IMAP

The Institute of Ambulatory and Preventive Medicine, IMAP, is a health entity of the FCV, created to provide primary care services for members of Fundación SaludMía with a comprehensive, unique and humane care model that allows us to provide timely and extensive services that directly impact better clinical results with a reduction and control of the morbidity of our patients.















IMAP MULTIDISCIPLINARY PRIMARY CARE

WELCOME CONSULTATION CHARACTERIZATION AND RISK DIAGNOSIS

AMBULATORY CARE & MORBIDITY

SPECIAL PROGRAMS BY HEALTH & SOCIAL DETERMINANTS

CARE PROGRAMS BY LIFE CYCLE

CARDIOVASCULAR COHORT CARE - PREGNANT COHORT WITH DIFFERENTIAL APPROACH

MULTIDISCIPLINARY TEAM OF FAMILY MEDICINE – OBSTETRICS – GYNECOLOGY – PEDIATRICS. SUPPORT TEAM - NUTRITION

TRAINED GENERAL MEDICINE TEAM

PROGRAM COORDINATORS

LABORATORY - IMAGENEOLOGY - VACCINATION

ARTICULATION IN AN INTEGRATED HEALTH ECOSYSTEM

Instituto de Medicina Ambulatoria y Preventiva - IMAP



Instituto Cardiovascular



Instituto de Medicina Ambulatoria y Preventiva - IMAP



Hospital Virtual

SPECIAL PROGRAMS FOR SOCIAL DETERMINANTS



FIRST LEVEL RESULTS AND SUCCESS FACTORS







CONSULTATIONS

PMS-CHRONIC >30% of total consultations

RESOLUTIVITY

96% in the first semester of 2023

USER SATISFACTION

99.1% in the first semester of 2023





TOWERS OF CONTROL

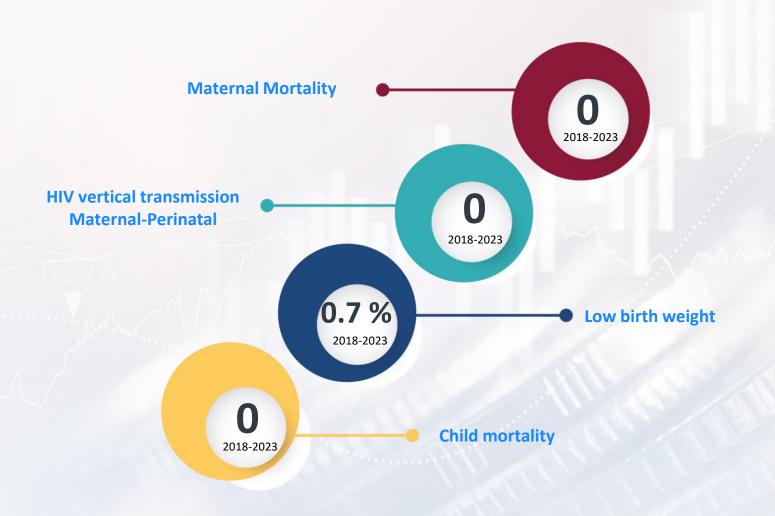


RONDA COMUNITARIA



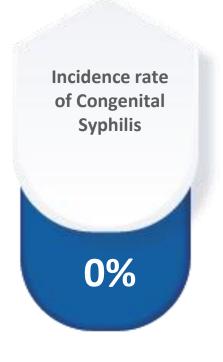
CONTROLLED FORMULATION AND EXPENDING

RESULTS OF OUR CARE



- Multidisciplinary care: General Medicine, Gynecology, Obstetrics, Perinatology, Nutrition, Psychology and Radiology.
- **Support strategies:** Maternity preparation courses, breastfeeding, institutional visit to the newborn.
- Monitoring and follow-up: Friendly line "Nueva Vida".

RESULTS OF OUR CARE



Proportion of pregnant women who have quarterly serology

100%

Proportion of children with a diagnosis of Hypothyroidism

0%

Rate of screening for chagas in pregnant women

97%

Proportion of pregnant women with a first prenatal check-up visit before week 10

90%

METABOLIC NUTRITION PROGRAM



Population **†** 357 **†** 845

< 18 Years	5
18-64 Years	398
>65 Years	369



Main health problems





Clinical Results

HbA1C 7.5% 6.5% Blood glucose 136 107



Dephasing

50%

Decrease in

basal insulin

39%

Basal insulin withdrawal

40%

Withdrawal of mealtime insulin



-12%

-13% -13%



Weight loss



5-10% weight loss: 40% Decrease >10% **22%**

COMPREHENSIVE INSULIN MANAGEMENT PROGRAM -PIMI



Population

† 204

< 18 Years 9 18-64 196 Years 178 >65 Years



Cohort Population:

383 patients



Program Coverage: 98%

Total home visits: 2023 - 961



Clinical Results

HbA1C

50.1 %

<7 %

Blood glucose PP

220

170



55%

8.9%

68.3%

Decrease

Total insulin withdrawal of insulin units

Only one insulin

MODEL ACHIEVEMENTS



Creation of differential programs according to population profiling



Better accessibility and opportunity



Elimination of administrative procedures



Awareness of shared risk and finite resources



Articulation of the ecosystem with better health results (clinical indicators)



Best experience



Comprehensive management



Recruitment of patients by the different Centers of Excellence, risk programs and IMAP differentials



Patient management continuity through virtual hospital



It is a health ecosystem where voluntary agreements are based on real costs and not on rates.



The entire available budget is assigned to the health service provider network

PROFILING OF THE POPULATION

Knowledge of people's health status from a multidimensional and predictive approach.

