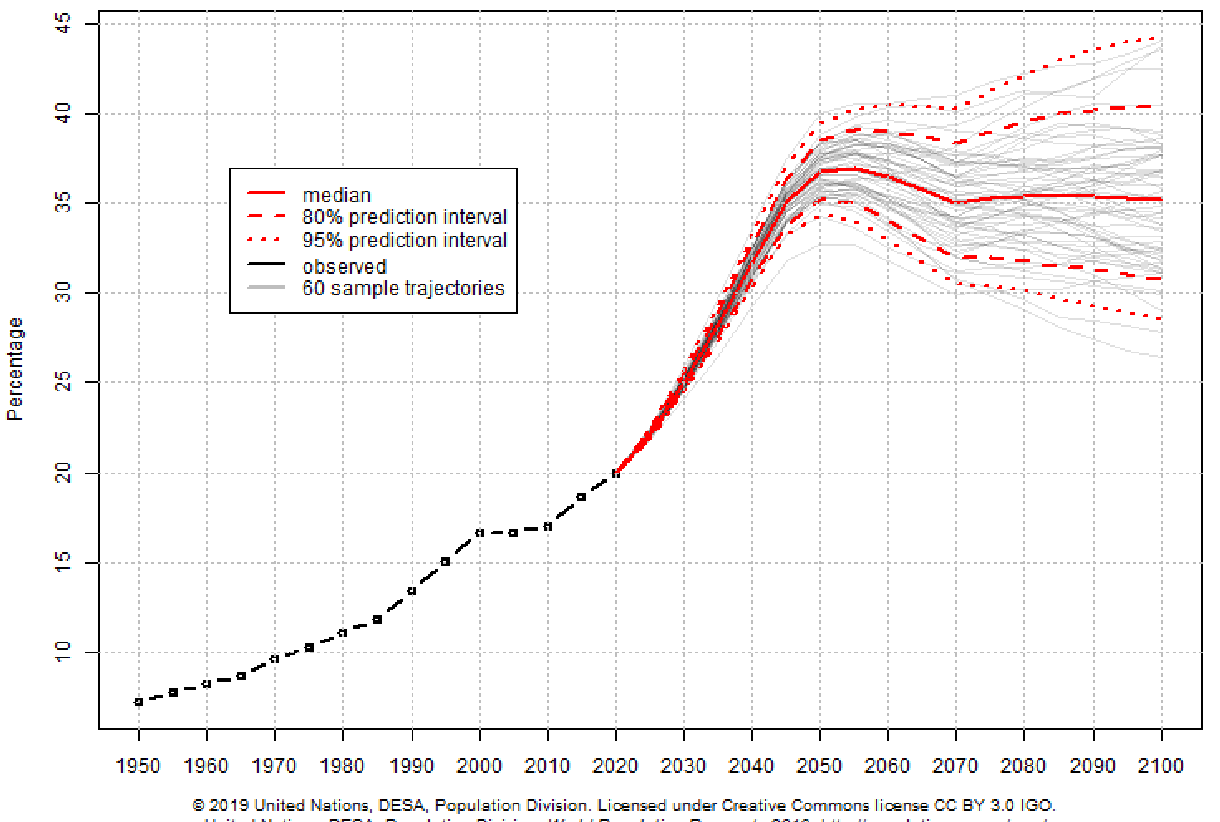
INTEGRATED CARE (Health& Social) In Catalonia

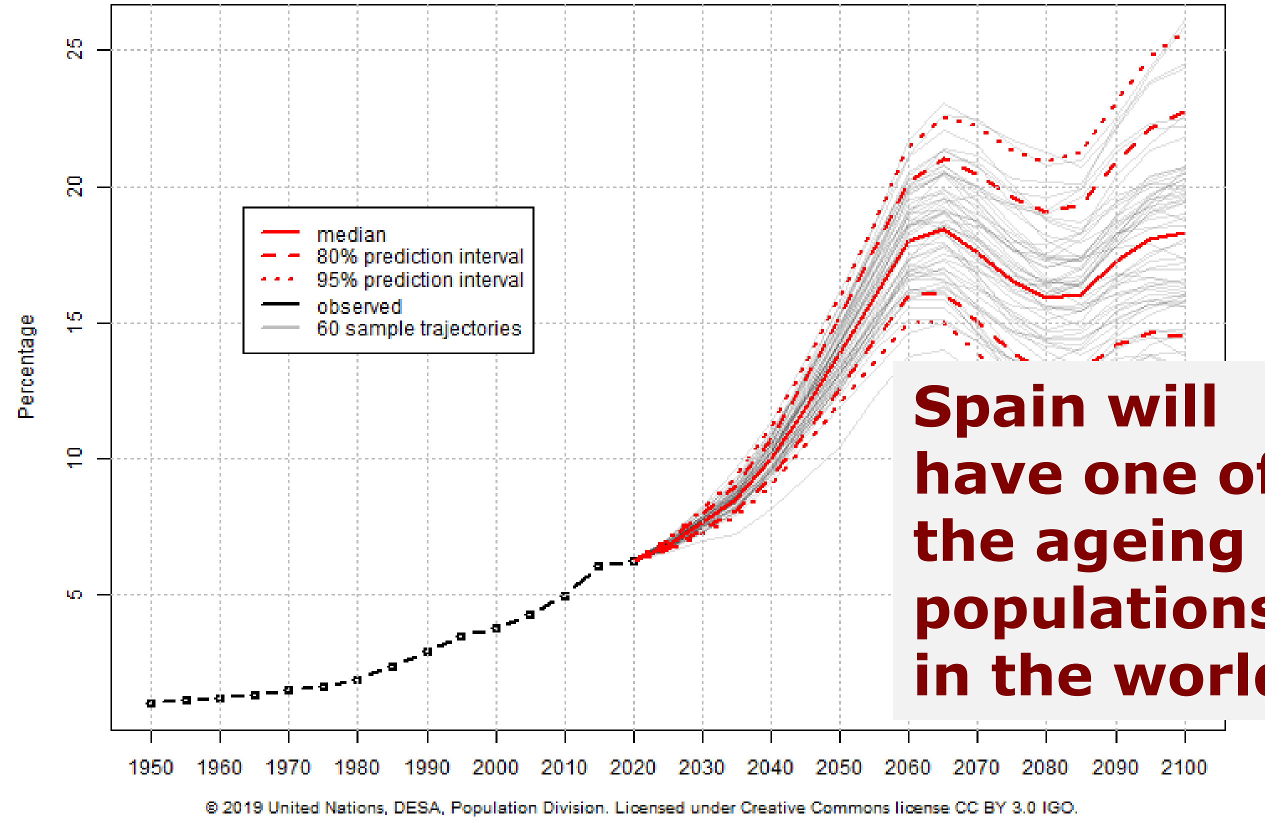
"Time of the truth"

Catalonia: our health and social services system

Social services	Healthcare services
• Exclusive **powers to regional & local government** • **Run by local and regional governments**	• Majority of **powers for the regional governments** according to Spanish law • Run by **regional government**
Different maps of service delivery areas	
Universal coverage and free access to some services (no equity among councils)	**Universal coverage & free access**
Funded by taxes but **with co-payment** for some services	**Funded by taxes**. Co-payment in pharmaceutical products
Multi-provision model	
Wide range of services covered publicly **by regional government and by local authorities**, provided directly publicly or by the Third Sector or private providers.	Wide range of publicly covered services provided mainly in public facilities **Good network of Primary Health Care (PHC) services** with practices/PHC centres covering 20-40.000 inh.
Budget: **€2.505** million €2,,090 million: regional government €415 million: local authorities	Budget: **€10.300** million

Intense ageing in Spain





Spain will have one of the ageing populations in the world

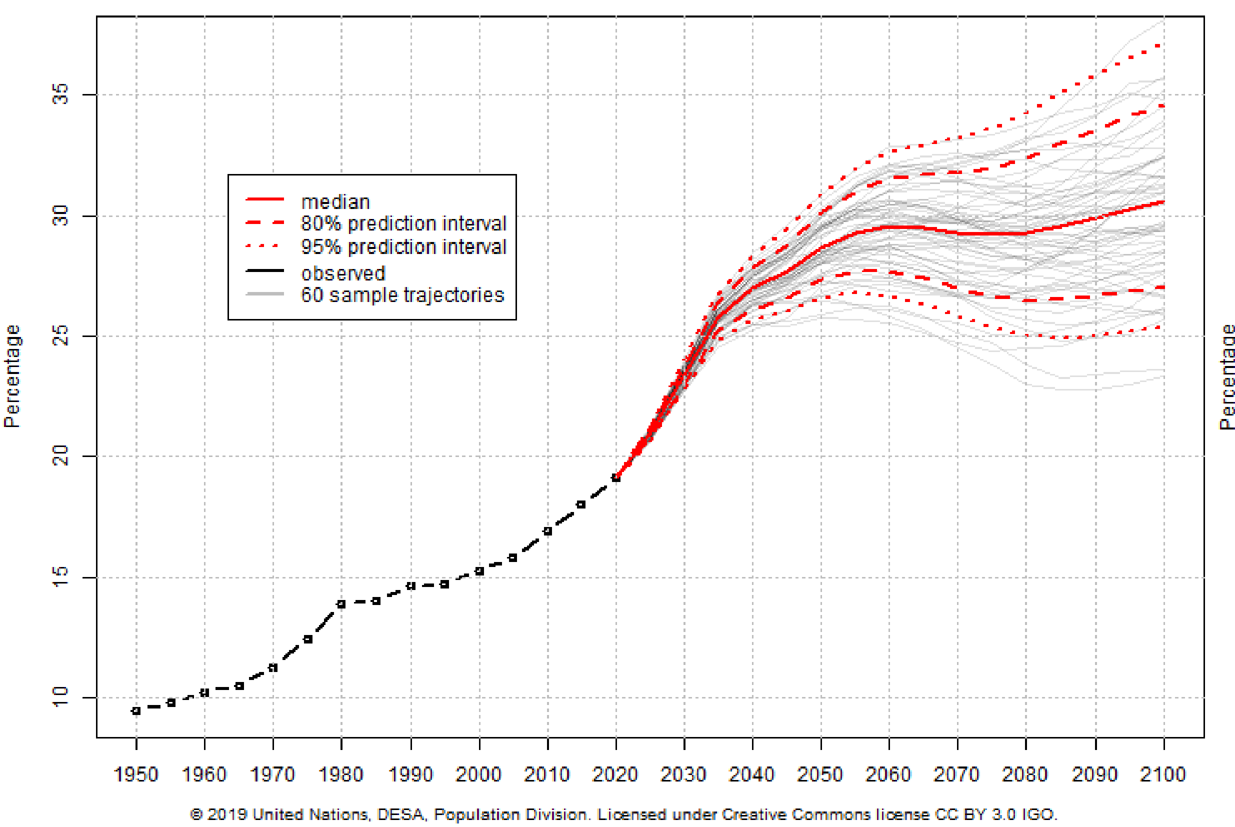
Population over 65 y.:
From current 20% till **36% in 2050**

