
SEMI
LA VISIÓN GLOBAL DE LA PERSONA ENFERMA
XXXV
Congreso Nacional de la Sociedad Española de Medicina Interna (SEMI)
IV Congreso Ibérico de Medicina Interna
II Congreso de la Sociedad de Medicina Interna de la Región de Murcia
Sociedad Murciana de Medicina Interna
SMI
19-21 de Noviembre de 2014
Auditorio y Centro de Congresos Víctor Villegas. Murcia

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19-21 Noviembre 2014
Auditorio y Centro de Congresos Víctor Villegas
Murcia

"MESA REDONDA 21: GESTIONANDO LA EFICIENCIA"

Cuidados tras hospitalización

Dr. Jesús Canora Lebrato
Servicio de Medicina Interna
Hospital Universitario de Fuenlabrada. Madrid

Lo que cuenta es lo que se hace y no lo que se tenía intención de hacer.
Picasso 1923

Informe de alta

- ☑ Diagnóstico principal
- ☑ Diagnósticos secundarios
- ☑ Procedimientos
- ☑ Tratamiento al alta
  - ~ Dosis, pauta, vía de administración, duración del tratamiento
- ☒ Medidas sobre estilo de vida
- ☒ Actividades no recomendadas
- ☑ Citas al alta (con fecha)
- ☒ Consejos para familiares
- ☒ Recomendaciones ante posibles eventualidades

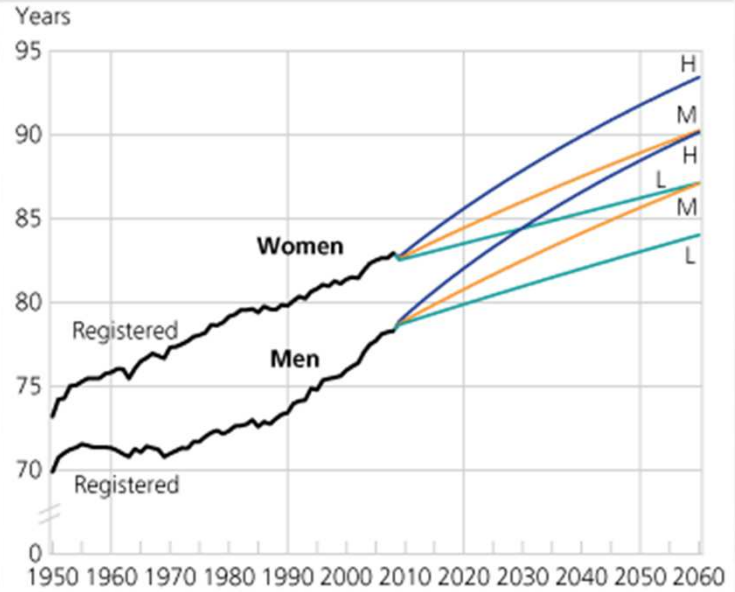
☒ FEEDBACK DEL PACIENTE

CONTEXTO 1

Population by age and sex in 2060

HHMH: High fertility, high life expectancy, medium internal migration and high net migration
MMMM: Medium fertility, medium life expectancy, medium internal migration and medium net migration
LLML: Low fertility, low life expectancy, medium internal migration and low net migration

Life expectancy at birth



H: High life expectancy
M: Medium life expectancy
L: Low life expectancy

Statistisk sentralbyrå
Statistics Norway

CONTEXTO 2

- Necesidad creciente de camas hospitalarias
- Incremento de hasta 62% para el 2050

CONTEXTO 3

Satisfacer sus necesidades

Conseguir la recuperación

Recuperar la confianza

Mantener la independencia

¿Qué buscan los pacientes tras el alta?

CONTEXTO 4

Altas complejas:

Necesidad de:

cuidados sociales o comunitarios
cuidados intermedios
de institucionalización

Altas sencillas

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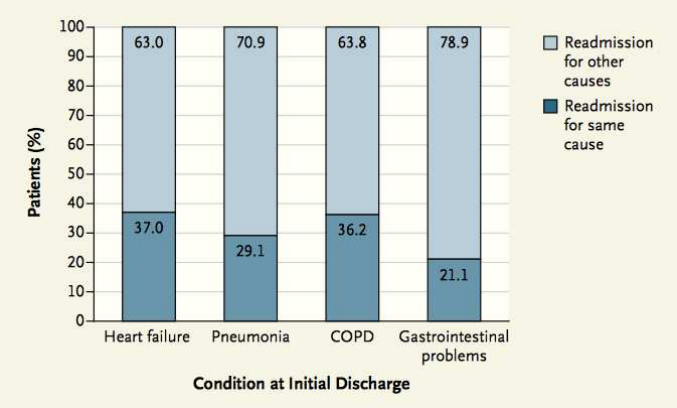
The NEW ENGLAND JOURNAL of MEDICINE

