

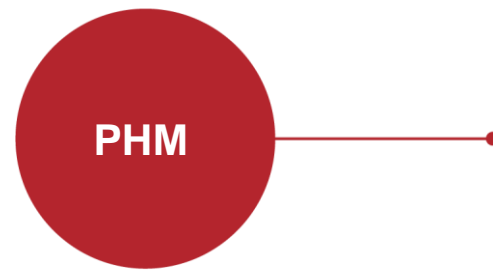


ribera salud grupo

Population Health Management (PHM)

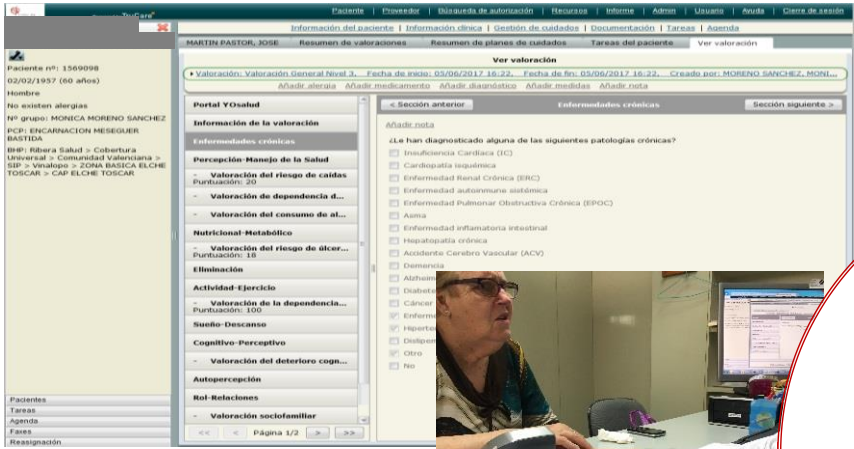
Population Health Management (PHM)

Definition




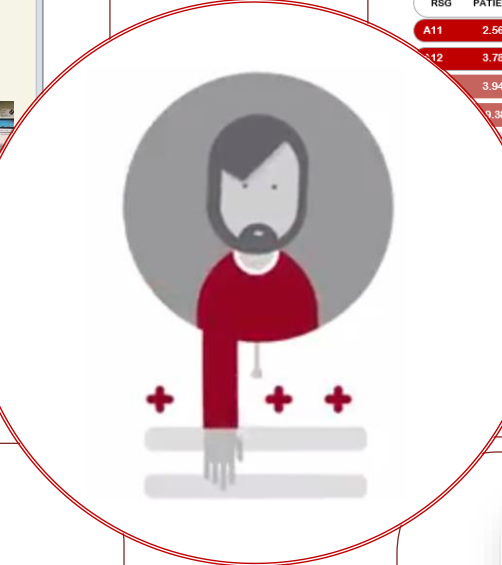
It is the efficient and constant management over time the health needs of the population, through care coordination, disease management, preventive detection and proactive action


POPULATION HEALTH MANAGEMENT EN RIBERA SALUD



TruCare







ATENCIÓN SANITARIA AJUSTADA A RIESGO
PIRÁMIDE DE POBLACIÓN DE RIBERA SALUD

DEMOGRAPHIC		UTILIZATION LEVEL			UNPLANNED INPATIENT		COST		OTHER			
RSG	PATIENTS	%PATIENT	AGE	INPATIENT	EMERGENCY	OUTPATIENT	>0	%RSG	IP DAYS	COST	RUB	FRAILTY
A11	2.569	0,5%	77	1,38	1,52	10,1	1.784	69,4%	13,6	9.498	4,6	19,9%
A12	3.788	0,7%	66	0,91	1,26	13,3	1.650	43,6%	13,6	7.077	4,1	8,3%
	3.945	0,7%	74	0,79	1,13	8,1	1.896	48,1%	10,4	5.915	4,3	15,5%
	3.380	1,7%	66	0,25	0,72	7,9	1.200	12,8%	6,3	2.190	3,5	2,3%
	29	2,5%	69	0,32	0,77	6,0	2.956	21,5%	7,9	2.600	3,6	8,8%
		3,6%	61	0,19	0,72	5,8	2.523	12,6%	6,5	1.747	3,4	17,8%
		0,5%	42	0,10	0,64	6,1	203	7,5%	9,7	1.051	3,1	1,0%
		6,7%	50	0,09	0,62	4,8	1.997	5,4%	4,8	1.041	3,0	0,8%
		10,7%	49	0,05	0,53	3,5	1.746	3,0%	3,6	746	2,7	0,2%
		0,8%	35	0,03	0,75	2,0	1.375	2,3%	3,1	591	2,5	0,2%
	26,5%	34	0,01	0,33	1,3	715	0,5%	1,9		273	1,7	0,0%
	35,2%	40	0,00	0,00	0,0	0	0,0%	0,0		0	0,0	0,0%
	100%	42,1	0,05	0,35	2,0	18.046	3,3%	7,3		592	1,6	1,1%

ribera salud grupo





SUSANA SERRANO MARIN

Inicio

Promociones de salud activas: 2

Novedades en Tus Planes de Salud

Últimos Mensajes: 1

Citas de Atención Primaria

Pulse el botón para solicitar cita con su médico de cabecera.

Solicitar cita

¿Tienes dudas? Contáctate con nosotros

Solicitar Cita Especialista

Enviar Documento

Solicitar cita Atención primaria

GRUPE: ¡APRENDE A COMBATIRLA!

Política Privacidad - Auto Legal - Preguntas Frecuentes

domingo, 26 de noviembre de 2023





AVAILABLE TOOLS FOR THE CITIZEN

- Health portal
- Paritorios Online (Maternity webpage)
- APPs
- Touch ATMs
- Information by SMS
- Waiting times in the emergency room
- Simultaneous translation
- Information to family members



¿Es Nuev@?: Regístrate

Identifíquese

Por favor, introduzca su tarjeta sanitaria y contraseña para acceder a los trámites disponibles de su centro de salud.

Tarjeta Sanitaria: ¿Qué es? (SIP)

Por favor, introduzca las siguientes posiciones de su contraseña: (2, 3, 4 y 6)

1	2	3	4	5	6	7	8
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[¿Olvidó su contraseña?](#)