Population over 80 y.:
From current 6% till **14% in 2050**

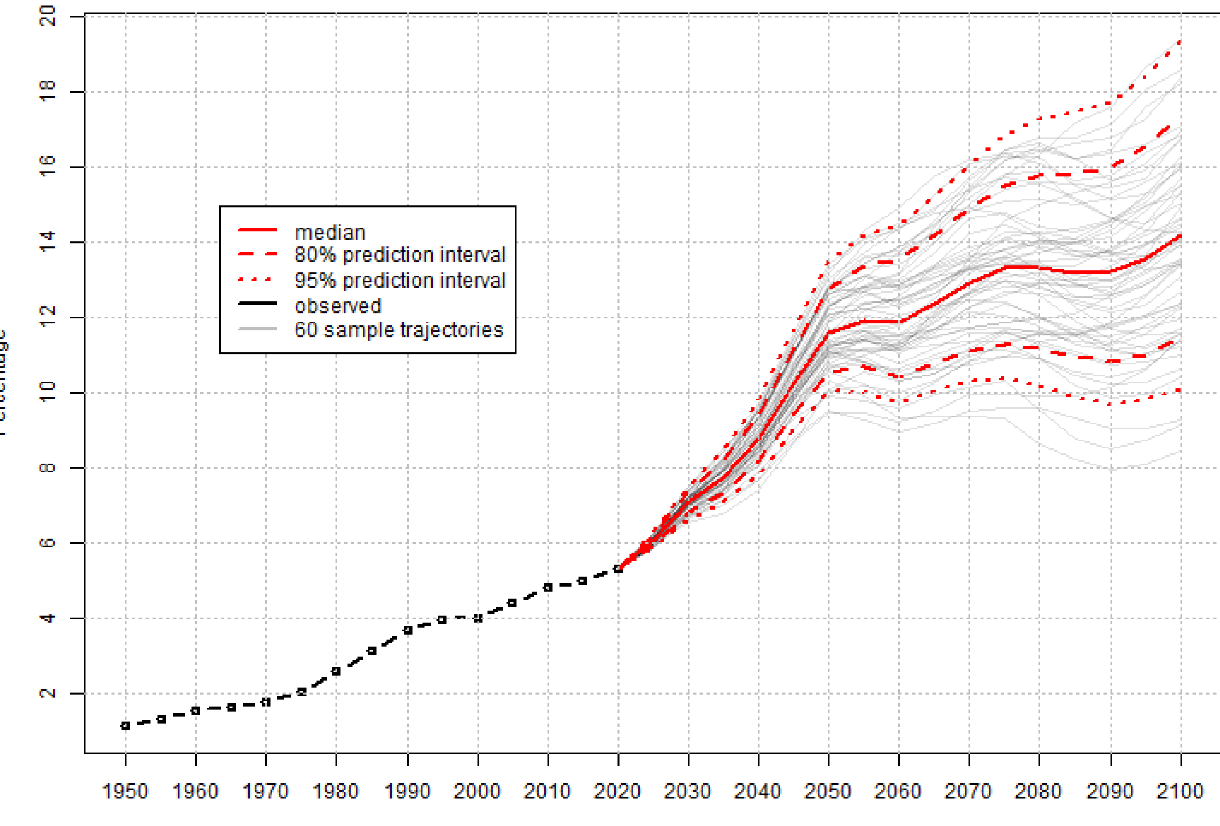
https://population.un.org/wpp/

Source: United Nations, 2019

Intense ageing in Switzerland



Switzerland: Percentage of population aged 80 years or over



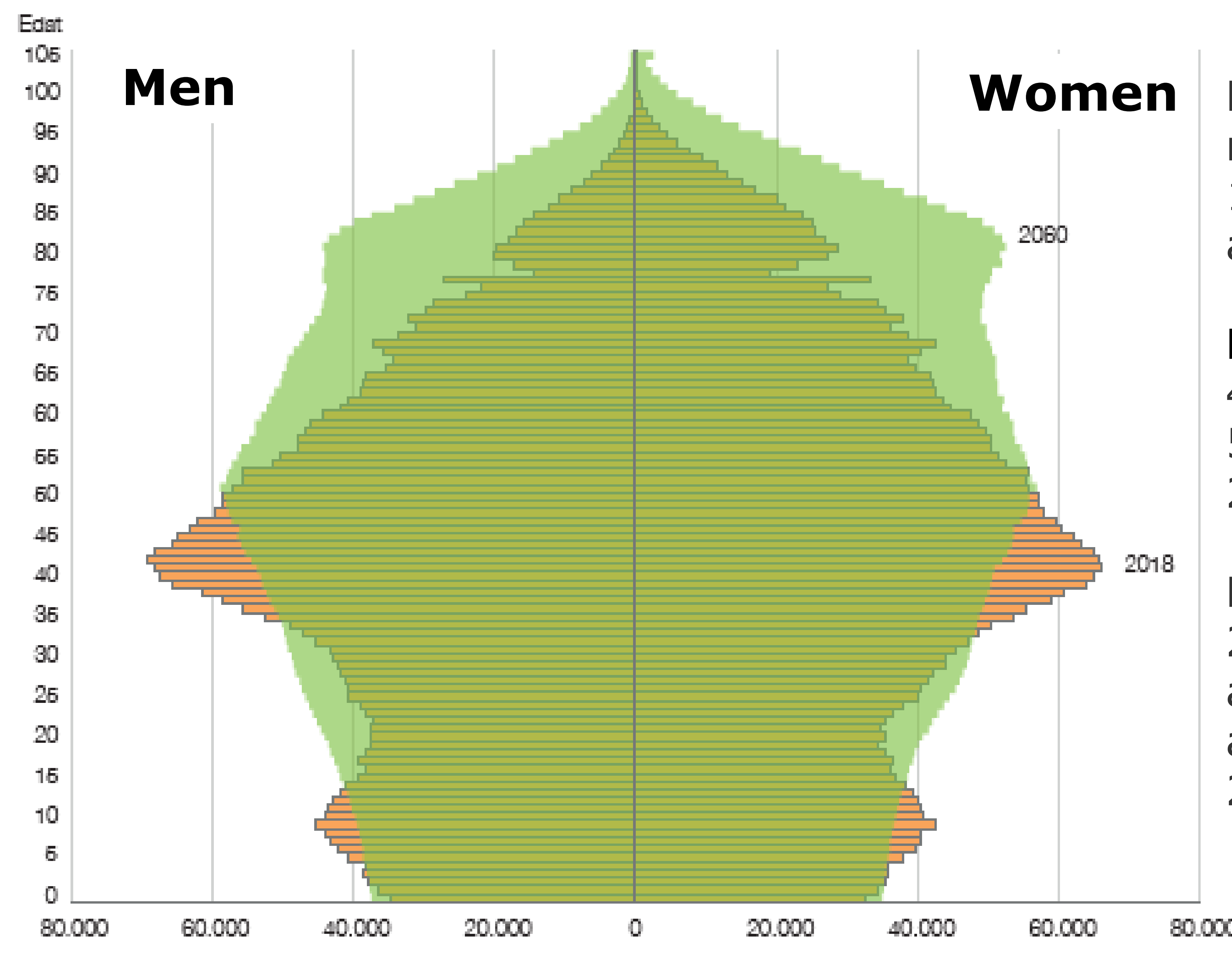
Population over 65 y.:
From current 19% till **29% in 2050**

Population over 80 y.:
From current 5% till **12% in 2050**

https://population.un.org/wpp/

Source: United Nations, 2019

Ageing in Catalonia 2013-2051



Pop. >65 years go from 1,4 million in 2018 (18,8% pop.) to 1,78 million in 2030 (22,3%) and at 2,6 million in 2060 (29,8%).

Pop. >80 years would go from 460.000 inhabitants in 2018 to 567.000 in 2030 and 1.173.000 in 2060.

Life expectancy will increase. In 2030 will be at 83,2 years in men and 88 y. in women (80,8 years and 86,3 years respectively the 2016).

Source: IDESCAT, 2019

The Catalan Health Plan 2011- 2015

Launched at the end 2011 and finished at December 2015

End of 2011

I Health Programs:
Better health and quality of life for everyone

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

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

1. **Objectives** and health programs

2. System more oriented towards **chronic** patients

3. A more responsive system from the first levels
More PHC !!!

4. System with better quality in high-level specialties

5. Greater focus on the patients and families

6. New **model for contracting** health care

7. Incorporation of professional and clinical knowledge

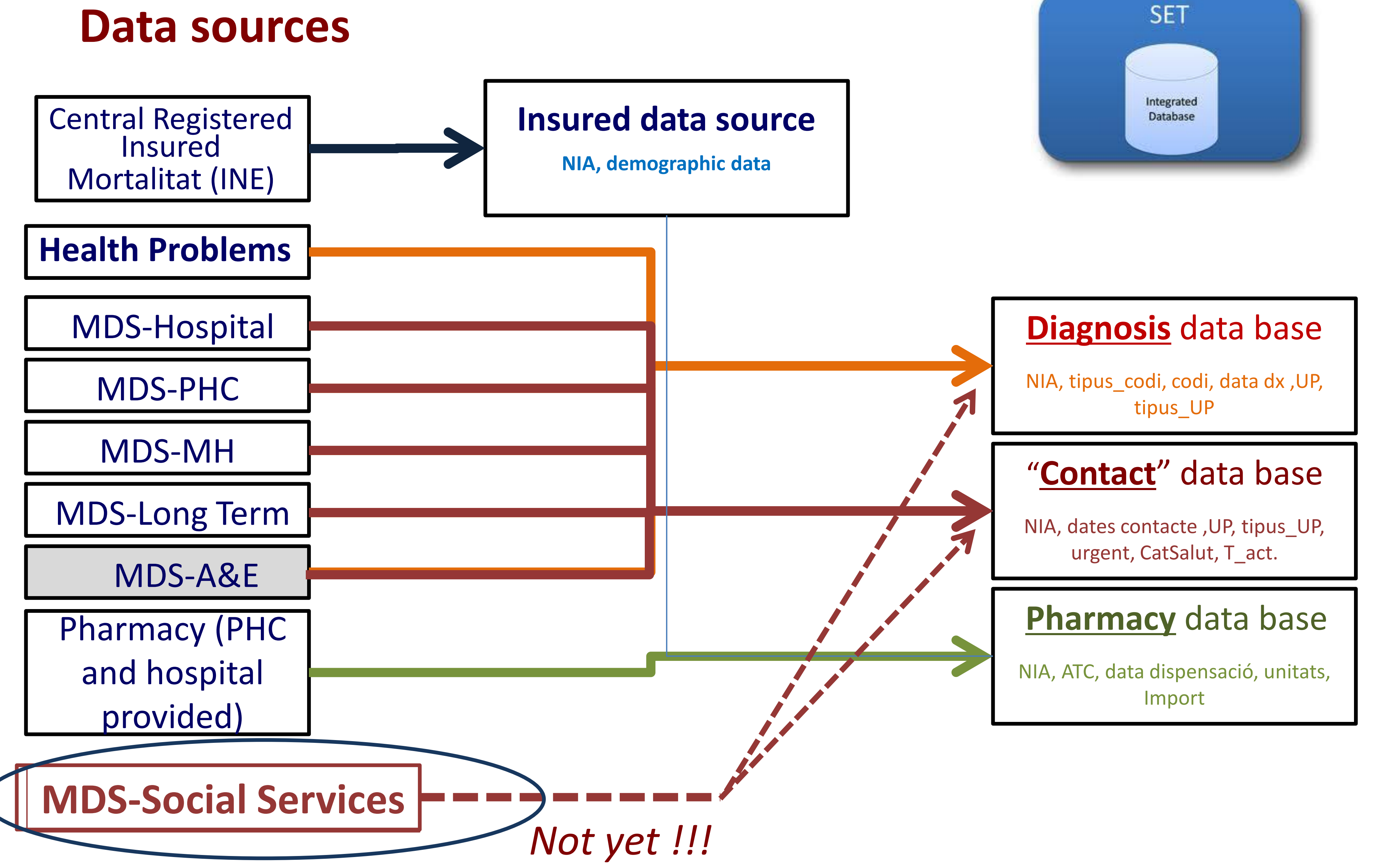
8. Improvement of the government and participation in the system

9. Improvements to **information**, transparency and **evaluation**

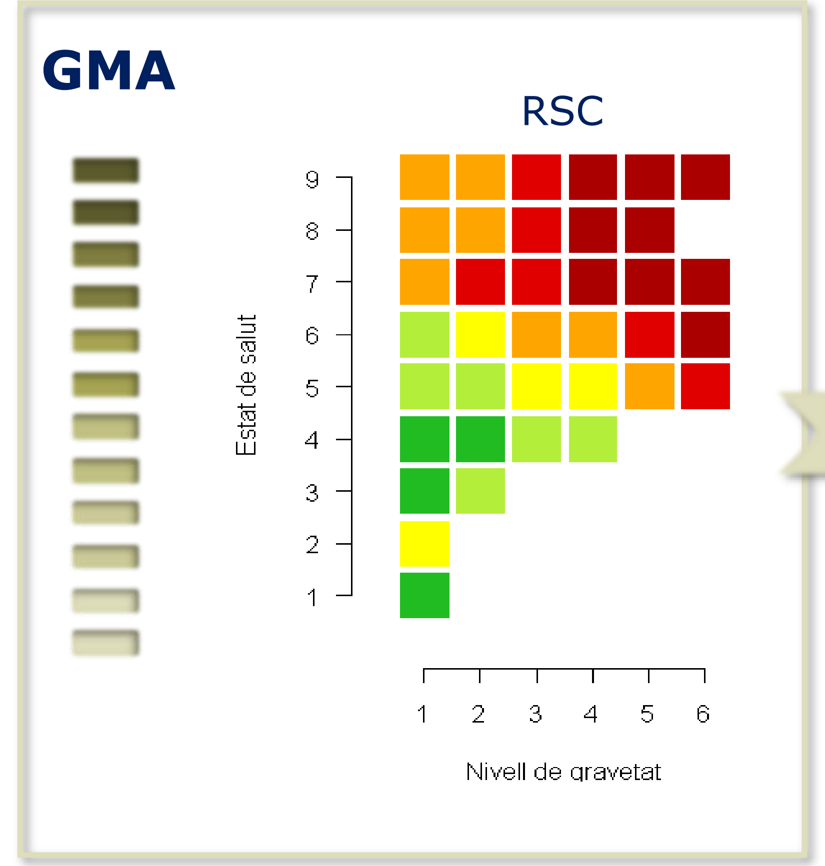
For each line of action, a series of strategic projects will be developed, which make up the 31 strategic projects of the Health Plan.

