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Conference Abstract

**Care transition and network activation within home supported discharge service for stroke patients in Portugal**

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**Abstract:**

**Introduction:** Strong evidence exists that there are serious quality problems for patients undergoing transitions across sites of care (1). This is a particularly acute and problematic issue at a time when care systems face the challenges brought about by increasingly elder populations (2), translated in rising levels of co-morbidities, chronicity, degenerative illnesses and disabilities, with escalating provision costs, and try to reconfigure the delivery of care services with strong emphasis on deinstitutionalization and community-based support. In Portugal, a number of top down regulated initiatives aiming at implementing integrated care in the country have been attempted in the last years but the care system still presents a remarkable diversity of entry points, inadequate many times duplicated use of scarce and expensive resources and difficult information flow between institutions and professionals. Coordination between health and social care including home-based care settings most of the times depends on the good will of dedicated professionals and the individual is many times left alone to navigate through the fragmented systems and the several care providers he might encounter in the path to rehabilitation.

The main goal of this paper is to report on the quality of care transitions including actions intended to activate networks of care from the perspective of the patient, in the context of a randomized control trial on home supported discharge service for stroke patients in Portugal.

**Theory:** A transition of care refers to a patient movement between care locations, providers or different levels of care within the same location as his/her condition and care needs change. It can be seen as a set of actions designed to ensure coordination and continuity of care (1) but also as a point in a care process and in space, to which the time dimension is always associated (3). Many of these care transition episodes are triggered by acute problems that are unplanned. Therefore, neither the patients nor their families know what to expect, and they do not even realize just how vulnerable patients can be during transitions. Nevertheless, coordination and continuity of care during this particularly vulnerable time often falls on family, patients, or other informal caregivers (4). It is therefore crucial to evaluate the quality of care transitions from the patients and/or their informal caregivers perspective.

**Methods:** We have studied the whole patient's course, from the admission to the stroke unit to six months after discharge. A methodology has been developed to assess the quality of care transitions including network activation actions, as the patients progressed from the stroke unit to rehabilitation care, either inpatient, ambulatory or at home and to normal life again. The scale developed also addresses the role of the family doctor as gate keeper.

**Results:** Four fundamental aspects have been researched at the moment of patient discharge from the several units involved in health care: dealing with medication at home, dealing with activities of daily living, finding help in community and dealing with the moment of discharge itself. More precisely, we have addressed patient self-reported ability to deal with these situations, the level of information provided to the patient by the health unit at discharge and the way the process was conducted. Additionally, we have investigated the way each node in the network provided the patient with an anchor contact point in the discharging unit, a referring contact point in the destination unit, a written care summary and plan and a discharge letter addressed to the patient's family doctor. Finally, we addressed the role and the actions of the family doctor, from the perspective of the patient.

**Conclusions:** In this work we have addressed and measured structural and procedural aspects of care transitions, from the point of view of the patients. Outside the RNCCI, the National Network for Integrated Care, that still handles a limited percentage of patients in need of rehabilitation after a stroke there is no integrated information system available to the providers involved in the chain of care. Tools such as case managers or care plans are not in use while discharging and referring letters are the preferred way of communication between hospitals and family doctors based in health centres of family health units. It is not common practice to provide the patients with an anchor contact point in the discharging unit or helping the patients finding help in the community. Based on these results, the widely adoption of a standard framework based on a conceptual model for the measurement of care transition quality is strongly recommended. The measure set should include structural, process and outcome measures and process measures should be paired, addressing both the sending and the receiving providers in order to promote shared accountability (1). As all evaluation efforts carries costs, the right balance between cost and benefit must be found keeping always in mind the logic of network.

## Keywords

care transition, care network activation, patient perceptions, stroke rehabilitation, health and social care services, homecare, RCT, Portugal

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