



*Murcia,
donde vive el sol*

**XI Reunión de
Insuficiencia cardiaca**

27 Marzo 2.009



Atrapados en urgencias del Hospital Montecelo

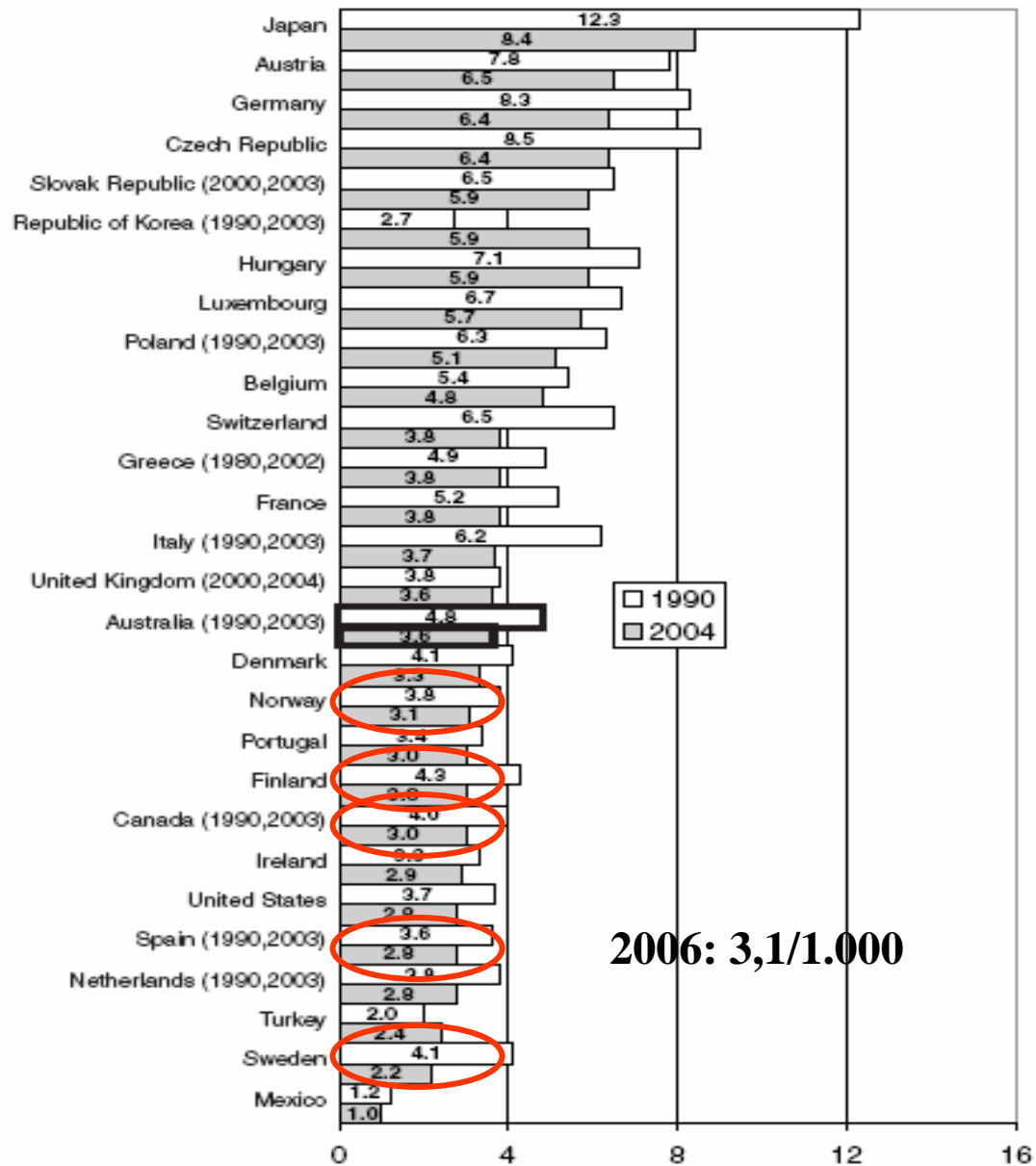
Los pacientes permanecen en la unidad hasta ocho días a la espera de habitación

Jaime Velázquez | 11/2/2008



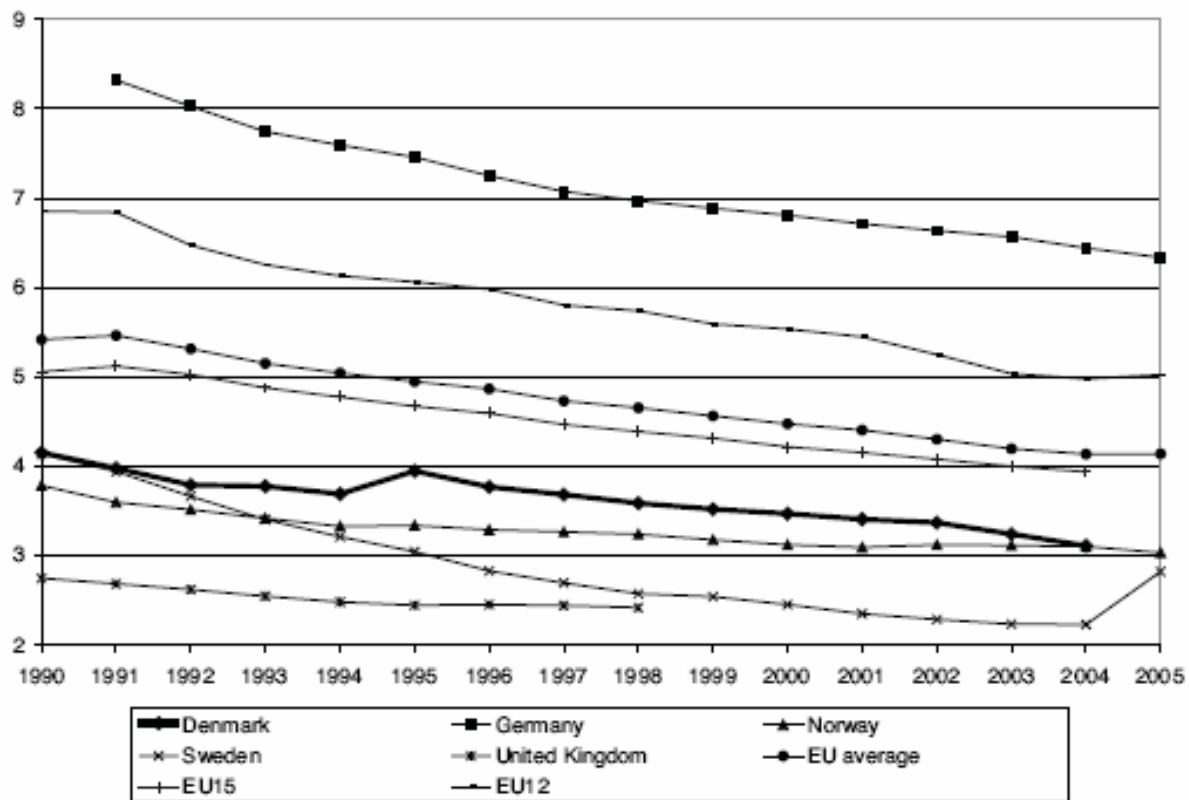


Fig. 5.1 Beds in acute hospitals per 1000 population in Australia and selected other countries, 1990–2004



Source: OECD Health data 2006.

Fig. 5.1 Beds in acute hospitals per 1000 population in Denmark, selected countries and EU averages, 1990–2005



Source: WHO Regional Office for Europe, January 2007.

Notes: EU: European Union; EU15: European Union Member States before May 2004; EU12: countries that joined the EU in May 2004 and January 2007.



Fig. 5.3 Number of physicians and nurses per 1000 inhabitants in Australia and western Europe, 2004 or latest available year (in parentheses)

