IEMAC-ARCHO

Assessment of Readiness for **Chronicity** in Health Care Organizations

Instrumento de Evaluación de Modelos de Atención ante la **Cronicidad**

UNIVERSITAS Miguel Hernández

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MSD

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INTRODUCTION

IEMAC/ARCHO is an instrument for health and social care organizations to perform a self-assessment in terms of their degree of implementation of chronic care management models. IEMAC/ARCHO is based on the CCM ("Chronic Care Model") and has been designed particularly for a national health system context. It enables the assessment of organizations at macro level (formulating policies and strategies and allocating resources), meso level (management of organizations, health and social care centres and programmes) and micro level (clinical activity between professionals and patients).

The prevention and management of chronic diseases is one of the greatest challenges faced by health systems worldwide. There is currently a wide consensus on the need for new models to improve the management of chronic disease, together with recognition that there is no universal model of chronic disease management and any initiative for improvement should be adapted to the specific context and circumstances of each system and organization.

One of the models that have achieved widespread acceptance and take-up on an international level is the "Chronic Care Model", or **CCM**, which was designed by the MacColl Institute for Health Care Innovation and adapted to other settings with additional contributions (Expanded CCM, ICCC).

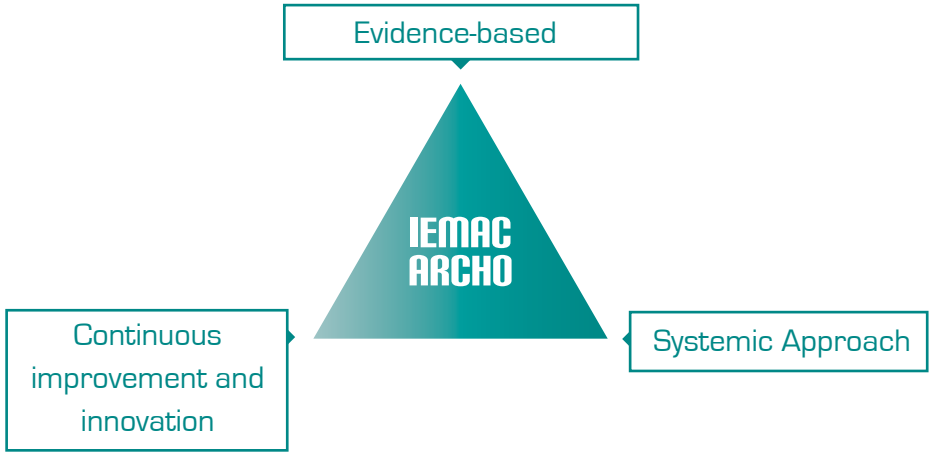
The **CCM** pinpoints the essential elements required by healthcare services to offer quality care to the chronically ill. It is based on productive interactions between an informed, empowered chronic patient and a prepared, proactive health team that can be achieved through 6 basic elements: the organization of the healthcare system, the community, the provision of care, patient self-care, decision-making tools and information systems. **There is growing evidence that interventions implemented on the basis of the CCM improve processes and outcomes.**

IEMAC/ARCHO is based on the CCM, yet it also includes additional perspectives with which to advance on the reorientation of health and social policies and services to prevent the development of chronic disease and provide integrated quality care to people with these conditions. The development of IEMAC is available in Gaceta Sanitaria. (1)

[1] Nuño R, Fernández P, Mira JJ, Toro N, Contel JC, Guilabert M, Solas O. Desarrollo de IEMAC, un Instrumento para la Evaluación de Modelos Asistenciales ante la Cronicidad. Gac Sanit. 2013; 27:128-134.

The principles inspiring IEMAC/ARCHO are:

- A systemic approach which considers the organization holistically and underscores the synergistic value of the interventions.
- The best available evidence as a basis for formulating interventions.
- Continuous improvement through systematic assessment and innovation, as a guarantee for the advance of care to chronic patients.



IEMAC/ARCHO may be useful for your organization because it:

- Enables the diagnosis of an organization to be performed in terms of the degree of implementation of an excellence model for chronic patients care, as well as its progress over time.
- Provides a map of interventions that comprise a model for approaching chronic disease, which may be used as a roadmap for management of change by clinicians, managers and health and social planners.
- Is an instrument of quality improvement as it enables the comparison/ benchmarking between similar organizations.
- Facilitates the direction of policies on planning, resource allocation and organizational changes.

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INSTRUCTIONS FOR SELF-ASSESSMENT

ARCHO, Assessment of Readiness for Chronicity in Health Care Organizations, is the English acronym for the original name in Spanish of IEMAC, Instrumento de Evaluación de Modelos de Atención ante la Cronicidad.

Please, refer to this instrument as IEMAC/ARCHO.

IEMAC/ARCHO was designed as an instrument to help healthcare agents wishing to improve their health system by adapting it to the needs of patients with chronic diseases. To get the best use of the tool, we suggest you read these instructions before performing the self-assessment.

