Basis for a Integrated Health and Social Care Plan for Catalonia:

The journey towards a new model of Integrate health and social care

Barcelona, 13rd November 2014
Session structure

- A new and different **Health Plan** and the introduction of a new STORY

- **Chronicity Prevention and Care Program**: the “journey” toward Integrated Care

- **Complex Chronic Care** as catalyst of Integrated Care

- A new journey toward a new Integrated health and social care model

- **ICT developments** to support new Integrated Care model. **HC3** and “**i-SISS.cat**” contribution
Health Programs: Better health and quality of life for everyone

Transformation of the care models: better quality, accessibility and safety in health procedures

Modernisation of the organisational models: a more solid and sustainable health system

For each line of action, a series of strategic projects will be developed, which make up the 31 strategic projects of the Health Plan.

Strategic lines of the Chronic Care Program

2.1 Integrated clinical processes
2.2 Protection, promotion and prevention
2.3 Co-responsibility and self-care
2.4 Alternatives in an integrated system
2.5 Complex chronic patients
2.6 Rational prescription and use of drugs

All strategic lines require ICT tools and developments
Taking care of complex patients

- Healthy: 33%
- Chronic non complex: 62%
- Complex: 3.5%
- Advanced: 1.5%
- End of life
- Bereavement

Approaches:
- Preventive approach
- Curative approach
- Palliative approach
- Selfcare
- Collaborative care
Integrated Care Pathways

- Integrated Care Pathways as a **formal agreement** among professional **clinical leaders** at local level
- Based on **reference clinical guidelines** and **best evidence practice**
- **Critical key points** identification
- **Critical variables** uploaded at **Shared Clinical record**
- 80% of territories implemented 3 of 4 chronic conditions: COPD, depression, heart failure and DM2. Now **Complex Chronic Care Pathways** work
- Other 6 conditions to be included in the future
**WARNINGS and ALERTS**

**Challenge:**
To incorporate new hospitals beyond ICS and long term care facilities guaranteeing “Transitional care” with Primary Health Care and Social Services.
Basis for a Social and Health Integrated Care Plan for Catalonia: PIAISS
25th February 2014: New Government Agreement where is launched a new Integrated Health and Social Care Plan in Catalonia Accountable and reporting to Department of Presidency
Policy

Making sure health and social care services work together

Integrated Health and Social Care is high priority and policy in England

Press release

Integration pioneers leading the way for health and care reform

Care Minister announces details of fourteen areas leading the way in delivering better joined up care.

Fourteen pioneering initiatives are transforming the way health and care is being delivered to patients by bringing services closer together than ever before.

The pioneers are showcasing innovative ways of creating change in the health service, which the Government and national partners want to see spread across the country. Care and Support Minister Norman Lamb announced today.

Integration of Adult Health & Social Care Integration Bill - Programme for Government 2012-13

The integration of adult health and social care represents the radical reform that is needed to improve care, particularly for older people, and to make better use of the substantial resources that we commit to adult health and social care.

The Integration of Adult Health and Social Care Bill will bring forward legislation to create Health and Social Care Partnerships, which will replace Community Health Partnerships and will be the joint and equal responsibility of Health Boards and Local Authorities.

The Bill will put in place:

- nationally agreed outcomes, which will apply across adult health and social care, and for which Health Boards and Local Authorities will be held jointly accountable
- a requirement on Health Boards and Local Authorities to integrate adult health and social care budgets
- a requirement on Partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services.

The Bill aims to ensure that adult health and social care budgets are used effectively to achieve quality and...
Consensus i leadership with and from the sectors:

Advice committee
Participation committee
2nd level of advice committee


PROPOSTA DE DOCUMENT DE BASES CONCEPTUALS DEL MODEL CATALÀ D’ATENCIÓ INTEGRADA SOCIAL I SANITÀRIA
Catalanian Integrated Care model: Set of elements to support Integrated Care

**ENABLING ELEMENTS**

- **Shared outcome framework**: shared responsibility & joint accountability
- **Aligned incentives**: shared vision about the use of resources
- **Stratification models**: assessing population needs
- **Shared Electronic Health and Social record**:
- **Culture and change management**:

