EXECUTIVE SUMMARY of EXPERT PATIENT PROGRAMME OF CATALONIA January 2015

INTRODUCTION

The Expert Patient Programme of Catalonia™ (EPPC) is a multidisciplinary initiative based on patient-healthcare professional collaboration and team work. In the EPPC it is the Expert Patient (EP) who leads the process and transmits knowledge about his or her disease to other patients who suffer from the same health problem. The healthcare professional becomes an observer, and only intervenes if it becomes necessary. The Expert Patient is a person suffering from a chronic disease who is able to take responsibility for his or her disease and self-care, identifying symptoms, and acquiring the skills to manage the physical, emotional and social aspects of the disease.

OBJECTIVES

General Objective: To promote change in daily life habits which will improve quality of patient life, with the exchange and transference of knowledge and experiences between the Expert Patient and other patients

Specific objectives: 1)Patient involvement, 2) Evaluate degree of patient satisfaction, 3)Improve perceived quality of life of the patients, 4)Improve patients' understanding of their disease, 5)Improve level of self-care in order to better manage the disease, 6)Improve treatment management, 7)Reduce the number of encounters with Primary care nurses and GPs, 8)Reduce hospital admissions and hospital emergency visits

METHODOLOGY

The EPPC consists of nine 90 minute sessions over 2.5 months, specifically designed for each chronic disease. Sessions are divided in two blocks, a theoretical and a practical one. The number of patients is limited to 10 to 12 per group, and the aim is to guarantee effective and free-flowing communication between the participants.

EVALUATION PROCESS

The evaluation of the EPPC is qualitative and quantitative. It is divided in two stages: First stage is carried out during group sessions and at the end of the session. The quantitative evaluation is performed in the 6th and 12th month after the group sessions have ended. We estimated the knowledge improved, the change in lifestyles, the degree of self-care and satisfaction of participants. Secondly we assessed use of health care services related to doctor and comunity nurse visit at the emergency department and emergency hospital admissions, making a comparative study of one year before intervention one year after the end of it.

RESULTS 2006-2015

Number of patients participating: **5669**, from which **360** have been Expert Patients who have led a group. **Coverage: 262** Primary Health Teams in Catalonia, **4** Hospital Units within Catalonia and **1** CSMA and with the involvement of various Healthcare providers of the Catalan Health System. **Diseases:** Chronic Heart Failure, COPD, Diabetes Mellitus type 2, Fibromyalgia, Oral Anticoagulant Therapy, Breaking the tobacco habit, Anxiety, Chagas disease in its chronic stage, Breast Cancer Survivors, Depression and Obesity. **Number of groups: 549. Number of healthcare professionals participating:** Total number as observers **902:** 614 nurses, 234 family doctors and 54 social workers

KEY CHANGE MANAGEMENT ELEMENTS THE EEP HAS BROUGHT

1. **For the patients**
   - Awareness of the disease they suffer from and the changes during the evolution of the disease
   - Provision of an active role and co-responsibility towards the disease they suffer from
   - Exchange of knowledge and experience among patients and the use of a patient-friendly, common language.
   - Facilitation of the acceptance and understanding of the disease, and the introduction of the concept of treatment adherence.
   - Improvement in self-care and quality of life
   - The ability to differentiate signs and alarm symptoms of their disease and to learn what to do and which health service to use for each situation.
   - Satisfaction improvement of the Expert Patient and patients participating in the programme.
2. **For the Healthcare Professionals participating in the programme**
   - To identify the skills of the patients in order to make decisions about their disease
   - To encourage self-reflection and self-evaluation. To encourage healthcare professionals improve their relationship with the patient in the following: active listening, patient engagement in the disease process, negotiation process, and facilitate agreement and consensus about the Health plan for the patient
   - To improve understanding of the challenges that patients suffering from a chronic disease face, including changes in lifestyle and habits.
   - To highlight the need to use appropriate patient-friendly language in order to improve communication between patient and healthcare professional.