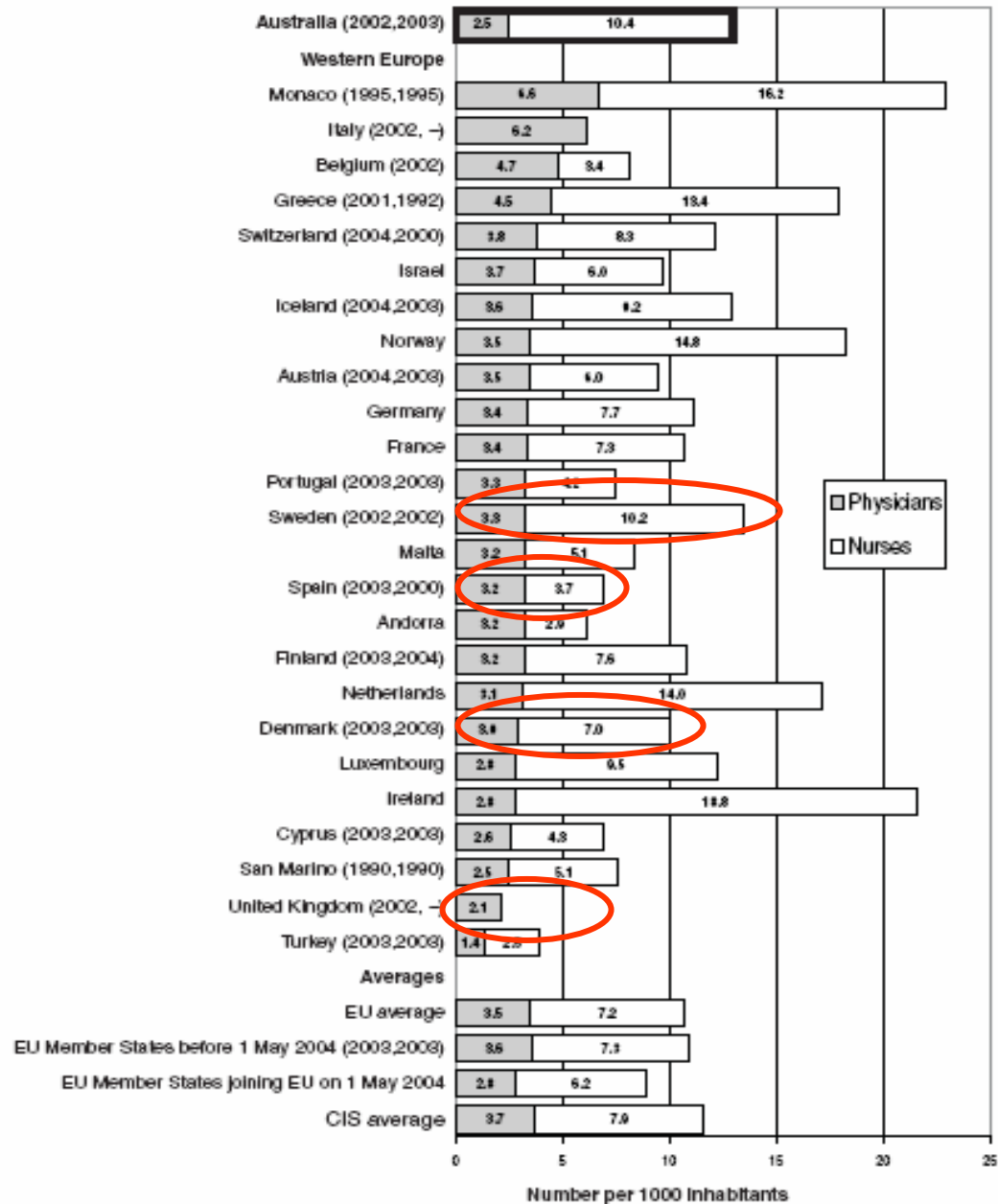
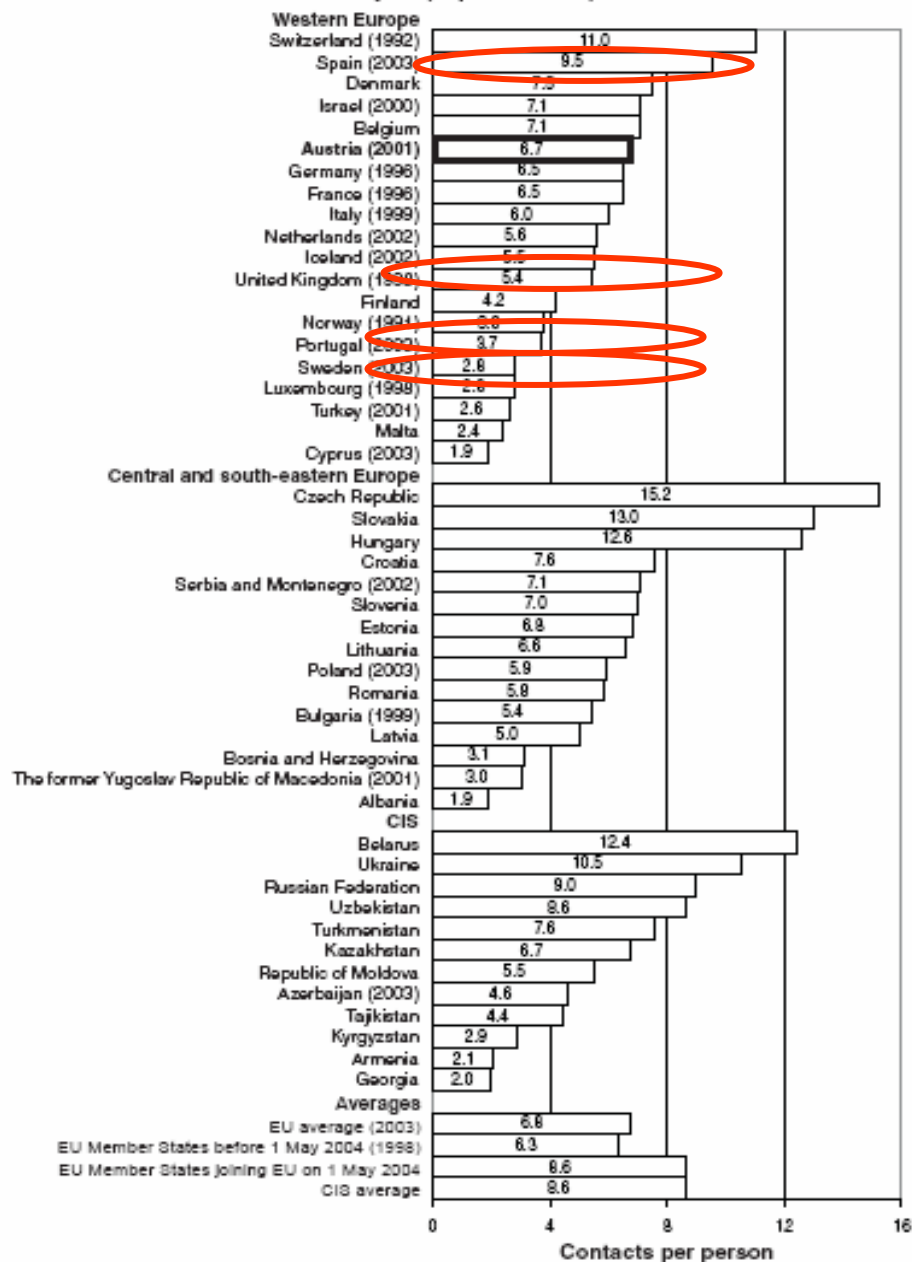




Fig. 4.2 Outpatient contacts per person in the WHO European Region, 2004 or latest available year (in parentheses)



Source: European Health for All database, June 2006 (9).

Notes: CIS: Commonwealth of Independent States; EU: European Union; countries without data not included.



Table 4.10 Inpatient utilization and performance in acute hospitals in the WHO European Region, 2004 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Andorra	2.1	10.0	6.7 ^a	70.0 ^a
Austria	6.0 ^a	28.8 ^a	6.4 ^a	76.2 ^a
Belgium	4.8	15.0 ^a	8.3 ^a	65.0 ^a
Cyprus	4.0 ^b	8.1 ^b	5.5 ^a	72.8 ^a
Denmark	3.2 ^a	17.8 ^a	3.6 ^a	84.0 ^a
Finland	2.2	10.0	4.2	74.0 ^a
France	3.8 ^a	16.6 ^a	6.1 ^a	84.0 ^a
Germany	6.4	20.4	8.7	75.5
Greece	3.8 ^b	14.5 ^b	6.4 ^a	68.6 ^b
Iceland	3.7 ^b	14.7 ^b	3.6 ^a	–
Ireland	2.0	14.1	6.5	65.4
Israel	2.1	17.3	4.2	98.0
Italy	3.8 ^a	15.2 ^b	6.8 ^a	76.9 ^a
Luxembourg	5.5 ^b	18.4	7.7 ^c	74.3 ^a
Malta	3.0	10.7	4.6	65.4
Monaco	15.5 ^c	–	–	–
Netherlands	3.1 ^a	8.8 ^b	7.4 ^a	58.4 ^a
Norway	3.1	17.3	5.2	86.4
Portugal	3.1 ^a	11.2 ^b	8.2 ^a	65.2 ^a
Spain	2.8 ^a	11.7 ^b	7.0 ^a	78.2 ^a
Sweden	2.2	15.1	6.1	77.5 ^a
Switzerland	3.0 ^b	16.3 ^b	9.0 ^b	85.2 ^a
Turkey	2.3	8.1 ^b	5.6 ^b	64.9
United Kingdom	2.4 ^a	21.4 ^b	5.0 ^a	80.8 ^a
Central and south-eastern Europe				
Albania	2.7	–	–	–
Bosnia and Herzegovina	3.3 ^b	7.2 ^b	9.8 ^b	62.6 ^b
Bulgaria	7.8 ^b	14.8 ^b	10.7 ^b	64.1 ^a
Croatia	3.8	14.6	8.2	80.0
Czech Republic	6.2	20.8	8.2	74.8
Estonia	4.3	17.2	6.2	68.4
Hungary	5.0	23.5	6.5	76.6
Latvia	5.4	18.8	–	–
Lithuania	6.1	21.0	7.0	77.4
Poland	4.7 ^b	–	–	–
Romania	4.4	–	–	–
Serbia and Montenegro	–	–	9.7 ^b	60.0 ^b
Slovakia	6.1	17.8	8.4	68.6
Slovenia	3.9	16.6	6.2	73.2
The former Yugoslav Republic of Macedonia	3.4 ^b	8.2 ^b	8.0 ^b	53.7 ^b
CIS				
Armenia	3.9	7.0	8.5	41.8
Azerbaijan	7.8 ^a	4.8 ^a	15.8 ^a	26.1 ^a
Belarus	–	–	–	88.7
Georgia	3.7	5.4	6.7	90.3
Kazakhstan	6.2	17.4	10.0	95.6
Kyrgyzstan	4.1	12.3 ^a	10.3	90.0
Republic of Moldova	5.2	15.4	7.8	62.0
Russian Federation	8.2	21.3	12.2	87.3
Tajikistan	5.7	10.2	12.0	58.1
Turkmenistan	3.8	13.3	7.9	81.8
Ukraine	7.1	20.0	11.0	91.2
Uzbekistan	4.5	14.2	–	86.5
EU average	4.2	17.5 ^b	6.9 ^a	77.5 ^a
EU Member States before 1 May 2004	4.0 ^a	18.0 ^b	6.9 ^a	77.0 ^a
EU Member States joining EU on 1 May 2004	5.2	20.6	7.4	73.8
CIS average	7.4	19.5	11.6	87.1

