Strategy for tackling the challenge of chronicity

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Health Policy Issues: Prevention, New Technology, Long term care, System Organisation/Integration, Quality Improvement, Responsiveness, HR Training/Capacities

Current Process Stages

1. Abstract

The Basque Chronicity Strategy aims to respond to the needs generated by the phenomena of chronicity in all affected groups: chronic patients: change from a reactive to a proactive system which offers better integrated care across the care continuum and in an approach better adapted to their needs, health workers: focus on tasks where the professionals provide the maximum value, citizens: more efficient use of public system resources, health promotion and prevention of chronicity

2. Purpose of health policy or idea

The Basque Chronic Patients Strategy aims to respond to the needs generated by the phenomena of chronicity in all affected groups: chronic patients and their carers, healthcare workers, and citizens in general.

- For the chronic patients and their carers it will mean changing from a reactive system to a proactive system which will offer them more integrated care (coordination between health levels and alignment with social care), more continuity during the development of the illness (from prevention to the end of life, including rehabilitation) and which will be better adapted to their needs. Furthermore, they will be given a role to fulfil and greater responsibility in the management of their own health. All with the final objective of being able to offer patients better health results, with greater levels of satisfaction as far as care and quality of life are concerned.

- For clinical professionals it will represent the possibility of devoting more time to work which returns higher added value and having available the necessary tools (e.g. electronic integrated health records, decision support systems) while the time invested in routine work will be automated (e.g. prescriptions for long term treatment, information systems), will be passed to intermediate levels (e.g. basic health advice by telephone, case nursing) or the tools will be given to the patients themselves or the carer (e.g. basic care, self management).

- For non-clinical professionals it will mean that their role will be given full recognition, their participation will be broadened to include areas that previously resisted their involvement (such as demand management in primary care), as well enjoying the opportunity to share with other professionals new areas of influence and collaboration (such as expanded participation in quality improvement and innovation teams).

- Healthcare managers will need to manage with a population health and quality of care focus that will replace
in a large extent the current activity focus. Greater involvement with clinicians in managerial issues is expected.

- For **citizens** there will be a double benefit. As tax payers they will benefit from a more efficient use of system resources, with the type and cost of each intervention being adjusted to meet the attention and care needs of each case, thereby contributing to the sustainability of the system. As potential chronic patients, they will participate in the prevention of chronicity and the promotion of their own health, avoiding the development of chronic conditions or at least reducing their impact on their health and quality of life.

This change will have an impact both on primary care and on hospital care. To a large extent, care for chronic patients nowadays is not as it should be due to the lack of care continuity across our structures. Thus the logic of this Strategy is based on the premise that we need to innovate in organizational processes for prevention and management of chronic diseases beyond the current institutional boundaries.

Care provided nowadays is basically reactive to acute illnesses and episodes; that is, in a model of acute illnesses the premise is to define the problem which is the subject of the consultation, to diagnose it and to initiate a treatment, usually pharmacological. The consequence of this model of organization is that the chronic patient receives attention which is more episodic than continuous, as this is how the system has been conceived. Moreover, the consultation is normally determined by the acute problems from which the patient is suffering. All this leads to a reactive model.

By contrast, the **Strategy proposes moving to a model of organization which is more proactive** in order to ensure:

- That patients have the confidence and the skills to manage their illness.
- That patients receive care that includes optimum monitoring of their illness and prevents complications.
- That there is a continuous monitoring system both remote and face-to-face.
- That the patients have a care plan, which has been mutually agreed with health professionals, with which to control their illness.

Experts agree that it is preferable to emphasize the management of chronic illnesses in Primary Care. This strategy continues this line of work, but it indicates that hospitals should also be innovative in their management of chronic patients, particularly regarding their connectivity with primary care providers or other settings such as nursing homes, sub-acute hospitals, etc.

Finally, what we are dealing with is a process of change. It is necessary, not only to provide the system with the necessary leadership, strategy, resources and tools, but also to change substantially the "way of doing things", with respect to the chronically ill; a change to be made both by the patients themselves and by healthcare professionals and managers. Thus the strategy combines several top-down initiatives with the key idea that the implementation requires the commitment of frontline staff and that bottom-up innovations and local adaptations are needed for success.

The **strategy consists of 5 main policies**, expected to be **implemented through 14 projects** in the next 3 years.

