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CONFERENCE ABSTRACT

Integrating Complex Services Through Primary Care: Research Results and Implementation in Practice

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People with complex medical and social profiles often receive non-integrated health-related services that fail to optimize their well-being or that of their carers. As a result, they use many expensive emergency and inpatient healthcare services, and they generate the majority of the overall population's healthcare costs. As a result of the rapid aging of society, the magnitude of this problem, if uncorrected, will soon reach crisis proportions.

Primary care is one venue for integrating services. One primary care-based model is known as "Guided Care." In this model, a specially trained nurse is co-located in the practice of 3-5 primary care physicians. For each of the practice's complex patients, this nurse completes a home assessment and then collaborates with the patient's physician in:

1. Creating and disseminating medical and behavioral plans that address each of the patient's health goals, i.e., an evidence-based "Care Guide" for health professionals and a lay-language "Action Plan" for the patient and carer

2. Facilitating the sharing of information as patients make transitions between sites and providers of care

3. Integrating "community resources" (e.g., transportation, meals, social services)

4. Monitoring, educating and supporting carers

5. Training patients in self-management (i.e., to lead healthy life styles, self-monitor their conditions and use medications and resources effectively

6. Monitoring the patient's health and self-management by monthly phone calls

7. "Motivational interviewing" during the monthly monitoring sessions to facilitate the patient's adherence to his or her Action Plan.

The Guided Care model was evaluated in a 32-month, matched-pair, cluster-randomized trial (n=904) in eight primary care practices in the mid-Atlantic region of the USA. The results showed that Guided Care is:

- Higher in quality and more satisfactory than "usual care" to primary care physicians and patients' carers

- Associated with 15% fewer hospital admissions, 49% fewer hospital re-admissions and 52% fewer nursing home days than "usual care" in an integrated insurer-provider healthcare system.

Based on Guided Care and similar models, Clalit Health Services, Israel's largest integrated insurer-provider system, developed its Comprehensive Care Multi-morbid Adult Program (CC-MAP) in which a nurse collaborates with 3-5 primary care physicians and provides a culturally adapted version of the seven processes described above to Clalit patients age 45+ who have 3+ chronic conditions and are at high risk for heavy utilization and cost.

After 12 months, 600 CC-MAP patients (vs. 608 controls) had:

- Higher quality of chronic care, quality of life, and ability to perform daily activities
- 40% fewer hospital days.

Subsequently, Clalit disseminated its CC-MAP program across 22 clinics (and plans expansion to 30 (6000 patients) during 2020.

These findings suggest that physician-nurse collaboration in integrating patient-centered medical and social services for older patients with complex needs improves the quality of care, reduces the use of expensive services (especially in integrated healthcare systems), and is preferred over "usual care" by patients, physicians and carers.

After brief presentations, attendees will have ample time to ask questions and explore possible pros, cons and tactics for implementing these models in their healthcare systems.