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# Chronic patients telephone follow-up, an alternative face-to-face

## Abstract

### Introduction
The Centre de Seguiment de Malalties Cròniques (CSMC) is an organizational innovation of the Institut Català de la Salut, framed as a disease management transversal model between primary and hospital care. Nurses provide structured telephone support to patients with heart failure (HF) and chronic obstructive pulmonary disease (COPD) in Barcelona.

### Objectives
To promote self-care and self-management to patients and/or caregivers. To participate in the coordination of care after hospital discharge. Methods: Structured telephone follow-up with surveillance and educational orientations, through motivational interview. The follow-up is monitored by computerized clinical practice guidelines, integrated to the clinical record, as well as by nursing methodology (NANDANOC-NIC).

### Results
The CSMC has enrolled 1586 patients from 58 primary care teams and three hospitals. The average age of patients is population is 78 years, with a higher percentage of women and functional advanced class. The pharmacological adherence, selfcare level and vaccination compliance has improved. A decrease in the use of healthcare resources is also observed.

### Conclusions
Telephone support has turned out to be positive in chronic patients shared management. Currently, it is being analysed the extension of the program both geographically and to other prevalent chronic diseases.

*Note*: the same programme included other complex and chronic conditions such as heart failure. See reference (2)

## Location

Barcelona

## Year

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## Related Integrated Care keywords

- SELF-CARE AND SELF-MANAGEMENT
- SERVICE, FUNCTION AND CARE INTEGRATION / COORDINATION – TRANSITIONS

## Pervasiveness

Large scale in a region

## Status

Completed

## Links

https://www.ijic.org/articles/abstract/10.5334/ijic.742/
(2) https://www.ijic.org/articles/abstract/10.5334/ijic.771/