CIPES PIEMONTE

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Continuity of care for elderly patients

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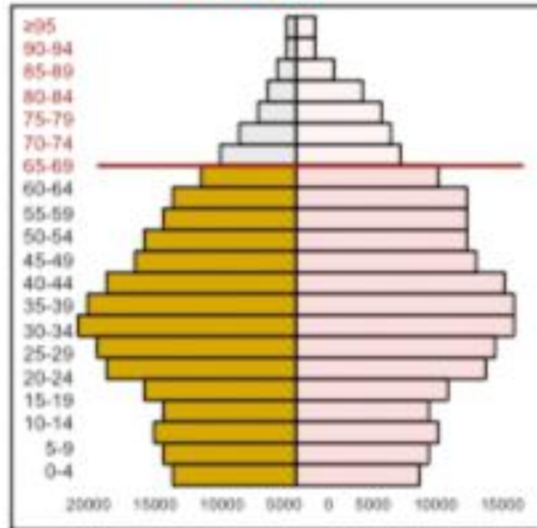
Continuity of care

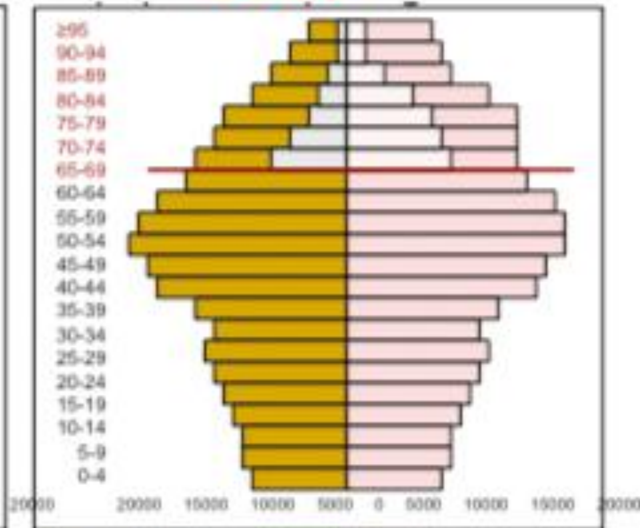
- age profile of general population is changing
- functional structure of hospital and community services are evolving

Age profile of general population of Geneva (CH)

2004



2025



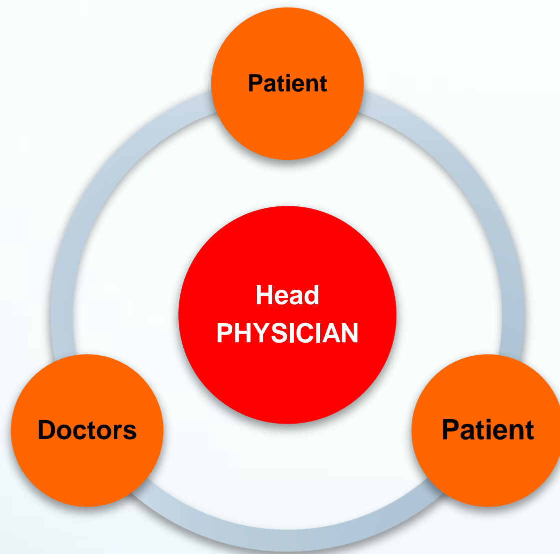
Men
Women

Source : OCSTAT, 2005. http://www.geneve.statistique.ch

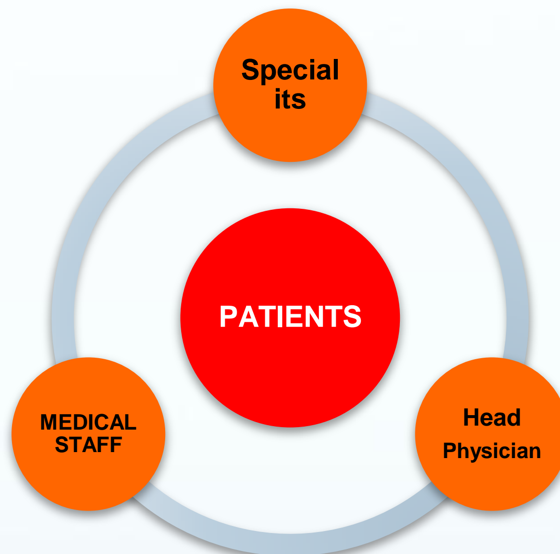
Hospital organisation Relevant evolution with time

