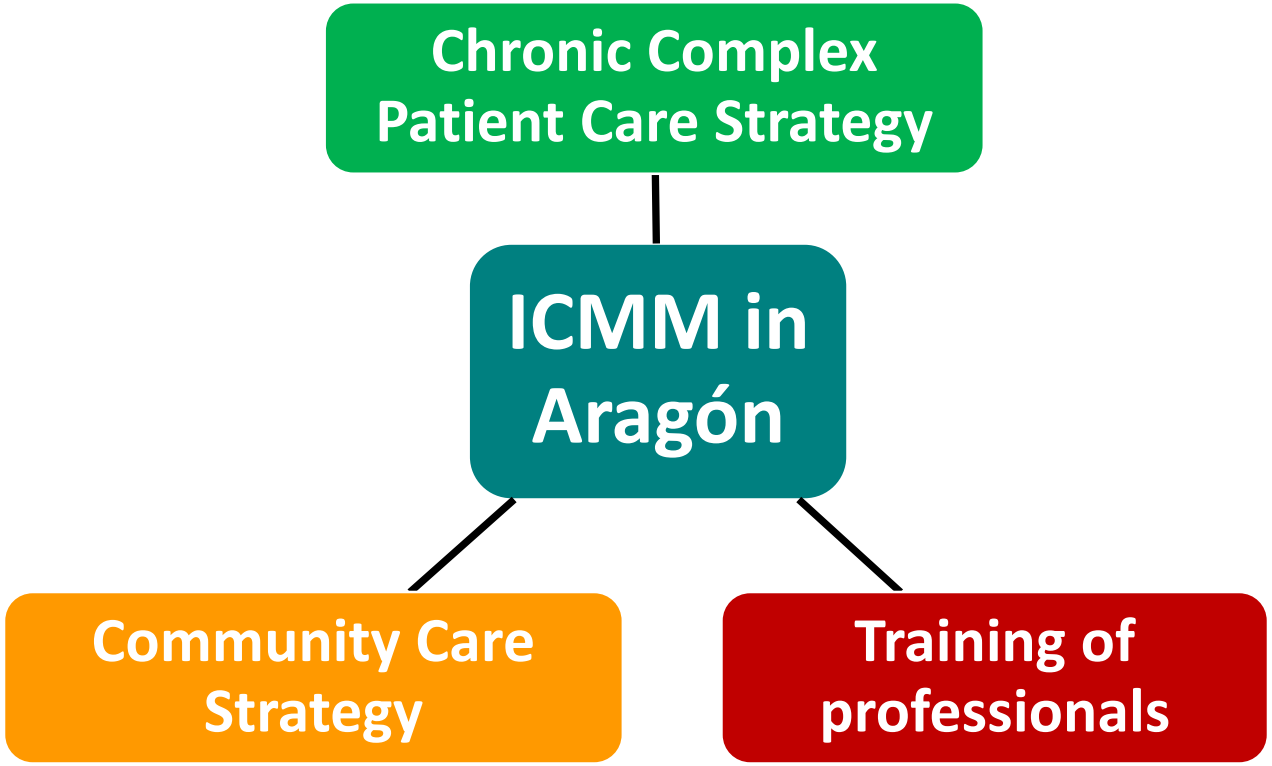
Description of the implementation



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Description of the implementation

13 PCHCs

Albalate de Cinca
Berbegal
Binéfar
Castejón de Sos
Fraga
Monzón Rural
Bujaraloz
Picarral
Actur Norte
La Jota
Grañén
Sariñena
Arrabal

3 Hospitals

H. Royo Villanova
H. Barbastro
H. San Jorge

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Description of the implementation

Chronic Complex Patient Care Strategy

- Comprehensive assessment and individualized care plan
- Designation of case manager
- Chronic Care Unit at hospital
- Interconsultation system
- Sharing of patient´s information among levels of care – module of record