These are the **5 policies**:

- Focus on stratified population health combined with a predictive risk approach
- Health promotion and prevention of chronic illnesses
- Greater responsibility and autonomy of patients
- Continuous care for chronic patients
- Efficient interventions adapted to patient needs (patient centered approach)

And these are the **projects and their main objectives**:
- **Stratification and targeting of the population**: To establish a predictive model of stratification of the population, according to care requirements and future demand for resources (considering demographic, diagnostic, utilization and socioeconomic data), enabling the design of specific actions for each group, with particular emphasis on polypathologic patients.

- **Interventions aimed at the principal risk factors**: To construct a common framework of health promotion and early prevention, combining the strategic lines on the principal risk factors with innovative bottom-up pilot projects, such as, for example, the De-Plan project: Primary prevention of the progression to Type 2 diabetes in high risk subjects between 45 and 70 years of age, or the Prescribe Vida Saludable aimed at the efficient integration of the promotion of healthy lifestyles in primary care settings.

- **Self-care and patient education**: e.g. the Active Patient Program: Launching of the "Chronic Disease Self-Management Program of the University of Stanford".

- **Setting up a network of activated patients, connected through web 2.0 with the patient associations**: Support for the associations of chronic patients in the adoption and use of new communication technologies (web 2.0) in order to facilitate access to information and promote interactions and mutual support among their members.

- **Integrated electronic health record**: To create and deploy Osabide Global, an integrated solution for health records for all levels of care throughout the whole network of centres which will enable professionals to access patient data in the Basque Country and modify it when necessary.

- **Integrated care**: To explore through the experiences of the pilot projects new ways of working and organizing the delivery of healthcare, integrating primary care and specialized care.

- **Development of sub-acute hospitals**: Definition of a model of care for chronic patients, consolidating an intermediate level of care (focused on rehabilitation) between specialized and primary care for the specific care of these patients.

- **Advanced nursing competencies**: To define and develop advanced nursing competences in Osakidetza in relation to dealing with chronic patients, in particular complex chronic patients (care management approaches).

- **Healthcare - Social Services collaboration**: To develop a framework of socio-health collaboration with all the social service stakeholders (Regional Government, Provincial Councils, Municipalities), which enables the definition of working master guidelines in order to be able to provide an integral response to chronic patients which have simultaneous need for social and health care.

- **Financing and contracting**: To adapt the mechanisms of financing health providers, moving progressively from an activity focus to a risk adjusted capitation scheme (considering also several quality of care items), aimed at providing care which fulfils the objectives of the chronic illness strategy.

- **Multi-channel centre**: To design and implement a technological and organizing platform which permits multi-channel interaction (Internet, phone, cells, etc) for all the population of the Basque Country with the health system, simplifying the life of the citizens and reducing the administrative workload of health professionals.

- **E-prescription**.

- **Chronic illness research centre**: The creation of a research centre with the purpose of generating "glocal" knowledge for innovation in organization and management and to improve health systems with the focus on chronicity.

### Main objectives

Respond to the needs generated by the phenomena of chronicity in all affected groups:

- **chronic patients**: change from a reactive to a proactive system which offers better integrated care across the care continuum and in an approach better adapted to their needs,
• health workers: focus on tasks where the professionals provide the maximum value,
• citizens: more efficient use of public system resources, health promotion and prevention of chronicity

Type of incentives

Bottom-up focus - Change and innovation coming from local health professionals and managers

The agent of the final change is not the corporate executives, though it is essential that these create the conditions for the change to take place at the operational level. Eventually, the objective of this Strategy is to set up more innovative health systems at a local level, and at practice level (micro-systems), and it is at this level at which the real agents of change can be found, and at which the interactions take place between the patient and the health professionals: the level at which the service is provided.

Therefore the bottom-up focus, complementary to the top-down focus, has to give autonomy and space to the local health professionals and administrators so that they can progress towards the vision and improve their working practices and the level of service they provide to chronic patients. This requires fostering change and giving the necessary support to those who try to implement it.

The first part of the bottom-up focus signifies giving freedom and “room to manoeuvre” to the doctors and local managers so that they can aim to approach the objectives in the most appropriate way according to their respective service organizations and circumstances.

To achieve this, it is necessary that the health professionals and local managers are given total support, fostering continuous improvement in their work; giving them responsibility to change the way things are done and giving them the time to analyze and experiment, which involves giving access to management information so that they can measure and assess their own activity and reach conclusions whether it is effective or not.

But this support cannot be given successfully without providing clinicians and managers with the training, the capacity and the responsibility of operating in this kind of environment. This distributed leadership requires being able to support people who manage with a different kind of mentality to that which is usually found in the leadership hierarchy.

The most important piece of the “bottom-up” model, which converts the aforementioned strategies into reality, is the process of innovation emerging from health professionals, which allows the energy for improvement and innovation generated by the managers and doctors to be channelled and focused.

