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Conference Abstract

DEPLOYING INTEGRATED CARE MODELS FOR FRAIL ELDERLY PATIENTS

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Abstract

Introduction: Population aging and the increased number of chronic diseases push the healthcare systems to design and implement new strategies to improve the quality of services. These strategies require investment in ICT tools, promotion of patient empowerment in the management of their disease and a better integration of health and social care services.

CareWell project will enable the delivery of integrated healthcare to frail elderly patients in a pilot setting through comprehensive multidisciplinary and tightly knit programmes. ICTs will play a major role in the coordination and communication of healthcare professionals and of patient centred delivery of care at home. CareWell will predominantly focus on the provision of care and support to older people who have complex health and social care needs, are at high risk of hospital or care home admission and require a range of high-level interventions due to their frailty and multiple chronic diseases. This will be achieved through ICT enabled health and social care services coordination, monitoring, patients self-management and informal care givers involvement. The ICT platforms and communication channels will avoid duplication of effort when dealing with patients' diagnostic, therapeutic, rehabilitation or monitoring and support needs. Additionally, ICT-based

platforms can improve treatment compliance, enhance self-care and self-management and increase patient and carer awareness on their health status.

All of which will improve clinical outcomes and enable people to lead fulfilled lives. Moreover technologies will support the patients' informal caregivers highlighting when respite care or additional professional input is required.

Aim: Identification of the impact of implementing an integrated care model for frail elderly patients, according to quality of care, efficiency and bot patients´ and professionals´ satisfaction.

Timeline: 100 patients will be recruited from February 2015 to June 2015 and each patient will be followed up during 12 months.

Methodology: Definition of crucial aspects of the intervention has been deeply discussed in an inter-organizational and multidisciplinary work group, reaching consensus on how to implement the services within an integrated organizational model.
The working group is composed by: managers (primary care and hospitals), professionals of internal medicine, general practitioners, nursing (from primary care, hospital and eHealth Center), Telecare Centre's director and staff from the Department of information systems.

Highlights: This group has defined the characteristics of the target population, the organizational model, the integrated care pathway to be implemented, as well as the functionalities required with respect to the corporative ICT tools (Electronic Health Record, electronic prescription, Personal Health Folder, web portal).

Conclusions: The conclusions reached at this point of the project are:
- Importance of reach consensus among all stakeholders in the definition of the care pathways in order to consider different perspectives and integrate them in the intervention.
- Need of resource re-organization and definition of new roles to improve coordination between different healthcare levels (primary and secondary care).
- Primary Care is responsible for proactive control of the patients.
- Patient and informal caregiver empowerment leaded by nursing is essential.
- Technology is crucial to facilitate both coordinated management of all processes and communication between healthcare professionals.
- Healthcare professionals do not have to deal with different technological platforms; they should work on the Electronic Health Record of each patient.

Keywords

integrated care; coordination; emporwerment; icts

PowerPoint presentation

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