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CONFERENCE ABSTRACT

Transversal implementation in Catalonia of the ICT process of transition of care between hospitals and Primary Care Centers (PCC).

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Background

Transversal implementation in Catalonia of the ICT process of transition of care between hospitals and Primary Care Centers (PCC).
The Catalan Health System(CHS) is made up of more than 160 health providers(70 hospitals, 365 PCC and 101 Long-term care centres(LTCC)). Most of them have their own information systems(IS), >27 IS. For this reason, the Health Department introduced transversal platforms to share clinical information. Shared Medical Record of Catalonia(HC3) was set in motion as a central repository of clinical data, Personal Health Record(PHR) was implemented to empower citizens as participants in their clinical processes and IS3 platform was introduced to exchange messages, referrals, care processes and warnings between different providers.
The planning of care after discharge improves the process and guarantees the quality of the transitions. The pre-discharge report details what care the patient should receive later at home, PCC should receive it 24-48 hours before discharge.
In Catalonia, the pre-discharge process was carried out in a heterogeneous way, using mails, local platforms or telephone so a unified alternative was proposed to integrate into the ICT process.

Description of practice change implemented and timeline

The incorporation of the pre-discharge process in our ICT platforms provides a secure and standardized method of work.
Adaptation phases:

1. Hospitals and LTCC upload “pre-discharge” pdf forms in HC3(2014-2019)
2. PC daily received HC3’s synchronised pre-discharge forms which generated alerts to the GP, nurse and the patient reference case manager(2017)
3. For adequate synchronisation and instant alerts with PCC, hospitals generate online messaging via IS3(2018)
4. Structure data into IS3 and programme appointments directly from Hospital and LTCC to PCC nurse.

Aim and theory of change

To offer secure ICT tools to share information between hospitals/ LTCC facilities and PCC. To guarantee quality of care and follow-ups for patients after being discharged.

Targeted population/stakeholders

Patients with higher risks of readmission who require aftercare and follow-ups.

Highlights(phases):

1. 166.371 reports have been upload in HC3
2. PCC implemented alert systems(2017).
3. 9 hospitals have incorporated the online messaging through IS3, generating 2250 alerts to PCC. All hospitals will be incorporated by 2020.
4. Phase 4 will be initiated in 2020

Sustainability

Since all hospitals and PCC have already been incorporated in the Catalan ICT platform, the electronic pre-discharge implementation will not cause an important additional cost.

Transferability

Transversal project implemented in CHS using standard communication and transversal platforms allows to standardize the pre-discharge process.

Conclusions

Homogenization and improvements have been achieved through all the systems. The standardization of variables allows better monitoring quality, better continuity with PCC and integration of information between IS. Alerts improve communication between professionals involved, process is shared with citizens through PHR.

Discussions

166.373 reports uploaded in HC3 in 4 years is a low number of pre-discharges as compared to all discharges.

It is necessary to continue promoting use of electronic pre-discharge forms in different hospital services to improve transitions of patients.

Lessons learned

For transversal implementation management strategy is the key, in our case we rely on contractual clauses with all providers.

It is important to promote coordination between all levels and inform professionals of the importance of generating pre-discharge forms.