The transformative project on Integrated Care

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C3RG – Research Group on Chronic Conditions in Central Catalonia

CONTEXT

The Challenge

↑ Multimorbidity
Clinical complexity

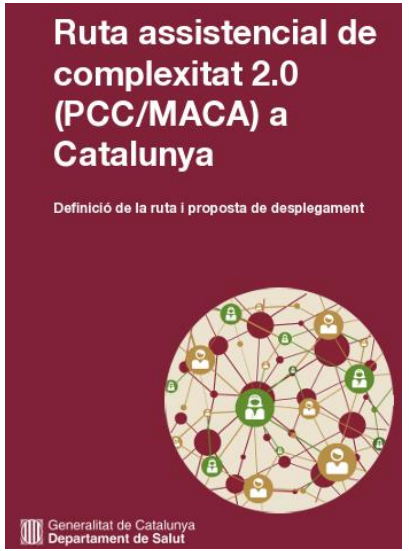
↓ Quality of life

↑ Healthcare utilisation and costs

Complexity Care Pathway

Improve coordination between levels of care

Adapted to each territory



However, the implementation of this pathway may vary depending on the **degree of integration** of care in each territory.

CONTEXT

To better organize care for this population, the Catalan Department of Health has defined **two patient profiles:**

CCP

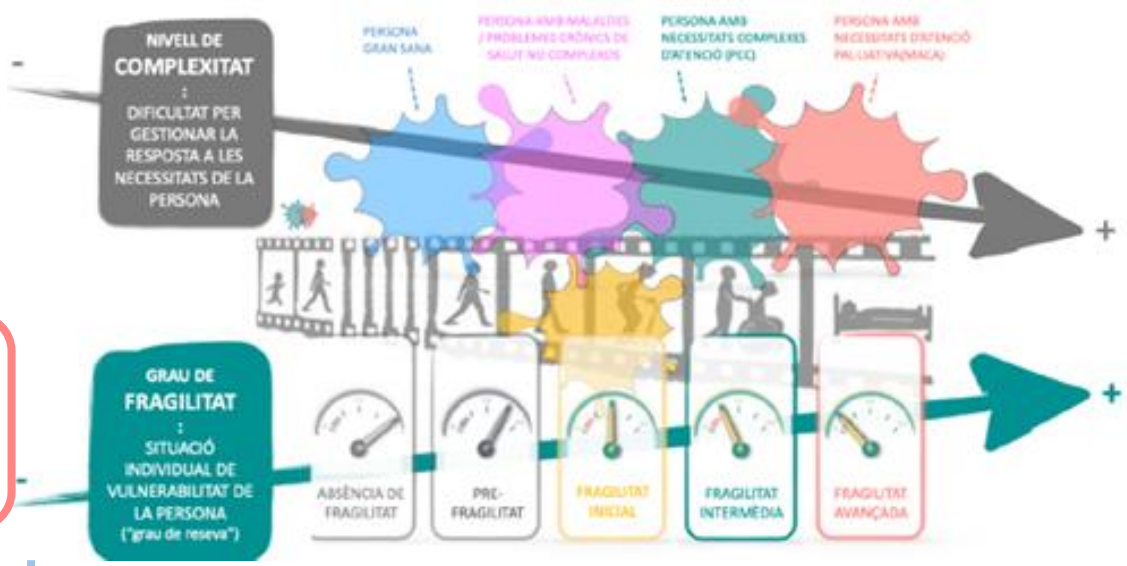
Patients with Chronic Conditions and Complex Care needs

