

Personalized Action Plan in Andalusia

Supporting the Chrodis-Plus Integrated Care Model for Multimorbidity (ICMM)

Background

Complex chronic patients (CCPs) present multiple chronic conditions and complex healthcare needs. Comprehensive care by multiple healthcare professionals at different settings is required to improve their outcomes. This challenge is faced by the *Andalusian Public Health System*, responsible for the provision of healthcare and public health services to the Andalusian population (8.5 million inhabitants).

Introduction

Andalusia is implementing personalised action plans (PAPs) for complex chronic patients in primary healthcare.

Overall aim of the pilot within the CHRODIS PLUS JA: to assess the implementation of PAPs to complex chronic patients within the framework of the Andalusian Public Health System strategies and plans (*Integrated Care Process “Healthcare for Multimorbidity Patients”)

Valuable outcomes

Expected positive changes of the intervention:

- Increase awareness and patient empowerment (adapted to their health and social conditions),
- Better coordination among different levels of care and healthcare professionals,
- Improvement of indicators related to the Integrated Care Model for Multimorbidity.

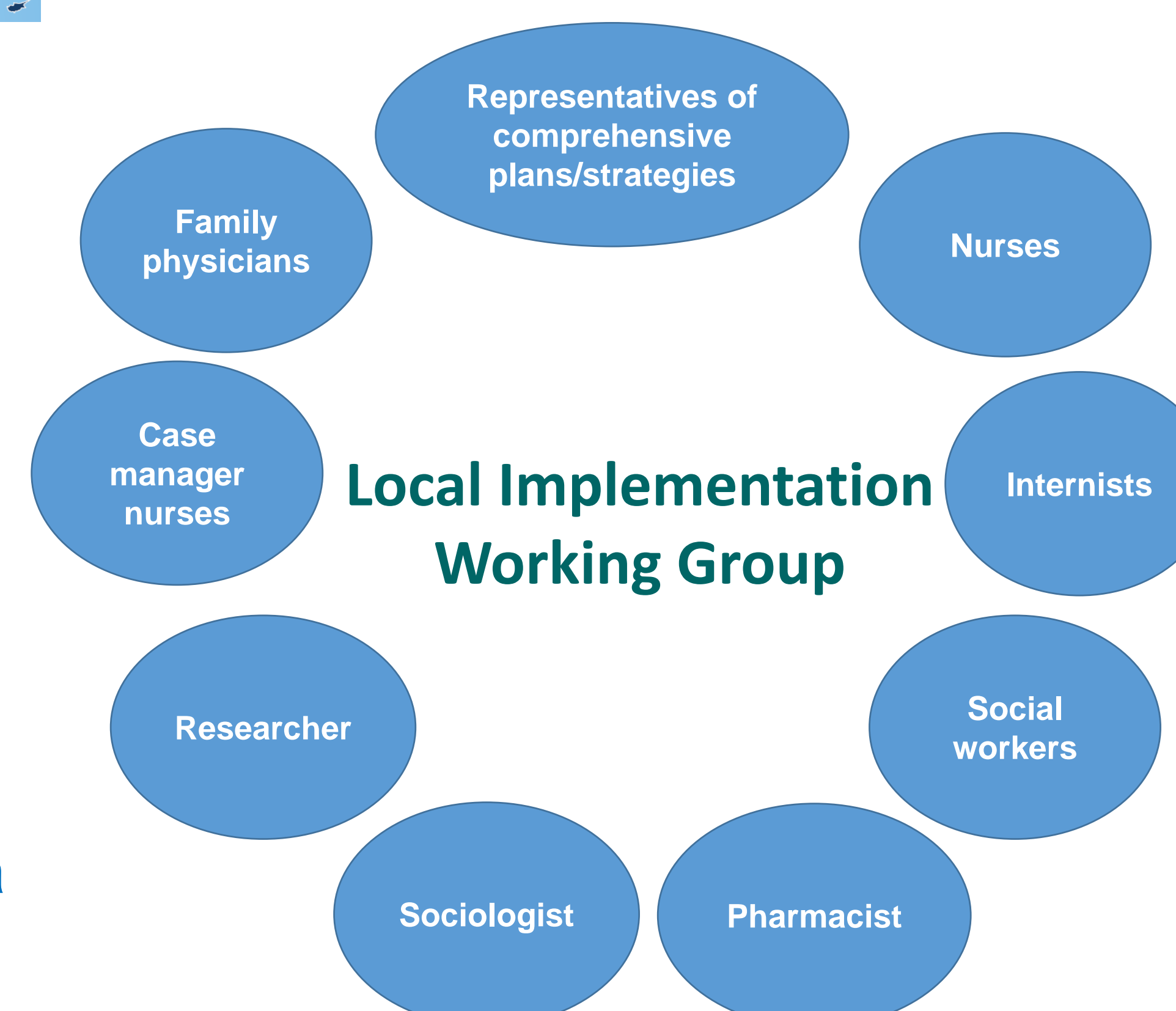
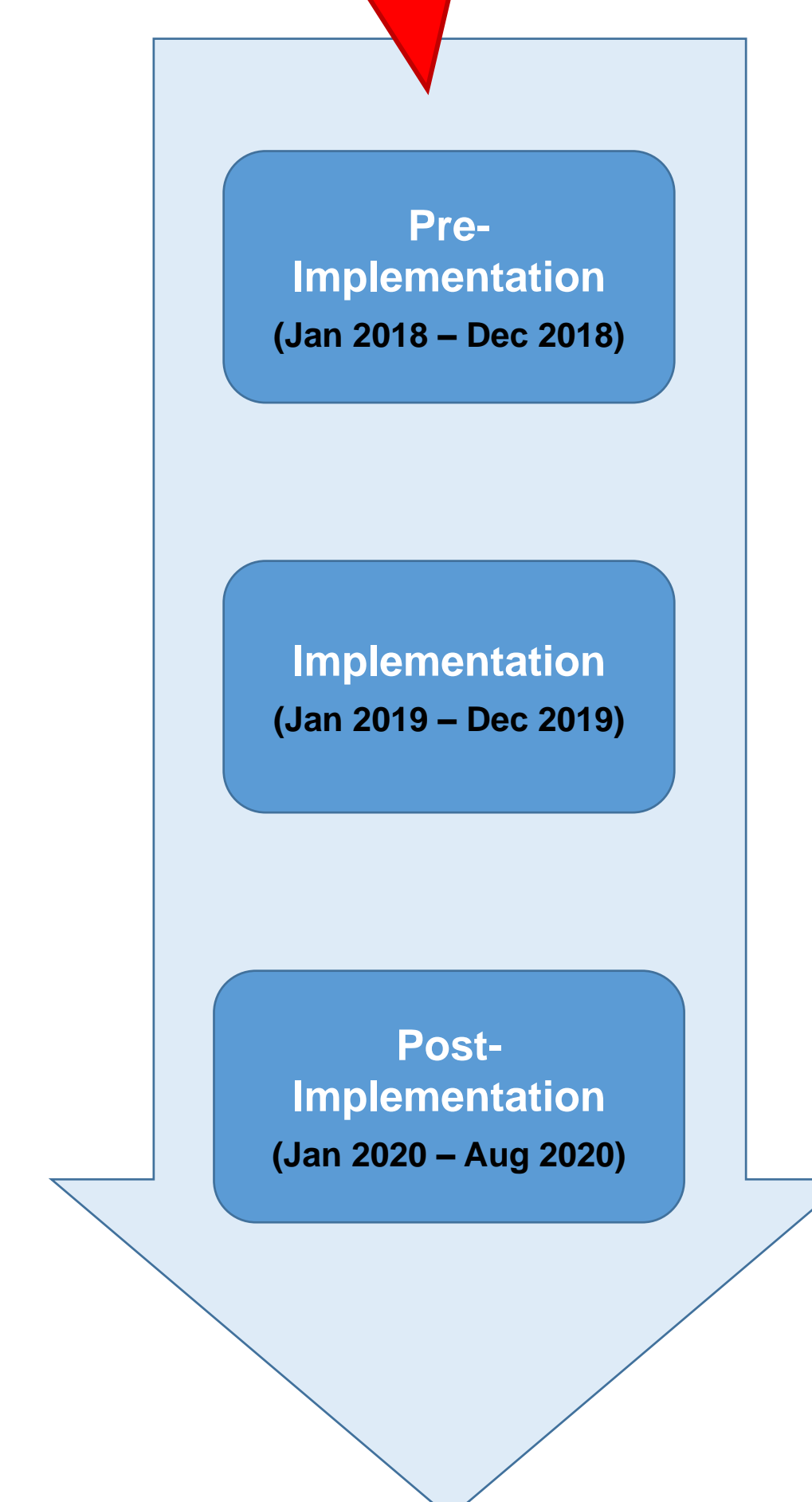
*<https://juntadeandalucia.es/organismos/saludyfamilias/areas/calidad-investigacion-conocimiento/gestion-conocimiento/paginas/pai-pluripatologicos.html>

