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## Poster Abstract

## Effects of a local pilot experience of integration of care in Catalonia

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## **Abstract**

**Introduction:** Strategies to manage patients with complex needs are necessary in order to delay disability and avoid institutionalization.

**Description of care:** Model of home care based on Comprehensive Geriatric Assessment (CGA) was developed with two strategies: preventive care and rapid response to health crisis (using admission avoidance or early discharge Intermediate Care resources).

**Methods:** Model was piloted during a two year period. Pragmatic criteria to select patients were used (based on co morbidity and disability). Preventive and rapid response protocols to health crisis were defined.

Highllights: innovation, impact and outcomes

**Innovations**: A model of patient centred care in the community is presented.

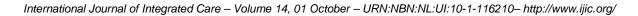
**Impact:** Aim to maintain vulnerable older patients at home.

**Outcomes:** 126 patients (83 years; Charlson 2; Barthel 47; Pfeiffer 3.7; number of geriatric syndromes 6). We found: no new institutionalizations; improvement of functional status (Barthel Index 51); 202 crisis attended by hospital-at-home schemes; 31 crisis attended by direct admission to Intermediate Care hospitalization units.

**Conclusion:** Strategies were useful to maintain complex patients in their own homes minimizing institutionalization.

**Discussion:** Main results could be related to new resources but more research is needed.

**Lessons learnt:** It was a positive experience of collaboration between Primary care and hospital care.



## **Keywords**

ageing, chronic conditions, disabilities