Summer School
In Public Health Policy, Economics and Management

Tackling the challenge of chronic illness from patient/family and health care organization perspective

August 29 - 31, 2016

1. Profile of facilitators

Name and title:	1. Prof. Sabina DeGeest 2. Prof. Dunja Nicca
Current position and affiliation:	1. Professor and Director of the Institute of Nursing Science & Chair Department Public Health, Faculty of Medicine, University of Basel 2. Assistant Professor at the Institute of Nursing Science, Faculty of Medicine, University of Basel and the University Hospital Basel, Ressort Pflege, MTT
Areas of interest:	1. Behavioural and psychosocial issues in chronically ill patient populations; adherence enhancing interventions, also including interactive health technology; care models for chronic illness management. 2. Dunja Nicca: Self-management of patients with chronic conditions and system readiness for chronic care approaches (focus infectious diseases)
Publications :	Sabina DeGeest published many papers focusing on medication adherence, chronic illness management, workforce issues and advanced nursing practice. Dunja Nicca is author or co-author of publications focusing on symptom management, adherence and treatment readiness in patients with HIV and/or Hepatitis.
Curriculum Vitae:	**Sabina DeGeest,** PhD, RN is a nurse who leads the Leuven Basel Adherence Research Group, an international, interdisciplinary research group focusing on behavioural and psychosocial issues in chronically ill patient populations. She heads the BRIGHT initiative, an international study exploring the practice patterns, health behaviours and the relationship between system factors and health behaviours in transplant recipients, which is conducted in 4 continents, 11 countries and 36 heart transplant centres. She is currently also co-investigator of the EU-ALL funded USE CARE project.

	Dunja Nicca, PhD, RN has broad clinical experience as advanced practice nurse caring for patients with HIV and other infectious diseases. She co-leads a training program for health care providers to support treatment readiness in patients with chronic conditions. The program has been implemented in several countries. She also leads a research program developing and evaluating a behavioral intervention aiming at prevention of Hepatitis C reinfection in men having sex with men.

2. Course description

Objectives:	Managing chronic illnesses is the health care challenge for all health care system in high, middle and low income countries. This course addresses chronic illness management at the level of patient/family, health care provider (micro level) and health care organization (meso level). The overall goal is to learn how to reengineer and optimize care processes towards evidence based chronic illness management in different settings varying in health care resources. At the end of the course, participants should: • be able to critically discuss the epidemiology of chronic illness and its implications for health care delivery • know principles and outcomes of chronic care models/approaches at the patient/family and institutional level • reflect critically on patients and families involvement in reengineering chronic care approaches • understand the basic principles of psychosocial and behavioural patient assessment and intervention and know how to integrate this on a program level • understand interprofessional collaboration and coordination of care within the frame of chronic care management and know how to integrate such issues on a program level • demonstrate skills in planning improvement of the care process for a defined chronically ill population and setting

Content of the course:	The course will make visible what chronic illness management entails at the patient/family and health care organization level. More specifically, the course will address what it means for patients and families to live with chronic conditions and provide the basic principles on how health care providers can assist patients in behavioral change to adhere to therapies and to modify behavioral risk factors. Further we aim at providing the conceptual basis for organizational change towards models of chronic illness management that also include coordination of care and interprofessional collaboration within health care organizations. We will use examples of a variety of settings differing in available health care resources as well as type of patient populations.
Prerequisites:	Basic knowledge in a medical or public health field. Interest providing chronic care, developing chronic care programs or policy.
Pedagogical method:	This course will have a student project as a backbone and student learning will be stimulated by specific state of science inputs of the faculty, case studies, group work and discussions.

3. Detailed content and structure of course

Morning 11 am - 1 pm	Content	Method	Afternoon 2 pm – 5 pm	Content	Method
Monday	Epidemiology of chronic illness worldwide and implications for health care Introduction into the work with case studies	Introductory lecture	Monday	Chronic care models, approaches and outcomes Presentation and discussion of case studies	Introductory lecture Group work and discussion
Tuesday	Integration of patient and families perspective into care planning Program development, based on needs assessment	Introductory lecture Group work	Tuesday	Psychosocial and Behavioral assessment and intervention to improve health outcomes Program planning: intervention and outcomes	Introductory lecture Group work and discussion
Wednesday	Interprofessional collaboration and coordination of care	Problem Interactive lecture and discussion	Wednesday	Presentation of case studies	Group discussion

3. Self study and assessment procedure

Self study:	Büsse et al. *Tackling chronic disease in Europe*. *Strategies, interventions and challenges.* European Health Observatory 2010: http://www.euro.who.int/__data/assets/pdf_file/0008/96632/E93736.pdf Institute of Medicine. (2014) *Capturing Social and Behavioral Domains and Measures in Electronic Health Records*, Phase 2.: http://iom.nationalacademies.org/Reports/2014/EHRdomains2.aspx Lim et al *A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions*, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 2012; 380: 2224–60 Michie, S., Richardson, M., Johnston, M., Abraham, C., Francis, J., Hardeman, W.et al. (2013). *The behavior change technique taxonomy (v1) of 93 hierarchically clustered techniques: building an international consensus for the reporting of behavior change interventions*. Ann Behav Med, 46(1), 81-95. & electronic appendix Nuno, R., Coleman, K., Bengoa, R., Sauto, R. (2012). *Integrated care for chronic conditions: The contribution of the ICCC Framework*. Health Policy 105 (2012) 55– 64. Thorne, S., Oliffe, J., Kim-Sing, C., Hislop, TG, Stajduhar, K., Harris, SR, Armstrong, EA, Oglov, V. (2010). *Helpful communications during the diagnostic period: an interpretative description of patient preferences. European Journal of Cancer Care*, 19 (6); 746-54. WHO 2010. *Framework for action on interprofessional education and collaborative practice*. http://www.who.int/hrh/resources/framework_action/en/
Assessment procedure:	The group work will be presented and evaluated using peer to peer review as well as faculty review based on a structured assessment sheet