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WORKSHOP ABSTRACT

Integrated Hospital Discharge Planning with Home Service for Complex Chronic Patients

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Population's aging and the increased number of Chronic Complex Patients (CCP) in unprepared environments for this complexity among a fragmented system which has a high variability and that is centered in chronic diseases acute failure and the lack of planning in the different levels of attention, may benefit hospital readmission which is expensive and unnecessary, avoidable adverse events and mistakes related with drugs, which may diminish the patient's level of satisfaction. This presents a scenario that poses important challenges for the health system organization and for the provision of services to improve the quality of the assistance, the patient's satisfaction and to diminish expenses.

All of these factors create the need of designing patient oriented care plans.

At HIBA (Hospital Italiano de Buenos Aires), we have an integrated attention program for CCP with a Home Care focus. We follow a Home Based Primary Care Model locally defined as Home Care. The 80% of admissions from a hospitalization to Home Care Medicine are of CCP. There is a complexity due to the clinical approach and the potential intensive use of resources.

The transition process has not been standardize among the different areas according to the complexity of CCP in Home Care. Nevertheless, in the clinical hospitalization area, many groups worked with different integration levels to approach these type of patients, working with episodic nonintegrated care plans.

We presented this problem and the proposal was to create an interdisciplinary work team. This team was composed by the different areas involved in the attention of these CCP candidates who were to be admitted in Home care (Geriatrics, Medical Clinic, Social Services, Rehab, Pharmacy, Nursing, Home Care, Health Plan Management, Dismissal Planning Unit, Palliative Care, and Medical Informatics) to improve care's continuity through a shared and customized care plan. The priority was to organize care goals according to the patient's needs by using a common language and precise tools. We ranked the population and decided to intervene the group with higher risk (Chronical Complex Patients). The different involved areas decided on the assistance process for the CCP: they defined roles and a set of steps to implement in each area oriented to improve the hospital-home transition in a way that benefits safety, quality of assistance, the patient's satisfaction and his environment and the health team.

After 3 months of training, we initiated the implementation increasingly and evaluated the process indicators quarterly with the goal of assessing adhesion and the proposal's feasibility. We reached more than a 60% in most of the interventions.

The path we have been through allows us to confirm that planning the patient centered transition of CCPs to Home Care benefits the comprehensive interdisciplinary care through a common language. It also enhances the patient's satisfaction and his environment by preparing the caregiver for the CCP's management at home care. It makes effective communication easier among the different attention areas and it provides the possibility to create a unique shared and customized plan for the CCP by benefiting continued assistance.