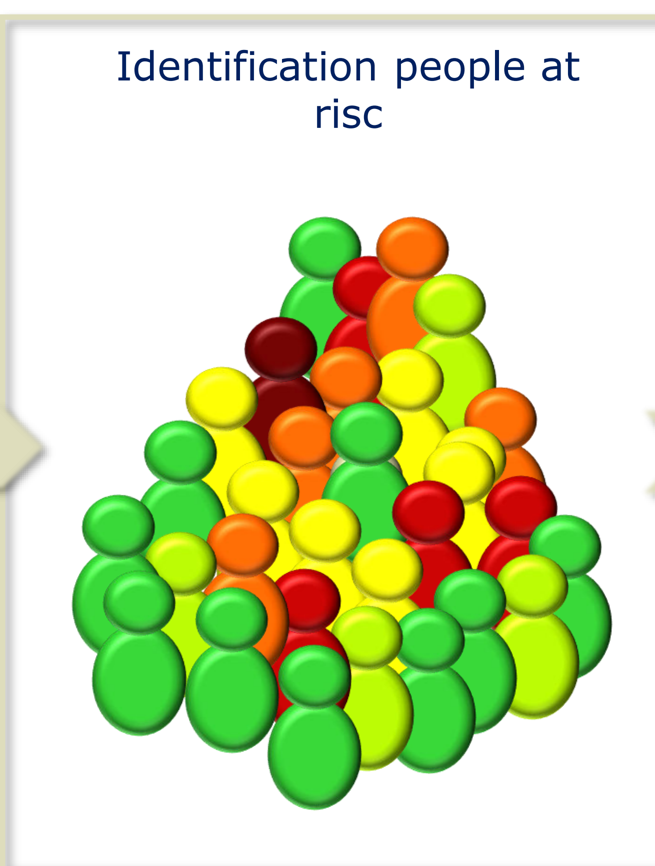
Source: Catalan Health Plan 2011-2015.

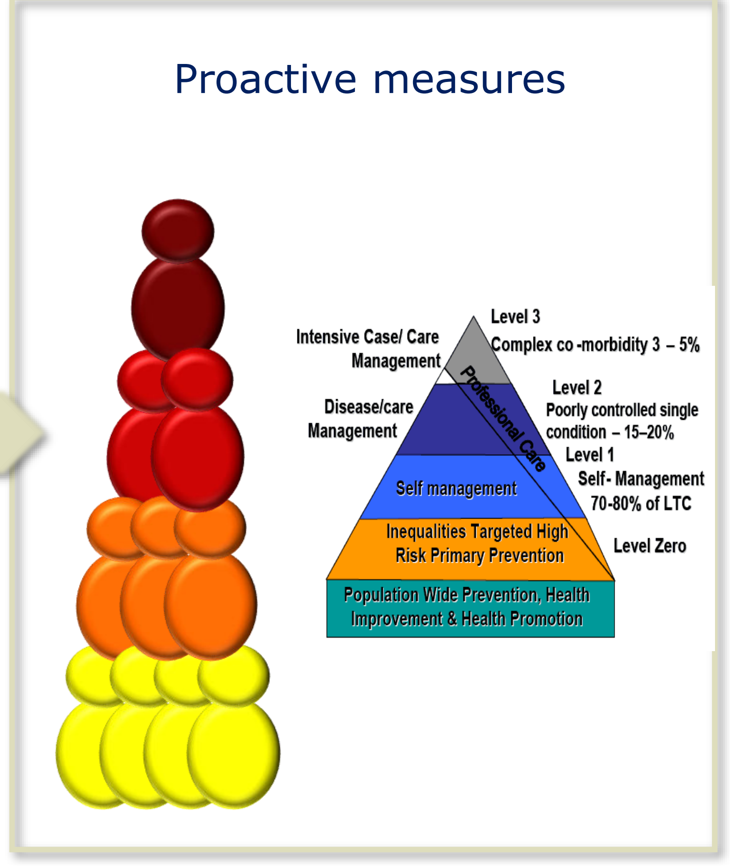
Multimorbidity unified data base in Catalonia



Stratification in Catalonia: construction own home made multimorbidity grouper (GMA)





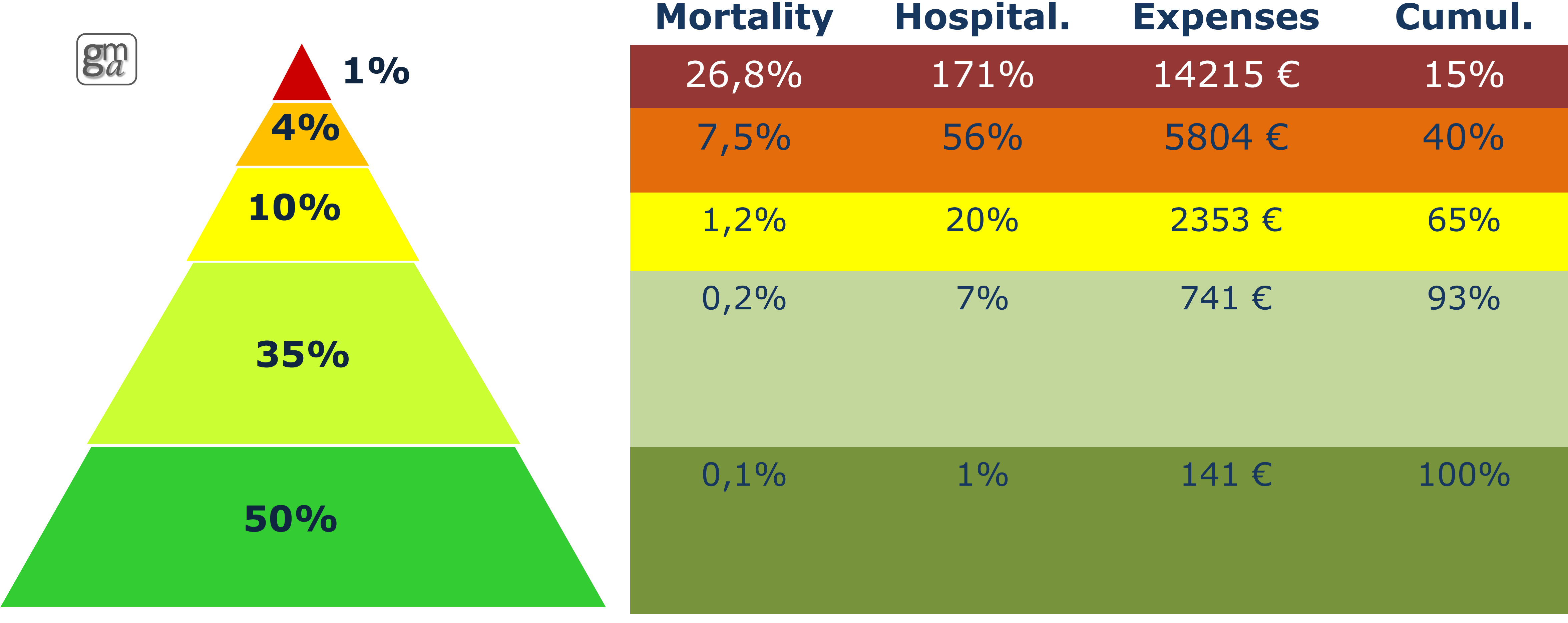


Classification people at risk

Identification and recording at ehealth Record

Segmentation for the proactive management of people at risk

Home Made Catalan "GMA" multimorbidity grouper



Mortality	Hospital.	Expenses	Cumul.
26,8%	171%	14215 €	15%
7,5%	56%	5804 €	40%
1,2%	20%	2353 €	65%
0,2%	7%	741 €	93%
0,1%	1%	141 €	100%

All citizens could be distributed in **different segments** related to expected **risk of hospitalization, death, high intensive PHC** and **pharmacy utilization**

Age-related morbidity burden related to chronic conditions

**The darkest red color the more Multimorbidity (MM) burden*

Information available at regional, county and Primary Healthcare level in a population base

Source: MSIQ, Catsalut
https://msiq.catsalut.cat/

Diabetes

COPD

Heart Failure

Chronic kidney Failure

Coronary heart disease

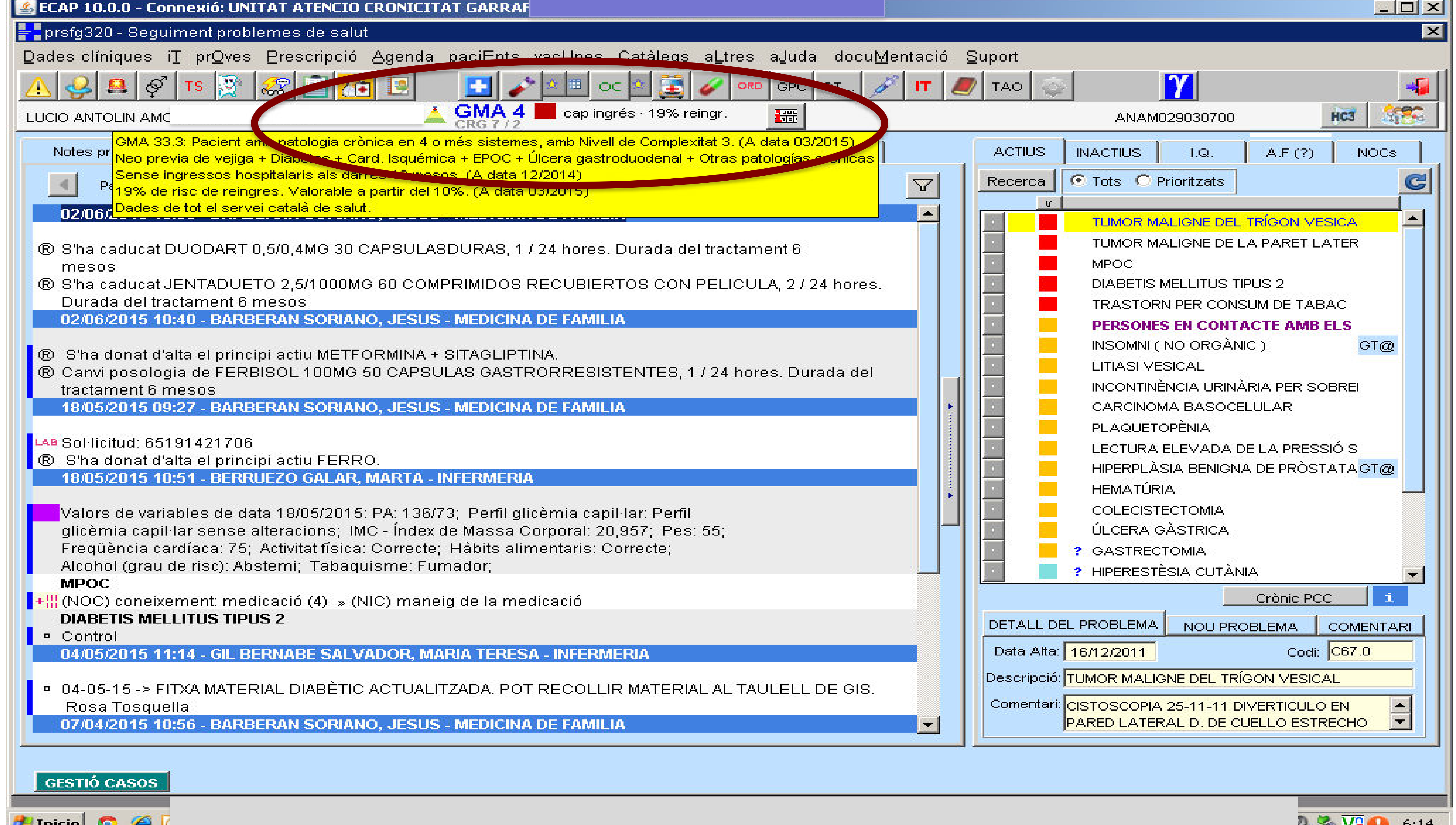
Cirrhosis

Homes | Dones

Percentatge | Percentatge

>95, 90-94, 85-89, 80-84, 75-79, 70-74, 65-69, 60-64, 55-59, 50-54, 45-49, 40-44, 35-39, 30-34, 25-29, 20-24, 15-19, 10-14, 5-9, 0-4

