POSTER ABSTRACT

Do we know the social complexity of the complex chronic patients?

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Introduction: Patient complexity is probably a multifaceted concept not fully captured by the number or type of medical conditions or by previous health care costs. Clinical and psychosocial issues should be taken into account when identifying people with chronic complex care needs. At least one third of patients in general practice have psychosocial problems that they perceive as influencing their present health. Social care and heath care fragmented framework does not respond properly to chronic patients needs.

Objectives:

1- Describe general practitioners’ knowledge of a range of psychosocial problems among their complex chronic patients

2- describe the distribution of being identified healthcare integration benefit criteria and being coded as Z60 by age.

Theory/Methods: Population-based cross-sectional study based on professional electronic medical records. Setting: primary care urban practice placed in Sabadell (Barcelona), Catalan Institute of Health (ICS). Clinical Risk Groups (CRG) ≥5 population older than 14 years old (24,762 inhabitants) were reviewed and identified as complex chronic patients (CCP) by Family Physicians using a construct based on clinical judgment and clinical and psychosocial issues, promoted by the Chronicity Prevention and Care Programme (CPCP),Catalan Department of Health. Psychosocial issues in electronic medical records are coded as Z60 (Problems related to social environment, ICD-10-CM Diagnosis Codes). The identification and data collection was carried out between 1 July and 30 September 2016.

Results: A total of 571 chronic patients were identified by their family physicians, prevalence of 4.16%, 52.3% (298) women. Mean age of males 70.4 (95% CI: 68.6-72.2), females 74.2 (95% CI: 72.5-75.8), p = 0.002. Of the 571, 23 (4%) had the diagnosis of Z60, men 13 (56.5%) mean age: 64.5 (95% CI 55.2-73.7) women 10 (43.5%) mean age 60.2 (95% CI 44-76.37).

There is an association between need for integration and being coded Z60 (p=0.018) but social coding is very low and the lack of knowledge of the social reality of CCPs is around 20%.
**Discussions**: Doctors’ knowledge of social problems influence management: extra time, advice, certifying a sick leave, and prescribing a psychotropic drug are the most common actions taken, while referral to other community services was seldom used. It could reflect that the patients had already made such contacts themselves, intend to do so or the doctors could have considered cooperation with community services not to be worth while.

**Conclusions**: Person-centered care implies attention within a health and social collaborative model. Our finding suggests that community services and Primary Heath Care practices are not yet well integrated in Catalonia

**Lessons learned**: Compared with clinical diagnoses, social diagnoses are scarce in electronic health records

**Limitations**: Different providers, different information systems and coding and lack of shared information limit proper social and health management. The review of the study is only done with the health database and therefore unknown social data for these patients.

**Suggestions for future research**: Healthcare integration needs to move from a fragmented framework, in which individuals apply for and receive health benefits and care benefits separately, to a new model of shared responsibility. Interministerial Social and Health Care and Interaction Plan (PIAISS) is already working on the integration of social and health information systems.

**Keywords**: integrated care; social care; complexity; information systems