ParitoriosOnline

contacta

videos

eventos

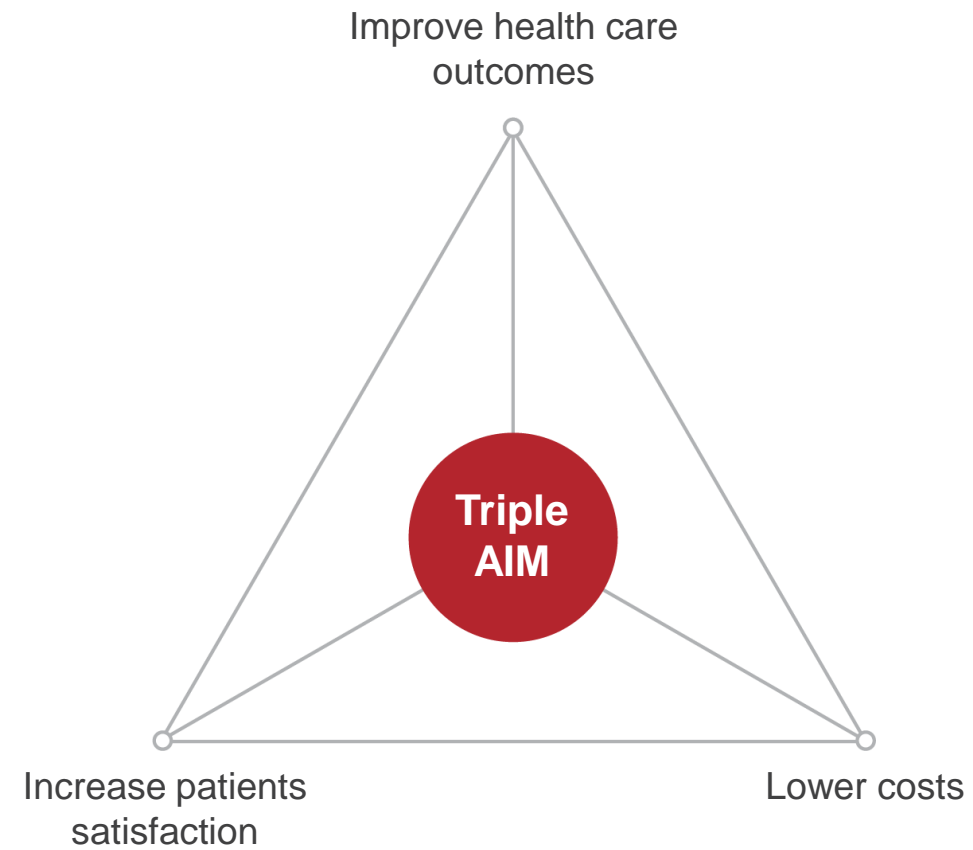
guías para descargar

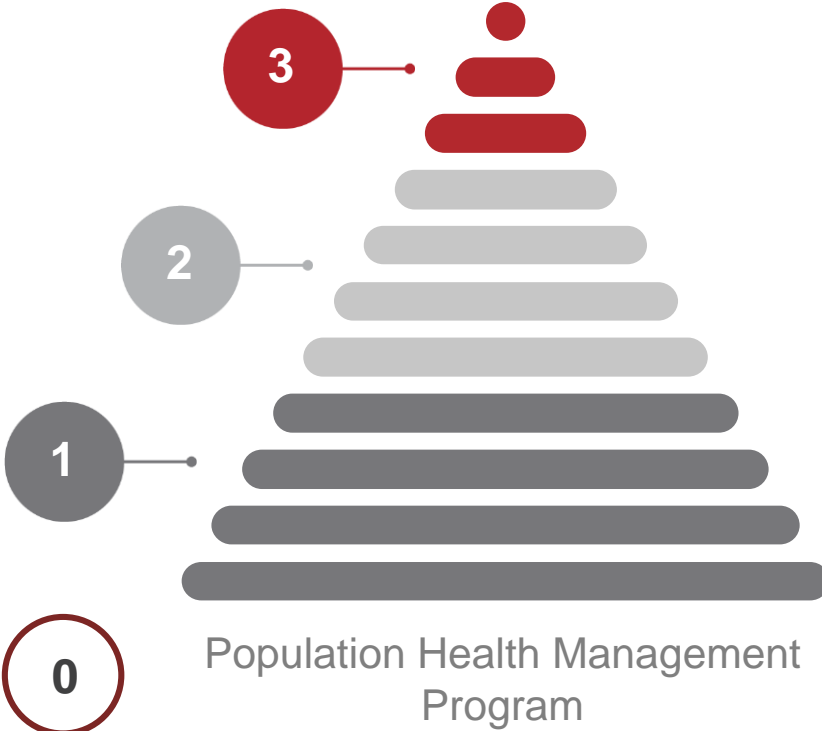
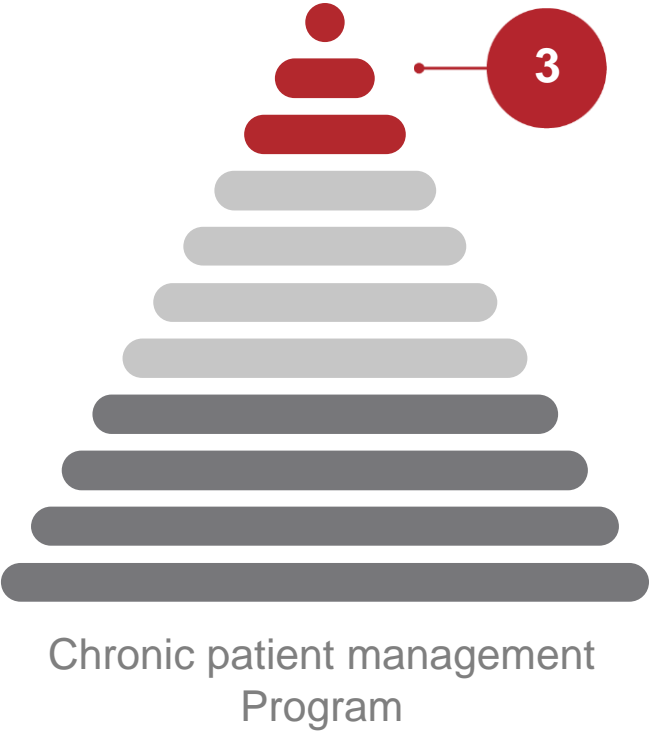


bera salud grupo

Population Health Management (PHM)

Objetives





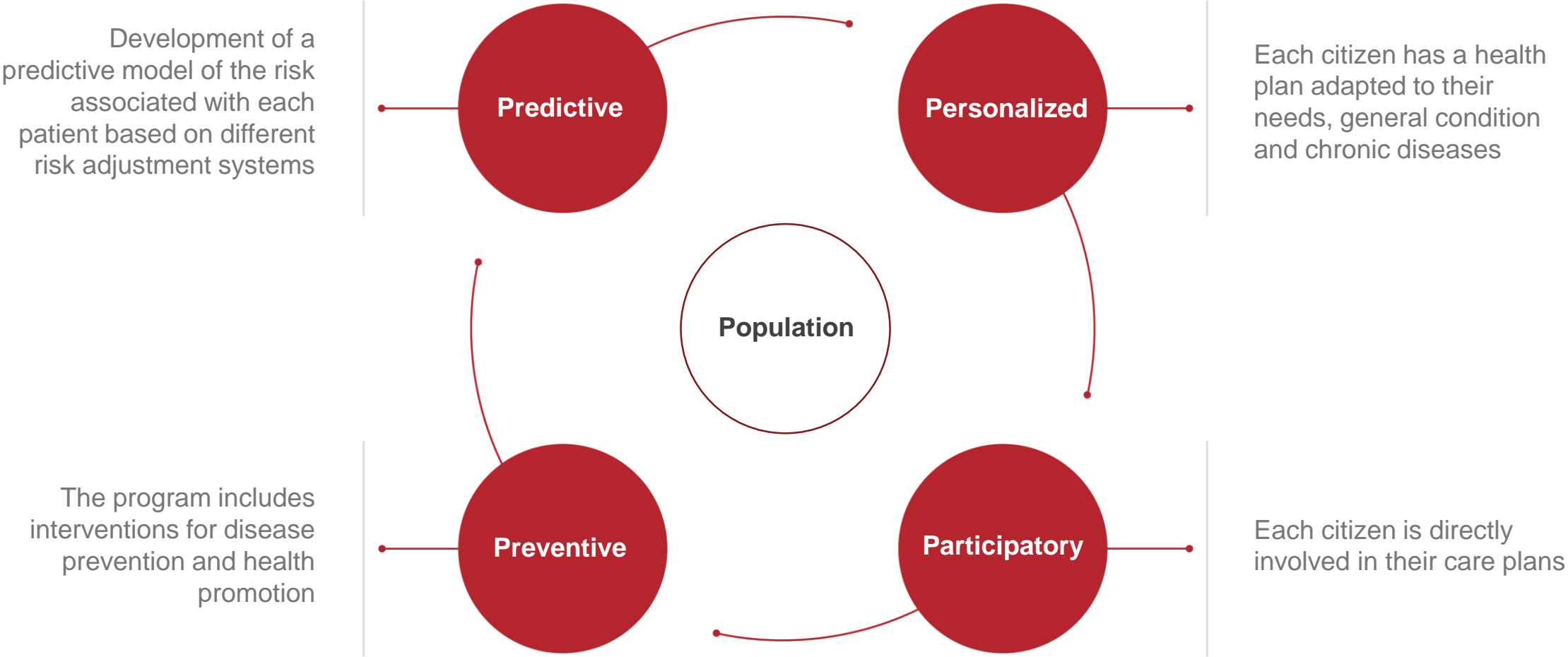
Clinical Management. Stratification

How is our population?