- Parts i nadons
- No usuaris
- Sans usuaris
- Trastorns aguts
- M. cròniques menors
- 1 M. crònica sig.
- 2 M. cròniques sig.
- Atencions especials



ECAP 10.0.0 - Connexió: UNITAT ATENCIO CRONICITAT GARRAF
prsfg320 - Seguiment problemes de salut
Dades clíniques iT prOves Prescripció Agenda paciEnts vacUnes Catàlegs aLtres aJuda docuMentació Suport
TS
OC
ORD
GPC
IT
TAO
LUCIO ANTOLIN AMC
GMA 4
CRG 7 / 2
cap ingrés · 19% reingr.
ANAM029030700
HC3
GMA 33.3: Pacient amb patologia crònica en 4 o més sistemes, amb Nivell de Complexitat 3. (A data 03/2015)
Neo previa de vejiga + Diabetes + Card. Isquémica + EPOC + Úlcera gastroduodenal + Otras patologías crónicas
Sense ingressos hospitalaris als darrers 12 mesos. (A data 12/2014)
19% de risc de reingres. Valorable a partir del 10%. (A data 03/2015)
Dades de tot el servei català de salut.
Notes pr
ACTIUS
INACTIUS
I.Q.
A.F (?)
NOCs
Recerca
Tots
Prioritzats
S'ha caducat DUODART 0,5/0,4MG 30 CAPSULASDURAS, 1 / 24 hores. Durada del tractament 6 mesos
S'ha caducat JENTADUETO 2,5/1000MG 60 COMPRIMIDOS RECUBIERTOS CON PELICULA, 2 / 24 hores. Durada del tractament 6 mesos
02/06/2015 10:40 - BARBERAN SORIANO, JESUS - MEDICINA DE FAMILIA
S'ha donat d'alta el principi actiu METFORMINA + SITAGLIPTINA.
Canvi posologia de FERBISOL 100MG 50 CAPSULAS GASTRORRESISTENTES, 1 / 24 hores. Durada del tractament 6 mesos
18/05/2015 09:27 - BARBERAN SORIANO, JESUS - MEDICINA DE FAMILIA
LAB Sol·licitud: 65191421706
S'ha donat d'alta el principi actiu FERRO.
18/05/2015 10:51 - BERRUEZO GALAR, MARTA - INFERMERIA
Valors de variables de data 18/05/2015: PA: 136/73; Perfil glicèmia capil·lar: Perfil glicèmia capil·lar sense alteracions; IMC - Índex de Massa Corporal: 20,957; Pes: 55; Freqüència cardíaca: 75; Activitat física: Correcte; Hàbits alimentaris: Correcte; Alcohol (grau de risc): Abstemi; Tabaquisme: Fumador;
MPOC
(NOC) coneixement: medicació (4) » (NIC) maneig de la medicació
DIABETIS MELLITUS TIPUS 2
Control
04/05/2015 11:14 - GIL BERNABE SALVADOR, MARIA TERESA - INFERMERIA
04-05-15 -> FITXA MATERIAL DIABÈTIC ACTUALITZADA. POT RECOLLIR MATERIAL AL TAULELL DE GIS. Rosa Tosquella
07/04/2015 10:56 - BARBERAN SORIANO, JESUS - MEDICINA DE FAMILIA
TUMOR MALIGNE DEL TRÍGON VESICA
TUMOR MALIGNE DE LA PARET LATER
MPOC
DIABETIS MELLITUS TIPUS 2
TRASTORN PER CONSUM DE TABAC
PERSONES EN CONTACTE AMB ELS
INSOMNI (NO ORGÀNIC) GT@
LITIASI VESICAL
INCONTINÈNCIA URINÀRIA PER SOBREI
CARCINOMA BASOCELULAR
PLAQUETOPÈNIA
LECTURA ELEVADA DE LA PRESSIÓ S
HIPERPLÀSIA BENIGNA DE PRÒSTATA GT@
HEMATÚRIA
COLECISTECTOMIA
ÚLCERA GÀSTRICA
? GASTRECTOMIA
? HIPERESTÈSIA CUTÀNIA
Crònic PCC
DETALL DEL PROBLEMA
NOU PROBLEMA
COMENTARI
Data Alta: 16/12/2011
Codi: C67.0
Descripció: TUMOR MALIGNE DEL TRÍGON VESICAL
Comentari: CISTOSCOPIA 25-11-11 DIVERTICULO EN PARED LATERAL D. DE CUELLO ESTRECHO
GESTIÓ CASOS
Inicio
6:14

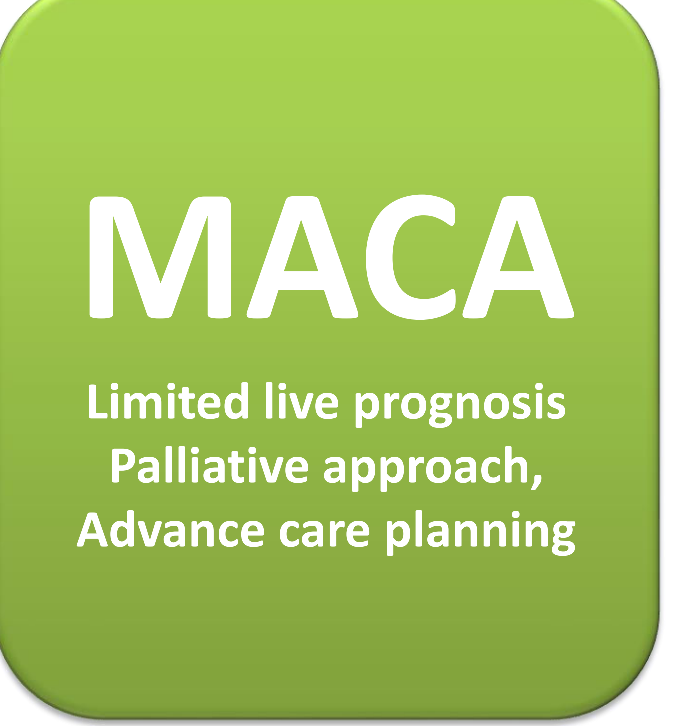
GMA 4 High Risk

...LIN AMOR (HOME, 86 ANYS)

cap ingrés · 19% reingr.

GMA 33.3: Pacient amb patologia crònica en 4 o més sistemes, amb Nivell de Complexitat 3. (A data 03/2015)
Neo previa de vejiga + Diabetes + Card. isquémica + EPOC + Úlcera gastroduodenal + Otras patologías crónicas
Sense ingressos hospitalaris als darres 12 mesos. (A data 12/2014)
19% de risc de reingres. Valorable a partir del 10%. (A data 03/2015)
Dades de tot el servei català de salut.

Two profiles of complexity



Stratification must be validated by clinicians determining "**complex chronic condition** and **advanced chronic disease**" condition

SHARED INTERVENTION PLAN (PIIC)

Informació Pla Intervenció Individualitzat Compartit

Data informe: 01/06/2013

CIP: ROEZ0620427014

Pacient: JOSEP RO EZQUE

Dades del pacient

Data naixement: 27/04/1962 Edat: 52 Sexe: Home
Domicili: CR MAJOR 109 Sabadell (08019)
Telefon1: Telefon2: Nacionalitat: ES

Dades dels professionals de referència

UP: Cap de Roses – 00130
Metge: Nom Cognom1 Cognom2 Número de col·legiat: 08041110
Infermera: Nom Cognom1 Cognom2 Número de col·legiat: 08041110

Diagnòstics rellevants

Data inici Data fi	Descripció	Centre
05/03/2006 04/05/2006	Esquinços i esquinçaments lloc inespecificat de genoll i cama. Genoll NOS, cama NOS.	Hospital Clinic de Barcelona
05/03/2006 04/05/2006	Esquinços i esquinçaments lloc inespecificat de genoll i cama. Genoll NOS, cama NOS.	CAP Sant Andreu

Pla de medicació

Data inici Data fi	Medicació	Dosis	Freqüència	Durada	Estat	Prescriptor	Finançada	Tipus de prescripció
01/11/2011 01/12/2011	COLESVIR 40MG 28 COMPRIMIDOS	1 mg	2 AL DIA	1 MES	Pendent de dispensar	Xavier Vinyals Prat	SI	Llarga durada
01/11/2011 01/12/2011	STIL BASS 310 TALLA 1 MEDIA CORTA (A-D) COMP FUERTE	1 mg	2 AL DIA	1 MES	Pendent de dispensar	Xavier Vinyals Prat	NO	Si cal

Reaccions adverses i al·lèrgies

Data inici Data fi	Tipus reaccions
05/03/2006 04/05/2006	Al·lèrgia a la penicil·lina

Recomanacions en cas de crisi o descompensació

Recomanacions específiques

	Nivell (1-5)*	Observacions
Febre	1	Comentaris
Dispnea	3	Comentaris
Dolor	5	Comentaris
Alteracions de la consciència o del comportament	4	Comentaris
Recomanació 1		
Recomanació n (fins a 5)		

* 1 Hospital d'aguts, 2 Centre sanitari de subaguts o d
immediata, 5 Consulta telefònica