1.- Self-assessment instrument

IEMAC/ARCHO is a tool that enables organizations to self-assess their implementation of models for the management of chronic illness. It measures the progression of organizations in their transformation to provide better care for chronic patients in a simple, valid and suitably sensitive way.

The assessment procedure is completed using an online tool for recording and processing the results, available on the link www.iemac.org

2.- Scope of application and assessment perspective

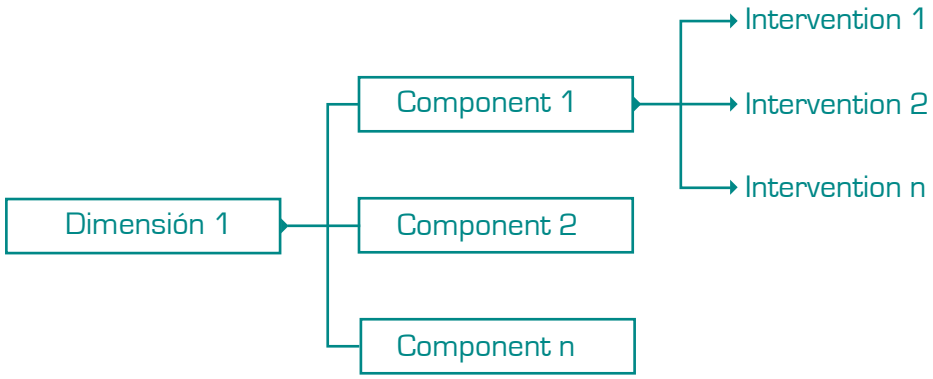
IEMAC/ARCHO enables the self-assessment of organizations in different contexts and organizational levels. It can be used at all decision-making levels: macro (policy and strategic formulation and resource allocation), meso (management of organizations, centers and care programmes) and micro (clinical activity between professionals and patients) and in the different care settings.

IEMAC/ARCHO proposes and assesses the degree of implementation of 75 interventions. As this is a systemic instrument, there is interconnection between the various dimensions and its fields of application and therefore, it is important to address it entirely. Although some interventions might seem more applicable to the activity of a specific professional or a specific part of the organization, all the interventions as a whole set allow a complete assessment of the approach of chronicity and its deployment in practice.

3.- Structure of the questionnaire

The questionnaire consists of 6 dimensions, related to the 6 elements of the Chronic Care Model. 27 components stem from the 6 dimensions and 75 interventions stem from the components, according to the following taxonomy:

Flowchart



For each dimension and component, a number of interventions or items are proposed, which must be assessed taking into consideration the real situation of the organization being evaluated, according to a rating scale from 0 to 100. Some of the interventions incorporate a supporting text or glossary describing key concepts, the scope of the intervention or examples are given to aid understanding of the intervention.

4.- Self-assessment process

IEMAC/ARCHO has been designed for self-administration by way of a process of self-assessment, although external assessments are also permitted. To conduct the self-assessment, a self-assessment team comprising a range of professionals is required. These professionals must answer the questions in IEMAC/ARCHO in agreement.

The self-assessment team should include professionals with different profiles, competencies and management responsibilities as regards chronic patients. It is advisable to include the various care settings (primary care, hospital), as well as other providers of social care. For some interventions, it may also be useful to include the perspective of patients and/or caregivers.

Before the meeting, it is necessary to read the assessment tool so assessors can acquaint themselves with the tool, its structure: dimensions, components and interventions and the rating score before beginning the assessment.

We suggest you follow the order of reading set by the questionnaire itself, i.e., starting with dimension 1 and ending with dimension 6. Nevertheless, when rating, it has been observed that in micro organization is its easier to start with dimension 3, Healthcare Model.

The score for each intervention should be accompanied with the specific activities rolled out, justifying it. It is important to record these activities in the space provided for this purpose in the tool, as well as their description: objectives, target population, performance stages and timeframes, process and outcome indicators and others for the purpose of specifying the scores and determining their interpretation. This will help the team assess and monitor these activities.

A self-assessment meeting may last 4 to 5 hours depending how prepared it is and the ease of reaching agreements on the scores

between the self-assessment team members. To facilitate the performance of the session and reach agreement on the scores, it is advisable for two team members to accept two important roles: facilitator or moderator and rapporteur or secretary of the session. Be aware of the interventions beforehand and describe the activities rolled out as per the criteria of the rating scale, facilitating agreement of the team.

