CONFERENCE ABSTRACT

Case management and coordination between primary and hospital care

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Introduction: The growing demand of health services, related with ageing, chronic diseases, social needs and higher users expectations, requires a transformation of the care process, shifting the approach from reactive to proactive, based in patient-centred services. The Case Management programs (CMP) are identified as the most efficient organizational intervention for patients with complex multimorbidity.

Description of the program, objectives, target population: Since 2017 we have been implementing in a Local Health Unit (LHU) a CMP for adult patients with complex multimorbidity. The case manager is a primary care nurse (CMN), integrated in a multidisciplinary case management team (CMT) - doctors (Internal Medicine and GP), nurses and social workers from Primary Care (PC) and Hospital Care (HC).

The main objectives are: 1) better continuity of care with clinical stabilization and social support 2) keeping the patient at home;3) reduction of healthcare resources utilization.

The core components are: pro-active case finding; care planning; patient and career empowerment; care coordination between PC, HC and others stakeholders (social services, pharmacies, patient associations); shared information and communication systems; CMN as the single point of access and the link between the levels of care

Case-finding can be undertaken at any level of care; the local CMT assesses predefined criteria for inclusion - adults; ≥ 4 ED visits or ≥ 3 inpatients admissions in the last 365 days; ≥ 2 co-morbidities (NICE criteria); ≥ 6 medications. We excluded end of life situations; mental diseases and nursing home residents.

The next step is a comprehensive clinical and social assessment and the establishment of a care plan, fit after the 1ª CMT home visit, that will determine the priorities of the CMN intervention (education and self monitoring; correct medication intake; alert signs)

Highlights - impact and outcomes: Between January 2017 and July 2018, 74 patients were admitted. We conducted an observational retrospective cohort study for the 43 patients, admitted for at least 6 months (6 – 17), using matched observation before (365 days) and after CMP.

The sample had a mean age of 76 years (52 -88), 58% were women; Charlson Index 6;mean medications 7,5; mortality rate 9%.

Reduction of health resources utilization: 66,3% (297-100) ED visits; 77,7% Acute Care visits(166-37); inpatient admission-52,7% (55-26); inpatients’ days- 62,1% (599-228);LoS-2,1 days(10,8-
8.7); GP consultations-60% (247-97); hospital consultations-11.5% (175-155). Savings of 2.558€/patient/year - 5% of capitation.

**Discussion:** The higher prevalence of chronic diseases challenges healthcare and social systems. The CMPs are referred as an effective intervention. Our program for high-risk patients is based on the integration of PC and HC, coordinated by generalist specialties, nurses as CM, proactive intervention and clinical stabilization at home, as well as patient and career empowerment.

In spite of the study limitations, the results reveal that the CMP reduces the number of ER visits, unplanned admissions and LoS with costs savings.

**Conclusions:** This CMP has had an important impact on patients with complex multimorbidity, resulting in reduction of health resources utilization and costs savings. More patients and longer study time are needed to confirm these results.

**Keywords:** integrated care; case management; complex multimorbidity; continuum of care