
POSTER ABSTRACT

Riudoms chronic care plan.

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Almudena Garnica¹, Montse Bonet¹, Montse Salvado², Jose A. Bilbao²

1: Hospital Universitario Sant Joan de Reus, Spain;

2: Area Basica de Salut de Riudoms, Spain

Introduction: Baix Camp County has a population of reference in 2015 of 188640 people with a 18.57% of over aging (population over 84 years divided by the population of 64 years). Eleven basic primary care settings serve this population with a unique reference for specialized care (SC) which is the University Hospital Sant Joan de Reus. There are two PC providers, the Institut Catala of health and Grup Sagessa, also the specialized care provider.

There is a system fragmentation regarding the chronic patient care with a lack of continuity between the two areas (SC and PC) which causes an increased risk in patients' transitions. This leads to a lack of comprehensive view of the patient with multiple chronic conditions, from a health and social perspective, with a poor management of its complex needs. It increases the number of readmissions and avoidable hospitalizations. There is a support team specialized in geriatrics care for these group of complex chronic patients but is underused by PC without an established system for the assessment and follow up.

Short description of practice change implemented, aims, target population and key stakeholders involved

We propose a new model of chronic care for older persons with multiple chronic conditions and complex needs. It consists on a program based on a horizontal integration across care settings, primary care (PC) and specialized care (AE). It started in March 2015, coinciding with the beginning of a case manager for chronic patients (GCP) at home in the town of Riudoms.

We agreed in the following activation criteria for specialized geriatrics support team (GT):

1. Reactive: acute decompensations, use of an emergency resource (PC or EC) , review of drug prescriptions and end-of-life situation.
2. Proactive: frequent attendance of emergency resources (> two visits in the last six months), polypharmacy (consumption > 7 drugs), support for continued care of PC and specific diseases as dementia, COPD and heart failure.

Main objectives:

- Increase the identification of complex chronic patients in the medical record shared for both levels(HC3)
- Reduce hospital readmissions

- Reduce avoidable hospitalizations
- Decrease polypharmacy

The target population are complex chronic older patients, either those already identified in the HC3 or those newly identified after using a health resource.

The program consists of a **comprehensive geriatric assessment** with GCP with GT. An intervention plan on the whole patient needs is done and jointly monitoring is agreed. It is established a weekly contact between the GCP and the GT, and assessment of the patients are scheduled. If the patient is admitted, the RG team is coordinated with Hospital case manager.

The key stakeholders are: 1. The patients enrolled in the intervention improving their continuity of care, reducing their vulnerability in transitions and speeding up access to specialized geriatric care.

2. PC professionals are stakeholders because they are offered a specialized geriatric support to facilitate the management of chronic patients. 3. Hospital professionals of different departments who helped with the coordination with PC team and facilitate early discharges with intensive monitoring of the GT

Key findings: Early data since the start of the program reflects an increase of the percentage of Chronic patients identification in the HC3 compared to December 2014. The comprehensive geriatrics assessments made by the GT together with the GCP have increased a 27%, being assessed a 75% of the patients identified who are at home. Globally it has decreased the readmissions' number in this group of patients. Regarding ambulatory care sensitive conditions, this index has remained stable.

The impact in terms of teams' integration is very positive with a fluent communication with GCP nurse.

Highlights: This integrated approach to patients with multiple chronic conditions and complex needs provides specialized attention across primary, secondary or home-based care. During its implementation, the program has faced challenges and developed key lessons learned including the importance of cultivating a **strong team-based** working environment across the care setting (PC and SC), integrated data systems, an emphasis on patient health, the use of patient-centered indicators, and provider satisfaction. Traditionally, the care has been structured around secondary care with less focus on primary care with a limited integration of care across providers. Our initiative focus on geriatrics specialist working in the community with an active engagement in the prevention of complications

Conclusion: This program is sustainable in its implementation as all resources (PC and GT) were already working. What is innovative is to integrate all the different levels of care in a systematic way, improving continuity of care. This intervention is clearly **patient-centered**, based on the needs of people with multiple chronic conditions. **Home care is a key setting** that is integrated into overall health system to increase care coordination and improve the patient's health outcomes.

Garnica; Riudoms chronic care plan.

Keywords: integrated care; primary care; geriatrics; chronic patients
