SGPP Marketplace on integrated health care

Good Practice on digitally-enabled, integrated, person-centred care in the Basque Country

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Ispra, Italy

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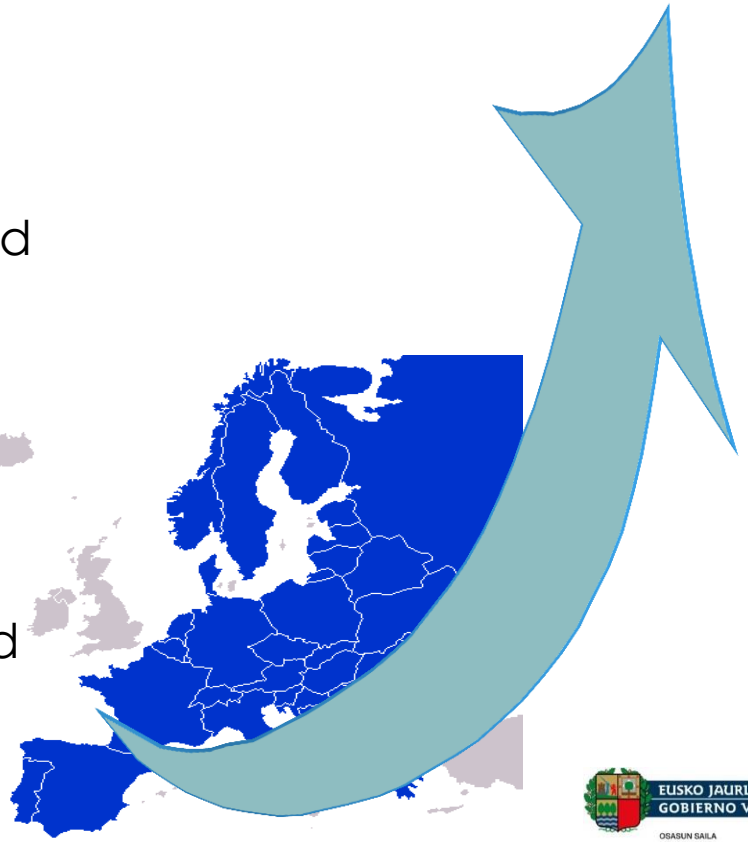
Items

- Basque Country and Good Practice main facts
- Why Chronic Diseases and Care problems
- Basque Country strategy
  - Risk stratification
  - Integrated care
  - Patient empowerment
- European Projects help
- Conclusions and challenges

Basque Country

- **High level of self-government:** Basque Parliament and Government with major legislative and executive powers (Education, Health, Police, etc.)
- Fiscal autonomy, own system of taxation
- Highest investment in R&D in Spain, around European average.
- **Basque health system:** financed by taxes (Beveridge model).
- Social services are managed by local and provincial authorities



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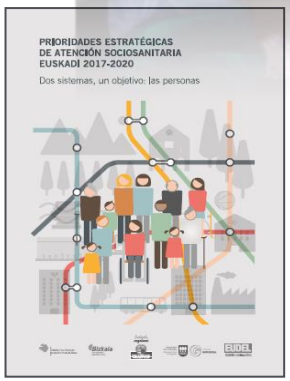
2017-2020 Basque Health Department Strategy

1. People as core of the system, and tackling health inequalities
2. Disease prevention and promotion of health
3. Ageing, chronicity and dependence
4. System sustainability and modernisation
5. Professionals of the health system
6. Research and innovation

Health Research & Innovation Strategy 2020

Health Ministry 2017-2020

Health Plan 2013-2020



Social and Health Care guidelines 2017-2020

Osakidetza Strategy 2017-2020

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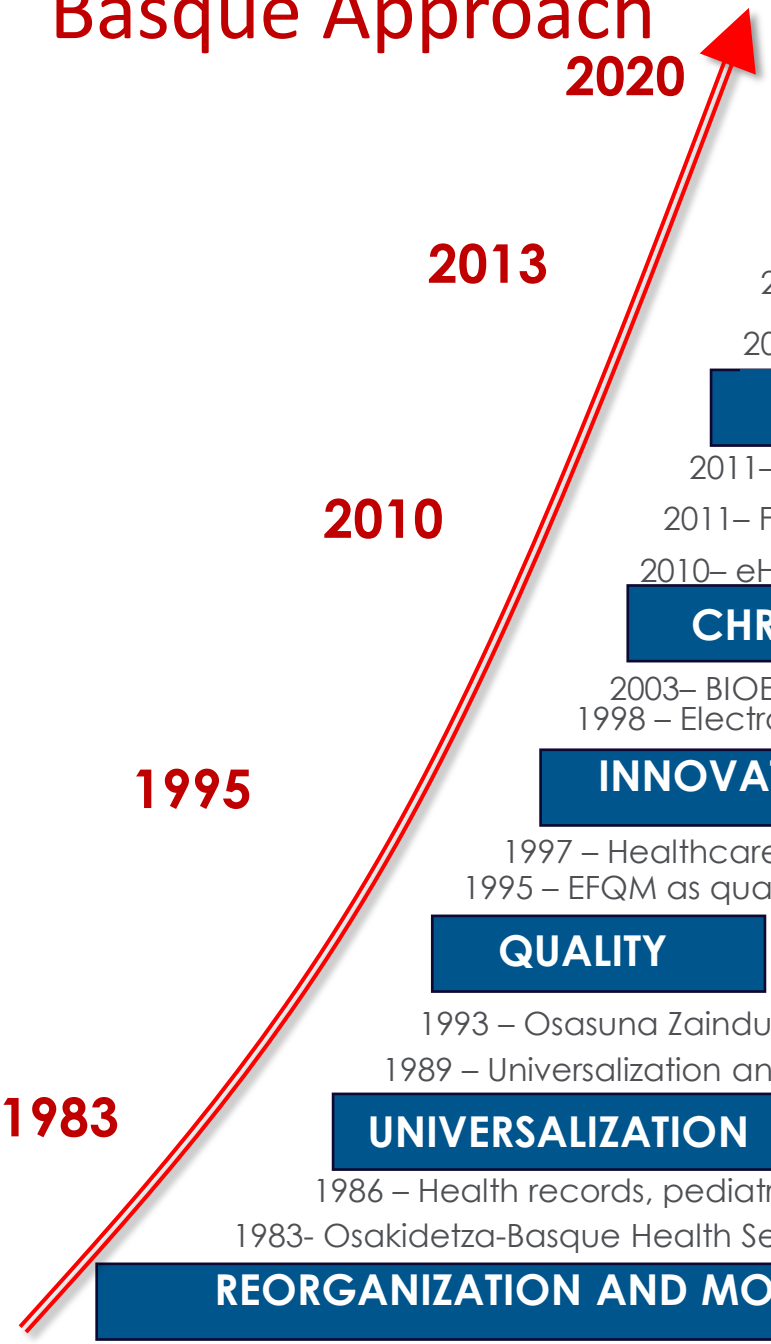
Basque Approach