		Communication	Professional in Charge
Level 3+	Case management	Care at home	Case management nurses Basic area nurses-Care Center Programmed telephone follow
Level 3	Case management	Face to face at Primary Care Center	Basic area nurses
Level 2	Disease management	Face to face at Primary Care Center	Basic area nurses
Level 1	Education in self-care and self-management of chronic disease	Health Portal-Phone	Basic area nurses Care Center
Level 0	Strategies for health promotion and disease prevention	Health Portal	Care Center

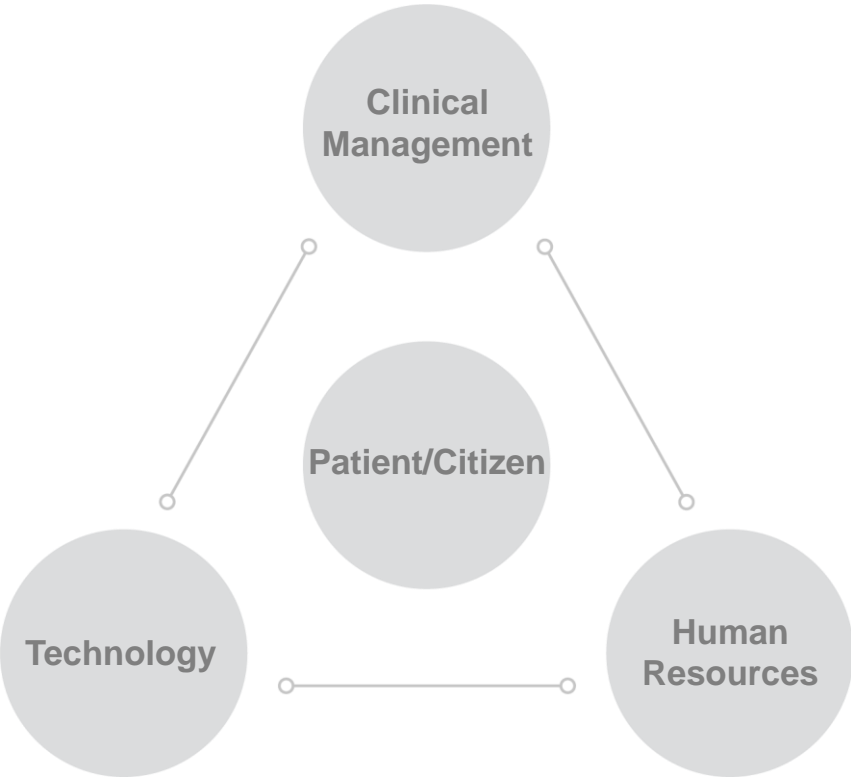
Population Health Management (PHM)

5P Model



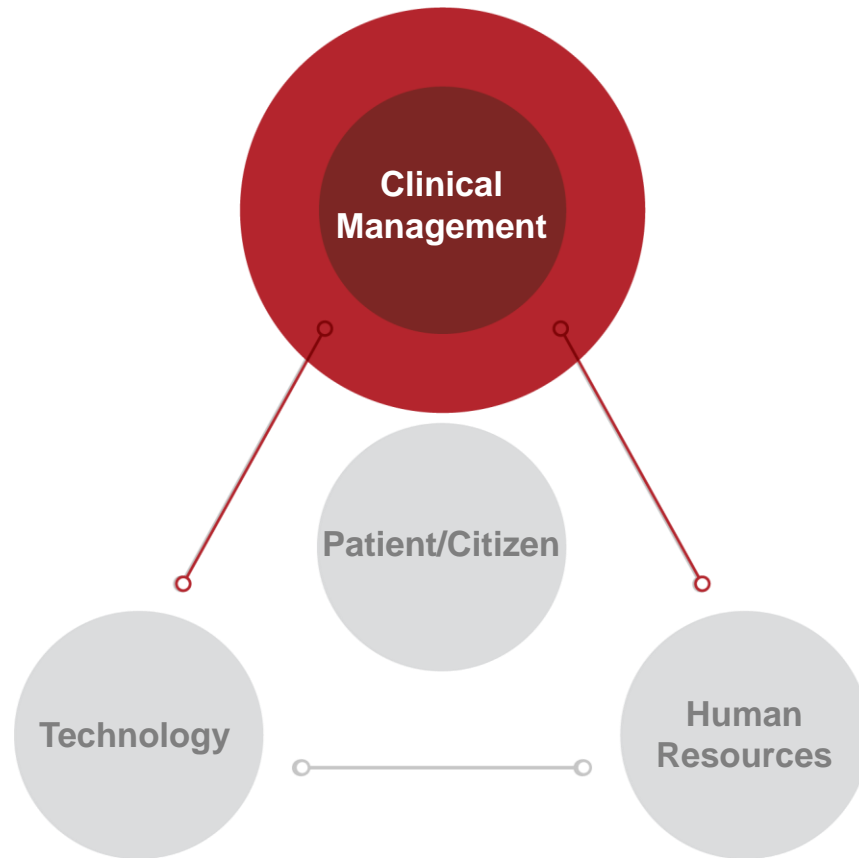
Population Health Management (PHM)

Triangle of Success



Population Health Management (PHM)

Triangle of Success

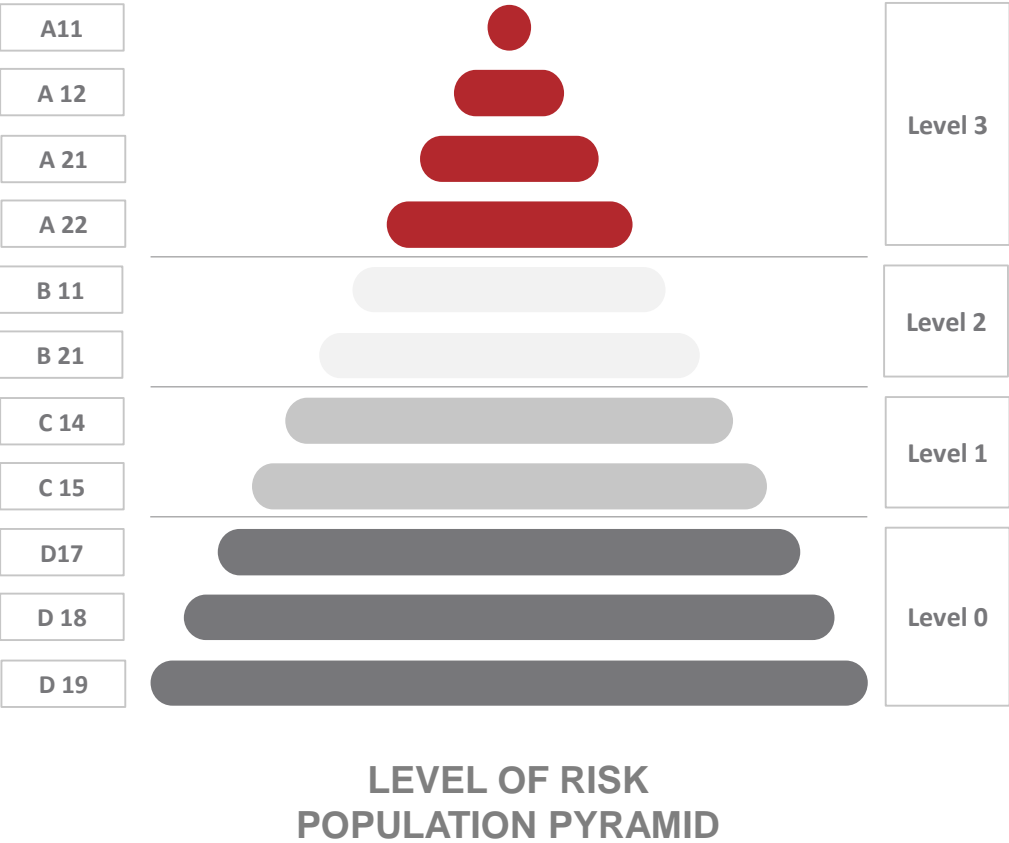
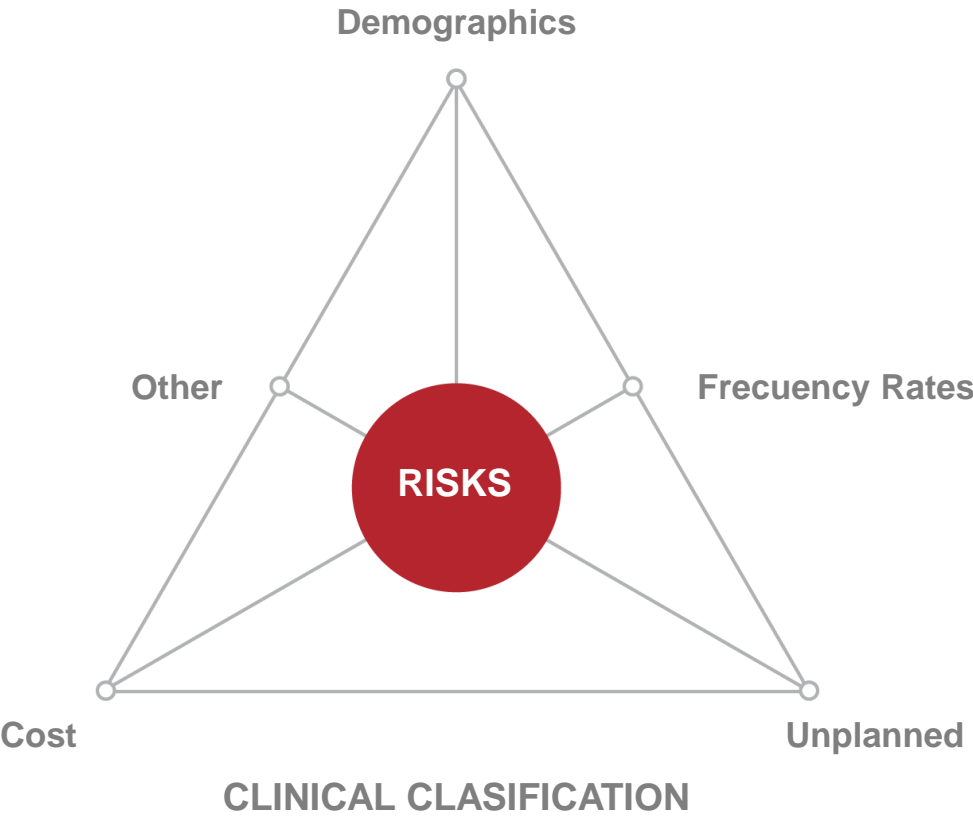