Source: European Health for All database, January 2008 (9).

Notes: ^a 2003; ^b 2002; ^c 2001; ^d 2000; ^e 1999; ^f 1998; ^g 1997; ^h 1996; ⁱ 1995; ^j 1994; CIS: Commonwealth of Independent States; EU: European Union.

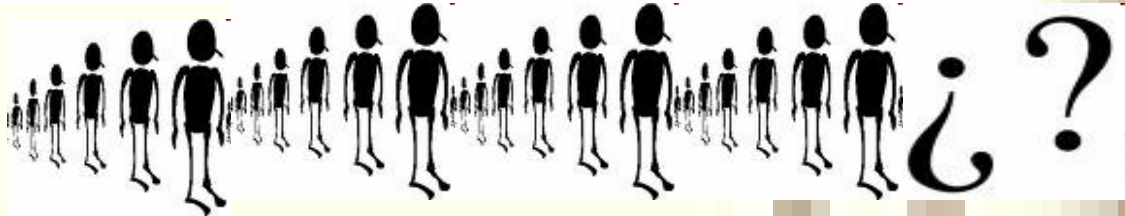


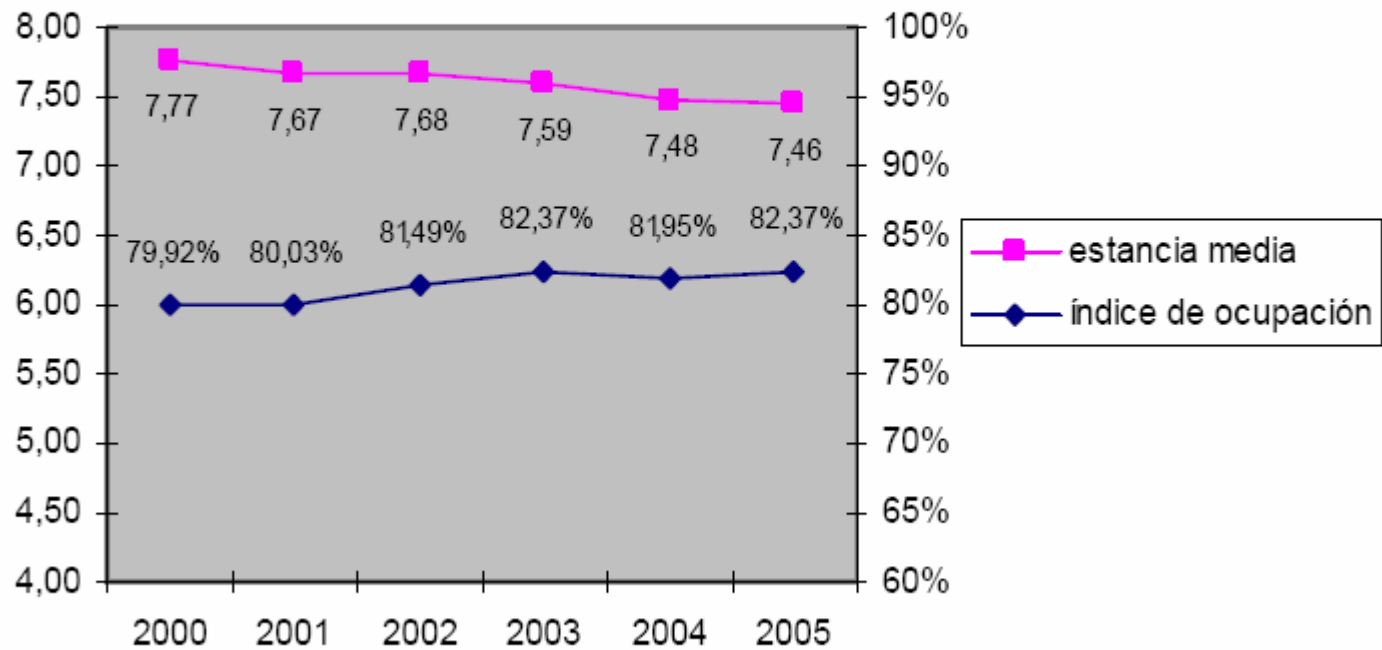
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France	3.8 ^a	16.8 ^a	6.1 ^a	84.0 ^a
Germany	6.4	20.4	8.7	75.5
Greece	3.8 ^a	14.8 ^a	6.4 ^a	68.6 ^a
Iceland	3.7 ^a	14.7 ^a	3.6 ^a	—
Ireland	2.0	14.1	6.5	85.4
Israel	2.1	17.3	4.2	98.0
Italy	3.6 ^a	15.2 ^a	6.8 ^a	76.9 ^a
Luxembourg	5.5 ^a	18.4	7.7 ^a	74.3 ^a
Malta	3.0	10.7	4.6	85.4
Monaco	15.5 ^a	—	—	—
Netherlands	3.1 ^a	8.8 ^a	7.4 ^a	58.4 ^a
Norway	3.1	17.3	5.2	86.4
Portugal	3.1 ^a	11.2 ^a	8.2 ^a	85.2 ^a
Spain	2.8 ^a	11.7 ^a	7.0 ^a	78.2 ^a
Sweden	2.2	15.1	6.1	77.5 ^a
Switzerland	3.9 ^a	16.3 ^a	9.0 ^a	85.2 ^a
Turkey	2.3	8.1 ^a	5.6 ^a	64.0
United Kingdom	2.4 ^a	21.4 ^a	5.0 ^a	80.8 ^a
Central and south-eastern Europe				
Albania	2.7	—	—	—
Bosnia and Herzegovina	3.3 ^a	7.2 ^a	9.8 ^a	62.6 ^a
Bulgaria	7.6 ^a	14.8 ^a	10.7 ^a	64.1 ^a
Croatia	3.6	14.6	8.2	89.0
Czech Republic	6.2	20.8	8.2	74.8
Estonia	4.3	17.2	6.2	68.4
Hungary	5.9	23.5	6.5	76.6
Latvia	5.4	18.8	—	—
Lithuania	6.1	21.0	7.9	77.4
Poland	4.7 ^a	—	—	—
Romania	4.4	—	—	—
Serbia and Montenegro	—	—	9.7 ^a	69.0 ^a
Slovakia	6.1	17.8	8.4	68.6
Slovenia	3.9	16.6	6.2	73.2
The former Yugoslav Republic of Macedonia	3.4 ^a	8.2 ^a	8.0 ^a	53.7 ^a
CIS				
Armenia	3.9	7.0	8.5	41.8
Azerbaijan	7.6 ^a	4.8 ^a	15.8 ^a	26.1 ^a
Belarus	—	—	—	88.7 ^a
Georgia	3.7	5.4	6.7	99.3
Kazakhstan	6.2	17.4	10.0	95.6
Kyrgyzstan	4.1	12.3 ^a	10.3	90.0
Republic of Moldova	5.2	15.4	7.8	62.9
Russian Federation	8.2	21.3	12.2	87.3
Tajikistan	5.7	10.2	12.0	58.1
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Ukraine	7.1	20.0	11.9	91.2
Uzbekistan	4.5	14.2	—	86.5
EU average	4.2	17.5 ^a	6.9 ^a	77.5 ^a
EU Member States before 1 May 2004	4.0 ^a	18.0 ^a	6.9 ^a	77.0 ^a
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Source: European Health for All database, January 2006 (9).

Notes: ^a 2003; ^b 2002; ^c 2001; ^d 2000; ^e 1999; ^f 1998; ^g 1997; ^h 1996; ⁱ 1995; ^j 1994; CIS: Commonwealth of Independent States; EU: European Union.

