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POSTER ABSTRACT

Integrated Care in practice: Improving population health across the care continuum at home.

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Introduction: The Carmel Health Center serves a population around 20000 inhabitants and it's located in a suburban deprived area of Barcelona city. The increase in the overaging index (22%), in addition to the topography of the neighbourhood and the number of architectural barriers, contributes to the difficulty in access to Primary Healthcare Centre (PHC). These circumstances prompted the creation, in 2014, of a specific team to take care of the people in need of health homecare

Description of practice change implemented: The aim of the home-visit team (ATDOM) is to provide a qualified and integrated care to people that are not able to move from home, based on their needs and doing network with other sanitary and social resources and using specifics tools for it

The target population (247 people) are all patients of assigned area that are not able to reach de PHC for health reasons, physical condition or their social or environment situation, either temporarily or permanently. The patient must agree to be treated at home. The activity is focused on the patient and his family and the goal is to provide quality care through a multidisciplinary team that ensures social and sanitary continuum care.

The home-visit team, formed by one family doctor and two nurses, represents an added value because are permanent references for patients and ensures a continuum of care and a systematic follow-up. The team is completed partial time with a case-manager nurse and a social worker, it has also administrative support and punctual collaboration of medical residents.

The home-visits are done in different situations:

- By demand of the patient or family

- After a hospitalization: the team receives via email information about day of discharge and diagnosis

- By alert of the Telecare service, the public network of social workers, the 7x24 circuit, or the emergency-room report assistance

- When scheduled follow-up by the team

All visits are done by nurse, doctor or both depending on each case. Some visits can be resolute via telephone

Different public programs are used as resources for the homecare team. All these programs facilitate coordination and continuity of care between different healthcare providers:

- The 7x24 circuit: it offers the possibility of calling from the Primary Care Emergency Centre (CUAP) to the patient that requires support during weekend.

- The Programme for patients in terminal situation (PADES) offers support to address situations of high complexity

- The Telecare service of the City of Barcelona

- The family workers of the public social services

- Protocols for convalescence stays, family breaks, palliative care and rehabilitation or admission to day-hospitals.

The main tools used by the ATDOM team are:

- Shared Medical Record (HCC 3): electronic record shared by primary care, hospital, CUAP and discharge reports from different reference health providers.

- Shared Individualized Intervention Plan (PIIC): gives useful medical and social information such as: main diagnoses, medication and recommendations in the event of medical decompensation.

- Advanced Chronicity Care Model: To identify patients with chronic complex health situations (PCC) or advanced chronic diseases (MACA) in order to offer them a more accurate follow-up. That includes the application of different scales and the Planning Living Wills (PDA) to know the values, preferences and expectations of the patients, and their relatives, in MACA situation

Key findings: The number of patients assigned to the service is 247 up today, that represents the 1,26% of the population assigned to PHC, and the 6,1% of the peopled over 65.

The assistential burden for medical doctor is 920 and 474 for nurses

There are no data yet to assess the effectiveness of the program. We are planning to assess the accomplishment of the standard set of scales that ATDOM team uses for each patient when is included to the programme and 3 month later

Highlights: The home care with this specialized team assures more continuum care than the previous situation when the patient was attended by doctor on duty. The relationship created is similar when the patients were coming autonomously to the PHC.

Contingencies: In the event that the doctor is not in service, the others doctors of the PHC assumes acute situations and the scheduled programme is assumed by the nurses of the team.

Conclusions: During 2015 the ATDOM professionals have consolidated as a team. It's a cohesive team and work on specialized care of patients in their own environment and offers a health and social continuum care.

Burch Piñol; Integrated Care in practice: Improving population health across the care continuum at home.

Keywords: homecare; continuum care; advanced-chronicity-care-model; chronic-complex-patients