2020

2017–2020 Research and innovation
2017–2020 Aging, Chronicity and Dependency
2017–2020 People as the central axis and combat inequalities in health

STRATEGIC LINES BASQUE DEPARTMENT OF HEALTH

2013

2013–2017 European Projects in integrated care and e Health
2013–2016 Euskadi EIP AHA Reference site
2013–2016 Strategic Lines Basque Department of Health,

INTEGRATED CARE

2010

2011– Kronikgune
2011– Full stratification of Basque population
2010– eHealth Strategy

CHRONICITY STRATEGY

1995

2003– BIOEF R&D
1998 – Electronic medical record in primary healthcare

INNOVATION

1997 – Healthcare organization law
1995 – EFQM as quality model

QUALITY

1983

1993 – Osasuna Zainduz Strategy
1989 – Universalization and individual medical card

UNIVERSALIZATION AND MANAGERIALISM

1986 – Health records, pediatric medical card and health transport
1983- Osakidetza-Basque Health Service Foundation Law

REORGANIZATION AND MODERNIZATION OF THE HEALTH SYSTEM

Digitally-enabled, integrated, person-centred care in the Basque Country Good Practice

- **Population model** focus based on **preventive interventions, patient empowerment, and personalized medical care**, with an increasing emphasis towards continuity of care, security, adherence and improving the patient experience.
- **Integration** of both **structura**l (Integrated Health Organizations) and in **care pathways**. There is a defined strategy for coordination of health and social care.
- Integration takes place at (a) disease management, or (b) case management, or (c) population-levels
- It is supported by an **eHealth strategy** comprising a unified universal EHR, ePrescription, Personal Health Folder, 24X7 Nursing and Call Centre.

Why Chronic Diseases

Demographics

Population (2015): 2.189.093

≥65 years: 19%→39% in 2050

Life expectancy

80,4 years men

86,1 years women

Source:Populatio and Household census in the Basque Autonomous Community (2011) and Eustat –Basque Institute of Statistics future scenarios

43% of total population with at least one chronic condition

85% of patients over 65 years with at least one

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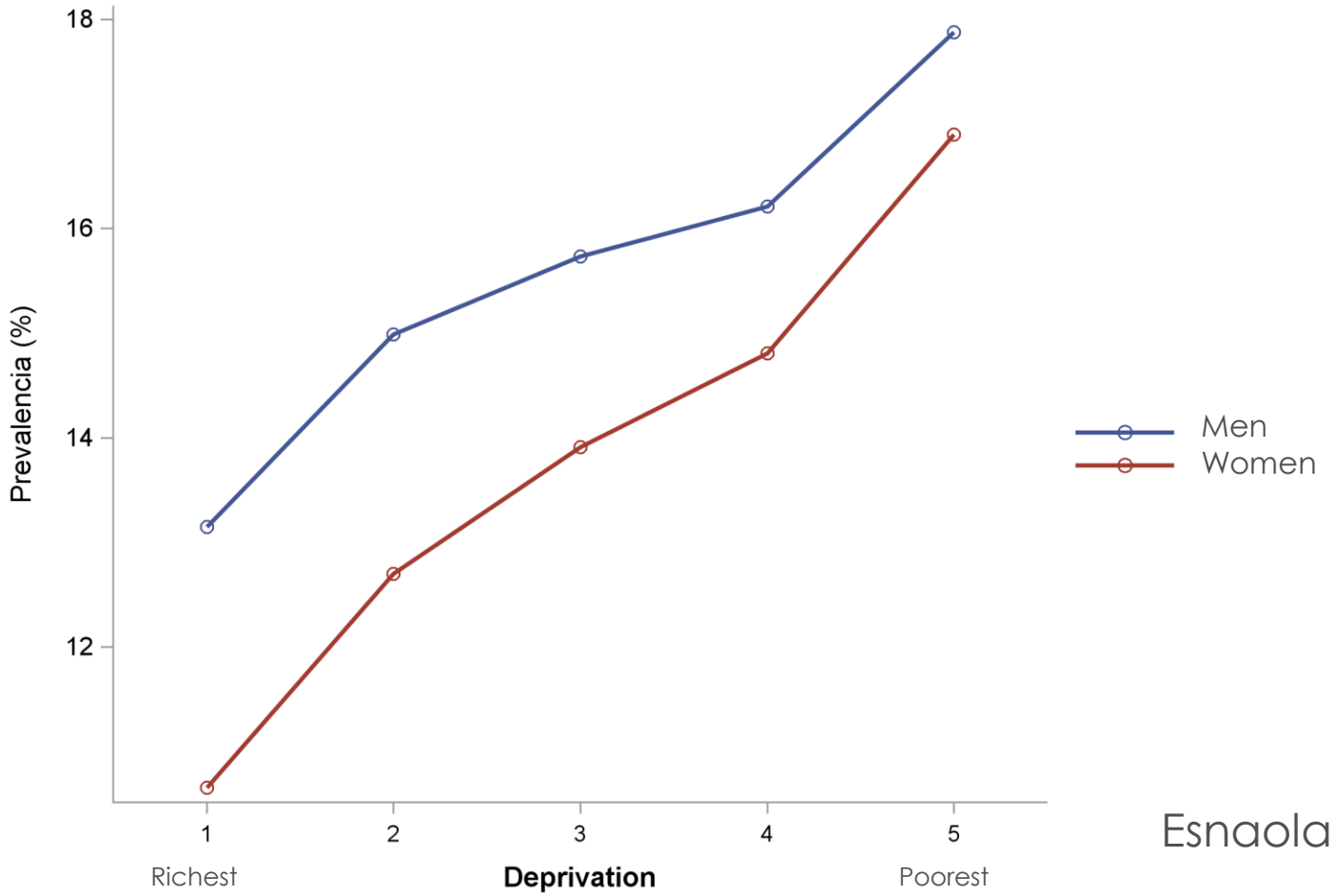
Age-standardized prevalence of intermediate and high comorbidity by deprivation, 2015



