

OP41.5

Experience of implementation of the integrated care process for pluripathologic chronic patient care access (PCPPC) in a regional health service

Maria del Carmen Fernández-Alonso(1), MA Guzman Fernandez(1), R Martinez Iglesias(1), S Lleras Muñoz(2), M Villacorta(1), F Peña Ruiz(3)

(1) Servicio de Programas Asistenciales de la Gerencia Regional de Salud, Valladolid, Spain

(2) Direccion Tecnica de Atencion Primaria, Gerencia Regional Valladolid, Spain

(3) Sistemas de Informacion, Gerencia Regional de Salud, Valladolid, Spain

Corresponding author: Dr M^adel Carmen Fernández-Alonso, Regional Health Service Of Castilla Y Leon. SemFyc, Servicio De Programas Asistenciales, Valladolid, Spain. E-mail: carmenferal@gmail.com

Justification: A region with 2.5 M/h, with a high rate of aging (23% > 65 and 9.4% > 80 years) large, with a dispersed population and high number of elderly patients with multiple diseases, in need of joint social and health responses Under of the Regional Strategy Patient Care Chronic¹ it was consider a priority to design and implement an Integrated Process of Care PCPPC², that integrates Primary Care, Hospital Care and Social Services, with the participation of patients and caregivers.

Objective: To provide an integrated health and social response to PCPPC with greater needs for services and resources Population Diana: Patients CPPC(G3) identified by stratification of the population by GRC adapted system (5.2% of the population) Key elements in the process. Accessibility, ease of communication between professionals, agility in the management of the patients, primary care leadership, importance of the role of nursing, stable clinical references in the hospital, proactive detection and early treatment of decompensations, close cooperation with the specialists and emergency services. Incorporation of patients and families in the process. The patient flows and pathways in health and social services are clearly defined. Specific functional structures are created in the hospital, Units of Continuity of Care and Units of Convalescence in Social Services.

Results: Implementation. Piloting the process in two health areas (2014-2015). Spread to all the 11 areas.

Conclusions: Although the level of development is not homogeneous, the results in the areas most advanced are promising: Improving communication PC-Hospital, increased telephone consultations, improved continuity of care, fewer hospitalizations of PCPPC and specialists consultations. Analyzed the factors that foster and the obstacles for the implementation, thereof is pending to evaluate the satisfaction of users and professionals. Although we are at an early stage of the process of development, initial results are encouraging supporting the appropriateness of the model.