
POSTER ABSTRACT

Derivation of case-mix for intersectoral care in Germany

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Introduction: The spectrum of diseases on the one hand and limited resources on the other will require greater continuity of care in the future, geared more to patients' needs than to structures. Many patients are currently treated in the inpatient sector, although this could be avoided with appropriate outpatient structures. On the same time, many smaller hospitals in Germany are currently threatened with closure looking for alternative concepts. This situation suggests the development of a care solution in the sense of intersectoral health centers, which as an intermediary structure offer round-the-clock monitoring without a continuous physician presence ("extended outpatient care (EAV)").

Aims, Objectives, Theory or Methods: The aim of our project was to investigate which patient groups or cases would be suitable from a medical point of view for such a structure.

We conducted 30 semi-structured expert interviews (medical specialists from 16 disciplines distributed between outpatient - inpatient or urban - rural location), nursing staff, nursing scientists, nursing support centers and consultants). Potential diagnoses, services and necessary resources as well as a general view on EAV were interrogated. In an iterative evaluation process, a list of "EAV-sensitive indication areas" and scenarios was compiled, to which the services and structures to be provided could then be assigned.

Highlights or Results or Key Findings: Specialty-related clinical pictures that could be safely managed in the setting of an EAV could first be classified into "avoidable life-threatening conditions" of acute diseases and "exacerbation / decompensation" in chronic diseases, multimorbidity or geriatric patients.

The aforementioned disease states were then assigned to ICD groups to allow for case volume estimation.

For patient-specific manageability in the context of an EAV, further criteria showed to be relevant in addition to the diagnosis. These were assigned to four categories: 1. disease-related criteria (diagnostic certainty, manageable complications, conservative therapy option) 2. individual case severity (medical history, prognosis, frailty, etc), 3. sociodemographic criteria (age, need for support, home situation...), 4. structure-related criteria (equipment and available qualifications, etc.).

Derived from this we could compile a minimum EAV structure to be provided as well as facultative structures, depending on the regional provider network that would offer additional benefits for patients in the region.

Conclusions: It is possible to define patient groups, that can vastly benefit from an intersectoral structure like EAV in the German setting, where a strict division between in- and outpatient care leads to potential inappropriate care levels and suboptimal care.

Implications: This analysis can be used to define a basic infrastructure that should always be provided in EAV and to describe other useful services that can make patient care more efficient, more patient-centered and also of higher quality. Additionally, it facilitates a volume-based economic estimate.