This approach that promotes and empowers local organizations and frontline teams is seen as the main incentive. Considering that locally-designed solutions are the best way to improve practices and provide services that respond to the needs of chronic patients. Financial incentives can play a minor role in the implementation of the strategy but they are not at the core of it.

Groups affected
Chronic patients and their carers, healthcare staff, citizens

3. Characteristics of this policy

Degree of Innovation

traditional traditional innovative

Degree of Controversy

consensual consensual highly controversial

Structural or Systemic Impact

marginal marginal fundamental

Public Visibility

very low very low very high

Transferability

strongly system-dependent system-neutral
This strategy tackles chronicity as a whole, from promotion of healthy lifestyles to improvements in rehabilitation and end of life care. The integrated and consistent approach and the focus on systemic integration and sustainability can be considered innovative as well as several technological and organizational innovations. The expected outcome of better integrated care for chronic patients is to a large extent system dependent.

4. Political and economic background

- Change of government
- Economic crisis and doubts about future sustainability of public healthcare
- Demographic issues; population becoming older; increase of chronic diseases

Change of government
In March 2009 a new government was formed in the Basque Autonomous Community.

5. Purpose and process analysis

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Origins of health policy idea

The core idea of the policy on chronicity origins from the current Minister of Health of the Basque Government, Rafael Bengoa (former Director at WHO HQ where he promoted the Innovative Care for Chronic Conditions framework) and his team.

The national strategies on chronic disease management and prevention of most OECD countries were reviewed and analyzed by the Basque Institute for Healthcare Innovation prior to the beginning of the strategic reflection and formulation process.

The strategy has been designed and it is being implemented with the participation of the different stakeholders involved in chronicity issues: Department of Health and Consumption Affairs of the Basque Government, health providers (mainly the Basque Health Service-Osakidetza and its health professionals, but also several private providers), patients (individuals, associations), research and innovation institutes (particularly O+Berri, Basque Institute for Healthcare Innovation), international experts acting as advisors, and the like. Different tools have been and are being used in this task: working groups, world cafe meetings, expert panels, consultation processes, formal conferences, etc. More than two hundred people have been involved actively at some stage in the formulation of the Strategy.

The strategy contains 14 main projects, and half of them are being implemented in a test basis, like pilot-projects, frequently on a small-scale and with an action-research approach. These projects are going to be evaluated, and if results are positive, the intention is to expand the projects to the whole Basque health system. The other half are corporative top-down projects particularly related to technological innovation and modernization like integrated electronic health records, e-prescription, multi-channel contact centre, etc. Pilots of these projects are being used but the vision of rapid extension has been taken in advance.
Initiators of idea/main actors

- Government: Basque Government
- Providers: The Basque health service Osakidetza, the public provider of health care with a share of 90% of the market.
- Patients, Consumers
- Others

Approach of idea

The approach of the idea is described as: new: Most of the projects in this strategy can be considered as rather new in the Spanish context and particularly innovative is the ambition of a combined impact of all of them in an integrated and synergic way.

Innovation or pilot project

Local level - Some local areas are acting as living labs incorporating most innovations at the same time.

Stakeholder positions

The Health Minister of the Basque Government and his team are the main leaders of the strategy, and they show a strong commitment with this policy, that is the main strategic priority for the next 3 years. There is not a clear opposition to the policy, but several stakeholders have a cautious attitude until the pilots and projects show positive results.

There is a clear alliance between the Department of Health and the Basque Health Service and both of them will deal with conflicts of interest in a joint approach.

Actors and positions

Description of actors and their positions

Government

- Prime Minister: very supportive
- Minister of Health: very supportive
- Vice-Minister of Health: very supportive

Providers

- Managers: very supportive
- Physicians: very supportive
- Nursing staff: very supportive
- Other staff: very supportive

Patients, Consumers

- Patient Associations: very supportive

O+Berri, Basque Institute for Healthcare Innovation

- O+Berri: very supportive
Influences in policy making and legislation

Although the strategy has been explained to Parliament (and it has been publicly announced), there has been no major law development related to it.

Legislative outcome

n/a

Actors and influence

Description of actors and their influence

Government
Prime Minister very strong none
Minister of Health very strong none
Vice-Minister of Health very strong none

Providers
Managers very strong none
Physicians very strong none
Nursing staff very strong none
Other staff very strong none

Patients, Consumers
Patient Associations very strong none

O+Berri. Basque Institute for Healthcare Innovation
O+Berri very strong none

Positions and Influences at a glance

Adoption and implementation

Accepting complexity

How do we advance to a more proactive health system? How do we educate patients to be active participants in the management of their illness? How do we improve medical integration between primary and hospital care? How can we make the leap in quality in the use of technologies and Web 2.0 applications in benefit of the patients?