- Proactive Population Health Management, personalized care and patient-care giver engagement
- Better coordinated care. Integration of primary care, acute and social care
- Resource management: the right in the right place, at the right time, by the right person and at the right cost
- Decision support and standardized workflows. Reduced clinical variation

Clinical Management. Stratification

How is our population?

Ribera Salud has been working on a clinical classification based on risk adjustment systems which allows us to building our own population pyramid and provides us with better information for more targeted care



Clinical Management. Standardization

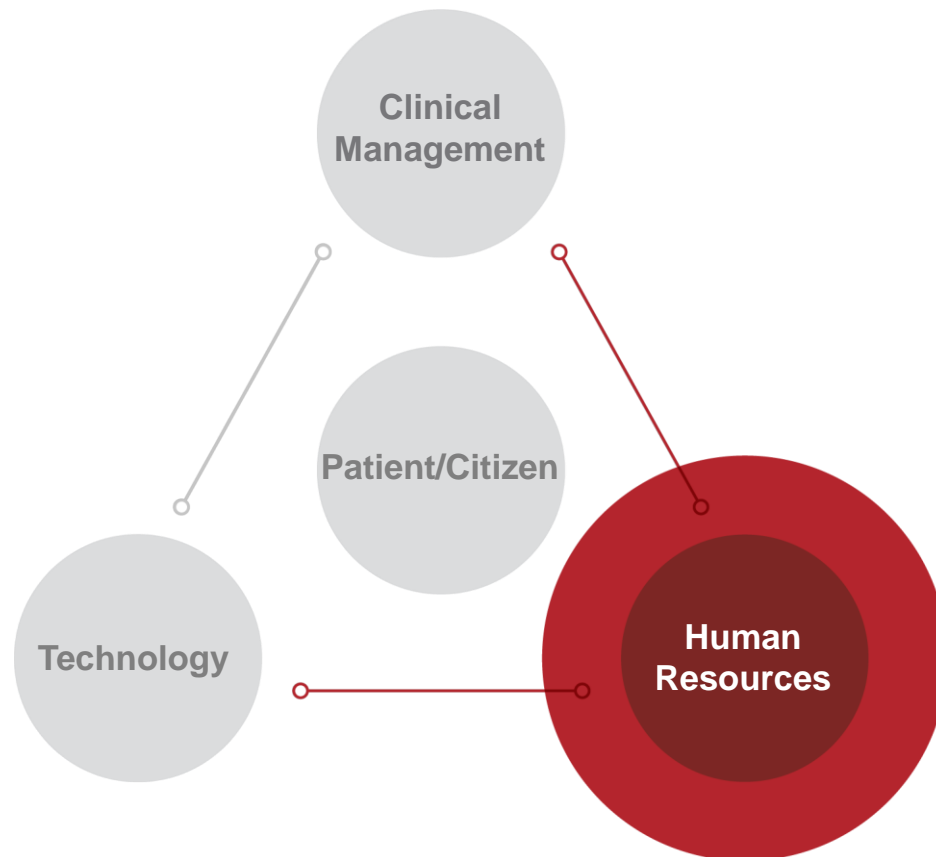
What do we have to do?

- Creation of multidisciplinary work groups with professionals from both hospital and primary care
- Review and update of the clinical practice guidelines of the main chronic pathologies
- Inclusion and exclusion criteria for each level of care
- Referral criteria between hospital and primary care center
- Medical follow-up in primary care

- Heart failure
- Chronic Kidney Disease
- Chronic obstructive pulmonary disease
- Diabetes
- Neurological disease
- Osteoarticular disease
- Intestinal Inflammatory Disease
- Prevention Factors Cardiovascular Risk
- Pregnancy control
- Control of childhood obesity

Population Health Management (PHM)

Triangle of Success



- Improve the training of professionals
- Empower primary care nurses with the development of new roles and competencies
- Improve trust in primary care professionals

Human Resources. New roles and functions

Who has to do it?

- **Case management nurse.** They are responsible for the program in each primary care center.
 - Identify and manage the most complex cases
 - Promote comprehensive care to the most complex patients
 - Coordinate and mobilize the most appropriate resources at all times, both social and health services
 - Increase the level of satisfaction of people in situations of dependency and their families in terms of their quality of life and the perception of the quality of the care received
 - Ensure the continuity of care as a fundamental element of quality care
 - Contribute to the sustainability of the system through the rational use of resources to support care
 - Work in coordination with the social network in health
 - Advise on care within the care teams

Human Resources. New roles and functions

Who has to do it?

- **Link Internists.** In the integration model, hospital specialists have a direct relationship with family doctors through weekly meetings in primary care centers
 - Act as a consultant in the requested diagnostic and therapeutic processes
 - Perform the hospital follow-up of patients, especially chronic patients, of the corresponding primary care center
 - Make the indications to the discharge of the patients by interconsultation with their family doctor
 - Prepare and evaluate the action protocols jointly
 - Coordinate the discharge of the patient with the primary care doctor

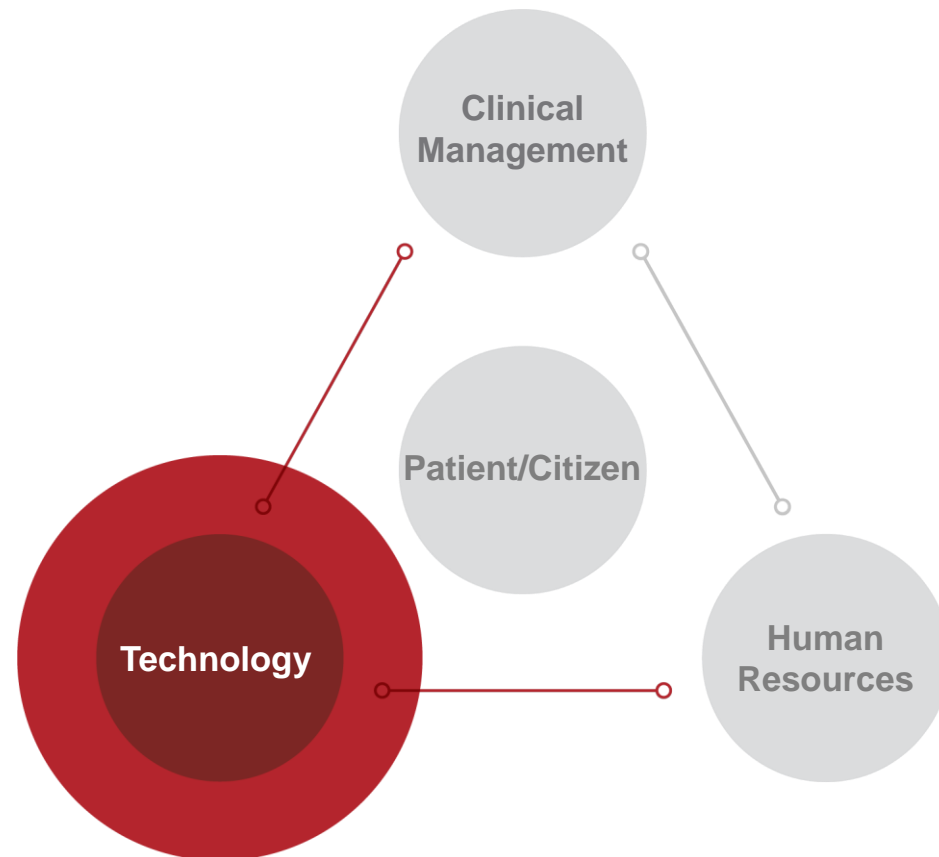
Human Resources. New roles and functions

Who has to do it?