Esnaola 2017

Why Chronic Diseases

- **84%** total **hospital admissions**
- **75% PHC** prescriptions
- **63% Specialist** visits
- **58% GPs appointments**

Basque Country Osakidetza

Why Chronic Diseases

- COPD, CHF, Diabetes, Renal Failure, Depression, …

SUFFERING: symptoms, disability, morbidity and mortality …

ALTERATION OF DAILY LIVING: income, consultations, emergency, medicine, …

LOSS OF AUTONOMY: control decisions, dependency, …

Care problems

Fragmentation

Discontinuity

Enviroment

Hospital centered care

Focused on episodes

Increasing costs

Patient out of the radar

Reactive

…

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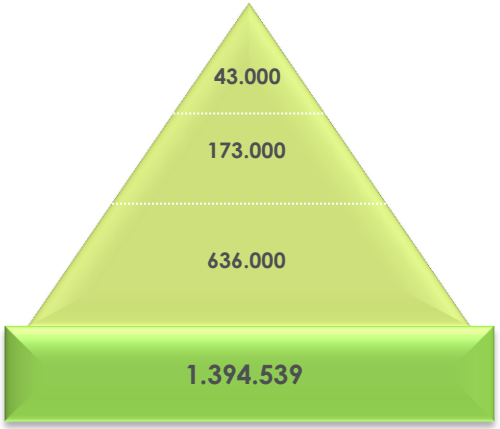
Challenges

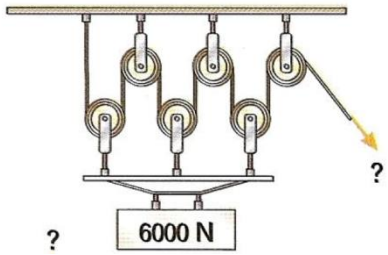


1. ANTICIPATION

- Prevent the occurrence
- Avoid predictable complications through treatment and optimal management.

2. LONGITUDINAL PERSPECTIVE CARE

- Well-defined Plan of care and follow UP,
- Self-management,
- Monitoring performance and compliance