ACTIVIDAD HOSPITALES DE AGUDOS. PÚBLICOS



CA.5.1 HOSPITALES Y DATOS ASISTENCIALES. Año 2006

	EM	Hospitales	Camas en funcionamiento	Pacientes ingresados	Pacientes dados de alta	Estancias causadas	Consultas totales	Urgencias	Actos quirúrgicos	Determinaciones de laboratorio
Andalucía	7,1	95	19.953	794.793	795.442	5.689.835	12.107.292	4.974.758	759.385	224.975.135
Aragón	9,01	28	5.035	162.735	161.671	1.475.031	2.414.426	693.663	116.892	40.227.339
Asturias (Principado de)	8,5	20	3.838	132.495	131.317	1.130.966	2.023.744	487.775	84.490	20.095.746
Balears (Illes)	6,2	22	3.188	145.408	146.180	913.370	1.798.660	770.634	111.298	11.633.222
Canarias	9,4	39	7.083	222.005	214.954	2.089.413	3.354.189	923.605	154.207	35.652.027
Cantabria	10,5	9	2.039	62.077	62.037	656.189	841.694	368.517	44.380	12.270.654
Castilla-La Mancha	7,6	26	4.976	188.440	187.576	1.434.895	3.208.889	866.955	144.025	34.555.659
Castilla y León	9,3	39	9.862	300.112	298.601	2.812.542	4.045.478	1.071.094	207.170	52.112.629
Cataluña	9,6	179	30.428	954.704	939.210	9.245.537	11.028.482	4.612.909	833.083	71.710.309
Comunidad Valenciana	6,3	59	11.697	521.896	520.163	3.316.294	7.901.847	2.620.419	449.516	82.852.390
Extremadura	8,8	19	3.685	114.421	114.702	1.011.704	1.590.672	527.644	87.540	20.227.905
Galicia	9,1	46	9.886	321.743	321.229	2.953.688	4.927.404	1.366.837	255.917	55.699.570
Madrid	8,1	72	18.826	697.701	697.307	5.653.384	12.319.406	3.452.655	621.706	107.294.803
Murcia	8,1	26	4.223	150.598	151.149	1.222.622	2.119.972	933.232	125.804	32.491.892
Navarra (Comunidad Foral de)	7,1	13	2.128	81.066	81.002	577.142	1.009.991	276.738	65.867	7.223.908
País Vasco	8,1	45	8.049	292.105	290.138	2.388.131	2.343.085	1.099.874	224.104	33.945.205
La Rioja	8,2	5	950	30.235	29.723	248.905	602.204	136.437	22.935	5.015.430
Ceuta y Melilla (C. Autónoma)	5,9	4	375	14.588	14.418	86.846	193.845	116.698	8.037	2.714.134
TOTAL NACIONAL		746	146.221	5.187.122	5.156.819	42.906.494	73.831.280	25.300.444	4.316.356	850.697.957

Actividade asistencial. Servizo Galego de Saúde 2006-2007 **Táboa 9.26**

	2006	2007	Δ % 07/06
HOSPITALIZACIÓN			
Estadías	2.233.894	2.248.767	0,67
Ingresos	248.371	244.033	-1,75
Altas	248.335	244.036	-1,73
Ingresos por mil habs.	90,41	86,91	-3,87
Estadía media global	9,00	9,21	2,44
Estadía media materno-infantil	4,56	4,46	-2,19
% de ocupación	82,37	82,37	-
Índice de rotación	33,58	32,77	-2,41
CIRURXÍA			
Intervencións totais	184.290	183.165	-0,61
Intervencións con hospitalización	94.334	93.253	-1,15
Intervencións ambulatorias	89.956	89.912	-0,05
Intervencións CMA	34.549	35.580	2,98
Intervencións ambulatorias non CMA	55.407	54.332	-1,94
Intervencións por mil habs.	67,08	65,23	-2,76
% de intervencións ambulatorias	48,81	49,09	0,56
Estadía media preoperatoria	3,38	3,63	7,40
PARTOS			
Partos vaxinais	13.165	13.595	3,27
Partos por cesárea	4.870	4.728	-2,92
Taxa de cesáreas (%)	27,00	25,80	-4,44
CONSULTAS EXTERNAS			
Consultas totais (informatizadas e non informatizadas)	4.297.896	4.348.793	1,18
Primeiras consultas (informatizadas)	1.431.011	1.437.085	0,42
Consultas sucesivas (informatizadas)	2.553.004	2.629.875	3,01
Primeiras consultas (non informatizadas)	61.909	49.908	-19,38
Consultas totais (non informatizadas)	306.808	273.778	-10,77
Consultas sucesivas/primeiras	1,87	1,92	2,40
Consultas de preanestesia	107.202	121.938	13,75
Consultas por mil habs.	1.564,44	1.548,80	-1,00

Fonte:
SAACI-Agregación e
Peche 1.0 e CM
Hospitalización de
Agudos v0.7.
División de
Asistencia Sanitaria

Táboa 9.27 Actividade asistencial. C.H. Universitario Juan Canalejo 2006-2007

Fonte:
SAACI-Agregación y
Cierre 1.0 e CM
Hospitalización de
Agudos v0.7

	2006	2007	Δ% 07/06
HOSPITALIZACIÓN			
Estadías	426.738	418.379	- 1,96
Ingresos	45.894	43.088	- 6,11
Altas	45.881	43.025	- 6,22
Ingresos por mil habs.	91,31	84,77	- 7,17
Estadía media global	9,30	9,72	4,52
Estadía media materno-infantil	3,60	3,41	- 5,28
% de ocupación	77,39	75,74	- 2,13
Índice de rotación	31,18	28,84	- 7,50
CIRURXÍA			
Intervencións totais	35.297	34.691	- 1,72
Intervencións con hospitalización	15.801	15.329	- 2,99
Intervencións ambulatorias	19.496	19.362	- 0,69
Intervencións CMA	4.705	6.649	41,32
Intervencións ambulatorias non CMA	14.791	12.713	- 14,05
Intervencións por mil habs.	70,23	68,25	- 2,82
% de intervencións ambulatorias	55,23	55,81	1,05
Estadía media preoperatoria	5,13	5,58	8,77
PARTOS			
Partos vaxinais	2.350	2.339	- 0,47
Partos por cesárea	676	640	- 5,33
Taxa de cesáreas (%)	22,34	21,48	- 3,83
CONSULTAS EXTERNAS			
Consultas totais (informatizadas e non informatizadas)	701.938	701.278	- 0,09
Primeiras consultas (informatizadas)	236.295	232.919	- 1,43
Consultas sucesivas (informatizadas)	459.015	462.891	0,84
Primeiras consultas (non informatizadas)	3.241	2.733	- 15,67
Consultas totais (non informatizadas)	6.628	5.468	- 17,50
Consultas sucesivas/primeiras	1,93	1,98	2,36
Consultas de preanestesia	19.738	20.079	1,73
Consultas por mil habs.	1.396,63	1.379,63	- 1,22

Táboa 9.29 Actividade asistencial. C.H. Universitario de Santiago 2006-2007

Fonte:
SAACI-Agregación e
Peche 1.0 e CM
Hospitalización de
Agudos v0.7

	2006	2007	Δ% 07/06
HOSPITALIZACIÓN			
Estadías	357.831	352.930	- 1,37
Ingresos	36.208	34.897	- 3,62
Altas	36.207	34.953	- 3,46
Ingresos por mil habs.	92,67	88,87	- 4,11
Estadía media global	9,88	10,10	2,23
Estadía media materno-infantil	5,04	5,21	3,37
% de ocupación	88,40	86,58	- 2,06
Índice de rotación	33,28	31,72	- 4,67
Estadía media preoperatoria	3,98	4,57	14,82

Actividade asistencial. F.P. Hospital Virxe da Xunqueira 2006-2007 Táboa 9.28

Fonte:
SAACI-Agregación e
Peche 1.0 e CM
Hospitalización de
Agudos v0.7

	2006	2007	Δ% 07/06
HOSPITALIZACIÓN			
Estadías	20.504	21.254	3,66
Ingresos	2.972	3.070	3,30
Altas	2.995	3.049	1,80
Ingresos por mil habs.	68,67	71,44	4,04
Estadía media global	6,85	6,97	1,75
Estadía media preoperatoria	2,34	3,51	50,00