≥80 years Moderate frailty

ACP

Patients with Advanced Chronic disease and limited life expectancy

≥80 years Advanced frailty

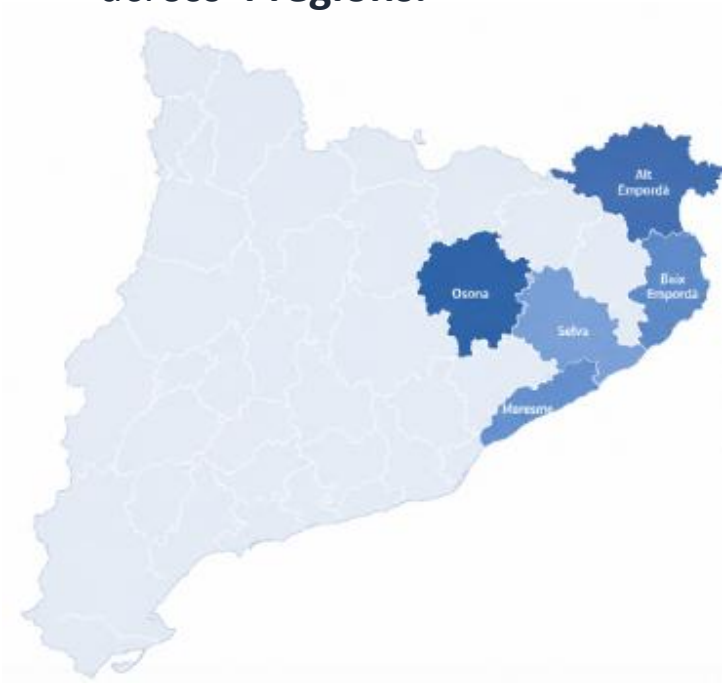


Multidimensional assessment and a shared care plan.

PROJECT DESCRIPTION

Transformative Project (TP) on Integrated Care

A research & innovation project funded by the **Catalan Health Service**, implemented across **4 regions.**



REGIONS

- Baix Empordà
- Alt Empordà
- Osona
- Alt Maresme – Selva Marítima

PROJECT OBJECTIVE

Design, implement and evaluate an effective integrated care model for complex patients aged ≥80 years.

1. Implementation of **Clinical Practice Communities**
2. **Technological Platform** — Supports care tools, resource management and patient follow up

PROJECT POPULATION

Transformative Project (TP) on Integrated Care

Study Population (2024): **36,810 individuals** ≥80 years (5.56% of total population of 4 regions)

11,510 **PCC** **31.27%** of total population	1,302 **MACA** **3.54%** of total population	23,998 **Non-identified** **65.19%** of total population

Study Population (2026): **38,930 individuals** ≥80 years (5.73% of total population of 4 regions)

13,350 **PCC** **34.3%** of total population	1,710 **MACA** **4.4%** of total population	23,870 **Non-identified** **61.3%** of total population

CPCs

What they are

DEFINITION

Groups of healthcare and social professionals working together around a shared clinical challenge to improve **practice, decision-making, and patient outcomes**.

KEY FEATURES

Multidisciplinary

Doctors · Nurses · Therapists · Social workers

Learning approach

Real cases · Collective reflection · Evidence + professional experience

Practice-oriented

Focused on improving real everyday care

Aligned with system goals

Quality · Safety · Value

C P C s

How CPCs are developed

Design/ Team formation

- Balance representativeness and effectiveness
- Configured according to each region resources and context.
- Ensure sufficient decision-making capacity and alignment with the existing governance framework.

Enablement

- Building relationships
- Action over theory
- Open & Clear communication

Agreements

Agreements formalise the commitment of all participants.

Monitoring and evaluation

- Periodic reviews → adaptation
- Assess team functioning
- Evaluate both processes & outcomes

