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Conference Abstract

Chronic care and integrated care in Catalonia

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Abstract

In Catalonia we are facing new challenges with a deep ageing process of population comparing with other European countries. In 2050 over 30% and 12% population will be over 65 and 80 years old respectively. As a consequence an increasing number of people with chronic conditions will increase very intensively. Nowdays we have 17% and 4,4% population over 65 and 80 years old

It has been introduced a new Chronic Care Programme within the new Health Plan 2011-2015, for an increasing number of population with concurrent health and social needs, especially complex chronic patients wit multimorbidity or advanced chronic patients with social needs or dependency

New goals and objectives developed by Chronic Care Programme has been incorporated into "Catalonia Health Plan" established at the end of 2011 for the 2011-2015 period. Catalonian Health Plan is one of the main important instruments elaborated by Catalonian Government. It has 31 strategic projects, 6 of them related to Chronic Care programme

This new Health Plan introduces the following areas of work:
• "Integrated Care" vision (within health sector but also with Social Services)
• New contractual and financial scheme to incentivate Integrated Care
• A more interactive and interoperative Health Information System (Common Clinical record, Personal Health Folder which facilitated non presential care and direct acces by patients and citizens)
• Population Stratification by using Clinical Risc Groups by 3M enterprise to support clinicians to identify people who could be at risk (hospitalization risk, readmission risk, death risk)
• Some HIS tools have been introduced to monitor indicators related to this programme, especially avoidable emergency admissions related to ACSC , based in AHRQ (American Healthcare Research and Quality Agency), 30 day readmissions, updated monthly and accessible to providers and observed chronic conditions prevalences identified by providers

The Chronic Care Programme is operating in some basic work projects:
☐ Developing Comprehensive Clinical Processes for the chronic conditions with the greatest impact in all areas, constructing Integrated Care Pathways in each geographical area which comprises a hospital, primary care centres, nursing home facilities and mental health network
☐ Strengthening health protection, promotion and prevention as instruments for maintaining health and preventing chronic disease.
☐ Promoting the self-care and personal responsibility of citizens for their health, risk factors or diseases. Successful Expert Patient Programme has been implemented with over 2,000 patients included in the programme till now

- Deploying social services and healthcare facilities working in a more integrated care approach and adequate comprehensive systems for providing care for chronic and dependent patients.
- Providing comprehensive and proactive care of patients with complex chronic disease and advanced chronic disease, assuring a 24/7 coverage model with good response to potential exacerbations of these group of patients
- Rationalizing the use of medications, especially with people with polipharmacy, improving adherence in chronic patients
- Promoting alternative non-presential model substituting presential vists by contacts (telephone and electronic messaging)
- Substituting acute conventional hospitalizations by alternatives: sub-acute facilities, day care facilities, a more proactive Home Care programmes in Primary Health Care
- Clinical Leadership will be involved in the provision design and working collaboratively with Commissioner

A pilot project implementing Integrated Health and Social Care projects in 7-8 territories will be develop in this year 2013, extending to new geographical areas in the next years.

"CatSalut" is the main guarantee of this project as a public Commissioner Authority contracting all providers operating at local level. CatSalut is the main commissioner to plan and evaluate the programme. It is the "major authority" at local level, responsible to create an Integrated Care environment

A new financial and contract scheme will be introduced in 2014 to change and transform the current health provision. Common and transversal targets have been introduced in the 2013 contract for both Primary care and Secondary Care like avoidable emergency admissions related to Ambulatory care Sensitive Conditions (ACSC)

Common and transversal objectives and indicators are being introduced like the following:
• Decreasing taxes of Avoidable Emergency Admission of Ambulatory Care Sensitive Conditions (ACSC) as both in a "composite" and specific diseases approach (COPD, Heart Failure). It has been decrease 9,43% number Avoidable Potential emergency admissions related to chronic conditions (ACSC) since the beginning of January 2012 till the end of August 2013, 18,4% in the case of emergency admissions related to COPD, 7% in the case of emergency admissions related to Heart Failure and 20,6% reduction in the case of emergency admissions related to diabetes complications
• Decreasing 30-day readmissions rates as both a "composite" and specific diseases approach (COPD, Heart Failure), with a 1,1% decrease in the case of 30-day readmissions in COPD and 4,5% in the case of Herat Failure
• Minimal rate of identification of Complex Chronic Patients and Advanced Chronic Patients who require Pal•liative approach. A basic and published Intervention Plan is expected accessible all providers through "Shared Clinical record" (HC3) and especially emergency services, from 061 Call Center till emergency provision services. Almost 50,000 patients have been identified in Primary Health care with one of the both conditions as "Complex chronic patient" or "Advanced chronic disease", with an attached and Intervention Plan published at Shared Clinical record accessible to all providers including secondary care and emergency and out-of-hours services
• Better health outcomes related to evidenced base chronic care programmes, improving health outcomes and good control in most common chronic diseases
• More than 3,000 patients have participated in Catalonia Expert Patient Program
• All geographical areas have designed and are implementing integrated care pathways related to priorised chronic conditions (diabetes, COPD, heart failure and depression)

Some of the barriers we have now to face and overcome are the following:
• Some fragmentation are present till now
• Different contractual and financial scheme for different lines (Primary Health Care, Hospital care, Mental Health, Residential Care).
• Different electronic clinical record related to different providers. Some umbrella "Shared Clinical record", called "Historia Clínica Compartida" (HC3) with increasing communication functionalities is being developed. All health providers could acces to HC3

General and extensible goals have been introduced everywhere to generate general and extensive progress but 2-3 “living labs” regions will be developed with a very intensive process of change to create an Integrated care environment incorporating synergic and concurrent actions with the same population in the same geographical area to cause strong transformation and change

Keywords

integrated care, chronic care

Powerpoint presentation:

http://www.integratedcarefoundation.org/content/policy-making-towards-integrated-care-apply-regional-policy-frameworks

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