**Catalanian Integrated Care model**
- **Joint case / care load**: Shared needs assessment + action plan
- **Multi-lever approach**: ALL things at the same time
  - **Culture and change management**
  - **Catalonian Integrated Care model**: Set of elements to support Integrated Care
  - **Shared outcome framework**: shared responsibility & joint accountability
  - **Aligned incentives**: shared vision about the use of resources
  - **Stratification models**: assessing population needs
  - **Shared Electronic Health and Social record**:
  - **Clinical and professional leadership**

**Microsystems**
- Community-based and primary care leadership
- Integrated care pathways
- Multiprofessional work
- Transitional care
- Out of hours care
- Home care strategy

**Person Empowerment and Self-care**

**Health and social care local governance**

**HSC Health and Social Care Board**
Challenges to construct and Integrated Health and Social Care record

**Shared information systems: constructing a new eClinical and Social care record**

- Identify the person with the CIP (Identification Number) as a common identifier.
- Prior agreement on the coding and register of social problems.
- Prepare the local social services information system for it to be ‘interoperable’ in a short-medium term and provide a minimum set of information and variables for a Shared Social and Clinical Record.
- Access to a minimum set of information and variables of common interest on social field for the Shared Clinical Record of Catalonia (HC3). Later stage: HCSC fed with input from both health and social parties.

1st stage: generation of a Social Intervention Plan incorporated to HCSC. 2nd stage: Shared Individual Intervention Plan.

- Communication systems to improve accessibility, messaging and virtual work between social and health areas.
- Introduce social variables gradually to available health stratification.

Generalitat de Catalunya

Pla interdepartamental d’atenció i interacció social i sanitària
“Health and Social” Integrated eCare

Pilot project in pioneer territories

Diagnostics/ Health problems

Pharmacy prescription

“PCC / MACA” condition

Shared Individual Intervention Plan ("PIIC")

Variables: functional, cognitive deterioration, ....

“Dependency degree” formal assessment

“Home Help” services label

“Telecare” services label

Social Care Intervention Plan

Variables: functional, cognitive deterioration, ....

Health Care

Social Care

Terminological consensus

Social diagnosis codification
North Ireland is developing and Integrated health and social care record !!!

Catalan Model of Care for people who live in nursing homes / residential care

Definició del model català d'atenció social i sanitària a les persones que viuen en els centres residencials

Challenge: We should introduce “interoperability solutions” between Shared eHR (HC3) and residential care HIS

Catalan Model of Care for home care (health and social home care & telecare)

Atenció social i sanitària integrada a domicili amb garanties
Two profiles of complexity

**PCC**
Multimorbidity
Severe unique disease
Advanced frailty

**MACA**
Limited live prognosis
Palliative approach,
Advance care planning
Care centres that have patients **classified and marked** in these two types, can **publish this label/mark in HC3**

- The classification / label must be **visible on all the screens**, given the importance of the condition

- It has been incorporated in July 2013 version to **HC3 stratification with Clinical Risk Groups (CRGs)**
共享综合性干预计划

<table>
<thead>
<tr>
<th>Key Components</th>
<th>Description</th>
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<td>Health problems/Diagnosis</td>
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<td>Active Medication</td>
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<td>Allergies</td>
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<td>Recommendations for “in case of crisis” or exacerbation</td>
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<tr>
<td>Advanced Care Planning</td>
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<td>Resources and services used</td>
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<td>Multidimensional assessment</td>
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<td>Carer whom are delegated decisions</td>
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<tr>
<td>Additional information of interest</td>
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</table>
Basic assessment in Complex Chronic Patients

- **Basic standardized and customized assessment**: Functional + Cognitive impairment + Social Risk + Depression
- **NECPAL assessment** to identify “Advanced Chronic Disease” condition
- Complementary assessment

**Challenge**: To construct an shared and joint Assessment and Intervention Plan
Complex health and social needs?

The need of incorporating Social Services in the definition of a JOINT Care Plan
Integrated health and social care: shared approach

- Multiple front door (mainly at Prim. care). Unique response
- Identification and registering (in the community)
- Join and comprehensive assessment for health and social needs
- Shared proactive action Plan
- Implementation (effectiveness, coordination, multidisciplinarity)
- Monitoring, evaluation and feedback

