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CONFERENCE ABSTRACT

We move forward the integration: Salut+Social.

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Introduction: In June 2014 an innovative experience that made it possible to carry out a health and social monitoring of the patients was initiated in Amposta. It is a coordination project with the help of the application Salut+Social [Health+Social] created to establish a quick and fluid communication between the Amposta primary care centre from the Institut Català de la Salut and the social services (SS) from the Amposta City Council.

This project was born out of the common concern of the primary care professionals from the CAP and the municipal social services, both from Amposta, with the intention to provide and integrated, efficient and high-quality attention to the patients with the need of complex social and medical cares: complex chronic patients (CCP), advanced chronic disease (ACD), home health care (HHC), patients with a 2nd or 3rd dependence degree or with home care services (HCS).

Brief description: The objectives of the project are to guarantee the continuity of the healings, strengthen the patients and their families autonomy, improve the assistance, reducing its variability and increasing its quality, establish a fluid and bidirectional communication, avoid duplicating efforts, coordinate the actions between the professionals, establish an interaction through an instant e-mail messaging service and integrate the social and medical services.

After several meetings between the SS professionals from the Amposta City Council and those from the CAP and being aware of the importance of both assistance levels, an interdisciplinary team was created.

This team, together with the IT department from the Terres de l'Ebre unit, created the ICT tool SALUT+SOCIAL. The initiative has gone ahead thanks to an agreement between the ICS and the Amposta City Council in order to share information through the tool.

The app, after the user sign up, lets the professionals to share its information and changes made after each visit always respecting the data confidentiality.

Conclusions: Speeding up of the procedures, communication and coordination improvement, IT app, in-person sessions, joint effort, framework updating, integration of the social professionals in the CAP

once a week, fluid communication, improvement of the accessibility for the user.

The tool has been the salutary lesson because with it we have been able to build an integration project, the social professionals from the City Council go to the CAP once a week in order to meet the rest of professionals and talk about each of the cases from the app and other ones that may need a specific work too.

934 users are included in the application and 983 movements (messages) have been carried out in order to treat 134 users in collaboration between both services.

The social professionals from the reference hospitals and the case manager, who work with the app and go to the coordination meetings to follow up the cases, have been incorporated to the project too.

Lessons learnt: The concept of services integration makes the attention to the user from a global vision possible. The joint effort allowed the long term consolidation of both teams coordination. It is necessary to move forward the integration of the medical and social systems in order to address the chronicity.

While the project was progressing, we have been presented with new challenges that we are now developing. We have incorporated the possibility of making the common interventions with the patients that do not comply with the usual requirements (CCP, HHC, HCS, etc.), but that they need it because they are complex care or social cases not known. We have achieved the maximum integration of the health and social services for the benefit of the patient and also the updating of the public services.

We have made a great dissemination of our task presenting the project to different territories, conferences and congresses.

We are now adapting the health professional schedules for the coordination of the social services.

We have developed the app for tablets and we are on the implementation phase in order to go to the patient home and directly registering the data.

We have implemented the tool Business Intelligent: Pentaho in order to work with the data and establish an analysis and treatment, and we are developing the evaluation indicators.

The project Salut+Social is included in the second line of action of the Health plan referring to the treatment of chronic patients using the new technologies and communication systems in order to create an innovative and accessible attention system for the chronic patients through an interdepartmental vision.

Other frameworks are the governmental agreement from the Interdepartmental plan for the health and social attention and interaction.

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Keywords: social; patient; integration; coordination; health