Generalitat de Catalunya

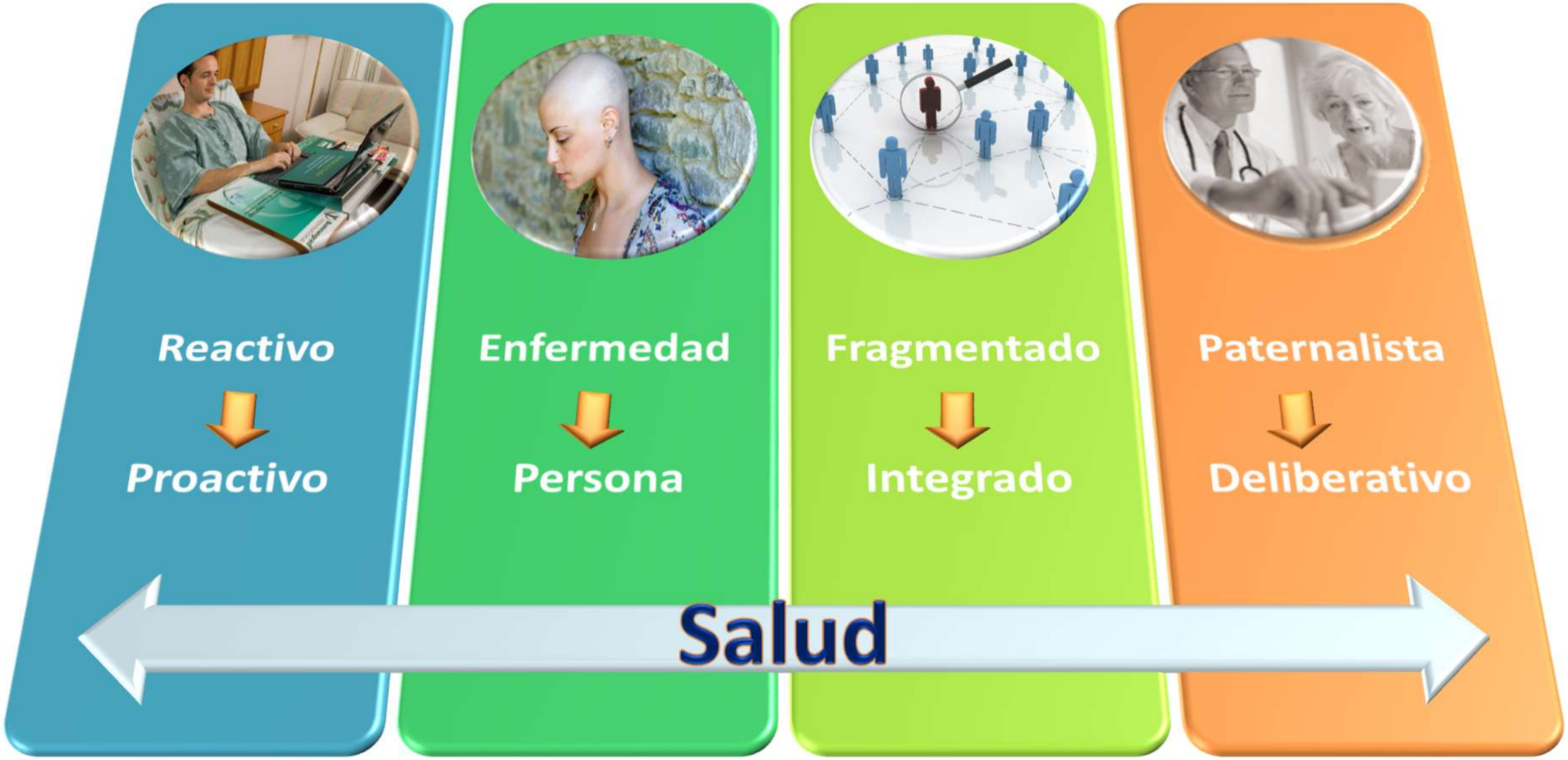
Programa de Prevención y Atención a la Cronicidad de Cataluña

Qué hemos hecho y qué hemos aprendido

Sebastià J. Santaeugènia Gonzàlez, MD PhD
Programa de Prevenció i Atenció a la Cronicitat
Departament de Salut. Generalitat de Catalunya
Programa Interdepartamental d'Atenció i Interacció Social i Sanitària
Generalitat de Catalunya

Aspecto nº1: Elaborando un nuevo entorno de salud

De qué va este nuevo entorno….



Reactivo → Proactivo

Enfermedad → Persona

Fragmentado → Integrado

Paternalista → Deliberativo

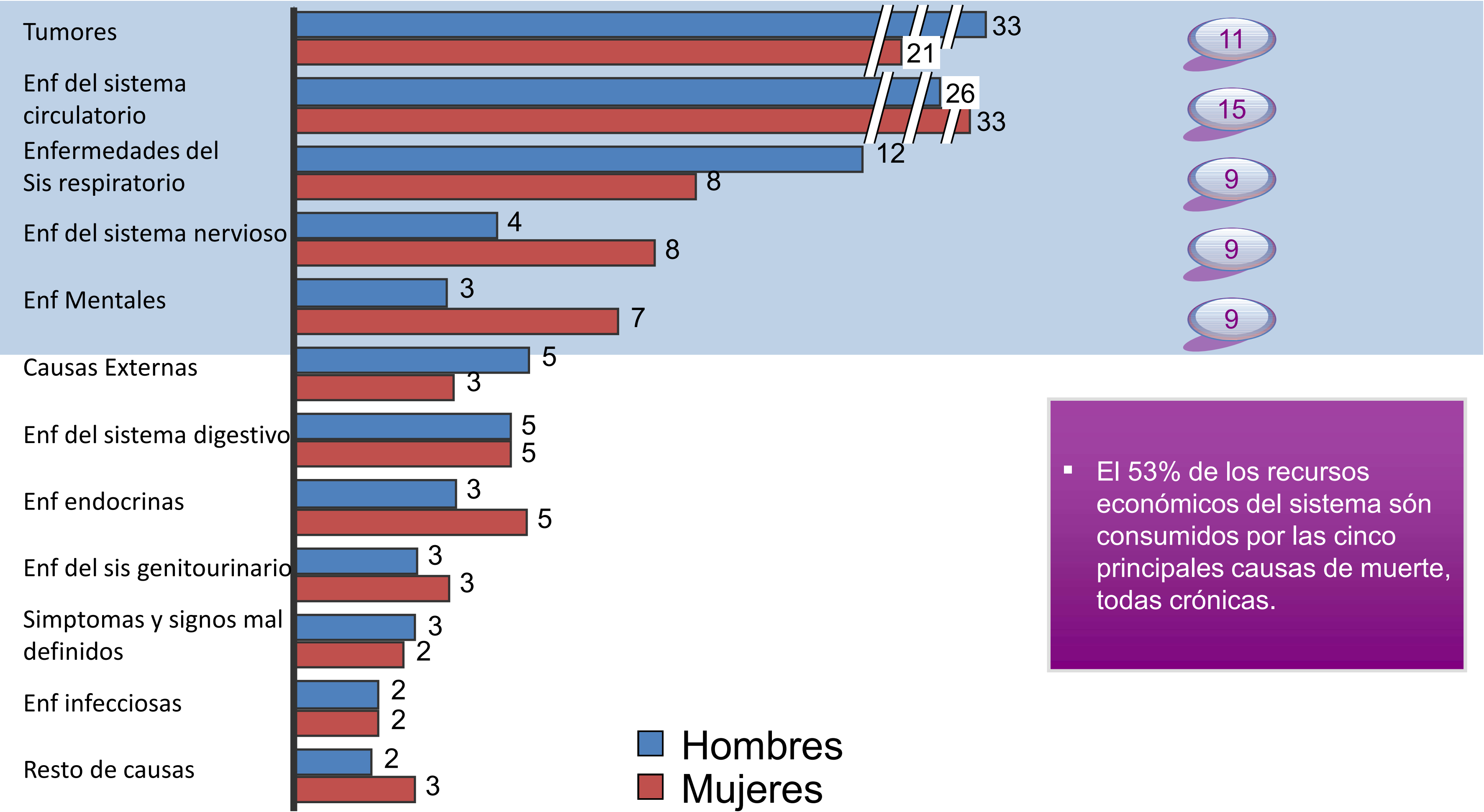
Salud

Las primeras cinco enfermedades causantes de muerte (75%) son crónicas y consumen más de la mitad de los recursos del sistema

Transición epidemiológica

Percentaje de muerte por causa y sexo

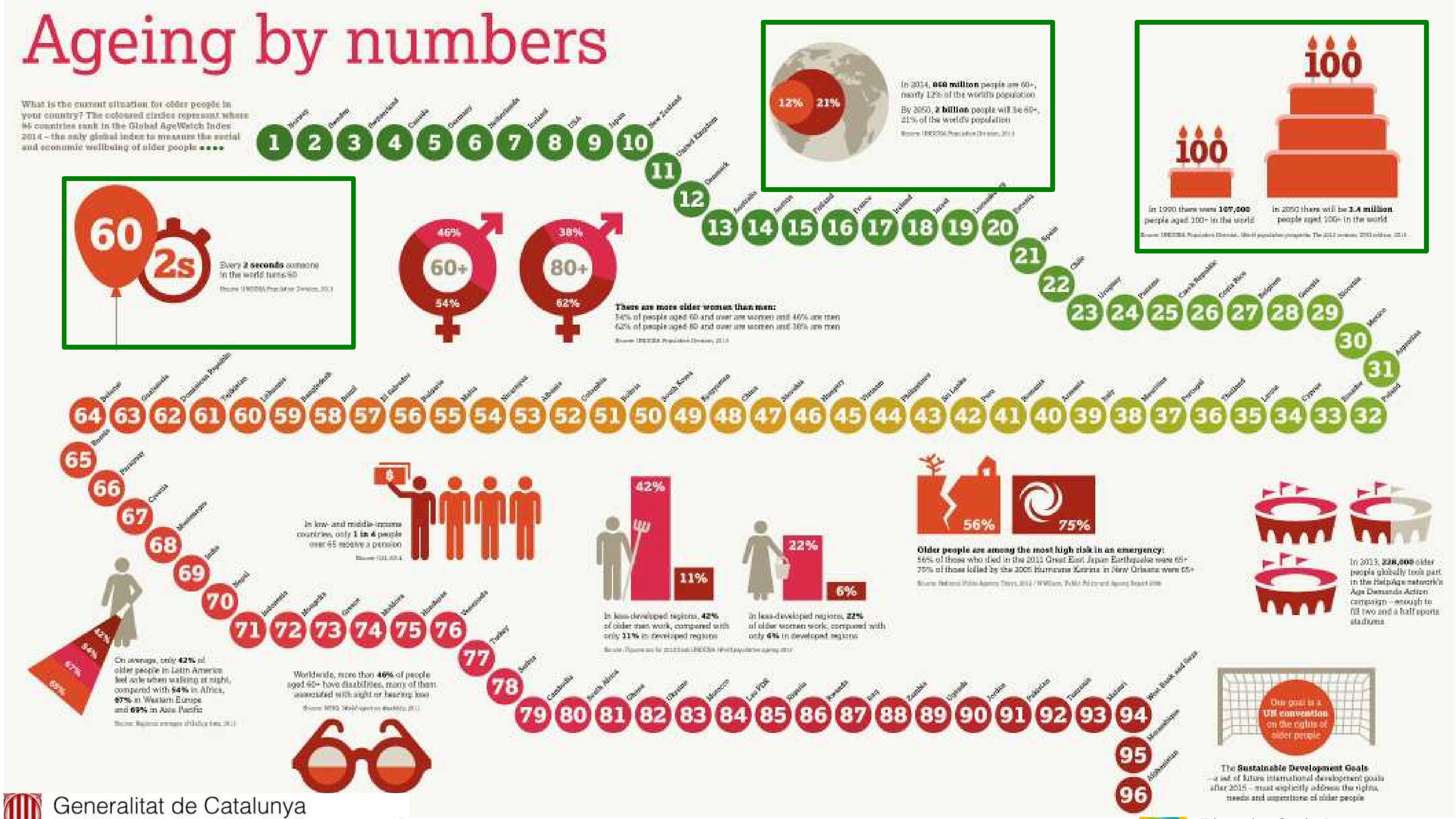
Porcentaje de recursos económicos consumidos del sistema



- El 53% de los recursos económicos del sistema són consumidos por las cinco principales causas de muerte, todas crónicas.

Font: Departament de Salut, Registre de Mortalitat de Catalunya, 2009.

Envejecimiento poblacional



What is the current situation for older people in your country? The coloured circles represent where 96 countries rank in the Global AgeWatch Index 2014 – the only global index to measure the social and economic wellbeing of older people ●●●●

In 2014, **868 million** people are 60+, nearly 12% of the world's population

By 2050, **2 billion** people will be 60+, 21% of the world's population

Source: UNDESA Population Division, 2013

In 1990 there were **107,000** people aged 100+ in the world

In 2050 there will be **3.4 million** people aged 100+ in the world

Every **2 seconds** someone in the world turns 60

Source: UNDESA Population Division, 2013

There are more older women than men:
54% of people aged 60 and over are women and 46% are men
62% of people aged 80 and over are women and 38% are men

Source: UNDESA Population Division, 2013

In low- and middle-income countries, only **1 in 4** people over 65 receive a pension

In less-developed regions, **42%** of older men work, compared with only **11%** in developed regions

In less-developed regions, **22%** of older women work, compared with only **6%** in developed regions

Older people are among the most high risk in an emergency:
56% of those who died in the 2011 Great East Japan Earthquake were 65+
75% of those killed by the 2005 Hurricane Katrina in New Orleans were 65+

In 2013, **228,000** older people globally took part in the HelpAge network's Age Demands Action campaign – enough to fill two and a half sports stadiums

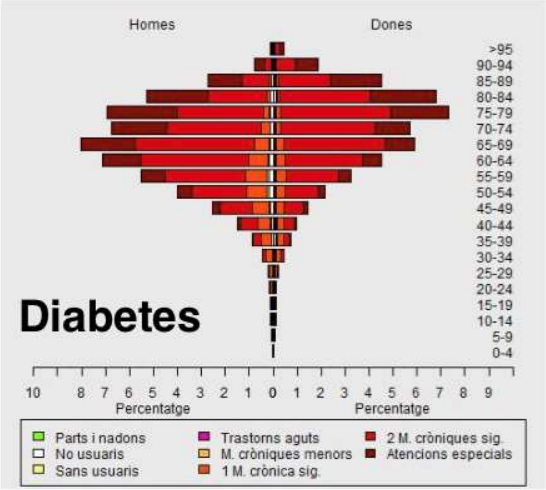
On average, only **42%** of older people in Latin America feel safe when walking at night, compared with **54%** in Africa, **67%** in Western Europe and **69%** in Asia Pacific

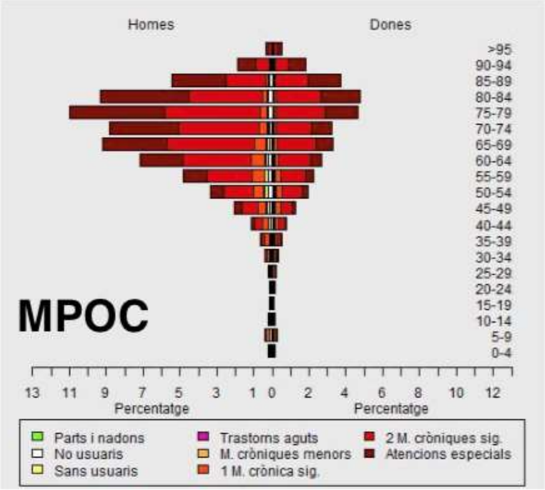
Worldwide, more than **46%** of people aged 60+ have disabilities, many of them associated with sight or hearing loss

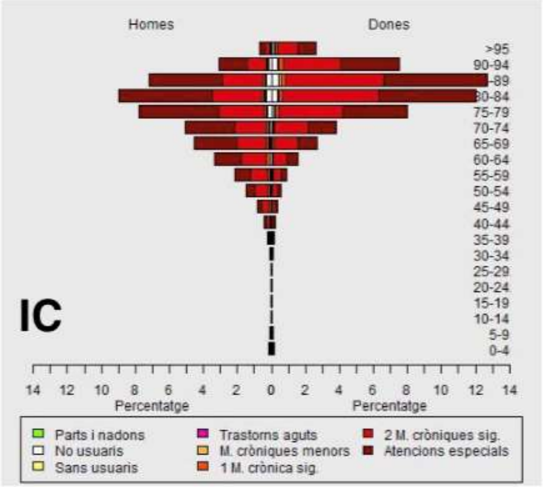
Our goal is a **UN convention** on the rights of older people

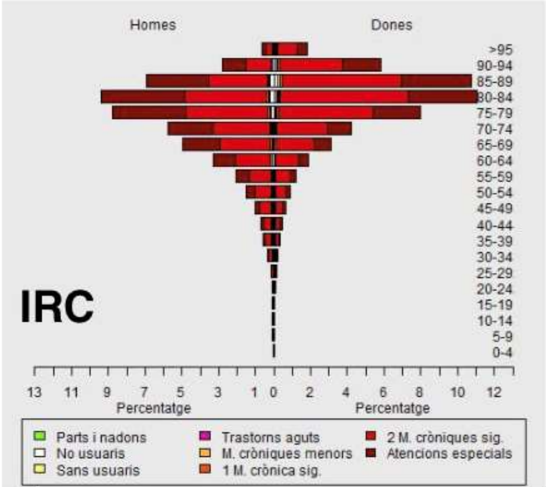
The **Sustainable Development Goals** – a set of future international development goals after 2015 – must explicitly address the rights, needs and aspirations of older people

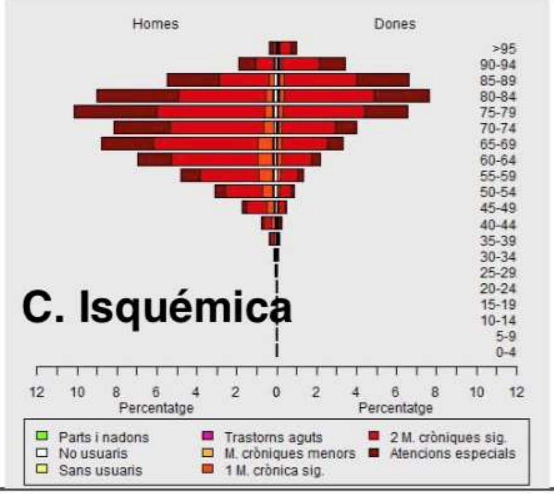
La cronicidad y la Edad

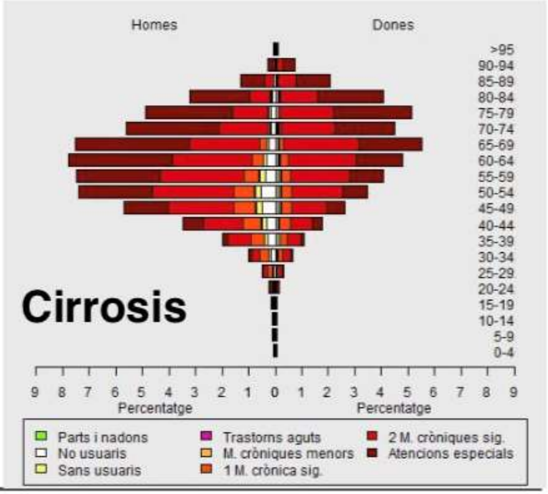




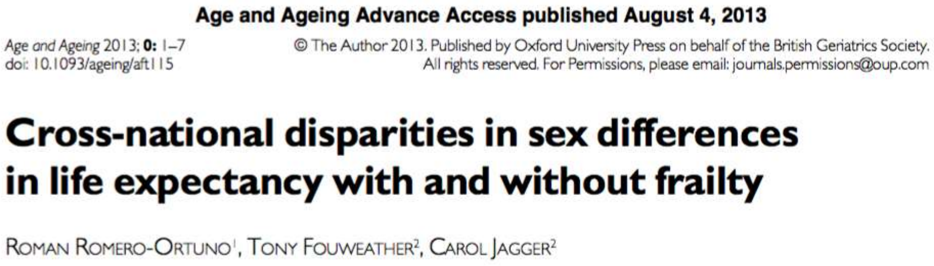








De las diferencias en el género y esperanza de vida



Age and Ageing Advance Access published August 4, 2013

Age and Ageing 2013; **0:** 1–7
doi: 10.1093/ageing/aft115

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Cross-national disparities in sex differences in life expectancy with and without frailty

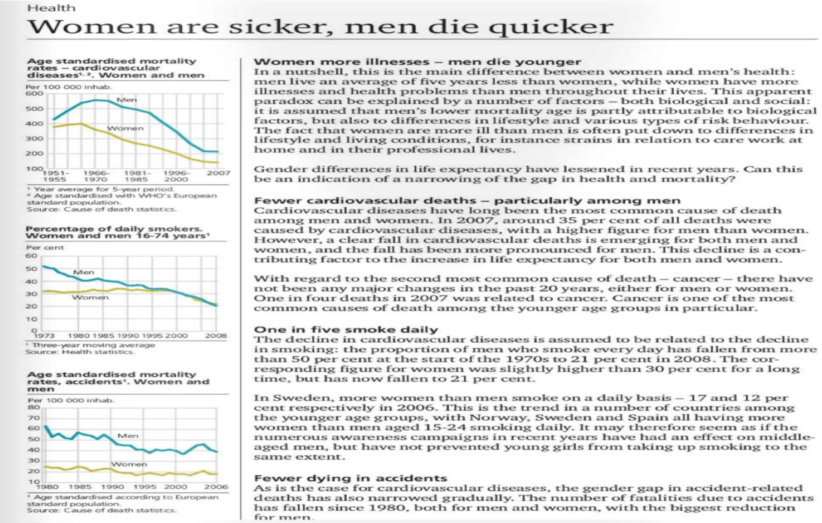
Roman Romero-Ortuno[1], Tony Fouweather[2], Carol Jagger[2]

Men die, women suffer?

Gender differences in health expectancy

REVES 2011,
Jan-Willem Bruggink,
Statistics Netherlands

Statistics Netherlands



Health

Women are sicker, men die quicker

Age standardised mortality rates – cardiovascular diseases[1, 2]. Women and men

Per 100 000 inhab.
600
500
400
300
200
100
Men
Women
1951-1955
1966-1970
1981-1985
1996-2000
2007

[1] Year average for 5-year period.
[2] Age standardised with WHO's European standard population.
Source: Cause of death statistics.

Percentage of daily smokers. Women and men 16-74 years[1]

Per cent
60
50
40
30
20
10
0
Men
Women
1973
1980
1985
1990
1995
2000
2008

[1] Three-year moving average
Source: Health statistics.

Age standardised mortality rates, accidents[1]. Women and men

[1] Age standardised according to European standard population.
Source: Cause of death statistics.

Women more illnesses – men die younger
In a nutshell, this is the main difference between women and men's health: men live an average of five years less than women, while women have more illnesses and health problems than men throughout their lives. This apparent paradox can be explained by a number of factors – both biological and social: it is assumed that men's lower mortality age is partly attributable to biological factors, but also to differences in lifestyle and various types of risk behaviour. The fact that women are more ill than men is often put down to differences in lifestyle and living conditions, for instance strains in relation to care work at home and in their professional lives.

Gender differences in life expectancy have lessened in recent years. Can this be an indication of a narrowing of the gap in health and mortality?

