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CONFERENCE ABSTRACT

Providing integrated care to persons with severe intellectual disabilities living in a residential facility

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Introduction: (comprising context and problem statement) Patients living in our nursing home suffer from severe intellectual disabilities (SID), need a widespread support, have legal incapacitation and their health status is characterized by aging, comorbidity, risk of complications and exacerbations, polypharmacy and high complex needs.

Due to their difficult clinical management and the high intensity of interventions, there is a huge use of health and social resources.

Lack of coordination is widely considered to be one of the key causes of poor quality of care, therefore primary and hospital coordination is important to avoid the negative impact derived from fragmented provision.

In this context, our challenge has been to develop an integral, integrated and patient-centred approach by working on collaborative strategies involving both health and social care across different providers of the territory.

Short description of practice change implemented, aims, target population and key stakeholders involved: An interdisciplinary team composed by centre professionals (manager, senior nurse, social worker and family physicians) and referent professionals from different territorial health services (general hospital, intermediate care hospital and community emergency departments), developed health and social integrated pathways aimed to:

- Promote best practices in SID population, improving their quality of life.

- Implement collaborative integrated care approaches.

- Ensure healthcare attention adjusted to values and preferences expressed by patient's relatives and legal representatives by an advance care planning (ACP) process.

- Develop case management-based procedures.

- Optimize the use of resources by reducing both avoidable admissions to hospital (specially for emergency visits and hospitalization) as well as transfers to outpatient clinics.

- Create an integrative model for SID that becomes a reference for other nursing home institutions.

Key findings (results, outcomes, impact) Since November 2013, 100% of persons living in our center have been identified by complexity profile and have an integral and proactive care plan to apply in case of crisis.

ACP with patient's relatives and legal representatives has been launched in 100% of patients with advanced conditions and limited life prognosis.

For high complex situations, interdisciplinary care plans have been established by collaborative case conference strategies.

All directives have been placed in shared electronic clinical charts that can be 7x24 consulted by all health professionals in all Catalan public health settings.

Formal agreements among all agents have been conducted to implement new modes of relationship and care maps.

Caregivers and family members actively participated along the project.

Medical interconsultations to hospital specialists are mainly done in a remote way (with a 73% decrease in on site visits to outpatient clinics).

Crisis are attended by a home-based approach, increasing the number of visits solved at the center, oftenly by intermediate care responses (68%), and finally reducing hospitalizations in a 20%.

Case manager (senior nurse) ensures quality and continuity of care and excellence of transitions.

Highlights: (discussions, lessons learned from the process of implementation, timeline, contingencies developed) Achieving integral needs assessment, proactive planning and a close co-ordination of care between territorial providers ensures optimal use of resources and improves quality of integrated healthcare, also in SID population.

ACP for persons with SID is attainable and useful to fit values, preferences and satisfaction of patient's relatives and legal representatives.

This collaborative project has been a great encouragement for working on integration between professionals from different services and thereby it has been able to acquire a better knowledge of all available resources, enabling better responses and more appropriate clinical management in the patients journey through the health care system.

As a result of the work done, the relationship between different care agents has significantly improved as well as has increased the satisfaction and security of family members and centre professionals.

Conclusion: (include comments on sustainability and on transferability) Care given in a integrated, integral and person-centered vision is effective, efficient and satisfactory in patients with SID profile.

The implementation of interdisciplinary teamwork programs in SID residential facilities involving primary care, intermediate care, hospital and emergency services as well as social facilities in the community is feasible, increases the quality of care and is associated with a better management of patient's morbidity.

Keywords: integrated care; severe intellectual disabilities; interdisciplinary teamwork; case management; advance care planning