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CONFERENCE ABSTRACT

Integrative Model for Treating Vulnerable Patients

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Introduction

Health systems strive to provide quality care with restricted resources and controlled budgets. A small cluster of elderly chronic patients consumes most of the system's resources.

Common practice is mostly reactive and fragmental. Vulnerable patients are frequently missed. They see many health professionals but are not treated by a single case manager.

Short description of practice change implemented

Integration 3600 is based on proactive approach, Chronic Care Model (CCM) and continuity of care. Proactive approach is opposed of the reactive nature of the current system. Health professionals are assembled to integrative units including a primary physician (case manager), a nurse (care integrator) and a multidisciplinary team involving social worker, dietitian and physiotherapist. Integrative units proactively identify patients and recruit them to intervention. The CCM includes the basic elements for improving care in health systems at the community. Continuity of care includes relational, management and information continuity.

Aim

Our goal is providing an integrative adapted care to vulnerable patients with complex socio-medical profile.

Target Population and stakeholders

The target population is vulnerable, 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.

Target population is characterized with high service consumption. Exploring this population we found that health cannot be addressed regardless the social or economic problems.

Stakeholders are the patients themselves, their families, care providers, MHS/HMO and society as a whole. Integrative care involves partners outside the HMO. These are: NGOs, local authority, municipal facilities, social services and National Insurance institution.

Timeline

Since December 2017 3500 patients were treated in the service. Currently, 2500 patients are treated by integrative units all over the country.

Highlights (innovation, Impact and outcomes)

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.

sustainability

The model is sustainable requiring an investment in creating a technological platform. Moreover, it concerns a paradigm shift and efficient resource allocation / implementing integrative model.

Comments on transferability

It is feasible to implement the model in almost any community care setting with the dominance of primary care physicians.

Conclusions

Number of contacts with the patients increased from 3.5 per patient prior the intervention to 7.5 during the intervention. Distribution of contacts indicates that half of the contacts are provided by nurses (51%) and the other half by multidisciplinary team (22% physiotherapist, 12% dietician and 15% social worker) indicating the application of the integrative model. Furthermore, there is evidence for cost reduction in patient's services usage mostly through hospitalization prevention.

Lessons learned

Health cannot be provided solely – an integrative perspective in needed to provide clinical, emotional and social needs of patients. It is feasible to implement the model in almost any community care setting with the dominance of primary care physicians and the close cooperation of nurses.