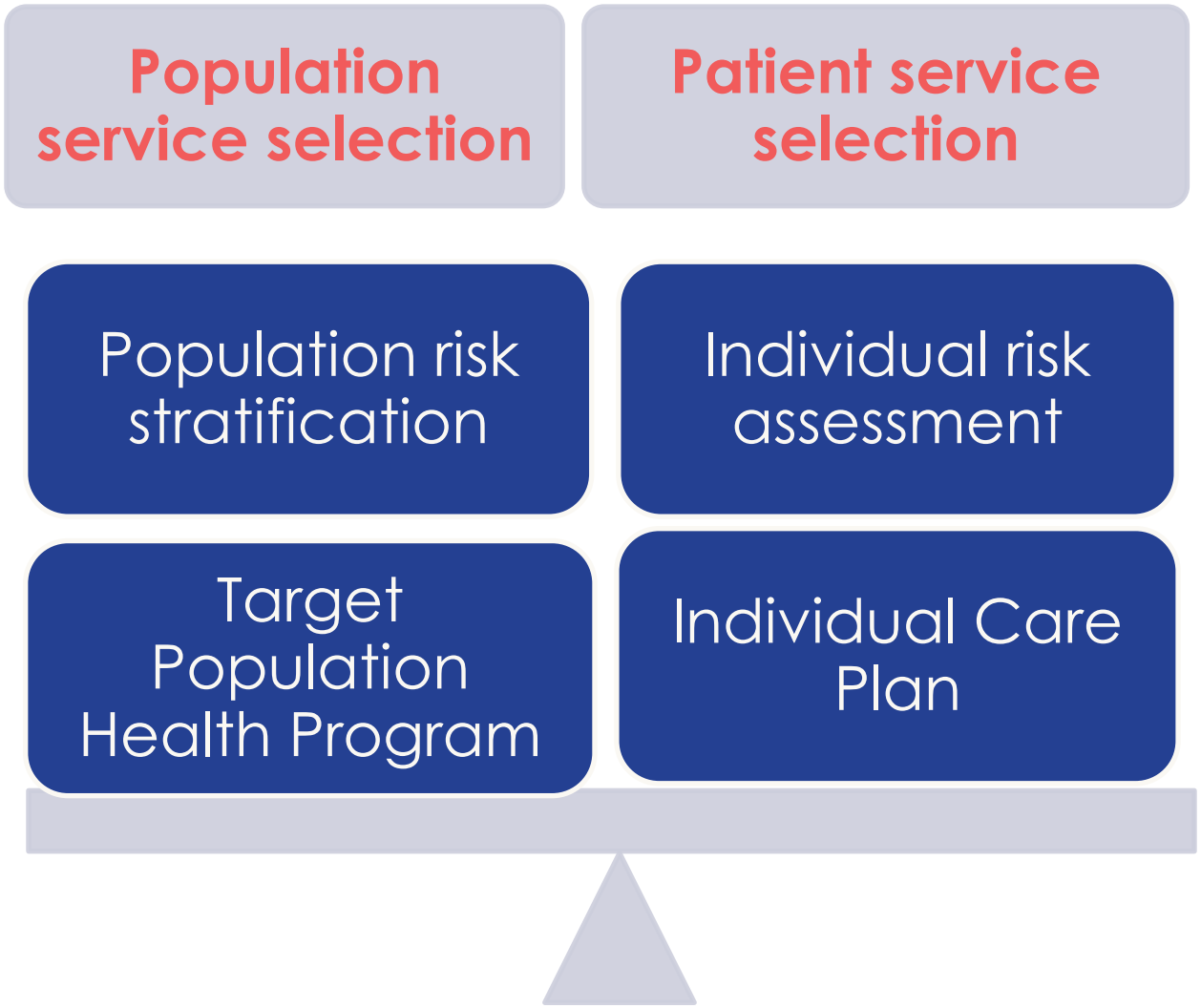


3. MULTIDIMENSIONAL ACTION

Risk stratification

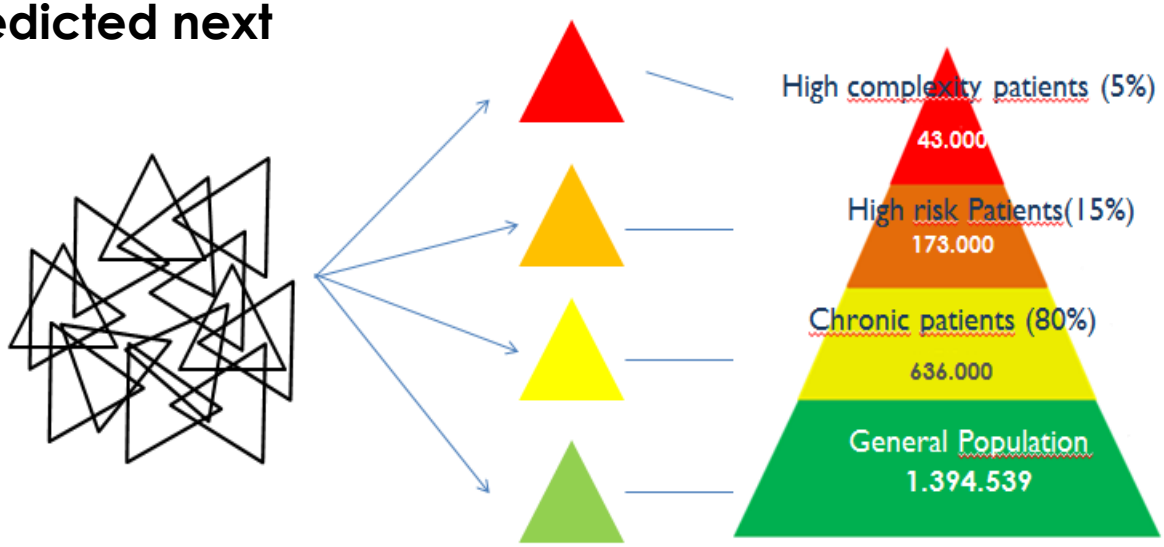
- Systematic process to define **patients** who **are at risk for worse health outcomes**, and who are **expected to most benefit from an intervention**.

Risk stratification and Service selection



Risk Stratification

- **Classify patients** according to their risk
- The stratification classifies more than two million citizens.
- The **data** are based on the previous use of health resources, demographic, socioeconomic and clinical variables.
- The outcome is the **predicted next year healthcare costs**.



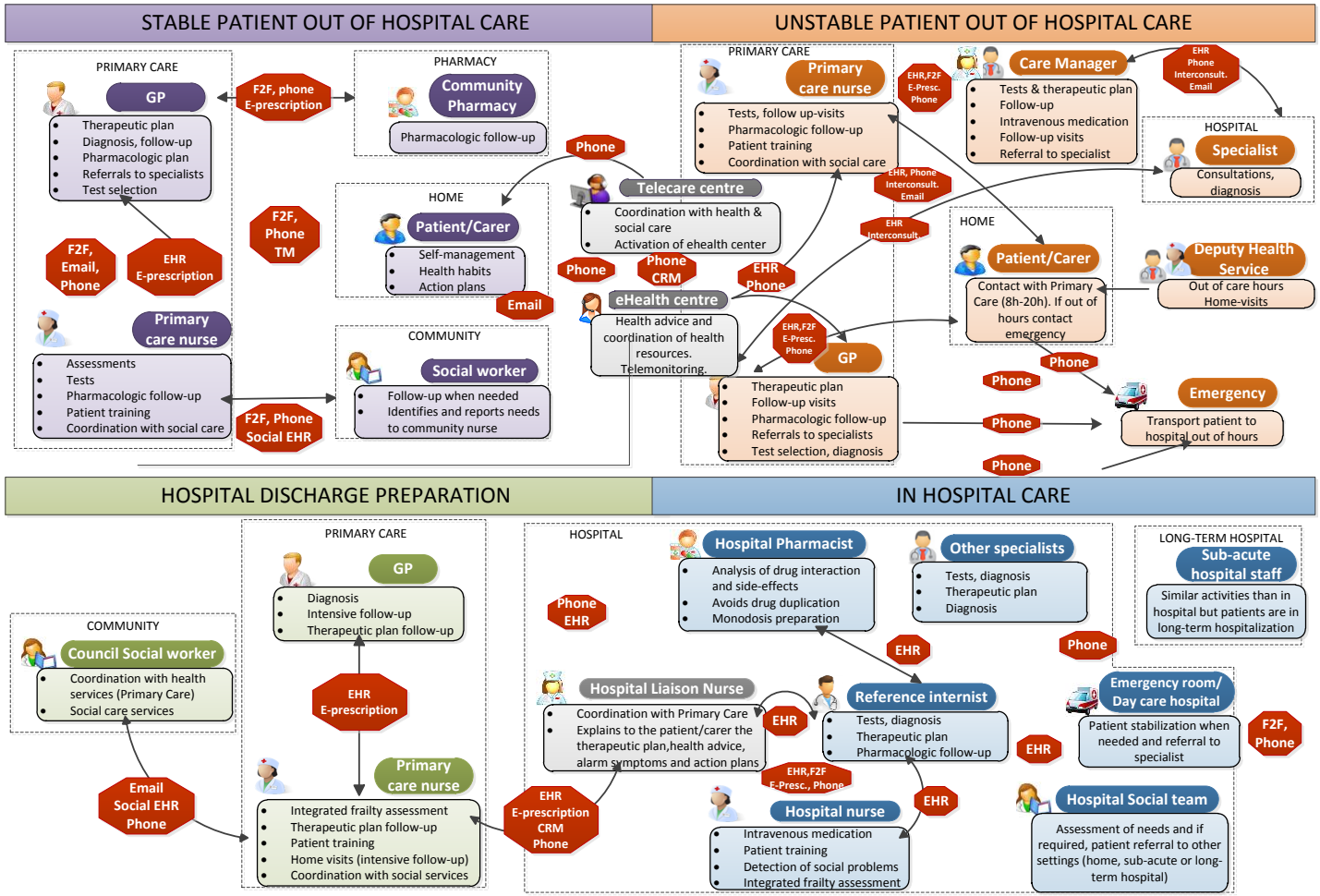
- It is a proxy of patient morbidity and severity with **different needs of care**.

