

## **INTEGRATED NETWORK FOR CHRONIC CARE IN COMPLEX PATIENTS**

Sonia Pérez, Carles Benet, Cristina Monteverde, Lourdes García

### **OBJECTIVE:**

Develop new strategies for the care of complex chronic patients in order to achieve more resolution, efficiency and satisfaction providing a proactive service in the northern areas of Barcelona. We want to obtain better health results, improve quality of life for patients and their families, enhance self care, diminish the number of visits to the emergency room and reduce or avoid hospitalizations keeping the patients in the community as long as possible.

### **METHODS:**

Coordination among 2 hospitals, 4 nursing homes, 2 primary care Emergency Units, 5 primary care teams, mental health services, palliative care, public health and social services.

The program covers 79.311 inhabitants. There were selected 180 adult patients with two or more non programmed hospital stays in the previous year (that generated 9 or more days of hospitalization), one or more diagnostics of heart failure, ischemic cardiopathy, COPD, DM, neoplasms, stroke, dementia, liver diseases, mental disorders, AIDS, and with 10 or more prescription drugs.

### **RESULTS:**

There were identified the sociodemographic characteristics, the chronic conditions and the prescriptions of the selected patients. A qualitative and quantitative study was done on the prescription drugs and their use. Clinical pathways have been established considering all providers and services offered to the patients. With a new protocol in place that allows for a clinical stabilization in the primary care Emergency Units, of all the patients that were attended in these units, 93% were discharged and only 7% were admitted to a nursing home. Another protocol facilitates admission to the nursing homes directly from primary care without the need for a visit to the hospital emergency room. A survey was conducted among the patients showing high satisfaction results. We collaborated with the AIAQS (Information, Evaluation and Quality in Health Agency) in order to build a general evaluation framework for a comprehensive care for our patients.

### **CONCLUSIONS**

The institutional commitment, the clinical leadership and the coordination in the territory between the different medical services is essential to create partnerships and develop this comprehensive model of health care.

Specific protocols that describe "what", "who" and "how" are absolutely necessary for a proper implementation of the program.

The Primary Care should be the coordinator and facilitator of the program.

The information and communication technologies must be used by professionals to manage the health care of the patients. We are exploring new ways of communication and broadcasting in Project 2.0 (a corporate website designed for dissemination of knowledge among professionals and the project) and also the use of tools such as blogs and social networks to disseminate knowledge.