Post-Hospital Syndrome — An Acquired, Transient Condition of Generalized Risk

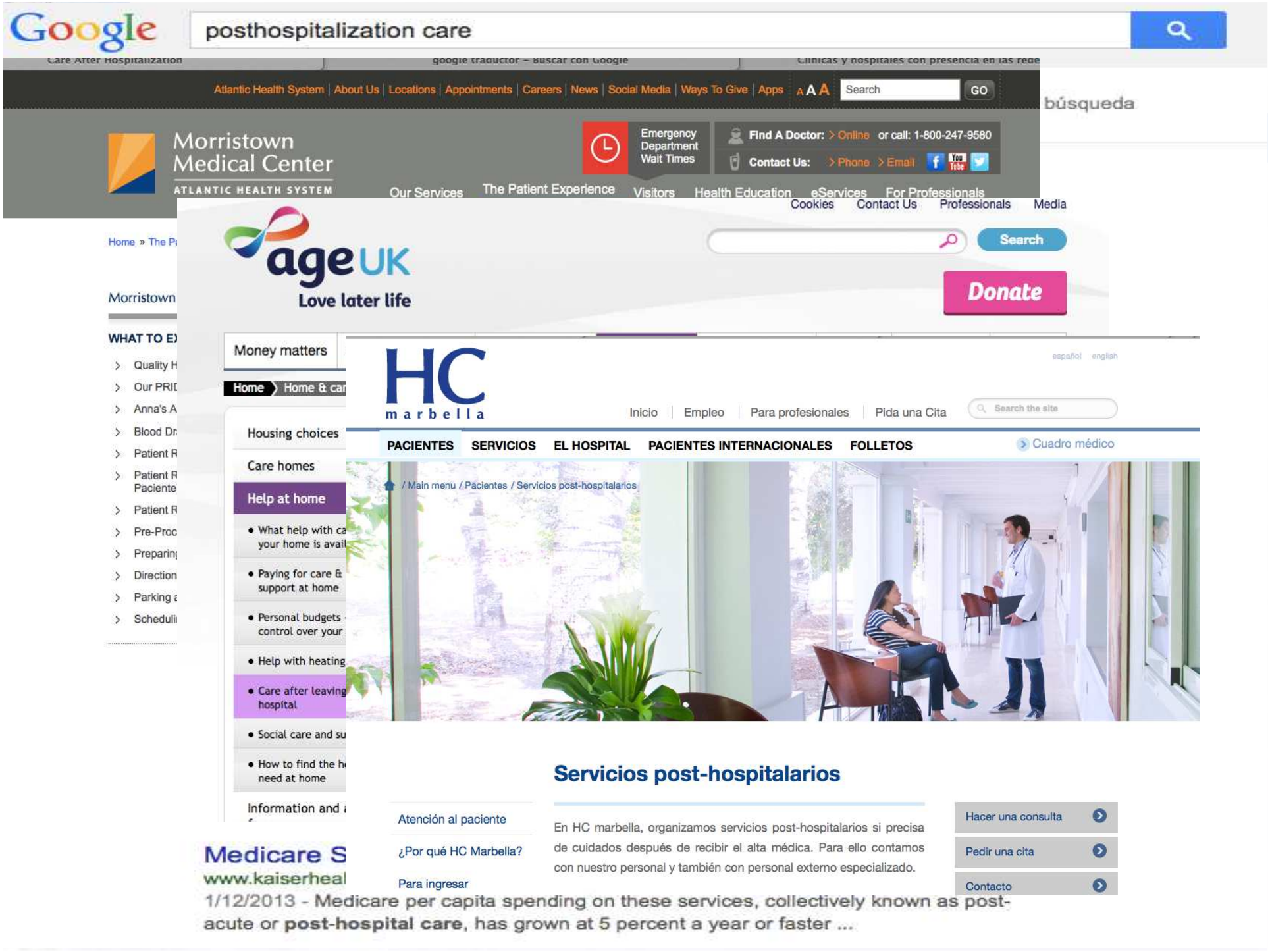
Harlan M. Krumholz, M.D.