Strengths and limitations

"prediction is very difficult,
specially if it's
about the future,"

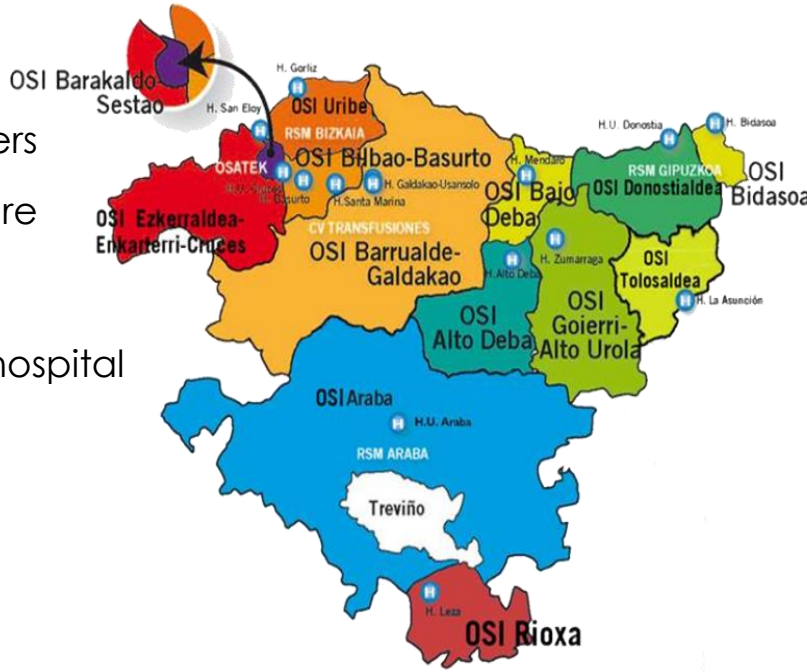
Niels Bohr

Complex care



Integrated Care in the Basque Country

- **Structural integration**:
  - The merger of a hospital and primary care centers under one organisation: 13 Integrated HealthCare Organizations (IHO).
  - Joint Governance bodies for primary care and hospital
  - With a defined population catchment area.
  - 2 Sub-acute Hospitals
  - 3 Mental Health Nets
  - +30.000 Healthcare professionals