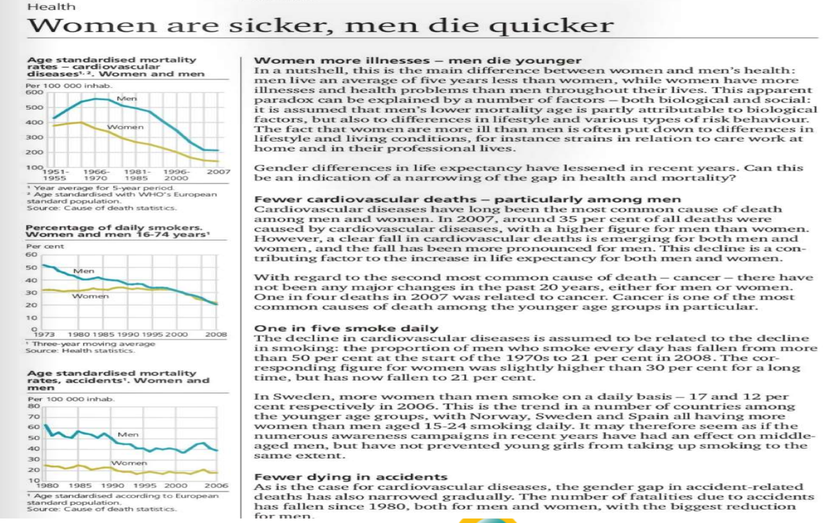
Fewer cardiovascular deaths – particularly among men
Cardiovascular diseases have long been the most common cause of death among men and women. In 2007, around 35 per cent of all deaths were caused by cardiovascular diseases, with a higher figure for men than women. However, a clear fall in cardiovascular deaths is emerging for both men and women, and the fall has been more pronounced for men. This decline is a contributing factor to the increase in life expectancy for both men and women.

With regard to the second most common cause of death – cancer – there have not been any major changes in the past 20 years, either for men or women. One in four deaths in 2007 was related to cancer. Cancer is one of the most common causes of death among the younger age groups in particular.

One in five smoke daily
The decline in cardiovascular diseases is assumed to be related to the decline in smoking: the proportion of men who smoke every day has fallen from more than 50 per cent at the start of the 1970s to 21 per cent in 2008. The corresponding figure for women was slightly higher than 30 per cent for a long time, but has now fallen to 21 per cent.

In Sweden, more women than men smoke on a daily basis – 17 and 12 per cent respectively in 2006. This is the trend in a number of countries among the younger age groups, with Norway, Sweden and Spain all having more women than men aged 15-24 smoking daily. It may therefore seem as if the numerous awareness campaigns in recent years have had an effect on middle-aged men, but have not prevented young girls from taking up smoking to the same extent.

Fewer dying in accidents
As is the case for cardiovascular diseases, the gender gap in accident-related deaths has also narrowed gradually. The number of fatalities due to accidents has fallen since 1980, both for men and women, with the biggest reduction for men.



Health

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[1] Year average for 5-year period.
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Source: Cause of death statistics.

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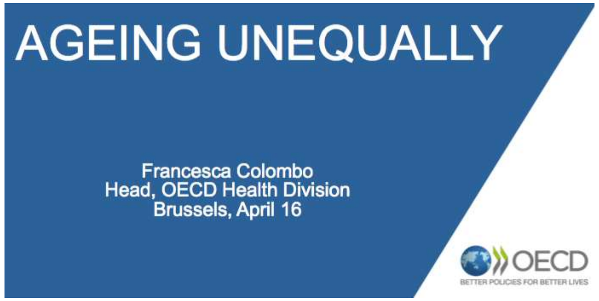
De Envejecer con desigualdad…

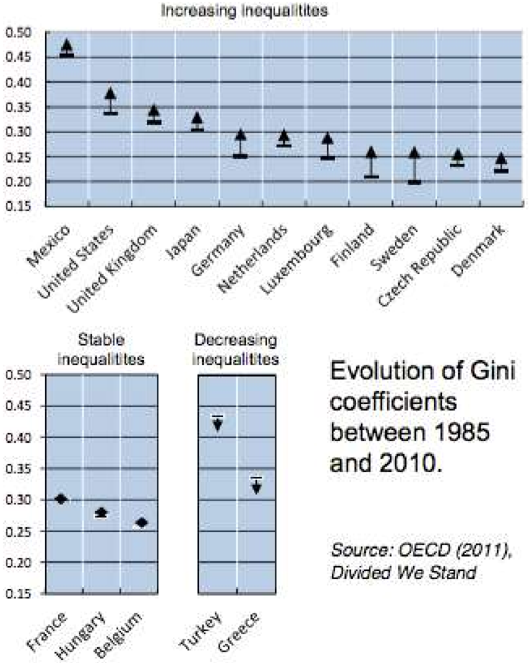


AGEING UNEQUALLY

Francesca Colombo
Head, OECD Health Division
Brussels, April 16

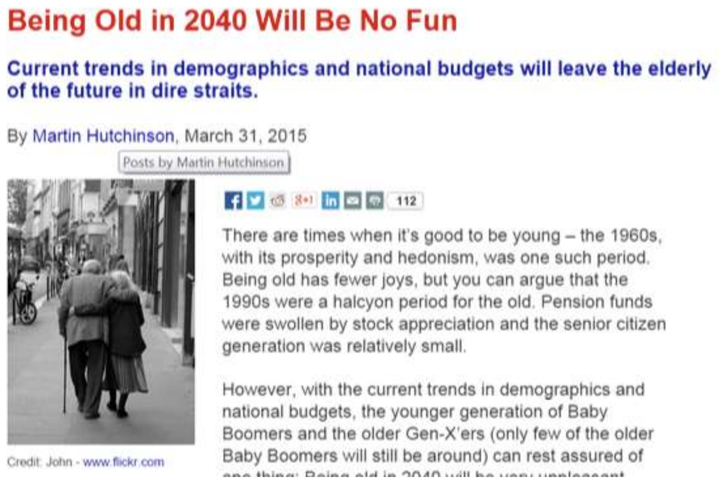
OECD
BETTER POLICIES FOR BETTER LIVES

Inequality has increased in most OECD countries



Evolution of Gini coefficients between 1985 and 2010.

Source: OECD (2011), Divided We Stand



Being Old in 2040 Will Be No Fun

Current trends in demographics and national budgets will leave the elderly of the future in dire straits.

By Martin Hutchinson, March 31, 2015

Posts by Martin Hutchinson

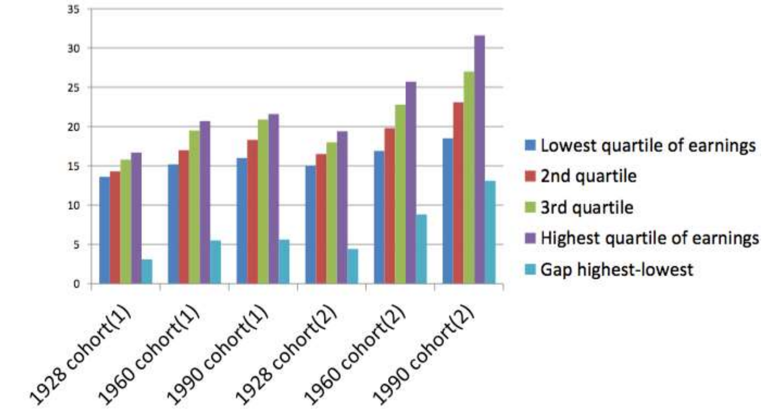
112

Credit: John - www.flickr.com

There are times when it's good to be young – the 1960s, with its prosperity and hedonism, was one such period. Being old has fewer joys, but you can argue that the 1990s were a halcyon period for the old. Pension funds were swollen by stock appreciation and the senior citizen generation was relatively small.

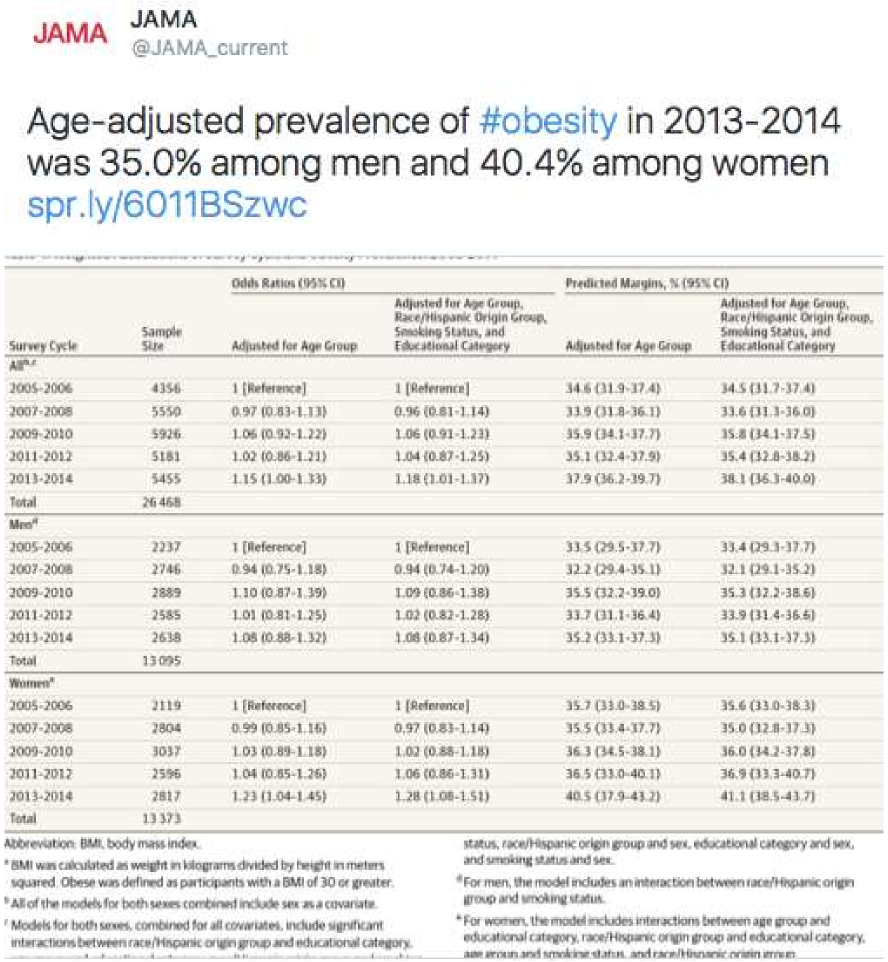
However, with the current trends in demographics and national budgets, the younger generation of Baby Boomers and the older Gen-X'ers (only few of the older Baby Boomers will still be around) can rest assured of

Growing gap in male life expectancy at age 65 by earnings levels in the U.S.



Source: Goldman and Orszag, 2014

Dos reflexiones de futuro



JAMA
@JAMA_current

Age-adjusted prevalence of #obesity in 2013-2014 was 35.0% among men and 40.4% among women spr.ly/6011BSzwc

Survey Cycle	Sample Size	Odds Ratios (95% CI)		Predicted Margins, % (95% CI)	
		Adjusted for Age Group	Adjusted for Age Group, Race/Hispanic Origin Group, Smoking Status, and Educational Category	Adjusted for Age Group	Adjusted for Age Group, Race/Hispanic Origin Group, Smoking Status, and Educational Category
All[b,c]					
2005-2006	4356	1 [Reference]	1 [Reference]	34.6 (31.9-37.4)	34.5 (31.7-37.4)
2007-2008	5550	0.97 (0.83-1.13)	0.96 (0.81-1.14)	33.9 (31.8-36.1)	33.6 (31.3-36.0)
2009-2010	5926	1.06 (0.92-1.22)	1.06 (0.91-1.23)	35.9 (34.1-37.7)	35.8 (34.1-37.5)
2011-2012	5181	1.02 (0.86-1.21)	1.04 (0.87-1.25)	35.1 (32.4-37.9)	35.4 (32.8-38.2)
2013-2014	5455	1.15 (1.00-1.33)	1.18 (1.01-1.37)	37.9 (36.2-39.7)	38.1 (36.3-40.0)
Total	26 468				
Men[d]					
2005-2006	2237	1 [Reference]	1 [Reference]	33.5 (29.5-37.7)	33.4 (29.3-37.7)
2007-2008	2746	0.94 (0.75-1.18)	0.94 (0.74-1.20)	32.2 (29.4-35.1)	32.1 (29.1-35.2)
2009-2010	2889	1.10 (0.87-1.39)	1.09 (0.86-1.38)	35.5 (32.2-39.0)	35.3 (32.2-38.6)
2011-2012	2585	1.01 (0.81-1.25)	1.02 (0.82-1.28)	33.7 (31.1-36.4)	33.9 (31.4-36.6)
2013-2014	2638	1.08 (0.88-1.32)	1.08 (0.87-1.34)	35.2 (33.1-37.3)	35.1 (33.1-37.3)
Total	13 095				
Women[e]					
2005-2006	2119	1 [Reference]	1 [Reference]	35.7 (33.0-38.5)	35.6 (33.0-38.3)
2007-2008	2804	0.99 (0.85-1.16)	0.97 (0.83-1.14)	35.5 (33.4-37.7)	35.0 (32.8-37.3)
2009-2010	3037	1.03 (0.89-1.18)	1.02 (0.88-1.18)	36.3 (34.5-38.1)	36.0 (34.2-37.8)
2011-2012	2596	1.04 (0.85-1.26)	1.06 (0.86-1.31)	36.5 (33.0-40.1)	36.9 (33.3-40.7)
2013-2014	2817	1.23 (1.04-1.45)	1.28 (1.08-1.51)	40.5 (37.9-43.2)	41.1 (38.5-43.7)
Total	13 373				

Abbreviation: BMI, body mass index.

[a] BMI was calculated as weight in kilograms divided by height in meters squared. Obese was defined as participants with a BMI of 30 or greater.

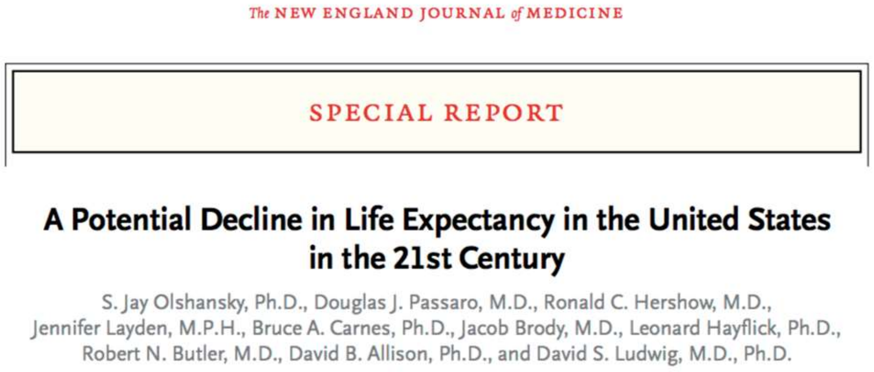
[b] All of the models for both sexes combined include sex as a covariate.

[c] Models for both sexes, combined for all covariates, include significant interactions between race/Hispanic origin group and educational category,

status, race/Hispanic origin group and sex, educational category and sex, and smoking status and sex.

[d] For men, the model includes an interaction between race/Hispanic origin group and smoking status.

[e] For women, the model includes interactions between age group and educational category, race/Hispanic origin group and educational category, age group and smoking status, and race/Hispanic origin group.

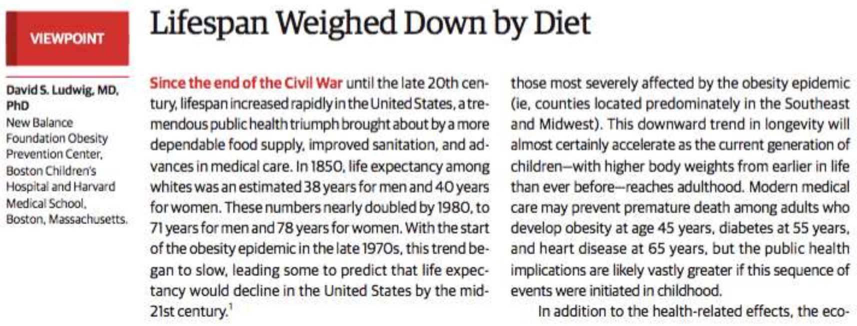


The NEW ENGLAND JOURNAL *of* MEDICINE

SPECIAL REPORT

A Potential Decline in Life Expectancy in the United States in the 21st Century

S. Jay Olshansky, Ph.D., Douglas J. Passaro, M.D., Ronald C. Hershow, M.D.,
Jennifer Layden, M.P.H., Bruce A. Carnes, Ph.D., Jacob Brody, M.D., Leonard Hayflick, Ph.D.,
Robert N. Butler, M.D., David B. Allison, Ph.D., and David S. Ludwig, M.D., Ph.D.



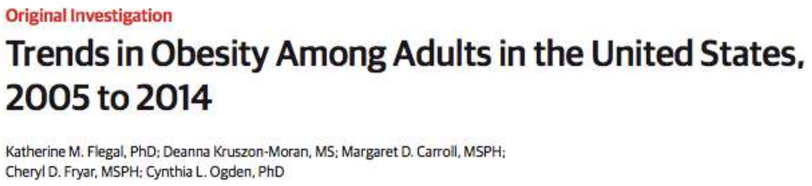
VIEWPOINT

Lifespan Weighed Down by Diet

David S. Ludwig, MD, PhD
New Balance Foundation Obesity Prevention Center, Boston Children's Hospital and Harvard Medical School, Boston, Massachusetts.

Since the end of the Civil War until the late 20th century, lifespan increased rapidly in the United States, a tremendous public health triumph brought about by a more dependable food supply, improved sanitation, and advances in medical care. In 1850, life expectancy among whites was an estimated 38 years for men and 40 years for women. These numbers nearly doubled by 1980, to 71 years for men and 78 years for women. With the start of the obesity epidemic in the late 1970s, this trend began to slow, leading some to predict that life expectancy would decline in the United States by the mid-21st century.[1] those most severely affected by the obesity epidemic (ie, counties located predominately in the Southeast and Midwest). This downward trend in longevity will almost certainly accelerate as the current generation of children—with higher body weights from earlier in life than ever before—reaches adulthood. Modern medical care may prevent premature death among adults who develop obesity at age 45 years, diabetes at 55 years, and heart disease at 65 years, but the public health implications are likely vastly greater if this sequence of events were initiated in childhood.

In addition to the health-related effects, the eco-



Original Investigation

Trends in Obesity Among Adults in the United States, 2005 to 2014

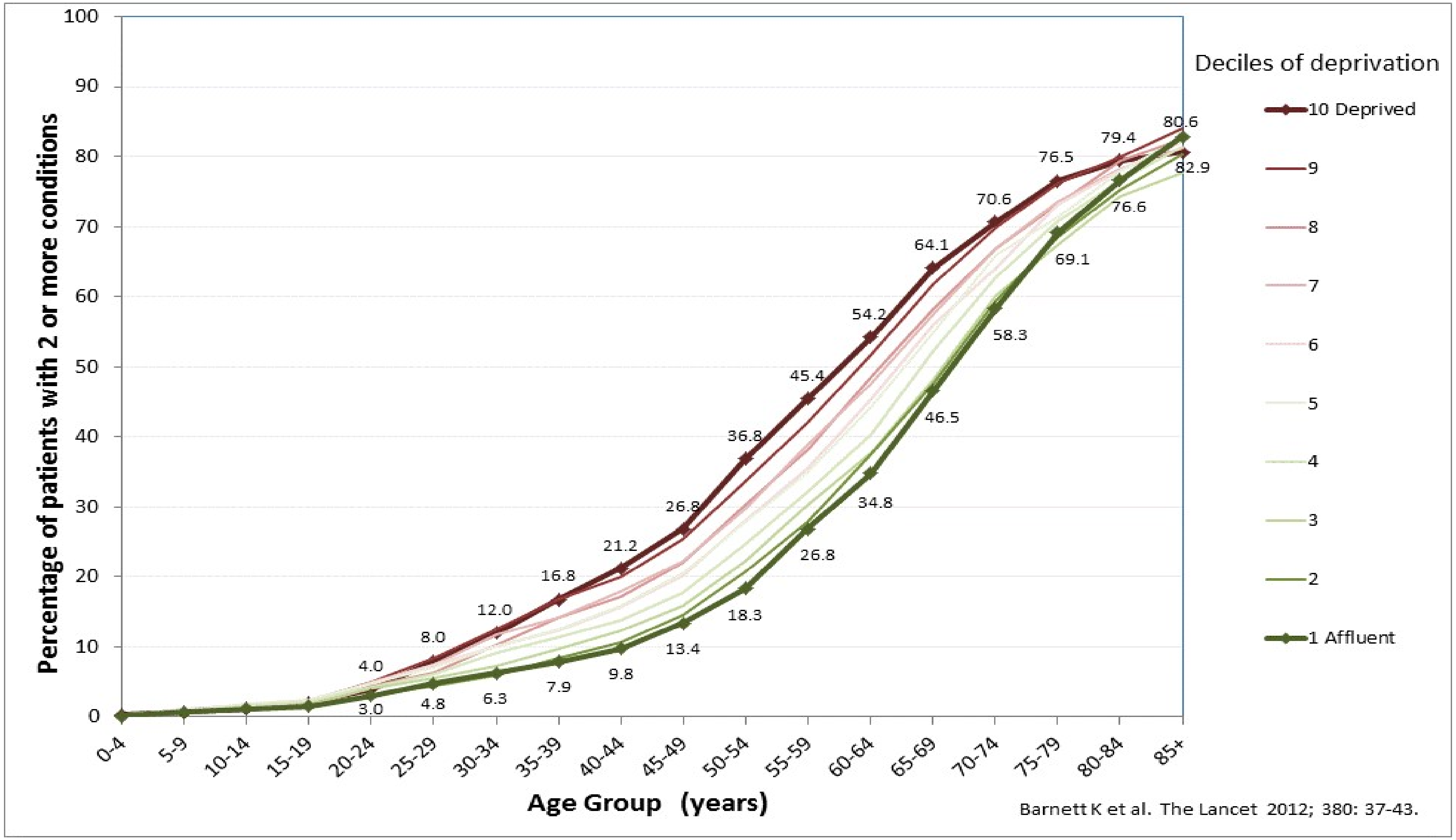
Katherine M. Flegal, PhD; Deanna Kruszon-Moran, MS; Margaret D. Carroll, MSPH;
Cheryl D. Fryar, MSPH; Cynthia L. Ogden, PhD

JAMA. 2016;315(21):2284-2291. doi:10.1001/jama.2016.6458

Generalitat de Catalunya
Departament de Salut

De determinantes sociales y enfermedad…

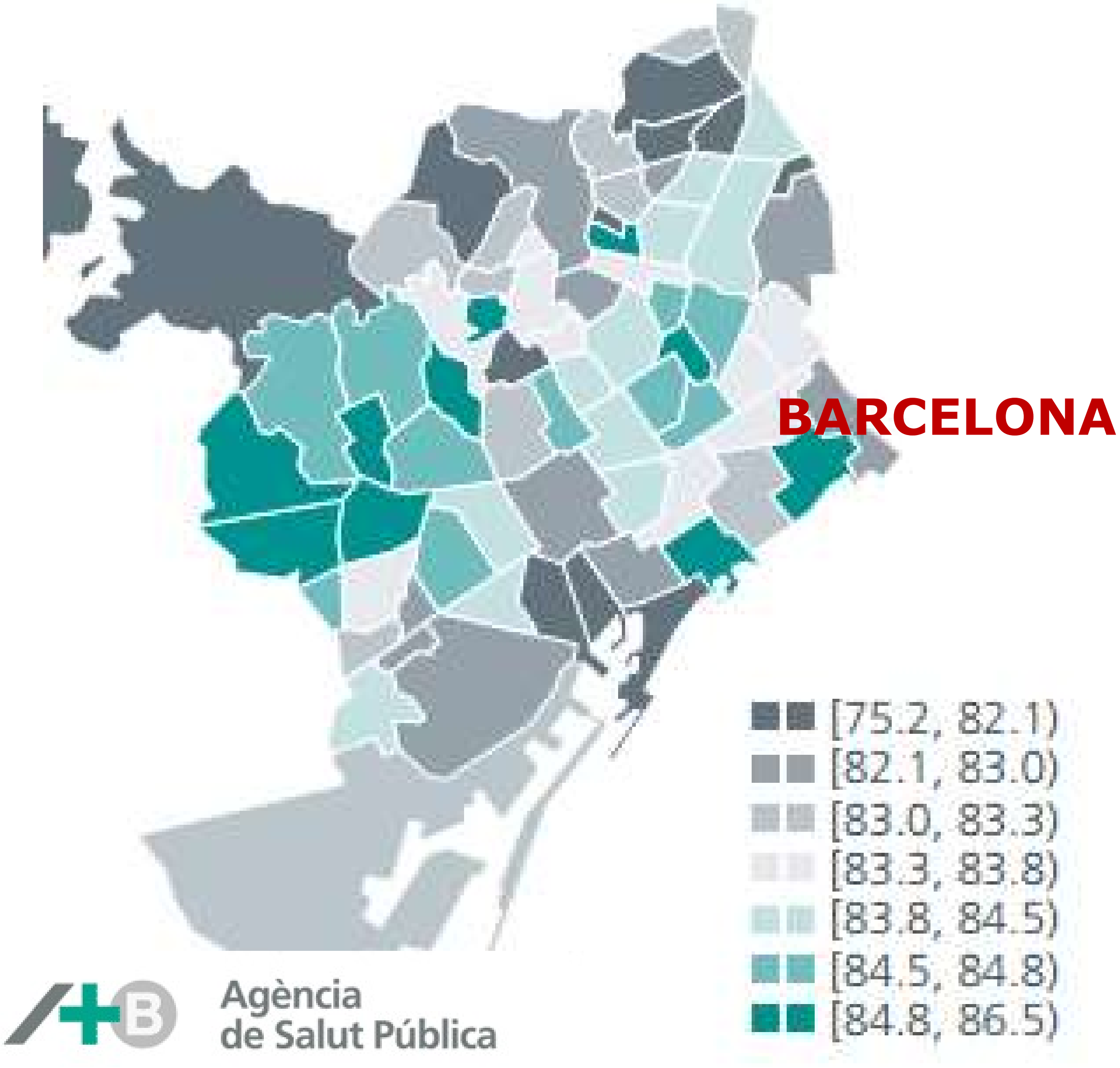
Personas que viven en zonas deprimidas adquieren enfermedades crónicas 10 años antes que viven en zonas menos deprimidas



Barnett K et al. The Lancet 2012; 380: 37-43.