Ongoing

Delivery of care

Information systems

Decision support

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Description of the implementation

Community Care Strategy

- Identification of social needs by FP-Nurse, registration in Primary Care EHR and referral to social services

- Mapping of community assets

- Recommendation of community assets

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Description of the implementation

Training of professionals

- Training in multimorbidity, polypharmacy and patient-centred care and shared-decision making
- Online training course
- Offered to FPs, Nurses and Internists

Decision support

Self-management support

multiPAP multimorbilidad y Polimedicación en Atención Primaria → **eMultiPAP** → **eMultiPAP Chrodis+ Edition**

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Description of the implementation

Training of professionals

eMultiPAP Chrodis+ Edition

MÓDULO 1:
Multimorbilidad y polimedicación.

MÓDULO 2:
Adecuación y conciliación.

MÓDULO 3:
Principios Ariadne. Aplicación en la práctica clínica. Concepto de deprescripción. Barreras asociadas a la deprescripción y seguimiento tras la deprescripción.

MÓDULO 4:
Herramientas para trabajar los principios Ariadne en la práctica clínica.

Fecha de celebración:
Del 22 de octubre al 02 de diciembre de 2018

Lugar de celebración:
Plataforma teleformación IAVANTE

Nº de matriculaciones:
55

Metodología:
On-line

Horas lectivas:
30 horas

Acreditación
6,45 créditos

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Participants enrolled so far

Participants enrolled

- 21 Family Physician – Nurse teams + 3 Internists

- 312 patients

- 65 years old or older

- With multimorbidity (2+ diseases) and polypharmacy (5+ drugs)

- From 13 PCHCs

- AMG + clinical criteria of Family Physician

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Barriers to implementation

Barriers to implementation and support needed

- Limited budget / human resources → Prioritization of actions
- Lack of awareness of the impact of multimorbidity → Awareness
- Conflict of roles → Definition of roles
- No time for training → Online course
- No external support needed to overcome barriers

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Possible deviations from PAP

Deviations from the PAP submitted in September 2018

- New actions implemented (Community resources)
- Add / change of some indicators
- Possibility of post-implementation PACIC (only)?

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Site visits

External monitoring visit

Date: 21 June 2019

Evaluator: ISCIII

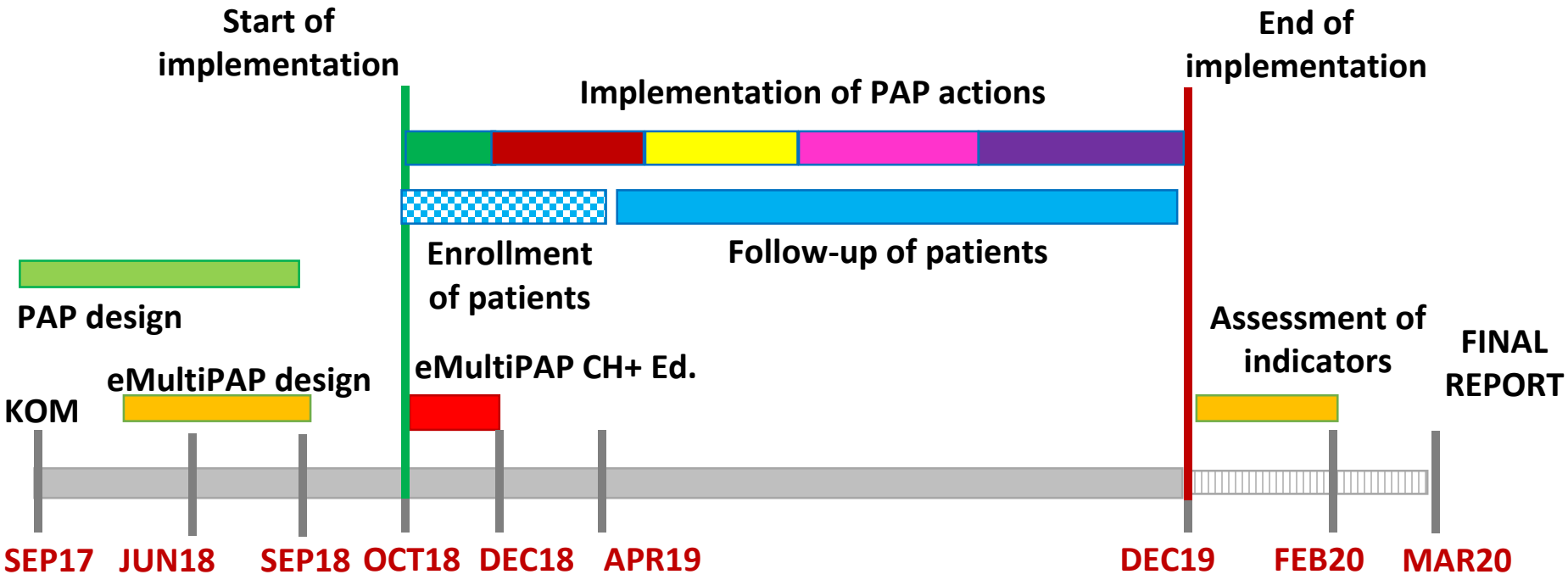
Setting: 1 Primary Care Health Centre + 1 Hospital of reference in Zaragoza