5.- Rating scale

The IEMAC/ARCHO rating scale ranges from 0 to 100. Each intervention should be scored based on the following criteria:

- **Deployment,** defined as depth and degree of the implantation of the intervention. According to the nature of each intervention, the deployment may have a different significance. For most interventions, deployment refers to the coverage of the population and/or coverage of the most prevalent chronic diseases. Other dimensions, in particular Dimension 1, Organization of the Health System, refer to the scope of the intervention in the corresponding management areas.
- Presence or absence of a **systematic continuous assessment** process over time of the progress and outcomes of the interventions implemented. The assessment implies the conduct of routine measurements and controls on deployment and the results obtained, as well as their recording. Systematic continuous assessment will be the basis on which the organization learns, enabling the identification, priority setting, planning and putting into practice of actions for improvement. As it is not possible for all interventions to perform a "hard" assessment, in practice different designs can be used to assess interventions: from descriptive studies, direct observations and expert reports to randomized clinical trials, using both quantitative and qualitative information.
- **Innovation,** by way of changes in interventions that lead to others with better patient care outcomes.

The scale is a continuum that allows the level of an organization's development to be positioned as regards each of the interventions defined in IEMAC/ARCHO. Even thought, to make it easier to allocate a score, 5 segments have been devised.

First segment: There are isolated activities or the intervention is being defined (or the action plan for the intervention). Deployment (territorial cover, number of diseases, number of patients and/or professionals involved) **is limited.** This corresponds to pilot experiences, limited actions with a certain group of patients or interventions at the design stage.

Second segment: The intervention (or action plan for the intervention) has started to be implemented but outcomes have not been evaluated. The plan is deployed in around 25% of the relevant areas. This will apply when the action plans have been implemented in some hospitals or by some professionals or in certain clinics and

for some chronic diseases, with a deployment of around 25%. In this segment no outcome assessment needs to have been made.

Third segment: The intervention (or the action plan for the intervention) is being developed systematically. Outcomes have been evaluated. The plan is deployed in around 50% of the relevant areas. This means that the intervention is being implemented systematically. That is, these are not isolated experiences or experiences based solely on the intention of a few professionals or of activities undertaken under the scope of a research project. The implementation of the intervention involves a greater number of hospitals and professionals from different disciplines, and several chronic diseases, usually the most common (such as diabetes, hypertension, asthma, COPD, depression, osteoarthritis, etc.), with a deployment of approximately 50%. In addition, the assessment system has already been designed.

Fourth segment: The intervention (or action plan for the intervention) has been assessed systematically for at least 2 years. The plan is deployed in 75% of the relevant areas. This segment will be used when the action plan has been in practice for at least 2 years. Interventions are deployed in approximately 75% of relevant areas and a wide range of professionals, hospitals and clinics are involved, as appropriate. These interventions are made in a wide range of chronic diseases. The interventions have been able to be assessed and the result of the assessment is allowing for innovations in patient care to be identified.

Fifth segment: The intervention (or the action plan of the intervention) is part of the organization's care model. It is deployed in over 85% of the areas and enhances innovation. This segment is limited to cases where the intervention is fully integrated in clinical practice and deployment throughout the organization is over 85%. Assessment is geared towards improvement and innovation of new, substantially different interventions, possibly of another type or with the application of new technologies.

It is important to remember that the tool has been developed under restrictive criteria, so for positioning itself in a given segment, it should fully meet the requirements contained in the previous segment.

6.- Rating

The overall IEMAC/ARCHO rating corresponds to the sum of the ratings of each intervention. It ranges from 0 to 7500 and is designed to facilitate comparisons of the organization itself over time.

Operationally, and when the scores from each intervention have been agreed on by the assessment team, a figure (ranging from 0 to 100) on the degree of implementation and development in each component and dimension can be collected from the average of the rating of the interventions for each component and for each dimension.

When interpreting the ratings, it should be noted that it is normal to begin with fairly low ratings. It is logical that as professionals acquaint themselves with chronic care models and key management items, the ratings get higher with the improvements made over time. However, it has been documented that sometimes the improvement process

is not fully understood until you are immersed in it, so it may be that in a given period the rating is lower than in earlier periods, in spite of incorporating improvements.

7.- Frequency of Assessment

The implementation of interventions for improving chronic care in a healthcare organization requires a period of time that may vary depending on the type of intervention and on the organization itself.

At the start, annual self-assessment is recommended for the organization and, depending on the levels achieved and the number, intensity and type of interventions for improvement developed, the frequency of self-assessment can be shorten or spaced out. More advanced organizations in terms of chronic patient management will require longer timelines to see significant improvements.

8.- Usefulness of the instrument

The IEMAC/ARCHO tool:

- Enables the diagnosis of an organization to be performed in terms of the degree of implementation of a model for excellence in care of chronic patients, as well as its progress over time.
- Provides a map of interventions that comprise a model for approaching chronic disease, which may be used as a roadmap for management of change by professionals, managers and decision-makers.
- Is a quality improvement instrument as it enables the comparison/benchmarking between similar organizations.
- Facilitates the direction of policies on planning, resource allocation and organizational changes.