C P C s

Roles & Structure of CPCs

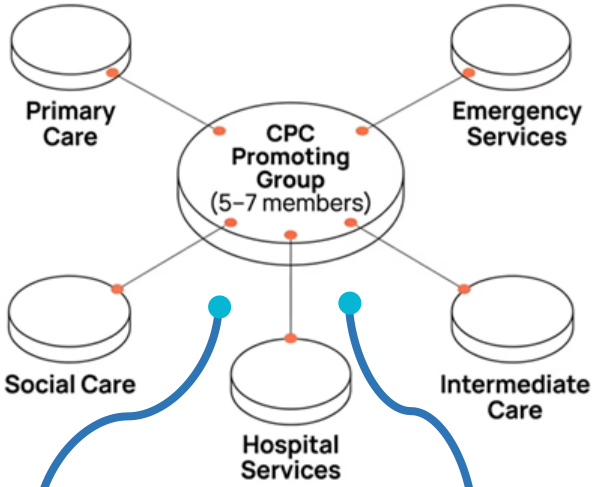
4 Active CPCs — 15 - 23 members

Across all entities and care levels, adapted to each region's resources

4 Promoting Groups — 5 - 7 members

- Defined roles
- Coordination functions
- Self-assessment criteria

Goal: ensure continuity of operations



Collective judgement

Shared responsibility

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What do CPCs do?

They meet once a month (in person & online)

Territorial Review
Analysis of local health data and performance indicators

Clinical case analysis
Review of real patient cases (successes and challenges) and patient flows.

Training needs
Identification of learning needs as drivers of change.

Evidence Review
Critical appraisal of scientific evidence and emerging trends.

Peer support
Supporting professional development.

CPCs

Territorial Review: Method (I)

INDICATORS STUDIED

Automatically collected from information systems.

Care Model

% identification as CCP or ACP

% of Shared Care Plan correctly completed

Healthcare Resource Use

Primary Care contacts (in-person & telephone)