N ENGL J MED 368;2 NEJM.ORG JANUARY 10, 2013

- 1 de cada 5 pacientes ingresados tendrá un problema de salud en los siguientes 30 días del alta que en ocasiones requerirá reingreso
- La mayoría de las veces sin relación con la causa del ingreso inicial
- Trastornos del sueño, alteraciones nutricionales, mal manejo del dolor, exceso de medicamentos (benzodiacepinas), síndrome confusional, pérdida de movilidad



Comprehensive strategies for mitigating post-hospital syndrome and its accompanying risks might begin with efforts to target the stressors that probably contribute to vulnerability in patients soon after discharge.


Google
posthospitalization care
Care After Hospitalization
google traductor – buscar con Google
Clínicas y hospitales con presencia en las rede
Atlantic Health System | About Us | Locations | Appointments | Careers | News | Social Media | Ways To Give | Apps
A A A
Search
GO
búsqueda
Morristown Medical Center
ATLANTIC HEALTH SYSTEM
Emergency Department Wait Times
Find A Doctor: > Online or call: 1-800-247-9580
Contact Us: > Phone > Email
Our Services
The Patient Experience
Visitors
Health Education
eServices
For Professionals
Cookies
Contact Us
Professionals
Media
Home » The Pa
Morristown
WHAT TO EX
Quality H
Our PRID
Anna's A
Blood Dr
Patient R
Patient R Paciente
Patient R
Pre-Proc
Preparin
Direction
Parking a
Schedul
ageUK
Love later life
Search
Donate
Money matters
Home
Home & car
Housing choices
Care homes
Help at home
What help with ca your home is avail
Paying for care & support at home
Personal budgets control over your
Help with heating
Care after leaving hospital
Social care and su
How to find the h need at home
Information and a
HC marbella
español english
Inicio | Empleo | Para profesionales | Pida una Cita
Search the site
PACIENTES
SERVICIOS
EL HOSPITAL
PACIENTES INTERNACIONALES
FOLLETOS
Cuadro médico
/ Main menu / Pacientes / Servicios post-hospitalarios
Servicios post-hospitalarios
Atención al paciente
¿Por qué HC Marbella?
Para ingresar
En HC marbella, organizamos servicios post-hospitalarios si precisa de cuidados después de recibir el alta médica. Para ello contamos con nuestro personal y también con personal externo especializado.
Hacer una consulta
Pedir una cita
Contacto
Medicare S
www.kaiserheal
1/12/2013 - Medicare per capita spending on these services, collectively known as post-acute or post-hospital care, has grown at 5 percent a year or faster ...

Future Hospital Commission

'The patient must be the first priority in all of what the NHS does. Within available resources they must receive effective services from caring compassionate and committed staff working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.'

(Robert Francis QC)[1]

'Patient safety should be the ever-present concern of every person working in or affecting NHS-funded care. The quality of patient care should come before all other considerations in leadership and conduct of the NHS, and patient safety is the keystone dimension of quality.'

(Don Berwick, 2013)[2]

Future hospital: Caring for medical patients

A report from the Future Hospital Commission to the Royal College of Physicians

September 2013

Sir Michael Rawins, chairman of the National Institute for Health and Clinical Excellence (NICE).

