CONFERENVE ABSTRACT

From Design to Action in Clinical and Social Complexity: Continuous Assessment of the Alt Penedés Program

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Introduction: Catalonia has started different strategies to respond to the care of complex chronic patients (CCPs) to maintain quality of care, optimize resources and respect the decisions of the patients. These experiences come under the health plan of Catalonia 2011-2015 and the Inter-departmental interaction of social and health care Plan (PIAISS).

The Alt Penedès Complex Chronic Patient Programme (PPCCAP) began in 2010 and is evolving from an oriented clinical care towards an integrated approach of complexity, incorporating social services providers in the territory and with a proactive and collaborative care strategy to improve the care of these patients and adapt the use of health and social resources.

We present the design and implementation of the program and a description of the results in 2014, fifth year of development, with the aim of measuring the impact and identify areas of improvement.

Description of the innovation or study: The previous assessments (2011-2013) of the program for Complex Chronic Patient about chronic heart failure and chronic respiratory insufficiency, showed favourable trends in the use of health resources at hospital level (reduction), and adequacy of outpatient resources (primary and hospital care) as a result of agreements between the providers of health services in the territory. In 2014, it was extended to all patients with chronic and complex profile. Agreements began with social services to establish collaborative strategies to meet the needs of chronic patients with social risk in the community environment. Likewise, began the collaboration with the Nursing Home Care Team (NHCT) in the area.

Stakeholders: two social service providers (County Council and City Hall of Vilafranca) and three health service providers (hospital care, intermediate care and three primary care teams).

2014 is the year that has included a greater number of patients in the program (1102) and which has had more organizational changes of structure and circuits:
- Inclusion of social work in the case management unit.
- Redesign and consolidation of case management circuits, continuity of care and social resources (single window).
- Shared clinical information between involved health care levels.
- Attention to relapses (Acute Chronic Patient Unit, Agreements 7x24) and end of life care.
- Agreements care for vulnerable social: Protocol of elderly abuse, Transient Home Care Service for hospital discharges...
- Start of activity of NHCT
- Improvements in the technical aids bank

**Discussion of its impact:** The expansion of the program and the qualitative aspects described in 2014 makes this as a year of reassessment of the situation and will allow us to evaluate the use of health and social resources.

**Analysis of why the innovation/study ended and an assessment of its legacy:** The included patients (1423) have an average age of 79.09 years (SD 12.3) and 52.1% (742) are men. 1062 (74.6%) are identified as CCP and 361 patients (25.4%) in Advanced Chronic Disease situation (MACA). 1022 patients (82%) have a CRG of 6 and 7. The 78% of patients have mild-serious dependency (Barthel Index) and the 38% have cognitive impairment (Pfeiffer Questionnaire).

226 patients (15.9%) were death in 2014. MACA patients’ mortality was 45.4%. 70% of MACA patients have an individual shared intervention plan (PIIC).

68.7% of patients have visited the emergency services and 48% were admitted at least one time. The use of long-term care and social resources is being analyzed.

**Key lessons:**

- The agreements between the different providers provide a comprehensive approach and individualized use of resources.
- The shared information is essential to provide consistent care while respecting individuals' decisions, as well as guidelines and agreements established with reference professionals.
- It is necessary the functional integration of all stakeholders and the establishment of new roles and devices respecting the different organizational dependencies. This is the framework that will define new resources.
- Evaluations are needed to measure the impact of the actions, identify areas of improvement and define new areas of the program.

**Conclusions:** The approach to the clinical complexity and social scene is always changing. It is necessary the constant review of the taken actions and the adaption of those actions to new realities, in order to meet the needs of people. This requires time, training of involved professionals and a strong institutional impulse that guides actions in a flexible and adaptable framework taking into account the different territorial realities.
The technologies of information and communication (TIC) are an essential tool for the exchange of information needed for the care of the CCP, for continuous evaluation to modulate attention and for the participation of patients.

The holistic approach of the Alt Penedés Program comes from previous collaborations between local health and social care providers, and the evidence obtained in previous assessments of the program that a weak social support determines greater use of inpatient resources at the expense of keeping the person in their environment.

**Keywords:** chronic complex patient; evaluation; collaborative; expansion