- — Care management nurse hospital inpatient.
 - — Realization of actions directed to the education on the knowledge of the disease, adherence to the treatment, self-care and monitoring of signs and symptoms of worsening or decompensation
 - — Establish a contact with Social Worker, and the main caregiver for the organization of devices for hospital discharge
 - — Provide all the necessary information to the patient and caregiver upon discharge.
 - — Coordination with the nurse who manages primary care cases and / or with the Home Hospitalization Unit, before hospital discharge

Population Health Management (PHM)

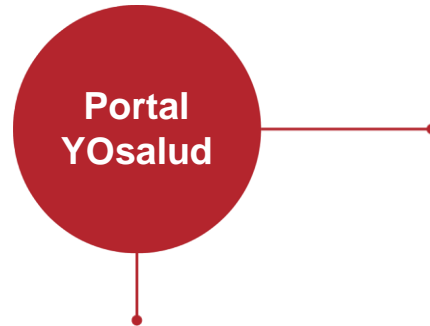
Triangle of Success



- Patients: world-wide on-line access to personal medical records, ability to interact with the hospital and primary care doctors and nurses
- Patient healthcare portal with personalized content for healthcare promotion, education and prevention
- Tool for the creation of standardized care plans

Technology. Tools

How do we do it?



The Health Portal is a fundamental tool for the empowerment of the patient with minimal intervention of health professionals. From any mobile device with internet connection, the patient can consult their discharge reports, test results and access to personalized health recommendations, as well as perform administrative procedures.


The main objectives of the Health Portal:

- Accessibility
- Communication channel
- Reduction of PC visits

- You can check if you have an appointment with any specialist and you can also ask for a visit
- You can ask your doctor or nurse by secure messages
- You can check your medical history everywhere
- You can upload your clinical documents in electronic format in order to attach them to your EMR
- You can check your blood test results without going to the doctor
- You can register and share with the doctor all the information related with your chronic diseases and check its evolution


Technology. Tools

How do we do it?





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YOsalud
iDisponible en app!




*Prescritos en Apple Store


Any doubts?
 Contact us





0


CastellanoValenciàEnglish


 Log out


 Health Folder


 Medical History


 Documents


 Discharges


 Tests


 Radiology tests


 My health plan


 My Engagements

 Appointments


 Appointment notes


 My Conversations


 Conversations


 New question

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 Home Page

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 Active Health promotions
5

 Primary Healthcare Appointments


Press the button to request an appointment with your primary healthcare provider.

Appointment

Specialist Healthcare Appointment

Send Document

Appointment Primary attention




Campaña Antigripal
2018-2019

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Technology. Tools

How do we do it?





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iDisponible en app!



*Prescritos en Apple Store


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
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Video Campaña Vacunación Antigripal 2018-2019



Novedades nueva versión YOsalud



Guía de uso YOsalud




app YOsalud
¡Descárgala aquí!



Specialist Healthcare Appointment

Send Document

Appointment Primary attention




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Technology. Tools

How do we do it?



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Technology. Tools


How do we do it?





FRANCISCO JAVIER BALLESTA LOPEZ





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Medical History


Documents


Discharges


Tests


Radiology tests


My health plan


My Engagements

Appointments


Appointment notes

My Conversations


Conversations

New question

Change Password

Antecedentes

Save Information

General Information


Height (cm):
184

Weight (kg):
80

BMI (Body Mass Index):
23.629

Allergies to medicines
No

Surgical operations:
No

Assessments


New assessment

Nivel 0

Specialist Healthcare Appointment

Send Document

Appointment Primary attention



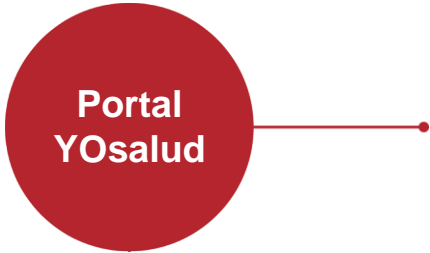
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Technology. Tools

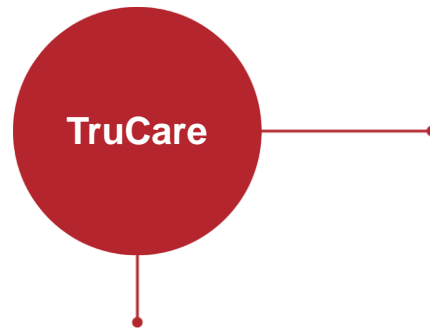
How do we do it?



Activity in the Health Portal.	
Population	309.430
% validated population	45,59%
Shared messages	1.009.738

Technology. Tools

How do we do it?



It allows standardized evaluations based on the level of chronicity and the chronic pathologies of the patient. Based on the responses recorded, an individualized care plan is drawn up and the appropriate follow-up of the pathology is established according to its level of severity

- The care plans are structured in 4 blocks
 - Education for health. It is one of the most important aspects. The nurse gives information about a healthy lifestyle and about the chronic pathology of the patient. A better knowledge of the disease allows informed participation in decision making and better health outcomes
 - Medication-treatment. Everything related to the prescription, administration and conciliation to improve adherence to treatment
 - Information on signs and symptoms of alarm and referrals. This knowledge is very important for the correct flow of patients through the different levels of care
 - Follow-up It is different for each pathology and is determined by the level of severity of it

Technology. Tools

How do we do it?

BA10000019 CB10000019, ANA

BA10000019 CB10000019, ANA

Paciente nº: 1516668
10/07/1976 (40 años)
Mujer
Alergias (Medicamentosa)
Nº grupo:
PCP: JULIA GO10000226 NT10000226
BHP: Ribera Salud > Cobertura Univers
Valenciana > SIP > Vinalopo > ZONA BA
TOSCAR > CAP ELCHE TOSCAR

Information integrated from the EMR

Alertas

Paciente en programa de inmovilizados
Nivel 1 - C15 - Enf crónica estable nivel 2

Demografía

Paciente: BA10000019 CB10000019, ANA
Identificación del paciente: 1516668
Fecha de nacimiento: 10/07/1976
Estado civil:
Direcciones
* [Institución] Direccion10000019 Num. 9 Piso 3 Puerta 5, Alicante, 03205 ELCHE / ELX, Spain
Números de teléfono **Ningún correo electrónico**
[Personal] +34 675807311
[Personal] +34 10000019
[Personal] +34 10000019

Métricas clave

Programas

24/11/2016 Programa Nivel 2 Inscrito

Information provided by the nurse / doctor after the assessment of the patient

Pacientes
Tareas
Agenda
Faxes
Reasignación

Technology. Tools

How do we do it?

Powered by TruCare

Member | Provider | Authorization Search | Resources | Reporting | Admin | User | Help | Logout

BA10000019 CB10000019, ANA

Member Information | Clinical | Care Management | Documentation | Tasks | Scheduler

BA10000019 CB10000019, ANA Assessment Summary Add Assessment Screen

Add Assessment Screen

Assessment: General Evaluation, Programme Level 1, Score: 0

Add Allergy Add Medication Add Diagnosis Add Key Metric Add Note

Chronic illnesses

Health perception-Management... *

Evaluation of the risk of falls *

Evaluation of smoking habits *

Evaluation of alcohol consu... *

Nutritional-Metabolic functional... *

Elimination functional pattern

Activity-Exercise functional pat... *

Sleep-Rest functional pattern

Cognitive-Perceptual functional... *

Self perception functional pattern

Role-Relationship functional patt...

