

CONFERENCE ABSTRACT

Impact on the use of services and quality of life of a continuity of care unit for multi-pathological patients.

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Introduction: Bidasoa Integrated Health Organisation was the first integrated health care organization IHO created in the Basque Country in January 2011. It comprises the hospital 96 beds and 3 primary care centres. The IHO catchment population is around 90,000 citizens. As has happened in other organisations, care delivery in Bidasoa area was fragmented, with poor communication between primary and secondary care professionals. This fragmentation affected especially chronic patients with several pathologies.

Description: In answer to this problem and focused on the management of complex chronic patients, Continuity of Care Unit CCU was created in Bidasoa IHO. Nowadays more than 200 patients are being taken care there. CCU worked as follows: the referral internist RI, one for each health centre, is responsible for the admission of patients with complex or multiple conditions in the event that they require admission to hospital. The mission of CCU is to stabilize patients and facilitate continuity of care by the general practitioner GP. These patients have a continuity of care plan between levels of care and they are admitted to the hospital through a special circuit not A&E when needed. The role of the liaison nurse is to support the patient in the transition from hospital to home, where they are followed up by the GP. The RI visits the health center every other week to undertake clinical sessions.

Aim: The aim is to improve the quality of life and care provided to complex chronic patients, by a multidisciplinary team, based on a patient-centred care and collaborative work among primary care, hospital care and social services.

Targeted population: Patients with two or more chronic conditions who have been admitted at hospital more than two times in the last year.

Timeline: CCU was created in 2011. Since 2016 the quality of life of patients that are incorporated in CCU is evaluated

Highlights: All patients n=247 included in the unit between 1st January 2011 and 31st December 2014, with a minimum one year follow up are analysed. These patients have an average age of 84.1 years. 56.4% are man. It is observed 45.5% reduction in emergency department visits and 41.9% in hospital admissions. Simultaneously, the number of nurse home

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visits increased significantly after patient CCU inclusion. Furthermore, analyzing a sample of these patients it is observed a significant improvement in the self-perceived health status that is related to age greater improvement in the youngest.

Sustainability: The change in the care model has been made with the reorganization of existing resources.

Transferability: That model could be transferred to a care model based on primary care as patients referral.

Conclusions: A care model based on a multidisciplinary team between primary and hospital care has improved the quality of care of chronic complex patients and their self-perceived health status

Discussions: The implementation of this practice involves a cultural change among professionals, new functional roles nurse, RI and a greater collaboration.

Lessons learned: The necessary cultural change is a slow process. The existence of shared areas plays a key role to get it.

Keywords: care continuity; quality of life; multidisciplinary team
