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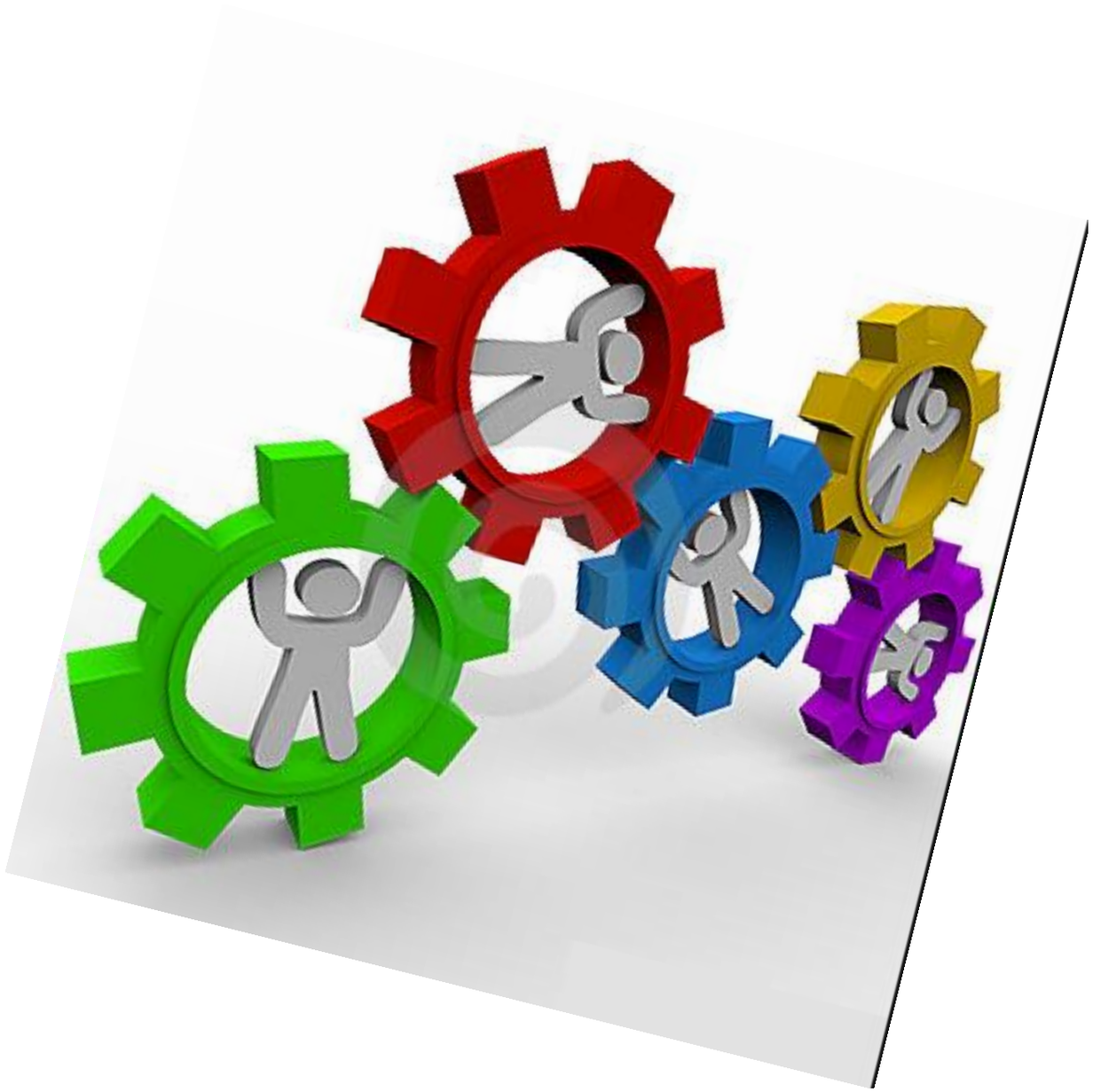

Frailty and Organization of Health and Social Care

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Interdiscipl Top Gerontol Geriatr. Basel, Karger, 2015, vol 41, pp 161–173 (DOI: 10.1159/000381233)

Lo que sabemos…

- Frágiles utilizan forma creciente Servicios de Salud
- Servicios abordan enfermedades que afectan 1 solo sistema típico (jóvenes)
- Sist Salud deben Reconfigurarse

Sist Salud

Comunidad

Academia

Soc Civil

Gobierno

Comedores Públicos

Apoyo Informal

ONG’s

Cuidados centrados en la Persona y Coordinados

Necesidades

Pacientes

Usuarios

Cuidadores

AVOIDING ESCALATION OF CARE

MANAGE RISK

- Identify and register all patients over 75 and stratify according to risk of hospitalisation
- Develop electronic alert system to flag risks with all local providers ideally via shared electronic patient records