The self-assessment process with IEMAC/ARCHO offers:

- The opportunity to share experiences and perspectives within the team of professionals that treat chronic patients.
- The identification of strengths and areas for improvement to advance in the change of the model for chronic patient care.
- A global score of the organization from 0 to 7500, in terms of its approach to chronic illness care.
- A relative position compared to similar organizations (for assessments made via web www.iemac.org).

It should be noted that:

- This instrument measures the perceptions of the assessors on chronic patient care. As with other self-assessment tools, these perceptions may be influenced by the motivations and expectations of the respondents and by their own understanding and interpretation of the interventions.
- Although this instrument addresses multiple improvement dimensions, it does not intend to be a comprehensive healthcare

system improvement plan. Basic aspects, for instance, human resources, financing or incentives, are only approached as they relate to the improvement of care in chronic patients.

- IEMAC/ARCHO has not been designed to compare organizations, hospitals, services, or healthcare practices based on the global rating.

9.- Assessment via the website www.iemac.org

Completing the assessments of the organizations online allows the following reports to be obtained:

- Report on the organization's position with its scores in each intervention, component and dimension, and global score.
- Progress report on the organization over a period of time.
- Report on the relative (comparative) position of the organization compared to similar organizations.

The person completing the assessment online should make sure they have authorization from the accountable person in the organization being self-assessed and that the same organization has not uploaded another assessment to the website in the last three months.

Likewise, they should specify the type of organization (public or private) and its scope of decision: macro (regional health services, integrated social and health organizations, etc.), meso (health areas, departments, counties, primary care trusts, hospitals, specialty centres, long term care centres, care programmes, etc.) or micro (primary care teams, hospital departments, clinical programmes, clinical management units, etc.). This record enables benchmark reports on similar organizations to be issued.

DIMENSIONS

1. DIMENSION 1. ORGANIZATION OF THE HEALTH SYSTEM
2. DIMENSION 2. COMMUNITY HEALTH
3. DIMENSION 3. HEALTHCARE MODEL
4. DIMENSION 4. SELF MANAGEMENT SUPPORT
5. DIMENSION 5. CLINICAL DECISION SUPPORT
6. DIMENSION 6. INFORMATION SYSTEMS

1 DIMENSION 1. ORGANIZATION OF THE HEALTH SYSTEM

This dimension deals with the transformation of the health system aimed at improving population health through a shared vision. It is based on adequate funding schemes, information systems that allow for evaluation, improvement and innovation, and the alignment of social and health policies.

1.1 Leadership commitment

1.2 Strategic Framework

1.3 Population-based approach

1.4 Evaluation, improvement and innovation

1.5 Funding scheme

1.6 Social and health care policies

1.1 Leadership commitment (*)

1.1.1 Leaders transmit an explicit vision of the chronic care model.

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1.1.2 Leaders reallocate resources to drive transformation of the healthcare model with the aim of improving care for chronic patients.

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1.1.3 Senior leaders of the organizations foster clinical leadership among members of multidisciplinary teams. (*)

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An action plan is written and/or isolated actions are in place. Deployment is limited.	The action plan has been implemented but outcomes have not been evaluated. The plan is deployed in 25% of the relevant areas.	The action plan is being developed systematically. Outcomes have been evaluated. The plan is deployed in 50% of the relevant areas.	The action plan has been systematically assessed for at least 2 years. The plan is deployed in 75% of the relevant areas.	The action plan is part of the care model. It is deployed in over 85% of the areas and enhances innovation.

i Describe the actions carried out that justify this rating:

*1.1 In this context, "leader" is defined as personnel with a management role in healthcare organizations and those responsible for teams of staff, depending on the setting in question: Regional Health Services, Health Area (District, Department, County), Hospital, Primary Care Centre.

*1.1.3. Clinical leadership refers to the development of skills to oversee strategies, inspire a vision and values shared in the professional practice, fostering teamwork, creating a culture of innovation and excellence in the organization and developing and enabling other professionals, all with the purpose of enhancing clinical practice and clinical and financials outcomes and providing excellent care to patients and families.

1.2 Strategic Framework

1.2.1 A chronic care strategy or plan is in place that includes vision, objectives, actions evaluation and follow-up.

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1.2.2 Indicators of population health outcomes, quality and patient experience of care, and efficiency are defined in the strategy.

0 5 10 | 15 20 25 30 35 | 40 45 50 55 60 | 65 70 75 80 85 | 90 95 100

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i Describe the actions carried out that justify this rating:

1.3 Population-based approach (*)

1.3.1 The care model is geared towards improving health and reducing inequalities and its progress is monitored using indicators.ç

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1.3.2 Population stratification systems providing useful information for clinical and management decisions have been devised and rolled out. (*)

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i Describe the actions carried out that justify this rating:

*1.3. A population-based approach is understood as one which takes the entire population of a certain region into consideration in the design of policies, strategies, and action plans for chronic care. Accordingly, it includes both, patients receiving care and the healthy population for health promotion and disease prevention purposes, as well as patients who do not use the health services but who could benefit from them.