All the aforementioned strategic projects have many aspects in common, but one in particular: their complexity. The fact is that many of the projects of change included in this strategic framework require a number of complex interventions in numerous areas of activity, without the benefit of the use of a "magic wand" to carry this out. It is necessary to work through many levers of change, to tackle the 14 strategic projects described above. Changing from the current system to one which is capable of providing excellent care to chronic patients cannot be achieved without a progressive and integral transformation of the system of care provision.

The temptation of the corporative directives may be to want to accelerate the pace of these collaborations by means of direct and regulatory structural changes. However, this Chronic Patient Strategy is riddled with complex changes and as a consequence its projects cannot be merely imposed in an interventionist fashion: to achieve our goal it is necessary to follow a path which is less interventionist and more adaptive.

A great number of the Strategic Projects in this document require new relationships and collaborations between different protagonists in the health system. Therefore the line of introduction to be followed in this transformation
process will be a mixture of bottom-up and top-down changes.

**Top-Down and Bottom-up**

There is always tension between an excessively centralized management approach and local decision making capacity. In the past, in the Basque Country managerial capacities and autonomy at the local level and in frontline teams have not been fostered enough. In the case of this Strategy the aim is to find a better equilibrium in decision making as it is our opinion that local managers and professionals will very often find more innovative solutions than central planners.

Many directors may think it ingenuous not to exercise a control of even greater imposition during these times of economic crisis with the objective of rapidly imposing the changes described in this text as, among other things, they open new ways to enhance the sustainability of the health system and hence their urgency. However, all the scientific and management evidence indicates that the naïve policy would be just the contrary: trying to impose this system transformation.

In the introduction of the Strategy for the Management of Chronicity in the Basque Country a new equilibrium is sought along with a more distributed style of leadership: neither a purely interventionist focus “top down” and more development focussed “bottom up” style would appear to be insufficient to act alone as motors of change:

On the one hand, an entirely interventionist focus "top down" often encounters difficulties with generating leadership and getting clinicians involved. This makes the adaptation of the interventions to the local reality impossible and, generally speaking, leads to failure in their introduction, either because the interventions are not taken onboard in the day to day clinical procedures or because they are not suitable to the specific needs of the patients and the doctors at a local level.

On the other hand, although a purely development focussed approach "bottom up" may be able to bring about successful experiences with very significant results for some doctors or at a particular health centre, but generally speaking, there will be a lack of support, tools, or formal mechanisms to extend the experience to a wider area; thereby generating an “island of excellence” which does not broaden its range and finally becomes obsolete or disappears along with its creator. Furthermore, even in the cases in which the range is broadened to a certain extent,
the focus soon stumbles with the lack of a common strategic direction which tends to make initiatives incompatible or redundant.

For these reasons, to implement the Basque Chronic Patients Strategy the option taken has been to systematically combine both focuses: adopting a clear strategic direction, which is interpreted through a development process originating from the front line of doctors and managers as it brings about the changes it seeks.

This requires a living strategy that evolves, so that the focus of the introduction is also a living process which will progress as the lessons learned from changes (in the Basque Country and elsewhere) are assimilated.

To combine these focuses requires that change is gradual, takes due time and is carried out with patience.

**Top-down focus - A Clear Strategic Direction**

The proposed change requires clear directions from management and the setting up of a playing field suitable for it to take place, one which provides support and the tools for its undertaking and the objective and standardized measurement of its progress.

To this end the first components are a vision and a list of common aspirations. It is necessary to make absolutely clear what the vision is and what goal is aspired to through the change; a vision and an aspiration which evolve and gather the knowledge from the organization, but at the same time are clearly communicated and shared by the executive, so that there is no doubt about the direction being taken and no opportunity is lost to underline its essence.

In the Chronic Patients Strategy the vision consists in transforming the system so as to be able to provide an excellent level of care for chronic patients as well as for acute patients; as an aspiration, a common target has been set focussed on the patient in terms of the number of patients in each stage of their pathology who will receive the new type of care which will adapt to his or her needs as chronic patients. This aspiration makes the change tangible, making it a real transformation for health professionals, patients, managers and catalyses the transformation as specific interventions are adapted to the results of the changes inspired by health professionals and the resulting scientific evidence.

