Integrated care for elderly receiving hospital-at-home care: designing an innovative home-based programme

Abstract

Introduction
Life expectancy has increased globally from 64 to 71 years. For many elderly people, hospitalization is followed by a fast decline of capacities and great mental challenges (1). This progressive decline of the oldest age groups after hospitalization has triggered an increase in the prevalence of specific health and social conditions. Among these conditions, loneliness and cognitive impairment have been revealed among the most important causing dependency and re-hospitalization in elders (2).

In order to effectively address these issues, identifying frail elderly patients after hospitalization, and providing them with home-based care to fulfil their needs, may help to reduce readmissions at hospital facilities, and, thus, contribute to the sustainability of care systems as ultimate goal.

Methodology – Intervention description
The intervention presented follows a holistic approach to hospital-at-home care, including the care of medical, social and psychological needs for elders.

The intervention programme presented in this study targets older people aged 75 and above, who have been admitted at the hospital through the emergency department, and it starts after discharge from hospital to hospital-at-home.

The programme is designed based on evidence, and is aimed to: 1 reduce loneliness and increase social participation; and 2 slow down the progressive cognitive impairment.

As part of the intervention, the following care pathways are designed in order to complement the medical treatment and achieve the proposed aims:

A motivational-based care pathway developed by social workers. This care pathway is intended to motivate the patient to take part in the community, based on patient’s personal likes, being the ultimate goal to reduce loneliness. The planned structure for this care pathway is a monthly face-to-face interview and telephone follow-up, in which the patient and the social worker check the accomplishment of a set of objectives and measures they have agreed-upon.

A cognitive impairment care pathway guided by psychologists. This care pathway is based on attention and memory training for those patients suffering from mild cognitive impairment. The training is delivered using a workbook including a set of exercises to train cognitive strategies. The planned structure for this care
pathway is performed by a psychologist by means of a face-to-face interview and two telephone interviews per month.

**Conclusion**
The proposed intervention programme follows a population-oriented approach focus on each patient needs. The two care pathways on which this programme is based on provide a complementary intervention to medical care, ensuring that psychological and social aspects are also covered as a part of holistic healthcare delivery. This intervention offers an innovative care strategy of integrated care for those patients receiving hospital-at-home care.

**Location**
Spain

**Year**
2017

**Related Integrated Care keywords**
- CARE PATHWAYS/ PROTOCOLS/ GUIDELINES
- HOLISTIC AND COMPREHENSIVE APPROACH
- PERSONALISED CARE

**Pervasiveness**
Small scale in a local jurisdiction

**Status**
Completed

**References**


**Links**

https://www.ijic.org/articles/abstract/10.5334/ijic.s2367/