MARCA MAS EL C.P. QUE LA CARGA DE MORBILIDAD

Hay **diferencias de esperanza de vida** de hasta **11,3 años** entre **diferentes barrios ciudad de Barcelona**

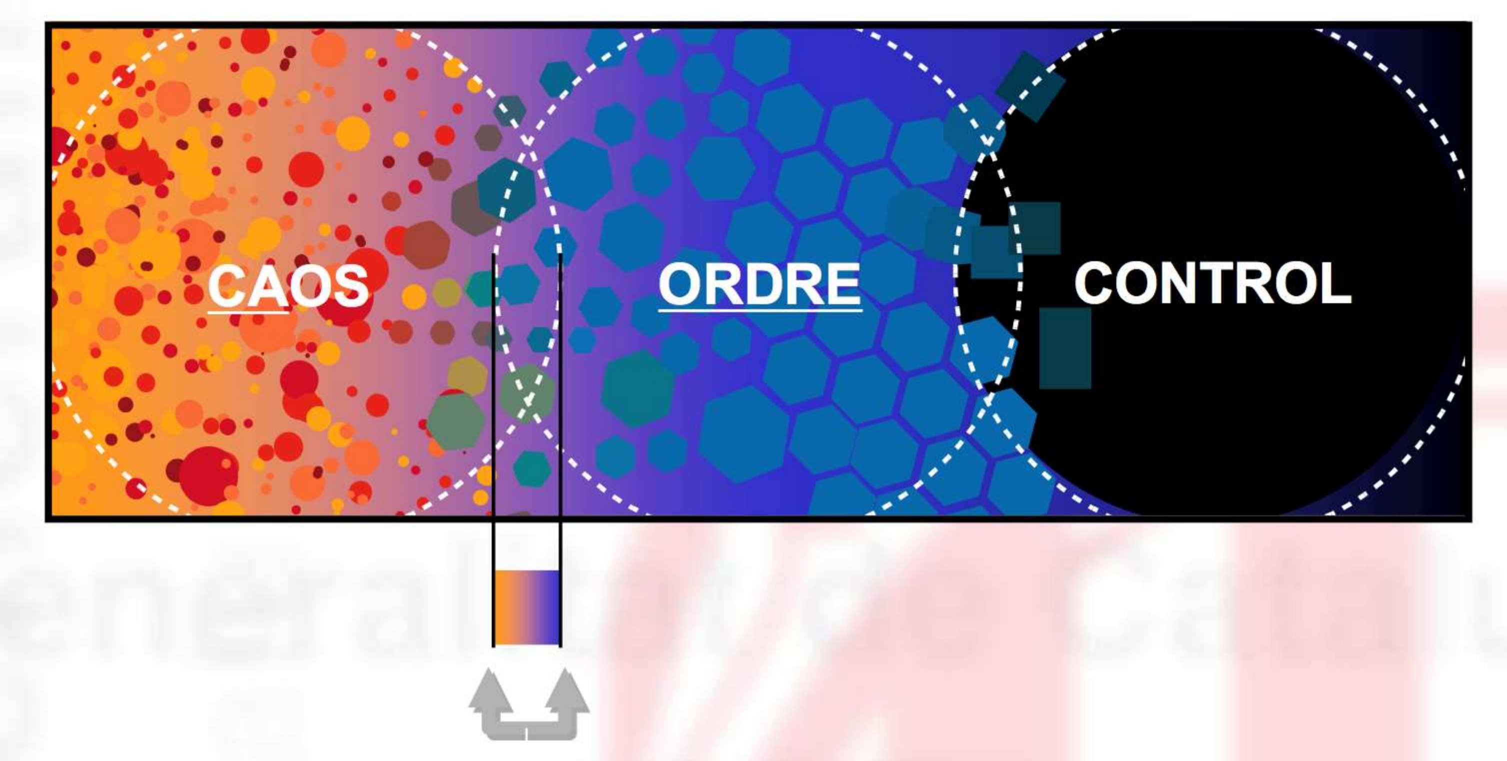

BARCELONA
[75.2, 82.1)
[82.1, 83.0)
[83.0, 83.3)
[83.3, 83.8)
[83.8, 84.5)
[84.5, 84.8)
[84.8, 86.5)

Generalitat de Catalunya
Departament de Salut

Agència
de Salut Pública

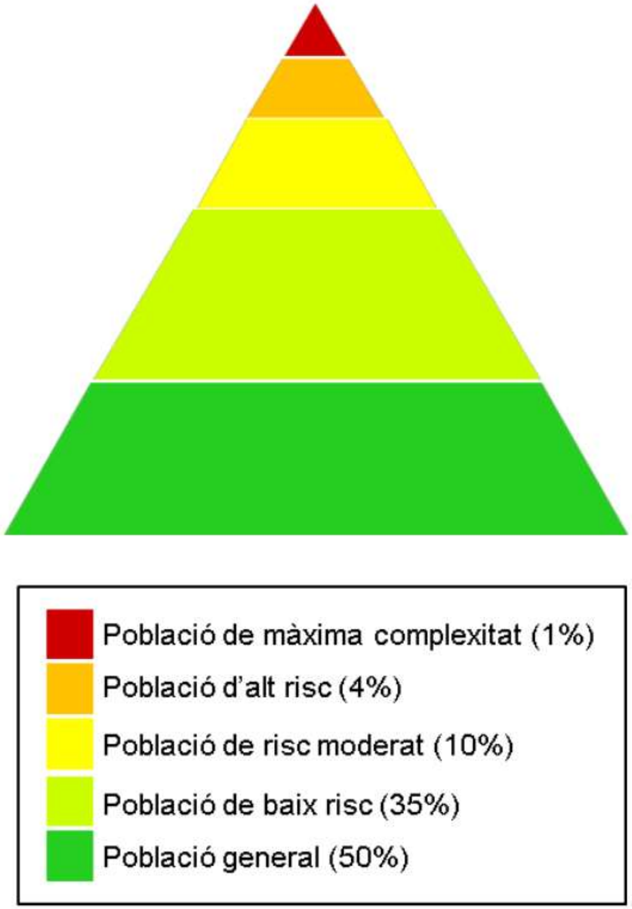
Aspecto nº2: Creando El CAORDEN

De la MULTIMORBILIDAD a la CRONICIDAD, de la cronicidad a la COMPLEJIDAD



"CAORDEN" Dícese del estado vital donde el Caos y el orden están en equilibrio.

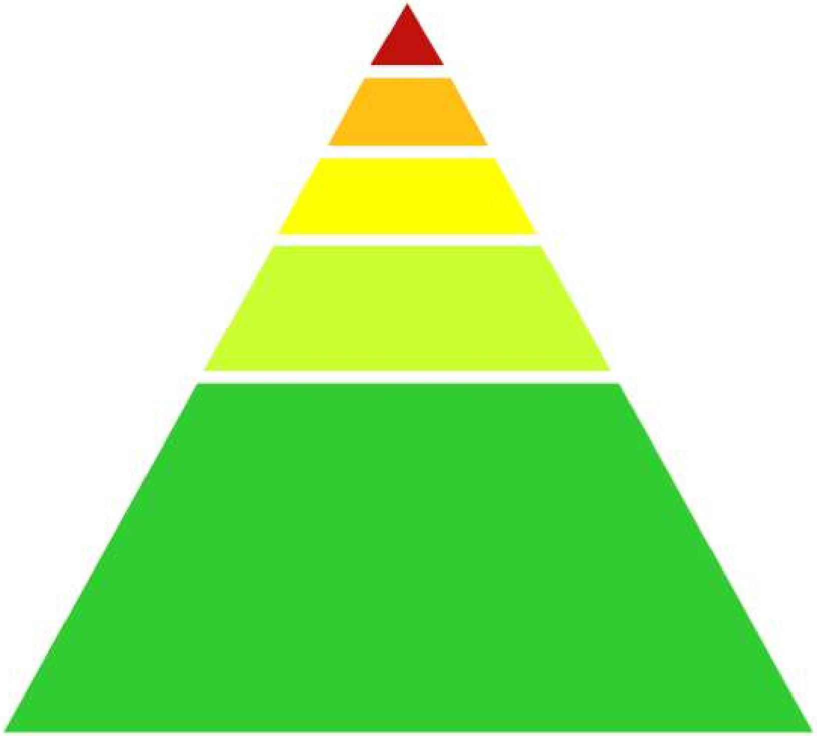
Modelo Poblacional vs Grupo Población


🟥 Població de màxima complexitat (1%)
🟧 Població d'alt risc (4%)
🟨 Població de risc moderat (10%)
🟩 Població de baix risc (35%)
🟩 Població general (50%)

Modelo	**Italia Vittorio Veneto**	**USA PACE**	**Canadá SIPA**
Descripción General	Red de atención integrada	Hospital de día para anciano	Equipos MD base Comunitaria
Población Diana	Mayores 65 años Discapacidad con necesidad At Domicilio	Todo paciente anciano en domicilio con discapacidad	Ancianos frágiles que residen en Comunidad
Gestor Caso	SI	NO	SI
PTI	SI	SI	SI
Equipo Multidiscipl	SI	SI	SI
Valoración Holística	SI	SI	SI
Resultados	Menor Hospital. Mejor resultados salud	Menor Hospital. Menor Instituciona.	Menor Hospital. Menor Instituciona.

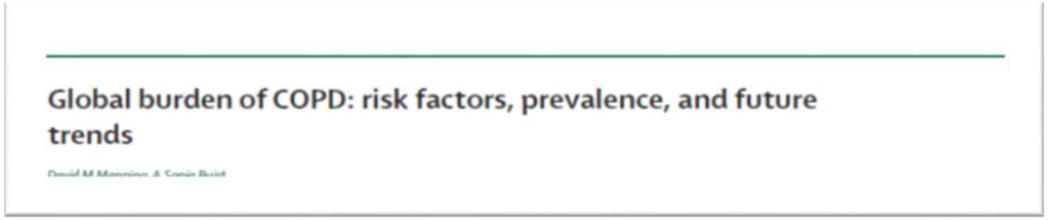
Santaeugenia S (2015). *Tesis doctoral. Efectividad de un modelo de atención geriátrica integrado en el marco de una OSI*. Universitat Autònoma de Barcelona, Barcelona.

La importancia de su impacto



% Pob.	%Mort.	%Ingres.	Gasto	% Gasto
1	28,9	138,4	12.273€	12,8%
4	8,4	33,5	5.326€	22,2%
10	1,3	7,5	2.321€	24,2%
35	0,2	2,6	850€	31,1%
50	0,0	0,4	188€	9,6%

EVOLUCIONAR DE ENFERMEDAD A MULTIMORBILIDAD …



Global burden of COPD: risk factors, prevalence, and future trends

Diabetes Atlas

IDF Diabetes Atlas: Global estimates of the prevalence of diabetes for 2011 and 2030

David R. Whiting[a,*], *Leonor Guariguata*[a], *Clara Weil*[a], *Jonathan Shaw*[b]

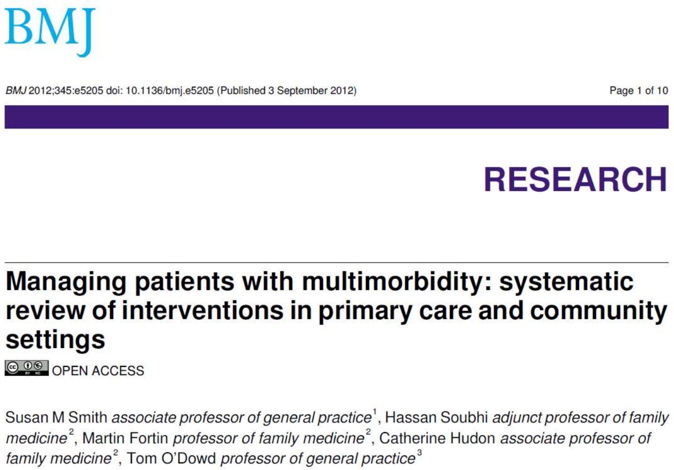
BMJ

BMJ 2013;346:f2510 doi: 10.1136/bmj.f2510 (Published 2 May 2013) Page 1 of 4

ANALYSIS

Better management of patients with multimorbidity

Martin Roland and **Charlotte Paddison** call for greater emphasis on continuity of care and clinical judgment to improve the experience of patients with multiple conditions



BMJ

BMJ 2012;345:e5205 doi: 10.1136/bmj.e5205 (Published 3 September 2012) Page 1 of 10

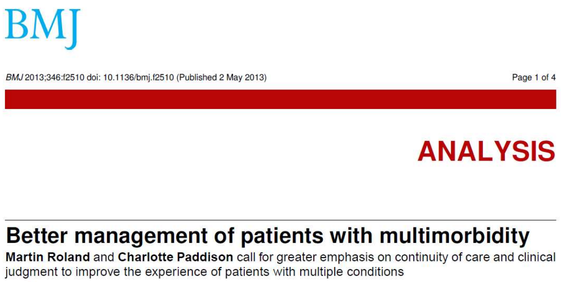
RESEARCH

Managing patients with multimorbidity: systematic review of interventions in primary care and community settings

OPEN ACCESS

Susan M Smith *associate professor of general practice*[1], Hassan Soubhi *adjunct professor of family medicine*[2], Martin Fortin *professor of family medicine*[2], Catherine Hudon *associate professor of family medicine*[2], Tom O'Dowd *professor of general practice*[3]

… Y AVANZAR HACIA LA ATENCION DE COMPLEJIDAD



BMJ

BMJ 2013;346:f2510 doi: 10.1136/bmj.f2510 (Published 2 May 2013) Page 1 of 4

ANALYSIS

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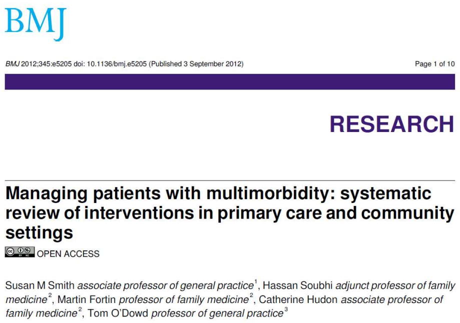

BMJ

BMJ 2012;345:e5205 doi: 10.1136/bmj.e5205 (Published 3 September 2012) Page 1 of 10

RESEARCH

Managing patients with multimorbidity: systematic review of interventions in primary care and community settings

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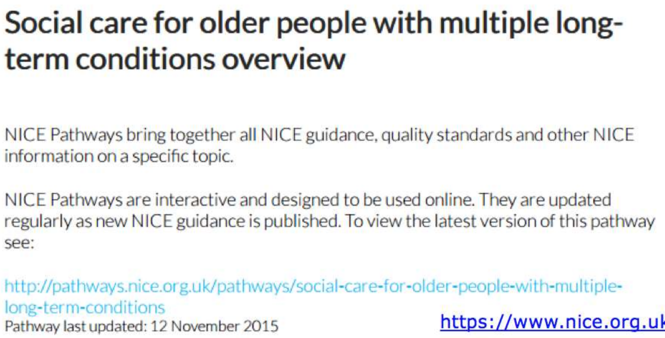
NICE National Institute for Health and Care Excellence

NICE Pathways

NICE ya elabora guías y rutas asistenciales para personas con necesidades de atención sanitaria y social



Social care for older people with multiple long-term conditions overview

NICE Pathways bring together all NICE guidance, quality standards and other NICE information on a specific topic.

NICE Pathways are interactive and designed to be used online. They are updated regularly as new NICE guidance is published. To view the latest version of this pathway see:

http://pathways.nice.org.uk/pathways/social-care-for-older-people-with-multiple-long-term-conditions

Pathway last updated: 12 November 2015

https://www.nice.org.uk/guidance/ng22

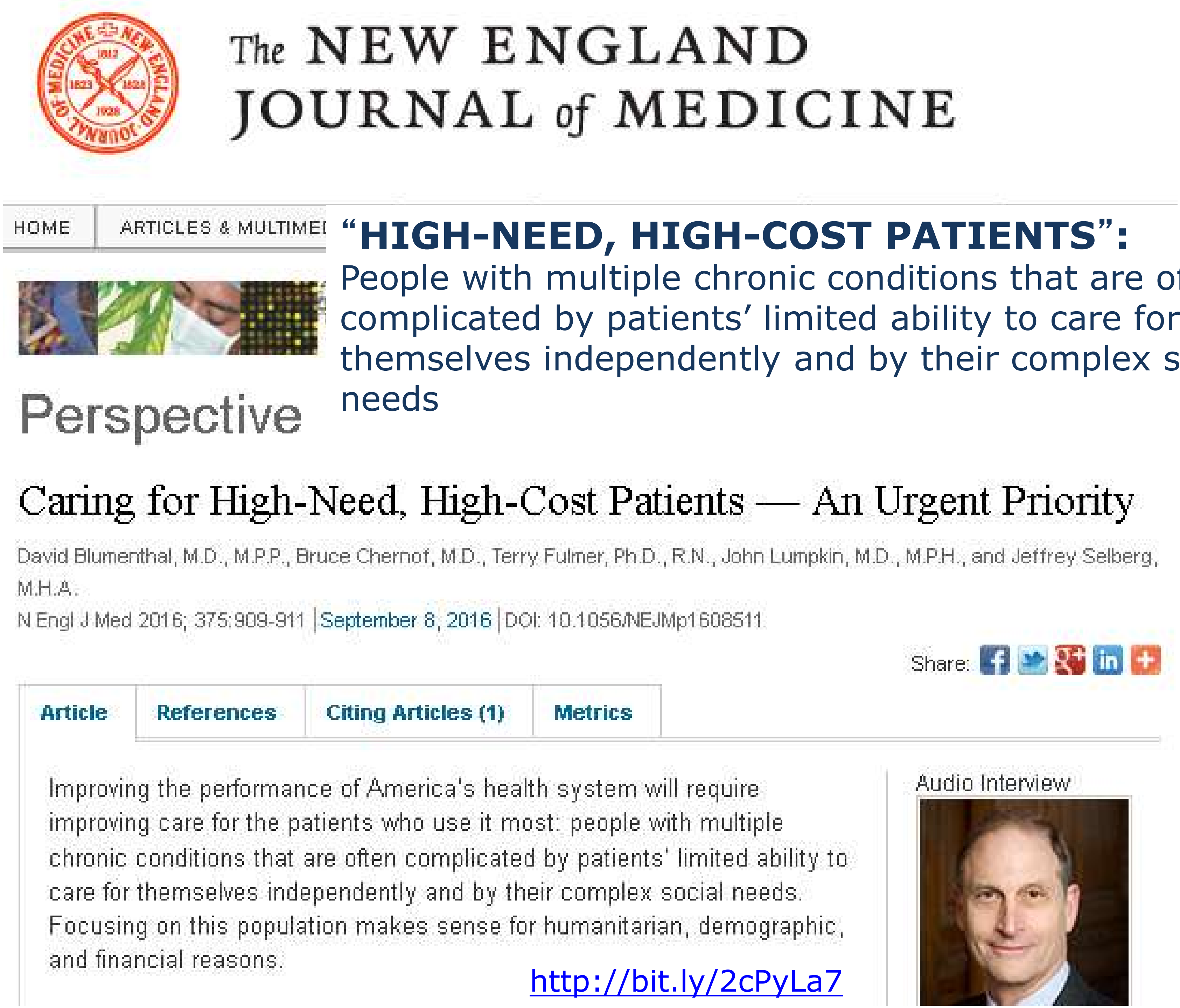
nuffieldtrust

Developing care for a changing population: supporting patients with costly, complex needs

Discussion paper

"HIGH-NEED, HIGH-COST PATIENTS":

People with multiple chronic conditions that are often complicated by patients' limited ability to care for themselves independently and by their complex social needs



The NEW ENGLAND JOURNAL of MEDICINE

Perspective

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

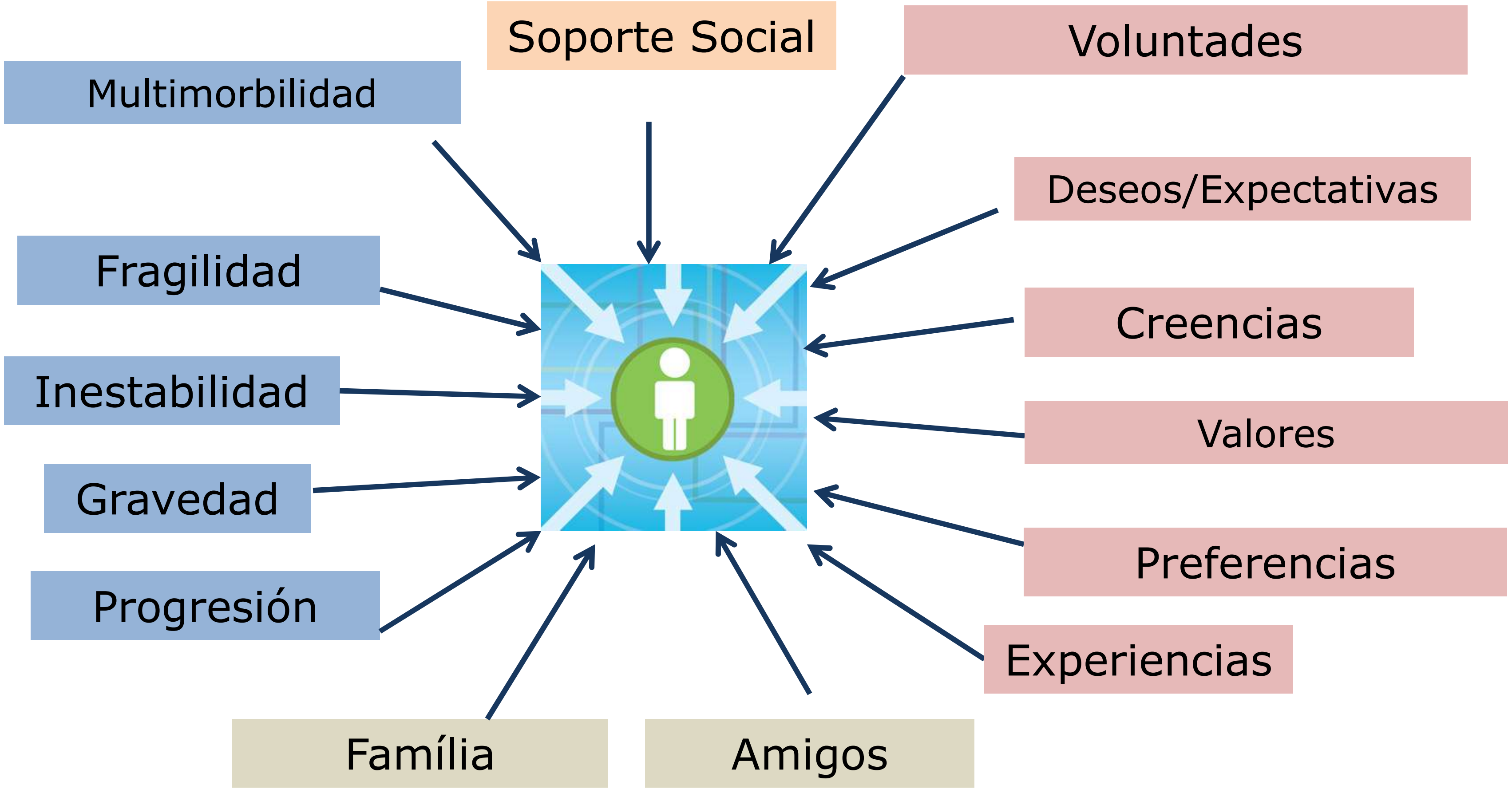
David Blumenthal, M.D., M.P.P., Bruce Chernof, M.D., Terry Fulmer, Ph.D., R.N., John Lumpkin, M.D., M.P.H., and Jeffrey Selberg, M.H.A.

