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CONFERENCE ABSTRACT

Up-scaling of an integrated care model for frail elderly patients

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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 focuses on the delivery of integrated healthcare to frail elderly patients 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. Carewell aims at deploying services supported by ICT which enhance the coordination and communication of healthcare professionals, improves patient´s remote follow up and boosts patient (and caregiver) empowerment.

The aim of the project is the identification of the impact of implementing an integrated care model for frail elderly patients, according to quality of care, efficiency and both patients´ and professionals´ satisfaction.

Short description of the intervention: Following the inclusion criteria and based on the population stratification dataset, the GP identifies potential candidates. Then, the GP proceeds to schedule a consultation with the patient to perform a comprehensive assessment, define the therapeutic plan and provide patient with educational material in order increase his/her self-management capability.

Then, the GP nurse schedules a face-to-face follow-up plan depending on the patient's needs. During this face-to-face consultation, the GP nurse analyses patient's therapeutic plan and his/her adherence to treatment, reinforces patient's self-management capacity through an educational plan, revises lab tests and performs medical examinations.

If no worsening symptoms are detected, the patient is reviewed approximately every three months. However, if any instability sign is identified, the patient is referred to the GP in order to reassess his/her clinical situation. If the patient can benefit from home care, a variety of resources can be activated.

If the patient cannot be treated at home, or his/her health status continues to worsen, the patient will be admitted to hospital. During the hospitalisation, the reference internist is in charge of assessing the patient's clinical situation, defining corresponding treatment, managing medical interventions and coordinating specialists.

Once the patient is stable, the reference internist will consider if the patient requires additional interventions such as home-hospitalisation, admission to a sub-acute hospital, social care, or special coordination with primary care.

At hospital discharge, the reference internist writes the discharge letter and contacts the GP to ensure continuity of care. In addition, the hospital nurse draws up the patient's follow-up plan, and schedules a face-to-face appointment between the patient and the GP nurse.

The visit with the GP nurse is the starting point of the integrated care pathway, from where the patient can be referred to periodic follow-up consultations or to hospital, depending on his/her health status.

Key findings: The definition of the care pathway supported by ICTs has been deeply discussed in an inter-organizational and multidisciplinary work group (managers, clinicians nursing of primary care and hospitals, eHealth Centre, Department of Information Systems, Department of Healthcare and Kronikgune), ensuring that all stakeholders´ opinions and needs are considered.

200 patients (100 intervention group and 100 control group) have been recruited and the services aforementioned are fully operational. At this moment the enrolment data is being collected and the baseline analysis (quantitative and qualitative indicators) will be performed during December. In addition, predictive modeling approach will be carried out to estimate the use of resources in mid- and long-term after the new service deployment.

Highlights and conclusions: Intervention perspective:

- Need of a clear methodology to design the intervention (analysis of current model, detection of improvement areas, prioritize actions and define the new care pathway)

- 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 coordination between healthcare professionals.

Implementation perspective:

- Need to align the objectives of the project with the strategic plan of the central organization so the deployment of the service becomes a priority.

- Importance of reach consensus among all stakeholders in the definition of the care pathways in order to consider different perspectives (managerial, technical and methodological competences).

- Ensure the service is adaptable and flexible enough to be adopted in new contexts.

- Distributed leadership is crucial from the implementation process perspective (clinical, managerial and methodological)

- Need to share midterm results and collect feedback from front-line professionals to detect improvement areas

Keywords: frail patients; integrated care; deployment