*1.3.2. This refers to the classification of the population in groups according to their health status, risk, complexity or specific needs, considering that each group may require differentiated interventions or health programmes. The stratification models most widely used to date classify the population according to their health status, risk of non-planned hospitalization or increased costs in the future. This intervention is addressed from a planning perspective and is complemented by intervention 6.1.1 on the individual classification of each patient recorded in their clinical history.

1.4 Evaluation, improvement and innovation

1.4.1 The indicators of the chronic care strategy and the results of its evaluation have been disseminated through the whole organization.

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1.4.2 Methods for collaborative learning and identification and dissemination of good practices have been implemented.

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1.4.3 Innovation with the participation of all stakeholders involved is encouraged.

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An action plan is written and/ or isolated actions are in place. Deployment is limited.	The action plan has been implemented but outcomes have not been evaluated. The plan is deployed in 25% of the relevant areas.	The action plan is being developed systematically. Outcomes have been evaluated. The plan is deployed in 50% of the relevant areas.	The action plan has been systematically assessed for at least 2 years. The plan is deployed in 75% of the relevant areas.	The action plan is part of the care model. It is deployed in over 85% of the areas and enhances innovation..

i Describe the actions carried out that justify this rating:

1.5 Funding scheme

1.5.1 A population-based, risk-adjusted funding scheme, aligned with the improvement of quality and health outcomes has been put in place. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

1.5.2 Incentives are in place to reach shared targets between the different levels of chronic care (primary, hospital, social, community...)

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i Describe the actions carried out that justify this rating:

*1.5.1. Per capita funding, that is funding based on the number of people assigned to a territory, is one of the funding schemes aligned with the improvement of results in health, as an alternative to systems based on funding by health centres or activity-based programmes. Per capita funding provides an incentive to keep the population in good health. Per capita payment can be risk-adjusted according to circumstances. In any case, the funding scheme used should incentivize the improvement in health quality and outcomes.

1.6 Social and health care policies

1.6.1 Coordination and/or integration of social and health care policies have been defined and implemented, especially in cases of frailty and dependence.

0 5 10	15 20 25 30 35	40 45 50 55 60	65 70 75 80 85	90 95 100
An action plan is written and/or isolated actions are in place. Deployment is limited.	The action plan has been implemented but outcomes have not been evaluated. The plan is deployed in 25% of the relevant areas.	The action plan is being developed systematically. Outcomes have been evaluated. The plan is deployed in 50% of the relevant areas.	The action plan has been systematically assessed for at least 2 years. The plan is deployed in 75% of the relevant areas.	The action plan is part of the care model. It is deployed in over 85% of the areas and enhances innovation.

i Describe the actions carried out that justify this rating:

2 DIMENSION 2. COMMUNITY HEALTH

This dimension refers to cooperation between the healthcare system and community resources, organizations and institutions in the prevention and management of chronic diseases.

2.1 Community health strategies

2.2 Alliance with community stakeholders

2.3 Connecting the patient to community resources

2.1 Community health strategies

2.1.1 Programmes and/or community projects are developed based on community health needs.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

2.1.2 Institutions, community agents, local bodies and the public work together with health agents in planning community health policies.

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An action plan is written and/or isolated actions are in place. Deployment is limited.	The action plan has been implemented but outcomes have not been evaluated. The plan is deployed in 25% of the relevant areas.	The action plan is being developed systematically. Outcomes have been evaluated. The plan is deployed in 50% of the relevant areas.	The action plan has been systematically assessed for at least 2 years. The plan is deployed in 75% of the relevant areas.	The action plan is part of the care model. It is deployed in over 85% of the areas and enhances innovation.

i Describe the actions carried out that justify this rating:

2.2 Alliance with community stakeholders

2.2.1 An up-to-date map on community resources impacting on health is in use. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

2.2.2 Partnership and cooperation agreements are in place between healthcare agents and community resources. (*)

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i Describe the actions carried out that justify this rating:

*2.2.1. This refers to the use of a directory on social and community resources, listing the type of services provided, suppliers, user profiles, access, etc. in the geographical area of reference.

*2.2.2. This refers to establishing active mechanisms that promote the coordination of healthcare services with community resources in the geographical area of reference.

2.3 Connecting the patient to community resources

2.3.1 The care processes include the referral of chronic patients to community resources and programmes.

0 5 10	15 20 25 30 35	40 45 50 55 60	65 70 75 80 85	90 95 100
An action plan is written and/or isolated actions are in place. Deployment is limited.	The action plan has been implemented but outcomes have not been evaluated. The plan is deployed in 25% of the relevant areas.	The action plan is being developed systematically. Outcomes have been evaluated. The plan is deployed in 50% of the relevant areas.	The action plan has been systematically assessed for at least 2 years. The plan is deployed in 75% of the relevant areas.	The action plan is part of the care model. It is deployed in over 85% of the areas and enhances innovation.

i Describe the actions carried out that justify this rating:

3 DIMENSION 3. HEALTHCARE MODEL

This dimension refers to how to advance towards proactive models of care which address the person in a comprehensive way, with an integrated approach and in which the different social and healthcare units and professionals involved carry out their functions in a planned, structured and coordinated manner.