N Engl J Med 2016; 375:909-911 | September 8, 2016 | DOI: 10.1056/NEJMp1608511

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.

http://bit.ly/2cPyLa7

A hablar de la complejidad… Intrínseca



Soporte Social

Multimorbilidad

Fragilidad

Inestabilidad

Gravedad

Progresión

Família

Amigos

Voluntades

Deseos/Expectativas

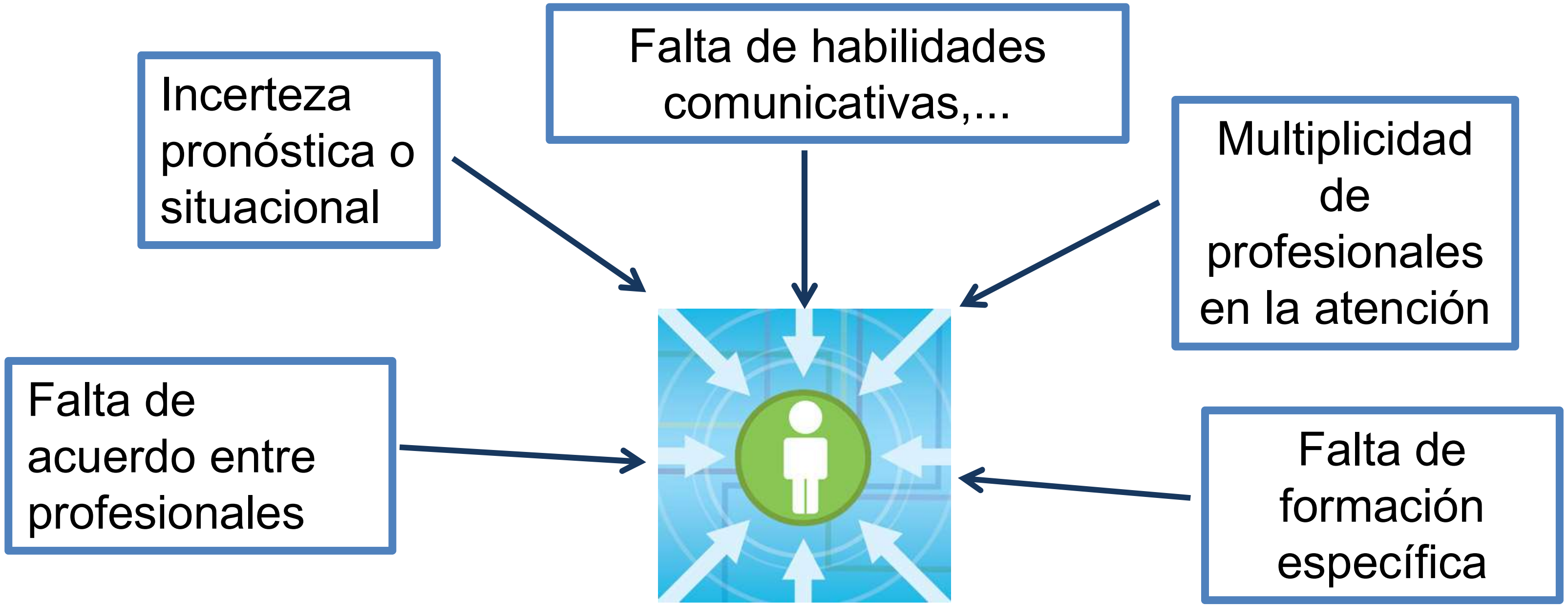
Creencias

Valores

Preferencias

Experiencias

A hablar de la complejidad… Extrínseca (Profesionales)



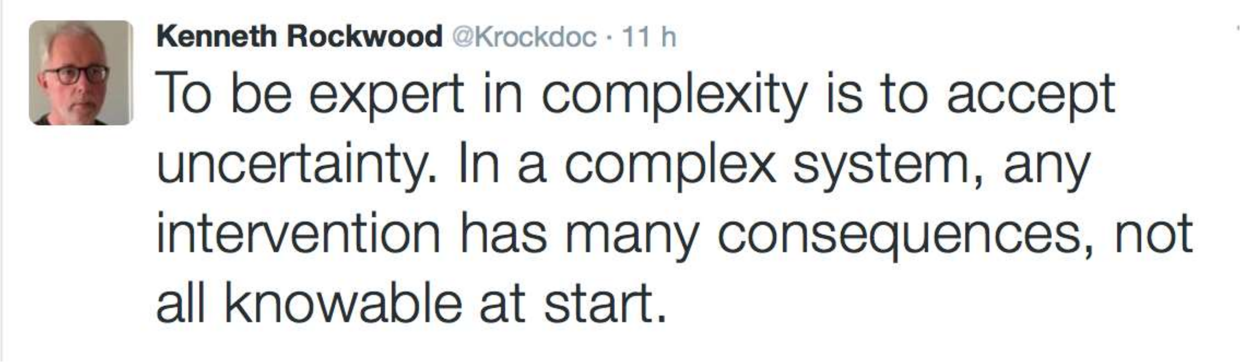
Incerteza pronóstica o situacional

Falta de habilidades comunicativas,...

Multiplicidad de profesionales en la atención

Falta de acuerdo entre profesionales

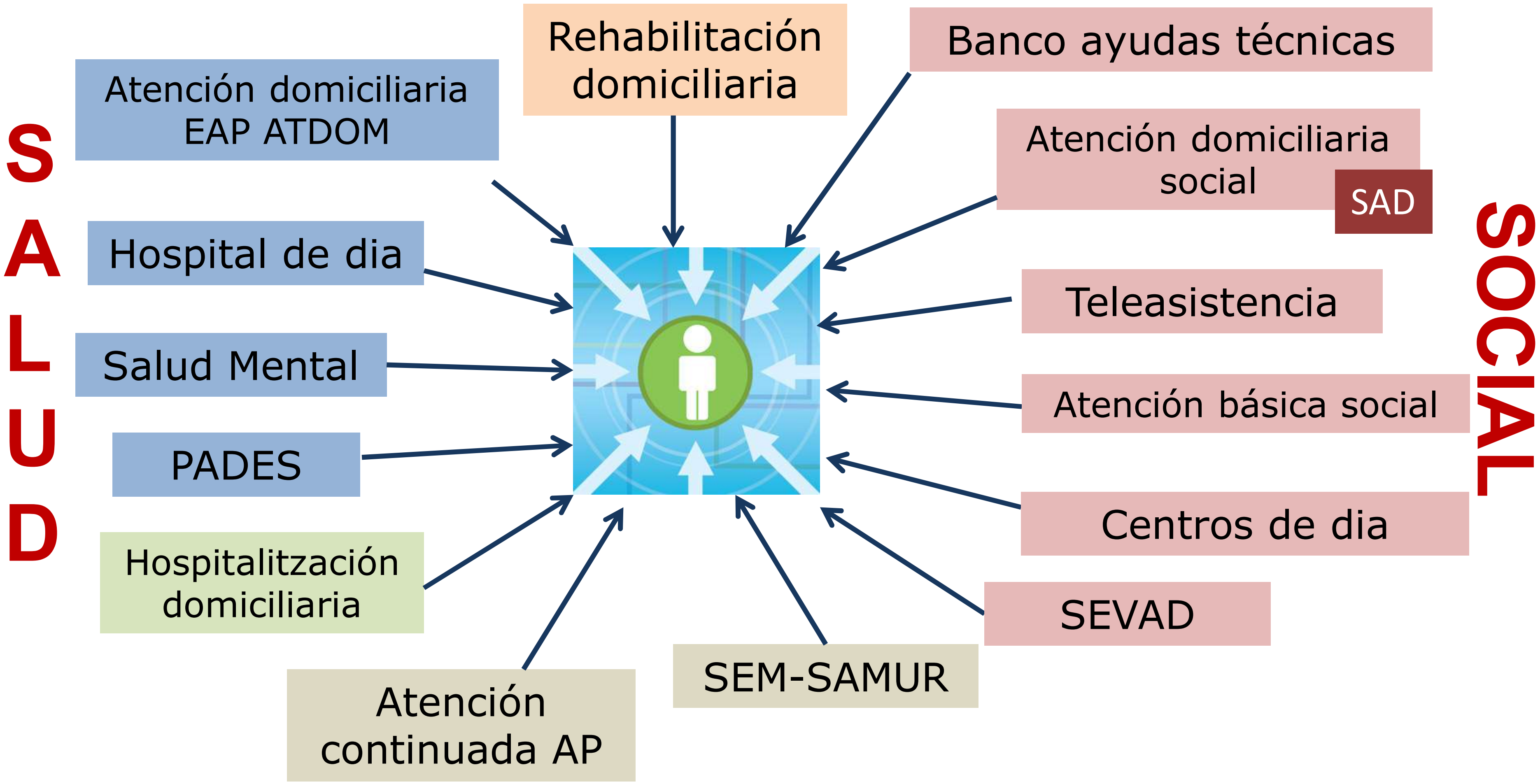
Falta de formación específica



Kenneth Rockwood @Krockdoc · 11 h

To be expert in complexity is to accept uncertainty. In a complex system, any intervention has many consequences, not all knowable at start.

A hablar de la complejidad… Extrínseca (Sistema)



SALUD

Atención domiciliaria EAP ATDOM

Hospital de dia

Salud Mental

PADES

Hospitalitzación domiciliaria

Atención continuada AP

SEM-SAMUR

Rehabilitación domiciliaria

Banco ayudas técnicas

Atención domiciliaria social SAD

Teleasistencia

Atención básica social

Centros de dia

SEVAD

SOCIAL

Plan de Crónicos de Catalunya: dos perfiles de complejidad

PCC:

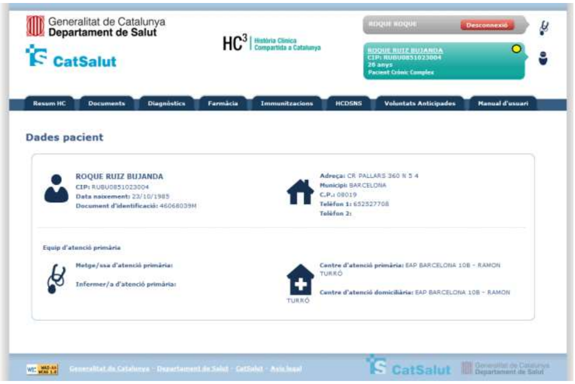
Paciente con multimorbilidad o condición única que comporta gestión clínica difícil

2-3%

MACA:

Pronóstico de vida limitado, altas necesidades, orientación paliativa, planificación de decisiones avanzadas

1,5%


Generalitat de Catalunya
Departament de Salut
CatSalut
HC3 | Història Clínica Compartida a Catalunya
ROQUE ROQUE
Desconnexió
Resum HC
Documents
Diagnòstics
Farmàcia
Immunitzacions
HCDSNS
Voluntats Anticipades
Manual d'usuari
Generalitat de Catalunya · Departament de Salut · CatSalut · Avís legal
CatSalut
Generalitat de Catalunya Departament de Salut

ROQUE RUIZ BUJANDA
CIP: RUBU0851023004
26 anys
Pacient Crònic Complex

Dades pacient

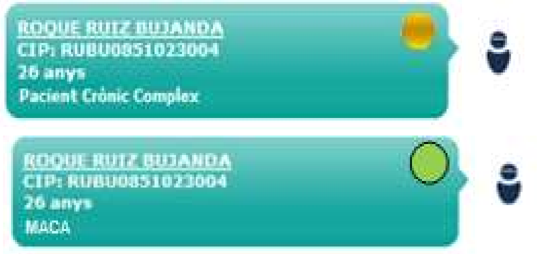
ROQUE RUIZ BUJANDA
CIP: RUBU0851023004
Data naixement: 23/10/1985
Document d'identificació: 46068039M

Adreça: CR PALLARS 360 N 5 4
Municipi: BARCELONA
C.P.: 08019
Telèfon 1: 652527708
Telèfon 2:

Equip d'atenció primària

Metge/ssa d'atenció primària:
Infermer/a d'atenció primària:

Centre d'atenció primària: EAP BARCELONA 10B - RAMON TURRÓ
Centre d'atenció domiciliària: EAP BARCELONA 10B - RAMON TURRÓ



ROQUE RUIZ BUJANDA
CIP: RUBU0851023004
26 anys
Pacient Crònic Complex

ROQUE RUIZ BUJANDA
CIP: RUBU0851023004
26 anys
MACA

Generalitat de Catalunya
Departament de Salut

Pla de Salut
de Catalunya 2016-2020

Paciente en situación de cronicidad compleja es identificado en base a tres pasos clave

1

Estratificación

+

Características Clínicas

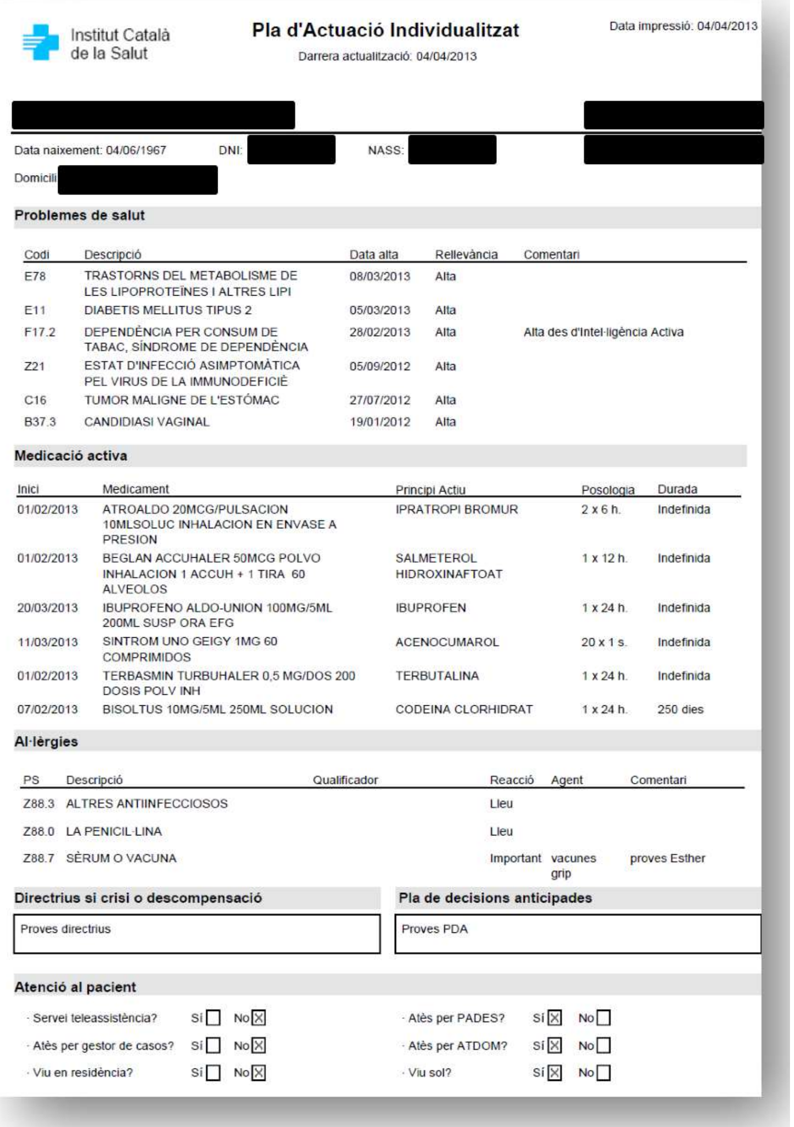
2

Criterio Subjetivo del profesional referente

3

El principio de mejoría

Font: Programa de prevenció i atenció a la cronicitat. Departament de Salut. 2012.



Institut Català de la Salut

Pla d'Actuació Individualitzat

Darrera actualització: 04/04/2013

Data impressió: 04/04/2013

[redacted] [redacted]

Data naixement: 04/06/1967 DNI: [redacted] NASS: [redacted] [redacted]

Domicili [redacted]

Problemes de salut

Codi	Descripció	Data alta	Rellevància	Comentari
E78	TRASTORNS DEL METABOLISME DE LES LIPOPROTEÏNES I ALTRES LIPI	08/03/2013	Alta	
E11	DIABETIS MELLITUS TIPUS 2	05/03/2013	Alta	
F17.2	DEPENDÈNCIA PER CONSUM DE TABAC, SÍNDROME DE DEPENDÈNCIA	28/02/2013	Alta	Alta des d'Intel·ligència Activa
Z21	ESTAT D'INFECCIÓ ASIMPTOMÀTICA PEL VIRUS DE LA IMMUNODEFICIÈ	05/09/2012	Alta	
C16	TUMOR MALIGNE DE L'ESTÓMAC	27/07/2012	Alta	
B37.3	CANDIDIASI VAGINAL	19/01/2012	Alta	

Medicació activa

Inici	Medicament	Principi Actiu	Posologia	Durada
01/02/2013	ATROALDO 20MCG/PULSACION 10MLSOLUC INHALACION EN ENVASE A PRESION	IPRATROPI BROMUR	2 x 6 h.	Indefinida
01/02/2013	BEGLAN ACCUHALER 50MCG POLVO INHALACION 1 ACCUH + 1 TIRA 60 ALVEOLOS	SALMETEROL HIDROXINAFTOAT	1 x 12 h.	Indefinida
20/03/2013	IBUPROFENO ALDO-UNION 100MG/5ML 200ML SUSP ORA EFG	IBUPROFEN	1 x 24 h.	Indefinida
11/03/2013	SINTROM UNO GEIGY 1MG 60 COMPRIMIDOS	ACENOCUMAROL	20 x 1 s.	Indefinida
01/02/2013	TERBASMIN TURBUHALER 0,5 MG/DOS 200 DOSIS POLV INH	TERBUTALINA	1 x 24 h.	Indefinida
07/02/2013	BISOLTUS 10MG/5ML 250ML SOLUCION	CODEINA CLORHIDRAT	1 x 24 h.	250 dies

Al·lèrgies

PS	Descripció	Qualificador	Reacció	Agent	Comentari
Z88.3	ALTRES ANTIINFECCIOSOS		Lleu		
Z88.0	LA PENICIL·LINA		Lleu		
Z88.7	SÈRUM O VACUNA		Important	vacunes grip	proves Esther

Directrius si crisi o descompensació

Proves directrius

Pla de decisions anticipades

Proves PDA

Atenció al pacient

- Servei teleassistència? Sí ☐ No ☒
- Atès per gestor de casos? Sí ☐ No ☒
- Viu en residència? Sí ☐ No ☒
- Atès per PADES? Sí ☒ No ☐
- Atès per ATDOM? Sí ☒ No ☐
- Viu sol? Sí ☒ No ☐

El PIIC como plan individualizado, interdisciplinario, compartido con la persona y disponible online para todo el sistema de salud

¿QUÉ TIENE?

¿QUÉ TOMA?

¿QUÉ HAY QUE HACER SI …?

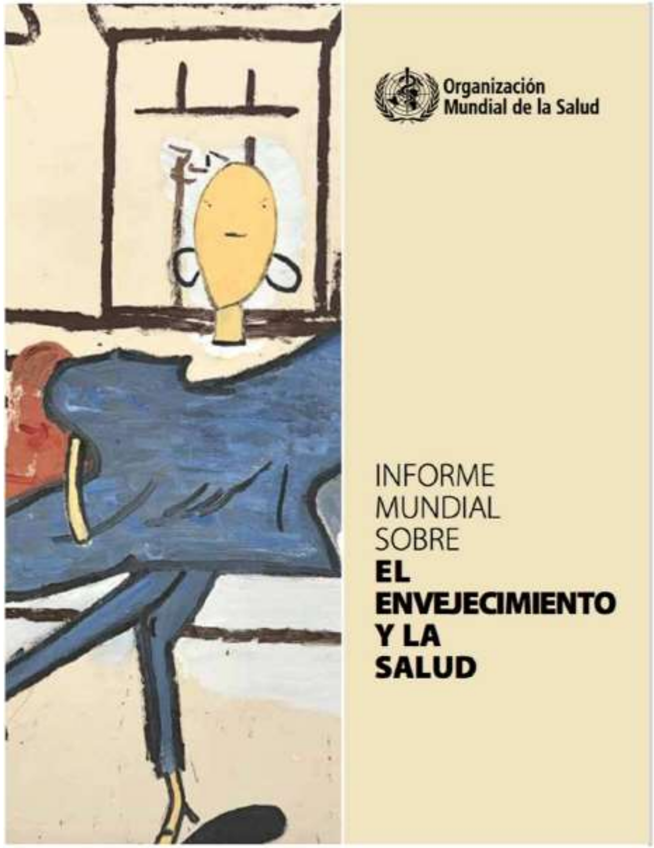
QUÉ PREFIERE

5 NIVELES DE ACTIVACIÓN:

Teléfono, domicilio immediato, domicilio diferido

Atención intermedia, hospital de agudos

Aspecto nº4: REORGANIZANDO EL SISTEMA



Organización Mundial de la Salud

INFORME MUNDIAL SOBRE **EL ENVEJECIMIENTO Y LA SALUD**

© Organización Mundial de la Salud, 30-09-2015

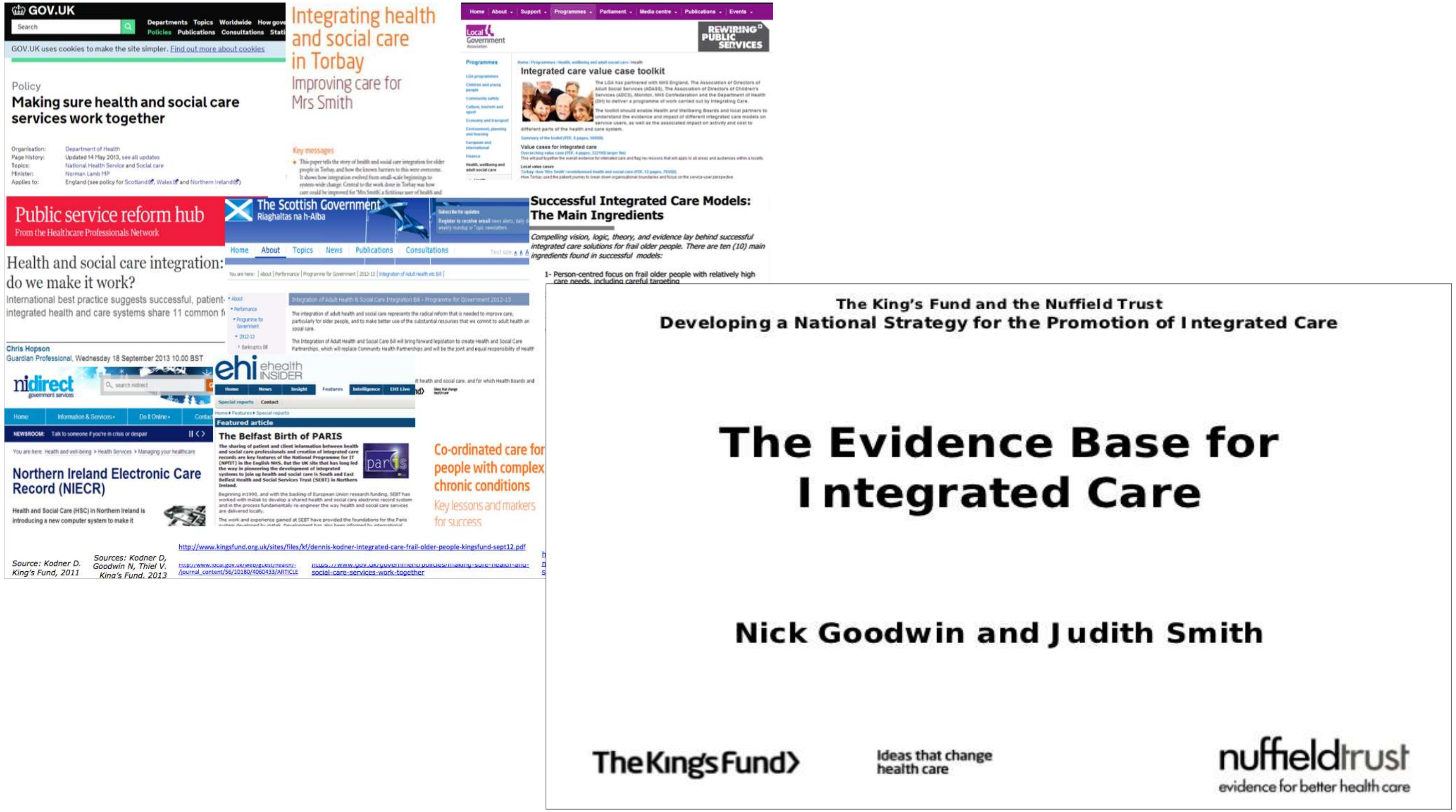
La respuesta actual de salud pública: más de lo mismo no es suficiente.

