Integrated Care model: Transition from acute to chronic care

ABSTRACT
Objective: Description and discussion dimensions of Integrated Care Model. Methods: A descriptive study is done that describe a technological innovation, intervention strategies for professional performance. Results: Integrated Care Model (ICM) has two main categories include individual and Group-and disease-specific Model. First, is used for risky patients or with comorbidities. In second category; Chronic Care Model (CCM) is common form of Integrated Care Model to improve resultants in the patients with chronic condition, to move from acute care to integrate, regular, long-lasting, preventative and community-based nursing. Final considerations: It is important to consider patient as an active member of the treatment team. It seems to be essential to monitor performance of care system. On the other hand, offer multidisciplinary care leads to present desirable care, tailored to the specific needs of patients regarding safety, patient-centered care and their culture.

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TECHNOLOGICAL INNOVATION.

RESUMO
Objetivo: Descrever e discutir dimensões do Modelo Integrado de Atenção. Métodos: Estudo descritivo que descreve uma inovação tecnológica, estratégias de intervenção para atuação profissional. Resultados: O Modelo de Cuidados Integrados (ICM) tem duas categorias principais: Modelo individual e Modelo específico para grupos e doenças. Primeiro, é usado para pacientes de alto risco e / ou com várias doenças. Na segunda categoria; O Modelo de Cuidado Crônico (CCM) é a forma mais conhecida de Modelo de Cuidados Integrados para melhorar os resultados em pacientes com condição crônica, para passar do cuidado agudo para a enfermagem integrada, regular, duradoura, preventiva e baseada na comunidade. Considerações finais: É importante considerar o paciente como um membro ativo da equipe de tratamento. Parece ser essencial monitorar o desempenho do sistema de atendimento. Por outro lado, oferecer assistência multidisciplinar leva a apresentar cuidados desejáveis, adequados às necessidades específicas dos pacientes quanto à segurança, ao cuidado centrado no paciente e a sua cultura.

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INTRODUCTION

The integrated care model is introduced by the World Health Organization (WHO), that is used to improve resultants of care in patients’ condition by integrated, regular, long-lasting and society-based nursing. According to the evidence, the resultants obtained from this model were desirable to make the caring qualities preferable and costs parsimony\(^1\). Regarding this model credibility and its opportunite in situations that patient is in transition from acute to chronic condition and because it’s unknown for nurses, we will discuss dimensions and benefits of this model briefly.

Integrated Care Model

Integrated care model is used opposed to fragmentary care and for once care and synonymous with coordinated care or seamless care\(^2\). Integrated care includes continuous process. The World Health Organization defined an integrated care model as people-based care during the life regarding multi-dimensions; this care is given by multi-disciplinary team in various settings and various care levels. This care needs to effectively manage and use credible resources based to present evidence, is also aligned to the feedback continuums to ensure about the quality of the care. It could be planned limited to hospitalization period or for the whole life of the patient in chronic cases\(^3\). The viewpoints make the concept are built by outlook and expectancy of different stakeholders in the medical team (Figure 1).

Figure 1 - Perspectives shaping Integrated Care Model (WHO,2016)\(^1\)

METHODS

A descriptive study is done that describe a technological innovation, intervention strategies for professional performance.

OBJECTIVE

Description and discussion dimensions of Integrated Care Model.

RESULTS

Models of integrated care

There are various models to offer integrated care that is mentioned in two main categories:

Individual integrated care model

This model is used for risky patients or with comorbidities and caregivers, thus it prevents to discontinuity in the care by different caregivers. Also, thus care to the patient will not be one episodic, but it can be done across the life-course. This model fits the patients who go to the hospital a lot, so care can be done in the house. The services include evaluation of the patient and giving care if it is necessary, regular patient visit and set a care plan. Although this model reduces the looking up to the hospital, but might not be economical in terms of costs.

Group-and disease-specific Model

In this Category, Chronic Care Model(CCM), is common and used form of integrated care model, CCM was first developed in 1998 by MacColl Institute in USA\(^4\). Chronic Care Model(CCM) is used to improve resultants in the patients with the chronic condition. This model proposes to move from acute and reactive care to integrate, regular, long-lasting, preventative and community-based nursing. According to the evidence, the resultants obtained from this model were desirable and qualified care, also better in patient’s outcomes and costs parsimony for patients. It also affirms to offer patient safety, regarding culture and special needs focused care (Figure 2).

Figure 2- Chronic Care Model(WHO, 2016)

This model includes six main dimensions: Community, Health System, Health Management Support, Delivery system design, Decision Support and Clinical Information system. In the revised version, cultural adaptability, considering community policies, coordination in giving care is added to the model\(^1\) (Chart 1).
DISCUSSION

Reviewing relevant studies in term of chronic and long term conditions, showed that the most used model is chronic care model of the integrated care model; which is appropriate for various conditions include transition from acute to chronic heart failure\(^4\), re-integration to normal life in patients following upper extremity amputation\(^5\), care of stroke and patients with transient ischemic attack\(^6\), care management of patients with Multimorbidity\(^7\), case management of patients at home\(^8\), chronic kidney disease patients\(^9\) and patients with chronic obstructive pulmonary disease (COPD)\(^10\).

In this model, it is important to consider patient as key member of the medical team. It seems to be essential to supervise function of clinical team and care system. On other hand, offer multidisciplinary care leads to present desirable care, tailored to the specific needs of patients by defining the role of each person in team, regarding safety, patient-centered care and according to patient culture. Eventually, the given care plan is appropriate for patients in their own culture.

FINAL CONSIDERATIONS

Multidisciplinary care with considering patients as an active member of the treatment team, according to patient culture tailored to the specific needs.
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