CONFERENCE ABSTRACT

Building connections between primary care and other specialties for a better patient experience

19th International Conference on Integrated Care, San Sebastian, 01-03 April 2019

Ander Berroeta, Juan Carlos Arbonies, Beñat Zubeltzu, Marta Vaquero, Naiara Perez, Ana Fuertes, Maitane Elola, Uxue Errasti, Ander Alberdi, Asier Mitxelena, Adriana Couto, Ignacio Sanz

Osakidetza, Spain

Introduction: Traditionally, the healthcare system has been organized in a fragmented manner with lack of connection among the different levels and departments. This problem leads to contradictory messages about diagnosis, treatment and prognosis. Moreover, it duplicates visits and creates greater expenditure in diagnostic tests and prescription changes. Most importantly, it generates a disruption feeling in the user.

Short description of practice change implemented: Creation of connection mechanisms between primary care and other specialties

Aim and theory of change: Integration of the primary care and hospital specialists is essential in the new demographic situation with an ageing population with more chronic diseases

Targeted population and stakeholders:

Chronic multi-pathological patients

Patients under diagnostic pathways

Diabetic patients managed among primary care, nephrology, vascular surgery and endocrinology.

Surgical complex patients

Timeline:

- 2012 Creation of an integrated health organization

- 2012 Pathways for decompensated chronic patients

- 2013 Monthly meetings between primary and a referral internist

- 2014 Non presential interconsultations

- 2015 Assessment of patient's feedback

- 2017 Connection with primary care through Microsoft Lync

 Highlights (innovation, Impact and outcomes):

- Decompensated chronic patients: a severity assessment is made and alarms are generated accordingly leading to telephonic attention, early appointment with GP, referral internist visit at the hospital or direct admission.

- Monthly meetings between referral internist and primary care: complex cases are discussed and critical points of the pathways are discussed to generate new solutions

- Non presential interconsultations: generated by the GP through the electronic medical record. A referral internist makes written recommendations about diagnostic or therapeutic issues or creates an appointment

- Patients' feedback: A qualitative study about patients' perception was done through interviews in deep

- Use of Microsoft Lync for written conversations between referral internist and GP

- Outcomes: Better coordination in the management of multi-pathological patients, reduction of hospital admissions, reduction of days spent at the hospital and ED visits. Reduction of face-to-face consultations. 1600 non presential consultations per year.

Comments on sustainability: Integration likely to increase cost-effectiveness by reducing ED visits, hospital admissions and face-to-face consultations while increasing electronic consultations.

Comments on transferability: Technology and protocols are available to all and easily transferable to other settings. The change has been made with existing resources.

Conclusions: Integration improves control of patients, reduces time of answer of interconsultations between the levels and is likely to reduce cost because of fewer face-to-face consultations and days spent at the hospital.

Discussions: Integration is especially beneficial when increasing complexity of patients and it facilitates case management strategies, the sessions among primary and internist and non presential interconsultations have helped to minimize the contradictory messages/actions (since these problems are treated in the sessions).

Lessons learned: A higher level of integration is possible when the tools and technology are available. Success depends also in the will of change of the healthcare workers who may initially be reluctant to new strategies. Patients' feedback is clear about the benefits and that should drive stakeholders to overcome the implementation barriers.