- Se necesita **un cambio sistémico**. Los sistemas de salud suelen estar mejor **diseñados para curar enfermedades agudas** que para gestionar y reducir al mínimo las consecuencias de los estados crónicos prevalentes en la vejez .

- Además, en estos sistemas frecuentemente se **trabaja de manera compartimentada**, por lo que se abordan cada una de estas cuestiones por separado.

- Se suelen utilizar los **costosos servicios de atención de casos agudos para atender cuadros crónicos** y no se logra fomentar plenamente el funcionamiento de las personas mayores que reciben atención a largo plazo.

Y sólo hay una opción basada en la evidencia



GOV.UK

Departments Topics Worldwide

Policies Publications Consultations

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Policy

Making sure health and social care services work together

Organisation: Department of Health
Page history: Updated 14 May 2013, see all updates
Topics: National Health Service and Social care
Minister: Norman Lamb MP
Applies to: England (see policy for Scotland, Wales and Northern Ireland)

Integrating health and social care in Torbay

Improving care for Mrs Smith

Key messages

- This paper tells the story of health and social care integration for older people in Torbay, and how the known barriers to this were overcome. It shows how integration evolved from small-scale beginnings to system-wide change. Central to the work done in Torbay was how care could be improved for 'Mrs Smith', a fictitious user of health and

Home About Support Programmes Parliament Media centre Publications Events

Local Government Association

REWIRING PUBLIC SERVICES

Integrated care value case toolkit

The LGA has partnered with NHS England, The Association of Directors of Adult Social Services (ADASS), The Association of Directors of Children's Services (ADCS), Monitor, NHS Confederation and the Department of Health (DH) to deliver a programme of work carried out by Integrating Care.

The toolkit should enable Health and Wellbeing Boards and local partners to understand the evidence and impact of different integrated care models on service users, as well as the associated impact on activity and cost to different parts of the health and care system.

Value cases for integrated care

Local value cases

Public service reform hub

From the Healthcare Professionals Network

Health and social care integration: do we make it work?

International best practice suggests successful, patient-integrated health and care systems share 11 common f

Chris Hopson

Guardian Professional, Wednesday 18 September 2013 10.00 BST

The Scottish Government

Riaghaltas na h-Alba

Home About Topics News Publications Consultations

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 an 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 Healtl

Successful Integrated Care Models: The Main Ingredients

Compelling vision, logic, theory, and evidence lay behind successful integrated care solutions for frail older people. There are ten (10) main ingredients found in successful models:

1- Person-centred focus on frail older people with relatively high care needs, including careful targeting

nidirect government services

Home Information & Services Do It Online

NEWSROOM: Talk to someone if you're in crisis or despair

You are here: Health and well-being > Health Services > Managing your healthcare

Northern Ireland Electronic Care Record (NIECR)

Health and Social Care (HSC) in Northern Ireland is introducing a new computer system to make it

ehi ehealth INSIDER

Home News Insight Features Intelligence EHI Live

Featured article

The Belfast Birth of PARIS

The sharing of patient and client information between health and social care professionals and creation of integrated care records are key features of the National Programme for IT (NPfIT) in the English NHS. But the UK site that has long led the way in pioneering the development of integrated systems to join up health and social care is South and East Belfast Health and Social Services Trust (SEBT) in Northern Ireland.

Beginning in 1990, and with the backing of European Union research funding, SEBT has worked with in4tek to develop a shared health and social care electronic record system and in the process fundamentally re-engineer the way health and social care services are delivered locally.

The work and experience gained at SEBT have provided the foundations for the Paris

Co-ordinated care for people with complex chronic conditions

Key lessons and markers for success

Source: Kodner D. King's Fund, 2011

Sources: Kodner D, Goodwin N, Thiel V. King's Fund, 2013

http://www.kingsfund.org.uk/sites/files/kf/dennis-kodner-integrated-care-frail-older-people-kingsfund-sept12.pdf

http://www.local.gov.uk/web/guest/health/-/journal_content/56/10180/4060433/ARTICLE

https://www.gov.uk/government/policies/making-sure-health-and-social-care-services-work-together

The King's Fund and the Nuffield Trust

Developing a National Strategy for the Promotion of Integrated Care

The Evidence Base for Integrated Care

Nick Goodwin and Judith Smith

The King's Fund

Ideas that change health care

nuffieldtrust

evidence for better health care

Crear sistemas de atención integrada social y sanitaria

An integrated care approach because...

Does Integrated Care Work?

Evidence from PACE, Torbay, PRISMA and Rovereto—and other programmes and pilots in North America, UK, Europe, and Australia specifically targeted to frail older people—strongly suggests that integrated care is capable of achieving positive outcomes, although it is not always clear which combination of strategies—and under what circumstances—produce the best results:

- Expanded service access, including primary care +++
- Enhanced co-ordination and continuity +++
- Improved health and functional status ++
- Reduced hospitalisation/nursing home admission/LOS ++
- Improved user experience, quality of life (QoL), and satisfaction +++
- Reduced carer burden ++
- Greater efficiency +
- Controlled/reduced costs +
- Perceived improvements in partnership working; also greater focus on governance and guidelines. +++

(Kodner, 2011)

Economic Impact of Integrated Care Models for Patients with Chronic Diseases: A Systematic Review

Melissa Desmedt, MSc[1,], Sonja Vertriest, MSc[1], Johan Hellings, PhD[1,2], Jochen Bergs, MSc[3], Ezra Dessers, PhD[4], Patrik Vankrunkelsven, PhD[5], Hubertus Vrijhoef, PhD[6,7,8], Lieven Annemans, PhD[9], Nick Verhaeghe, PhD[9], Mirko Petrovic, PhD[10], Dominique Vandijck, PhD[1,11]*

Source: Kodner D. King's Fund, 2011

http://www.kingsfund.org.uk/sites/files/kf/dennis-kodner-integrated-care-frail-older-people-kingsfund-sept12.pdf

…con elementos concretos para facilitar la integración

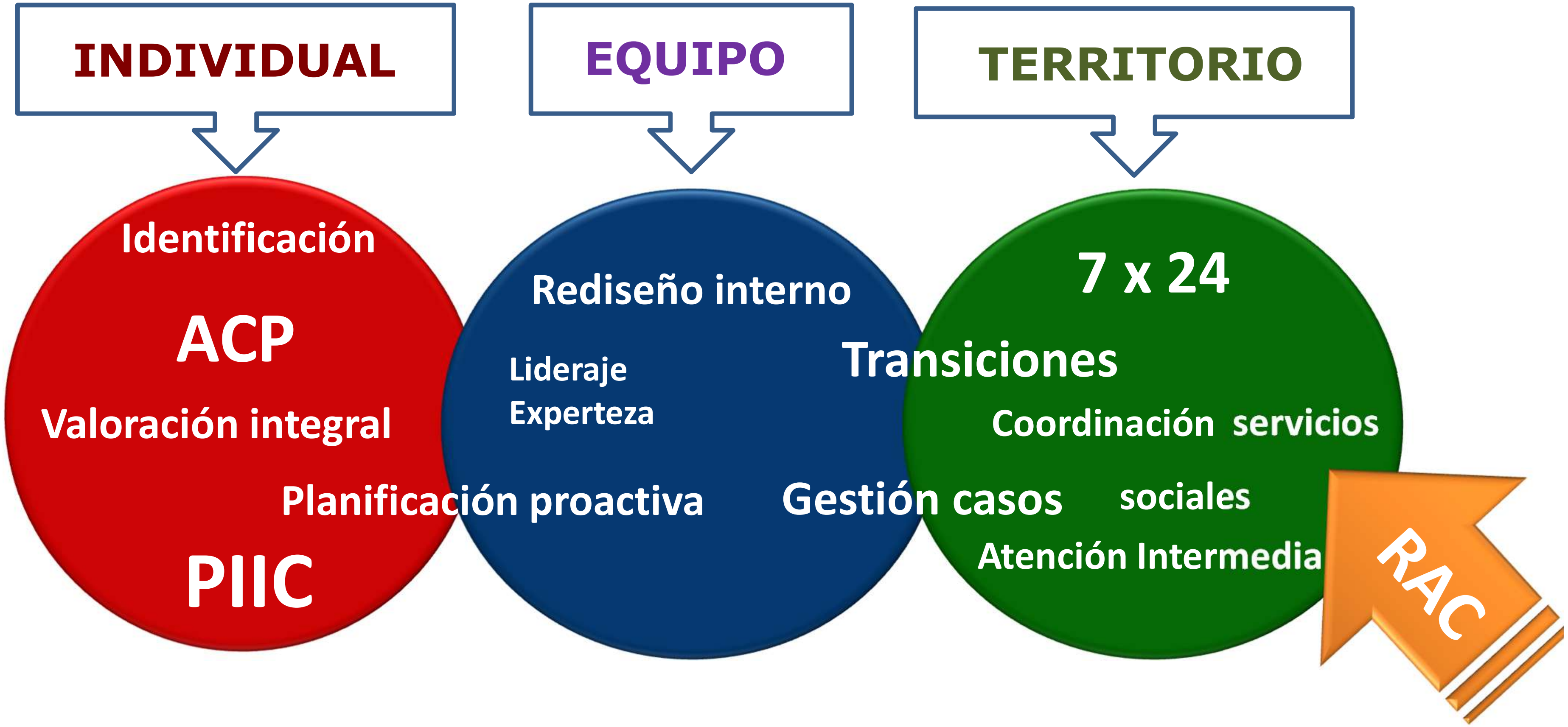
ACCIONES DE MEJORA PROFESIONAL

REDISEÑO DE EQUIPOS

ORDENACIÓN TERRITORIAL

Font: Programa de prevenció i atenció a la cronicitat. Departament de Salut. 2013.

…con elementos concretos para facilitar la integración (II)



INDIVIDUAL

Identificación

ACP

Valoración integral

Planificación proactiva

PIIC

EQUIPO

Rediseño interno

Lideraje

Experteza

TERRITORIO

7 x 24

Transiciones

Gestión casos

Coordinación servicios sociales

Atención Intermedia

Font: Programa de prevenció i atenció a la cronicitat. Departament de Salut. 2013.

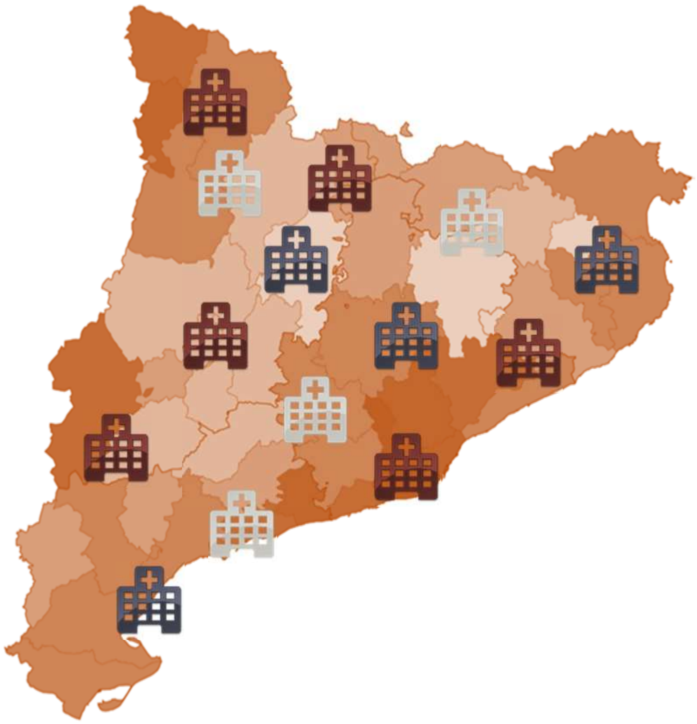
Aspecto 4: La Historia clínica compartida como herramienta clave de comunicación

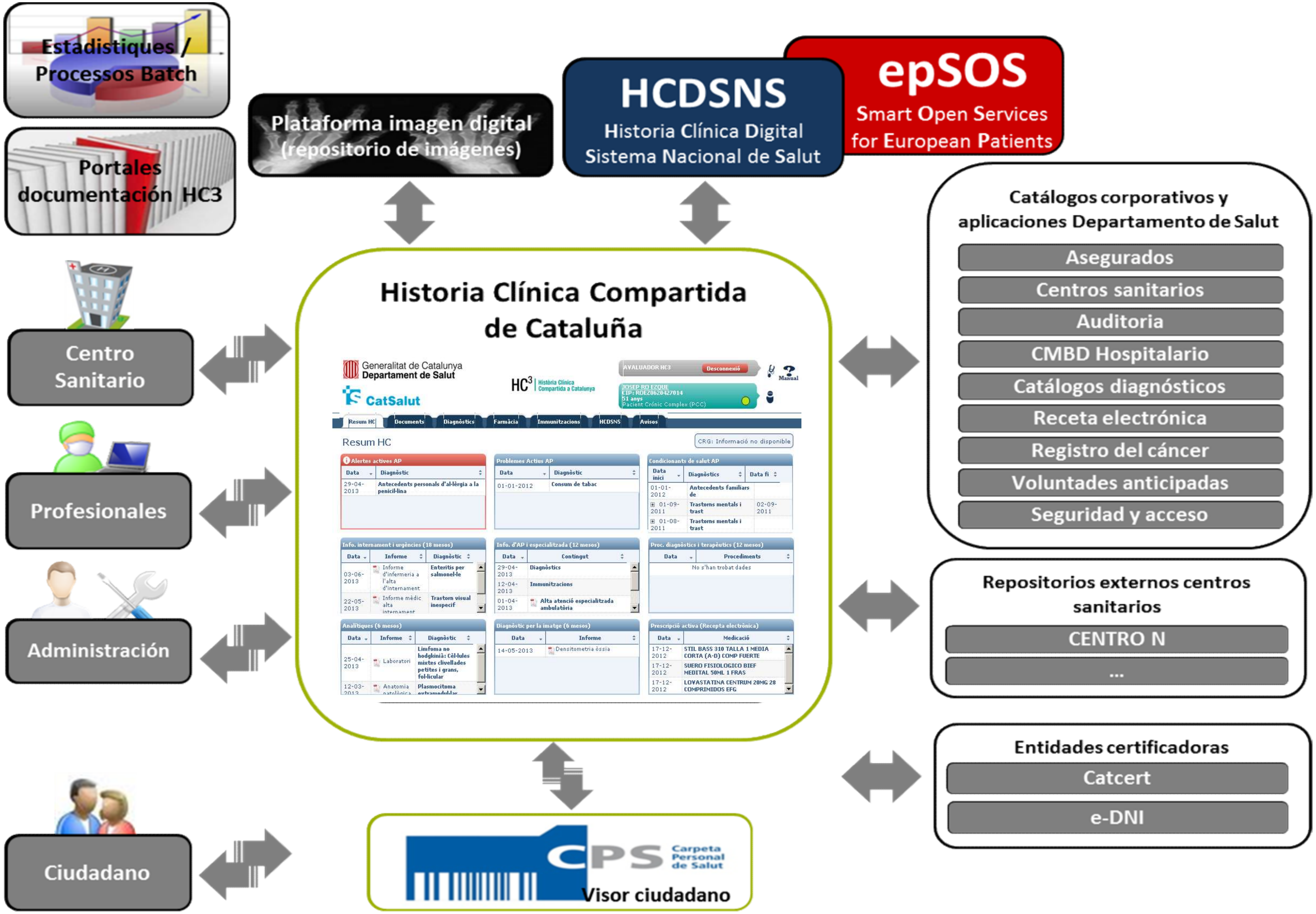
HC3 Història clínica compartida de Catalunya

THIS IS THE **ELECTRONIC MEDICAL RECORD** THAT COLLECTS ALL IMPORTANT INFORMATION ON THE STATE AND EVOLUTION OF A PATIENT THROUGHOUT THEIR HEALTHCARE PROCESS

Sistema catalán es complejo...

- **Modelo multiproveedor** (> 160 proveedores – 32 IT systems) integrado en una sola red pública
- **Permite la gestión autónoma** de cada proveedor
- **Los proveedores son libres de seleccionar sus sistemas de información**
- **El 94% de los centros de atención primaria tienen el mismo sistema (eCAP)**
- **La interoperabilidad debe garantizarse**





Estadístiques / Processos Batch

Portales documentación HC3

Plataforma imagen digital (repositorio de imágenes)

HCDSNS
Historia Clínica Digital
Sistema Nacional de Salut

epSOS
Smart Open Services
for European Patients

Centro Sanitario

Profesionales

Administración

Ciudadano

Historia Clínica Compartida de Cataluña

Generalitat de Catalunya
Departament de Salut
CatSalut

HC³ | Història Clínica Compartida a Catalunya

AVALUADOR HC3 — Desconnexió — Manual

JOSEP RO EZQUE
CIP: ROEZ0620427014
51 anys
Pacient Crònic Complex (PCC)

Resum HC | Documents | Diagnòstics | Farmàcia | Immunitzacions | HCDSNS | Avisos

Resum HC

CRG: Informació no disponible

Alertes actives AP

Data	Diagnòstic
29-04-2013	Antecedents personals d'al·lèrgia a la penicil·lina

Problemes Actius AP

Data	Diagnòstic
01-01-2012	Consum de tabac

Condicionants de salut AP

Data inici	Diagnòstics	Data fi
01-01-2012	Antecedents familiars de	
⊞ 01-09-2011	Trastorns mentals i trast	02-09-2011
⊞ 01-08-2011	Trastorns mentals i trast	

Info. internament i urgències (18 mesos)

Data	Informe	Diagnòstic
03-06-2013	Informe d'infermeria a l'alta d'internament	Enteritis per salmonel·le
22-05-2013	Informe mèdic alta internament	Trastorn visual inespecif

Info. d'AP i especialitzada (12 mesos)

Data	Contingut
29-04-2013	Diagnòstics
12-04-2013	Immunitzacions
01-04-2013	Alta atenció especialitzada ambulatòria

Proc. diagnòstics i terapèutics (12 mesos)

Data	Procediments
No s'han trobat dades	

Analítiques (6 mesos)

Data	Informe	Diagnòstic
25-04-2013	Laboratori	Limfoma no hodgkinià: Cèl·lules mixtes clivellades petites i grans, fol·licular
12-03-2013	Anatomia patològica	Plasmocitoma extramedul·lar

Diagnòstic per la imatge (6 mesos)

Data	Informe
14-05-2013	Densitometria òssia

Prescripció activa (Recepta electrònica)

Data	Medicació
17-12-2012	STIL BASS 310 TALLA 1 MEDIA CORTA (A-D) COMP FUERTE
17-12-2012	SUERO FISIOLOGICO BIEF MEDITAL 50ML 1 FRAS
17-12-2012	LOVASTATINA CENTRUM 20MG 28 COMPRIMIDOS EFG

CPS Carpeta Personal de Salut
Visor ciudadano

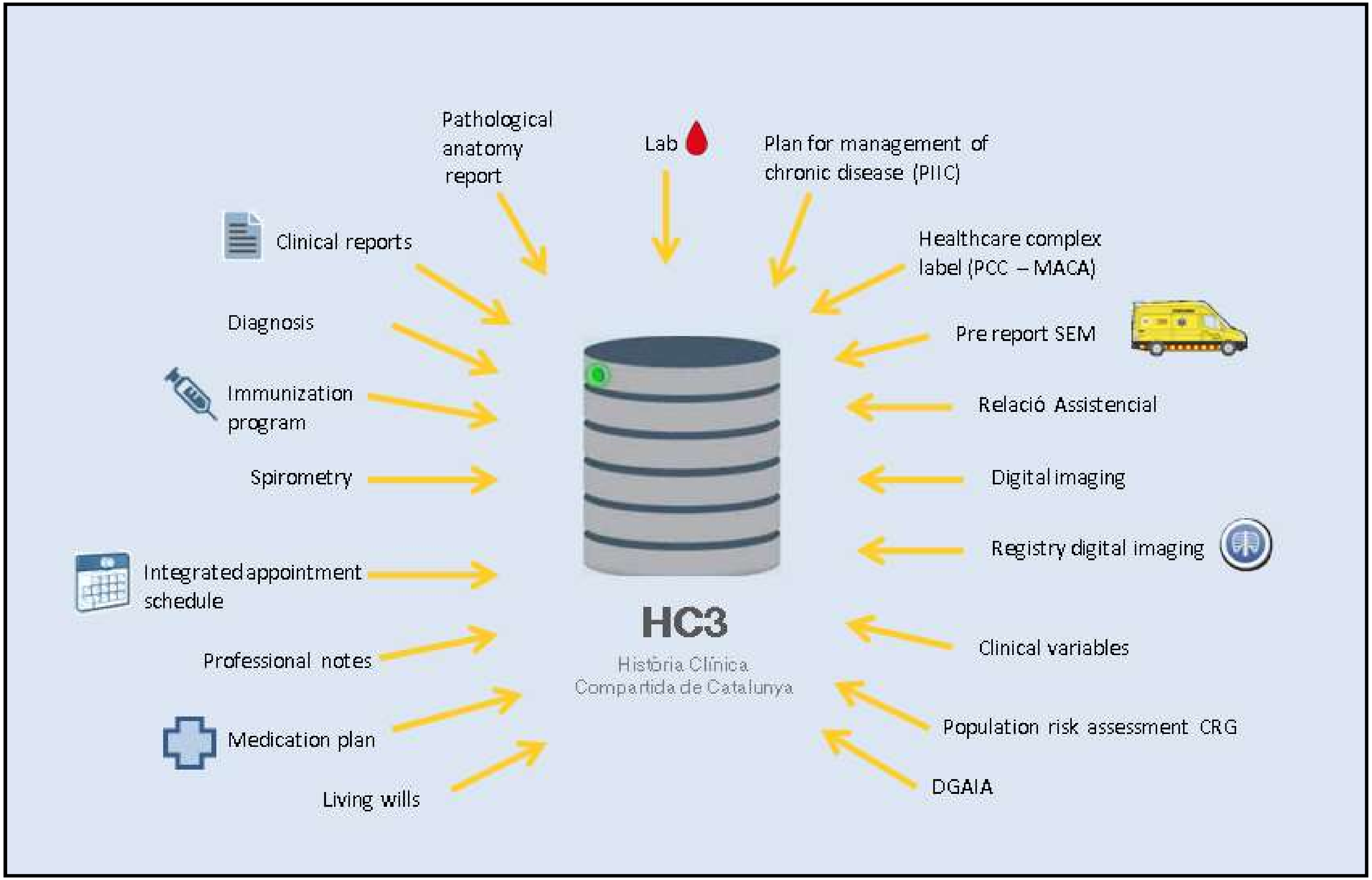
Catálogos corporativos y aplicaciones Departamento de Salut
- Asegurados
- Centros sanitarios
- Auditoria
- CMBD Hospitalario
- Catálogos diagnósticos
- Receta electrónica
- Registro del cáncer
- Voluntades anticipadas
- Seguridad y acceso

Repositorios externos centros sanitarios
- CENTRO N
- ...

