Integrated care

Supporting the needs of citizens with varying degrees of dependency…

The Portuguese National Network for Integrated Care (RNCCI) was established to solve an existing long-term gap in social support and healthcare in Portugal. This places Portugal at the same level as its counterparts in the European Union regarding concerns of public financed policies for social wellbeing.

The RNCCI promotes new organisational approaches, incorporating a new paradigm that builds on the principles of intersectoral partnerships, integral planning and multidisciplinary practice, which satisfy the identified needs of citizens with varying degrees of dependency.

The RNCCI coordinates its nationally decentralised operations by integrating both social and health policies, and establishing partnerships with the public sector, the non-for-profit or third sector and the private sector in a model of cooperation and shared financing; where state and civil society share the burden of the investment and the development of new structures and services.

It is also relevant to recognise that the RNCCI establishes several levels and services of post-acute, rehabilitation and long-term care, namely: convalescence care, post-acute rehabilitation services, long-term care, palliative care, and home care.

The network's plan is to grow, over a period of 10 years (2006-2016), the number of beds available, the organisational arrangements and integrated care practices according to the consensus between two governmental departments: social services and health services. At this present time, there are 3,734 beds and 84 home care teams in the RNCCI.

The main objective of the RNCCI is to increase the degree of autonomy of the citizens who are in a situation of dependency and need of social and health care, regardless of their age

The management model adopted for the RNCCI is based on the international principles of integrated care. It assumes that both social care and healthcare are part of a care continuum. Therefore, the network establishes intersectoral links and promotes new responses for unattended caring needs with a basis on local and community planning and service development.

The guiding principles stated above have been the inspiration for practical activities and actions aimed at reaching the objectives defined. The implementation has followed a set of management principles:

- The model of coordination at the RNCCI is decentralised and supported by three levels of coordination integrating health and social professionals: national (the national coordinator unit for implementation and management control); regional (five regional coordinating teams focused on identifying regional needs and implementing regional activities); and local (82 local coordinating teams focused on implementing care at local level in close relationship with primary care);
- The management tools to support implementation and monitoring of the RNCCI, both at national and regional levels, allow the monitoring of the activities and the evolution of the network services, as well as initiating a close review of the results and impact of the care delivered. Patients referrals to the network and clinical activity (in all in-bed types of care delivered) are registered, since January 2008, in a web-based information system;
- The RNCCI, as an innovative model and approach to care has been identified by the Treasury (ie. Finance Ministry) as a new Budget Execution Programme based on the inter-ministerial use of financial resources for the 2009 Budget.

The objective of this national programme is to enhance the process of allocating intersectoral financial

resources, as well as improving the use of public budgets. It implements mechanisms for transparency and responsibility at national, regional and local levels. This project pilot is the only one involving the Ministry of Health, the Ministry of Work and Social solidarity (responsible for the development of social policies) under the supervision of the Ministry of Finance (ie. the Treasury).

Budgeting based on programmes is a new form of budget execution and control that evolves from the traditional forms of budgeting and transfers the focus from resources to results, since it correlates the planned expenses to objectives and includes indicators that allow the performance of the entity managing the budget to be assesses. This is particularly relevant to further elevate the network to a project of national interest.

The fact that a specific financial model for the network has been clearly defined is a crucial element for its long-term consolidation and sustainability. Verified growth between January 2009 and June 2009 turned into a 22% budget increase in relation to 2008 and allowed a rapid growth of the number of beds contracted.

This sustainability is also evident when considering that the daily cost in the RNCCI is about one-third of the usual hospital costs related to medicine departments and that it allows for adequate early discharges from the hospital.

The evolution of the RNCCI is based on the development of new skills and thorough human resources policies. Between January 2008 and June 2009, 5,300 members of the RNCCI went through rigorous management and organisational training as well as integrated care practices training.

In 2008, the network defined a set of health gains as indicators to measure the impact and the effects of the services delivered by the units/beds contracted.

Since January 2009, 85% of the population admitted in the RNCCI was over the age of 65. The biggest health issue was stroke, representing 41% of all diagnoses. Multidisciplinary care practice allows health gains regarding issues of dependency.

One example of the type of patient in the RNCCI is a 44 year old female stroke victim patient who was admitted in the RNCCI from a central hospital. She was suffering from left hemiparesis, and speech and balance issues. She required assistance at all basic levels: feeding, dressing, going to the toilet, etc. A multidisciplinary approach was established, focusing on rehabilitation and promoting autonomy. After a 30-day programme, the patient was discharged and went home fully able to perform her normal daily activities by herself.

With this approach geared to a patient's physical autonomy, since January 2009, there has been a 43% decrease in disabled, a 72% increase in autonomous and 154% increase in independents.

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