
CONFERENCE ABSTRACT

The chronic care attention in OSI Debarrena: an integrated management model

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Objective: Our organization OSI Debarrena is working on an interdisciplinary program to achieve the goal of chronic care attention: to develop a sustainable chronic care model.

Methods: The backbone of the program is the centered-patient care. These high-need, high-cost (HNHC) patients deserve higher attention because they have major health care problems and because it is necessary to prevent exacerbations and consequent hospitalizations. Chronicity needs to be approached from a multidisciplinary work team that ensures the care the HNHC patients need in each moment. The integrated management model in which Primary and Hospital care work together has promoted this target. Our Chronic care model program performs four essential activities: 1 Identifying patients who are at high risk for poor outcomes and unnecessary interventions. 2 Performing comprehensive health assessments to identify problems and ensure effective interventions. 3 Working closely with patients and their caregivers, primary care specialty and social service providers. 4 Rapidly and effectively responding to changes in patients' conditions to avoid use of unnecessary services, particularly emergency departments or hospitalizations. To achieve a cost-effective attention is necessary to ensure close coordination and communication between the different healthcare levels (outpatient and inpatient care). In this point, different strategies have been implemented: mobile phone calls, chat online, remote consultations and face to face meetings between Primary Care team and Hospital team. There are two reference internists assigned to each outpatient clinic and nursery teams also work together to ensure the care continuity.

Results: In 2017, there were 1912 patients evaluated in our organization (641-628-643 per quarter), being the 65% male. The 59% of the patients were over 80 and 20% identified as palliative care patients. The 18% (n=346) were hospitalized (45.9% of them for a medical problem) and the 15.6% of the admitted in Internal Medicine were scheduled hospitalizations (avoiding the emergency department) after keeping in touch with the reference internist and agreeing the need of hospital admission for treatment. There has been a significant decline in the number of hospital admissions in the third trimester of 2017 comparing to 2016 (516 vs 451 p=0.001), due to the progressive use of other assistance processes such as Day Hospital (15,4%) and home hospitalization (22,1%). The 29.5% have been evaluated external consultation (4% quick response consultation). The main form of communication between General Practitioner to Internal Medicine is by mobile and chat online. The 100% of the patients and families received recommendations to

prevent exacerbations and health assessments to identify problems by nurses and doctors during the hospitalization. Face to face meetings between hospital and ambulatory teams are held every two months in the outpatient clinics.

Conclusions: The program and the goals are well defined being necessary to keep on working together in the same direction and closely to patients and caregivers so as to optimize results. Due to a reflection an improved model is being recently designed where nursing and doctors' care frequency depends on the stage of disease. Primary care and hospital integration is promoting the global approach to the chronic patients but we still have to work hard in achieving the social and sanitary integration as well due to the complex social needs of these patients.

Keywords: chronicity; integration; primary care; reference internist; multidisciplinary
