Basque Country: Integrated approach in pain management

Part 1: General Information

Publication on EIP on AHA Portal	Yes
Copyright	No
Verification of the Good Practice	No
Evaluation of the Good Practice	Yes
Type of the Good Practice	Good practice

Part 2: Description of the Good Practice

Name of the Good Practice	Integrated approach in pain management
Short name (Acronym)	Not applicable
URL of the Good Practice	Not applicable
Geographical scope	Regional level
Country	Spain
Region(s) involved	Basque Country
Status of the Good Practice	Completed
Stakeholders involved	• Hospitals • Primary care centres • Specialised physicians • Nurses • Pharmacists • General Practitioners • Day care centres
Size of population covered	>100,000
Targeted audience	Irrelevant

Summary of the Good Practice

The aim of this practice is to solve problems in both the healthcare service (drug prescription is unified, the clinical course of patients is monitored) and social care settings (avoids the movement of patients with functional limitation, consultations with caregivers are provided, wider agenda to treat patients that do not have a specific appointment).

The main goal of the practice is to improve the care of patients with pain, coordinating the conventional personal assistance with various forms of non in-person care, which allows to improve the delays of waiting lists, avoids impediments to the arrival of patients to the Pain Units and duplication of simultaneous treatments.
To this end, it has designed a Functional Plan for pain treatment by transversal and continuous health-care agreements between primary care, specialized care and the Pain unit.

The specific objectives of the practice include an average delay in first consultation lower than 30 days, more time for face—to-face consultations for infiltrations and reduce to zero the referrals documented in paper.

In addition, the Unified Electronic Health Record (HER) is incorporated, along with the development of non-face-to-face care pathways, with very positive results measured through quantitative and qualitative methods. Thus, the time available for personal assistance has been increased, and training and the collaboration between professionals of different levels of care have been improved.

Finally, it is necessary to emphasize that the EHR is a key facilitator. It allows sharing all patient information between all professional sand with the patient. It also allows instant electronic consultation and prescription, avoiding duplications and errors of treatment. Its use, along with the development of a non-face-to-face care pathways are transferable key aspects. Thanks tour practice the time available for personal assistance has been increased, and education and collaboration with clinicians in health centres and specialized consultations have been improved.

Key words: pain, non face-to-face care, unified electronic health records

Good practice being part of the larger programme

Yes.

According to the "Health Plan 2013-2020" of the Department of Health of the Basque Country and the strategic plan of Osakidetza, this is the solution proposed for the "Integrated Care Organisation Araba" in the care of patients with chronic pain.

Challenges / problems addressed by the good practice

1. Improve the satisfaction of users of the health system in relation to pain care.
2. Decrease the high delays to address first consultations in chronic pain patients in the Pain Unit. 3. Enhance training of healthcare professionals of the Primary Care in pain care.
4. Avoid unnecessary travel of patients to hospitals.
5. Improve the satisfaction of health professionals dedicated to the care of the pain.

Importance of the challenges / problems before starting to implement good practice

1. The delay to address first consultations in chronic pain patients in the Pain in the province of Álava was more than 90 days on average.
2. Referrals from Primary Care to the Pain Unit were not possible.
3. In many cases, patients treated by other specialists did not follow the conventional nor coordinated analgesics treatments.
4. The dissatisfaction of health professionals dedicated to pain care was growing due to the lack of solutions.

Environment before the good practice was implemented A traditional circuit was in place. Patients were referred to the Pain Unit from other departments through a consultation paper sheet. Patient assessment and the proposed treatments were recorded in a paper form of the Unit. The paper form was given to the patient who was asked to carry it with him/her, to be able to show it to other professionals The Treatment changes proposed by any of the professionals of the health system, or complications or side effects were only known in the Pain Unit in the following consultation with the patient if he/she brought the document. The appointments for check-up were about 30 days in preferential cases and about 120 days in conventional cases. It was not possible to know the evolution of patients without direct contact.
Key innovative elements of the good practice and how the good practice improved situation compared to previous practice 1. The Unified Health Record allows real-time sharing of all patient information among all professionals and the patient, as well as consultation and electronic prescription, avoiding duplicities and errors of treatment. 2. Functional Plan for pain management with ongoing agreements and transversal care between primary care, specialized care and the Pain Unit allows homogenizing the care of these patients. Now the clinical discharge of the patients loses sense, given the ease of communication and coordinated care between different levels of care. 3. More time for in-person care according to patient needs, by avoiding many unhelpful face-to-face consultations. 4. Ecological perspective by saving paper costs. 5. An average delay in first consultations lower than 30 days.

