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CONFERENCE ABSTRACT

Care paths as a tool for integration and change

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Introduction: Chronic diseases are currently a significant health problem, conditioning the patient into a progressive deterioration and gradual autonomy loss.

The study focuses on the organization of health service systems , in order to achieve a better preventive control and management of chronic disease treatment.

Our route, incorporates risk stratification, considering the natural course of Diabetes Mellitus, Primary Care's prominence, the cooperation between health care areas and support for patient's autonomy.

The allocation of dual, and shared leadership between clinical specialists (primary and hospital care) and Primary Care management within the Department is one of the most innovative and genuine contributions of the study.

In this scenario, communication, becomes a fundamental element, for a comprehensive care which guarantees continuity. It is present at all stages of the route development and considers every person in the process, regardless their field.

The methods are multifactorial, organizational attention, nursing care, clinical care and the improvement of drug treatment.

Change of practice: A care path, is a pact among professionals, to provide a specific solution, to a specific health problem. It responds to foreseeable scenarios, within the good medical practice framework (ethical commitment).

It is designed with a global and, integrated vision which organizes change and sequence of the intervention, has an owner, the founding group and a director of path.

The patient is part of the group, and as a collaborator, gives his opinion about the form of work methodology and expresses their needs and priorities.

While the fragmentation of care is inefficient, the integrated cares, applied to small systems, has room for efficiency.

Main objective: To establish and implement an assistance strategy continued and integrated into patients with Tipe 2 Diabetes Mellitus, in the Department of health of Elda.

Specific objectives: To minimize the involved processes. To improve the clinical approach, reduce the clinical variability. To promote the continuity of care. To reduce morbidity. To improve the quality of life. To promote self-care and self-control. To promote the engagement of professionals in the various evolutionary stages of disease. To standardize registration processes. To improve perceived quality and patient satisfaction.

Target population: Type 2 Diabetics of the Department of Health of Elda.

Main involved: General Practitioner (MFyC), Nursing of Primary care, Endocrinology, Nurse Educator, Nephrology, Social work, Ophthalmology, Clinical Psychology, Emergency, Clinical analysis, Cardiology, Area pharmacy, Neurology, Ambulatory information systems, Patient, Primary Care Management.

Key findings: Care routes have in themselves the perfect equation for change. We started working in the welfare path in 2014. Since its submission to the Department in March and implementation in April and May 2015 to the primary care centers, evaluation of the indicators during the first six months, has been satisfactory.

In 2015, there has been an improvement in the control of HbA1c, of 22.83% in 2013, 51.24%. Likewise, decreased the percentage of patients with a BMI > 30, 29.91% in 2013 to 22.10% in 2015.

Both hypoglycemia and hyperglycemia registered declined in percentage: 1.32% in 2013, 1.17% in 2015 and 0.39% in 2013 to 0.32% in 2015, respectively.

HTA control, has improved by 84,62% in 2013, to 86,06% in 2015. We are waiting to receive more hits that will be showcased in May 2016.

Lessons learned since the implementation: The attention must be focused on people, professionals (they are people) and to provide an "ethical" follow-up.

- The Department must be ready to change. Solve the lack of communication, the biased view and learn how to work in a team, creating the appropriate environment, then see what we can improve.

- Meet the clinicians' prioritizes.

- Listen to the patient.

- It is important to prioritize the contents of the route to implement, do it gradually, evaluating, redirecting and consolidating.

- Corporative intervention in small groups in conjunction (different members of the Working Group) provides an additional plus and allows you to combine various lines of action.

- There is a need for management of consultation and use training tools.

Conclusion: Teamwork and collaborative work, create a wide opportunity for improvement. Proposals should focus on the patient and the practice of the profession. Care routes are an excellent tool for the improvement of the comprehensive and integrated care: more health, better care, more efficiency; always framed in departmental areas, as small systems of action,

so it supports the sustainability of the system and can be easily extrapolated to others departments.

Keywords: change; diabetes; integration; path; people