euriphi
European wide Innovation
Procurement in Health and Care

This project has received funding from
the European Union's Horizon 2020 research
and innovation programme under grant agreement
No 825922-EURIPHI

Case management programme for complex chronic patients with mental health disorders

Abstract

Introduction

Chronic Complex Patients have been a priority for National Health Systems recently. A care program for Complex Chronic Patients with Mental Health Disorders (CCP-MHD) was developed in MutuaTerrassa in 2013. The goal of this program was to take care of patients with specific diagnosis and a particular social and clinical setting, giving them an integrated, coordinated, proactive, efficient and adapted attention.

Goals

Assess the impact of this care program for CCP- MHD in preventing unplanned hospital admissions.

Description

In 2013 a care program for the CCP-MH was designed and carried out a year later throughout the territory depending on the Community Hospital.

The goal was to treat patients with at least one of the following criteria of complexity: a) 2 or more hospital admissions in the last year b) Individual Support Program discharge (ISP) c) one clinical criteria of poor prognosis according to the medical team (poor compliance of medication, absenteeism from scheduled appointments, insufficient family support or being under multiple medications).

The multidisciplinary team chooses the patients, defines their Individualized Therapeutic Plan (ITP) and labels their medical record to be seen by all professionals. A nurse case manager follows up all patients and is in charge of coordinating their multidisciplinary attention with defined care routes and performing patients and family visits follow-ups, home visits and multiple phone calls to patients.

Results

In June 2014, the CCP-MHD program was launched. 45 patients have been included so far: 20 male and 25 female, mean age 44.7 and 48.5 respectively. Patients were classified according to their diagnosis: schizophrenic disorders (n = 29), borderline personality (n = 7), bipolar (n = 7), schizotypal (n = 1) and recurrent depressive (n = 1). Poor compliment of treatment was the first cause to be included (n=18), poor family support (n=11), emergency hospital admissions in the last months (n=8, mean: 2.6), absenteeism to scheduled appointments (n=5) and clinical instability after hospital discharge (n=3).

From June 2014 to December 2015, 14 out of 45 patients were discharged from the program; mean time of assistance was 301 days. Among the causes of discharge are clinical improvement (n=7), being accepted in a different care unit (n=5), prison admission (n=1) and death (n=1).

This project has received funding from
the European Union's Horizon 2020 research
and innovation programme under grant agreement
No 825922-EURIPHI

Eight patients were included for having 2 or more emergency admissions, with a total of 21 hospital admissions. Four of they were discharged after 211 days and there were only 2 admissions during follow-up. Ten patients who had had 1 emergency admission along the previous year, with a total of 10 hospital admissions, presented 2 re-admissions and 27 patients admitted in the program for other reasons had no urgent hospital admission during follow-up.

Conclusion and impact

The care program for Complex Chronic Patients with Mental Health Disorders in this Community Hospital has fostered better control and management of the most fragile patients. This program has reduced significantly the number of readmissions. The nurse case manager has optimized the resources and the possibilities of each patient.

Location

Catalunya

Year

2016

Related Integrated Care keywords

- MULTI-DISICIPLINARY/ INTER-DISCIPLINARY TEAM WORKING
- PERSONALISED CARE
- SERVICE, FUNCTION AND CARE INTEGRATION / COORDINATION – TRANSITIONS
- SINGLE POINT OF ACCESS

Pervasiveness

Small scale in a local jurisdiction

Status

Ongoing

Links

Moyá Ferrer F, del Río Meyer M, García González M, Fernandez Garcia R, Barrachina JG, Soler Insa PA, et al.. Case management program for complex chronic patients with mental health disorders. International Journal of Integrated Care. 2016;16(6):A48. DOI: http://doi.org/10.5334/ijic.2991

https://www.ijic.org/articles/abstract/10.5334/ijic.2991/