Patient centeredness in the identified European integrated care programmes on multimorbidity

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Complex patients,complex needs

- Disease specific approach is not ideal
- Increased awareness that a different approach is needed
- No widely accepted, clear care model for multimorbidity

→ Towards a more integrated way of care delivery!

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Integrated patient centered care

- Not merely better integration of services, but also pro-active, well coordinated and multidisciplinary. Supporting collaboration between care providers.
- Goal oriented in stead of problem oriented.

→ Care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions[1]: patient centered care!

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1. Committee on Quality of Health Care in America of the Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century. 2001, National Academy Press: Washington, D.C.

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Patient centeredness

- Important elements are[1]:
  - mapping the needs of the patient including medical as well as psychosocial needs
  - respecting the patients' illness perception, preferences and values
  - shared responsibility through shared decision making, while taking into account a patients' skills and competencies
  - including family and informal carers in the care process
  - integration of services that are convenient and accessible

→ Today: patient centered communication, values and preferences, involvement of informal carers, patient –relevant outcomes

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1. Beach et al. The role and relationship of cultural competence and patient centeredness in health care quality

Patient centered communication

- Central care provider
- Shared decision making competencies
  - Training for health professianals in POTKU and Gesundes Kinsigtal programmes
- Patient education
  - Information materials: 59%, tailored 17%
  - Peers informing patients and their relatives on how to live and cope with chronic illness

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Values and preferences

- Shared goal setting
- Personal care plan
  - In the Gesundes Kinsigtal a personal care plan is developed by the patient with their central care provider. The goals are evaluated regularly.
- Available resources
  - In the Potku project an individual health and care plan is developed, taking into account a patients resources!

→ The POTKU project is an interesting example!

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The POTKU project

- Patient Profiles
  1. Self-management clientship (not complex, good resources)
  2. Co-operation clientship (complex, good resources)
  3. Community clientship (not complex, poor resources)
  4. Network clientship (complex, poor resources)
- Health and Care Plans
  1. My needs
  2. My goals
  3. My measures
  4. Follow-up and assessment
  5. Medication, diagnoses and contact person.

"Giving patients the strength to take care of their own health!"

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Involvement of informal carers

- Co-clients
  - The Belgian ADS project structurally applies tools to gain insight in the burden of informal carers.

- Fears and worries
  - The Telerehabilitation programme has innovative information-kiosks in the waiting room to inform family and friends about the ICU, its staff and the technical equipment.

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Barriers

- Inadequate knowledge of all involved
- Lack of time
- Inadequate funding
- Lack of managerial vision

- Inadequate support!

→ Is everybody ready?

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Implications

- The goal oriented approach: a different way of thinking and acting!

- Heavy reliance on self-management: support patients, teach them!

- Patient-relevant outcomes: how to measure “patient centered care”?

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In disease self-management, you are the most qualified expert – health care professionals provide you with the support you need.