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# Internist and General Practitioner: A Pilot Model of Integrated Care for the Management of Complex Chronic Patients

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**Background and Aims:** The growing number of older patients with multiple chronic conditions demands better integration between hospital and primary care. This study aimed to assess the feasibility and impact of a structured hospital–general practitioner (GP) care continuity model after discharge from an Internal Medicine unit.

**Materials/Patients and Methods:** A prospective pilot study was conducted from July 2024 to May 2025 in the Internal Medicine department of Polla Hospital. Thirty-six patients aged ≥65 years with at least three chronic conditions were enrolled. The intervention group (n=18) received structured discharge documentation, direct GP contact within 72 hours, and follow-up via outpatient visit or teleconsultation within 10 days. The control group (n=18) received standard discharge care. We assessed 30-day readmissions, inappropriate emergency department (ED) visits, treatment adherence, and patient satisfaction [1].

**Results:** In the intervention group, 30-day readmissions were 1/18 (5.5%) vs 4/18 (22.2%) in controls; ED visits: 1/18 (5.5%) vs 3/18 (16.6%); adherence to therapy: 16/18 (88.8%) vs 11/18 (61.1%); patient satisfaction score (mean): 8.7 vs 6.9 on a 10-point scale.

**Discussion:** The integrated model showed promising trends in reducing readmissions and improving adherence, though statistical significance was not reached. A structured care continuity model involving internists and GPs appears feasible, effective, and replicable. It may represent a valuable strategy to improve chronic care management and reduce avoidable readmissions. These findings highlight the potential value of structured hospital-GP collaboration, but needs to evaluate such models on a larger scale.

**References**

1. Maider Mateo Abad, Ane Fullaondo, Marisa Merino, Stefano Gris, Francesco Marchet, et al. (2020) Impact Assessment of an Innovative Integrated Care Model for Older Complex Patients with Multimorbidity: The Care Well Project. International Journal of Integrated Care 20: 8.





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