Táboa 9.33 Actividade asistencial. Hospital da Costa 2006-2007

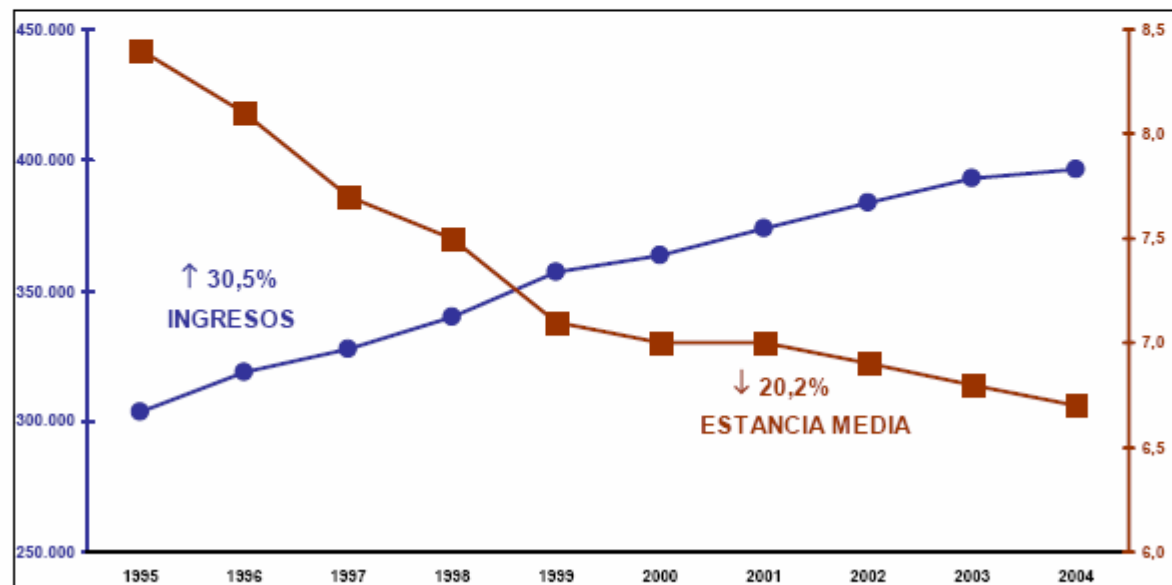
Fonte:
SAACI-Agregación e
Peche 1.0 e CM
Hospitalización de
Agudos v0.7

	2006	2007	Δ% 07/06
HOSPITALIZACIÓN			
Estadías	38.467	39.222	1,96
Ingresos	5.744	5.620	- 2,16
Altas	5.729	5.624	- 1,83
Ingresos por mil habs.	80,01	78,13	- 2,35
Estadía media global	6,71	6,97	3,87
Estadía media preoperatoria	1,52	1,53	0,66

Comunidad Valenciana

Actividad de hospitalización

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Ingresos	303.783	318.719	327.404	339.777	356.952	363.521	373.687	383.628	393.229	398.495
Núm. Estancias	2.551.777	2.581.624	2.521.011	2.548.328	2.534.359	2.544.647	2.615.809	2.647.033	2.673.957	2.658.517
Estancia Media	8,4	8,1	7,7	7,5	7,1	7,0	7,0	6,9	6,8	6,7



La estancia media se redujo un **20,2%** en el periodo 1995-2004 y un **1,5%** en 2004
El nº de ingresos aumentó un **30,5%** en el periodo 1995-2004 y un **0,8%** en el último año.

Año 2006

Hospital de Elche

	Cam. Func.	Internos	Ex. Progr.	Ex.Urg.	Tot. Ingr.	Urgen-cias	Estan-cias	Altas Total.	Volun-tarias	Trasla-dos	Exitos	Est. Media.	Ind. Ocup.
CRITICOS	24	528	6	766	1300	0	6746	191	0	63	122	5,2	84,3
QUIRURGICA	160	527	3670	2894	7091	9993	40249	6666	22	43,0	76,0	5,7	75,6
MEDICA	210	1195	846	9524	11565	94463	74442	10714	37	133	619	6,4	106,2
MATER-INF	64	160	266	4409	4835	27801	21097	4770	25	43	0	4,4	98,9
TOTAL	458,00		4788	17593	22381	132257	142533	22341	84	282	817	6,37	85,26

Evolución Histórica Hospital General Valencia

Concepto	2005	2006	2007	DIF 2007-2005	%
Camas Funcionales	590	569	560	-30	-5,08%
Estancias	170.266	166.442	164.953	-5313	-3,1%
Ingresos Urgentes	17.154	16.931	17.244	90	0,52%
Ingresos Programados	8.091	7.771	7.697	-394	-4,86%
Total Ingresos	25.245	24.702	24.941	-304	-1,20%
Estancia Média	6,70	6,70	6,60	-0,10	-1,49%
Indice de Ocupación	81,70%	80,1%	80,70%		-1,22%
Indice de Rotación	44,20	43,4	44,50	-0,3	-0,67%
Presión de Urgencias	68%	68,5%	69,10%		1,61%

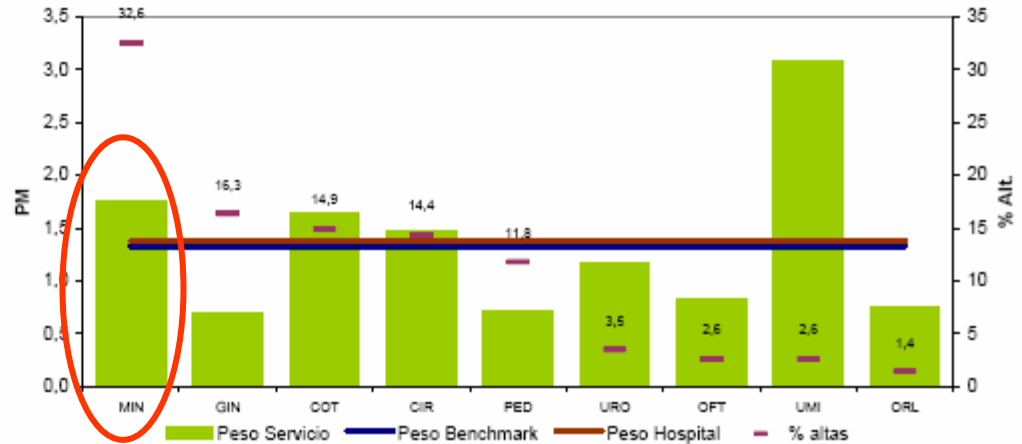
Evolución Casuística Hospitalización. CMBD (AP21) Hospital La Ribera, Alzira

	2004	2005	2006	2007
Nº Altas	19.564	20.526	20.943	21.900
Edad Media	49,7	50,3	50,3	50,9
Media Diagnósticos	4,19	4,40	4,40	4,80
Estancia Media	4,66	4,61	4,54	4,72
Peso Medio	1,6176	1,6249	1,6674	1,7199
Peso Total	31.647,38	33.353,05	34.920,57	37.665,56
Indice de Charlson (promedio)	0,82	0,90	0,91	1,02

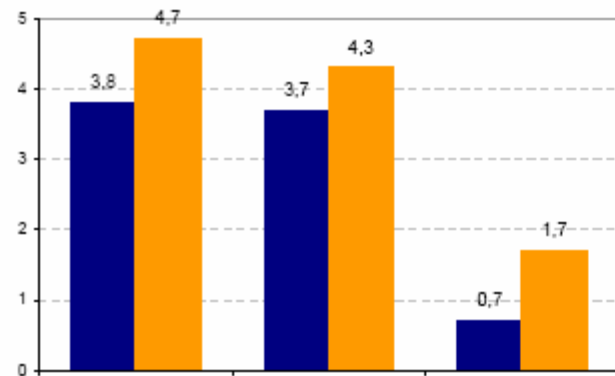
Perfil de la casuística

Hospital General de Requena

El peso medio de los servicios más importantes en cuanto a volumen de pacientes es el que se observa en el gráfico.

