euriphi
European wide Innovation
Procurement in Health and Care

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No 825922-EURIPHI

Program to improve the discharge process : TRANSICIONA

Abstract

Introduction

High-quality coordination during transitions across different setting is especially important for older adults with multiple chronic conditions and complex needs. Evidence suggests an increased risk of decompensations of chronic conditions, hospital readmissions and death, following transitions. For example, in complex chronic patients, 30-days readmissions can reach 20-25%, according to the literature. Although several factors have been associated with "unsafe transition", mostly unidimensional interventions have been designed. We implemented a multidimensional patient-centred intervention program, aimed to increase patient's empowerment on self-management and improve the coordination among the different settings of care.

Objectives

Main outcome: reduction of 30-days readmissions. Intermediate outcomes: to promote early follow-up by primary care.

Methods

We include all the patients admitted to our intermediate care hospital who meet at least 2 of the following criteria's: ≥2 chronic conditions, polypharmacy ≥ 8 drugs, cognitive impairment, previous hospital admission <6 months, poor social support and high risk of readmission perceived by the referral team.

The intervention is carried out on 5 domains: a) Medication patient-centred conciliation and education; b) Physical activity encourage and promote the practice of physical activity, according to physical function; c) Patients' empowerment encourage and promote the incorporation of healthy habits, improve the patients' knowledge of their disease and treatments; d) Identification of other risks of hinder patients' empowerment and confidence e Coordination of different settings primary care, nursing homes, etc. .

The multidisciplinary team includes: two nurses leaders of the project, a social worker and a geriatrician. In order to improve patients' empowerment, the two nurses have received training on motivational interview and specific techniques such as "teach-back".

We collected demographic, clinical and health process variables in order to performed quantitative analyses, as well as 30-days readmissions using the shared IS3 platform available in all Catalonia.

Results

After 12 months, a total of 182 patients were included mean age 82 years and 54% females; 24 patients were missing during the intervention due to early discharge. The intervention was done mainly on the medication domain 77.1%, N=140, patients' empowerment 78.8%, N=143 and physical activity 76%, N=138
Coordination and contact with primary care was done mainly through telephone calls, followed by email and written pre-discharge notifications. Regardless the method use for coordination, a high percentage of

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patients 47%, N=60 of 128 de patients from Home Care ATDOM; 67%, N= 86 de 128 patients of Primary Care of patients had a follow-up visit soon <7 days post alt. On the other hand, bad health outcomes, as hospital readmission within 30-days was 18.8%.

Futures steps

We plan to complete the assessment looking at patient's adherence to recommendations pharmacological and non-pharmacological as well as to analyse qualitative feedback of patients and staff about the program implementation.

Location

Catalunya

Year

2018

Related Integrated Care keywords

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

Pervasiveness

Small scale in a region

Status

Completed

Links

https://www.ijic.org/articles/abstract/10.5334/ijic.s2168/