
POSTER ABSTRACT**Improving integrated care for frail elderly patients through ict – the veneto region experience**17th International Conference on Integrated Care, Dublin, 08-10 May 2017Stefano Gris¹, Erika Sampognaro¹, Antonella Forestiero², Claudio Saccavini², Silvia Mancin²

1: Azienda ULSS n.2 Feltre, Italy;

2: Cosnorzio Arsenà.IT, Italy

Ageing population and the related increasing incidence of chronic and frail patients are the main challenges that the EU countries are facing nowadays, these challenges affect directly the sustainability of the social and health care systems and impact on life quality of the people. In this context, the European project CareWell, started in February 2014 and with a 37 month duration, aims to improve and develop a better coordination among the social and healthcare professionals using the ICT. The idea is to achieve a more multidisciplinary approach of the professionals and a more close integration in frail-elderly patients treatments in the six European regions. This project pursues its aim through two pathways: the integrated care coordination and the patient empowerment. The Veneto pilot site (Local Health Authority n.2-Feltre) has developed and implemented a new model of integrated care delivery based on three services: ICT platform called "patient's dashboard"; inter-consultation among professionals via Health Electronic Record (HER) and vital signs monitoring services at patient's home. This new model has been tested by an intervention group (81 patients that fulfill the inclusion criteria: older than 65 years old, at least two chronic conditions one among COPD, CHF and diabetes, and in social or health frail condition) - followed with the new services- for at least 9 months and compared with a control group (that received the usual-care services) with the same characteristics. The delivery of integrated care is supported by the Patient's dashboard, an ICT platform that shares all the relevant information coming from health and social care, home-care services, and hospital records. Regarding the patient empowerment, training materials have been uploaded on the website and the home care nurses provided a training service to patient's home in order to increase illness-management of the patients. The new model implementation is expected to improve the quality of the chronic patient's life. The first results are going in this direction, in fact, in the intervention group, the user's satisfaction increased, in particular they felt more looked after and acknowledged a better coordination among professionals. From the professional's perspective the new services allow a better coordination, thanks to the possibility to access the patient's information collected by other professionals, and a reduction in time been wasted.

The positive impact in our organization spurs the willingness to maintain and develop the CareWell services for the next years and the willingness to transfer it to other sites. Thanks to an ICT data/information sharing approach that allows to different health and social care providers to have a look at the information collected and reported by other services avoiding misunderstandings and time wasting, this experience is easily transferable and also sustainable on an economic level because it is focused to change the methodologies the different entities used to deliver services to frail patients.

This experience has highlighted the relevance of a changing management approach that involves the professionals at the beginnings of the new model implementation in order to reduce the professionals' resistance.

Keywords: integrated care; frail chronic patient; change management; ict; health and social care
