Integrated Care: International examples of good practice

System: Metropolitana Nord, Barcelona, Catalonia, SPAIN				
Contact details: Miquel Mas - c/o ificscotland@integratedcarefoundation.org				
Name of good practice: ProPCC: Person-centred anticipatory care				
Select (x) all areas that apply to your good practice (select more than one if applicable)				
CLIENT GROUP	Children and young people		Older adults	x
	Younger adults	x		
SETTING	City	x	Remote & rural (incl islands)	
	Corporate		Urban	x
SERVICE AREA	Addictions		Management team	
	Admission avoidance	x	Mental health	
	Community care services incl care at home/care homes		Physical disabilities	
	Day services		Physical health	x
	Housing incl Homelessness		Primary care	x
	Intermediate Care incl Hospital at Home	x	Rehabilitation	x
	Justice services		Social care services	
	Learning disabilities		Supported discharge	
	Other – please specify			
ELEMENTS of FRAMEWORK	Anticipatory care planning	x	Live independently at home or in a homely setting	x
	Assets based approach		Manage own care	x
	Connect with communities		Reablement	x
	First point of contact		Seamless working with acute	x
	Enhanced care in care homes / supported accom		Short term targeted interv to meet more complex needs	
	Fully integrated community teams		Teams aligned with general practice	x
	Other – please specify			
ENABLERS	Agile working		Information sharing	x
	Aligned plans		Infrastructure	
	Clarity of vision		Management information	
	Clinical and care governance	x	Shared accountability	
	Collaborative leadership		Strong team ethos	x
	Culture and values		Technology	x
	Fit for purpose premises		Well-developed lead professional roles	x
	Improvement capacity		Well-developed relationships	x
	Other – please specify			

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Name of good practice: ProPCC: Person-centred anticipatory care	
Summary of situation	The Catalan Institute of Health and the Metropolitana Nord Chronic Care Management Team (CCMT) co-designed ProPCC: a primary care led, community-based anticipatory care programme for the 64 Primary Care teams that provide healthcare to around 1.9 million people in this district. ProPCC builds on learning from the regional Chronic Care Program introduced in 2011 to improve the identification and management of people with chronic complex conditions and advanced life limiting disease in Catalonia.
Actions taken	The ProPCC programme is based on the international evidence for population health, chronic disease management and case management. The approach was informed by local co-design involving 60 professionals from both primary care and hospital, two focus groups with patients, and a series of interviews with unpaid carers and staff working in community facilities. The resulting place based model ensures collaboration across primary care, community services and hospital care to deliver high quality personalised care for people with chronic, complex health problems, frailty or palliative care needs. The aim is to increase the time spent at home and provide high quality, coordinated, anticipatory care that is well integrated with reablement, intermediate care, palliative care and acute care interventions. Multidisciplinary teams (MDTs) in each primary care neighbourhood work closely with local reablement, home-based palliative care, Hospital@home and hospital teams to identify and jointly manage their complex chronic caseload. The interdisciplinary model involves the following steps / interventions: ❖ Identify adults with high needs using primary care electronic risk prediction tools ❖ Hold weekly multidisciplinary meetings in primary care centres ❖ Provide comprehensive assessment by a multidisciplinary community team ❖ Care planning and shared decision making communicated in electronic health records ❖ Proactive anticipatory care and education and support for self-management ❖ Provide pharmaceutical care to optimise use of medicines and adherence ❖ Direct access to reablement and intermediate care alternatives for managing crises ❖ Case manage individuals during transitions of care ❖ Advance care planning and early identification of palliative care needs ❖ Fortnightly collaboration between palliative care teams and care homes. Most of these steps were already in place but they were not being implemented systematically, intensively or in an integrated way.