Entidades certificadoras
- Catcert
- e-DNI

Generalitat de Catalunya
Departament de Salut

Pla de Salut
de Catalunya 2016-2020



Pathological anatomy report

Lab

Plan for management of chronic disease (PIIC)

Clinical reports

Healthcare complex label (PCC – MACA)

Diagnosis

Pre report SEM

Immunization program

Relació Assistencial

Spirometry

Digital imaging

Registry digital imaging

Integrated appointment schedule

HC3

Història Clínica Compartida de Catalunya

Professional notes

Clinical variables

Medication plan

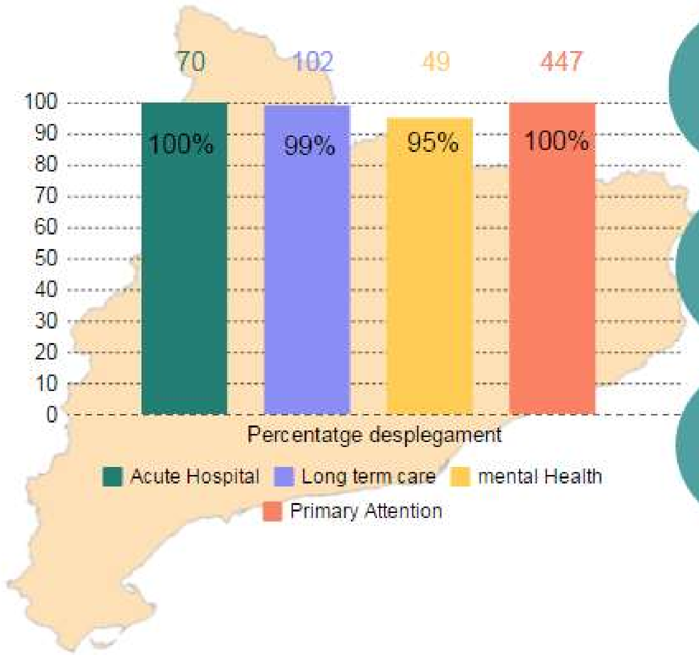
Population risk assessment CRG

Living wills

DGAIA

HC3 Deployment

SISCAT CENTRES WITH AN AGREEMENT WITH HC3



152
Milions of published documents

99%
centres SISCAT connected

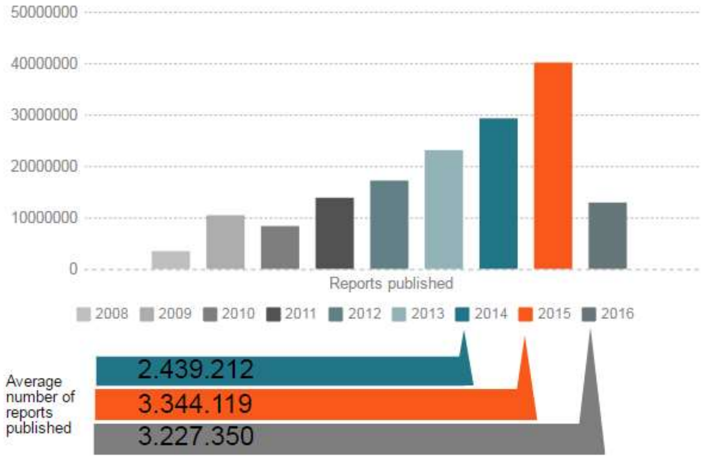
665
Health Care Centres connected

Epidemiologists, ASP, ASPB and SEM

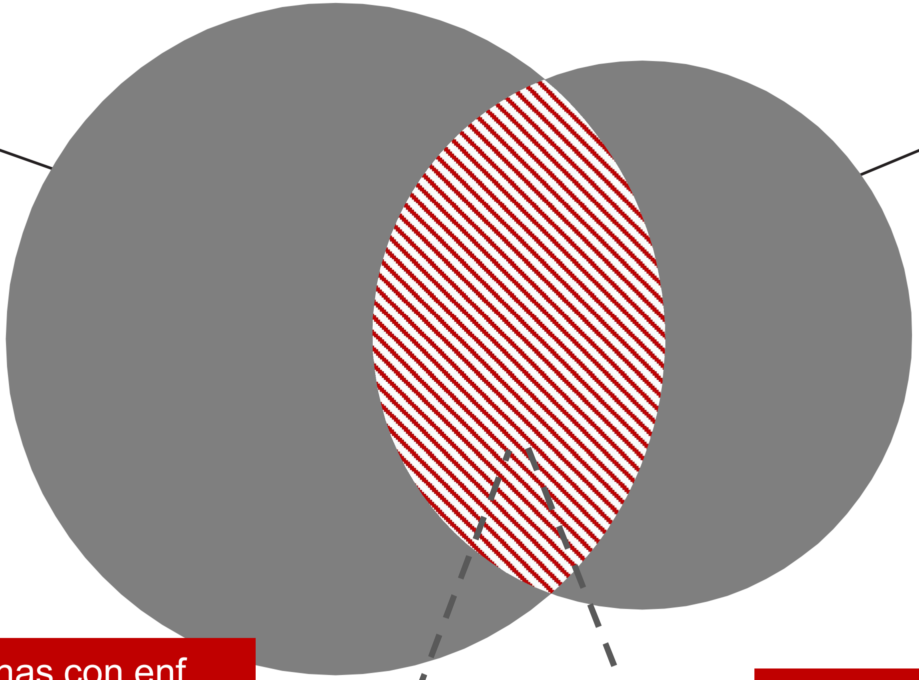
Other Departaments in process: Social Welfare and Family

HC3 Publication

↑ 25%



Aspecto 6: Inclusión de la complejidad en Salud Mental



Enfemedades crónicas:
30% de la población

Trastornos mentales:
20% de la población

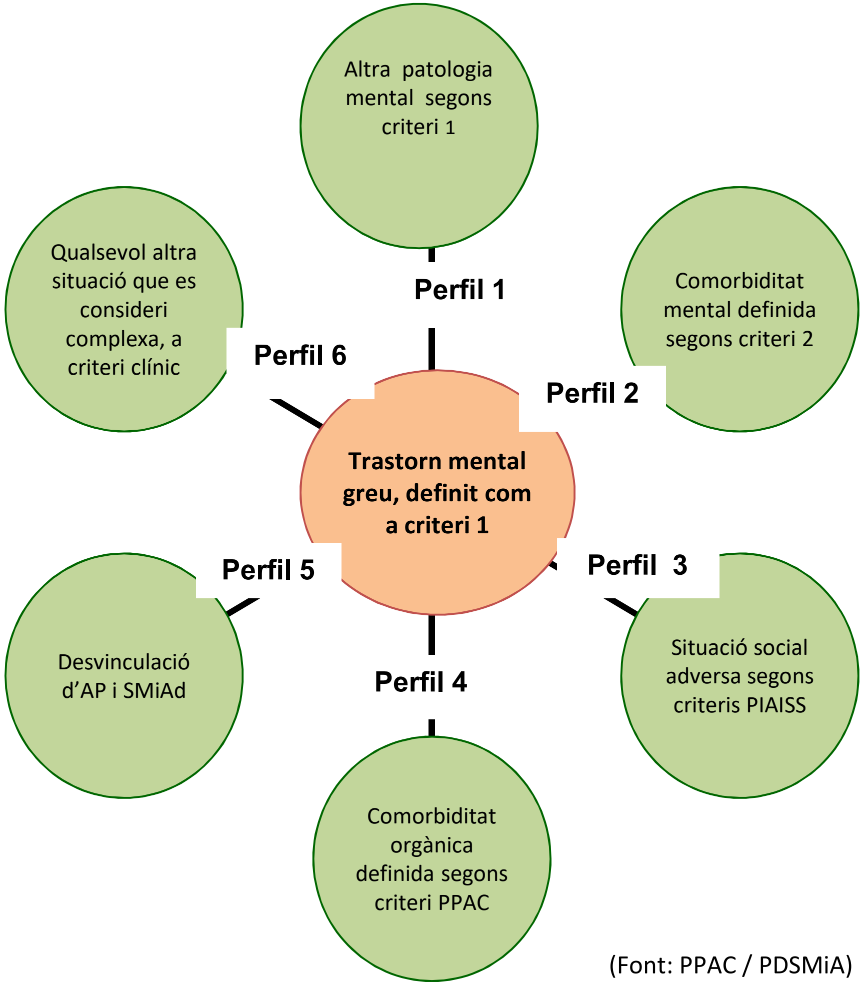
El 30% de personas con enf crónica tiene además problema de salud mental

El 46% de personas con trastorno mental tiene enf. Crónicas

Font: Naylor et al, 2012. Kings Fund.

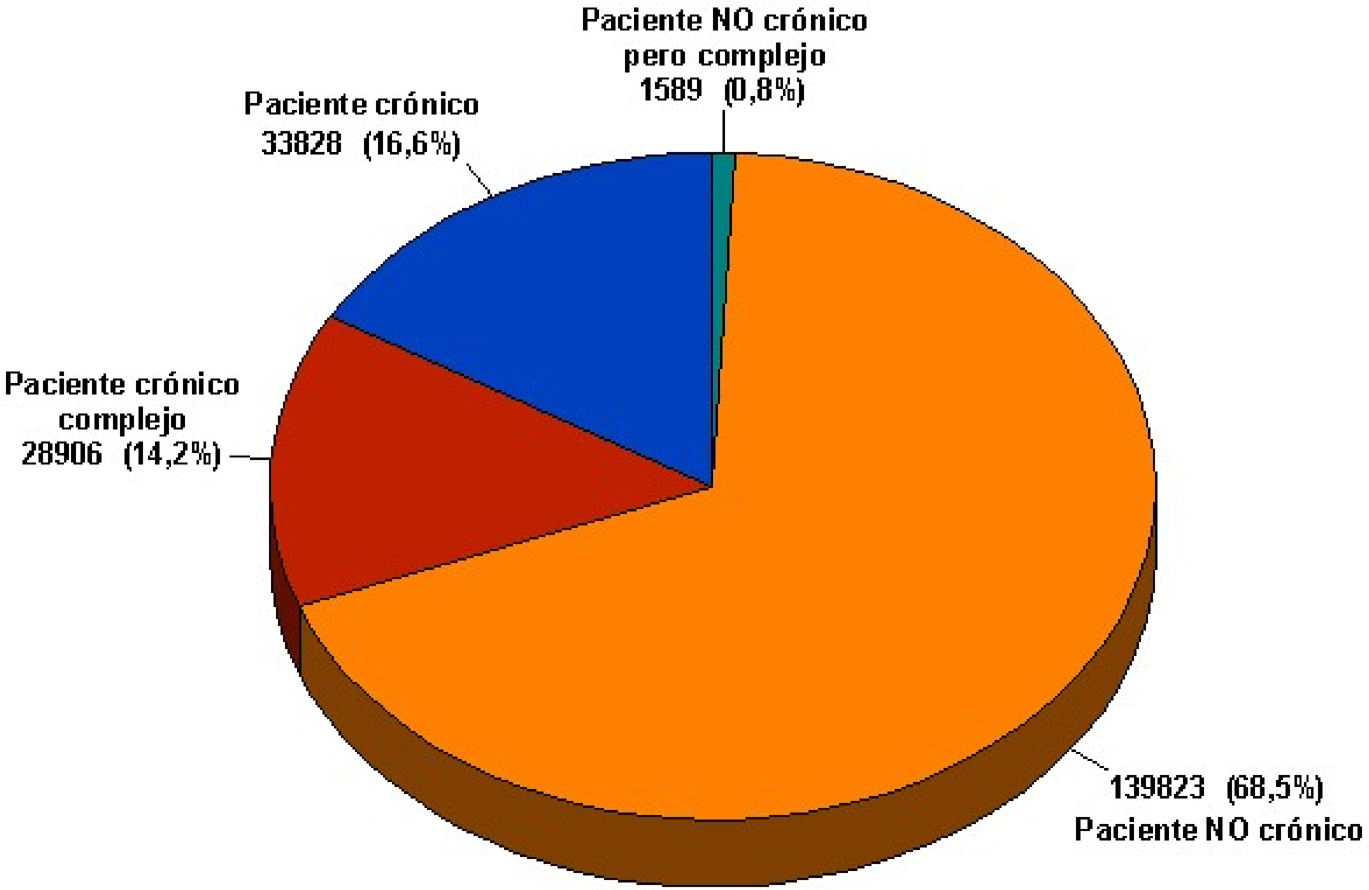
PCC en SM y Adicciones: Perfiles de cronicidad

- **Perfil 1**. Concurrencia de dos o más patologias mentales identificadas con criterio 1.
- **Perfil 2**. Concurrencia de una patologia de criterio 1 y como mínimo una de criterio 2.
- **Perfil 3**. Concurrencia de una patologia del criterio 1 y condiciones sociales adversas.
- **Perfil 4**. Concurrencia de una patologia criterio 1 y comorbilidad física relevante
- **Perfil 5**. Personas desvinculadas de APS y de SM.
  - Personas con trastorno mental crónico sin contacto en 1 año
  - Personas atendidad más de 10 veces en un servicio de UCIAS, en los últimos 6 meses.
- **Perfil 6**. Cualquier condicion de SM de difícil manejo, a criterio profesional


Altra patologia mental segons criteri 1
Perfil 1
Comorbiditat mental definida segons criteri 2
Perfil 2
Qualsevol altra situació que es consideri complexa, a criteri clínic
Perfil 6
Trastorn mental greu, definit com a criteri 1
Perfil 5
Perfil 3
Desvinculació d'AP i SMiAd
Perfil 4
Situació social adversa segons criteris PIAISS
Comorbiditat orgànica definida segons criteri PPAC

(Font: PPAC / PDSMiA)

Clasificación de las personas atendida en los servicios de SM, según cronicidad y complejidad



No se incluyen adicciones

Resultados nº1: ¿COMO se COMPORTAN?

PCC

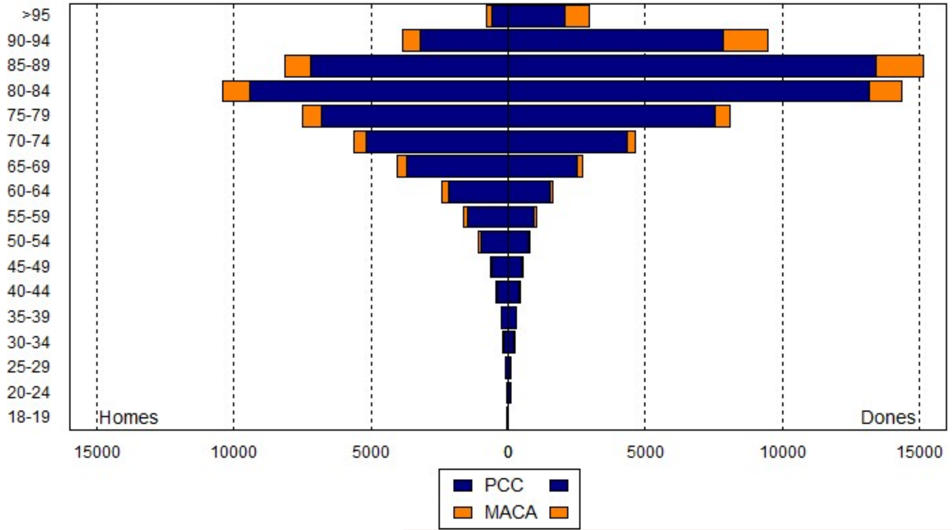
Paciente con multimorbilidad o condición única que comporta gestión clínica difícil

2-3%

MACA

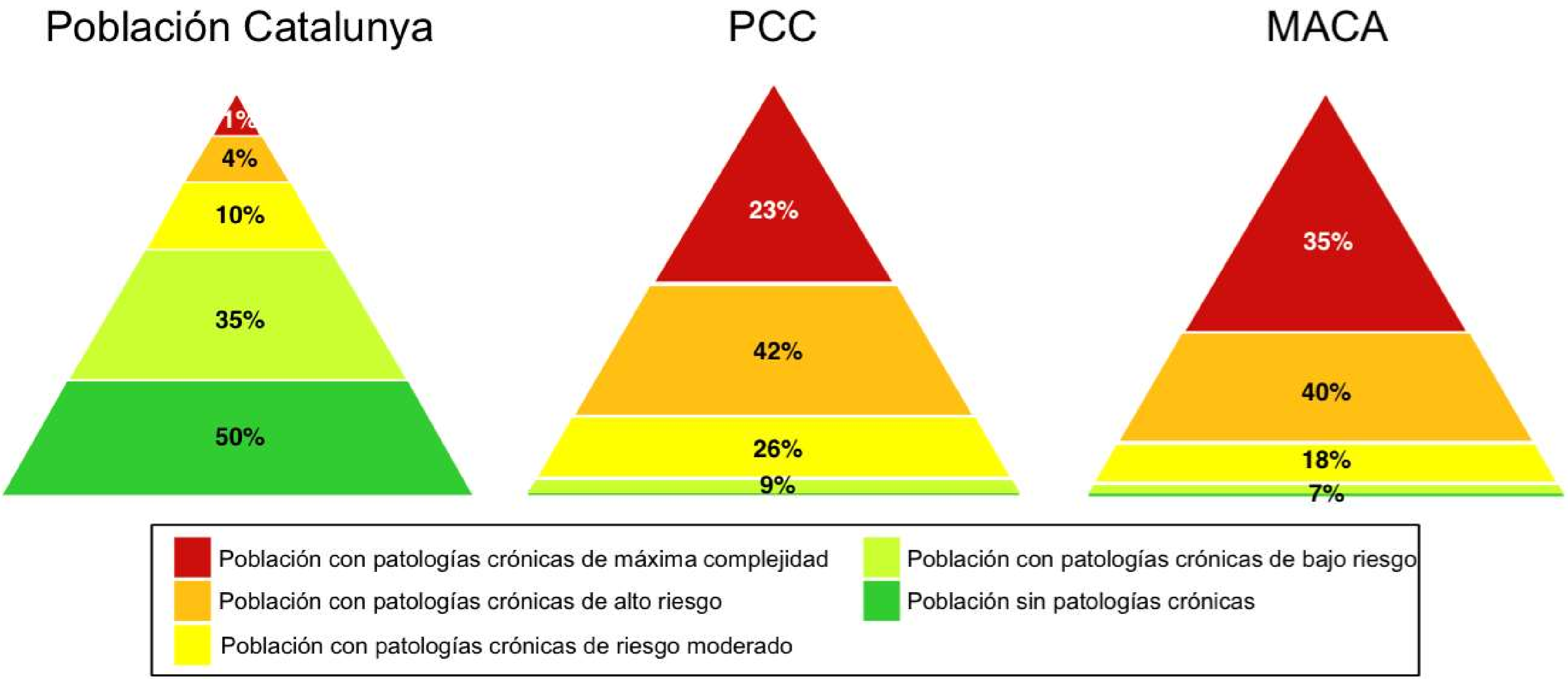
Pronóstico de vida limitado, altas necesidades, orientación paliativa, planificación de decisiones avanzadas

1,5%

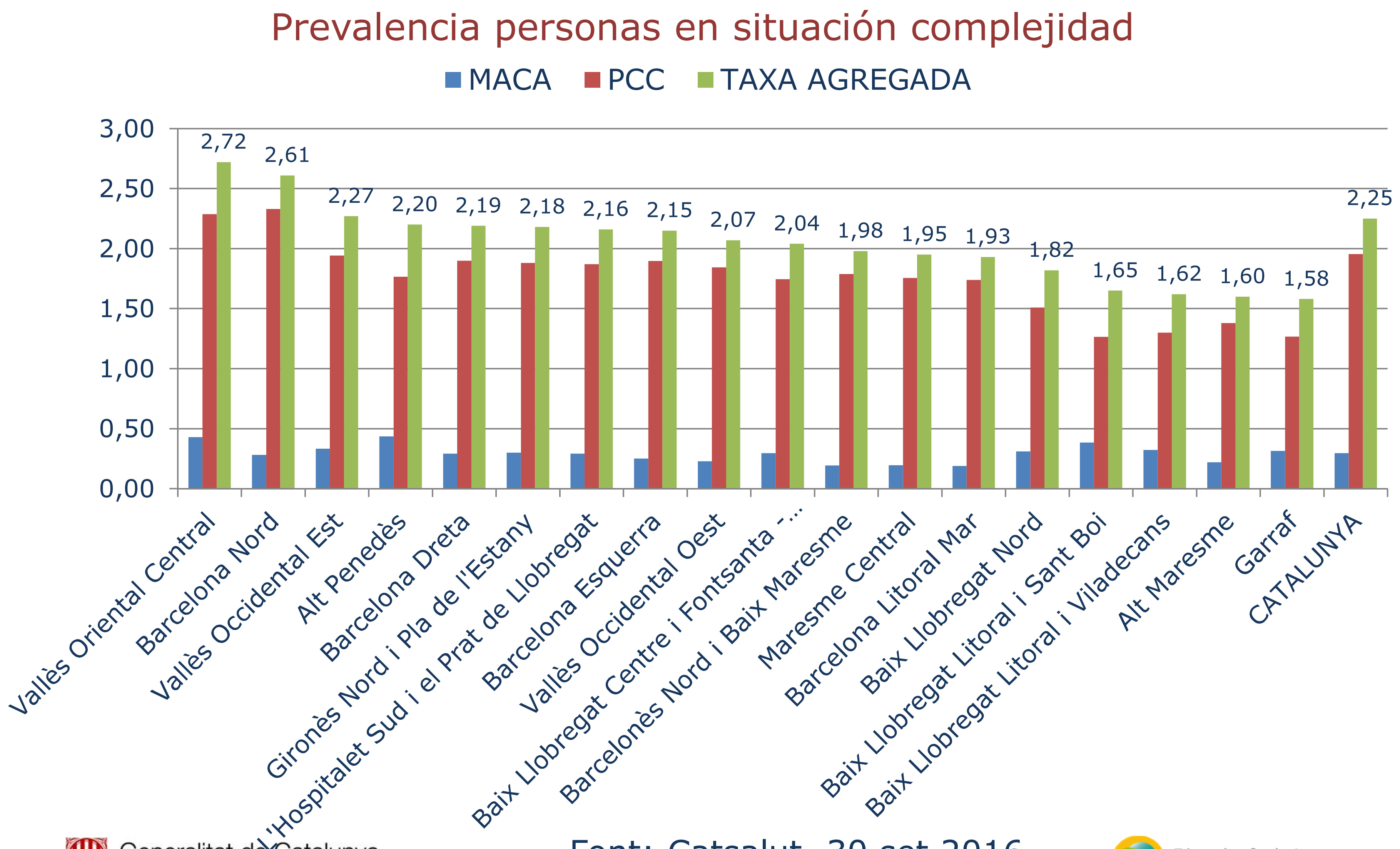


N= 98.000 personas	No PCC	**PCC**	**MACA**
Tasa mortalidad (x100)	0,8	12,8	42,4
Media visitas AP	5,8	22,9	20,7
Usuario Trabajo social sanitario (%)	2,8	35,4	30,8
Proporción en at. Domiciliaria (%)	3,9	48,2	63,6
Proporción usuarios servicios sociales (%)	0,9	13,4	30,8
Tasa ingresos urgentes (x100)	4,9	41,0	52,3
Proporción pacientes reingresadores (%)	0,7	8,9	11,4
Media visitas a CCEE	1,5	4,3	3,1
Media fármacos	3,7	12,6	11,2

Resultados nº1: ¿COMO se COMPORTAN? (II)