Sexuality-Reproduction functio... *

Coping-Stress tolerance function...

Value-Belief functional pattern

< Prev Group

Chronic illnesses

Next Group >

Add Note

Have you been diagnosed with any of the following chronic illnesses?

☒ Chronic Heart Failure (CHF)

☐ Ischaemic heart disease

☐ Chronic Kidney Disease (CKD)

☐ Systemic autoimmune disease

☐ Chronic Obstructive Pulmonary Disease (COPD)

☐ Asthma

☐ Inflammatory bowel disease

☐ Chronic liver disease

☐ Cerebrovascular Accident (CVA)

☐ Dementia

☐ Alzheimer's disease

☐ Diabetes

☐ Cancer

☐ Osteoarticular disease

☐ Hypertension (HTN)

☐ Dyslipidaemia

☐ Others

☐ No

Save Submit Cancel

Members

Tasks

Scheduler

Faxes

Ownership

User and Team Management

Technology. Tools

How do we do it?

Member | Provider | Authorization Search | Resources | Reporting | Admin | User | Help | Logout

Member Information | Clinical | Care Management | Documentation | Tasks | Scheduler

BA10000019 CB10000019, ANA | Assessment Summary | Add Assessment Screen | Member Tasks | Care Plan Summary

Care Plan Summary

-- Select --

Start Care Plan

Create from Care Plan Builder

Filter By: Care Plan

Close Care Plan

Create PDF


Actions	Care Plan	Care Plan Own	Case	Start Date	Closed Date	Last Update
Edit	▼ CARE PLAN: ICC	SUSANA SERRAN	General	24/11/2016		24/11/2016
Edit	INTERVENTION: Enseñanza: proceso de la enfermedad. ICC 5602					24/11/2016
Edit	INTERVENTION: Aumentar el número de raciones de legumbres-pasta-arroz-patata hasta el rec					24/11/2016
Edit	INTERVENTION: Aumentar el número de raciones de proteínas animales					24/11/2016
Edit	INTERVENTION: Ayuda con los autocuidados: AIVD 1805					24/11/2016
Edit	INTERVENTION: Cribado de retinopatía diabética					24/11/2016
Edit	INTERVENTION: Cuidados al paciente con catéter central, reservorio o PICC (Procedimiento)					24/11/2016
Edit	INTERVENTION: Derivación, si procede, a la consulta médica para ajuste de tratamiento analgé					24/11/2016
Edit	INTERVENTION: Derivación, si procede, a la consulta médica por negación del proceso de enfer					24/11/2016
Edit	INTERVENTION: Disminuir el número de raciones de fuentes de magnesio					24/11/2016
Edit	INTERVENTION: Disminuir el número de raciones de lácteos hasta el recomendado					24/11/2016
Edit	INTERVENTION: Disminuir el número de raciones de verdura cocida					24/11/2016
Edit	INTERVENTION: Enseñanza: actividad/ejercicio físico prescrito. Diabetes 5602					24/11/2016
Edit	INTERVENTION: Enseñanza: dieta prescrita. Diabetes 5602					24/11/2016
Edit	INTERVENTION: Enseñanza: medicamentos prescritos. Diabetes 5616					24/11/2016
Edit	INTERVENTION: Enseñanza: medicamentos prescritos. ICC 5616					24/11/2016
Edit	INTERVENTION: Enseñanza: proceso de la enfermedad. Diabetes 5602					24/11/2016
Edit	► PROBLEM: Seguimiento programado en Atención Primaria. ICC					24/11/2016
Edit	INTERVENTION: Facilitar el aprendizaje. Diabetes 5520					24/11/2016
Edit	INTERVENTION: Facilitar el aprendizaje. ICC 5520					24/11/2016
Edit	INTERVENTION: Manejo de la inmunización (vacunación) 5520					24/11/2016

Technology. Tools

How do we do it?

Consultas Externas - Lista de Trabajo - Jesus Pastor FernandezNo presentadosNEW USER DESARROLLO S - ALG - Alergia - Prueba

FACULTATIVO



JESUS PASTOR FERNANDEZ

Agendas Monitor Reclamada

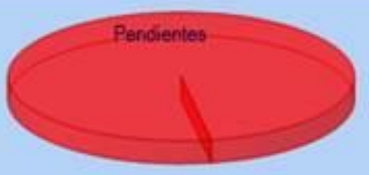
- ALG - Alergia - Prueba
- ALG - Alergia - Agenda Dr. Juan
- RAD - Agenda Torax Factoria
- ALG - Alergia - Alergia TM
- CAR - Cardiología - Autocitas Cardio Primera
- GIN - IVES - Ives
- CAD - Cardiología - Autocitas Cardio Primera

octubre de 2016

lun	mar	mié	jue	vie	sáb	dom
26	27	28	29	30	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Hoy: 20/10/2016

Estadísticas



H. Llegada	Hora	T. Consulta	Ubic.	Est.	Obs	Plus	Inte	H. Clínica	Paciente	F. Nac.	Edad	T.	RX	Lab.	End.	AP.	Otr.	Procedimiento
12:50	10:00	Sucesiva	169-A					246444	FELICISIMO DES LV10264854 RT	25/04/1937	79							Carencia de piridoxina

Refrescar

A pendiente

No Asistencia

Pendiente

No Asisten.

Atendida

Solicitados e Informados

Solicitados No Informados

Cargar Tareas

Otra Agenda

Citar

Propuesta Consulta

Intercons.

Tele Medicina

Pasar Consulta


Consultar Historia

Technology. Tools

How do we do it?

Consultas Externas - Lista de Trabajo - Jesus Pastor FernandezNo presentadosNEW USER DESARROLLO S - ALG - Alergia - Prueba

FACULTATIVO



JESUS PASTOR FERNANDEZ

Agendas

Monitor Rellamada

- ALG - Alergia - Prueba
- ALG - Alergia - Agenda Dr. Juan
- RAD - Agenda Torax Factoria
- ALG - Alergia - Alergia TM
- CAR - Cardiología - Autocitas Cardio Primera
- GIN - IVES - Ives
- CAD - Cardiología - Autocitas Cardio Primera


octubre de 2016

lun	mar	mié	jue	vie	sáb	dom
26	27	28	29	30	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Hoy: 20/10/2016

Estadísticas

Pendientes



H. Llegada	Hora	T. Consulta	Ubic.	Est.	Obs	Plus	Inte	H. Clínica	Paciente	F. Nac.	Edad	T.	RX	Lab.	End	AP	Otr.	Procedimiento
12:50	10:00	Sucesiva	169-A					246444	FELICISIMO DES LV10264854 RT	25/04/1937	79							Carencia de piridoxina

TruCare

Planes de Cuidado Actividades Notas Valoraciones PATRICIA SUSANA LB10228013 XX10228013

Nivel: 2 - A22 - Oncológico órgano no vital

Work on Intervention - Derivación, si procede, a la consulta médica para solicitar valoración por el servicio de neumología

19/10/2016

Prioridad: MEDIUM

Rebasada

Work on Intervention - Consulta. Seguimiento médico de familia. Primera visita EPOC 7901

19/10/2016

Prioridad: MEDIUM

Rebasada

Work on Intervention - Consulta. Seguimiento enfermera

Refrescar

A. pendiente

No Asistencia

No Asisten.

Atendida

Solicitados No Informados

Cargar Tareas

Otra Agenda

Citar

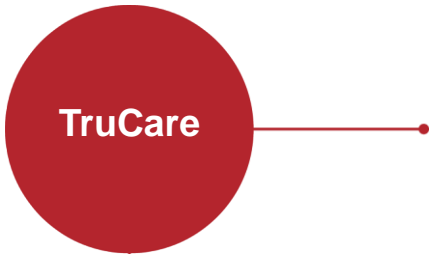
Propuesta Consulta

Intercons.