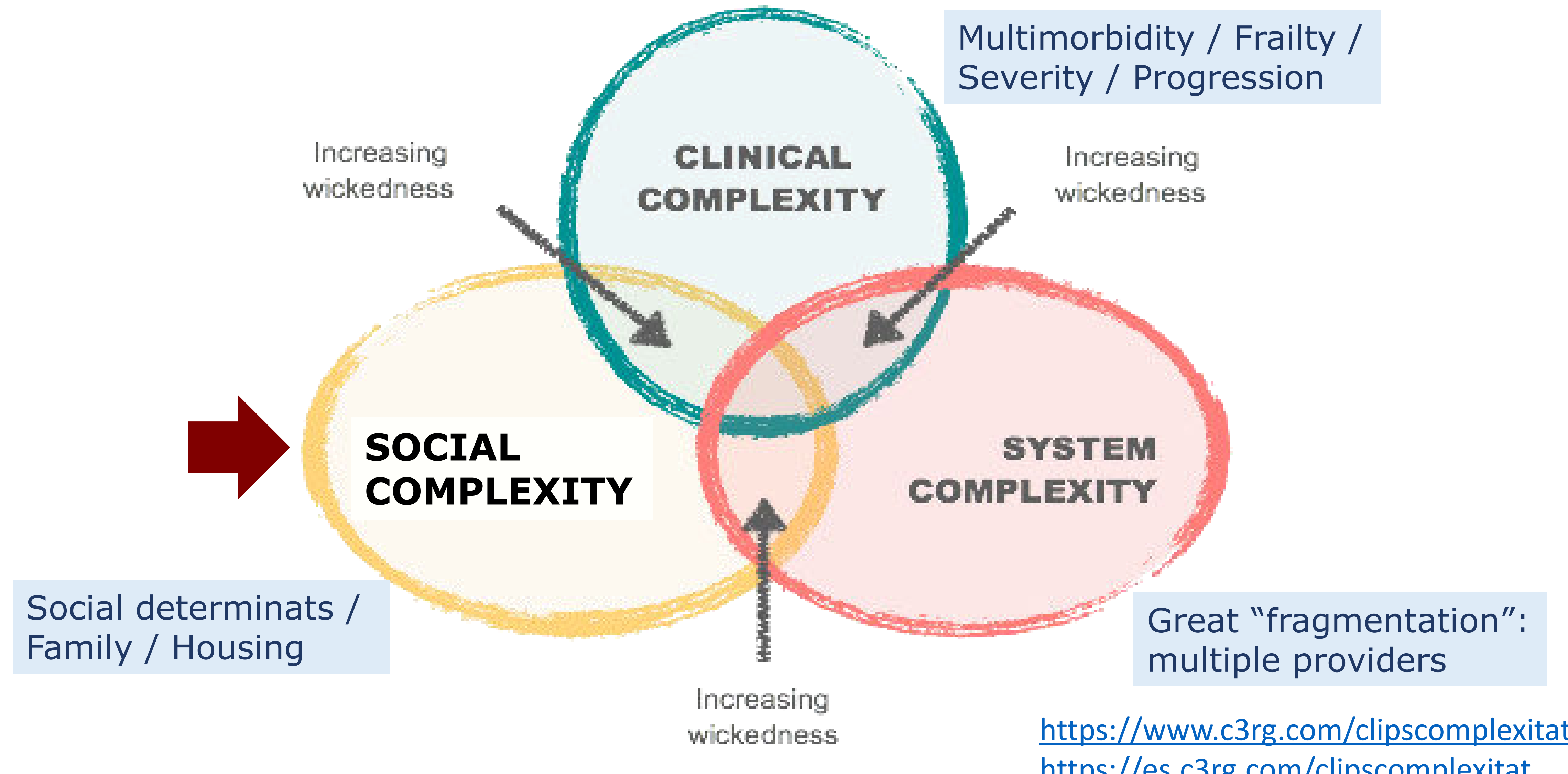
Recomanacions genèriques

El pacient ha expressat preferències sobre el lloc on vol ser at
S'han pactat explícitament amb el pacient propostes d'adequ terapèutic?
S'ha pactat explícitament amb el pacient alguna consideració

BUT only available a PIIC elaborated and published by PHC (?)

- **Diagnostics**
- **Medication Plan**
- **Allergies**
- Recommendations in case of **CRISIS/acute exacerbation** dyspnea, pain, fever, behavior change
- **Advanced Care Planning:** preferences, values, therapeu adequacy
- **Multidimensional Assessment**: functional, cognitive and social risk
- **Social Services utilization**: Home care, Home help, telecare, case management
- **Emergency admissions** and **A&E visits** in last 12 months
- **Living alone** ?
- **Caregiver** information

Conceptual model of complexity (the second conceptualization)

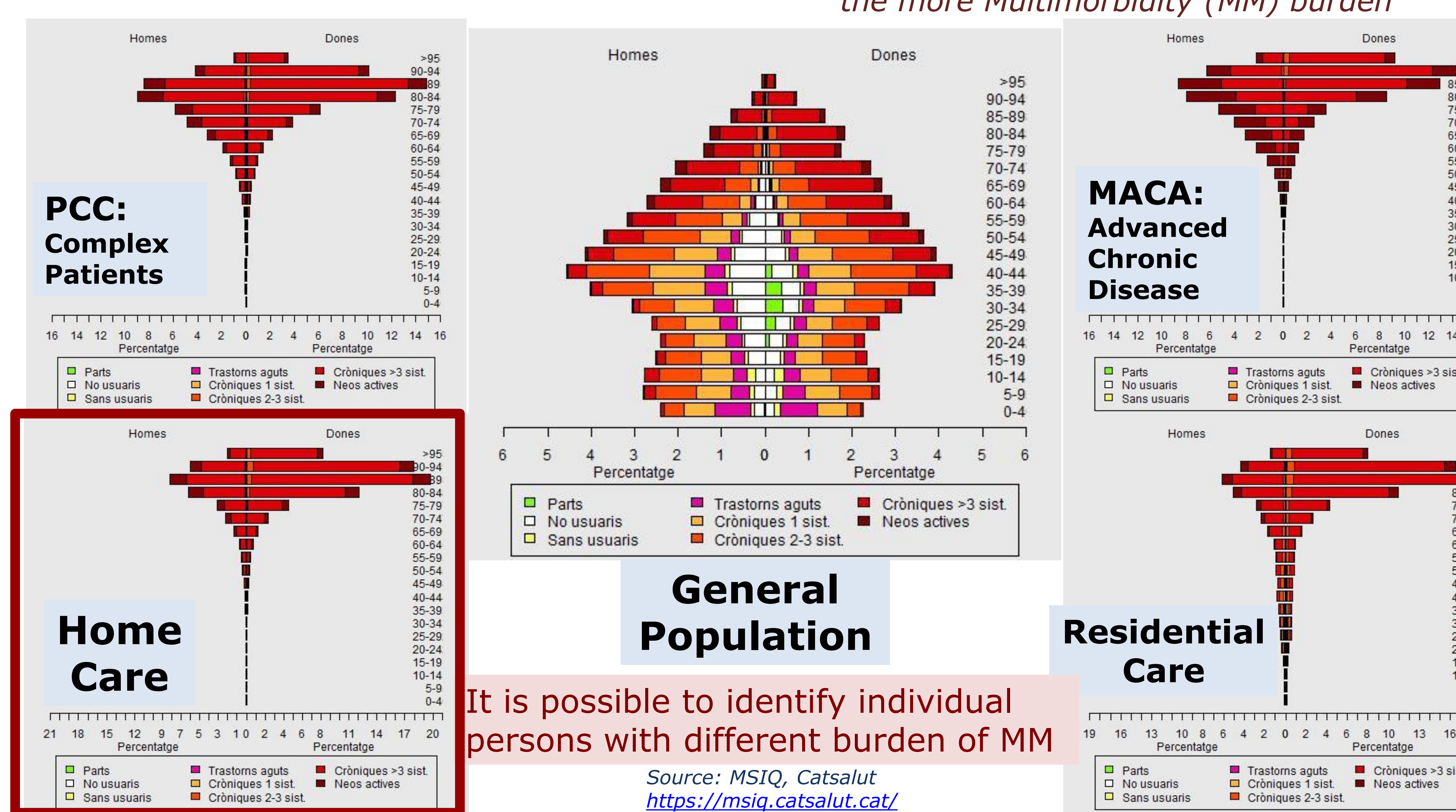


https://www.c3rg.com/clipscomplexitat
https://es.c3rg.com/clipscomplexitat

Adapted by **Jordi Amblas** of Kuipers P et al. Complexity and Health care: health practitioner workforce services, roles, skills and training, to respond to patients with complex needs (2011)

“High need” people profile

**The darkest red color the more Multimorbidity (MM) burden*



“High need” people profile

Emergency admissions rate

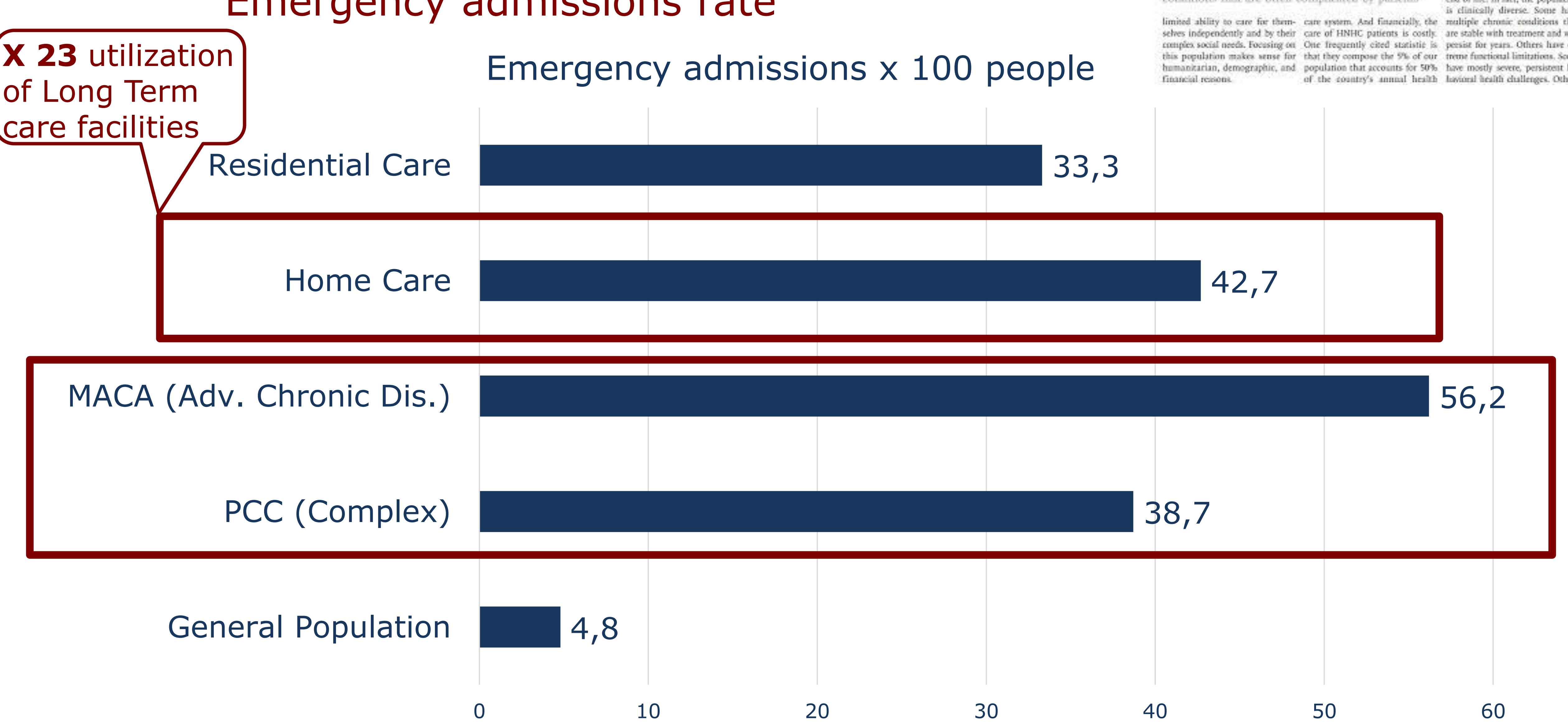
Caring for High-Need, High-Cost Patients — An Urgent Priority

David Blumenthal, M.D., M.P.P., Bruce Chernof, M.D., Terry Fulmer, Ph.D., R.N., John Lumpkin, M.D., M.P.H., and Jeffrey Selberg, M.H.A.

Improving the performance of America's health system will require improving care for the patients who use it most: people with multiple chronic conditions that are often complicated by patients' limited ability to care for themselves independently and by their complex social needs. Focusing on this population makes sense for humanitarian, demographic, and financial reasons.

care system. And financially, the care of HNHC patients is costly. One frequently cited statistic is that they compose the 5% of our population that accounts for 50% of the country's annual health

should avoid stereotypes and oversimplification. For example, some observers mistakenly believe that most HNHC patients are near the end of life. In fact, the population is clinically diverse. Some have multiple chronic conditions that are stable with treatment and will persist for years. Others have extreme functional limitations. Some have mostly severe, persistent behavioral health challenges. Others



Source: Catsalut, 2021 (data from 2020)

Emergency admissions related to Chronic cond. exacerbation

Taxa per 100.000 habitants

600
400
200
0

CatSalut
Garrotxa

2006 2008 2010 2012 2014 2016 2018 2020

"La Garrotxa" is an high performing Integrated Heath and SOCIAL Care model ("**Catalan Torbay**")

1.0
0.8
0.6
0.4

2006 2008 2010 2012 2014 2016 2018 2020

Information available at "county" level

Less than a half emergency admissions compared to Catalan average (-58%)

(x 100.000 inhab.)