PROMOTE SELF MANAGEMENT

- Support patients and carers to self-manage by providing guidance, education materials and advice service
- Use technology assisted support where indicated

EARLY INTERVENTION

- Commission prevention and early intervention strategies targeted at those with greatest need
- Provide all over 75s with annual health check
- Joint GP and consultant led service including consultant led community clinics and enhanced support to care homes

ADMIT ONLY WHEN NEEDED

- Implement a referral gateway to control referrals and appropriate hospital use
- Priority access to diagnostic tests for patients at risk

HOME CARE

INTERMEDIATE CARE

HOSPITAL CARE

PROMOTING RETURN TO HOME CARE POST ESCALATION

PROVIDE HOSPITAL SERVICE VIA INTERMEDIATE & PRIMARY CARE

- Provide hospital input to primary care and care homes via technology e.g. telehealth
- Deliver hospital at home or other re-ablement service
- Upskill community and primary care workers

BETTER ENABLE PATIENTS TO RETURN HOME

- Develop frailty pathway protocols to support efficient transition from hospital into home/intermediate care
- Multi-disciplinary team (MDT) agree on medical needs, post discharge
- Agree discharge plan with patient and carer
- Assign dedicated social worker to each patient on risk register to advise on eligibility and provide social care packages

ENHANCE EFFICIENCY OF ACUTE TREATMENT

- Provide access to patient records from multiple settings via IT solutions
- Implement a hospital frailty pathway including geriatric assessment and medication review

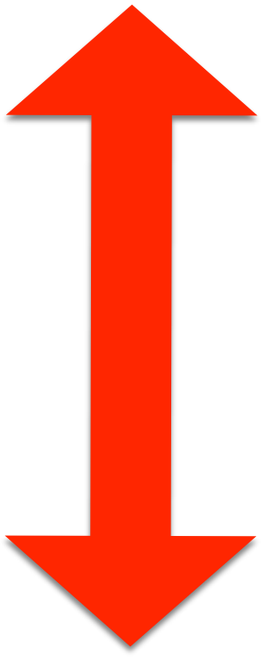
PLAN FOR DISCHARGE ON ADMISSION

- Trigger frailty patient alert on admission including alerting MDT discharge team
- Engage social care and adopt co-ordinated discharge plan on admission

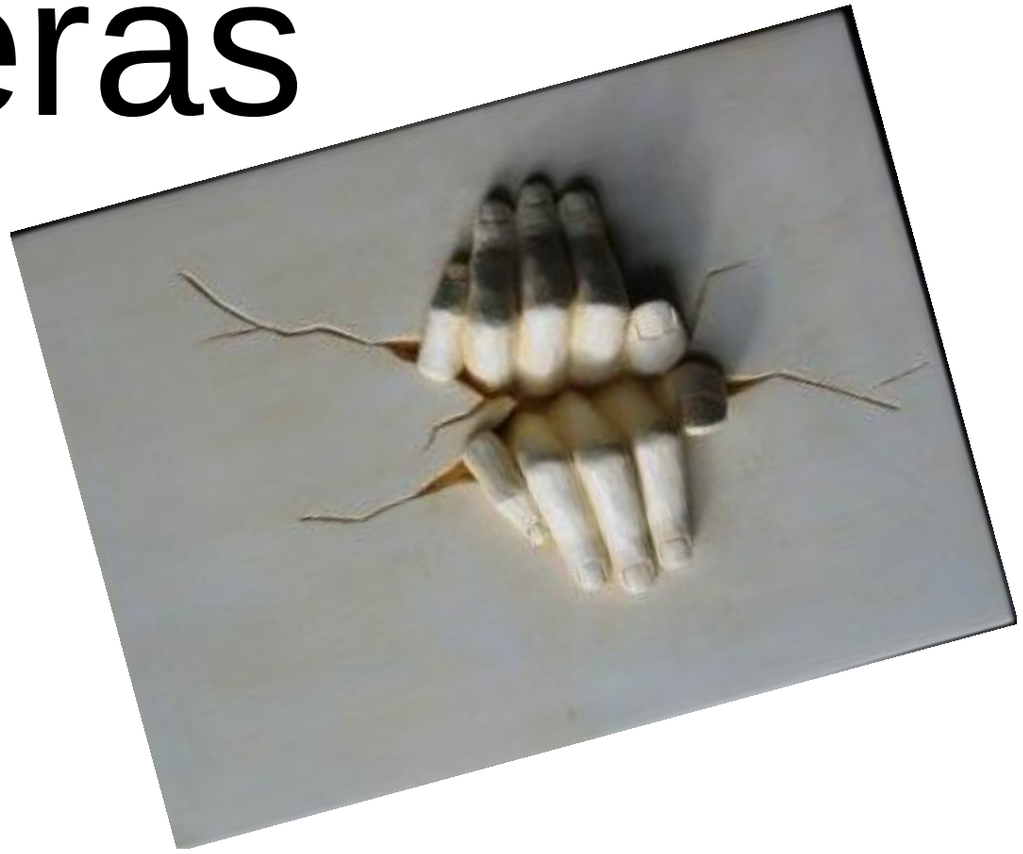
MULTIDISCIPLINARY TEAMS OF PRIMARY, COMMUNITY AND SOCIAL CARE STAFF WORKING TOGETHER ACROSS THE TRADITIONAL BOUNDARIES