Resultados nº2: Calidad o Cantidad

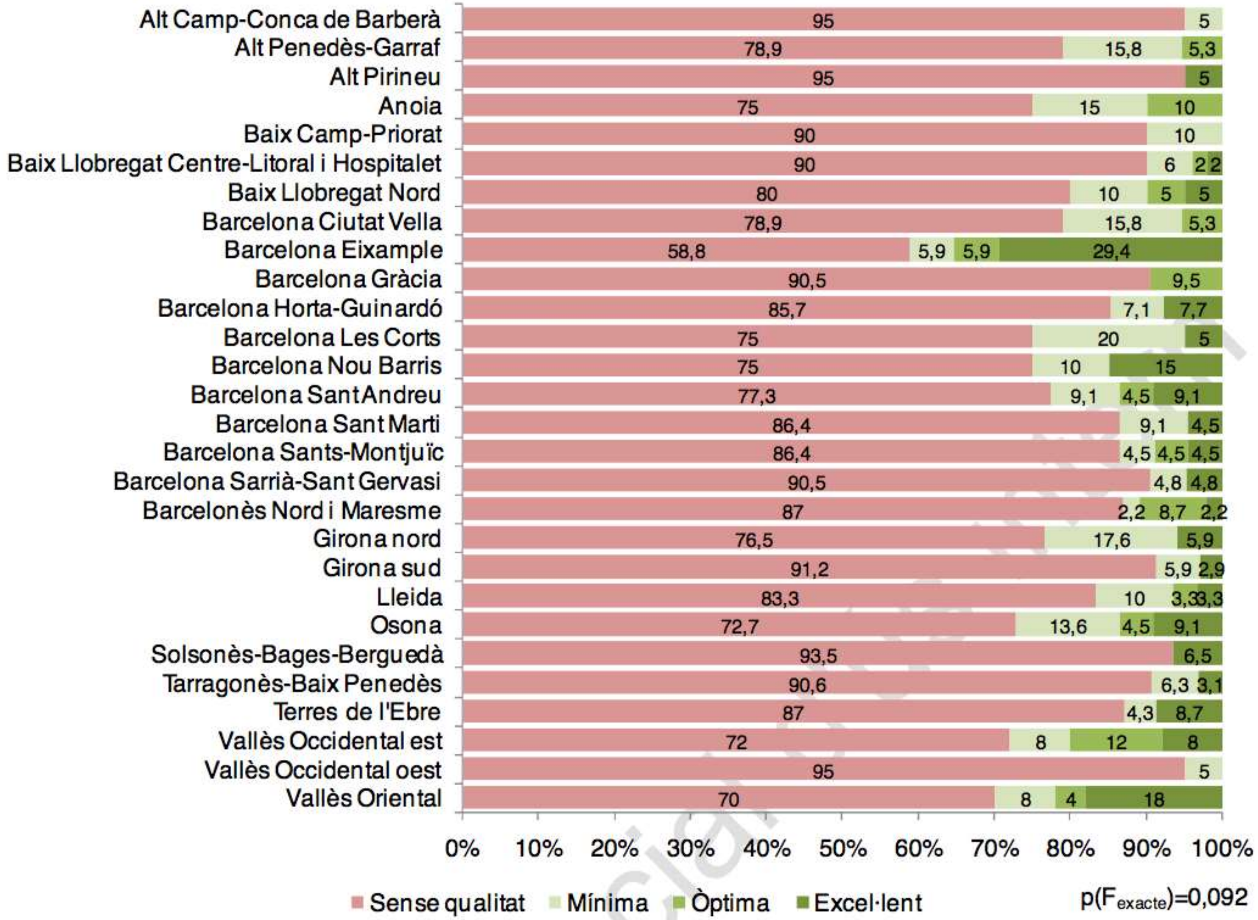


Prevalencia personas en situación complejidad

Font: Catsalut, 30 set 2016

Resultados nº3: Aprendemos y por ello mejoramos

Prevalencia personas con PIIC bien hecho

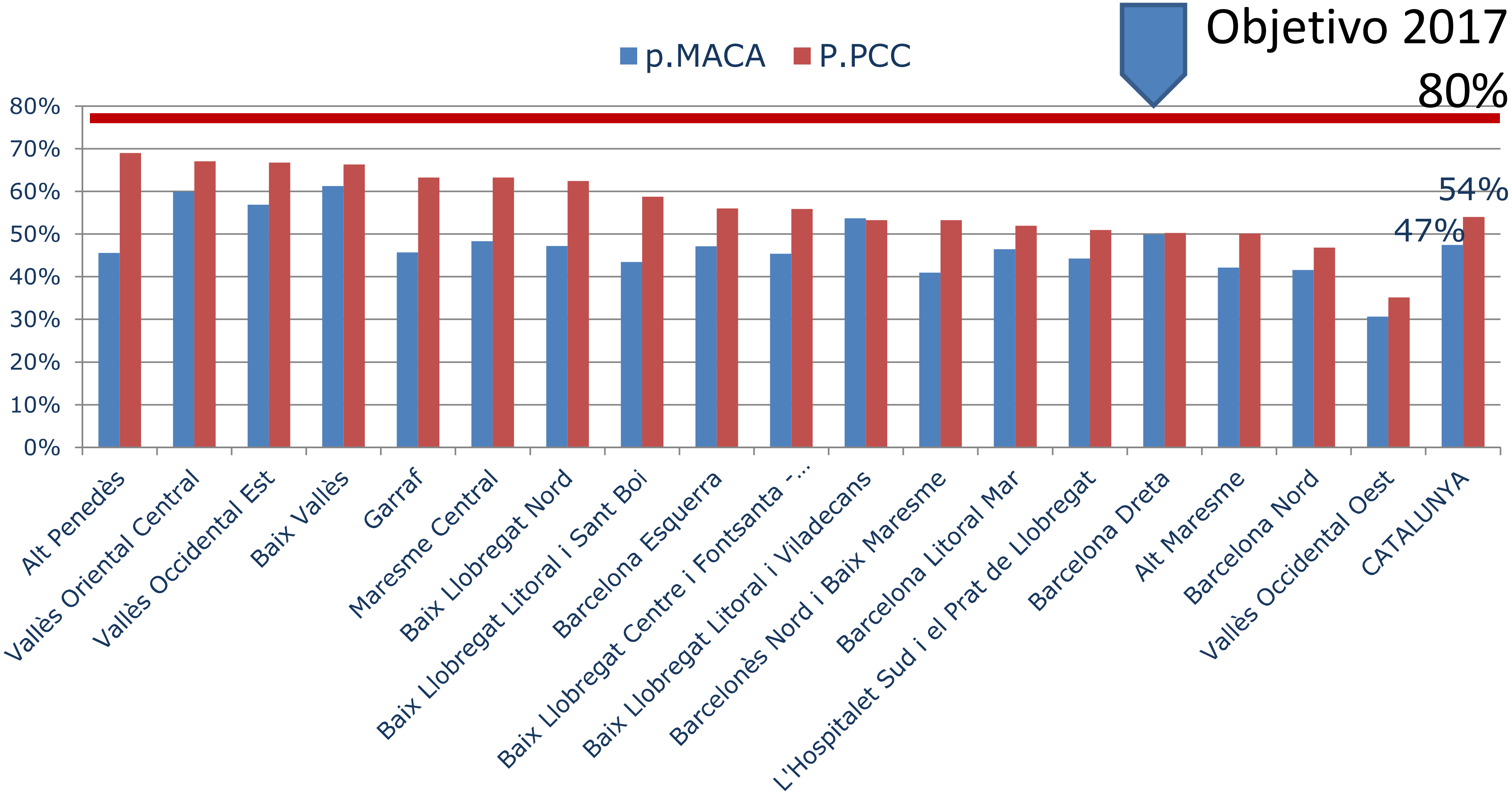


Generalitat de Catalunya
Departament de Salut

Font: Catsalut, 31 desembre 2014

Pla de Salut
de Catalunya 2016-2020

Resultados nº3: Aprendemos y por ello mejoramos



Ayudando a Atención Primaria desde Geriatría, Cuidados Paliativos y Salud Mental

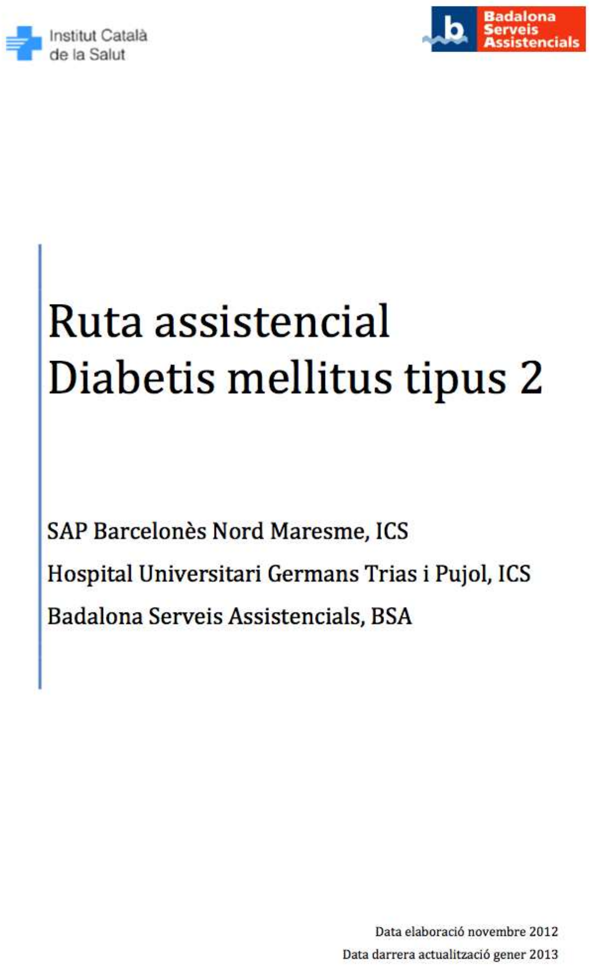
Generalitat de Catalunya
Departament de Salut

Font: Catsalut, 30 set 2016

Pla de Salut
de Catalunya 2016-2020

Rutas Asistenciales - Presente y Futuro

- **Reflexión estado actual** y Detección de los **déficits**
- Inclusión **ámbito residencial** y **Salud Mental**
- Generación del **modelo RAC 2.0 (+ operativo!)**
- Mejorar la capacidad de evaluación:
    - Evaluación accessible y transparente
    - Detección de buenas prácticas territoriales


Institut Català de la Salut

Badalona Serveis Assistencials

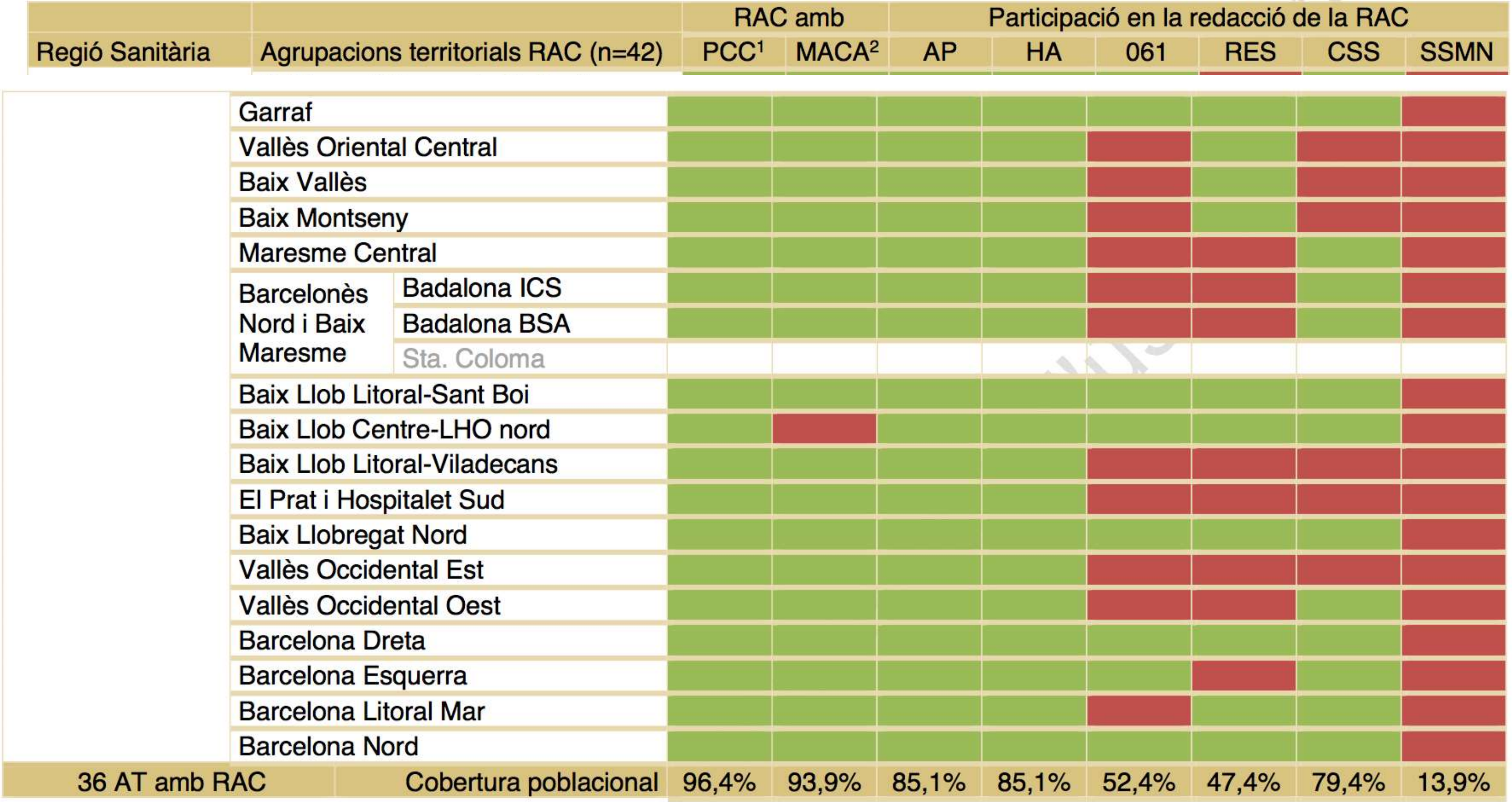
Ruta assistencial
Diabetis mellitus tipus 2

SAP Barcelonès Nord Maresme, ICS
Hospital Universitari Germans Trias i Pujol, ICS
Badalona Serveis Assistencials, BSA

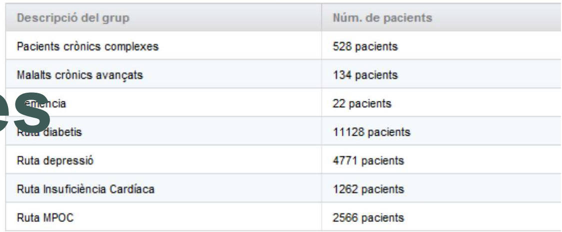
Data elaboració novembre 2012
Data darrera actualització gener 2013

Resultados nº4: Rutas Asistenciales

Taula 72. Resum dels ítems usats per avaluar el disseny de la RAC per a cada agrupació territorial amb RAC disponible



			RAC amb		Participació en la redacció de la RAC					
Regió Sanitària	Agrupacions territorials RAC (n=42)		PCC[1]	MACA[2]	AP	HA	061	RES	CSS	SSMN
	Garraf		🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟥
	Vallès Oriental Central		🟩	🟩	🟩	🟩	🟥	🟩	🟥	🟥
	Baix Vallès		🟩	🟩	🟩	🟩	🟥	🟩	🟥	🟥
	Baix Montseny		🟩	🟩	🟩	🟩	🟥	🟩	🟥	🟥
	Maresme Central		🟩	🟩	🟩	🟩	🟥	🟥	🟩	🟥
	Barcelonès Nord i Baix Maresme	Badalona ICS	🟩	🟩	🟩	🟩	🟥	🟥	🟩	🟥
		Badalona BSA	🟩	🟩	🟩	🟩	🟥	🟥	🟩	🟥
		Sta. Coloma								
	Baix Llob Litoral-Sant Boi		🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟥
	Baix Llob Centre-LHO nord		🟩	🟥	🟩	🟩	🟩	🟩	🟩	🟥
	Baix Llob Litoral-Viladecans		🟩	🟩	🟩	🟩	🟥	🟥	🟥	🟥
	El Prat i Hospitalet Sud		🟩	🟩	🟩	🟩	🟥	🟥	🟥	🟥
	Baix Llobregat Nord		🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟥
	Vallès Occidental Est		🟩	🟩	🟩	🟩	🟥	🟥	🟥	🟥
	Vallès Occidental Oest		🟩	🟩	🟩	🟩	🟥	🟥	🟩	🟥
	Barcelona Dreta		🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟥
	Barcelona Esquerra		🟩	🟩	🟩	🟩	🟩	🟥	🟩	🟥
	Barcelona Litoral Mar		🟩	🟩	🟩	🟩	🟥	🟩	🟩	🟥
	Barcelona Nord		🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟥
36 AT amb RAC	Cobertura poblacional		96,4%	93,9%	85,1%	85,1%	52,4%	47,4%	79,4%	13,9%



Descripció del grup	Núm. de pacients
Pacients crònics complexes	528 pacients
Malalts crònics avançats	134 pacients
emencia	22 pacients
Ruta diabetis	11128 pacients
Ruta depressió	4771 pacients
Ruta Insuficiència Cardíaca	1262 pacients
Ruta MPOC	2566 pacients

Resultados nº4: Rutas Asistenciales

Procés

Ruta diabetis Procés

(10.293 pacients)		indicador 1-a	indicador 1-b	Total Ind 1	%	2	%	3	%	4	%	indicadorFU	%	sense HbA1c	%
EAP Lluçanès	347	104	157	261	75,2%	256	73,8%	269	77,5%	179	51,6%	122	35,2%	86	24,8%
EAP Centelles	688	208	276	484	70,3%	452	65,7%	495	71,9%	216	31,4%	134	19,5%	204	29,7%
EAP La Vall del Ges - Torelló	1258	463	424	887	70,5%	965	76,7%	998	79,3%	736	58,5%	350	27,8%	371	29,5%
EAP Manlleu	1506	471	528	999	66,3%	1110	73,7%	1153	76,6%	744	49,4%	440	29,2%	507	33,7%
EAP Roda de Ter	791	264	267	531	67,1%	588	74,3%	606	76,6%	381	48,2%	206	26,0%	260	32,9%
EAP Sant Hipòlit de Voltregà	436	140	165	305	70,0%	325	74,5%	347	79,6%	191	43,8%	84	19,3%	131	30,0%
EAP Sant Quirze de Besora	441	143	126	269	61,0%	309	70,1%	334	75,7%	193	43,8%	102	23,1%	172	39,0%
EAP Santa Eugènia de Berga	1077	447	291	738	68,5%	822	76,3%	869	80,7%	593	55,1%	273	25,3%	339	31,5%
EAP Tona	770	291	230	521	67,7%	555	72,1%	593	77,0%	352	45,7%	208	27,0%	249	32,3%
EAP Vic 1 - Nord	1242	443	505	948	76,3%	959	77,2%	1029	82,9%	593	47,7%	444	35,7%	294	23,7%
EAP Vic 2 - Sud	1233	320	674	994	80,6%	963	78,1%	1014	82,2%	793	64,3%	282	22,9%	239	19,4%
Sense especificar	14	0	3	3	21,4%	3	21,4%	4	28,6%	2	14,3%	1	7,1%	11	78,6%
	10.292	3.305	3.672	6.977	67,8%	7.347	71,4%	7.760	75,4%	4.993	48,5%	2.651	25,8%	3315	32,2%

Els indicadors són els següents:

Indicador 1-a: Pacients amb diagnòstic DM2 i 2 determinacions HbA1c en un any

Indicador 1-b: Pacients amb diagnòstic DM2 i 1determinacions HbA1c en un any

Indicador 2: Pacients amb diagnòstic DM2 i 1 determinació LDL-c en un any

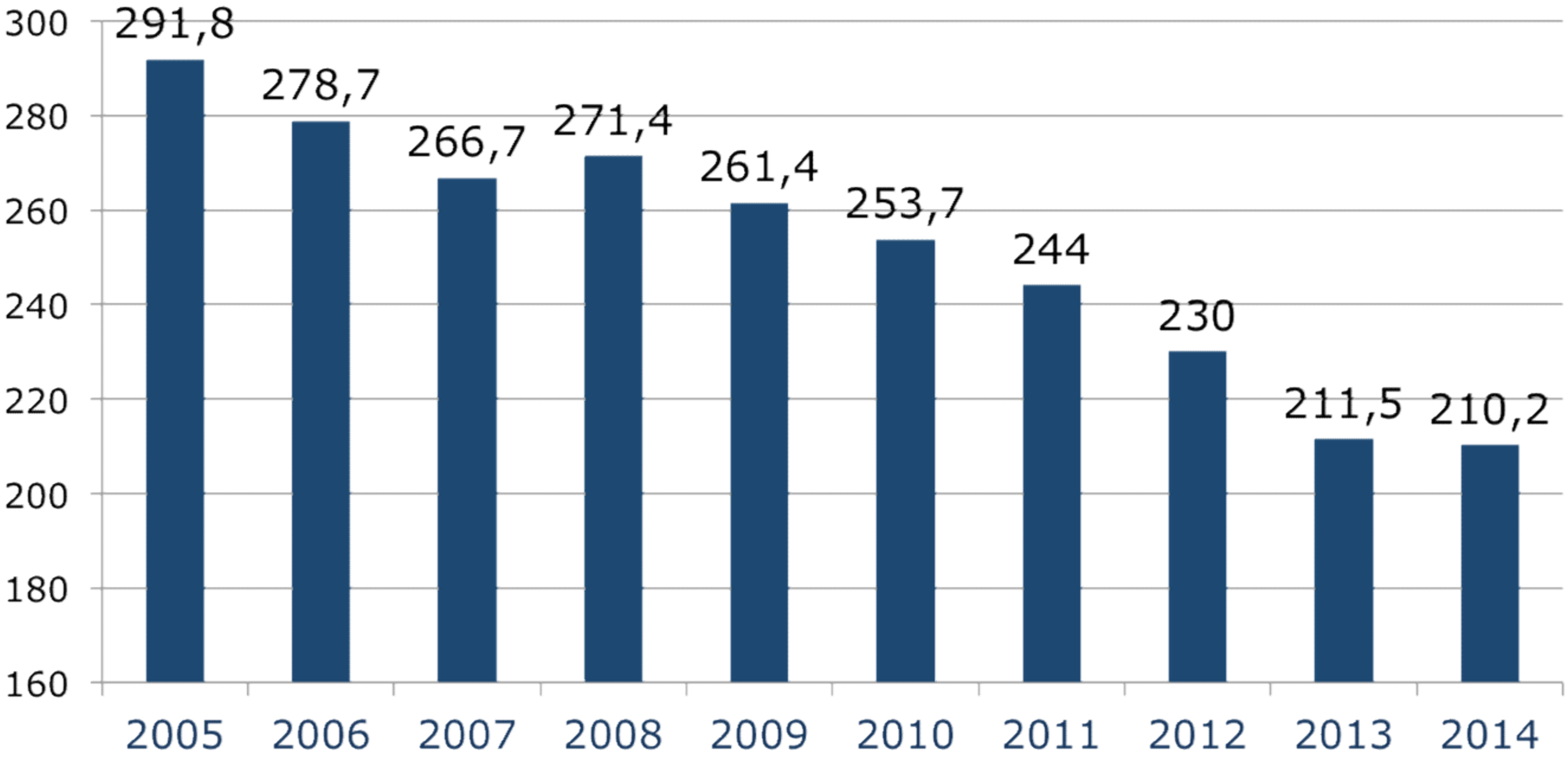
Indicador 3: Pacients amb diagnòstic DM2 i que tenen resultat laboratori FG

Indicador 4: Pacients amb diagnòstic DM2 i que tenen quocient Alb/Creatina en orina

Indicador FU: Pacients amb Fons Ull

Tasa Hospitalización potencialmente evitable en complicaciones EPOC

Disminución 13,8% entre Dic. 2011 a Dic. 2014 (36 meses)



x 100.000 hab.

