International Journal of Integrated Care

Vargiu, E et al 2019 Connected care for complex chronic patients in Lleida. *International Journal of Integrated Care*, 19(S1): A102, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.s3102

CONFERENCE ABSTRACT

Connected care for complex chronic patients in Lleida

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

Eloisa Vargiu[1], Gerard Torres[2,3], Mireia Masip[2,3], Juan Manuel Fernández[1], Felix Michel[4], Florian Matthes[4], Felip Miralles[1]

1: Eurecat Centre Tecnòlogic, Spain;
2: Hospital Universitario de Santa Maria, Spain;
3: Institut de recerca biomédica (IRB), Spain;
4: Technische Universität München, Germany

Nowadays, patients' health care is still fragmented: primary healthcare professionals are responsible when the patient is in the community, whilst hospital care staff take the lead during hospitalization. Over the years different systems have buttressed this disconnection with linking mechanisms but, unfortunately, a comprehensive solution has not yet been achieved.

The EU project CONNECARE is implementing a new organizational model for Integrated Care, enabled by ICT tools which allow adaptive case management and clinical pathway personalization of complex chronic patients (CCP). This model is based on a 5-dimension score strategy: Case Identification, to select patients eligible for entering the program; Case Evaluation, to stratify patients based on multilevel risk assessment (clinical, environmental and social); Workplan definition, to plan proactive and preventive interventions based on personal circumstances of the patient; Workplan execution, to continuously monitor the evolution of the personalized therapeutical action plan (through questionnaires, measurements with medical devices, educative material, etc. in a patient self-management App), and Discharge, to evaluate the overall intervention. All professionals, both from primary care (PC) and hospital, social workers included, may interact with each other by leaving notes on a virtual wall to agree upon the Workplan, keeping the continuum of care before hospital discharge. Hospital staff may provide support to PC professionals beyond hospital discharge, and all of them may help and accompany the patient through direct communication tools. In any moment, professionals in charge of a case can have a schematic summary organized in 3 parts: the health status of the patients with the results of the most relevant taken measures and calculated metrics; the diagnosis through a graphical representation of the human body with the status of her organ under revision; self-care skills and socio-environmental conditions through a list of barriers.

Studies started on July 2018 in Lleida region focuses on integrated management of (i) CCP with medical worsening (CS1) and (ii) CCP undergoing surgical procedures (CS2). Right now, a case manager from the Hospital Santa Maria is in charge of recruitment and patients' follow-up; 31 hospital professionals and 50 PC professionals are working on the project. The summer holidays circumstances have slowed the recruitment process because hospital admissions of COPD and IC patients decrease and organizational changes are performed at PC. Despite this, 4 patients from CS1 (1 female, mean age 75 ± 15.66) and 8 for CS2 (3 female, mean age 70.5 ± 8.38, knee replacement surgery) have been recruited and are using the system. To maximize patients'

inclusion, we decided to lower the limit age from 65+ to 60+. Results after 1 month of studies show a successful involvement of a wide range of professionals from both hospital and primary care settings. The overall system is working smoothly without any issue and professionals like it.

Keywords: adaptive case management; organizational model; ict tools