The JA-CHRODIS ICMM		
Type of component	Name	
Delivery of care	1	Regular comprehensive assessment of patients
	2	Multidisciplinary, coordinated team
	3	Professional appointed as coordinator of the individualized care plan and contact person for patient and family (“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 outside of the core team
Self-Management support	8	Training of care providers to tailor self-management support based on patient preferences and competencies
	9	Providing options for patients and families to improve self-management
	10	Shared decision making (among care providers and patients)
Information system and technology	11	Electronic patient records and computerized clinical charts
	12	Exchange of patient information (with permission of patient) between care providers and sectors by compatible Clinical information systems
	13	Uniform coding of patients’ health problems where possible
	14	Patient-operated technology allowing
Social and community resources	15	Supporting access to community- and social-resources
	16	Involvement of the informal social network

Palmer et al. Health Policy 122 (2018) 4–11



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How do we do this?

2742 CCPs included (PAPs initiated between Dec. 2018 – Feb. 2019). 50 PACIC+ completed.

Inclusion Criteria: disease patterns, physical function, mental health, and socioeconomic status among others*.

Assessment: CCPs will be followed up for 12 month. Data is routinely collected in the corporate eHR-DIRAYA.

Key Indicators:

- Potentially preventable unplanned hospitalisations
- Primary care units included and team meetings
- Primary healthcare visits
- Quality of individualized care plans
- Inpatient episodes
- Outpatient visits
- Emergency episodes

Conclusions

- PAPs are a key element in the healthcare process for CCPs, and the assessment of its implementation in Andalusia is contributing to generate evidence within CHRODIS PLUS.
- PAPs implementation and assessment are crucial to better address CCPs health needs, facilitating a patient-centred healthcare approach, and contributing to a European model of care.
- Involving patient, family carers together with the professional team facilitates achieving better healthcare outcomes.

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