3. **For the Healthcare System**
   - Bring about the transition from a paternalistic approach to healthcare from the professional point of view to a participative process with the patient
   - An informed and co-responsible patient makes better and more efficient use of the healthcare services. Knows better what to do and when to ask for the support of a healthcare professional or when to go to a healthcare centre.
   - Reduce burden on resources and the use of services such as the number of visits to primary health centres, emergency units or hospital admissions due to worsening of the disease. This would contribute to the sustainability of the Health System.
   - Results obtained to date, comparable with other similar International programmes, shows that this is a cost-effective intervention.

EVALUATION OF THE PROCESS

RESULTS IN COPD

1. Group of patients suffering from COPD

Total Participants: 140 (*excluded Expert Patients*)

Participant profile: Gender and Age

Male	Female
79%	21%

50-65	66-75	76-85	>85 yr
19.28%	46.42%	30.00%	4.28%

Degree of severity of disease: degree of Dyspnoea

Level 0	Level 1	Level 2	Level 3
28%	45%	18%	7%

Level of satisfaction: 4.6 out of 5 **|** **Level of participation:** 88%

Survey results

	Start of sessions	End of sessions	*% of improvement In relation to start of sessions*	6 months after sessions finish	*% of improvement 6 months after finish in relations to start of sessions*	12 months after sessions finish	*% of improvement 12 months after finish in relations to start of sessions*
Knowledge	63.40%	79.39%	*15.99%*	75.86%	*12.46%*	77.59%	*14.19%*
Habits and lifestyles	64.00%	68.00%	*4%*	69.00%	*5%*	71.00%	*7%*

	Start of sessions	End of sessions	6 months after sessions finish	12 months after sessions finish
Self-care	20.88	17.20	16.81	16.41

When evaluating the results of Self-care it should be noted that the lower the score the better

Quality of life: The Saint George questionnaire

	Pr_Symptoms	Pr_Activities	Pr_Impact	Pr_Total
Start	40.85%	41.45%	24.31%	32.25%
End	38.62%	44.51%	21.45%	31.29%
6 Months	34.88%	43.46%	20.05%	29.61%
12Months	36.69%	43.60%	22.56%	31.28%

When evaluating the results of Quality of life it should be noted that the lower the score the better

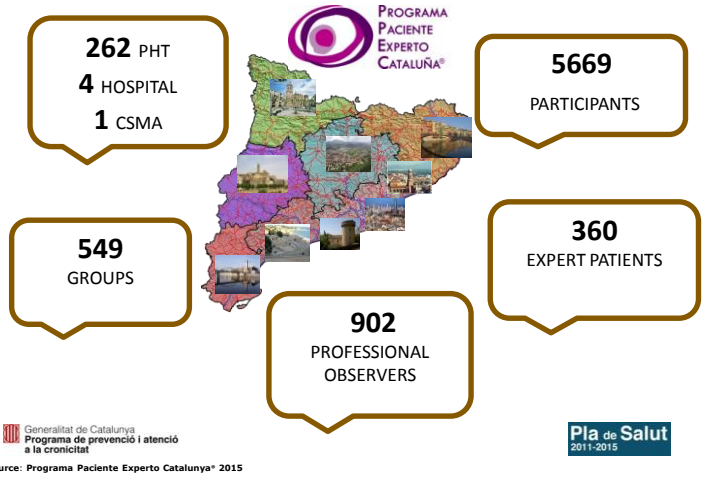
2. Results of healthcare service utilisation. Groups of patients suffering from COPD

Total Participants: **140**

Average visits/patient for worsening of the disease

Visits Primary Care GP//Nurse 1 year before starting sessions	Visits Primary Care GP//Nurse 1 year after finishing the sessions	*% reduction*	Emergency visits 1 year before starting sessions	Emergency visits 1 year after finishing the sessions	*% reduction*	Hospital admissions 1 year before starting sessions	Hospital admissions 1 year after finishing sessions	*% reduction*
2.86	1.64	*42.65%*	0.39	0.21	*46.15%*	0.19	0.11	*42.10%*

ACTIONS 2006-2015



Source: Programa Paciente Experto Catalunya® 2015

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