LIGHTEN THE BURDEN OF CHRONIC DISEASES!

How can your region or your health and social services centre (CSSS) offer better primary health care, improve patient health and reduce the costs of all services for the population in the area? Many would say that such a formula is impossible, given the system's budget situation, pressure from the growing demand for services, overcrowded emergency rooms, etc. False, say the health care systems experts. There is a way out of these endless situations, and it lies in providing optimal primary health care management for a population, with priority given to patients with chronic diseases.

Three optimal strategies

Coordinating health care as early as primary care requires managers and professionals to commit to offering services adapted to each of the four groups in the chronic disease management pyramid. The Concerto health model proposes three strategies to optimize deployment of this proven structured approach.

+ Nurses to coordinate all the care offered by the interdisciplinary team providing primary care.
+ Family physicians ready to respond better to a growing demand for services and constantly increasing requirements related to multiple pathologies.
+ Interdisciplinary care pathways and tools designed for the interdisciplinary practice of family medicine, and structured to follow up the healthy population, and patients with multiple chronic diseases, complex cases and at high risk of complications.

Three deployment phases

Three major deployment phases are envisioned. The first phase involves defining a detailed portrait of the efforts required by the family medicine groups (FMG) and CSSS to maximize the chances of success. The second phase enables the implementation of standardized clinical practices. The third phase provides an opportunity to measure the results and introduce continuous assessment mechanisms.

PHASE 1	**Assessment for each FMG and CSSS** • Maturity indexes based on 15 dimensions **Coaching and knowledge transfer** • Conversion plan		
PHASE 2 **Adoption of clinical protocols**	**Care pathways** *Primary care range* ● ***CD+***		**Follow-up pathways** *Primary care range* ● ***Life+***
Training **Coaching** **Change management** **IIIP* and telehomecare protocols for cases at risk of complications**	**Group 1** • Diabetes, HBP, Dyslipidemia • COPD, Asthma **Group 3** • ADHD • Mental health Depression, anxiety disorders, adjustment disorders	**Group 2** • Chronic heart failure • AHSD • Chronic renal failure **Group 4** • Oncology, palliative care • Chronic pain • Dementia, loss of autonomy	**Ongoing** • Neonatal follow-up • Neonatal follow-up • Regular clinical assessment • Testing for chronic diseases • Prevention – health promotion and healthy lifestyles
Case management for frequent users of CSSS resources			
PHASE 3 ● **Concerto dashboard** **Assessment and accountability**	**Care process indicators** Appropriateness, quality, continuity, productivity, treatment compliance, satisfaction	**Outcome indicators** Patient state of health, change in multiple pathologies, behavioural changes, empowerment, level of use of health services (emergency, hospitalization), avoided costs and societal costs	

* Interdisciplinary and individualized intervention plans

Step forward!

You don't have the time or resources to start transforming the primary health care services you offer? Would you like to enhance the CSSS programs and achieve efficiency gains? Request a free consultation or write us. info@groupesanteconcerto.com

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