
CONFERENCE ABSTRACT

The Return Home Program: integrated health and social care for post-stroke patients.

16th International Conference on Integrated Care, Barcelona 23-25 May 2016

Aina Plaza¹, Marta Fabà², Marco Inzitari³, Mercè Salvat⁴, Patricio Hernández⁵, Carla Hernández³, Sabrina Romera³, Susana González⁶, Conxita Closa⁷, Esther Duarte⁸, Ma José López⁹, Carles Ariza⁹, Aida Ribera¹⁰, Elvira Torné¹¹, Pepita Rodríguez¹²

1: Regió Sanitària Barcelona, Servei Català de la Salut, Spain;

2: Desenvolupament tècnic i organitzatiu, Institut Municipal de Serveis Socials, Ajuntament de Barcelona, Spain;

3: Parc Sanitari Pere Virgili, Spain;

4: Pla Director de la Malaltia Vascular Cerebral, Departament de Salut, Spain;

5: Cap Institut Municipal de Serveis Socials, Ajuntament de Barcelona, Spain;

6: Hospital de l'Esperança, Consorci Parc de Salut Mar, Spain;

7: Directora assistencial, Corporació Fisiogestió, Spain;

8: Servei de medicina física i rehabilitació, Hospital Mar i Esperança, Consorci Parc de Salut Mar, Spain;

9: Servei d'Avaluació i Mètodes d'Intervenció, Agència de Salut Pública de Catalunya, Spain;

10: Unitat d'Epidemiologia Cardiovascular, Servei de Cardiologia, Spain;

11: Sistemes d'informació, Regió Sanitària Barcelona Servei Català de la Salut, Spain;

12: Atenció primària Institut Català de la Salut, Barcelona, Spain.

Introduction: Stroke represents the third cause of morbidity and mortality in adults, the first medical determinant of disability and the second of dementia. Around 50% of stroke survivors develop mobility limitations and disability in the activities of daily living (ADL). After a stroke, treatment aims include the recovery of the maximum possible independence and the promotion of social and working reinsertion, while reducing the risk of institutionalization and mortality. Early supported discharge from acute care has demonstrated quicker return home and a higher chance of achieving independence. Efficiency of such programs is associated, among other factors, with an appropriate selection of patients and with coordination with community and social services.

In Barcelona, both the healthcare and social systems provide a wide range of resources, but the two systems are not integrated. After a stroke, patients admitted to acute or intermediate care hospitals are currently discharged with a personal healthcare plan, but the activation of social resources requires further assessments by primary healthcare and municipal social services at the patient's home; this activates a process to assign resources and to establish the economic contribution of the user.

The Return Home Program (RHP) aims at facilitating home discharge and the achievement of maximum possible independence. It is directed to improve coordination in order to:

- Early detect post-stroke patients admitted to acute or intermediate care hospitals and candidate to home-based social and rehabilitation interventions.
- Direct activate municipal social services (including personal assistance, house cleaning, tele-care, meals-on-wheels, rehabilitation aids) through the empowerment of social workers staff of the hospitals, which traditionally could only refer the person to primary care or social services. During the first weeks after discharge, activation is independent of the economic situation of the person.
- Guarantee the availability of social resources right at discharge.
- Provide the most efficient rehabilitation resource.

Methods: Quasi-experimental study, with pre-post intervention and comparison groups.

Aims: to evaluate short and middle-term impacts of RHP on functional recovery, quality of life and return home, as well as patients' and caregivers' satisfaction; to evaluate cost-effectiveness of RHP, compared to usual care.

Target population: stroke patients admitted to acute or intermediate care hospitals, with >2 impaired ADL and social needs. Barcelona healthcare services are organized in 4 Integral Healthcare Areas (IHA): the intervention group includes hospitals of the Left and Seaboard IHAs (reference population= 815.285 inhabitants), whereas the control group includes hospitals of the other 2 IHAs (812.177 inhabitants).

Progress report: RHP will start in January 15th 2016, and the pilot will run for 1 year.

So far, we concluded:

- Bibliographic review about similar interventions and outcomes
- Program and study design, by 3 parallel and partially overlapping working groups: 1) "intervention working group", including specialists in rehabilitation and geriatrics, nurses, social workers from the healthcare and social sectors, psychologists, who defined the program, target population and screening and assessment tools; 2) "evaluation working group", which sums, to the previous profiles, experts in public health and healthcare assessment, who refined study design and methods; 3) "implementation working group", expanded to strategic stakeholders from the participants institutions, in charge of the training and follow-up.
- Institutional support and funding (gratuity of municipal social resources and study funding), by the Government of Catalonia and the Municipality of Barcelona.

Discussion: This experience, in a highly fragmented environment such as the city of Barcelona, adds the value of integrating healthcare social services in the hospital and basic municipal social services in the community. Early detection of needs in the hospital is cardinal for the effectiveness of the intervention. A further innovative aspect is the gratuity for the patient, independent of the economic level.

The design of the study will allow the estimation of effectiveness and cost-effectiveness of the program through the comparison between the study groups.

Plaza; The Return Home Program: integrated health and social care for post-stroke patients.

In order to guarantee the feasibility of the study, we included in the project all the relevant stakeholders, experts professionals, who allowed taking into account the context and possible barriers, and leaders from the involved public administrations. We will present preliminary results at ICIC16.

Conclusions: RHP is an innovative program which will promote integrated health and social care for a group of particularly vulnerable adults, in a high fragmented environment. Due to these elements of difficulty, in case of positive results we envision the translation of this program to other groups and contexts. After completing the design and planning phases, we will start the program shortly.

Keywords: integrated; return home; post-stroke patients; quasi-experimental study