Royal College of Physicians

Future Hospital Commission

Future hospital: Caring for medical patients

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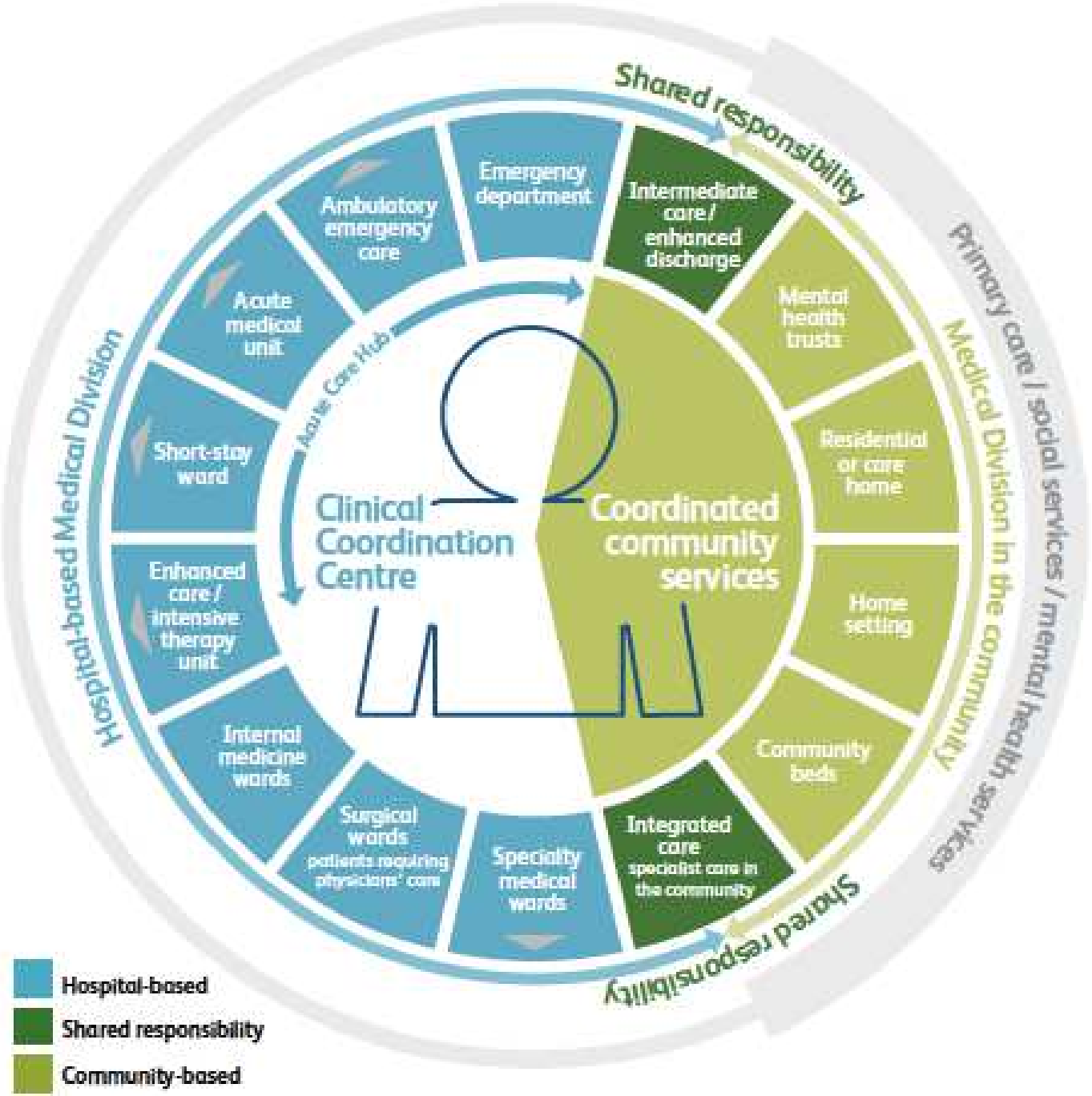
September 2013



BMJ

BMJ 2013;347:f7171 doi: 10.1136/bmj.f7171 (Published 16 December 2013)

RESEARCH

Causes and patterns of readmissions in patients with common comorbidities: retrospective cohort study

Jacques Donzé *research associate*[1 2 3], Stuart Lipsitz *professor*[1 2], David W Bates *professor*[1 2 4], Jeffrey L Schnipper *associate professor*[1 2 5]

Conclusions

By providing a description of primary diagnoses and patterns of readmissions for patients with common comorbidities, our study supports the need for post-discharge care to focus attention not just on the primary index hospital admission diagnosis but also on the underlying comorbidities that may cause acute new complications that lead to readmission.