3.1 Patient-centred care

3.2 Professional competencies

3.3 Multidisciplinary teamwork

3.4 Integration and continuity of care

3.5 Active patient follow-up

3.6 Innovation in interactions between patients and professionals

3.7 Clinical management of chronic disease and incentive schemes

3.1 Patient-centred care (*)

3.1.1. The organization assigns a professional to each chronic patient to act as their care referent in each setting. (*)

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3.1.2. High-risk patients have a helpline available 24/7 run by professionals with access to their clinical record (excluding emergency services).

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3.1.3. A specific action plan has been devised for patients with advanced chronic disease, according to their values and preferences.

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3.1.4 The aim of social care and healthcare is for the patient to remain in their environment and in the community with the best quality of life possible.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

*3.1. This refers to planning, organization and provision of care, taking into account the patient's values, preferences and needs and encourages the patient's involvement in the whole process, assisting them in their interaction with the healthcare system and professionals as a means to improve the quality of care they receive.

*3.1.1. The healthcare contact person is the professional the patient identifies as their reference in the event of any incidents or questions and whose name is known by the patient. This person could be their family doctor or nurse, their consultant, case manager or another professional engaged in the field of care. There may be more than one healthcare contact person.

3.2 Professional competencies (*)

3.2.1 Professional healthcare competencies which must come into play in the management of a chronic patient are incorporated and developed.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.2.2 There are professionals responsible for the coordination and continuity of care, especially in processes of transition between areas of care and in the planning of hospital discharge. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.2.3. Professionals responsible for community case management are available for the management of high-risk chronic patients.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.2.4. Competencies of professionals are developed in relational skills and in motivating patients so they become engaged in the own care.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

*3.2. This refers to the inclusion and development of new skills in the professionals and the development of new profiles of professionals with a combination of competencies, who are better prepared to provide quality care to their chronic patients. Examples of these new responsibilities may be health coaching, telephone counselling or those referred to in 3.2.2, 3.2.3 and 3.2.4.

*3.2.2. They are professionals, such as coordination nurses, who actively participate in the planning process at the time of discharging hospitalized or institutionalized patients, with the purpose of ensuring continuity in the process of care, maintain care in the home, health centre or residence, and preventing readmission.

3.3 Multidisciplinary teamwork

3.3.1 Multidisciplinary teamwork is undertaken at healthcare centres and other settings. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.3.2 A formal and informal relationship between professionals in the different healthcare settings is encouraged with joint activities. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.3.3 Collaborative teamwork among professionals of health, social, occupational and community settings is facilitated to improve care for chronic patients.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.3.4 There are joint targets (shared goals) between the various teams and care organizations aligned with the good management of the chronic patient.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

* 3.3.1. This refers to the rolling out of a team development strategy including the following key elements: identification of team members; definition of their roles and functions; definition of joint targets with systematic assessment of targets reached; determining information and communication channels and their frequency so that effective cooperation is reinforced among members. The teams may range from the basic care unit of the primary care physician and nurse to larger teams (internal medicine specialists, other specialists, pharmacists, psychologists, physiotherapists), and other larger multidisciplinary and/or inter-area care settings.

* 3.3.2. This refers to providing opportunities for professionals to come together and debate, whether by organizing structured activities (seminars, conferences, meetings, etc.) or providing more informal opportunities for interaction (social networks, knowledge management platforms, social activities, etc.).

3.4 Integration and continuity of care - 1/2

3.4.1 Pathways between primary and specialist care in the most common chronic diseases have been designed and put into place. These pathways include circuits and healthcare settings based on patient needs.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.4.2 The care pathways incorporate social, occupational and community settings.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.4.3 The process of integrated and multidisciplinary care of the patient with multiple chronic conditions is defined and in place.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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Describe the actions carried out that justify this rating:

3.4 Integration and continuity of care - 2/2

3.4.4 Alert systems are in place for informing and activating the clinical teams during referral processes and in care transition (emergencies, hospital or clinic admission and discharge).

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.4.5 There are alternative circuits to the emergency room for chronic patients with problems of control and/or exacerbation of their condition: day hospital, admission requested by primary care, telephone access and others.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.4.6 Drug reconciliation is performed during transitions between care settings. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

* 3.4.6. This refers to the formal process of verification of the patient's regular medication at the time of hospital/clinic admission or discharge and comparison with any new medication prescribed, to avoid duplication, interactions or contraindications between the two treatments. The reconciliation process should ensure continuity of treatment during transition (between primary care, specialist care and long-term care) and ensure the continuity and compatibility of the treatments.