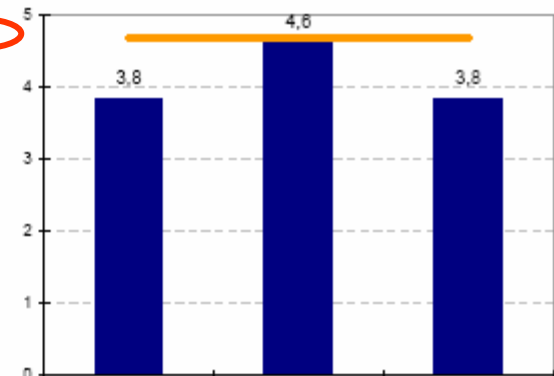


Funcionamiento



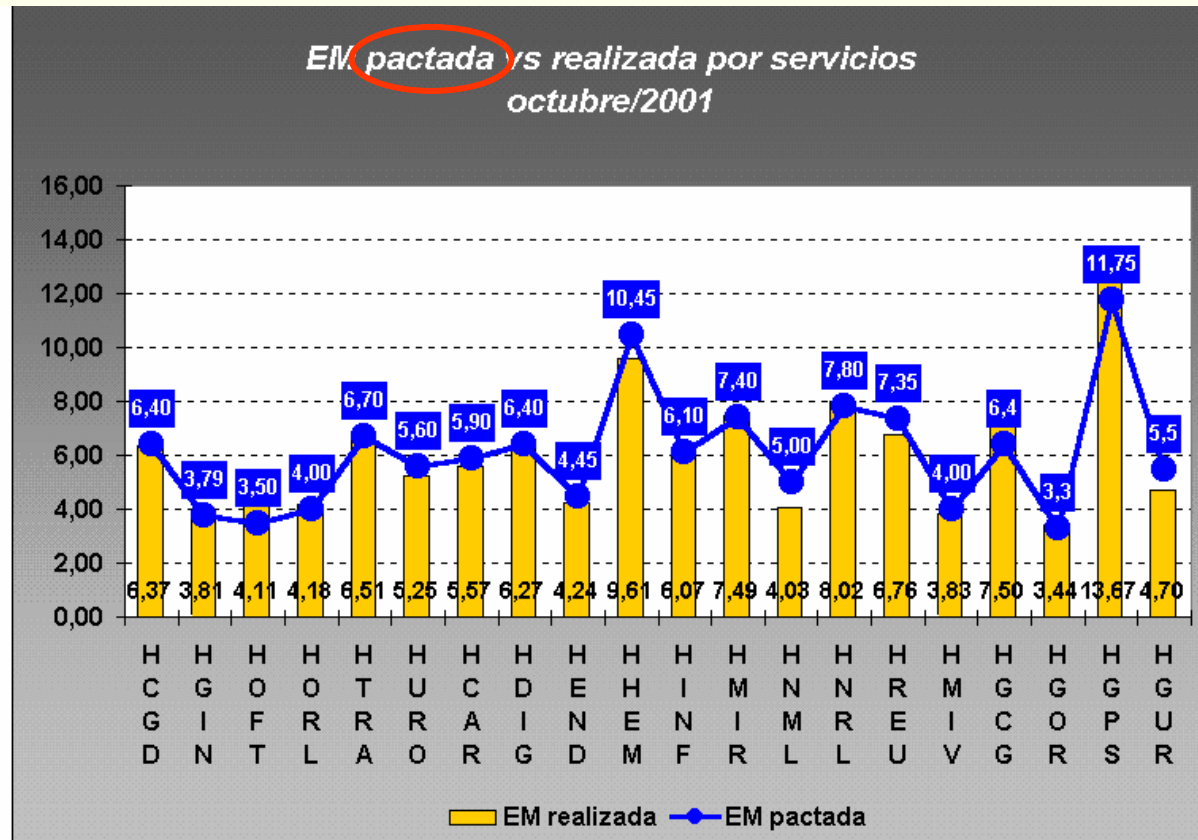
La estancia media bruta del Hospital es de **3,8** días, frente a los 4,7 días que presenta el Benchmark.

La razón de funcionamiento estándar 0,8332 nos indica una mayor eficiencia en la gestión de camas respecto a los hospitales que componen el Benchmark, tratando los dos igual casuística.



Comunidad Murcia

Hospital Universitario Virgen Arrixaca EM (2008) 6,86 días
Hospital General Universitario Reina Sofía EM (2005) 9 días



Hospital Moragues Meseguer

⇒ Complejidad paciente



⇒ Situación social para el alta

⇒ Complicaciones durante su estancia

⇒ Retraso en pruebas diagnósticas

⇒ Actitud del médico



Crear cultura de cambio



Procesos/Vías clínicas



Incentivar, comparar



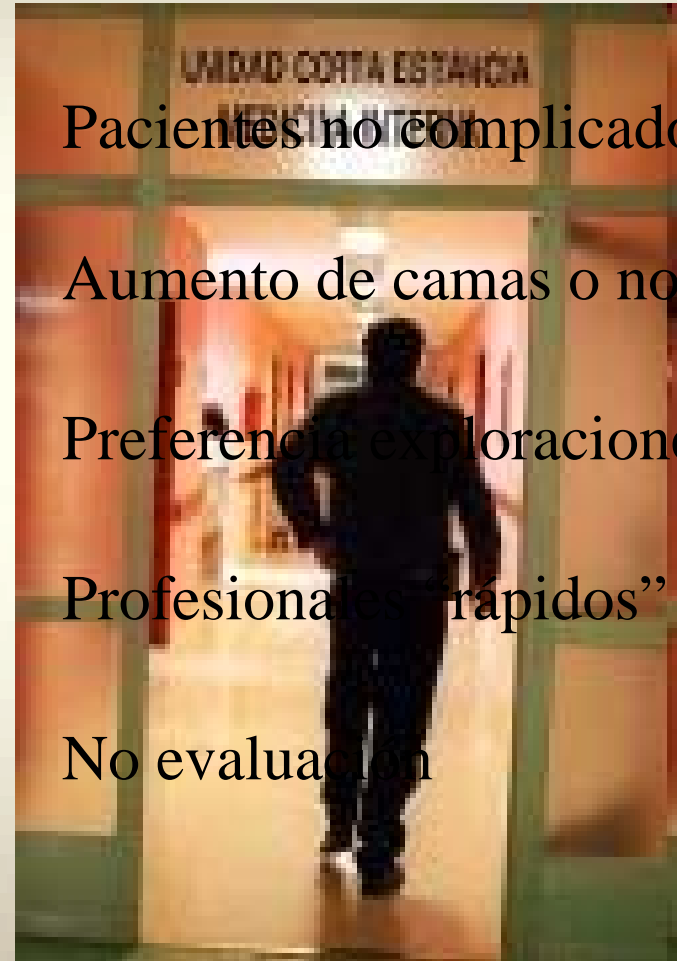
Calidad/Eficiencia



Coordinación Primaria



Evaluar resultados



Pacientes no complicados

Aumento de camas o no

Preferencia exploraciones o no

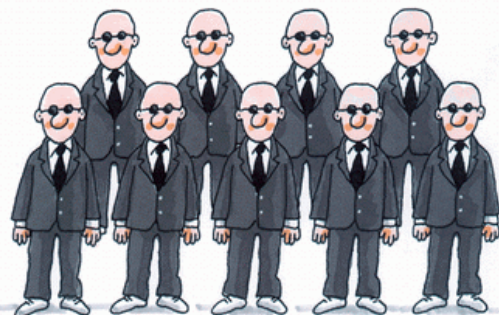
Profesionales "rápidos"

No evaluación

Unidad Médica de Corta Estancia

Muiño Miguez A. *Unidad Médica de Corta Estancia. An Med Interna (Madrid) 2002; 19: 219-220.*

Somos el cambio ...



Guillo
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Las Unidades Médicas de Corta Estancia nacen con la hipótesis de que la eficiencia y calidad de la atención a un paciente que no requiere una estancia hospitalaria prolongada, puede mejorar si es ingresado en una unidad diferenciada y con médicos familiarizados en la atención a pacientes de esas características, que no deban simultanear su atención con la de pacientes más complejos.

Entre los factores para el correcto funcionamiento de estas unidades, se ha destacado la importancia de una adecuada selección de los pacientes, que debería ser realizada por el mismo equipo que atiende la unidad; no utilizar la unidad para pacientes sin las características prefijadas, para lo que es fundamental un número de camas adecuado a las características del centro, y nunca superior; y tener organizado un sistema eficaz de seguimiento en consulta externa (14).

1: [Aust Health Rev.](#) 2007 Nov;31(4):633-41.

Can medical admission and length of stay be accurately predicted by emergency staff, patients or relatives?

[Dent AW](#), [Weiland TJ](#), [Vallender L](#), [Oettel NE](#).

Emergency Practice Innovation Centre, Department of Emergency Medicine, St. Vincent's Hospital, Melbourne, Melbourne, VIC.

OBJECTIVES: To determine the accuracy of predictions of the need for hospital admission and, if admitted, length of stay (LOS) made early in an emergency attendance by emergency department (ED) doctors, nurses, patients and relatives, and the characteristics of ED presentations predictive of admission and short stays (≤ 3 days). **METHODS:** Prospective collection of predictions by medical and nursing staff, patients and relatives of ED departure status and LOS (1 day, 2-3 days, 4-7 days or longer) of a convenience sample of adults presenting with medical symptoms. Predictions were made before full medical assessment and matched against actual departure status and LOS. Vital signs and demographics were recorded. **RESULTS:** Seventy five percent (2159/2904; CI 73%-77%) of all admission predictions in 704 patients were correct with 85% (575/673; CI 81%-88%) of doctors' predictions correct. Thirty-five percent (361/1024) of all LOS predictions for 331 patients were correct with 46% (122/268; CI 40%-52%) of doctors' predictions correct. Risk factors for short-stay over longer admission included age less than 65, normal oxygen saturations and self-referral. **CONCLUSION:** Emergency admissions can be predicted with reasonable accuracy but LOS is difficult to predict. Development of a prediction tool may facilitate streaming and appropriate use of short-stay units.

1: [Cochrane Database Syst Rev. 2004;\(1\):CD000313.](#)

Update of:

[Cochrane Database Syst Rev. 2000;\(4\):CD000313.](#)

Discharge planning from hospital to home.

[Shepperd S](#), [Parkes J](#), [McClaren J](#), [Phillips C](#).

Centre for Professional Development, Department of Continuing Education, University of Oxford, 16/17 St. Ebbes Street, Oxford, UK, OX1 1PT.