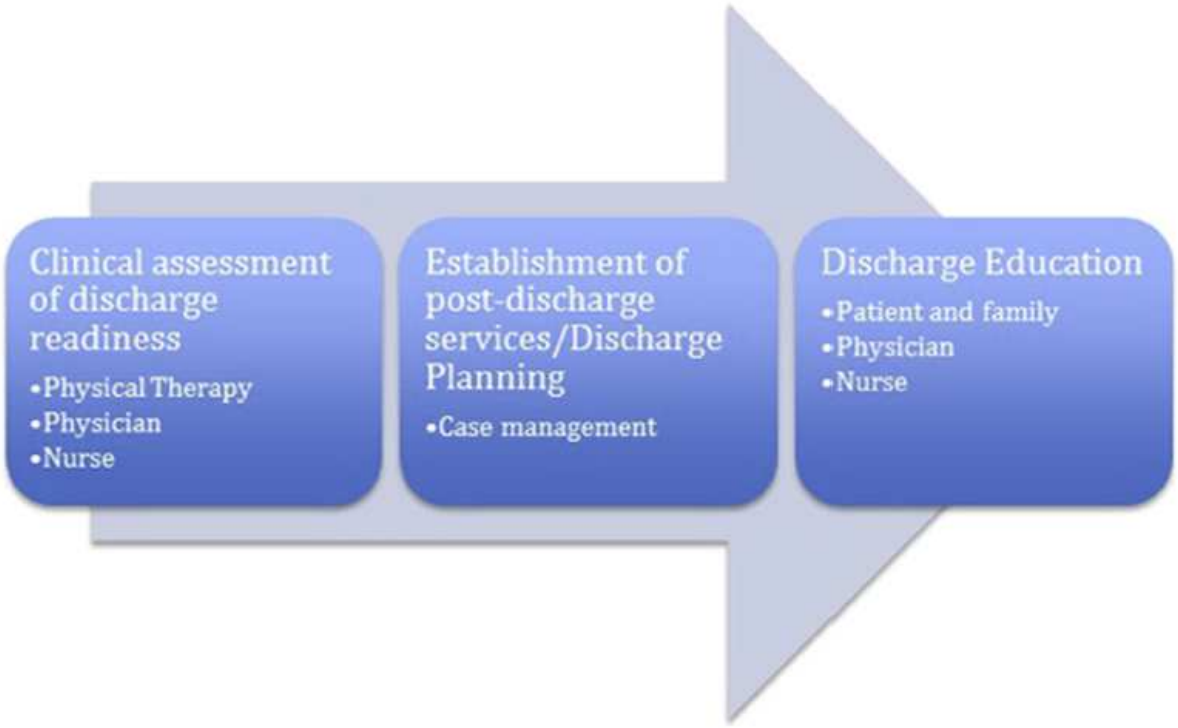


Fig.1. Dischargeprocess.

Lauren Doctoroff, Diane McNally. Handoffs in Hospital Medicine. Hosp Med Clin 2014: e1–e14

HOSPITAL MEDICINE CLINICS CHECKLIST

1. Care transitions encompass transitions from one facility to another, or from outpatient to the hospital and back home.
2. Risks of care transitions include adverse drug events, symptomatic worsening, hospital readmission, and missed follow-up.
3. Patients with depression, substance abuse, multiple prior hospitalizations, and/or complex medication regimens are at high risk for readmission.
4. Readmissions may be costly for your hospital if the Medicare readmission rate is too high.
5. Discharge planning should include patients and their family and caregivers and should start early in the hospitalization.
6. Communication of discharge instructions should be done using teach-back and other strategies to improve information retention.
7. Discharge summaries should be completed on the day of discharge and provided to the next care provider and the primary care provider.
8. Discharge summaries should include a summary of the hospitalization, updated medication list, outstanding tests, and key recommendations for follow-up.
9. Careful medication reconciliation is best accomplished with a dedicated program, and may reduce adverse medication events at discharge.
10. Multidisciplinary programs, such as Project RED, Project BOOST, and the Care Transitions Intervention, may help reduce preventable readmissions.

Lauren Doctoroff, Diane McNally. Handoffs in Hospital Medicine. Hosp Med Clin 2014: e1–e14

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Lauren Doctoroff, Diane McNally. Handoffs in Hospital Medicine. Hosp Med Clin 2014: e1–e14

Preparar el alta desde el ingreso

Reconciliación de fármacos (LISTA COMPLETA)

FEED BACK

Comunicación activa con todos los actores

IMPROVING PATIENT CARE | Annals of Internal Medicine

A Reengineered Hospital Discharge Program to Decrease Rehospitalization

A Randomized Trial

Brian W. Jack, MD; Veerappa K. Chetty, PhD; David Anthony, MD, MSc; Jeffrey L. Greenwald, MD; Gail M. Sanchez, PharmD, BCPS; Anna E. Johnson, RN; Shaula R. Forsythe, MA, MPH; Julie K. O'Donnell, MPH; Michael K. Paasche-Orlow, MD, MA, MPH; Christopher Manasseh, MD; Stephen Martin, MD, MEd; and Larry Culpepper, MD, MPH

Background: Emergency department visits and rehospitalization are common after hospital discharge.