Tele Medicina

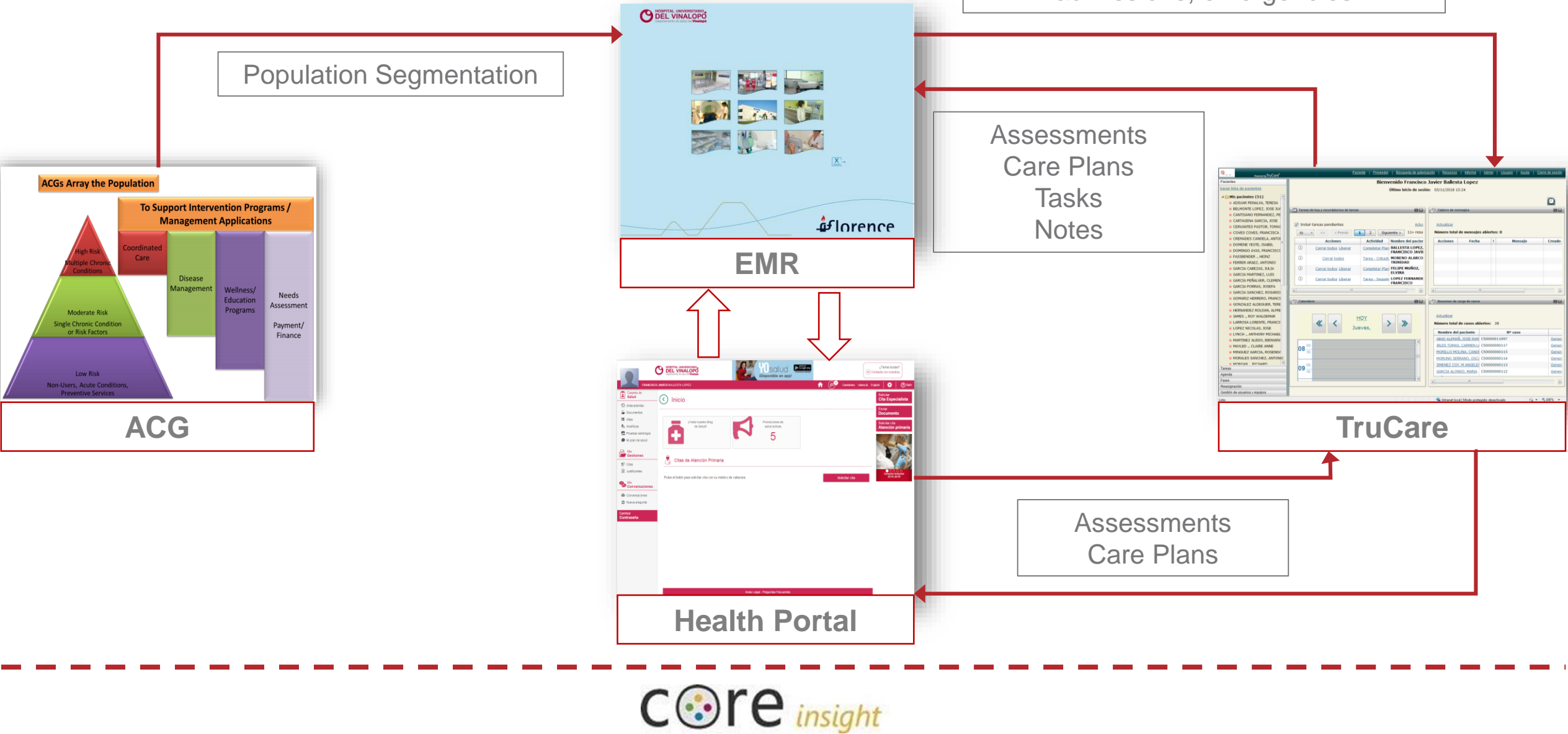
Pasar Consulta

Consultar Historia



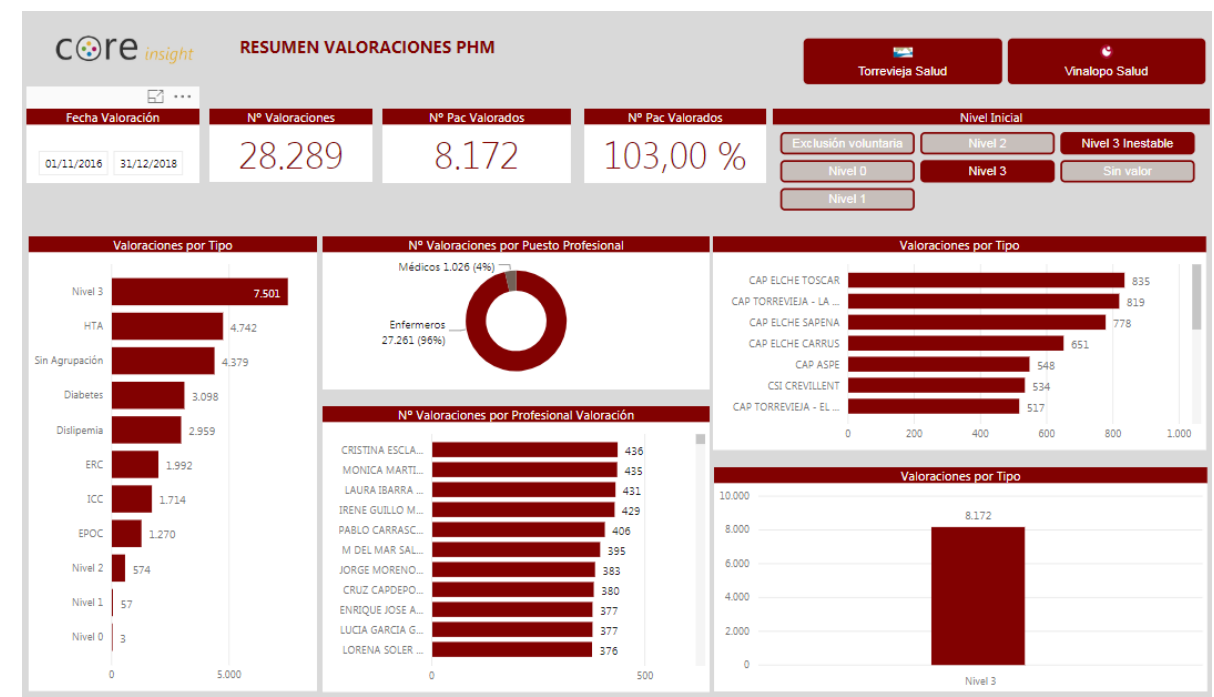
Assessments in TruCare. Level of chronicity.	
Level of Chronicity	Number of patients (alive and exitus)
Level 3	10.164
Level 2	21.326
Level 1	5.441
Level 0	1.039
TOTAL	34.534

Technology. Tools
How do we do it?

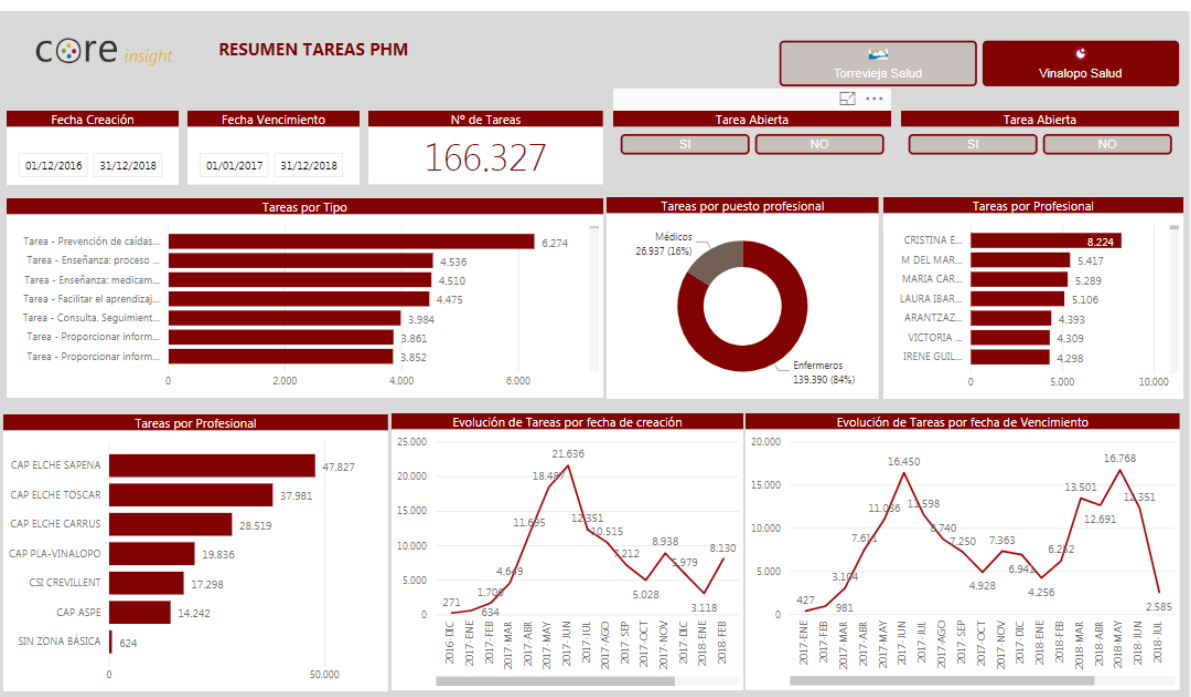


Population Health Management (PHM)