Emergency Department visits

Acute Hospital admissions

Intermediate Care admissions

General Indicators

Mortality rate

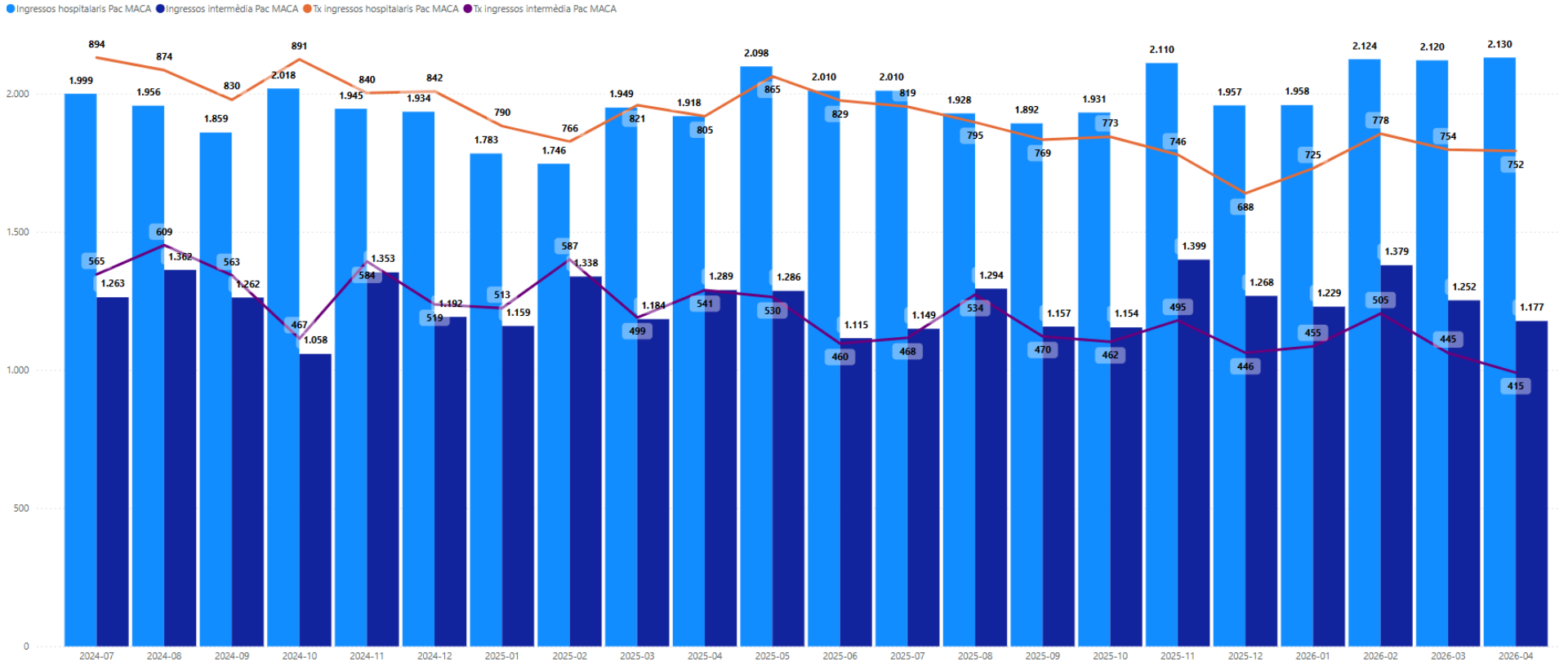
Readmissions

Polypharmacy (≥10 chronic medications)

Days spent at home

CPCs

Territorial Review: Method (II)



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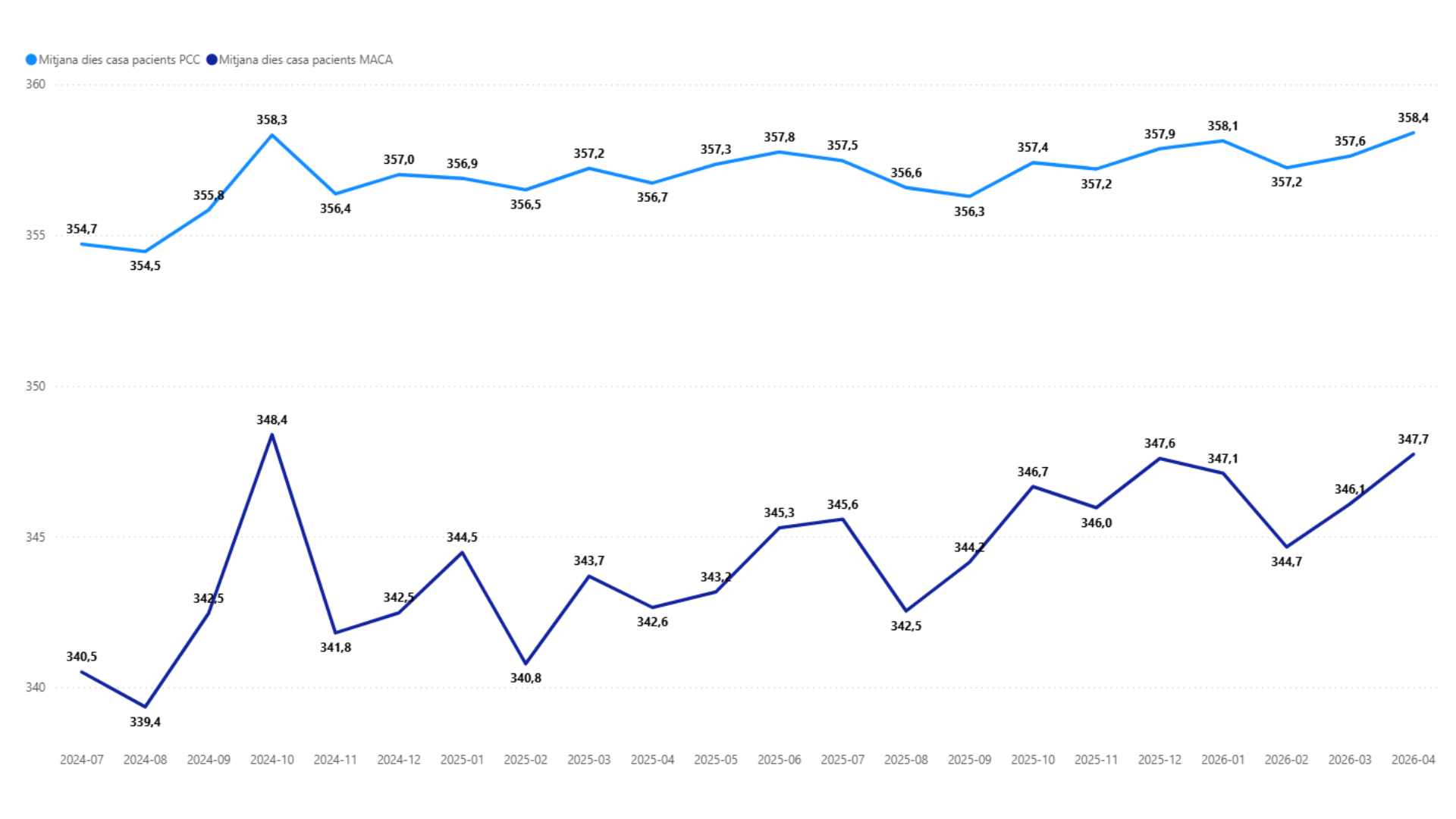
Territorial Review: Method (III)