Source: Catsalut, 31 Dec 2020

Salut/LogoVisor

New created Complex Care visor in eHealth record

Cronicitat

1 **Identification** — Fragilitat inicial | PCC | MACA

2 Diagnòstic situacional — **Multidimensional Assessment**

2.1 VALORACIÓ MULTIDIMENSIONAL/GERIÀTRICA RÀPIDA — Data:15/02/2021

Índex FRÀGIL-VIG — 0,70 Fragilitat avançada (0.00 — 0.35 — 0.80 — 1.00)

Dimensions

Malalties cròniques	Polifarmàcia /adherència	Funcional	Cognitiu	Emocional	Nutricional	Síndromes geriàtriques	Símptomes	Social
■ (red)	■ (green)	■ (red)	■ (green)	■ (green)	■ (red)	■ (red)	■ (green)	■ (red)

2.2 ESCALES

Funcional	Nutricional	Síndromes geriàtriques	Social
LAWTON-B 5/8 (Data: 15/02/21); I.BARTHEL 70/100 Dependència lleu-moderada (Data: 15/02/21)	MNA-SF 8/14 Risc de desnutrició (Data: 15/02/21)	EAT-10 25/40 Disfàgia (Data: 15/02/21)	E. Gijón 15/0 Risc social (Data: 15/02/21)

2.3 CATEGORIES IDENTIFICADES

	15/02/2019
Oxigenació	■ (green)
Nutrició	■ (green)
Eliminació	
Mobilitat	■ (green)
Repòs	! (red)
Vestir	■ (green)
Termoregulació	■ (green)
Higiene	■ (green)
Seguretat	! (red)
Comunicació	■ (green)
Adaptació	! (red)
Relacions	! (red)
Aprenentatge	! (red)
Dispositius	! (red)

Valoració social/psicosocial

Valoració persona cuidadora

3 **Intervention Plan**

4 Pla d'atenció individual compartit (PIIC) — Data:15/02/2021

360º vision: Retrospective contacts, emergency admissions and A&E

Health and social information sharing

Category	HCCC (Shared Medical History of Catalonia)	SIAS (Social Service Information System of Barcelona)
ID information	Name and surname ID card Date of birth Address Telephones Age	Name and surname Gender Date of birth ID card or passport Address Telephones E-mail Census
Services information	• Professionals: general practitioner, nurse • Health centre, palliative care, home care, nursing homes...	• Professional (social worker) • Social services centre
Supplementary information		• Economic information: pharmaceutical copayment • Legal incapacity: process, date, guardian
Health information	• Health factors (diagnostic) • Chronically ill categorization • Very ill categorization	• Disability: recognized level, kind of disability, disable scale. • Dependent people: recognized level. • Risk alert (coronary heart disease, fall s...)
Needs assessment	• Barthel ADL index • Lawton-Brody's index • Pfeiffer cognitive evaluation test • Zarit Burden Interview	• Barthel ADL index • Lawton-Brody's index • Pfeiffer cognitive evaluation test • Zarit Burden Interview
	Social risk factors (Health at home - *Salut a Casa*)	Social diagnosis
Intervention	• Individual health intervention plan • Individual Treatment • Previous medical discharge (24-48 ours before) • Medical discharge documents • A&E documents • EMS (emergency medical services)documents	Services: ▪ Home care services ▪ Telecare ▪ Food assistance ▪ Day care centres
Community	Programs/projects	Programs/projects

Need of Social Problems codification

SNOMED CT

- Example:

ConceptId

Concept
[81877007] Housing problems (finding)

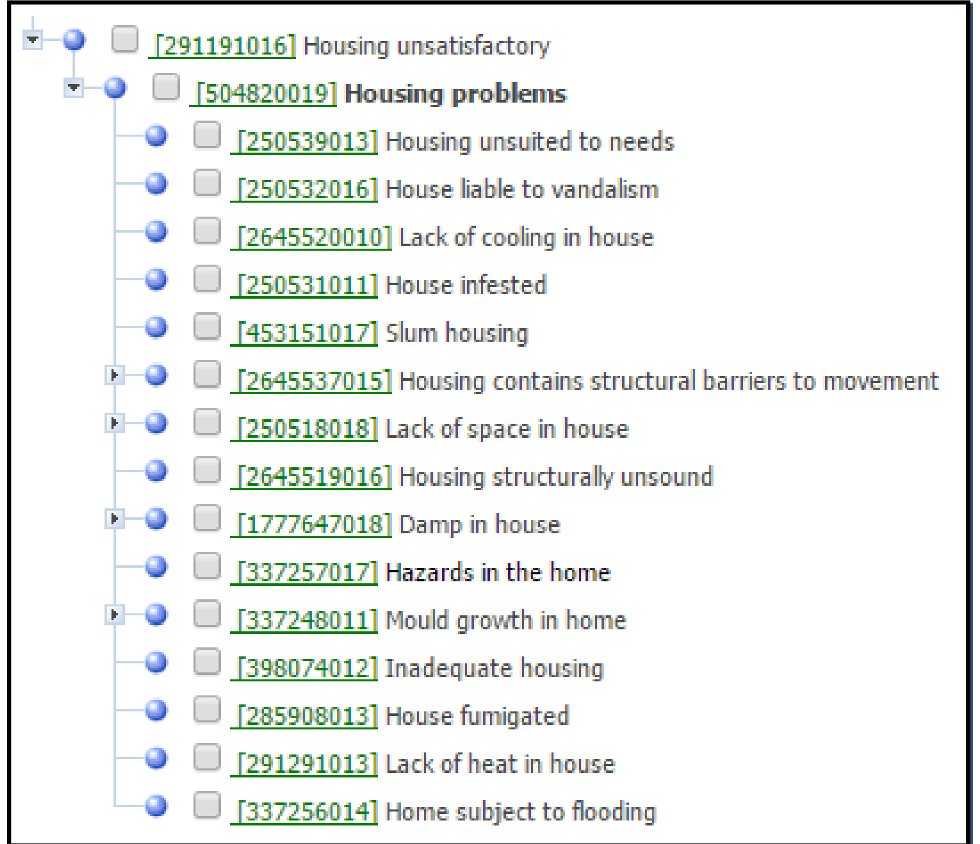
Fully Specified Name
[823196015] Housing problems (finding)

Preferred term
[504820019] Housing problems

Sinonyms
[504822010] Accommodation unsuitable
[504821015] Living conditions unsatisfactory

DescriptionIds

Hierarchy relationships



NO available international social care problems codes !!!

https://ticsalutsocial.cat/en/noticia/completion-of-the-third-phase-of-the-intersocial-project/

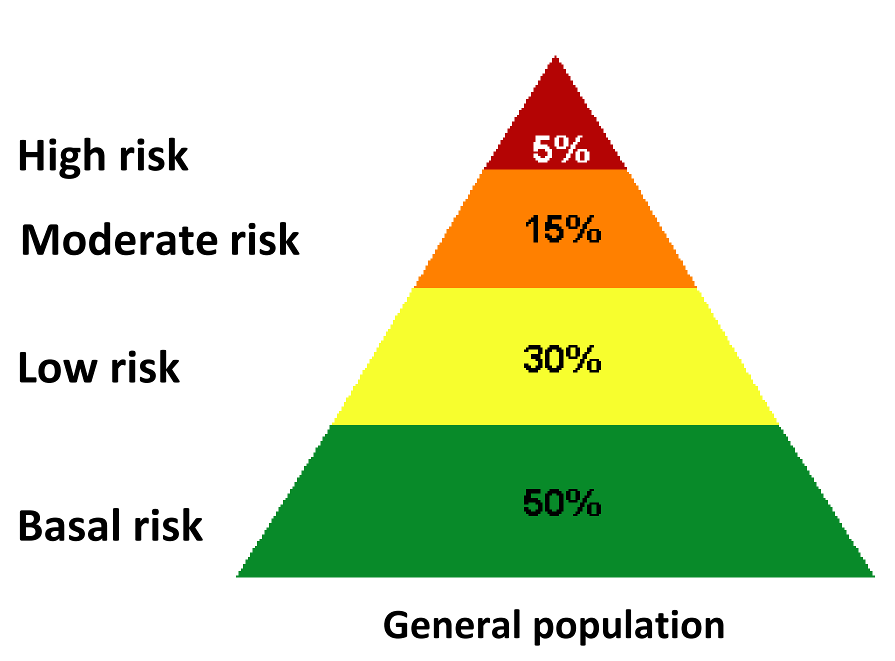
Impact analysis of Integrated home care

- Description of people included in Social Home Care (SHC): morbidity

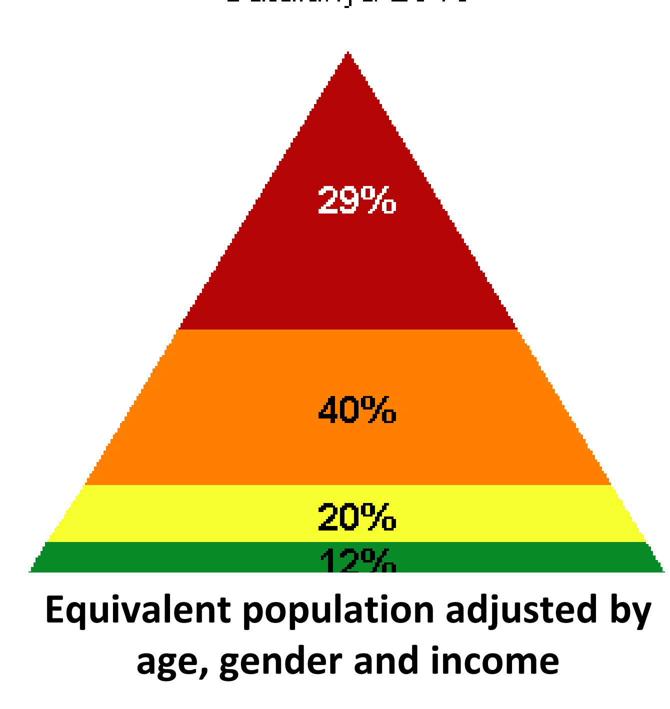
People covered in SHC have a high burden of morbidity, more than population with the same age, gender and income

Population segmentation related to risk stratification

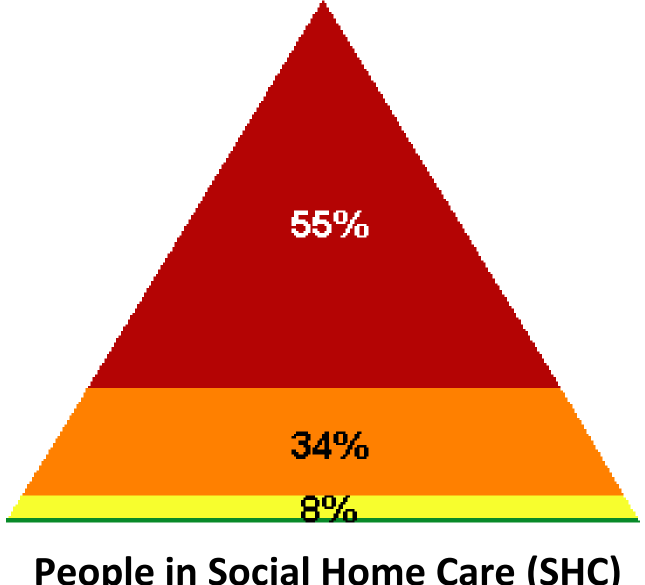
Catalunya 2019



General population



Equivalent population adjusted by age, gender and income



People in Social Home Care (SHC)

Source: CHSS | DSA

Impact analysis of Integrated home care

- Description of people included in Social Home Care (SHC): morbidity

One of the **most prevalent conditions is dementia**

Psychiatric conditions and dementia are the most prevalent conditions in **people who are covered by Social Home Care**

People included in social home care

Main comorbidities and prevalent conditions. Catalonia 2019

Source: CHSS | DSA

Impact analysis of Integrated home care

- Home Care services: Social Home Care (SHC) and Home healthcare (HHC)