Objective: To test the effects of an intervention designed to minimize hospital utilization after discharge.

Design: Randomized trial using block randomization of 6 and 8. Randomly arranged index cards were placed in opaque envelopes labeled consecutively with study numbers, and participants were assigned a study group by revealing the index card.

Setting: General medical service at an urban, academic, safety-net hospital.

Patients: 749 English-speaking hospitalized adults (mean age, 49.9 years).

Intervention: A nurse discharge advocate worked with patients during their hospital stay to arrange follow-up appointments, confirm medication reconciliation, and conduct patient education with an individualized instruction booklet that was sent to their primary care provider. A clinical pharmacist called patients 2 to 4 days after discharge to reinforce the discharge plan and review medications. Participants and providers were not blinded to treatment assignment.

Measurements: Primary outcomes were emergency department visits and hospitalizations within 30 days of discharge. Secondary outcomes were self-reported preparedness for discharge and frequency of primary care providers' follow-up within 30 days of discharge. Research staff doing follow-up were blinded to study group assignment.

Results: Participants in the intervention group ($n = 370$) had a lower rate of hospital utilization than those receiving usual care ($n = 368$) (0.314 vs. 0.451 visit per person per month; incidence rate ratio, 0.695 [95% CI, 0.515 to 0.937]; $P = 0.009$). The intervention was most effective among participants with hospital utilization in the 6 months before index admission ($P = 0.014$). Adverse events were not assessed; these data were collected but are still being analyzed.

Limitation: This was a single-center study in which not all potentially eligible patients could be enrolled, and outcome assessment sometimes relied on participant report.

Conclusion: A package of discharge services reduced hospital utilization within 30 days of discharge.

Funding: Agency for Healthcare Research and Quality and National Heart, Lung, and Blood Institute, National Institutes of Health.

Ann Intern Med. 2009;150:178-187. www.annals.org

For author affiliations, see end of text.

ClinicalTrials.gov registration number: NCT00252057.

project BOOST
Better Outcomes for Older adults through Safe Transitions

Improving the Care of Patients as They Transition from Hospital to Home

Our Vision

By improving hospital discharge processes, Project BOOST aims to:

- Reduce 30 day readmission rates for general medicine patients (with particular focus on older adults)
- Improve patient satisfaction scores and H-CAHPS scores related to discharge
- Improve flow of information between hospital and outpatient physicians and providers
- Identify high-risk patients and target specific interventions to mitigate their risks for adverse events
- Improve patient and family preparation for discharge

Background

According to recent research published in the *New England Journal of Medicine*, about 1 in 5 hospitalized Medicare beneficiaries were readmitted within 30 days after discharge. Unplanned re-hospitalizations cost Medicare $17.4 billion in 2004.

Project BOOST is led by a national advisory board of recognized leaders in care transitions, hospital medicine, payers and regulatory agencies. The board is co-chaired by Eric Coleman MD, MPH and Mark Williams, MD, FACP, FHM and includes representatives from the Agency for Healthcare Research and Quality (AHRQ), Blue Cross and Blue Shield Association, Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, Institute for Health Care Improvement (IHI), The Joint Commission, and Kaiser Permanente. Medical, pharmacy and nursing professional societies, and patient advocates participate and contribute to Project BOOST's development.

Clinicians & Providers
Education & Training
Hospitals & Health Systems
Hospital Resources

Project RED (Re-Engineered Discharge) Training Program

The Project RED (Re-Engineered Discharge) training program is designed to help hospitals re-engineer their discharge process. Using the study modules and supporting materials, hospitals will become familiar with Project RED's processes and components, determine metrics for evaluating impact, and learn how to implement Project RED.

Contents

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PROJECT RED
Re-Engineered Discharge

A Research Group at
Boston University Medical Center

BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

BU
Boston University School of Medicine

Funded by the Agency for Healthcare Research and Quality, National Heart, Lung and Blood Institute, the Blue Cross Blue Shield Foundation, and the Patient-Centered Outcomes Research Institute

Table 4. Patient Discharge Survey Tool

The Nine Survey Questions (Yes or No answers)
I was taught about my diagnosis during my hospital stay.
I have received a written discharge plan that is easy to read and understand.
I have follow-up appointments with my physicians.
I have received a written discharge plan that has the information I need to take care of myself at home.
I have been told about test results or studies that have not been completed before I go home.
I have a written list of my discharge medications and know which medications are new or changed.
If I need home health care, medical equipment, or other help or services after I go home, it has been arranged.
When the nurses were teaching me, they asked me to explain what I had learned in my own words.
I understand what to do and who to call if a problem arises after I am home.