PERIODE	2024-11	2026-04
Grup territorial	Tx Pacients polimedicats	Tx Pacients polimedicats
Selva Marítima i Alt Maresme	39,43%	37,78%
Osona	37,34%	35,15%
Baix Empordà	47,09%	39,69%
Alt Empordà	30,66%	29,55%
Total	**38,42%**	**35,66%**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Clinical case analysis

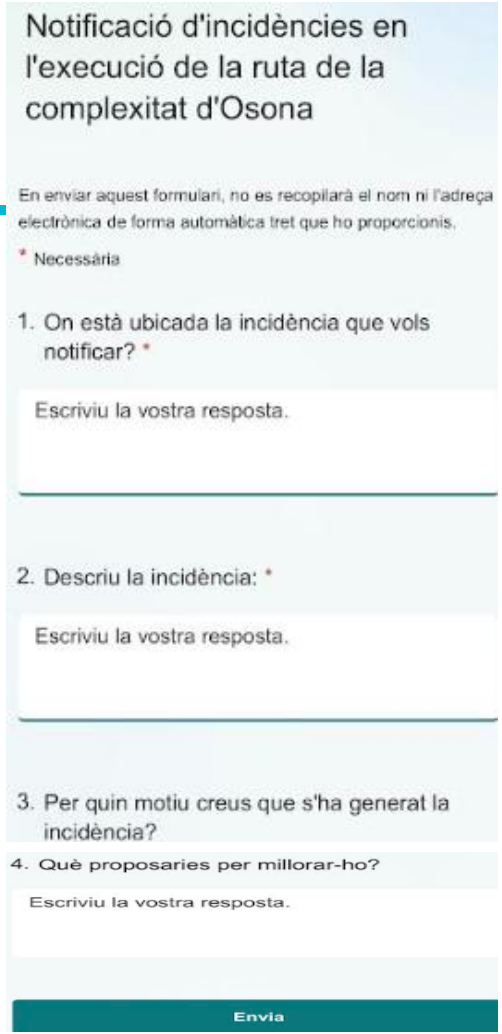
A shared reporting form enables professionals across affiliated institutions to submit clinical cases to the CPCs for review.

Cases submitted may include:

- Positive practices to be shared
- Situations with opportunities for improvement

Key information collected:

- Case location and description
- Rationale for review
- Improvement proposals



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Training needs / Support

Organizing expert-led sessions to address specific needs

Promoting improvement actions in targeted areas:

- E.g., Identification of **barriers** and **facilitators** in developing shared Care Plan (PIIC).
  - → **Simulation-based training for PIIC development**.
  - → **PIIC information leaflets** for caregivers and patients.