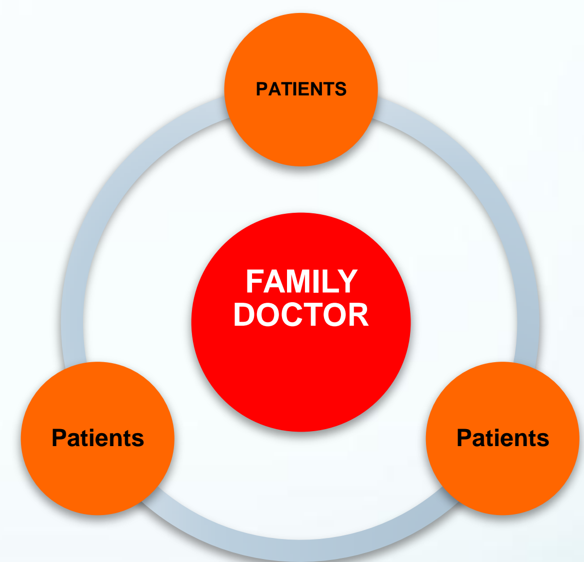
Commun ity health Services No changes with time

1910



2010





Such different organisation model can hardly interact within each-other

Relevant evolution of the organisation model of community health service is required

Continuity of care

@ Digital communication at discharge poorly effective

@ More interacting organisation model highly promising

What is being made for improving the continuity of care?

Several contexts have been analyzed

- The onco/haematological department of the Regional-University Hospital of Turin.
- The protected discharge and hospital at home services of the same hospital
- The hospital of Savigliano, one of the largest district hospitals in Piedmont
- The geriatric service of the University of Genéva (CH)
- An innovative cooperative group of 16 family doctors active in Fossano

The onco/haematological department of the Regional Hospital Molinette of Torino

Two clinical units:

@ patients admitted 60 per month (average)
median duration of hospital stay 16 days

@ patients treated in day hospital 61% of the patient discharged

@ total number of admission in day hospital 540 per month

Due to the complexity of problems of the haematological and oncological patients continuity of care is assured by the integration of the activity of family doctors (mostly psychological and general support) with that of hospital specialists (mostly specific chemo-radiotherapy) through the DH, that enable the patients to remain at home

Protected discharge Unit of the Molinette Hospital

Patients treated in 2010 476 (median age (81+/- 9 years)

- 156 (32.8%) could return home
- 132 (27.7%) admitted to retirement homes
- 28 (5.9%) entrusted to social services
- 52 (10.9%) returned to hospital ward
- 89 (18.1%) died

“Hospital at home” service of the Molinette Hospital Multidisciplinary team:

4 geriatrics, 14 nurses, 1 nursing coordinator 1 advisor 1 social operator, 3 physiotherapists - patients treated in 2010 550 (median age 80 years – 20% older than 90 years

- median duration of hospitalisation at home 14 days
- 90% could be entrusted to their family doctors
- 4% moved to a retirement home
- 6% died

Protected discharge unit and hospital at home are both very useful tools for assisting

family doctors in assuring the continuity of care and for reducing the hospital costs the cost per day per patient in hospital at home is 145.00 Euros (as compared to about 1000,00 Euros for in-patient)

District Hospital of Savigliano

- Admission to hospital: about 30% f people aged more than 65 years every year
- Mean hospital stay 9,5 days
- 76% of patients need further treatment at home after discharge

Of these:

- 4% are treated in hospital at home
- 13% need integrated social and health services
- 83% are attended by their family doctors

For the continuity of care after discharge a digital programme has been designed that creates a shared data base accessible to everybody concerned

- It worked very well for patients entrusted to the integrated social and health service
- It did not work with family doctors because of the different organisation

A cultural change is needed for enabling family doctors to interact with hospital services

The Medigranda (family doctors group) experience

- 14 family doctors 3 nurses 2 social operators 2 physiotherapists 1 administrative clerk
- 22.500 people assisted 9.500 patients treated in 2010
- operating from 8 a.m. to 8 p.m., integrated by the night medical ward
- the clinical card of each patient is kept at his home in a folder including laboratory tests and radiological picture. Each doctors visiting the patient makes annotations in the card

This group assured effective continuity of care for all their patients discharged by hospital.
This seems to be the right way for assuring continuity of care
New cooperative groups of family doctors are being formed in different areas in Piedmont

Community geriatric unit of the University of Genéva

includes:

◎A mobile team of doctors, nurses, physiotherapists and social workers integrated by specialists when needed

◎A day hospital

◎About 500 patients treated in 2010（1/3 sent by family doctors, 1/3 by social services, 1/3 by hospital wards

◎Regular meetings of the unity staff and family doctors

◎Patients and doctor satisfaction very high – Continuity of care attained