Fuente: MSIQ, Catsalut

Generalitat de Catalunya
Departament de Salut

AHRQ Advancing Excellence in Health Care

MSIQ

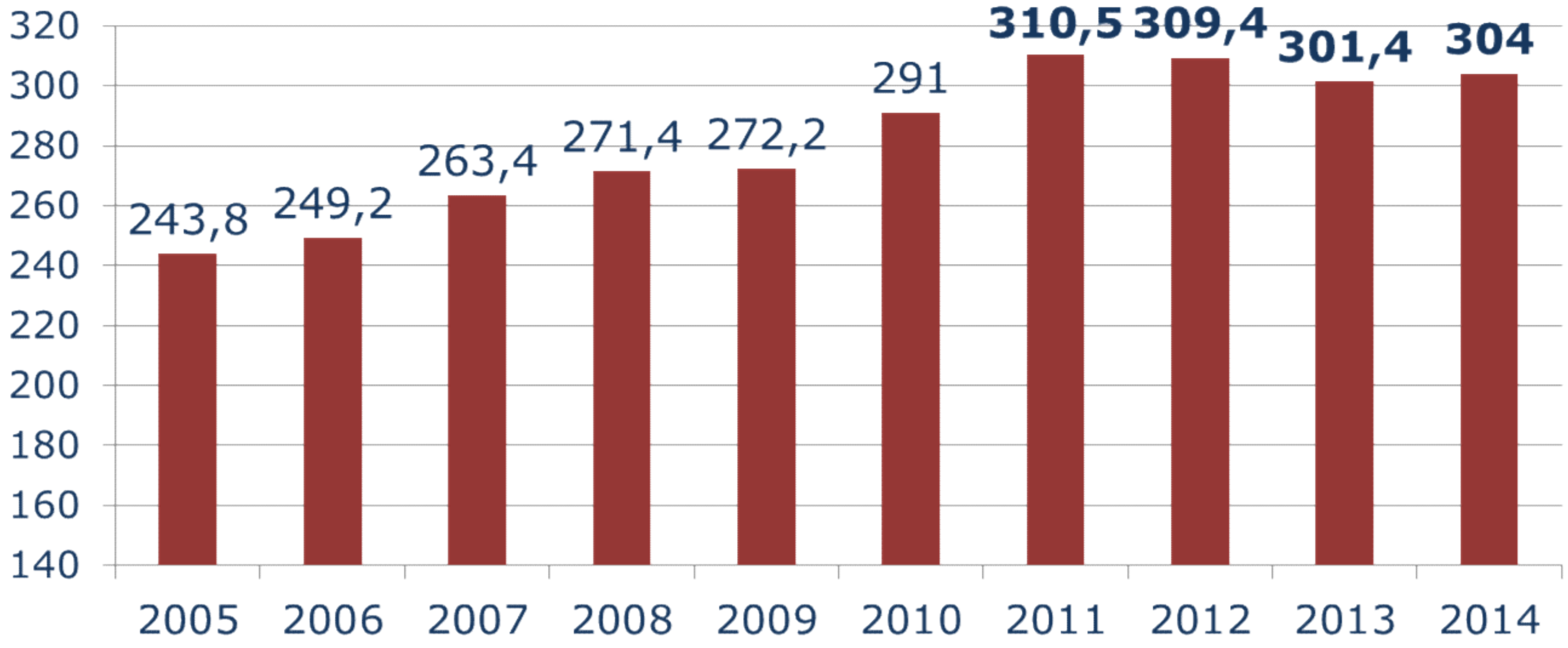
Pla de Salut de Catalunya 2016-2020

Tasa Hospitalización potencialmente evitable en Ins Cardiaca

Disminución 2% entre Dic. 2011 a Dic. 2014 (36 meses)

Nueva tendencia!

Incremento del 27% desde 2006 a 2011



x 100.000 hab.

Fuente: MSIQ, Catsalut

Generalitat de Catalunya
Departament de Salut

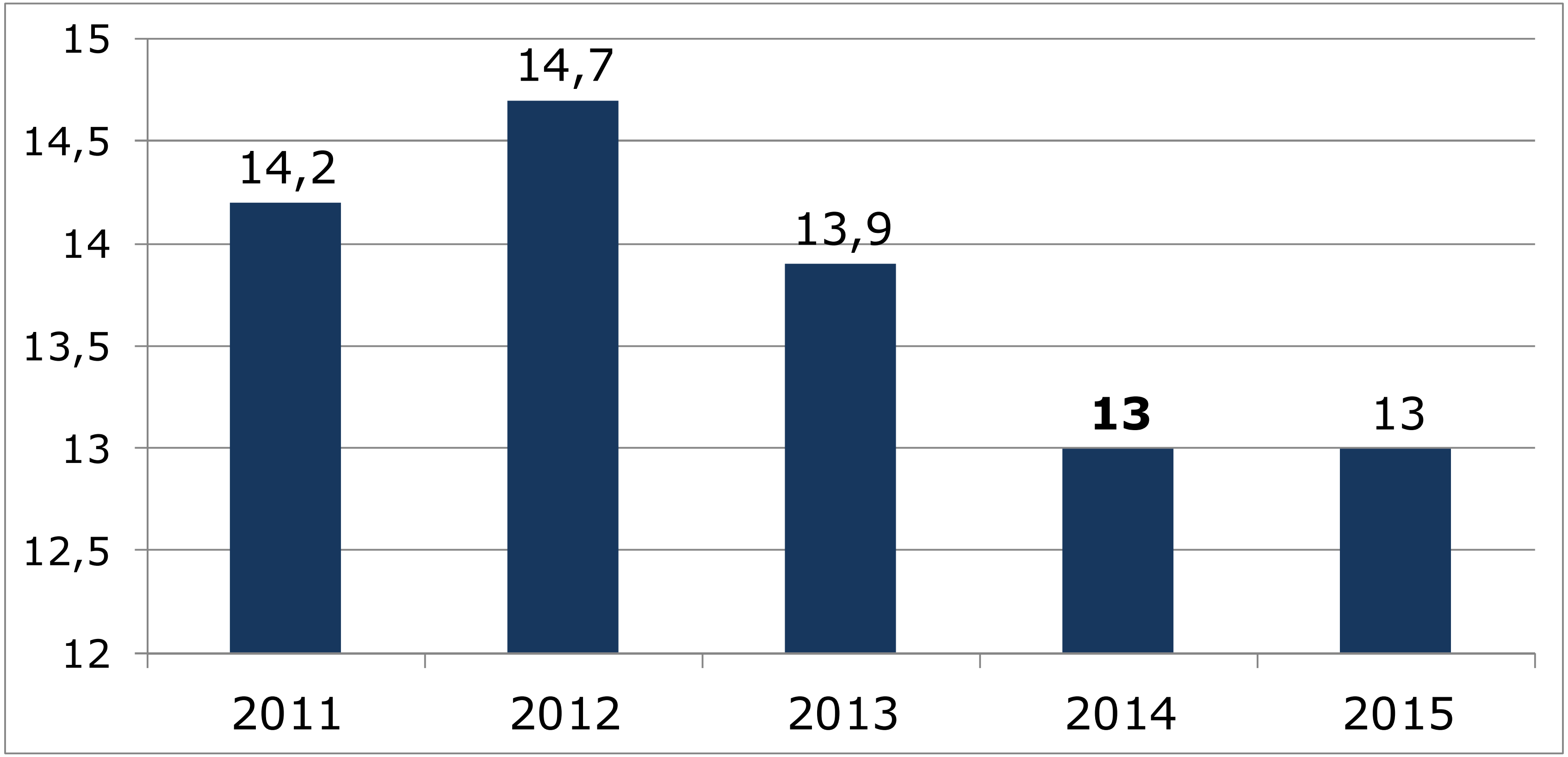
AHRQ Advancing Excellence in Health Care

MSIQ

Pla de Salut de Catalunya 2016-2020

Reingresos a 30 días para un conjunto procesos crónicos

Disminución 8,5% entre Dic. 2011 a Dic. 2015 (4 años)



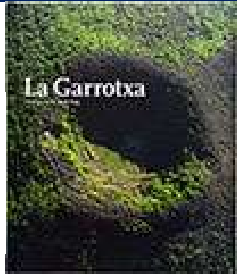
Incluye: EPOC, Ins. Cardiaca, DM, asma, enf. coronarias

Generalitat de Catalunya
Departament de Salut

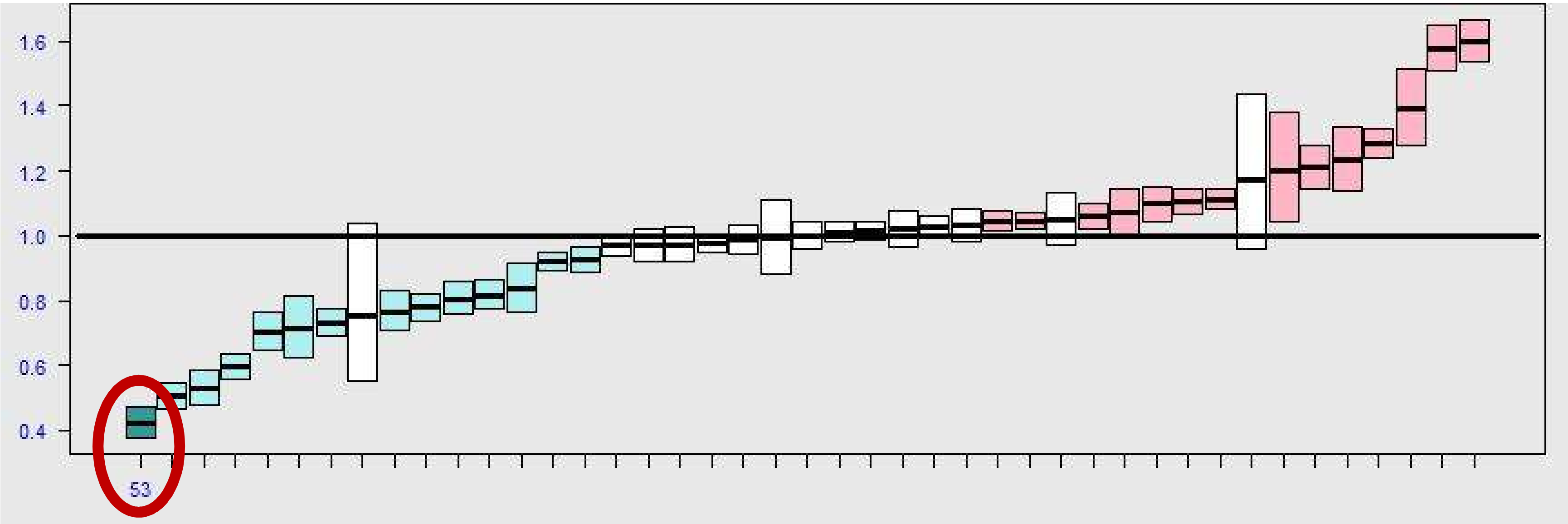
MSIQ: **http://146.219.25.61/msiq/index.html**

Pla de Salut
de Catalunya 2016-2020

Hospitalizaciones enf. crónicas en La Garrotxa

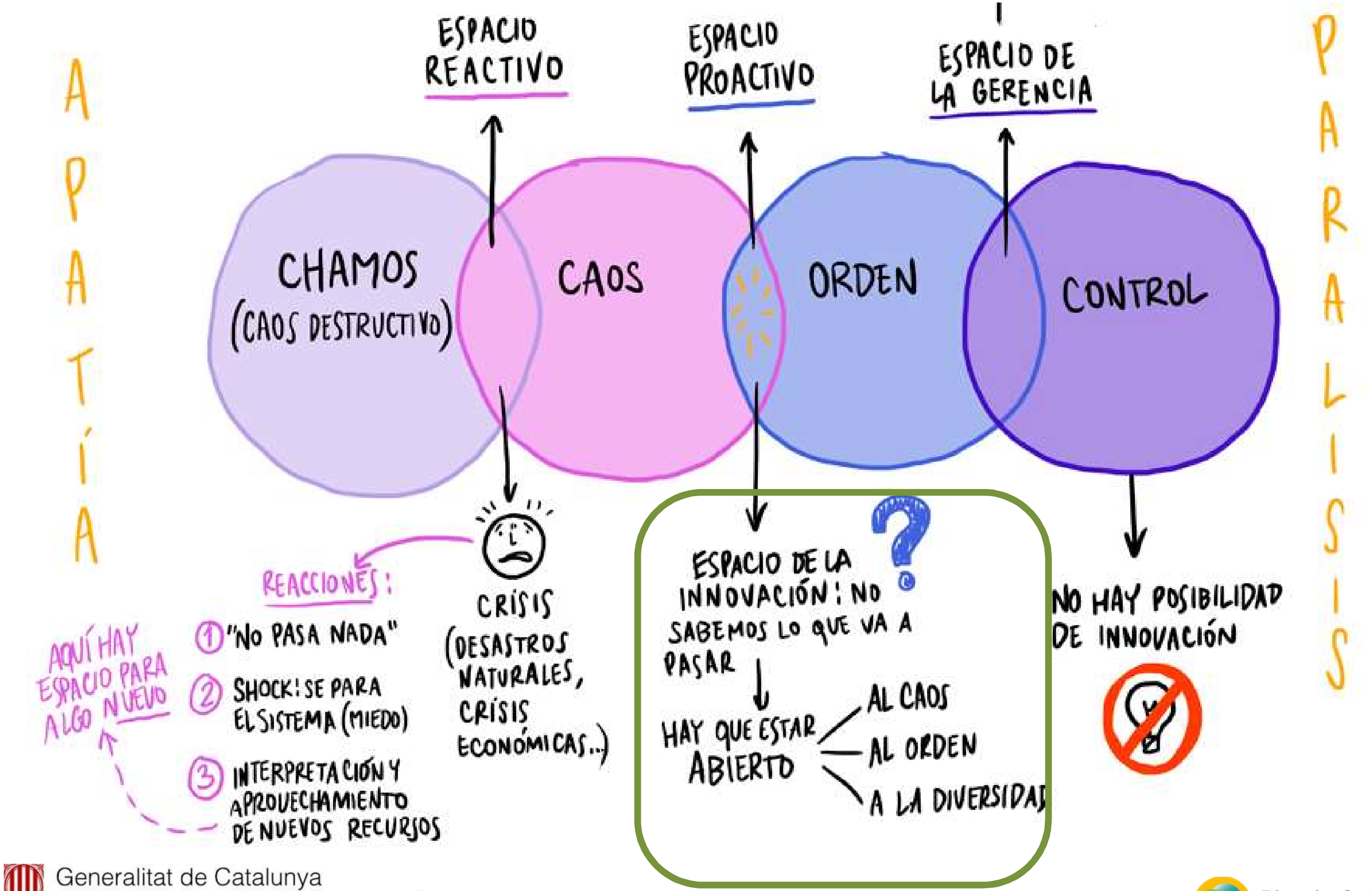


Comparativa con el resto de AGA (áreas)
1ª posición en 2015

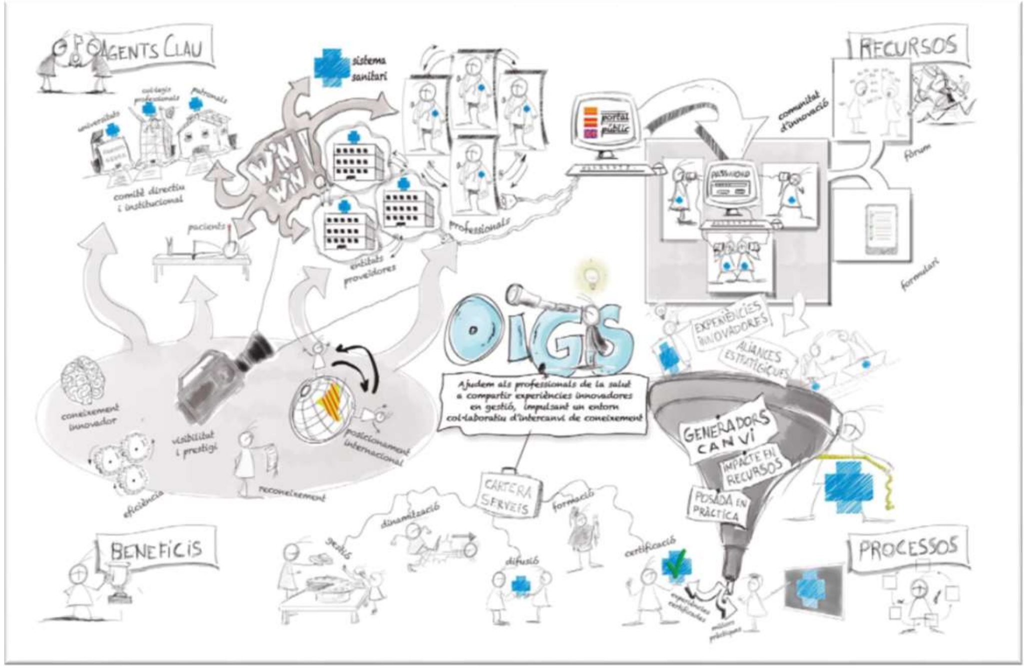


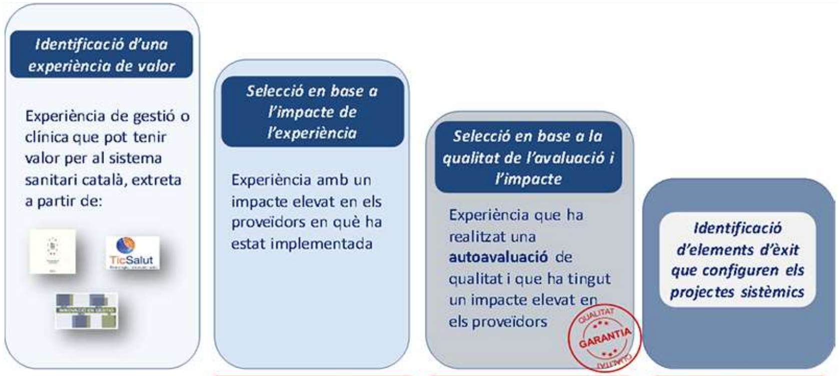
"La Garrotxa" tiene nivel muy alto desarrollo servicios sociales ("Torbay catalán")

Ventaja nº6: LA COMPLEJIDAD FUENTE DE INNOVACIÓN


APATÍA
ESPACIO REACTIVO
ESPACIO PROACTIVO
ESPACIO DE LA GERENCIA
PARÁLISIS
CHAMOS (CAOS DESTRUCTIVO)
CAOS
ORDEN
CONTROL
REACCIONES:
① "NO PASA NADA"
② SHOCK: SE PARA EL SISTEMA (MIEDO)
③ INTERPRETACIÓN Y APROVECHAMIENTO DE NUEVOS RECURSOS
AQUÍ HAY ESPACIO PARA ALGO NUEVO
CRISIS (DESASTRES NATURALES, CRISIS ECONÓMICAS...)
ESPACIO DE LA INNOVACIÓN: NO SABEMOS LO QUE VA A PASAR
HAY QUE ESTAR ABIERTO
AL CAOS
AL ORDEN
A LA DIVERSIDAD
NO HAY POSIBILIDAD DE INNOVACIÓN

Los Profesionales como agentes innovadores


AGENTS CLAU
RECURSOS
BENEFICIS
PROCESSOS
sistema sanitari
universitats
col·legis professionals
patronals
comitè directiu i institucional
pacients
professionals
entitats proveïdores
portal públic
comunitat d'innovació
fòrum
formulari
OIGS
Ajudem als professionals de la salut a compartir experiències innovadores en gestió, impulsant un entorn col·laboratiu d'intercanvi de coneixement
EXPERIÈNCIES INNOVADORES
ALIANCES ESTRATÈGIQUES
GENERADORS CANVI
IMPACTE EN RECURSOS
POSADA EN PRÀCTICA
coneixement innovador
visibilitat i prestigi
posicionament internacional
reconeixement
eficiència
CARTERA SERVEIS
dinamització
formació
difusió
certificació
experiències certificades



Identificació d'una experiència de valor

Experiència de gestió o clínica que pot tenir valor per al sistema sanitari català, extreta a partir de:

Selecció en base a l'impacte de l'experiència

Experiència amb un impacte elevat en els proveïdors en què ha estat implementada

Selecció en base a la qualitat de l'avaluació i l'impacte

Experiència que ha realitzat una **autoavaluació** de qualitat i que ha tingut un impacte elevat en els proveïdors

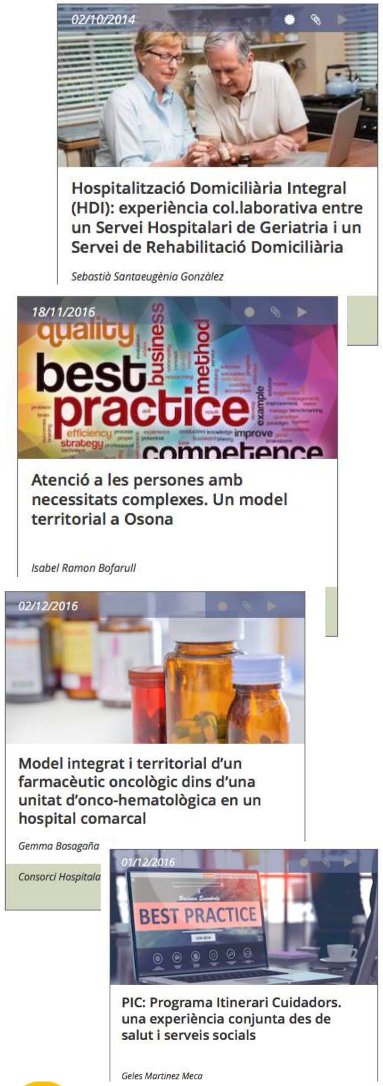
Identificació d'elements d'èxit que configuren els projectes sistèmics

Experiència destacada → **Experiència certificada** → **Projecte sistèmic**

TicSalut
QUALITAT
GARANTIA

248
experiencias registradas

48
Certificadas implantables



02/10/2014

Hospitalització Domiciliària Integral (HDI): experiència col.laborativa entre un Servei Hospitalari de Geriatria i un Servei de Rehabilitació Domiciliària

Sebastià Santaeugènia González

18/11/2016

Atenció a les persones amb necessitats complexes. Un model territorial a Osona

Isabel Ramon Bofarull

02/12/2016

Model integrat i territorial d'un farmacèutic oncològic dins d'una unitat d'onco-hematològica en un hospital comarcal

Gemma Basagaña

Consorci Hospitala

01/12/2016

PIC: Programa Itinerari Cuidadors. una experiència conjunta des de salut i serveis socials

Geles Martinez Meca

quality
best practice
business
method
competence
efficiency
strategy
improve
example
BEST PRACTICE

Líneas estratégicas…

Fuente: **PPAC 2017**

Estrategia de Formación

2012- 2016 Formación presencial /on-line sanitaria.

2016-2020 Formación on-line MOOC , tranversal social y sanitaria.

HC3
Canal Salut
061 CatSalut Respon
la meva salut
@

...de futuro...

HC3 como herramienta comunicativa bidireccional "clave"

Sistemas de información interoperables social y sanitarios

Desarrollo y **implementación de nuevos contenidos *La Meva Salut***

Desarrollo y implementación de **modelos de atención no presencial**: e.Consulta, telemonitorización, teleasisténcia...

Sistema de información claro, transversal de "**gestión caliente**"

Estratificación (GMA) como herramienta de soporte a evolucionar

Generalitat de Catalunya
Departament de Salut

Pla de Salut
de Catalunya 2016-2020

Fuente: PPAC 2017

Atención Integrada: elementos nucleares para el nuevo modelo

Modelo de **governanza territorial** social i sanitari

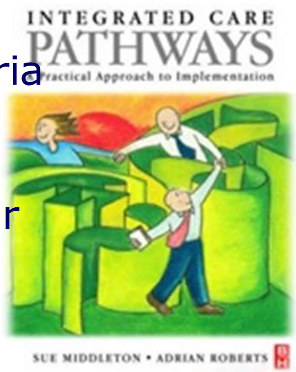
Health and Social Care Board

ACP: empoderam./ autocuidado

Programa Pacient Expert Catalunya®

"Microsistemas":

- Orientación comunitaria
- Rutas asistenciales integradas
- Trabajo interdisciplinar
- Buenas transiciones
- Atención 7/24
- Impulso atención domiciliaria
- Buena atención residencias


INTEGRATED CARE
PATHWAYS
A Practical Approach to Implementation
SUE MIDDLETON • ADRIAN ROBERTS

Valoración y **Plan intervención "compartido" + Gestión caso**

A → C T
I O N →
P L A N

Liderazgo clínico y profesional

ELEMENTOS FACILITADORES

Marco avaluativo compartido: Responsabilidad compartida en resultados

EVALUATION
Excellent
Good
Average
Poor

Alineación incentivos

Modelos **estratificación** que incorporen datos sociales

Gestión del cambio y culturas organizativas

Historia clínica y social compartida

Estrategia multipalanca: *TODO al mismo tiempo*

Generalitat de Catalunya

Muchas gracias

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