Process indicators



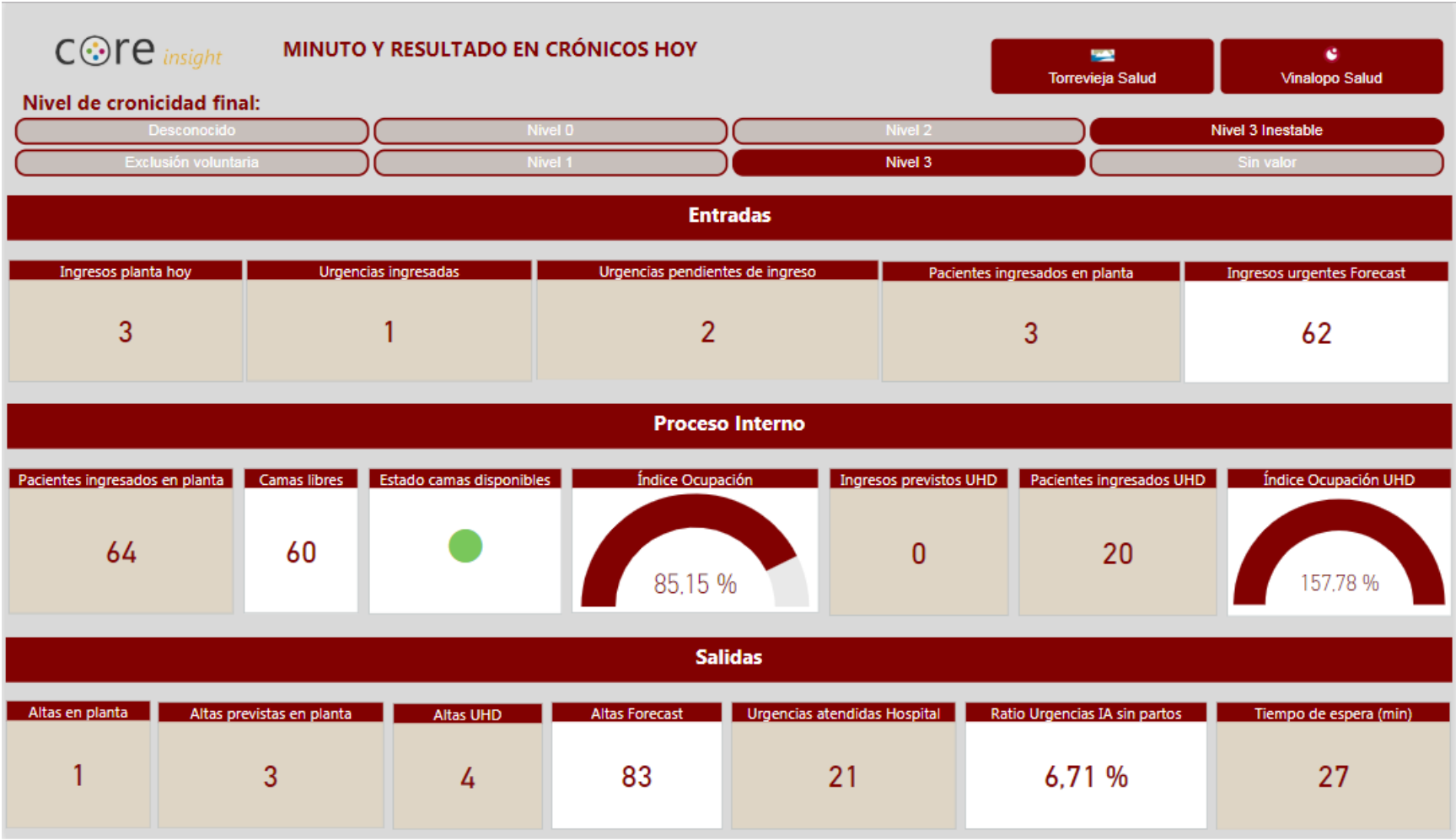
Patient Level 3 assessments



Interventions Care Plans

Population Health Management (PHM)

Process indicators



Hospital chronic patient activity

A black and white photograph of a woman holding a baby, with a large red circle overlaid in the center containing the word 'CONCLUSIONS'.

CONCLUSIONS

MAIN HEALTH RESULTS

Patients with more admissions at hospital (level III)

- Data to 3/2019
- More than 6 months in TruCare
- Patients **alive** to date
- Comparison of activity in the same period of time before and after being included in TruCare (Post-incl.: activity after inclusion in TruCare; Pre-incl.: activity before inclusion in TruCare)



Sample/department	Torre Vieja	Vinalopó	Ribera Salud
Level 3 patients in TruCare	4.038	4.044	8.082
Average age	74	75	74
Average number of days in TruCare	431	445	438

level 3 patients alive in TruCare	Torre Vieja	Vinalopó	Ribera Salud
	Var.pre-post	Var.pre-post	Var.pre-post
1st consultations	-27%	-26%	-27%
Medical admissions	-35%	-29%	-32%
Medical stays	-40%	-34%	-37%
Readmission within 30 days	-26%	-30%	-28%
Hospital at Home (HaH) admissions	-18%	19%	5%
Hospital emergencies	-20%	-14%	-17%

El % de reducción de ingresos o estancias ha empeorado unos puntos respecto al mes de enero, pero aún así está en unos niveles muy buenos. En valores absolutos hemos pasado en un mes de una diferencia de 8.239 a 10.773 estancias.

MAIN HEALTH RESULTS

Patients level 3

Sample/Department	Torreveija	Vinalopó	TOTAL
Citas 1as	6.440	6.189	12.629
Citas 1as PC	4.832	4.622	9.454
Citas Suc	24.364	24.017	48.381
Citas Suc PC	21.409	20.302	41.711
Ingresos Med	1.708	1.628	3.336
Ingresos Med PC	1.099	1.048	2.147
Estancias Med	9.690	9.692	19.382
Estancias Med PC	5.342	5.801	11.143
Ingresos UHD	130	220	350
Ingresos UHD PC	111	211	322
Estancias UHD	1.976	3.295	5.271
Estancias UHD PC	1.412	2.426	3.838
Urg ATP	3.777	1.286	5.063
Urg ATP PC	3.273	2.027	5.300
Urg Hosp	4.742	6.164	10.906
Urg Hosp PC	3.844	5.221	9.065
Reingresos 30	181	189	370
Reingresos 30 PC	140	117	257

- 8.239
medical stays

+ 1.400.000 Eur

MAIN HEALTH RESULTS

Patients with more admissions at hospital (level III +)

- Patients with 4 medical admissions or more in the previous 12 months
- Data to 3/2019
- More than 180 days in TruCare
- Patients **alive** to date
- Comparison of activity in the same period of time before and after being included in TruCare (Post-incl.: activity after inclusion in TruCare; Pre-incl.: activity before inclusion in TruCare)

-1.142
estancias

3,13 camas
/año

188.000 eur

Sample/department	Torre Vieja	Vinalopó	Ribera Salud
Level 3+ patients in TruCare	172	141	313
Average age	68	69	69
Average number of days in TruCare	415	458	434

	Torre Vieja	Vinalopó	Ribera Salud
level 3+ patients alive in TruCare	Var.pre-post	Var.pre-post	Var.pre-post
1st consultations	-30%	-25%	-27%
Medical admissions	-27%	-17%	-23%
Medical stays	-22%	-25%	-24%
Readmission within 30 days	-28%	-32%	-30%
Hospital at Home (HaH) admissions	-15%	50%	19%
Hospital emergencies	-22%	-9%	-16%

Mejor resultados del conjunto de los pacientes NIII + frente a meses anteriores. Notable incremento en el uso de la UHD.



ribera salud grupo

Thanks