Part 3: Transferability of the Good Practice

Cost-effectiveness of the good practice (including all kind of costs and outcomes such as better health, quality of life or other resources)	Lower costs, improved outcomes
Resources required for the deployment of the good practice (personnel, equipment, facilities, ICT and other resources required Health workforce capable to adapt to changes in all levels of care. Time to get agreements between levels. Time for non-face-to-face care. Patient-centred Unified electronic health record, not in professionals. Suitable deployment of information systems.	
Total budget of the Good Practice	Not available

Source of funding	Regional funding
The main actions that have to be done to deploy the Good Practice No special effort except training meetings and agreements between professionals.	
Issues during the implementation of the Good Practice 1. Some professional not made aware with the changes. 2. Clear information to professionals and patients about non-face-to-face care is needed.	
Additional resources required to scale up Good Practice No.	
Basis to support sustainability of the Good Practice 1. The use of the electronic tool has completely displaced (in a 100%) the traditional care format. 2. The drug prescription is 100% in electronic. 3. In the past 3 years, the average delay for first consultations of patients with chronic pain has been less than 20 days in the Pain Unit, compared with over 90 days of the previous practice. 4. The 100% of primary care consultations are conducted virtually as non-face-to-face consultations. 5. The 96% of patient and family respondents are grateful of not having to go to the hospital if it is not essential.	
Evidence to observe the Good Practice A practice report, a visit to implementation site.	

Part 4: Viability assessment of the Good Practice

Time needed to deploy the Good Practice Less than a year. The practice took place in 2011, once unified EHR was implemented. To do this, the Pain Unit developed a management plan that was agreed with the various Primary Care Centres. According to this agreement, primary care professionals have a non-face-to-face consultation , with the 100% of patients referred from the pain Unit.. Similarly, the Pain Unit committed to attend all referrals in a weekly basis. Based on all relevant data, the Unit Pain performs a treatment proposal and either recommends follow-up by Primary Care, or arranges an in-person appointment at the Pain unit. This in- person appointment is scheduled within a week in preferential cases, within a month in ordinary cases and within three months in cases of reassessment of an already known case. In addition, any patient who has pain is considered a candidate to be assessed, if his/her

physician considers that the patient requires a therapeutic advice, asking for a suggestion or a face-to-face consultation. Therefore, silos in care are avoided and the care is coordinated and transversal, rather than successive and pyramidal.

These agreements are supported by the Care Management of the Integrated Health Organisation Araba, and an implementation chronogram was scheduled starting from 1st of January of 2013, with annual reviews. From January 1st of 2016 onwards referrals from specialized care are also included.

Investment per citizens / patient / client in terms of financial resources

Between €100 – €1.000 per targeted citizen / patient.
The cost of the project is 0€.

Evidence behind the Good Practice

Documented evidence. Evidence is based on systematic qualitative and quantitative studies.

The information is in the following link of the Spanish National Health System: http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/excelencia/CISNS_DocumentoMarcoDolor.pdf

Maturity of the Good Practice

The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.

The Plan is completely developed since January 2014, for the entire province of Alava. Results are very satisfactory from a quantitative point of view: 52% of the healthcare activity is performed in non- face-to-face manner supported by the integrated management systems of the organisation (unified EHR, ", the Personal Health Folder, etc.). The referral and response commitments are met and delay of the first in-person consultation is always less than 15 days.

Estimated time of impact of the Good Practice

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began.

Impact observed

Better health (societal). Other include decreased delays, expedite care, avoid unnecessary movement, improving teaching with case studies in primary care.

Transferability of the Good Practice

The innovative practice has been transferred within the same region.

This model is applicable in any European region to a greater or lesser extent, depending on the degree of development and implementation of the electronic medical record. This

change in the care model combines face-to-face consultation with care pathways that do not require the travel of patients, caregivers or professionals. While the unified electronic record is a very desirable tool, this management change can be applied without its full development, achieving much of its benefits: referrals are scheduled and arranged, appointments are speed up and care provision is coordinated, avoiding the unnecessary travel of patients and families, with a consequent increase of their comfort.

Part 5: Your organisation

Name of the organisation	Integrated Care Organisation Araba
Address of the organisation	C/ Jose Atxotegi, s/n - 01009 Vitoria-Gasteiz, Araba
Type of organisation	Integrated Care Organisation
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