
CONFERENCE ABSTRACT

Active Patient Programme: a local approach of integrated care in the Basque Country.

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Introduction: The management of chronic diseases represents a challenge for healthcare services. It is necessary to provide more efficient and coordinated care to patients with chronic conditions. As in other developed countries, the Spanish Health System is outdated, and a new organisational model is needed to provide a better care to chronic patients. A key role is given to self-management and educational programmes, implying a more active role of the patient

In 2010 the Health Department of the Basque Country Government promoted a new strategy for chronic patient care based on the Chronic Care Model. Two of the cornerstones of this model are self-care promotion and community education. In this context, the "Active Patient" programme, based on the Chronic Disease Self-Management Program, has been proposed as a useful instrument.

Description: The Active Patient programme is aimed at patients with a chronic condition or/and at their caregivers. It consists of 2.5 hours group sessions (8 to 15 people) once a week for 7 or 8 weeks. These sessions enable participants to acquire knowledge and skills related to the disease and its management, placing a strong emphasis on proactive tools (how to set realistic achievable targets, cope with problems related to their disease, effectively communication, share decision making...) to achieve healthier lifestyles (in terms of diet, physical exercise, management of emotions, and correct use of medication, among others).

Each session is conducted by two leaders. At least one of them should be a chronic patient him/herself or caregiver. Lay leaders who are themselves chronic patients, or have close

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personal experience of a chronic condition, show greater empathy and tend to suggest more appropriate and realistic options than health professionals. They are volunteers.

In this programme there are involved a lot of different stakeholders, among others, the public health system, citizens, patient associations, city halls, culture houses...

Key findings: This programme was implanted in 2010 in 4 Osakidetza health care organisations. From 2012 has been expanded to all of them.

Since November 2010 we have trained 3030 patients in two different courses.

The effectiveness of the programme was evaluated by a randomized controlled clinical trial and a qualitative research.

Participants satisfaction is very high 4.5/5. Nowadays we have 219 leaders, 80 are lay leaders and 139 professional leaders.

During the past years the programme has been spread inside as well as outside the organisation. Focusing on the responsibility of the citizens towards their own health.

Highlights: This innovative approach implies care from a holistic perspective and empowers patients through :

- A better relationship between clinicians and patients
- And extended knowledge of the illness and the habits recommended
- Taking the drama out of the illness
- Facilitating strategies to face the chronic condition and to strengthen self-esteem
- Achieving a better quality of life and family relationships.
- Supporting them to self-care, self-manage, engage in share decision making and co-develop and implement personalised care plans

Self-efficacy significantly improved in diet, physical activity and control of the disease but no statistically significant differences have been found in cardiovascular variables. .

On the other side bringing this new approach has also found resistances among many clinicians, some agents and even some patients. We come from a traditional paternalist model and we are trying to change to a more cooperative model and so this needs some measures in order to readjust

The main resistance we want to focus on is the fear and insecurity that comes up in some clinicians regarding their ability to work with and empowered patients. We must support clinicians to better support the health needs and goals of people

This kind of change is progressive and need time

Conclusion: It's necessary to empower, activate and engage citizens, patients, families, carers and communities to coproduce health care service.

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At the same time we put in action a programme like this, we must train clinicians to encourage patients to be proactive. We must also help communication between patients and clinicians in order to make this change of philosophy possible. To involve clinicians is crucial to succeed.

Even senior managers of healthcare organisations should have no doubts about the benefits of this new paradigm and should be aligned with it.

The success of this innovative program will be possible when all the implicated parts are able to see the advantages that empowerment brings to all of them.

Keywords: self-management; chronic disease; education; empowerment; integrated delivery of health care