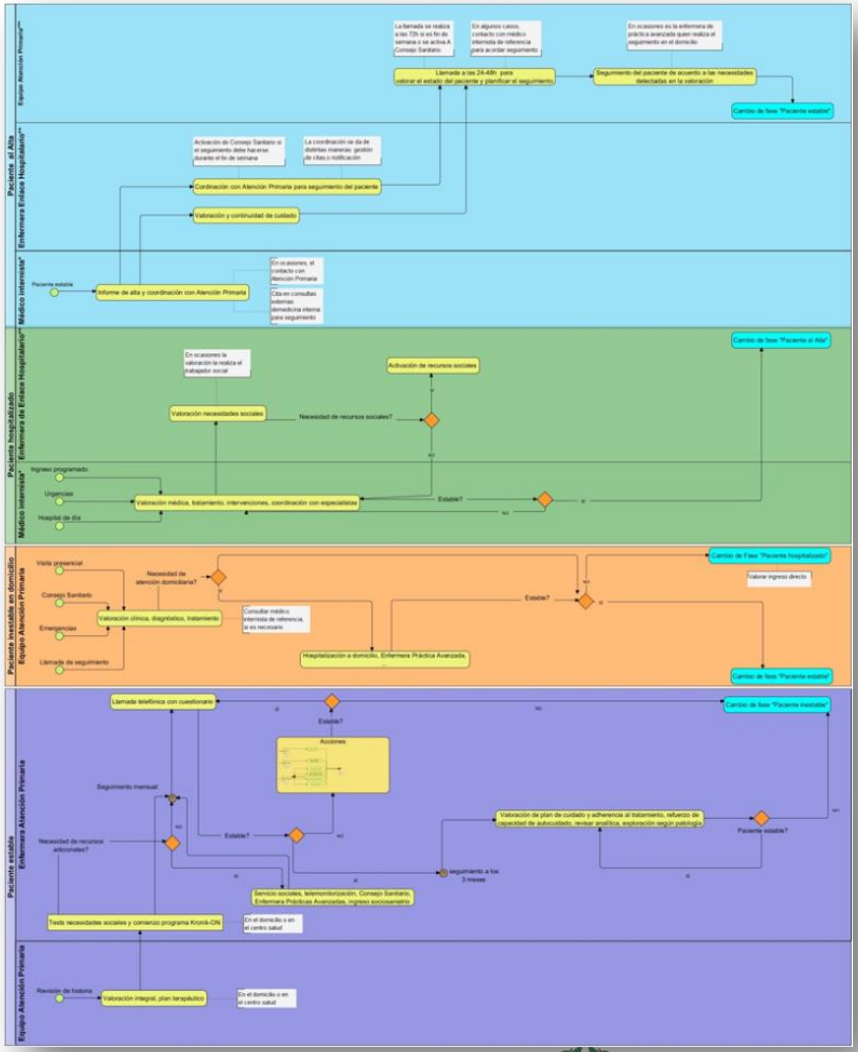


- **Functional integration**:
  - Coordination of care process between primary and specialist care
  - Design clinical pathways for High Complexity Patients or Multi morbid patients,
  - Polypharmacy management
  - Social and Health coordination

Integrated care pathway

Design, implementation and scaling up of an integrated pathway for multimorbid patients, through:

1. **Coordination** and communication among **professionals**
2. **Patient-centered** care based on empowerment of the patient/caregiver, and the monitoring of their health status
3. **ICT tools** as an enabler for the implementation of the interventions



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What is now different?

Integrated care and coordination pathway:

Redefinition of roles

- Referent Internist: coordination of specialists during hospitalization
- Hospital Liaison Nurse: links at discharge time
- Nurse Practitioner
- eHealth Center

Having criteria in decision making explicit

- Scales used in the initial assessment to detect social needs
- Identification of patient empowerment reinforcement need
- Criteria for care intensification
- **Polipharmacy management**: drug prescription and adherence improvement.

Telephone follow-up by the PC nurses

- Frequency established: monthly
- Consensus and validated questionnaire
- Specific actions to trigger in concrete situations

E-HEALTH

Program Integration Management Tool GIP: pathways, priority circuits, Prevention and Health Promotion

Telemonitoring (both telehealth or telecare), mHealth

OSABIDE Integra: EHR Nursing Homes

Tools

Mental health

Social Resources

Public Health

Third Sector

Other community workers: Education, industry, entrepreneurship, environment

Primary Care

Hospital Care

H. Subacute

Research and innovation

PATIENT

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O-sarean

24X7 Nursing and Call Centre

Osasun eskola

PAZIENTE BIZIA
PACIENTE ACTIVO

osanaia

Nursing care record

CARPETA de SALUD

Personal Health Folder

erezeta

Electronic Prescription

Personal Care Plan

Osabide Global
Historia Clínica

Unified Electronic Health Record

Risk Stratification

Data analytics: OBI

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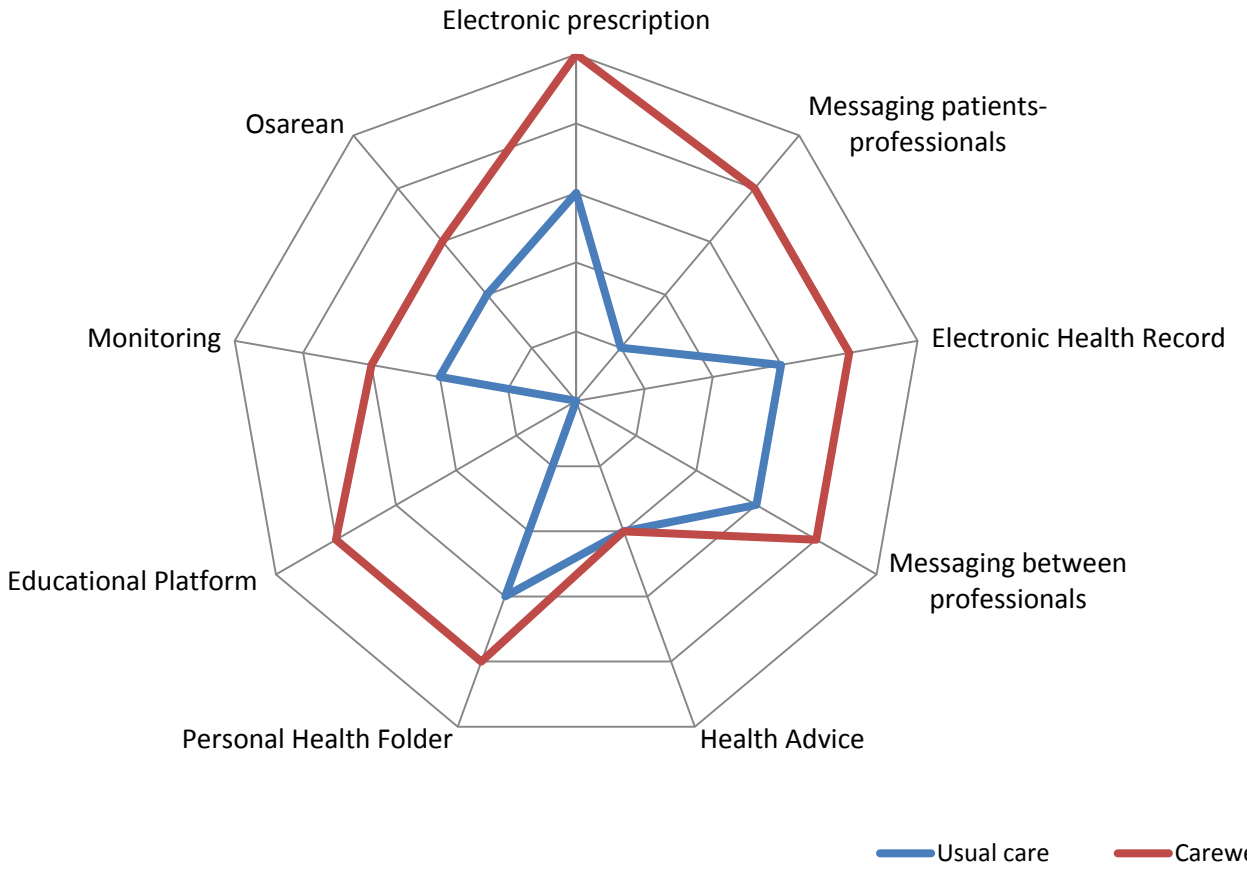
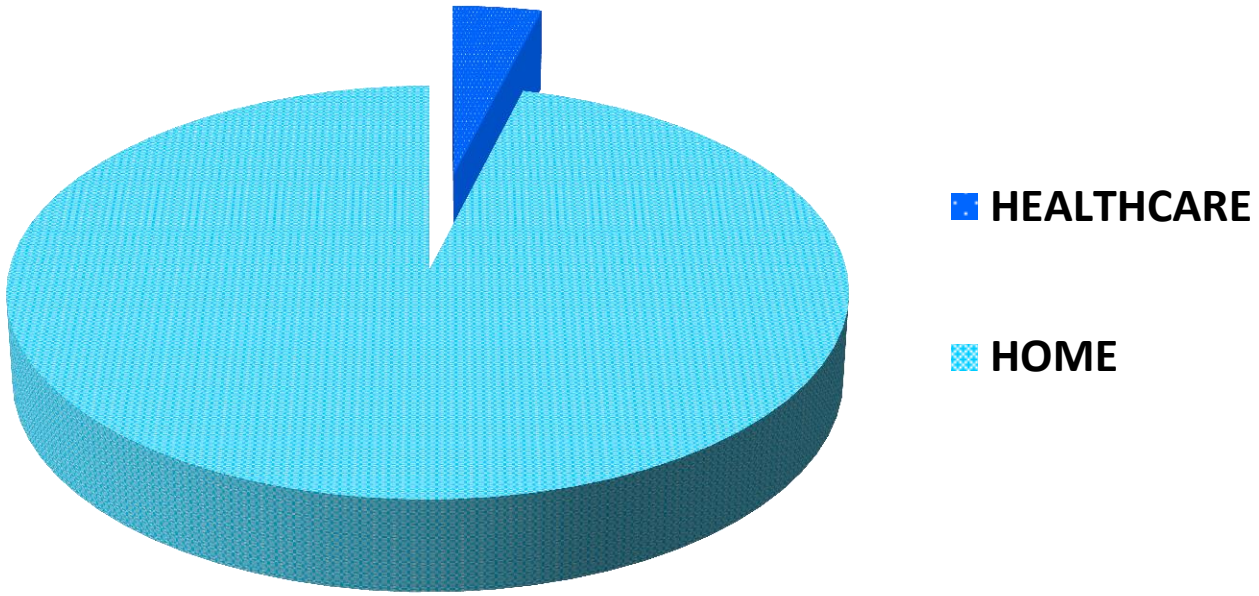
ICT Evolution