BACKGROUND: Discharge planning is a routine feature of health systems in many countries. The aim is to reduce hospital length of stay and unplanned readmission to hospital, and improve the co ordination of services following discharge from hospital thereby bridging the gap between hospital and place of discharge. Sometimes discharge planning is offered as part of an integrated package of care, which may cover both the hospital and community. The focus of this review is discharge planning that occurs while a patient is in hospital; we exclude studies that evaluate discharge planning with follow up care. OBJECTIVES: To determine the effectiveness of planning the discharge of patients moving from hospital. SEARCH STRATEGY: Relevant studies were identified using Medline, Embase, SIGLE database for grey literature, Bioethics database, Health Plan, Psych. Lit, Sociofile, CINAHL, Cochrane Library, Econ Lit, ... Social Science Citation Index, EPOC register. The review was updated using the EPOC trials... compared with those who received routine discharge. No statistically significant differences were reported for overall health care costs. REVIEWER'S CONCLUSIONS: The impact of discharge planning on readmission rates, hospital length of stay, health outcomes and cost is uncertain. This reflects a lack of power as the degree to which we could pool data was restricted by the different reported measures of outcome. It is possible that even a small reduction in length of stay, or readmission rate, could have an impact on the timeliness of subsequent admissions in a system where there is an shortage of acute hospital beds.

ORIGINAL BREVE

Adecuación de la hospitalización en una unidad de estancia corta de un hospital universitario. Un estudio controlado

Jaume Villalta^a, Antoni Sisó^b, Anna-Clara Cereijo^b, Ethel Sequeira^b y Alejandro de la Sierra^a

^aServei de Medicina Interna. Hospital Clínic. Facultat de Medicina. Universitat de Barcelona. Barcelona.

^bServei de Medicina Familiar i Comunitària. Hospital Clínic. Facultat de Medicina. Universitat de Barcelona. Barcelona. España.

TABLA 1

Estancias medias y estancias inadecuadas en ambos grupos de pacientes

	Grupo de estudio	Grupo control	p
Estancia media (días)	4 (2-5)	7 (5-8)	< 0,001
Estancias inadecuadas	87 (6,9%)	247 (18,7%)	< 0,001

La estancia media se expresa con la mediana (intervalo intercuartil).

TABLA 2

Causas de inadecuación de estancias hospitalarias

	Grupo de estudio (n = 352)	Grupo control (n = 203)	P
Retraso en exploraciones complementarias	12 (3,4%)	23 (11,3%)	< 0,001
Problemas sociofamiliares	10 (2,8%)	19 (9,4%)	0,001
Medicación innecesaria	24 (6,8%)	73 (36%)	< 0,001
Retraso en el alta	1 (0,3%)	8 (3,4%)	0,002
Cuidados de enfermería innecesarios	8 (2,3%)	17 (8,4%)	0,001
Atención médica conservadora	33 (9,4%)	84 (41,4%)	0,001

La atención médica conservadora se ha definido como la presencia de alguno de los 3 criterios siguientes: medicación innecesaria, retraso en el alta o cuidados de enfermería innecesarios.

Recomendaciones generales de admisión en UCE

- Procesos agudos o crónicos agudizados no graves
- Diagnóstico conocido
- Pocas exploraciones complementarias
- No problemas socio-familiares
- No deterioro funcional previo



Unidad Médica de Corta Estancia, una alternativa a la hospitalización convencional

R. Guirao Martínez^a, M. T. Sempere Selva^a, I. López Aguilera^a, M. P. Sendra Pina^a
y J. Sánchez Payá^b

^aUnidad Médica de Corta Estancia. Hospital General Universitario de Elche. Alicante. España.

^bServicio de Medicina Preventiva. Hospital General Universitario de Alicante. España.

TABLA 2
Características básicas de los pacientes atendidos en la Unidad Médica de Corta Estancia
según diagnóstico principal

	Sexo (%)			Edad, años	Estancia, días	Destino tras el alta (%)			
	N	Hombre	Mujer			Domicilio	UHD	Traslado hospital convencional	Otros
Infección respiratoria	1.297	46,3	53,7	74,7 ± 13,1	3,2 ± 1,4	81,4	8,6	8,9	1,1
EPOC	1.210	87,8	12,2	74,5 ± 9,0	3,4 ± 1,4	83,6	4,0	12,2	0,2
Anemia	737	52,8	47,2	67,4 ± 14,2	1,1 ± 0,3	96,9	0,7	2,1	0,3
Insuficiencia cardiaca	689	39,5	60,5	78,2 ± 8,6	3,1 ± 1,3	76,5	6,4	16,7	0,4
Gastroenteritis	512	44,3	55,7	53,5 ± 23,4	2,5 ± 1,2	95,7	0,4	3,7	0,2
Síndrome febril	455	48,6	51,4	75,3 ± 15,0	3,2 ± 1,4	58,2	16,5	24,4	0,9
Asma	250	22,8	77,2	56,2 ± 19,1	2,7 ± 1,3	90,0	3,6	6,4	0,0
Otras infecciones urinarias	233	47,2	52,8	75,0 ± 13,9	3,0 ± 1,3	82,0	9,4	8,2	0,4
PNA	127	7,9	92,1	39,2 ± 18,7	2,9 ± 1,0	88,2	1,6	10,2	0,0
Neumonía	120	50,0	50,0	76,5 ± 15,9	3,4 ± 1,5	49,2	21,6	22,5	6,7
HDA	77	64,9	35,1	56,5 ± 23,1	2,3 ± 1,2	76,6	6,5	15,6	1,3
Insuficiencia respiratoria	69	34,8	65,2	76,2 ± 13,0	3,2 ± 1,3	56,5	21,7	18,9	2,9
Diabetes mellitus	60	50,0	50,0	61,0 ± 20,9	2,3 ± 1,3	71,6	11,7	15,0	1,7
Cardiopatía isquémica	60	53,3	46,7	78,9 ± 6,7	2,2 ± 1,2	45,0	0,0	55,0	0,0
Demencia	56	39,3	60,7	82,2 ± 8,1	2,9 ± 1,5	60,7	10,7	23,2	5,4
Fibrilación auricular	46	37,0	63,0	77,3 ± 8,2	2,5 ± 1,1	82,6	6,5	10,9	0,0
Deshidratación	30	46,7	53,3	85,3 ± 6,3	3,1 ± 1,4	66,7	23,3	6,7	3,3
Otros diagnósticos	1.590	52,3	47,7	69,8 ± 17,7	2,2 ± 1,4	70,4	7,8	19,5	2,3
Total	7.618	52,9	47,1	70,6 ± 16,9	2,7 ± 1,4	79,1	6,7	13,1	1,1

EPOC: enfermedad pulmonar obstructiva crónica; HDA: hemorragia digestiva alta; PNA: pielonefritis; UHD: Unidad de Hospitalización a Domicilio; UMCE: Unidad Médica de Corta Estancia.

Short-Stay Respiratory Unit: A New Option for Inpatient Care

Joan Maria Broquetas,^{a,b,c} Roser Pedreny,^a Juana María Martínez-Llorens,^a Jacobo Sellarés,^a and Joaquim Gea^{a,c}

^aServicio de Neumología, Hospital del Mar-IMIM, Barcelona, Spain

^bUniversitat Autònoma de Barcelona, Barcelona, Spain

^cCIBER de Enfermedades Respiratorias, ISCIII, Ministerio de Sanidad, Spain. Universitat Pompeu-Fabra, Barcelona, Spain

Alta Productividad

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MENUDOPASTEL



TABLE 2
Description of the Impact of the Short-Stay Respiratory Medicine Unit on the Respiratory Medicine Department as a Whole^a

	Before Opening the Short-Stay Respiratory Medicine Unit	After Opening the Unit ^b	P
Hospital admissions, no.	547	531	
Age, mean (SD), y	74 (12)	147 (79% men) 76 (12) 64 (17) ^c	NS
Hospital stay, d	6.471	4.419 4.82 (1.1) ^c	<.001
Length of stay, mean (SD), d	11.8 (4.6)	8.3 (2.6) 3.3 (1.6) ^c	<.001
Occupancy rate, %	120.4	82.2 67.1	<.001
Disease complexity	1.0473	1.1443 0.8608	<.001
Readmissions, %	21	15 2.7	<.05
Mortality, %	3.0	3.1 0	NS

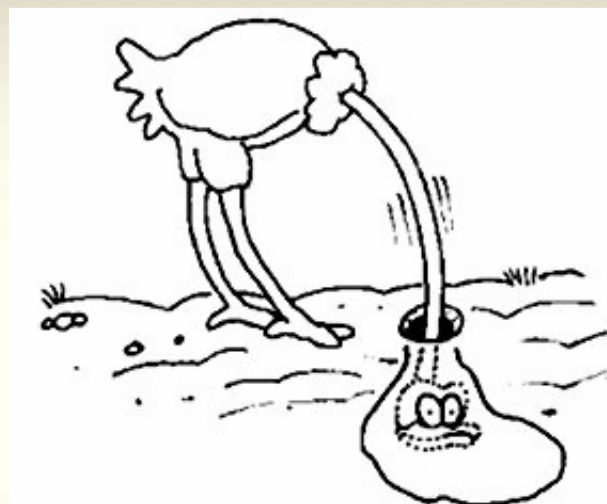
Abbreviation: NS, not significant.

^aData are means (SD) or number (%) unless otherwise indicated.

^bFigures for the short-stay respiratory medicine unit are given in italics.

