POSTER ABSTRACT

Organizational and care model analysis for c3-cloud deployment preparation

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Introduction: The C3-Cloud project http://c3-cloud.eu/ aims to enable the development of personalised care plans for multi-morbid conditions, supported by innovative ICT components, to improve delivery of integrated and patient-centred care. This is achieved through the coordination by a multidisciplinary care team MDT. To demonstrate feasibility, pilot studies will be conducted in 3 European regions: Region Jämtland Härjedalen RJH, Sweden, South Warwickshire SWFT, UK and Basque Country BC, Spain.

Short description of practice: We describe the pre-implementation phase to support the implementation of the C3-Cloud care model during the pilot study. The results comprise of prototypes that will be tested in each site. They include: i organizational model description in C3-Cloud scenario, ii key factors at system level and care coordination iii relation between actors, activities and C3-Cloud solutions.

Aim and theory of change: The aim is to define organizational prototypes in each site. The theory of change is based on the identification of the organizational model changes required for C3-Cloud solutions to work consistently across different organizational settings and population groups, accordingly to C3-Cloud care model.

Targeted population and stakeholders: Multimorbid patients who are 65+ and have at least two or more of diabetes, heart failure, renal failure and depression.

600 intervention and 600 control patients and 62 MDT members. MDT is comprised of health professionals, social care workers and homecare providers.

Timeline: The study is divided into a pre-study phase, a study phase and a post-study. This work has been developed in pre-study phase.

Highlights: The analyses of system factors have shown differences among the three sites, in various domains, as the resources of the community. The implementation of C3-Cloud speeds up communication among actors. The patients participate in a higher number of activities and the teamwork is strengthened. C3-Cloud supports the formal introduction of all actors in the preparation of the work plan and increases patient involvement.

Sustainability: We will use the human resources available in the settings and the technological resources generated along the project, facilitating subsequent deployments.

Transferability: It will be supported by the development of guidelines for any organisation to implement the necessary changes.

Conclusions: The three pilot sites have good health systems that comply with most of the organizational model prototype requirements. Organizational and geographical settings and place of service for interventions are defined. Care coordination actors, activities and interpersonal communication are in place. However, several areas as alignment of incentives and patient involvement require further research for C3-Cloud care model.

Discussion: With the information collated to date, pilot sites are carrying out further work to develop the capability identified infrastructure, skills and organizational practices to provide the C3-Cloud model care. The aim is to implement the suggested changes to adequately deploy the pilot phase of the project in the three environments.

Lessons learned:

The contribution of MDT members and patients has been crucial.

The involvement of the patient in all aspects of care is key for successful care.

Change management has to consider what is currently possible for integrated multi-morbidity care pathway adoption.