Furthermore, certain basic rules of play have to be laid out and shared between managers and health professionals, these have to be the same for everyone, and be orientated to the vision defined above and adhered to without exception. In this case, the rules of play consist in common financing framework (based on adjusted capitation combined with some quality and outcomes objectives) which promotes the use of the most efficient and best adapted resources for each case, an adaptation of the use of each resource and its potential and the choice of interventions according to the criteria of the scientific evidence.

At the same time, it is essential to provide support from the top, with the necessary technological, technical and organizational tools for the administrators and health workers for them to make the vision a reality. In the Chronic Patients Strategy the tools are technology (Integrated Electronic Health Record, Multi-channel Service Centre, e-prescription), methodological support for innovation (e.g. Innovation from frontline teams, Research Centre on Chronicity), a joint working framework in and outside of the system (e.g. Healthcare-Social services partnership, Care integration) and the population vision at the reach of all health professionals and managers (stratification to enable “targeting” of interventions, predictive modelling).

Finally, the last task to be carried out by the management is that of monitoring progress: a transparent tracking in relation to the shared aspirations and indicators, and monitoring which will be able to establish unequivocally if the targets are being achieved or not at each of the levels, with the aim of supporting and expanding measures which work and abandoning those which do not.

**Creating the conditions to innovate from bottom-up**

Specifically the actions which are being carried out to achieve bottom-up advances are the following:

- To promote action research in health services aimed at quality improvement with scientific evaluative methods
- To promote an organization whose function is to support this emerging process of research/innovation in
• To offer specific training to all local managers of service organizations (Hospitals and Primary Care) in order to give them the tools and the clear message to operate in the desired fashion. Distributed leadership, clearly different to the classic hierarchical leadership, requires training of managers so that they can acquire new capabilities with which to develop their new responsibilities in an environment of this kind.

• To launch ambitious Aid Award Programmes from the Department and the Contract Programme for 2010 with the aim of offering incentives for local innovative organization. The ideas which are selected will receive methodological support (e.g. action research methodology, improvement science, implementation science), procedural (e.g. follow-up, breaking deadlocks) and financial so as to fund them, by means of a methodology of action research, to a sufficient scale to be able to underwrite their effectiveness.

• From these pilots a connection will be made, both face-to-face and remotely, with the various innovative microsystems with the aim of passing on and disseminating lessons and coordinating action.

• To develop a rigorous assessment of the innovative microsystems and to select those which demonstrate effectiveness in the context of the Basque Country in order to be able to extend them throughout the system, by their inclusion in the list of available services. The innovative microsystems are encompassed within a wider health system. They are not isolated islands. Their lessons will be disseminated to the rest of the system in an organized fashion in order to improve the entire Basque Health System.

• To continually align these processes at a local level with the general strategy of the Department of Health and Osakidetza. The idea is to develop numerous microsystems capable of providing a level of care which is more integrated and more proactive.

Finally, the inspiration for this Strategy and implementation approach is based on models like Wagner’s Care Model and WHO’s Innovative Care for Chronic Conditions, delivery systems like Jonköping Council in Sweden and Kaiser Permanente in California and methods like Institute for Healthcare Improvement’s Breakthrough Series, Dartmouth’s Clinical Microsystems and the overall Quality Improvement, leadership and learning approach of Qulturum in Sweden. The OPIMEC observatory in Andalusia (Observatory for people living with multiple chronic conditions www.opimec.org ) and the former Kroniker observatory in the Basque Country have provided information on best practices for managing chronic patients worldwide.

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**Monitoring and evaluation**

Several ways of evaluation have been set up. Among them, a Balanced Scorecard, a Technical Office for monitoring and accelerating progress and a follow-up Commission. Each project manager regularly reports on the progress of the project, and each project has its own indicators and evaluation scheme, depending on the nature of the project.

**Review mechanisms**

Mid-term review or evaluation

**Dimensions of evaluation**

Structure, Process, Outcome

**Results of evaluation**

No results are available yet. Most projects have been launched or are being launched in 2010.

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**6. Expected outcome**

Most experts -local and foreign- consider that the implementation of the Strategy will achieve its main objectives related to the improvement of care quality for chronic patients, patients and carers satisfaction, several health
outcomes, and a more efficient use of resources. Long term sustainability is also an expected result but it is based on projections and prospective studies, clear evidence about this issue is lacking. The transformation process can lead eventually to resistance to change but capacity building in leadership and change management combined with the empowerment of frontline staff is expected to help to reduce these potential undesirable effects.

As we have already mentioned quality improvement and sustainability are key drivers of the strategy. Potential inequalities are explicitly evaluated in the projects and special interventions are being put in place towards a more equitable system, e.g. removing technological barriers for elders, including socioeconomic factors in predictive modelling, etc.

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