Empowered citizens - selfcare
Comprehensive approach
Person-centred
Community based care
Shared information
Continuity of care
Professional leadership
Shared vision & shared outcome

Case management / Shared care
2 alternative options to be decided:

1. To adapt a validated commercial solution: interRAI, SMAF, ...

2. To construct a shared need assessment instrument based on professional consensus:

*It is required to facilitate collaborative environment between professionals working in different areas of health and social services
The i-SISS.Cat solution overview:

- **INTEROPERABILITY PLATFORM**
  - **GLOBAL CARE PLAN**
  - **COLLABORATION ENVIRONMENT**
  - **360º PERSON VISION**

Generalitat de Catalunya
Pla interdepartamental d’atenció i interacció social i sanitària
Individual health and social care event timeline over a three-year period

This figure shows all contacts that one individual person had with all health and social care services over a three year period.
WHO do we like to identify people at risk?

Level 1
People with stable chronic diseases at early stage

Level 2
Chronic patients at risk

Level 3
Complex chronic patients
Comorbidity, emergency hospitalizations, A&E visits, moderate and severe dependency, polypharmacy

Self-care support

Disease Management

Case Management

HEALTH PROMOTION

Healthy people

WHO do we like to identify people at risk?
Multimorbidity unified data base

Data sources

Central Registered Insured Mortalitat (INE)

Health Problems

MDS-Hospital
MDS-PHC
MDS-MH
MDS-NH
MDS-A&E
Pharmacy (PHC and hospital provided)

Insured data source
NIA, demographic data

Diagnosis data base
NIA, tipus_codi, codi, data dx, UP, tipus_UP

“Contact” data base
NIA, dates contacte, UP, tipus_UP, urgent, CatSalut, T_act.

Pharmacy data base
NIA, ATC, data dispensació, unitats, Import

MDS-Social Services
Clinical Risk Groups and levels of aggregation

Standard aggregation → 1,000 groups (CRG)

- Health Status
  - St. 9: High need condition
  - St. 8: Severe neoplasm
  - St. 7: Chronic condition 3 or more organs
  - St. 6: Chronic condition 2 organs
  - St. 5: Chronic condition
  - St. 4: Minor chronic condition diff. organs
  - St. 3: Minor chronic condition
  - St. 2: Acute condition
  - St. 1: Healthy

- CRG Basic
  - History of Heart Transplant
  - Metastatic Colon Malignancy
  - Heart Failure + Diabetes + COPD
  - HF + Diabetes
  - Diabetes
  - Migraine + Hiperlipidemia
  - Migraine
  - Pneumonia
  - Healthy

- Severity
  - Status 9
  - Status 8
  - Status 7
  - Status 6
  - Status 5
  - Status 4
  - Status 3
  - Status 2
  - Status 1

More than 1,000 groups. Too much!!!

In the standard aggregation (health status, basic CRG and level of severity) we obtain a basic information about health status and level of severity in less than 40 groups.
Multimorbidity in Catalonia obtained by stratification

Challenge: It is required to include “social data” to adjust stratification.
Stratification and Emergency admission risk

Classification people at risk

Identification and recording at Clinical Record

Segmentation for the proactive management of people at risk
Constructing a new GMA morbidity grouper in Catalonia

Source: CatSalut, 2013
Constructing a new stratification model for Integrated health and social care

Predictive modelling for social care: Next steps workshop

Event report

11 May 2011

To identify people at higher risk to be admitted in a nursing home or to be home social care high intensity user
Visualization in Shared Clinical Record and different RISK scores

Morbidity group and RISK calculated and published twice a year

Description of different RISK segments
Ad-hoc “queries”: Every professional could perform a basic query combining stratification and current chronic conditions and other variables (pharmacy,...)