Admission Criteria for Short-Stay Respiratory Medicine Unit

1. General exclusion criteria (high risk of readmission)
 - Member of a dysfunctional family
 - Dependency or age >80 y
 - Absence of diagnosis
 - ≥4 serious concomitant diseases
 - Associated psychiatric condition
2. Disease-specific admission criteria
 - 2.1. Chronic obstructive pulmonary disease
 - Inclusion criteria
 - FEV₁ >35% predicted
 - Exacerbation without severe symptoms such as pneumonia, cor pulmonale, arrhythmia, respiratory acidosis (pH <7.35), marked tachypnea (>35 breaths/min)
 - Exclusion criteria
 - Chronic respiratory failure treated with home ventilation
 - Cachexia
 - ≥2 admissions in past year
 - Colonization by multidrug-resistant bacteria
 - 2.2. Asthma
 - Inclusion criteria
 - Unstable clinical condition after 12 h of intensive treatment
 - Respiratory failure
 - Peak expiratory flow <300 mL/min
 - Exclusion criteria
 - Near-fatal asthma
 - History of orotracheal intubation
 - Corticosteroid dependency
 - 2.3. Pneumonia
 - Inclusion criteria
 - Pneumonia severity index II-IIIa
 - Exclusion criteria
 - Human immunodeficiency virus positivity
 - Decompensated chronic disease
 - Associated pleural effusion
 - 2.4. Lung cancer
 - Inclusion criteria
 - Clinical suspicion of lung cancer
 - Exclusion criteria
 - Pneumothorax or massive hemoptysis



The main differences between our short-stay respiratory medicine unit and general medical short-stay units in our setting are related to mortality and, above all, readmission rates, which have been seen to be as high as 30% in the latter.^{16,21,23} Another difference is that a considerable number of patients admitted to short-stay general medical units need to complete their treatment on conventional hospital wards.^{17,24} It is difficult to compare prognostic factors for inappropriate stay in this study with those reported by other authors as only a few analyzed social factors. We believe that appropriate triage is essential.¹⁶ The fact that a pulmonologist supervised the admission of patients in our case may have contributed to the success of the unit as it is known that health care is more efficient when managed by a specialist.^{9,10}

□ 1: [Eur J Intern Med.](#) 2008 May;19(3):198-202. Epub 2007 Oct 26.

Admission characteristics predicting longer length of stay among elderly patients hospitalized for decompensated heart failure.

[Formiga F](#), [Chivite D](#), [Manito N](#), [Mestre AR](#), [Llopis F](#), [Pujol R](#).

Geriatric Unit, Internal Medicine Service, Hospital Universitari de Bellvitge, L'Hospitalet de Llobregat 08907, Barcelona, Spain. fformiga@csub.scs.es

BACKGROUND: Acutely decompensated heart failure (HF) has become the leading cause of hospitalization for people aged 65 or older. Hospital length of stay (LOS) is a key determinant of higher hospitals costs. The aim of our study is to identify the admission characteristics that predict a longer LOS for elderly patients admitted for an acute exacerbation of HF. METHODS: We prospectively evaluated 324 patients (65 years of age or older), who were consecutively admitted for decompensated HF to a tertiary teaching hospital. Variables present at the time of emergency room evaluation that could predict a longer hospital LOS were determined by comparing the characteristics of patients hospitalized for less than 4 days with those of patients needing a longer stay. RESULTS: There were 191 women (59%) and 133 men in the study, with an average age of 78.6 years and a mean LOS of 7.1 days. Multivariate regression models identified two independent predictors of a hospital stay longer than four days: female gender ($p=0.03$, OR 1.645, 95% CI 1.047-2.584) and poorer NYHA functional class ($p<0.01$, OR 1.699, 95% CI 1.135-2.542). CONCLUSION: In elderly patients admitted for decompensated HF, the female gender and a worse functional class at the time of admission were associated with a longer subsequent LOS.



Memòria 2008

avançament

Hospital Universitari de Bellvitge

1r, 2n, 3r i 4t trimestre

- Total any 2007
- Total any 2008

Hospitalització

	Total any 2007	Total any 2008
Ingressos totals	32.560	33.372
Estades a l'alta	249.638	226.625
Pressió d'urgències	50,2%	49,0%
Estada mitjana	8,0	7,9
Índex d'ocupació	83,2%	85,6

LINEES ESTRATÈGIQUES

Activitat assistencial

1. Hospitalització:

	2006	2007
Lits disponibles	38,0	37,4
Ingressos totals	1.494	1.668
Programats	160	159
Urgents	1.220	1.383
Trasllats	114	126
Pressió d'urgències	88,4	89,7
Estada mitjana dels episodis	9,8	10,0
Defuncions	201	235
Índex d'ocupació	109,4	128,2

Activitat per grups relacionats pel diagnòstic (GRD) **Bellvitge**

GRD	Altes	Estades totals	EM bruta	% extrems	EM depurada
127 - Insuficiència cardíaca i xoc	178	1.443	8,1	4,5	7,3
544 - Insuf. cardíaca cong. i arítmia a/CC major	149	1.699	11,4	10,1	7,8
541 - Trast. respir. exc. infec./bronq./asma a/CC major	124	931	7,5	4,8	5,9
189 - Altres diagnòstics aparell digestiu >17a s/CC	62	98	1,6	-	1,6
082 - Neoplàsies respiratòries	60	573	9,6	5,0	8,0
751 - Abús/dependència alcohol s/CC	54	526	9,7	-	9,7

Servicio: **MED.INTERNA Requena**

GRD	CDM	T	DESCRIPCIÓN	Hospital		Estándar	Dif.EM	Impacto
				N	EM	EM		
541	04	M	TR RESPIRAT #INFECC/BRONQUITIS/ASMA,C/CC MAYOR	189	5,7	6,8	-1,1	-216
533	01	M	OTRO TR NERV. #AIT/CONVULS/CEFALEA, C/CC MAYOR	24	5,3	9,0	-3,8	-90
014	01	M	ICTUS CON INFARTO	62	5,0	6,1	-1,1	-69
078	04	M	EMBOLISMO PULMONAR	17	4,2	7,8	-3,5	-60
127	05	M	FALLO CARDIACO Y SHOCK	37	4,1	5,4	-1,3	-49
478	05	Q	OTRAS INTERVENCIONES VASCULARES CON CC	10	4,8	9,1	-4,3	-43
543	05	M	TR.CIRCULAT #IAM/I.CARD.CR./ARRITM, C/CC MAYOR	21	5,0	6,6	-1,6	-33
124	05	M	TR.CIRCUL.#IAM, C/CATETERISMO,C/DIAGN.COMPLIC.	15	3,4	5,6	-2,2	-33
584	18	M	SEPTICEMIA CON CC MAYORES	10	5,2	8,3	-3,1	-31
140	05	M	ANGOR PECTORIS	50	4,0	4,6	-0,6	-30
175	06	M	HEMORRAGIA GASTROINTESTINAL, SIN CC.	32	2,8	3,7	-0,9	-29
126	05	M	ENDOCARDITIS AGUDA Y SUBAGUDA	2	6,0	20,3	-14,3	-29
082	04	M	NEOPLASIAS RESPIRATORIAS	13	3,7	5,9	-2,2	-28
544	05	M	INSUF CARDIACA CRONICA / ARRITMIA C/CC MAYOR	25	5,8	6,7	-0,9	-23

What Works In Chronic Care Management: The Case Of Heart Failure

Multidisciplinary provider teams with in-person communication lead to fewer hospital readmissions for people with heart failure.

by Julie Sochalski, Tiny Jaarsma, Harlan M. Krumholz, Ann Laramee, John J.V. McMurray, Mary D. Naylor, Michael W. Rich, Barbara Riegel, and Simon Stewart

ABSTRACT: The evidence base of what works in chronic care management programs is underdeveloped. To fill the gap, we pooled and reanalyzed data from ten randomized clinical trials of heart failure care management programs to discern how program delivery methods contribute to patient outcomes. We found that patients enrolled in programs using multidisciplinary teams and in programs using in-person communication had significantly fewer hospital readmissions and readmission days than routine care patients had. Our study offers policymakers and health plan administrators important guideposts for developing an evidence base on which to build effective policy and programmatic initiatives for chronic care management. [*Health Affairs* 28, no. 1 (2009): 179–189; 10.1377/hlthaff.28.1.179]

EXHIBIT 3
Percentage Reduction In All-Cause Hospital Readmissions And Hospital Readmission Days Per Month Associated With Delivery Personnel And Method Of Communication In Chronic Care Management Programs

	Percent reduction in readmissions per month	Percent reduction in readmission days per month
Delivery personnel		
Single heart failure expert	0.9	2.6
Multidisciplinary team	2.9****	6.4****
Method of communication		
Telephonic	0.4	1.5
In-person	2.5****	5.7****
Delivery + communication		
Single expert + telephonic	0.4	1.5
Single expert + in-person	1.8 ^a	4.3 ^b
Team + in-person	2.9****	6.4****

SOURCE: Authors' analysis.

NOTES: Figures in the exhibit represent authors' conversion of log-transformed regression coefficients from linear mixed-model regressions adjusted for age, sex, history of hypertension, prior heart attack, and original trial. Routine care patients are the reference group in each comparison. N = 2,028.

^ap = 0.05.

^bp = 0.06.

****p < 0.001

¡¡GRACIAS!!