A Project to Reengineer Discharges Reduces 30-Day Readmission Rates

A Texas hospital achieves improvement in its readmission rate by implementing Project RED.

AJN ▼ July 2013 ▼ Vol. 113, No. 7

Have You Had the Talk?

Make your wishes known with an advanced directive

Saint Luke's Health System

If my agent is unavailable, please contact these alternate agents:

1st alternative

Name _____

Phone _____

2nd alternative

Name _____

Phone _____

Your life. Your voice. Your wishes.

Who will speak for me?

What medical treatment do I want?

How comfortable do I want to be?

How do I want people to treat me?

What do I want my loved ones to know?

Advanced directive notification

_____

Print name

☐ I have an advance directive.

☐ I have a power of attorney for health care.

I've talked with my family and doctor about my care wishes. If I'm unable to speak for myself, please contact:

_____

Name (Agent)

_____

Phone

Hosp Med Clin 3 (2014) e15–e31
http://dx.doi.org/10.1016/j.ehmc.2013.10.001

- **Planificación del alta**
  - Desde el ingreso
  - Valoración del paciente, entorno social y familia
  - Detectar precozmente problemas
  - Sistema de apoyo del paciente
  - Valorar la capacidad funcional y potenciales preocupaciones cuando llegue el alta
  - Grado de disponibilidad de la familia o cuidadores
  - Posible existencia de problemas económicos

Elementos clave en los proyectos de reingeniería del proceso alta:

Cobertura durante 24 h al día 7 días por semana

Circuito de acceso ágil para los pacientes

Modelo de atención basado en un equipo multidisciplinar (médico, coordinadores de atención, farmacéutico, enfermera, y apoyo administrativo.

Journal of the
AMERICAN GERIATRICS SOCIETY

ETHICS, PUBLIC POLICY &
MEDICAL ECONOMICS

Physician Follow-Up Visits After Acute Care Hospitalization for Elderly Medicare Beneficiaries Discharged to Noninstitutional Settings

Caroline Y. Lin, MD, Amber E. Barnato, MD, MPH, MS,* and Howard B. Degenholtz, PhD†*

Visitas de seguimiento post hospitalización: 10.000 $ de ahorro anual por paciente y año

Original Investigation

Continuity and the Costs of Care for Chronic Disease

Peter S. Hussey, PhD; Eric C. Schneider, MD; Robert S. Rudin, PhD; D. Steven Fox, MD; Julie Lai, MPH; Craig Evan Pollack, MD

JAMA Internal Medicine Published online March 17, 2014

Pacientes con Diabetes, EPOC e ICC

Asociación entre:

- Altos niveles de cuidados ambulatorios

Y

- Menos necesidad de urgencias e ingresos hospitalarios
- Menos complicaciones
- Menores costes de los episodios

CONCLUSIONS AND RELEVANCE Modest differences in care continuity for Medicare beneficiaries are associated with sizable differences in costs, use, and complications.

Although it has been used frequently in health services research, the Bice-Boxerman COC index may be unfamiliar to many readers and difficult to interpret. Assuming the num-


LOST
CONFUSED
UNSURE
UNCLEAR
PERPLEXED
DISORIENTED
BEWILDERED

CARE OF THE AGING PATIENT:
FROM EVIDENCE TO ACTION

CLINICIAN'S CORNER

JAMA. 2011;305(3):284-293

www.jama.com

Background

Nos hemos especializado tanto que somos capaces de mantener con vida mucho tiempo a los pacientes

La coordinación m[illegible] problema.

