International Journal of Integrated Care

Chandre, Marta et al 2016 Addressing health care to geriatric patients in nursing homes in Barcelona and its metropolitan area. *International Journal of Integrated Care*, 16(6):A140, pp. 1-8, DOI: http://doi.org/10.5334/ijic.2688

CONFERENCE ABSTRACT

Addressing health care to geriatric patients in nursing homes in Barcelona and its metropolitan area

16th International Conference on Integrated Care, Barcelona 23-25 May 2016

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The increase in life expectancy of the population suggests a scenario for the next few decades with an aging population and exponential increase in multimorbidity. These factors determine a high risk of health and social complexity. In recent years, there has been a general movement toward implementing alternative care models. We must respond to new arising needs from this population that has become more fragile, suffering a higher level of physical and / or psychological dependence, and is highly consumer of health and social resources.

The geriatric population living in a nursing home keep their allocation to primary care team (public health) in the geographical area where it belongs. Nursing homes are required to provide enough staff to adequately care for residents (mostly private management).

Mainly action from the primary care team becomes reactive to the demands of urgent attention and the resulting administrative processes, without any proactive action scheduled. And regarding the health teams of the nursing homes, these are a heterogeneous group with a high number of professionals who do not belong to the public health system and therefore do not make use of the tools it has to ensure the continuity of care for residents.

In 2009 the CatSalut (Catalonia Department of Public Health) detects the need to strengthen care for this population. It creates a public competition to develop this program of care for institutionalized patients and Mutuam provider ends up being responsible for its implementation, and they creates the residential care teams (EAR).

The main objective is to contribute to integrated care, resolute, efficient, adequate intensity and person centered of reference population. Always according to the frailty and morbidity of this population, adapting their care and treatment plans to existing needs. The EAR works in coordination and cooperation with both the direct care staff in nursing homes as primary care and hospitals in the area.

In an initial pilot phase two basic indicators are monitored: the adequacy of prescription pharmaceuticals and the number of referral hospital emergency services. It creates a control and an intervention group and assessed the situation pre and post intervention.

The chosen area is the area north of the city of Barcelona (n=1025). The first results are rated as very good and it was decided to extend it to the entire city of Barcelona, making a

progressive deployment phases. Deployment further extends the area of Vallès Occidental and Oriental Est (2013) and in the area of Baix Llobregat Litoral i Centre (2014). All EAR that are in these areas are managed by Mutuam.

Actually the EAR are managing a population of 21.045, who are distributed in 322 nursing homes.

The service model is based on comprehensive geriatric assessment and planning approach specific to each case. Following the lines that mark the last Health Plan (2011-2015), the corrent one (2016-2020) and the PPAC (program of prevention and chronic care). In this sense, once valued residents, we identify them with the criteria PCC/MACA (high complexity /terminal illness) and we developed a plan of individualized intervention (PIIC).

The team is active all year round from 8 to 20 hours to provide scheduled service, acute care and urgent attention. It has a call-center reception where adequate resources are activated on demand.

The main results are: decrease 13.1% in overall spending pharmacy in the intervention group (according to case-control study evaluation of the pilot in 2009) and variation in emergency referrals in the Hospital Tauli Sabadell from nursing homes in the opening hours of EAR is a reduction of 27.14% ($p < 0.0001$). In the follow-up interval during 2012-2014 the reduction is 23, 26% ($p < 0.0001$).

What we've learnt from this experience is that the EAR program offers institutionalised people the most appropriate resources in the right place, avoiding inadequate transitions in health and social system.

At the same time, these results are a reflection of personalized attention focused on the person and the decisions agreed with him and / or his family, to secure the quality and continuity of care and clinical safety, when it is made appropriate use of social and health resources.

In the near future we must improve our results by identifying areas of improvement, ensuring quality and safety care, and sustainability.

The model discussed, with minor adaptations to local conditions, we believe that is transferable to other areas with high / medium concentration of nursing homes.

Keywords: nursing home; residential care teams; integrated care; frailty; comprehensive geriàtric assessment