Almost **130.000 people** are cared by any public financed home care service. **16% receive joint SHC and HHC**

SHC coverage:

- > 64 : 2,5%
- > 74: 4,4%
- > 84: 7,5%

HHC coverage:

- > 64 : 7,6%
- > 74: 13,7%
- > 84: 26,6%

People in social home care and/or home healthcare

Distribution per age, gender and risk level (morbidity). Catalonia 2019

	Social home care and NO home healthcare	Social home care and home healthcare	Home healthcare and NO social home care
N	28.910	20.442	79.917

Source: CHSS | DSA

The more red colour the more multimorbidity

Impact analysis of Integrated home care

- **Impact evaluation: institutionalization**

Be cared in a territory with Integrated SHC and HHC **decreases risk of institutionalization and be admitted in a Nursing Home (NH) by 20%**

Probabilitat d'ingressar en una residència geriàtrica

Persones amb SAD segons grup. Catalunya 2018-2019

Source: CHSS | DSA

Variable	HR	IC95%
Group		
Controls (without service Integration)	1,000	--
Cases (with service integration)	0,805	0,716 - 0,904
Age (in years)	1,034	1,028 - 1,039
Gender		
Male	1,000	--
Female	0,939	0,846 - 1,043
Formal level of dependency		
Level I (less dependency)	1,000	--
Level II	2,591	2,324 - 2,887
Level III (higher dendency)	2,629	2,220 - 3,113
Higher risk according burden of multimorbidity		
Base risk (lowest)	0,172	0,024 - 1,124
Low risk	1,000	--
Moderate risk	1,003	0,780 - 1,289
High risk	0,952	0,739 - 1,223
Income		
Medium and high income	1,000	--
Low or very low income	1,111	0,942 - 1,309
Rural / Urban		
Urban	1,000	--
Semi urban	1,044	0,859 - 1,269
Semi rural	1,270	1,083 - 1,489
Rural	1,357	1,14E0 - 1,616
Earlier health expenditure (per each 100€)	0,999	0,998 - 1,000

Impact analysis of Integrated home care

- Impact evaluation: health services

Starting SHC increases Primary Health Care utilization.

In **territories where there is Integrated Home Care**, the increase is higher, especially **home visits and virtual contacts.**

Decrease in admission cumulative days (including Nursing Homes)

Impact of Integrated Home Care in utilization of services (2018-2019)

1.3
1.2
1.1
1.0
0.9
0.8

PHC visits
FM visits
Nursing visits
SW visits
PHC visits
PHC home visits
PHC virtual visits
Hospi tal admis sions
ER admis sions
A & E visits
Outpa tient clinics
Phar macy
Trans port
Inter media te Care days
Admis sion cumul ative days

Source: CHSS | DSA

New Residential Care Scorecard

- New scorecard related to all Residential Care population refreshed and updated monthly
- Different indicators disaggregated to PHC areas and nursing home with benchmarking view

SISAP - Residències

Gestió d'Atenció Primària Resi

Mar 21 | QC Residències | EQA Residències

Resum | Longitudinalitat | Activitat | Perfil Residencial | GID | Cronicitat

Territori: Residències | Tria una opció:

Indicador	Resultat	Numerador	Denominador	Detall
QCRES - Quadre de comandament de residències				
QCRES01 - Longitudinalitat				
LONG0002 - % de visites fetes pel seu referent en població general	66,98	286	427	+
CONT0002 - Índex del proveïdor assistencial principal (Usual provider of care index)	57,79	9.987	17.282	+
QCRES02 - Activitat				
RES003A - Percentatge de pacients visitats en els últims 12 mesos per Infermeria	65,05	26.906	41.360	+
RES004A - Percentatge de pacients visitats en l'últim mes per Infermeria	15,14	6.263	41.360	+
RES007A - Percentatge de pacients visitats en els últims 12 mesos per MFiC	52,33	21.644	41.360	+

Indicator	Value
% people visited by PHC nurse in last 12 months	65%
% people visited by nurse in the last month	15,1%
% people visited by GP in last 12 months	52,3%
% people visited by GP in last month	15,4%
Mean score of multimorbidity burden (GMA) (score 6 in general population)	14,14
Median Barthel (“0” higher dependency)	42,62
Median Pfeiffer (cognitive)	4,23
Mean age	85,6 y.

Source: SISAP, March 2022

New Residential Care Scorecard

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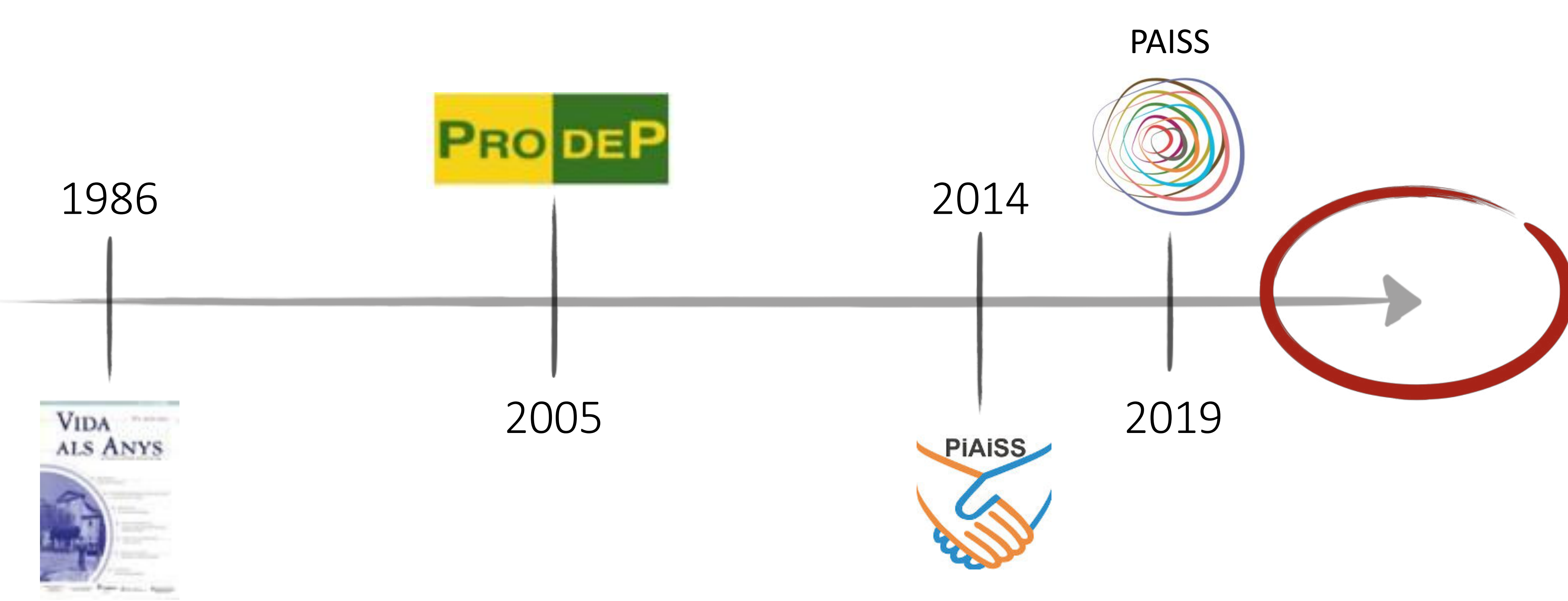
RES007A - Percentatge de pacients visitats en els últims 12 mesos per MFiC	52,33	21.644	41.360	+
RES008A - Percentatge de pacients visitats en l'últim mes per MFiC	15,42	6.377	41.360	+

Indicator	Value
% PCC (complex patients)	26,3%
% MACA ("advanced chronic disease" patients)	3,67%
% PCC patients with Individual Intervention Plan (PIIC)	79,87%
% PCC patients with recommendation in case of crisis in PIIC	95,84%
% MACA patients with reccommendation in case of crisis in PIIC	85,03%
% PACA patients with Advanced Care Planning	98,1%
Polipharmacy > 10 medicines	27%
Median psychotropic drugs	0,43
Prescription of statins in MACA patients	8,4%

Source: SISAP, March 2022

CONSTRUCTING AN AGENCY OF INTEGRATED CARE:

PREVIOUS ATTEMPTS IN CATALONIA



INTEGRATED CARE: CONSIDERATIONS IN CATALAN CONTEXT

STRATEGY 3:
INTEGRATED
HEALTH CARE

9. Atenció integrada social i sanitària

L'experiència de la pandèmia de la COVID-19 en relació amb múltiples situacions viscudes tant a l'àmbit residencial com a l'atenció primària i l'atenció hospitalària constata un camí de no retorn pel que fa a l'imprescindible abordatge integral de les necessitats socials i sanitàries de la ciutadania i al treball compartit de tots dos àmbits.

La pandèmia ha accelerat la confluència del full de ruta sanitari i el full de ruta social i ha permès vèncer dificultats que fins ara semblaven insalvables per poder posar la persona al centre del sistema[116]. Es tracta de prestar una atenció integrada i fer front a un dels reptes actuals de la societat: garantir que qualsevol persona, en qualsevol moment de la vida, sigui considerada en la seva globalitat, promovent-ne el nivell màxim d'autonomia personal, i tingui sempre un projecte vital de futur que pugui desenvolupar a l'entorn familiar i social on viu. Així, emergeix com a necessitat dur a terme una pràctica col·laborativa conjuntament amb els serveis socials quan la persona tingui necessitats concurrents d'atenció sanitària i social.

Hi ha evidència que l'atenció integrada és capaç de millorar els resultats d'atenció de la població amb necessitats complexes[117,118].

Estratègia 3. Integració de l'atenció a la salut	
Eix estratègic	[9] Atenció integrada social i sanitària
Objectius específics	3.9.33 Crear l'Agència de l'Atenció Integrada per avançar en la integració social i sanitària.
	3.9.34 Avançar en el desplegament territorial de projectes integrats d'atenció social i sanitària.

New Strategic Plan in Social Care Services (PESS)

PERSONES I PROFESSIONALS
Motors del sistema

CITIZEN AND PROFESSIONALS

VERTEBRACIÓ I REORGANITZACIÓ
Millor qualitat i integració

REDESIGN

GOVERNANÇA I CONEIXEMENT
Decisions basades en l'evidència

GOVERNANCE

COMMUNITY CARE
AND PREVENTION
Acción comunitària y prevención

INTEGRATED CARE !!!

Intersectorialidad

ACCIÓ COMUNITÀRIA I PREVENCIÓ
Un sistema més proactiu

INTERSECTORIALITAT
Intervenció holística

https://treballiaferssocials.gencat.cat/ca/ambits_tematics/serveis_socials/pla-estrategic-de-serveis-socials-de-catalunya/PESS2020-24/

Font: Departament TASF, 2020

PRIORITIES in Catalonia in INTEGRATED CARE

Deployment of **PRIORIZED PROJECTS OF INTEGRATED CARE**

Integrated Care in RESIDENTIAL CARE

Integrated HOME CARE (involving health and social care)

integrated Care in MENTAL HEALTH

Integrated INFORMATION AND COMMUNICATION SYSTEMS

Creation of **AGENCY OF HEALTH AND SOCIAL CARE INTEGRATION**

Participated both by Department of Health and Department of Social Rights

Creation of AGENCY OF INTEGRATED HEALTH AND SOCIAL CARE

PARTICIPATION TABLES

DECISION ABOUT CHARACTERISTICS AND FUNCTIONS OF AGENCY

START PARLAMENTIARY PROCESS

MAY 2022

JUNE 2022

ANALYSIS OF INFORMATION AND DEFINITION OF CHARACTERISTICS AND FUNCTIONS OF THE AGENCY (2-3 SCENARIOS)

REGULATORY DEVELOPMENT OF THE LAW

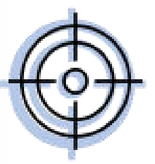
WORK GROUP ABOUT FINANÇING

WORK GROUP ABOUT CITIZEN PARTICIPATION

CONSTITUTION OF THE AGENCY OF INTEGRATED HEALTH AND SOCIAL CARE

Deployment of **PRIORISED PROJECTS OF INTEGRATED CARE**

INTEGRATED CARE IN RESIDENTIAL CARE



Integrated health care of **people** who live in **residential homes** involving **Primary Health Care teams (PHC)** in the integrated care pathways

1A **Initiate deployment of the model of health care** for residential homes — 1er SEMESTER 2022

1B **Monitor implementation** of the model of care according expected results and outcomes. — 1er SEMESTER 2022

1C Initiate a new model of **pharmaceutical care** for the people living in residential homes

1D **Deploying EPHC record in residential homes** + **Interoperability between ePHC and own electronic records in residential homes** — 2n SEMESTER 2022

Deployment of **PRIORISED PROJECTS OF INTEGRATED CARE**

INTEGRATED HOME CARE

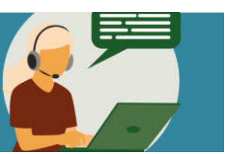
1. Deployment of a model of Integrated Home Care (IHC) in Catalonia.

