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Conference Abstract

From care in clinically complex cases to a model of integrated health and social care: The Alt Penedès Experience

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Abstract

Introduction: The Program of Chronic Complex Patient of the Alt Penedés (PCCPAP) faces the challenge of improving the quality of care to this patient profile. It determine collaborative and proactive care strategies, which are directed at adapting the use of the health and social care resources.

Location：The Health District of the Alt Penedès (Catalonia- Spain) has a population of 97.000 inhabitants and several health and social service providers. In 2010, the health care of CCP was fragmented, with a recurrent and high-frequency use of health emergency, hospital and community service. It was a determining factor to prioritize the health care to Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD) patients.

Objectives：To provide integrated health care to CCP in community environment, promoting maximum autonomy within the individual situation of complexity and dependence.

Identification of population target and organizations implied (stakeholders)：Initially CCP were identified through a predictive model of hospital re-admissions. At the present time the classification system used is Clinical Risk Group (CRG): CRG 6 to 9 with hospital admissions and long term-care during the last year. Along side the clinical criterion of the health care professionals.

PCCPAP is integrated by the three suppliers of health care of the territory (Primary Care, Hospital and Long-term care) and two providers of social services.

Timeline:

2010- 2011: design of the program, agreements and pathways in health care environment.
2011-2012: implementation in HF patients with comorbidities; evaluation of results and economical impact (16 months activity, N 149).
2012-2013: incorporation of COPD patients; evaluation 28 months later, (N 290).
2013-2014: incorporation of other chronic pathologies (N 768); implementation in the home care clinical team; agreements with the 7x24 service. Agreements with social services (pending evaluation on December 2014).

Highlights：PCCPAP reorients the existing resources, developing specific devices for the health care of CCP: A Day Hospital Unit for exacerbations of HF and COPD, a Case Management Unit (case manager nurses and social workers) by ensuring the continuity of care and managing resources.

Agreement of clinical pathways that prioritize access to resources in a personalized way. Elaboration of Integrated Care Pathways.
Development of a computer platform to share information amongst all professionals involved.

Impact and results：Evaluation results at 28 months: N= 290.
91% of CCP including CRG 6 and 7. Average age 81 years, 41% are women.
The cumulative mortality rate is 26%. The functional situation does not change, except Barthel Index.

Increase of the use of Primary Health Care resources.
Reduction of hospital admissions (Initially vs 28 months later): percentage of CCP visited in Emergency department (84.6% vs 52.4%) and hospital admissions (70.5% vs 42.8%).

Conclusions： Results show a favourable trend in reduction on the use of specialized health care resources and the adequacy of the use of primary care resources. The proactive care is efficient to control exacerbations and complications, allowing to adapt the resources to patient profile of clinical and social complexity.

Learned lessons: The integral and integrated approach between health and social care levels of CCP is a challenge for professionals, which requires time, training and periodic evaluations to guide the consolidation of efficient strategies.

Keywords

chronic complex patient; proactive care; integral approach

PowerPoint presentation

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