It could be selected 1 or more chronic conditions
### Proposal of sharing indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Primary Care</th>
<th>Hospital Care</th>
<th>Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avoidable Hospital Admissions</strong></td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td><strong>Home Care program Coverage</strong></td>
<td>++</td>
<td>-</td>
<td>++</td>
</tr>
<tr>
<td><strong>Health outcomes</strong>: good control, process and treatment</td>
<td>++</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td><strong>Readmission</strong> rate in Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure (HF)</td>
<td>++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td><strong>COPD/HF Avoidable Hospital Admission</strong></td>
<td>++</td>
<td>++</td>
<td></td>
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<tr>
<td>Discharge planning in “PRE-Discharge” program</td>
<td>++</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>To ensure continuity care in “POST-Discharge” program</td>
<td>-</td>
<td>++</td>
<td>++</td>
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<tr>
<td>“Quality of life’ assessment”</td>
<td></td>
<td></td>
<td>++</td>
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<tr>
<td><strong>Challenge:</strong> To aggregate health and social care data</td>
<td></td>
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<td>++</td>
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</table>
New contract in 2013: Common **PHC-Hospital** Targets

### COMMON TRANSVERSAL OBJECTIVES (20%)

- Reduction **Avoidable Hospital Admissions Rate** (composite, HF and COPD)
- Reduction **30-day Readmission Rate** for HF and COPD (also composite)

Get minimum value prescription pharmaceutical index

- % minimum discharges with contact before 48 hours after discharge
- % minimum register screening risk factors Metabolic syndrome TMS

### SPECIFIC TRANSVERSAL OBJECTIVES ("TERRITORY") (20%)

- % minimum **PCC/MACA with Intervention Plan ("PIIC")**
- % minimum **PCC/MACA with medication review**
- % minimum **PCC/MACA with post-discharge medication conciliation**

Reduction emergency admissions in PCC/MACA

Minimum number participants Expert Patient Program

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**Challenge:**

**A new Shared and Joint Integrated Health and Social Care Outcome Framework should be developed**
Hospital admissions for ACSC

Availability of evolution of avoidable emergency admissions for ACSC per region / sector / PHC team (x 100.000 inhab. Tax)

"Composite" emergency admission tax

Includes: COPD, HF, pneumonia, DM complications, asthma, urinary infections, dehidratation, HTA

Monthly updated information!

Source: MSIQ, Catsalut

-6.5% last 24 months
Hospital admissions for chronic conditions

Availability of evolution of avoidable emergency admissions for a range of chronic conditions per region / sector / PHC team (x 100.000 inhab. Tax)

Includes: COPD, HF, DM complications, asthma, coronary diseases, HTA

Monthly updated information!

Source: MSIQ, Catsalut
Emergency admissions related to COPD exacerbation

More than a half emergency admissions compared to Catalan average (x 100,000 inhab.)
More than a half emergency admissions compared to Catalan average (adjusted data)
Emergency admissions related to HF exacerbation

Almost half emergency admissions compared to Catalan average (x 100,000 inhab.)
More than a half emergency admissions compared to Catalan average (adjusted data)
Multimorbidity unified data base

**Data sources**

- Central Registered Insured Mortalitat (INE)
- **Health Problems**
  - MDS-Hospital
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**Insured data source**

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**MDS**

- Hospital
- PHC
- MH
- NH
- A&E

SET

Integrated Database
Catalan Integrated Care model: Set of elements to support Integrated Care

- Community-based and primary care leadership
- Integrated care pathways
- Multiprofessional work
- Transitional care
- Out of hours care
- Home care strategy

Joint case / care load:
Shared needs assessment + action plan

Clinical and professional leadership

Shared outcome framework: shared responsibility & join accountability

ENABLING ELEMENTS

- Aligned incentives: shared vision about the use of resources
- Stratification models: assessing population needs
- Culture and change management

Multi-lever approach: ALL things at the same time
Integrated, community-based care, i.e. primary social and health care

Integrated Care "Home care" model

Adaptation of long-term health and social care and mental health

Regulation of care in residential care facilities

Interaction between the health and social care areas of the mental health and drug addiction and HIV/AIDS network

Improvement of the "dependency care" system

**Integrated information systems**

Collaborative and relational ecosystem

Sustainability and stability

Population-based framework of joint assessment

Integrated care as an innovative practice

Other activities

Fòrum ITESSS

# Línies de treball

1. El paper de les persones en el nou context d’atenció
2. L’atenció compartida: treballant junts amb una visió comunitària
3. El redisseny d’equips
4. Noves maneres de relació: model d’atenció no presencial
5. Sistemes d’informació sanitàries i socials compartits
6. Un marc d’avaluació comú social i sanitari

Atenció integrada: entorn d’innovació