Improvement Planning – Lithuania

(extract from D8.1 Improvement Planning Programme)

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National partner engaged identified improving the existing multimorbidity care model as the objective. Partners involved in logic model development had expertise in indicators development and population health management. Regional partners showed high capability in logic model development during working meeting and were more independent in the logic model construction process. Activities to implement include capacity building on integrated care best practices for providers and primary care centres, to reorganise administrative processes to better establish a structure that encourages interprofessional collaboration including the creation of case manager role, educating patients on self-management, and building relationships between government and provider organisations. Activities as implemented are expected to lead to improved organisation of care and quality of life for patients with multi morbidity, increased access to care according to need and increased interprofessional collaboration.

Goal: Improve the multimorbidity pilot model

Planned Work		Intended Results			
Input	Activities	Outputs (Sample)	Short-term Outcome	Medium-term Outcome	Long-term Outcome
# of pilot sites Primary care centres	Capacity Building -Knowledge exchange between primary care centres (pilot sites) -Integrated care training for providers (on structure, implementation, and patient inclusion & self-management)	# of knowledge exchange occurring/year # of providers participated in the training/year	Improved knowledge of integrated care best practice and implementation (incl. care coordination across levels of care) Improved awareness and knowledge of patient-centred care (eg inclusion & self-management)	Improved care for multimorbid patients (>2 chronic diseases) Improved patient safety (due to coordinated treatment plan, eg avoiding contraindicated medications) Increased access to healthcare services according to need Improved quality of care (measured from patient perspective) -> improved patient-centred care Improved usage of community and social services along the care continuum improved % of patient who participated in preventive programs Improved access to social care Decreased # of hospitalisation and readmissions	Improved quality of life for patients with multimorbidity Increased healthy life expectancy
	Translation -Adapt model to local context	Model adapted	Increased number of primary care centres utilising model		
	Administration -Define case manager role and scope of practice Develop an agreed upon individual healthcare plan template - assess multimorbid patient social conditions and involve social workers	case manager role created (HR) # patients assigned to case manager (max 200) # of multimorbid pts with individual healthcare plan	Improved care coordination and decrease duplication in care provision (tests ordered etc) Providers and patients engage in shared decision-making Patients are empowered to be involved in care Social workers involved in primary healthcare teams		

	in care of multimorbid patients (when needed)	% of multimorbid patient care with social worker involvement % of multimorbid patient care screened for social problems	Patient social conditions assessed improved access to community services (through social care involvement)	Improved patient self-management of chronic conditions (defined individually by GPs for specific patient demographics) Improved intersectoral collaboration in patient care and management Improved communication and coordination among providers between different levels of care	
	Patient Education -Training patient on self-management -Collect patient self-management resources	Resources organised and disseminated to patients	Improved patient self-care and self-management		
	Relationship-building -Intersectoral collaboration between providers and health bureaus (government agency) -voluntary stakeholder meetings for dissemination of initiative (require funding by MoH)	Types (or #?) of collaborations formed # of stakeholder meetings held/year Purpose of meetings established	Improved understanding of practice scope among different providers		