CONFERENCE ABSTRACT

From fragmentation to integration – the "unseen" patient 3600

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Angela Irony, Haled Abu-Hussain, Yulia Nigel, Ash Nachman

Maccabi Healthcare Services, Israel

Introduction: The management and control of multiple chronic conditions is on the global public agenda. While massive efforts are invested in chronic populations the outcomes are only partly satisfactory. Common practice is still mostly reactive and fragmental and health costs are overwhelming. Patients in need may be high consumers though unseen by the system.

Short description of practice change implemented: Maccabi Health Care Services, 2nd HMO in Israel, has developed a multi-dimensional solution that combines a conceptual, technological and treatment model. Conceptually, there is a shift to integrative approach.

The patient is perceived as a whole – his/her complete health is considered referring to health, social and economic welfare. The care plan is tailored according to patient’s needs and is based on collaboration of health and social services along with community mapping for optimal use and geographic adjustment of community resources.

The integration 3600 is based on proactive approach, Chronic Care Model (CCM) and continuity of care. According to the treatment model the primary physician is the case manager with a supportive multidisciplinary team of integrative nurse, social worker, service coordinator, dietitian and physiotherapist.

Aim and theory of change: Our goal is providing an integrative adapted care to "unseen" patients with complex socio-medical profile.

The target population is characterized with high service consumption though not optimally treated. Inquiring this population we found out that health cannot be addressed regardless the social or economic problems. Thus, the treatment solution dictates an integrative approach

Targeted population and stakeholders: The target population is chronic patients with complex socio-medical profile.

Potential cohort is derived from a matrix including the following parameters: age 50+, chronic diseases, multiple/high risk drugs, cognitive decline, function level, socioeconomic status (SES) and annual expenditure.

Stakeholders are the patients themselves, their families, care providers, MHS/HMO and society as a whole.
Timeline: The potential target population include about 20,000 patients. The pilot began in December 2017 and includes five active regions with 500 patients for whom a care plan has been adapted.

Highlights: MHS has developed a platform including: Identification and stratification population, registrars, clinical and social parameters. Moreover, the technology infrastructure includes an operational system connecting between providers, BI systems, mapping services system (GIS) as well as BIG DATA.

Furthermore, the use of community services include the involvement of volunteer citizens as supporters in the intervention process.

Comments on sustainability: The initiative is sustainable. It demands an investment in creating a technological platform. Beyond that it concerns a paradigm shift and efficient resource allocation / implementing integrative model.

Comments on transferability: The initiative is transferable. It is feasible to implement the model in almost any community care setting with the dominance of primary care physicians.

Conclusions: Preliminary results show that the integrative model is definitely implemented and there are indications for cost savings.

Lessons learned: Health cannot be provided solely – an individual has to feel maintained and safe before he/she is ready to take care of his/her health.

Keywords: integrative model of care; “unseen” patient; technological platform