C P C s

Evaluation of CPCs

Professionals' satisfaction indicators → Surveys

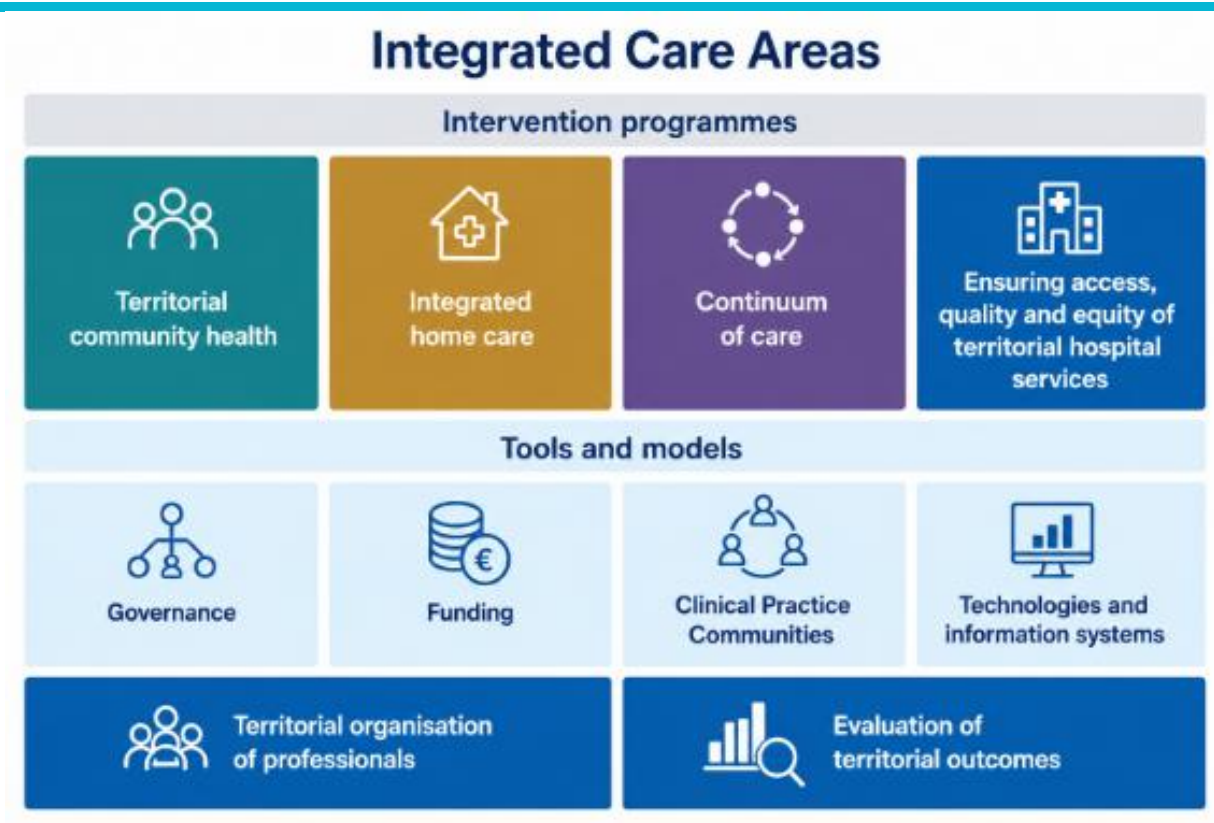
Process indicators → Evaluation of working dynamics

Attendance and follow-up indicators

Indicators of documentation generated and reviewed by the community

C P C s

Impact of CPCs on healthcare delivery



CONCLUSIONS

Take-away messages

Co-production

- Integration is built collectively.
- CPC as the bridge from healthcare systems to real-world practice.

Intelligent data

- From raw data to clinical insight: **humanizing data.**
- Supports contextualized decisions.

Complex frailty

- Requires **integrated territorial response.**
- Focus on **coordinated care.**

Continuous improvement

- Real-world data enables **learning systems.**
- Drives better outcomes.

Thank you for your attention

Feel free to contact me:

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