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CONFERENCE ABSTRACT

Metropolitana Nord Community Based Integrated Care Programme to People with Complex Chronic Conditions (Programa ProPCC): description of an ongoing implementation process

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Introduction

New theories for change are needed to adapt the care to People with Complex Chronic Conditions and high health and social needs in a more integrated way.

Short description of practice change implemented

The Programa ProPCC is a community-based programme designed in 2018 based on international evidence, a consensus reached by clinical leaders involved on care, and active people (patients and carers) involvement. The beginning of the implementation process was led by a management team expert in chronic care, and it was supported by the Department of Health of Catalonia.

Aim and theory of change

In order to improve the quality of the care process and to obtain patient-centred outcomes in an efficient way, it was urged to change the usual model, to a new multidisciplinary, multidimensional, patient-centred provision of integrated care.

Targeted population and stakeholders

People with complex chronic conditions, including advanced illnesses.

Stakeholders are several units from the Catalan Health Institute in Badalona area, North of Barcelona (territorial public provider of primary care and hospital care), that collaborate with other care providers, as home-based rehabilitation and intermediate care teams, and social services from the municipality.

Timeline

Integrated care project that started in December 2017. Three phases: Phase 1: development of theory for change (2018); Phase 2: implementation (2018-2020); Phase 3: evaluation (2021).

Highlights

- 7 multidisciplinary units in the community were involved (5 primary care units, 1 hospital-at-home unit and 1 palliative care team), that collaborate with 2 rehabilitation teams and social services from the municipality.

- In the acute hospital, a new multidisciplinary care management unit was created, to assure patient-centred care plans and support complex decisions across the whole hospital pathway.
- Several hospital departments reoriented their units to provide patient-centred care, to avoid unnecessary emergency department use and to facilitate early discharge from wards.
- Different multidisciplinary meetings were organized across the territory for the consensus of clinical decisions based on patients and carers views.
- Every primary care unit provides care to 50-100 patients. At the end of the implementation we expect having included a maximum of 500 patients.
- A reduction in hospital use (32% in emergency department visits and 14% in hospitalisations) was detected for those patients included in the programme in 2018.
- An increment of visits by primary care teams was detected.

Comments on sustainability

High sustainability expected due to the pragmatic approach.

Comments on transferability

High transferability expected due to the position of our institution in the health system.

Conclusions

We are developing a strong accessible primary care network.

Several units are collaborating with primary care teams to keep patients in the community.

Different units in the hospital are working to optimise hospital resources use.

Discussion

The programme supports a network of teams that uses a shared clinical integrated care model.

Multidisciplinary meetings and Information Technology tools facilitate patient-centred outcomes.

Lessons learned

The implementation process advances slower than expected (compassionate leadership is needed to support changes). Patient-centred outcomes have been created for the final evaluation.