3.5 Active patient follow-up

3.5.1 Standardized action plans are in place for different patient profiles, which approach the integrated care process, including promotion and prevention activities.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.5.2 There is a comprehensive therapeutic plan for each patient with objectives of prevention, clinical control and symptoms control and self-care, recorded in the clinical records.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.5.3 There are alerts in place in the clinical records to let the professional know when the patient has an inadequate control (out-of-range parameter, non-performance of a test, missing result, etc.).

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.5.4. The patient's medication is systematically reviewed with the patient to detect and resolve any efficacy, safety or adherence problems.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

3.6 Innovation in interactions between patients and professionals

3.6.1 Technology is used to allow off-site (remote?) interaction between patients and professionals (telephone, e-mail, teleconsultation, telemonitoring, telephone service, apps).

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.6.2. Group consultations are used.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.6.3 Websites, social networks, blogs with health education content of verifiable quality are prescribed.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

3.6.4. Structured and proactive programmes are in place to control and follow-up chronic patients off-site.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

3.7 Clinical management of chronic disease and incentive schemes

3.7.1 Healthcare teams are able to manage their own resources, organization and operations.

0 5 10 | 15 20 25 30 35 | 40 45 50 55 60 | 65 70 75 80 85 | 90 95 100

3.7.2 The professional's incentive scheme is aligned with the sound management of the chronic patient.

0 5 10 | 15 20 25 30 35 | 40 45 50 55 60 | 65 70 75 80 85 | 90 95 100

3.7.3 Information feedback is routinely provided to clinicians so that they can improve their practice.

0 5 10 | 15 20 25 30 35 | 40 45 50 55 60 | 65 70 75 80 85 | 90 95 100

0 5 10	15 20 25 30 35	40 45 50 55 60	65 70 75 80 85	90 95 100
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i Describe the actions carried out that justify this rating:

4 DIMENSION 4. SELF MANAGEMENT SUPPORT

This dimension refers to the involvement of the patient in the management and care of his/her disease. This requires the effective use of support and training strategies to ensure that the patient acquires the necessary motivation, knowledge, skills and resources to cope with their chronic condition.

4.1 Patient assessment for self management

4.2. Structured therapeutic education

4.3. Psycho-social activation of the patient and mutual support

4.4 Tools to facilitate self management

4.5 Shared decision-making

4.1 Patient assessment for self management

4.1.1 The professionals, along with the patient, or their caregiver, (*) perform a comprehensive assessment of the case to pinpoint the patient's needs, attitude and abilities for self-care.

0 5 10	15 20 25 30 35	40 45 50 55 60	65 70 75 80 85	90 95 100
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i Describe the actions carried out that justify this rating:

* 4.1.1. If the patient lacks autonomy.

4.2. Structured therapeutic education

4.2.1. The patient is instructed on all aspects of his/her chronic illness, according to structured programmes.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

4.2.2 Assorted methods of therapeutic education are provided according to the patient's needs and preferences: individual visit, group visit, telephone call, online, specialized websites, workshops, teaching materials, etc.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

4.3. Psycho-social activation of the patient and mutual support (*)

4.3.1 Management skills (problem-solving, decision-making, proper use of healthcare and social resources) are developed to increase the motivation and confidence of patients with regard to their self-care capacity (expert patient programmes).

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

4.3.2 The participation of the patient and caregivers in associations, self-help groups, social networks and patient forums is encouraged.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

* 4.3 Interaction, exchange of knowledge and experiences between people in the same situation facilitate the involvement of the patient in the management of their disease.

4.4 Tools to facilitate self management

4.4.1 The patient has useful and clear written information regarding their personal treatment plan.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

4.4.2 The patient has secure electronic access to the health canal which contains his/her personal health record, options to communicate with their professionals and other health resources.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

4.4.3 Self-management tools (telephone, remote access, patient notes, alert system, devices for measuring biological parameters, self-assessment questionnaires, pillboxes and others) are used as appropriate to the patient's profile.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

4.4.4 Collective programmes fostering the personal autonomy of chronic patients are prescribed. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

* 4.4.4. Programmes such as group exercise, quit smoking, fall prevention classes, etc.

4.5 Shared decision-making

4.5.1 The patient receives accurate, clear, relevant information about his/her health problem and care options.

0 5 10 | 15 20 25 30 35 | 40 45 50 55 60 | 65 70 75 80 85 | 90 95 100

4.5.2 The patient is involved in defining problems, in the action plan for negotiating priorities and objectives and in evaluating his/her progress.

0 5 10 | 15 20 25 30 35 | 40 45 50 55 60 | 65 70 75 80 85 | 90 95 100

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5 DIMENSION 5. CLINICAL DECISION SUPPORT

This dimension refers to the commitment of the organization to improve health outcomes using decision support tools, training professionals and exchanging knowledge among providers of care to chronic patients.

