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CONFERENCE ABSTRACT

Effectiveness of an integrated care program for intensive home care services after discharge of stroke patients

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Introduction: The continuity of care in hospital discharge is a cornerstone of patient-centred care, particularly after an acute episode with a high impact on patients' autonomy. In the setting of stroke, a highly disabling disease, early delivery of post-discharge support services has been associated with better health outcomes. However, the lack of integration between social and health care services often delays the start of home care services in these patients, likely worsening health outcomes. In our area, a post-stroke intensive home care program (RHP) was launched to integrate social and health care services for improving the domiciliary care of stroke patients after hospital discharge.

Aims and Methods: In this retrospective, matched-comparator study, we aimed to assess the effectiveness of the RHP program. The study included all consecutive patients entering the program between February 15, 2016 and February 15, 2017. A comparator group was built using patients from the general population admitted to any of the tertiary hospitals of the area (Barcelona, Spain) within the investigated period, paired 1:4 for age, sex, and comorbidity burden. The RHP intervention included three consecutive phases: candidate screening, assessment and prescription of social needs, and activation of domiciliary care provided by the local social care service before patient discharge. The integration of health and social care information systems, active in our area by the time of deploying the program, acted as a facilitator.

Results: The study included 92 participants of the RHP (71 ischemic stroke and 18 haemorrhagic stroke) and the corresponding population-based controls. RHP participants and controls showed similar survival on a 2-year survival time frame. However, compared with RHP participants, controls were more likely to be admitted to a long-term care facility; two years after the index episode, 14%

and 5% of patients in the control and RHP groups, respectively, had been admitted to a long-term care facility. Participants in the RHP were more likely to receive earlier key social and health home care services, including domiciliary care (92% and 19% among RHP participants and controls at two years, respectively), telecare (76% vs. 45%), and at-home rehabilitation (98% vs. 84%). The longitudinal analysis of the place of stay showed a faster and earlier increase of RHP patients staying at home than controls.

Conclusions: Our analysis showed that an integrated care program of health and social care for stroke patients at discharge successfully promotes early delivery of intensive home care, including key services for stroke patients such as at-home rehabilitation and telecare. The early delivery of these services resulted in a less frequently and later institutionalization in a long-term care facility.

Implications for applicability and limitations: Intensive and integrated post-acute home care packages provide an opportunity for patient-centred care in a critical step of healthcare pathways, such as hospital discharge. In the case of conditions like stroke, these programs can successfully reduce the disability burden of the disease. The integration of health and social information systems and pooling budget approaches are facilitators of integrated care in this setting.