1A Initiate **implementation of a model of Integrated Care (named "PAID")** in **10 territories** in different regions overall Catalonia — 2022-2023-2024

1B Promote incorporation of key components of Integrated Home Care in Catalonia, **reaching 50% territories covered by IHC of Catalonia in 2024** — 2022-2023-2024

1C Incorporate in the model a better coverage of **home care aids supply and aids and Occupational Therapy** — 2022-2023-2024

NEW ACT TO SHARE INFORMATION



DISPOSICIONS GENERALS

DEPARTAMENT DE LA PRESIDÈNCIA

LLEI 2/2021, del 29 de desembre, de mesures fiscals, financeres, administratives i del sector públic.

El president de la Generalitat de Catalunya

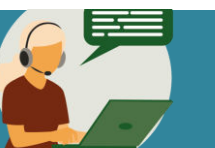
Els articles 65 i 67 de l'Estatut preveuen que les lleis de Catalunya són promulgades, en nom del rei, pel president o presidenta de la Generalitat. D'acord amb l'anterior promulgo la següent

29th December:

New Act where it will be allowed to **share information between Health and Social Care without personal consent** when both health and social care professionals need to know information from each other

Integrated ICT Priorities

Integrated ICT



Initiating first part process of formal assessment → Reference data / Basic clinical information → Central assessment performed by oficial team

- Yes → Favorable resolution generating report → Loading data in different Social Services and Health ICT applications
- No → Negative resolution

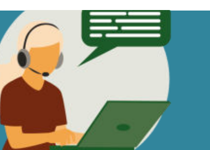
1. Develop environment of **interoperability** in process of **formal assessment of dependency and disability** (both protected by law)

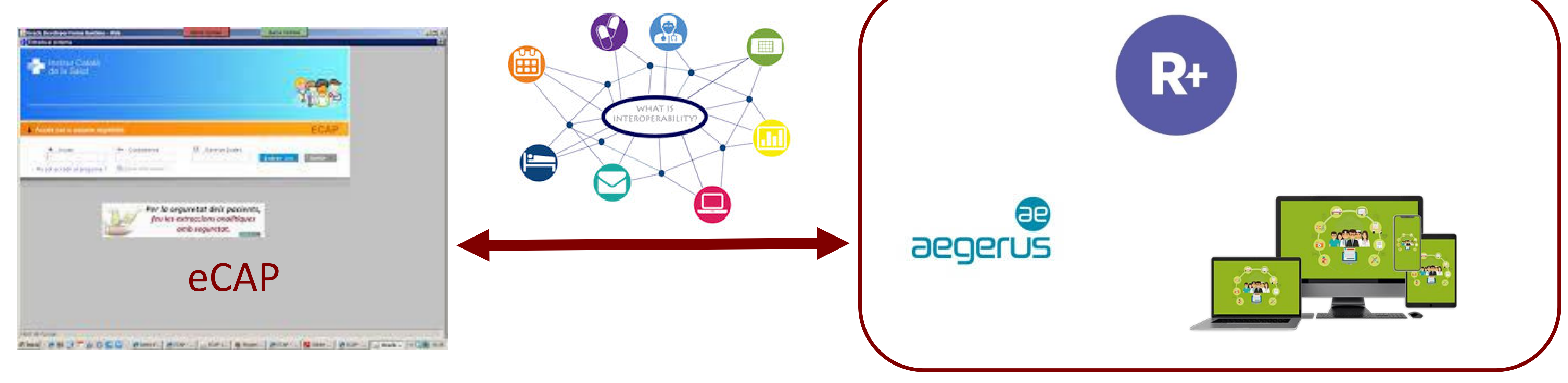
1A ***Provide key health information to teams responsible for formal assessment***

1B ***Incorporate*** *in Shared electronic record "HC3", PHC record "eCAP" and future eHR "HES"* ***information of special interest*** *related to* ***dependency and disability****.*

Integrated ICT Priorities

Integrated ICT





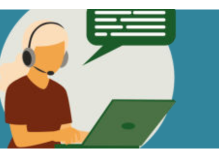
2. Develop an **interoperability environment in residential care**

2A ***To complete Deployment of Primary Health Care application "eCAP"*** *in ALL nursing homes for elderly people and disabled*

2B *To identify* ***information to share*** *between eCAP and main ICT applications in residential homes. Initiate interoperability process; now functional work in progress*

Integrated ICT Priorities

Integrated ICT



GESS (SUMAR in Girona counties)

SIAS (Social Services in Barcelona municipality)

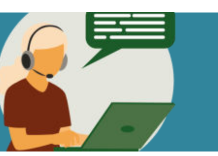
OBJECTIUS I ACCIONS

3. Generate a **interoperability environment** between **PHC record and different Social Care records**

3A *Go forward with **interoperability environment between PHC and Social care services***

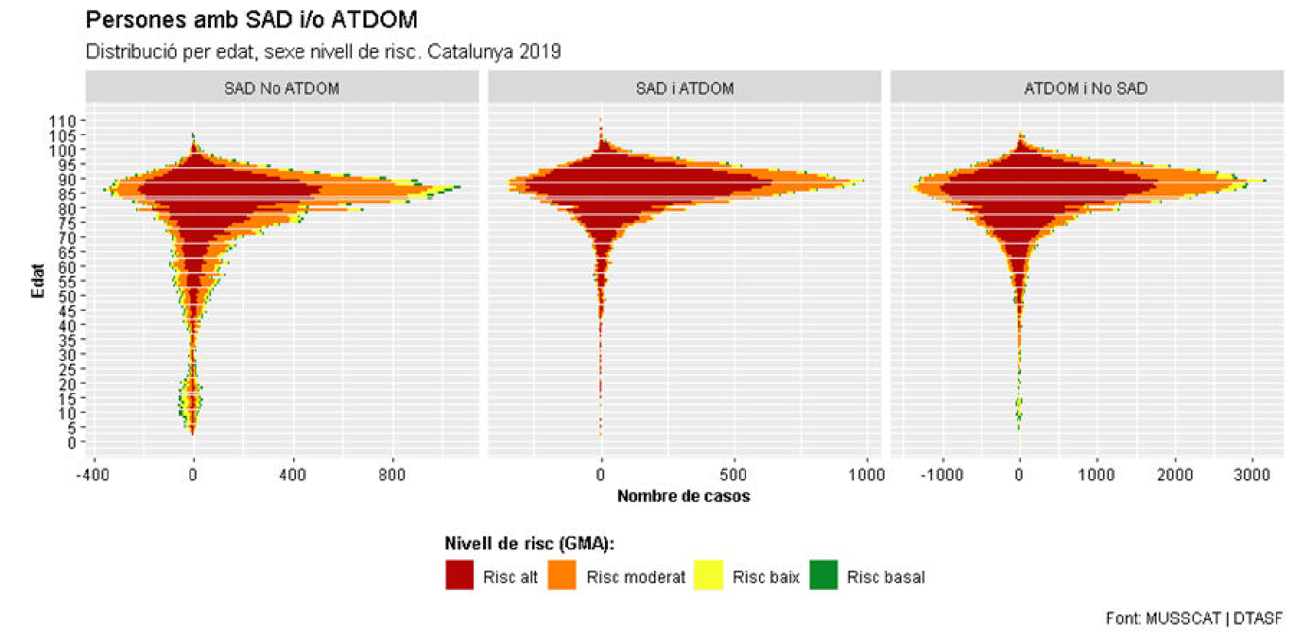
Integrated ICT Priorities

Integrated ICT

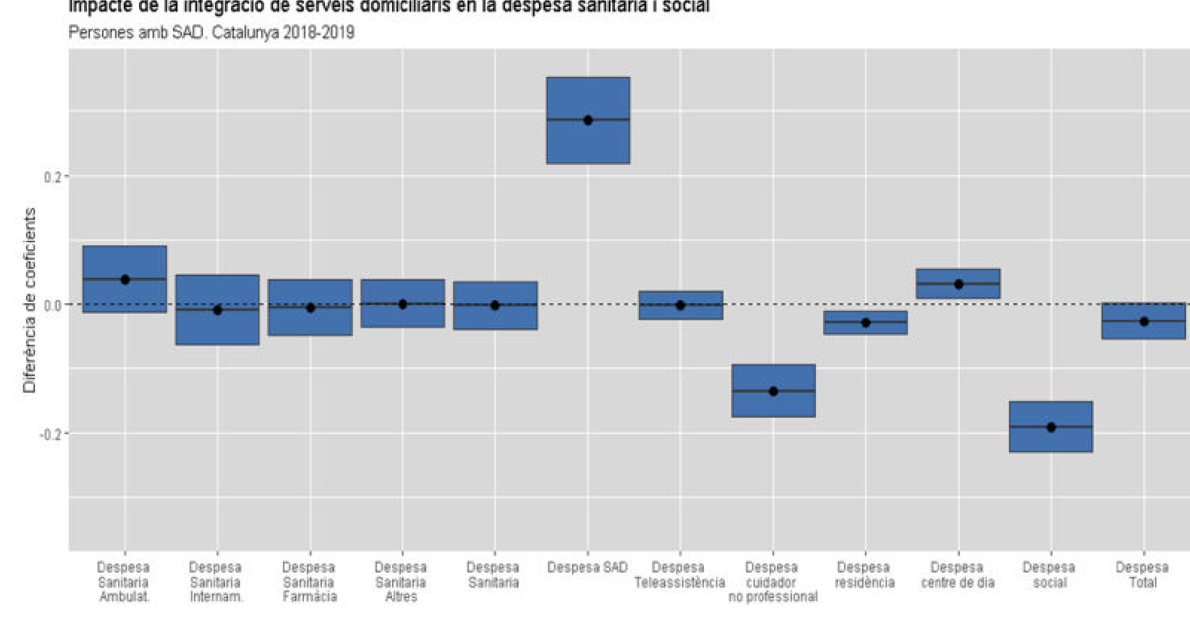


4. Integrate both health and social care data to facilitate joint evaluation in residential care and integrated home care (IHC)

4A Agree and operate ***minimum* range of indicators** related to Integrated Care to support **balanced scorecard in residential care and integrated home care**



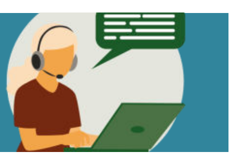
Population characterization in Home Health Care (Health) and Social Home Care (Social Care)



Impact evaluation in Integrated Home Care

THE VISION

Integrated ICT



My Shared Care Plan

- Home Health Care (by Primary Health Care)
- Day Care Facilities
- Mental Health
- Palliative Support Teams
- Hospital at Home
- Home care Rehabilitation
- PHC Out of Hours
- 999 SEM-Emergency Services
- Loan Appliances / Occupational Therapy
- Home Help Services "SAD"
- Telecare
- Social Care Services
- Social Day Care
- Dependency assessment Teams
- Volunteer Sector

NOW there are as many Care Plans as areas (Health and social care), organizations, teams and professionals are involved !!!

"JOINT" SINGLE CARE PLAN

COMMUNICATION: New WEB

https://salutweb.gencat.cat/ca/site/aiss/inici/

Juan Carlos Contel

Chronic Care Program. Department of Health

https://salutweb.gencat.cat/ca/inici

jccontel@gencat.cat

@conteljc