	There are 3 levels of integrated MDTs: ❖ Weekly Primary care MDTs to identify the high-need patients and review care plans for a chronic complex caseload (50 -100 patients per practice) ❖ Fortnightly community MDTs (bringing together Primary care + reablement + hospital@home + home-based palliative care teams) to review care plans and agree interventions together for the more complex / deteriorating patients in the neighbourhood ❖ Fortnightly MDTs between local hospitals and community case managers to discuss patients requiring prompt access to diagnostics / specialist decisions At all levels, the MDTs focus on people with high or rising risk / needs: ❖ High-risk of admission due to multimorbidity ❖ High-risk polypharmacy (e.g. adherence, complexity, etc.) ❖ High-need advanced illness (complexity at end-of-life) ❖ High-need disability (e.g. geriatric syndromes) ❖ High-need in people living with dementia (e.g. stress/ distress behaviour) ❖ Multiple visits to the Emergency Department ❖ Caregiver difficulties in coping with caring ❖ Difficulties in accepting a deteriorating health status The initial pilot of ProPCC commenced in Badalona in 2018 in 10 Primary care centres serving a population of 220,000. The second phase from 2021 extended the model to Santa Coloma (120,000 population), a town with higher levels of deprivation. A new multidisciplinary care management unit was created in the local acute hospital to promote personalised care planning and support complex decision making across the whole hospital. Several hospital departments reoriented their units to provide more person -centred care, offer alternatives to Emergency Department visits and to facilitate early discharge. Catalan electronic health records already include individualised care plans, including crisis care plans, that can be accessed by all primary care and acute clinicians. This integrated health IT system was adapted for the new ProPCC care processes and to track quality indicators.
Outcomes / impact	ProPCC programme managed over 1000 patients between June 2018 and Jan 2022. ➢ 79% had high risk multimorbidity. ➢ 37% high risk polypharmacy. ➢ 30% had high levels of frailty/ disability. ➢ 21% had complex end of life care needs. ➢ Around one third had a pattern of multiple Emergency Department visits prior to enrolment in the programme.

	40% of the caseload have died since enrolment, reflecting their level of complexity and advanced disease status. Comparing healthcare use by patients in the 6 months before and after they enter the programme, participating patients experienced • 50% increase in visits by the MDT (mostly by a nurse / case manager) • 28% reduction in Emergency Department visits • 27% reduction in hospital admissions • 4% increase in the number of days spent at home
Links to presentation and recording	 Mas_MetroNord_IFIC_IFIC02092022.pdf https://vimeo.com/701175036
Related publications	*Designing a Person-Centred Integrated Care Programme for People with Complex Chronic Conditions: A Case Study from Catalonia* https://www.ijic.org/articles/10.5334/ijic.5653/ Read more about the Catalan chronic care strategy here and in these 3 publications: ❖ The Catalan Risk prediction tool is described in this BMJ Open paper: *Proposals for enhanced health risk assessment and stratification in an integrated care scenario* https://bmjopen.bmj.com/content/6/4/e010301 ❖ *Clustering Complex Chronic Patients: A Cross-Sectional Community Study From the General Practitioner's Perspective* describes three distinct groups of complex chronic patients in Catalonia https://www.ijic.org/articles/10.5334/ijic.5496/ ❖ *Characteristics and Service Utilization by Complex Chronic and Advanced Chronic Patients in Catalonia: A Retrospective Seven-Year Cohort-Based Study of an Implemented Chronic Care Program* https://www.mdpi.com/1660-4601/18/18/9473
Even better if … ➢ **Social care information, records and delivery were better integrated with the ProPCC model.** ➢ **Third sector and community volunteers were embedded as part of the local MDTs.**	
Similar international examples of primary care led anticipatory care A prospective, pragmatic, matched-control multicentre trial at 19 primary care practices in **Sweden.** ***Costs and effects of comprehensive geriatric assessment in primary care for older adults with high risk for hospitalisation*** **https://bmcgeriatr.biomedcentral.com/articles/10.1186/s12877-021-02166-1** **Identifying "high need" patients with multimorbidity within primary healthcare in the Netherlands** **https://vimeo.com/542627909**	

Report of a study of ICT enabled coordination, communication, patient empowerment and home-based care conducted in **8 European regions.** ***Impact Assessment of an Innovative Integrated Care Model for Older Complex Patients with Multimorbidity: The CareWell Project*****:** https://doi.org/10.5334/ijic.4711

Recording

NATIONAL HEALTH AND WELLBEING OUTCOMES	
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	x
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	x
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	x
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	x
5. Health and social care services contribute to reducing health inequalities.	
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	x
7. People who use health and social care services are safe from harm.	x
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	x
9. Resources are used effectively and efficiently in the provision of health and social care services.	x
Health and Social Care Scotland's 5 Essential Elements (click link to listen to statement of intent)	
1. Transforming the approach to improving health, wellbeing and independence	x
2. Building stronger community care systems and primary care services	x
3. Establishing a new focus on mental health	
4. Securing a sustainable acute hospital service and specialist care service	
5. Strengthening future partnerships to ensure a modern sustainable workforce	

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