Morral, Rosa et al 2016 GeriatrICS Project: Support to Chronicity and Prescription Adequacy in Nursing Homes for the Elderly. *International Journal of Integrated Care*, 16(6):A244, pp. 1-8, DOI: http://doi.org/10.5334/ijic.2792

CONFERENCE ABSTRACT

GeriatrICS Project: Support to Chronicity and Prescription Adequacy in Nursing Homes for the Elderly

16th International Conference on Integrated Care, Barcelona 23-25 May 2016

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Background: (Introduction) The sustained increase of life expectancy that results from socioeconomic and health improvements has shifted health priorities. Most significant change arises from the increase of patients with chronic conditions and subsequent heightened socioeconomic burden on health systems.

Comorbidities are common in institutionalized elderly; some of them can be classified as chronic complex patients(CCP). GeriatrICS project was originated by the need to improve care of these patients, with a reorganization of health care in Nursing Homes(NH) ensuring integrated care approach by primary care teams and all the stakeholders .

Baseline conditions: The healthcare model in our setting was based on primary care teams providing on demand assistance when required by (NH). While the prevalence of dementia was known, comorbidity, dependency and frailty were under-registered. Indeed, these elderly patients often attended emergency services(ER) and experienced multiple preventable and avoidable hospital admissions. Medication was not adequately reviewed in terms of efficacy, safety, cost and adequacy of prescription.

Project description:

Aims:

- Provide from Primary care quality health care to elderly in NH based on proactive and integrated care approach.

- Develop a program based on patient safety, and review adequacy of treatments according health and dependency , based on efficacy, efficiency of prescription.

- Connection computerized medical data record in NH. Access to electronic prescribing.

- Coordination between Stakeholders: hospital, ER, community pharmacists, NH, etc., to ensure integrated care.

- Streamlining healthcare resources, avoidable and preventable hospitalizations.

Intervention: In 2012 a group (GPs, nurses, pharmacists and epidemiologist) was created.

Intervention model was developed to ensure its consistency and to achieve healthcare objectives determined by proactive and integrated care formulae (comprehensive evaluation and requirements plan). CCP that required the intervention of nurse case managers were considered particularly important.

Settings: 8743 institutionalized patients (IP) In north metropolitan area of Barcelona. Catalan Institute of Health. Catalonia.

Methods. Multicenter intervention in 184 NH assigned to our primary care centers

Target population: 8743(IP) living in NH. Identified with code (Z 59.3)ICD10

1 – Primary care teams reorganized in doctor-nurse units, with support of administrative staff; these teams acquired specific skills to assist IP in aim to provide proactivity care actions, decompensation prevention to prevent avoidable and preventable hospitalizations . The model also included the approach to a consistent quality end-of-life care based on screening with the NECPAL CCOMS-ICO©10 project criteria and a training of healthcare professionals to support the end-of-life process.

2- Creation and implementation of a therapeutic drug guide, criteria based on safety, effectiveness and efficiency, free access in blog format (https://farmageriatrics.wordpress.com/) to be shared for all physicians. Pharmacotherapeutic Guideline Farmageriatrics® was based on STOPP-START and Beers criteria

3 - Primary care electronic medical record (ECAP) has been installed and became accessible to professionals in NH, to facilitate the register of all clinical events and drug prescription.

Results , outcomes and impact: Intervention was carried out in 184 NH, 8,743 IP . Patient's profile: 77.3% were included in CRG (Clinical Risk Groups 3M©) 6-7 (2 or more chronic conditions), 42.9% have dementia diagnosis, 28.9% were CCP and 6% with Advanced Chronic Disease(ACD)

Decreased of hospital admissions by 31.1% and 7.6% in attendance to ER; use of internal health resources has increased 20.4% (primary care emergency services). The cost/resident in pharmacy has decreased by 18.1% since 2012. Pfeiffer's test was conducted in 74.3% of patients (29.9% in 2012), resulting in patients' cognitive status of 6. Barthel test was administered to 74.8% of patients (36.2% in 2012) with mean score of 47.4.

Highlights:

Lessons learned: 1-A centered-person point of view the most valuable and powerful argument for all stakeholders involved put aside personal goals, sit around a table, work together to focus on the patient and his environment: family, etc.

2-Teamwork is essential and necessary to carry out this project.

3-Both the design process and during the implementation is very important don't forget any of the parties. In this regard, it's essential that both : those directly involved and those who

are indirectly involved, sit in the project, and always, without losing sight of the common goal: the patient

4- Patient is only transferred to hospital when it's strictly necessary

5- Highlight some difficulties in terms of administrative bureaucracy when facility installation of electronic medical record in NH. In our country health and social welfare depend on two different Departments.

Keywords: primary care; nursing homes; integrated care