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POSTER ABSTRACT

Integrated Care Hospital at Home: a 3 years' experience of a geriatric H@H based in Barcelona

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Introduction

In the past decades, various home hospitalisation models have been developed, as an alternative resource to conventional hospitalisation, focusing on avoidance of admission or early discharge, encouraging the continuity of care in the patient's environment.

The model developed so far in our environment is based on the classic health scheme (medical and nursing, with a provision of services equivalent to acute hospitalisation, usually not adapted to older patients, with high needs for comprehensive care.

Practice change implemented

Ours is an interdisciplinary team formed by geriatricians, specialised nurses, occupational therapists, physiotherapists and a social worker, and we give a multidisciplinary approach, focused on the comprehensive geriatric assessment, and with an individualised work plan for each patient, providing a critical approach to rehabilitation. With results equivalent to or greater than the maintenance of conventional hospitalisation.

Aim and theory of change

To improve the care of frail older adults in their environment. We aim to explain our Hospital's experience at Home (H@H) service in the first three years of activity.

Targeted population and stakeholders

Older adults with acute processes or exacerbation of one of their chronic conditions.

Timeline

The H@H unit started in December 2017 and is still on-going.

Highlights

We have visited 434 patients, 56.2% females, 82 yo, with a Barthel Index (BI) at admission of 50, and gaining an average of 10 points at discharge. Most of our patients lived with their partners (51%) and only 31% had a professional caregiver at least 1h per day.

The Charlson Comorbidity Index (CCI) was 2, and the most common chronic conditions were high blood pressure (74%), followed by chronic heart failure (HF) (37%), diabetes (32%) and atrial fibrillation (30%).

The main source of referrals to H@H was acute hospitals (51%) and primary care (27%). The most common cause of admission to our unit was hip fracture (30%), followed by HF (16%) and acute infections (11%).

At discharge, 74% of our patients remained at home, 14% had to go back to acute hospitals, 8% were sent to an Intermediate Care Hospital (ICH) and 4% died.

Comments on sustainability and transfer-ability

Sustainability is guaranteed as it has been proved by previous research that H@H teams are cheaper than conventional hospitalisation and as effective. Experience can be transferred and replicated in other Intermediate Care centres in other regions, adapting the interventions to the population and environment characteristics.

Conclusion

Geriatric H@H is an effective way to treat older patients with chronic or acute conditions that cause a functional impairment.

Discussion

Our intervention allows to treat and rehabilitate patients in their environment, reducing geriatric syndromes such as delirium, immobility and falls.

Lessons learned

The multidisciplinary work is the key component of the program.