Esta c[illegible] reingresos

Inform[illegible]re lo[illegible]dados que sean más efectivos para el paciente

Ayudar al paciente y familiares a tomar decisiones

Informar sobre la probabilidad de mejoría con más o menos cuidados agresivos

JAMA. 2011;305(3):284-293

www.jama.com

Post acute care

45%

Long term care

Case or care manager

Protectores
Conocedores del sistema
Mediadores
Escuchar la voluntad del paciente

CARE OF THE AGING PATIENT:
FROM EVIDENCE TO ACTION

CLINICIAN'S CORNER

JAMA. 2011;305(3):284-293

www.jama.com

SEGURIDAD

AUTONOMÍA

Discharge planning from hospital to home (Review)

Shepperd S, Lannin NA, Clemson LM, McCluskey A, Cameron ID, Barras SL

SÍ

Reducen estancias, reingresos

THE COCHRANE COLLABORATION®

WILEY
Publishers Since 1807

NO

Reducen costes

Impacto sobre resultados en salud

Research

JAMA. 2014;312(13):1305-1312. doi:10.1001/jama.2014.11492

Original Investigation

Effect of a Postdischarge Virtual Ward on Readmission or Death for High-Risk Patients
A Randomized Clinical Trial

Irfan A. Dhalla, MD, MSc; Tara O'Brien, MD, MSc; Dante Morra, MD, MBA; Kevin E. Thorpe, MMath; Brian M. Wong, MD; Rajin Mehta, MD; David W. Frost, MD; Howard Abrams, MD; Françoise Ko, PhD; Patrick Van Rooyen, MSc; Chaim M. Bell, MD, PhD; Andrea Gruneir, PhD; Geraint H. Lewis, MB, BChir, MSc; Stacey Daub, MBA; Geoff M. Anderson, MD, PhD; Gillian A. Hawker, MD, MSc; Paula A. Rochon, MD, MPH; Andreas Laupacis, MD, MSc

OBJECTIVE To determine whether a virtual ward—a model of care that uses some of the systems of a hospital ward to provide interprofessional care for community-dwelling patients—can reduce the risk of readmission in patients at high risk of readmission or death when being discharged from hospital.

DESIGN, SETTING, AND PATIENTS High-risk adult hospital discharge patients in Toronto were randomly assigned to either the virtual ward or usual care. A total of 1923 patients were randomized during the course of the study: 960 to the usual care group and 963 to the virtual ward group. The first patient was enrolled on June 29, 2010, and follow-up was completed on June 2, 2014.

INTERVENTIONS Patients assigned to the virtual ward received care coordination plus direct care provision (via a combination of telephone, home visits, or clinic visits) from an interprofessional team for several weeks after hospital discharge. The interprofessional team met daily at a central site to design and implement individualized management plans. Patients assigned to usual care typically received a typed, structured discharge summary, prescription for new medications if indicated, counseling from the resident physician, arrangements for home care as needed, and recommendations, appointments, or both for follow-up care with physicians as indicated.

CONCLUSIONS AND RELEVANCE In a diverse group of high-risk patients being discharged from the hospital, we found no statistically significant effect of a virtual ward model of care on readmissions or death at either 30 days or 90 days, 6 months, or 1 year after hospital discharge.

Avances en Gestión Clínica

una iniciativa de gcvarela

miércoles, 12 de noviembre de 2014

Unidades Virtuales: ¿un modelo para prevenir reingresos hospitalarios?

Los resultados obtenidos al comparar 2.000 pacientes asignados de manera aleatoria (la mitad de ellos a una Unidad Virtual y la otra mitad a cuidados habituales) no han sido los esperados. Una combinación de reingreso o muerte a los 30 días en el 24% de los pacientes asignados al grupo de cuidados habituales, y en cerca del 21% de los pacientes en el grupo de Unidad Virtual, si bien la diferencia no fue estadísticamente significativa. En los resultados a los 90 días, 6 meses y un año, no se observa ninguna diferencia.

CONCLUSIONES

Aunque no se ha demostrado que sean medidas coste-efectivas……, deberíamos:

- Planificar el alta desde todas sus perspectivas. Listados de actuación.
- Comunicación y feed-back con paciente y familiares
- Buscar la seguridad del paciente
- Programas de conciliación de medicación
- Trabajo comunitario. Equipos multidisciplinares
- Seguimiento post hospitalización. TICs (mail, teléfono)

Informe de alta

- ☑ Diagnóstico principal
- ☑ Diagnósticos secundarios
- ☑ Procedimientos
- ☑ Tratamiento al alta
  - ☑ Dosis, pauta, vía de administración, duración del tratamiento
- ☑ Medidas sobre estilo de vida
- ☑ Actividades no recomendadas
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- ☑ Consejos para familiares
- ☑ Recomendaciones ante posibles eventualidades

- ☑ FEEDBACK AL PACIENTE