Patient empowerment

8.760 HOURS/YEAR



Patient empowerment

Do Patients decisions and circumstances matter?

- Most Family Doctor contacts, self referred
- 20-50% of patients do not take drugs as prescribed*
- 75,57% A&E visits without referral (18.035.233)
- 17% inpatient days due to non medical causes: 7.185.553
- 87% Hospital discharges over 65 sent Home

*Kripalani S, Yao X, Haynes B.. *Arch Intern Med. 2007;167:540-550.*

Patient empowerment

- Change the way people interact with health care services and empower them to take greater ownership of their health.
- Taking into account home conditions
- *Strengthened health literacy and ensure the participation in decision making and self-care.*

Patient empowerment

Kronik ON Programa

Structured Program for Empowerment of Patients and Caregivers

- How many? Minimum of 4 sessions.
- Duration of each session? 20-30 min.
- How often? One session per week.
- Follow up: At 2 months.
- Scenarios: Health center or home.
- General objectives of the sessions:
  - Patient assessment
  - Identification and explanation of diseases.
  - Adherence to treatment.
  - Assess empowerment.
  - Close goals and objectives.
  - Self-control of symptoms and warning signs.

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What is now different?

- Patient empowerment and home support:
  - Personal Health Folders
  - Personalised programme of integrated care
  - Mobile app to access EHR for the district and specialist nurses to use when they make visits to patients' homes.
  - Telemonitoring services.
  - Single databases with information for community services.
  - Education for patients, formal and informal care givers

Osasun Eskola, Osakidetza
www.osakidetza.euskadi.eus/kronikonprograma

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Impact

✓ **Lower number** of hospitalizations, and visits to the ER
✓ **Higher number** of visits to GP

✓ **Perspectives of professionals and managers**
- Better coordination and communication among professionals
- Increased workload in primary care ⇒ reorganize the resources

✓ **Patient´s perceptions**:
- More secure and empowered in the management of their health
- Higher satisfaction with the care received

✓ **Predictive analysis has confirmed that intervention is cost effective**

✓ **No change in clinical variables** (BMI, heart rate, oxygen saturation…)

Impact: % diff. 2018 – 2017 (January-June)

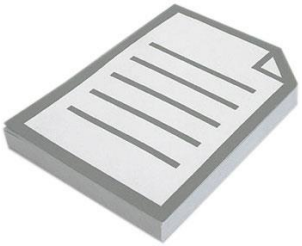
- 17631 complex patients identified
- 12,2% less hospital days for multimorbid patients (MMP)
- MMP Readmission rate (-16.7%)
- 287 courses for patient activation
- 91.310 calls made to the e-health centre (+4.5%)
- 11.580 Patients included in Telemonitoring Programmes (+18.92%)
- 1.183.026 web appointments (+13.21%)
- 981.849 telephone consultations in Primary Care (-3.27%)
- 265.585 accesses to the Personal Health Folder (+42.4%)
- 4083 patients viewed their surgical waiting lists
- 66.438 digital consultations between professionals from primary and specialized care (+33%)