Niveles de Integración

- Macro: entre Organizaciones
- Meso: misma Organización
- Micro: cuidados en un mismo individuo



Romper barreras



- Primer / Segundo Nivel
- Sistema de Salud Física y Mental / Sistemas de apoyo Social

Gac Sanit. 2011;25(S):138–146

Review

Integrated models of care delivery for the frail elderly: international perspectives

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ABSTRACT

Introduction: Interest is growing in integrated systems of care for the frail elderly. Few such systems have been both documented and evaluated in a rigorous manner. The present article provides an international review of such systems.

Methods: The literature on integrated care covered the period from 1997 to 2010, inclusive. Some 2,496 citations were identified from Age Line, PsycINFO, CINAHAL and MedLine and were reviewed. To be included in this paper, articles had to provide a good description of the care delivery system and good quality evaluations. Only nine articles were retained. Most of the articles reviewed described some form of coordinated care without evaluation.

Results: There were essentially two types of models of integrated care delivery for the frail elderly. One was a smaller, community-based model that relied on cooperation across care providers, focused on home and community care, and played an active role in health and social care coordination. The second type of model was a large-scale model that could be applied at a national/provincial/state, or large regional health authority, level, had a single administrative authority and a single budget, and included both home/community and residential services.

Discussion: Integrated care delivery can be achieved in various ways. Irrespective of which model is adopted, some of the key factors to be considered are how care can be coordinated effectively across different types of services, and how all the care provider organizations can be coordinated to ensure continuity of care for frail elderly persons.

Diabetes outcomes within integrated healthcare management programs

V. Baldo[b,*], S. Lombardi[a,1], S. Cocchio[b], S. Rancan[a,1], A. Buja[b], S. Cozza[a,1], C. Marangon[a,1], P. Furlan[b], M. Cristofoletti[a,1]

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[b] Department of Molecular Medicine, Institute of Hygiene, Laboratory of Public Health and Population Studies, University of Padua, Italy

- Observacional.
- Centros de especialistas, centros de médicos generales, centros de cuidados integrados
- Italia 2008 a 2010
- Diabéticos mayores de 20 años

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Table 2 – Mortality rate (per 1000 person years) for outcomes by level of care.

	GP-DS		GP		DS	
	n	1000 py	n	1000 py	n	1000 py
All-cause mortality	66	8.8	352	26.1	263	21.7
Cancer mortality	20	[illegible]	87	[illegible]	67	[illegible]
Cardiovascular mortality	13	1.7	75	5.6	60	5.0
Metabolic disorders mortality	6	0.8	40	3.0	36	3.0
Stroke mortality	6	0.8	28	2.1	17	1.4

Table 3 – Adjusted Rates ratios (HR) and 95% confidence intervals for all-cause mortality by characteristic.

	HR	IC 95.0%		p
GP (ref GP-DS)	2.71	2.07	3.6	.000
DS (ref GP-DS)	1.77	1.34	2.3	.000
Previous hospitalization	9.49	7.74	11.63	.000
Age	1.08	1.08	1.09	.000
Gender (males vs females)	1.56	1.33	1.83	.00
Nationality (UE vs non-EU)	1.08	.47	2.45	.86
Insulin (ref only diet)	.81	.65	1.01	.06
Oral drugs (ref only diet)	.63	.52	.76	.000

Qué sabemos de esos modelos?

Qué sabemos de esos modelos?

- Temas claves en integración de los servicios:
  - Equipos FUERTE de **ATENCIÓN PRIMARIA** en el CENTRO del eje de los diferentes Servicios de Salud
  - Acceso **INFORMACIÓN** fácilmente (Tecnología)
  - Abordaje **DINÁMICO** que fluye en de abajo hacia arriba y viceversa

Quién se beneficia?

Población de riesgo?

- Por edad? - > 75? / 80?
- Por fragilidad? - Suficiente Evidencia?
- Herramientas estratificación de riesgos
- Funcionalidad (GRUPO 1)

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Learning together to work together for better health

World Health Organization: Framework for action on interprofessional education and collaborative practice. 2010. http://www.who.int/hrh/resources/framework_action/en/ (accessed May 21, 2014).