
CONFERENCE ABSTRACT

Integrated Care Program for the very old adults

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Alberto Sánchez^{1,3}, Elena Villalba-Mora^{1,2}, Ignacio Peinado¹, Leocadio Rodríguez-Mañas^{1,2}

1: Hospital Universitario de Getafe, Madrid, Spain;

2: Centro de Tecnología Biomédica, Universidad Politécnica de Madrid, Spain;

3: Assistive Healthcare IT, AIT Austrian Institute of Technology GmbH, Graz, Austria.

Introduction: The University Hospital of Getafe (HUG) is a public reference Hospital belonging to the Servicio Madrileño de Salud (SERMAS). It provides service to patients older than 65 (in most cases over 75), showing the usual features of older frail patients: multiple chronic comorbid conditions, multi-drug intake and high risk of developing new disability when acutely stressed. Their status must be continuously assessed and they often undergo recurrent hospitalisation.

The Geriatrics Service (GS) has implemented an Integrated Care Program (ICP) to fill service gaps, to prevent tasks overlapping and to assure continuum of care. HUG shifted Disease Management Processes (DMP) to new models, engaging different professionals from different units and at different levels both horizontally and vertically.

Description of practice: The ICP at HUG and the research described in this paper are aligned with the World Report on Ageing and Health (WHO), which recommends the organisation of services for the older focused in function and not on disease. They also follow the 'Consensus document on frailty and falls prevention among the elderly' released by the Spanish Ministry of Health as a part of the 'Prevention and health promotion strategy of the Spanish NHS' and approved by the Inter-territorial Council of the NHS in 2014.

The ICP promotes the transition from costly inpatient settings to the community. Discharge Criteria from inpatient settings were modified and the Acute Care Unit collaborates with the Community Care Unit (CCU) and the General Outpatient Unit (GOC) to devise discharge plans guaranteeing assessment in the community and care delivery until stabilization. These include ICT-supported continuous follow up in the community (CCU) and visits to outpatient settings in the HUG (GOC).

Besides, the GS created a Day Hospital to implement training and preventive programs for frail patients (i.e. recurrent fallers accomplish personalized physical training programs to prevent sarcopenia and are educated on action protocols to react if a fall occurs; neuropsychological rehabilitation is conducted for cognitive impaired patients and education ; education on desirable life habits and physical therapy are devised and implemented for diabetic patients). A multidisciplinary team (geriatricians, nurses and occupational therapists) devises

personalized programs following a patient centered approach, in which patients are engaged and empowered to self-manage their chronic conditions.

The ICP enhances the seamless delivery of care and improves patient outcomes in the GS. However, the implementation of the CGA and the new care processes enlarged the set of data harvested. Before, this information is stored on dedicated data tables that are independent from the General Health Information System (GHIS). This gap constraints information availability within the Service and with other Units and care levels, and hinders integration. An in-depth analysis of the ICP at HUG through case study research identified the barriers for its operation. We designed an innovative information management system to overcome these drawbacks and facilitate full integration, engaging final users (healthcare professionals). This Integrated Health Information System (IHIS) has the following characteristics: (1) it is an extension of the GHIS, it avoids duplicities; (2) it structures information and make it available; (3) it enables dynamic patient evolution visualization; (4) it is interoperable (following CDA architecture) and scalable.

Key findings: The average length of stay in the GS Acute Care Unit is lower than at other departments treating similar patient segments (6.8 vs 9.1 days). Moreover, mortality and re-admissions have not increased and patients' functional status has improved thanks to the Day Hospital performance. The number of unnecessary hospitalisations has been reduced by around 400 patients/year with a direct impact of €1.5 million.

Highlights: Integration must be built over the complete understanding of the environment and its requirements. Otherwise, it may not become a facilitator for integration but a burden for users.

The multilevel and multidisciplinary integrated delivery of care services requires the comprehensive knowledge of patient status and care processes. In this sense ICT become an unavoidable tool enhancing information availability.

User collaboration led to more effective, efficient and user-friendly system and contributed to the acceptance of the final model.

After the modelling stage and validation, the HUG ICT department and the GS are working together to fully develop the IHIS.

Conclusion: The GS had already built a successful ICP, but the absence of dedicated information management tools prevents complete integration. We proposed an IHIS devoted to the real requirements at GS.

The functional status and frailty determine the outcome of elderly chronic patients. In this sense, IHIS provides Geriatric Teams with a tool to perform CGA, improving the availability of information and allowing the efficient follow-up of older patients.

Keywords: integrated care; frailty; older people; ict; care continuum