European Projects

- Calls´review
- Regional programs´ analysis

Project Design (management, intervention, evaluation)

Final Propoosal



- Health Department and Osakidetza Strategic Lines
- Existing Health System´s Projects

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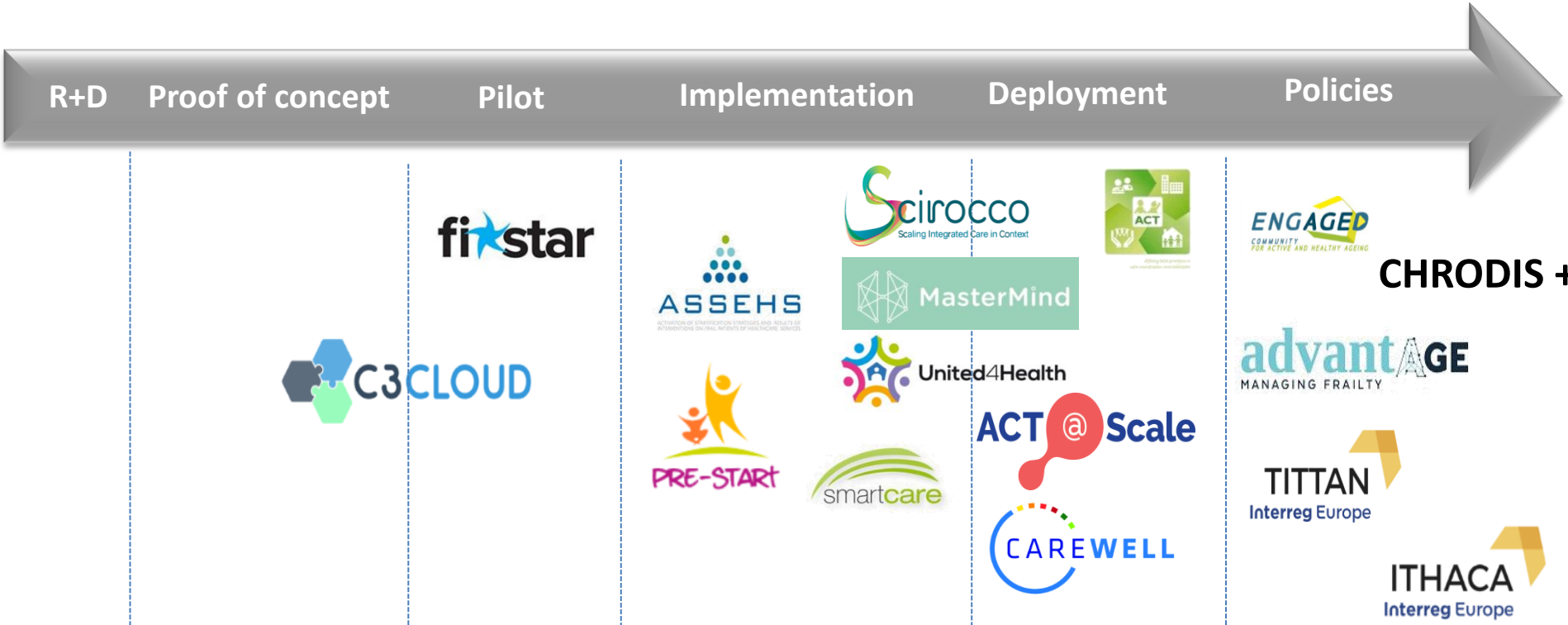
Different types of projects



Basque Country and EIP on AHA

Basque Country 2016
Refence Site

European Innovation Partnership on Active and Healthy Ageing
REFERENCE SITE

Good Practices:

- Integrated Care
- eHealth
- Euskadi Lagunkoia

Basque Country 2016

28 Commitments

The 2016 Call for Commitments of the European Innovation Partnership on Active and Healthy Ageing is open.

21 come from the Ministry of Health

Basque Country 2017

4 Twinning

- 3 as Reference region
- 1 as Adopter region

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Self - Assessment in The Basque Country

Scirocco
Scaling Integrated Care in Context

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Conclusions

All stakeholders needs accounted for when defining **new organizational models.**

New care pathways have to be integrated into day to day practice: care as usual

Use population **risk stratification**

Involvement of decision-makers to facilitate new organization and working procedures and encourage up taking new responsibilities.

Learning curve: It takes time and resources, facilitate them!

European projects help!

But…

Challenges

- **Health Promotion Innovations in models and approaches**
  - Dealing with social determinants of health
  - Taking a life-course approach including early years development
  - Focusing on population health
  - Enabling equity and access
  - Engaging people, businesses and institutions.
- **Re-orienting the model of care**
  - People-centered care
  - Health care at homes
  - Health and social integration
  - Networks and multidisciplinary health and social care partnerships
  - Personalized and predictive medicine

Challenges

- **Management paradigm changes**
  - Outcome and experience measurement
  - Empowering patients, people and communities
  - Participant co-design and co-decision
  - Rights and responsibilities: accountability
  - Workforce redesign – the future workforce
- **Sustainability**
  - Community development
  - Integrated care business models
  - Funding and contracting that promote health outcomes
  - Social return on investment
  - Standards, accreditation and regulation

Web-links

- https://www.osakidetza.euskadi.eus/
- http://www.euskadi.eus/gobierno-vasco/departamento-salud/inicio/
- http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/how_to.pdf (pages 90-92)
- https://www.scirocco-project.eu/basque-country-b6-care-plan-for-the-elderly/
- https://www.act-at-scale.eu/wp-content/uploads/2014/08/ACT@Scale-Telehealth-and-Care-Coordination-Lessons-Learned-WHINN-2017.pdf (pages 12-13)
- https://www.scirocco-project.eu/basque-country-b5-design-implementation-of-interventions-aimed-at-improving-the-safety-of-prescription/
- http://www.kronikgune.org

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