5.1 Protocols and shared guidelines

5.2 Continued Education and Training

5.3 Consultancy and liaison

5.1 Protocols and shared guidelines

5.1.1 Clinical practice guidelines shared between care settings are used.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

5.1.2 Algorithms for supporting the therapeutic intervention and alerts based on clinical practice guidelines are built in the clinical record.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

5.1.3 The guidelines, protocols and other instruments of expertise include the most common comorbidity situations.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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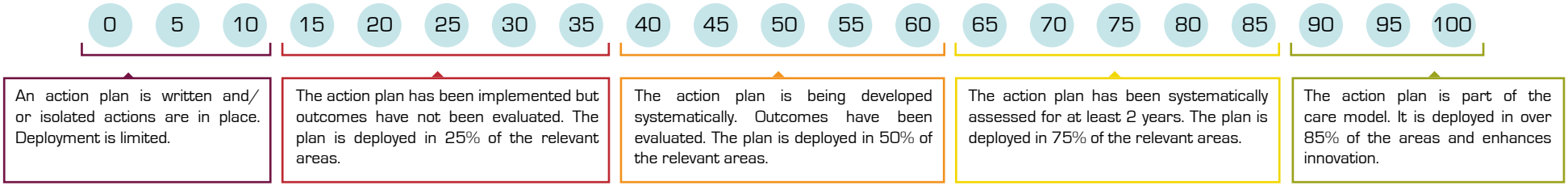
i Describe the actions carried out that justify this rating:

5.2 Continued Education and Training

5.2.1. The impact on practice of continued education and training about the management of the chronic patient is evaluated.



i Describe the actions carried out that justify this rating:

5.3 Consultancy and liaison (*)

5.3.1 Face to face consultations (clinical sessions, referrals, rotations, etc.) are used for the multidirectional transfer of expertise.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

5.3.2 Remote consultations (electronic referral of patients, consultation via e-mail or online platforms) are used for the multidirectional transfer of expertise.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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i Describe the actions carried out that justify this rating:

* 5.3. This refers to the transmission of theoretical and empirical knowledge and experience among professionals to assist in the treatment of specific cases or to support training in specific areas. The transfer of knowledge may occur between professionals with different levels of specialization, different healthcare setting (primary care, hospital, social services, public health) and on an inter-professional level (medicine, nursing, pharmacy and others). It works in either one or both directions.

6 DIMENSION 6. INFORMATION SYSTEMS

This dimension refers to the use of information and communication to support clinical and population management in a structured, proactive and integrated manner between the various information subsystems, to improve care for chronic patients.

6.1 Information for management and clinical practice

6.2 Integration of patient clinical data

6.3 Communication of clinical information between professionals

6.1 Information for management and clinical practice

6.1.1 The predictive classification of the patient based on the expected care needs is available in his/her clinical record. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

6.1.2 Clinicians have direct access to patient lists according to health problems, clinical parameters or situations of risk.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

6.1.3 A panel of clinical assessment parameters that covers significant aspects of the most relevant chronic diseases is in place. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

6.1.4 Processed information and assessment indicators are provided to clinicians and managers on a regular basis to improve practice and management.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

6.1.5 The health record is designed to be user-friendly and ergonomic in order to facilitate clinical monitoring by professionals.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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* 6.1.1. The patient's health record includes their risk level according to the degree of severity of the disease, comorbidity, associated disability, risk of hospitalization, foreseeable complications during treatment, type of medication, difficulties of social support, etc.

* 6.1.3. The system of indicators should include at a minimum: expected prevalence, diagnostic level, appropriateness of treatment and compliance, use of hospitalization and emergencies (general and specific), preferential visits, complications, disability and mortality.

6.2 Integration of patient clinical data

6.2.1 The electronic health record can be shared and updated by all care areas with legitimate access.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

6.2.2 Systems are in place to ensure patients' safety. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

6.2.3 The patient can include clinical information in his/her personal health record. (*)

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

6.2.4 Information generated in other areas (social services, public health, occupational) is shared among professionals.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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*6.2.2. These systems should include the unequivocal identification of the patient and other mechanisms of risk prevention according to the patient's characteristics and treatment.

*6.2.3. This refers to information on general health, symptoms, therapeutic adherence, general and specific self-completed questionnaires, non-prescription medicines, data from occupational health check-ups, results from other providers, etc.

6.3 Communication of clinical information between professionals

6.3.1 An e-referral or online consultation between professionals from different care settings with electronic interchange of information is in place.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

6.3.2 A channel (direct phone line or other means of contact) is in place for consultation in real time across the different care settings.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

0 5 10	15 20 25 30 35	40 45 50 55 60	65 70 75 80 85	90 95 100
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IEMAC-ARCHO

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UNIVERSITAS Miguel Hernández

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MSD