
CONFERENCE ABSTRACT

3 Dimensions for Long Term Conditions - creating a sustainable bio-psycho-social approach to healthcare

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Introduction: 30% of people with long-term conditions also have a mental health condition. 3Dimensions for Long-term Conditions (3DLC) integrates psychosocial care into heart failure, COPD and resistant hypertension treatment. It is a joint effort between a mental health trust, two major acute trusts, and a university to bridge the divide between mental, physical and social care for the chronically ill— a divide costing the NHS 8-13 billion a year. 3DLC's team includes a psychiatrist, psychologist and social support worker.

Practice change implemented: Routine psychosocial screening and stepped-care referral pathway implemented, resulting in ~2000 patients electronically screened for anxiety and depression. 30% positive and referred on as appropriate. Frequent multi-disciplinary training offered to about 600 staff across primary and secondary care. Direct clinical and joined-up care were also provided to >600 complex patients who have significant mental health issues affecting the management of their LTCs.

Aim and theory of change: 3DLC aims to improve patients' physical and mental health outcomes, quality of life, and reduce unscheduled service use. We use principles of human-centred design to develop systems and infrastructure, education and training, and offer holistic clinical care so that patients are treated with a bio-psycho-social approach at all stages of their care.

Targeted population and stakeholders: We serve patients with heart failure, COPD or treatment resistant hypertension living in Southeast London. Stakeholders include trust executives, commissioners, clinical leads, community partners (charities, community psychology and social support services), academics, and patients.

Timeline: >200 patient baseline data have been collected and 6-month follow-up health and economics data will be collected and analysed by Dec 2018.

Highlights: >95% staff across 20 clinics routinely assess patients' psychosocial needs. Mental health is also embedded in regular continuing professional development for both GPs and specialists. Anxiety and depression are most common reasons for referral. 85% of appropriate patients referred engaged with 3DLC and those completed treatment demonstrated improved self-management, mood and quality of life.

Sustainability: Executive support, routine screening, multidisciplinary team working, education and training, and outcomes data collection to show value all contribute to sustainability.

Transferability: 3DLC successfully scaled up a collaborative care model from diabetes to multiple LTCs (cardiology, hypertension, respiratory) and can spread further to other specialties. We shared

our learnings and model at professional conferences in cardiology, gerontology, psychiatry, and the King's Fund.

Conclusions: 3DLC developed good working relationships with medical teams, significantly raised awareness of mental health issues and changed the delivery of care to being more patient-centered. Both staff and patients have benefited from this integrated model although the rate of adoption varies. Some have become champions for integrated care.

Discussions: Generalisable effective components of integrated care includes joint working, co-location, routine screening, and shared learning plugged into existing routines. Adaptations were needed based on nature of disease and each team's readiness for change, subculture, and existing knowledge and attitudes about mental health and social needs.

Lessons learned: Relationship building and being flexible to meet our stakeholders' needs is key to smooth adoption and creation of high value patient-centred care.

Keywords: integrated care; collaborative care; physical-mental healthcare integration; mind and body; bio-psycho-social; long-term conditions
