

Volume 15, 27 May 2015

Publisher: Uopen Journals

URL: <http://www.ijic.org>

Cite this as: Int J Integr Care 2015; Annual Conf Suppl; [URN:NBN:NL:UI:10-1-116950](https://nbn-resolving.org/urn:nbn:nl:ui:10-1-116950)

Copyright: 

---

## Conference Abstract

### **Intermediate care as a key for integrated care: collaborative practice and research for acute admission avoidance in Barcelona.**

*Marco Inzitari, Parc Sanitari Pere Virgili; Universitat Autònoma de Barcelona, Spain*

*Neus Gual, Parc Sanitari Pere Virgili; Universitat Autònoma de Barcelona, Spain*

*Daniel Colprim, Parc Sanitari Pere Virgili; Universitat Autònoma de Barcelona, Spain*

*Monica Casco, Parc Sanitari Pere Virgili, Spain*

*Remedios Martín, EAP Vallcarca-Sant Gervasi, Spain*

*Francesc Xavier Jimenez, Hospital Universitari de la Vall d'Hebrón, Spain*

*Cristina Méndez, Parc Sanitari Pere Virgili, Spain*

Correspondence to: **Marco Inzitari**, Parc Sanitari Pere Virgili, Spain, E-mail: [minzitari@perevirgili.catsalut.net](mailto:minzitari@perevirgili.catsalut.net)

---

## Abstract

**Introduction:** Admission to a general acute hospital is a risk factor for disability, institutionalization and death for older adults, and a burden for the system (Poteliakhoff E., King's Fund 2011). Integrated care might reduce unnecessary hospitalizations promoting right care in right time and place for people with complex needs. Where care provision is fragmented, micro-integration (combining coordination and continuity of care, care planning, person centered care, case management and ICT solutions) is a way to integrate (Ham C, King's Fund 2011).

**Practice change implemented:** Parc Sanitari Pere Virgili, a geriatric intermediate care facility in Barcelona (350 beds of geriatric rehabilitation and palliative care plus outpatients and hospital-at-home), developed a network of collaborations with "neighbor" university hospitals and primary care.

**Aims:** To avoid admissions to the general hospital, we sought to:

1. Foster direct admission to intermediate care of selected older adults needing continuative care.
2. Foster admission from the Emergency Department (ED) of a general university hospital to intermediate care.
3. Implementing interventions to avoid unnecessary readmissions from intermediate care to acute hospitals.
4. Foster collaboration of professionals from intermediate, primary and acute care in healthcare services research and evaluation.

**Target population:** Older adults with exacerbated chronic diseases or minor acute events (i.e. urinary tract infections) superimposed to an underlying complex situation (i.e. dementia).

**Timeline:** The project is framed within the Health Plan of Catalonia (2011-2015).

**Highlights (innovation, impact, outcomes):** Intermediate care provides specialized coordinated care to avoid unnecessary acute hospitalizations. Impact relies on: 1) possible prevention of risks associated to hospitalization through multidimensional and interdisciplinary geriatric care; 2) reduction of acute beds use. For aim 1, we compared matched groups of patients admitted to intermediate care and rehabilitation directly from home or after a stay in the general hospital: health outcomes were similar, whereas the group admitted from home experienced a significant reduction of global length of stay ( $p < 0.001$ ). For aim 2 (admissions from ED), >75% were discharged home after a mean of 10 days in intermediate care, meeting the local authority's quality standards; 90% remained home after 30 days. For aim 3, assessed risk factors for transfers from intermediate to acute care and designed an intervention based on nursing education and advanced care planning. Facilitating elements were the adoption of the health electronic record (EHR) shared by the university hospital and 90% of primary care, and a specific coordination committee.

The collaborative approach to research and evaluation (2 collaborative papers published in peer-reviewed international journals in the period) stimulated team building, shared responsibilities and rewards.

**Sustainability and transferability:** The project is based on re-organization and coordination of existing resources. Regarding EHR, the added value was switching to a shared solution. Translation to other settings might be conditioned by the existing models of intermediate and primary care. Limitations include the lack of integration with basic social services and the absence of economic or value-based evaluations.

**Conclusions and lessons:** Even in a fragmented territory, intermediate care might foster micro-coordination to avoid unnecessary acute hospitalizations.

## Keywords

intermediate care; integrated care; geriatrics; admission avoidance; healthcare services research

---

## PowerPoint presentation

<http://integratedcarefoundation.org/resource/icic15-presentations>