2 `model patients´

Agenda and materials for evaluator: to be finished and distributed

Simulation visit: 23 May 2019

Timeline



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Poster sessions

14 May, Tuesday from 16:45h to 17:45h
15 May, Wednesday from 11:00h to 11:50h

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IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

Implementation of CHRODIS Integrated Care Model for Multimorbidity in Aragón, Spain

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Antonio Gimeno[1], María Bestué[2], Mabel Cano[2], Carmen Chaverri[2], Mercedes Febrel[2], Alexandra Prados[1], MultiPAP Group; on behalf of the LIWG*

[1]EpiChron Research Group, IACS, Zaragoza, Spain
[2]Departamento de Sanidad, Gobierno de Aragón, Spain
*Local Implementation Working Group
agimenomi.iacs@aragon.es

Our goal

To pilot the implementation of the **Integrated Care Model for Multimorbidity** (ICMM) in an Spanish regional healthcare setting to:

- Test the **feasibility** of implementation
- Assess the **success** of the implementation
- Develop country-specific **adaptations**

Kronikgune´s Implementation strategy

Aragón (Spain)

13 Primary Care Centres + 3 Hospitals
21 Family Physician – Nurse teams involved
312 patients: 65+ yrs, multimorbidity, polypharmacy
December 2018 – December 2019

Training of professionals in multimorbidity, polypharmacy and patient-centred care through an **online course**

eMultiPAP

Complex Chronic Patient Care Strategy

- Comprehensive assessment and individualized care plan
- Case manager
- Chronic care unit at hospital
- Interconsultation system
- Sharing of patient´s information among levels of care

Community Care Strategy

- Detection of social needs and referral to social services
- Recommendation of community assets

Better healthcare models for better health outcomes in multimorbid patients

gramme

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PI15/00996; PI15/00276; PI15/00572
CHRODIS PLUS Budapest Conference 14-15 May 2019
IACS Instituto Aragonés de Ciencias de la Salud
GOBIERNO DE ARAGON
Departamento de Sanidad

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Thank you for your attention

CHRODIS PLUS

The Joint Action implementing good practices for chronic diseases

This presentation is part of the CHRODIS PLUS Joint Action. This Joint Action addresses chronic diseases through cross-national initiatives identified in JA-CHRODIS, in order to reduce the burden of chronic diseases while assuring health system sustainability and responsiveness, under the framework of the Third Health Programme (2014-2020). The content of this presentation is the sole responsibility of the author. Consumers, Health, Agriculture and Food Executive Agencies cannot be held liable for any use of the information contained within this document.

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