BRINGING CARE HOME

From institutional delivery to health delivered at home – EIT Health supports optimal home-based healthcare for older citizens, and the consequent financial benefits this can bring to society, by designing and demonstrating innovation in home care service and systems.

Rationale

European citizens are now living longer than ever before[1]. The trend towards increasing longevity is likely to continue. and, along with the decline in the birth rate, it is expected to create a situation by 2020 in which one quarter of Europeans will be over 60 years of age[2]. At the same time, a majority of Europeans at retirement age are affected by more than one chronic disease which underlines the importance of addressing the challenge of co-morbidities. The EU has an eHealth Action Plan (2012–2020) in place to specifically look at innovations in healthcare to respond to the challenges of an ageing population, rising expectations of citizens, and mobility of patients and health professionals[3]. Solutions are needed that can promote a shift towards outcome-based delivery of integrated (health and social) care, which can be realised in a realistic operational, organisational and financial setting.

Shifting healthcare delivery from the hospital to home / primary care settings is the solution that delivers cost savings and releases pressure on increasingly stretched hospital services. In addition, it has the potential to deliver higher quality and more personalised care to individuals – and it is the model of care generally preferred by patients and their families, thus delivering outcome based delivery of integrated (health and social) care.

Activities executed within EIT Health in the Focus Area

Activities executed by EIT Health Partners will address these challenges and achieve tangible outcomes. Activities need to be: solutions tested/demonstrated during the project, solutions that may be introduced into the market in the course of the project and solutions to reach the market no later than 3-4 years after the project initiation. Therefore, activities may be targeting the hospital and/or the community, to reduce the hospital burden through:

1. decreasing the number of new patients admitted;
2. decreasing the readmission;
3. decreasing the days in the hospital.

Activities must use validated patient reported outcomes instruments.

1. Hospital:
   a. Shortening stays for those patients where hospital or residential care is the only option
   b. Ensuring effective transition from hospital to the primary/home care setting and maintaining effective services in that setting.
   c. Implementing active management of transitions and structured discharge planning, including timely and accurate information within unique coordination units
   d. Training medical specialists to perform in the domestic setting

1. Community
    a. Providing critical links to the specialist expertise of hospital-based clinics and clinicians when they need them
    b. Training healthcare professionals ('the new community nurses')
    c. Installing new surveillance and support structures in the community, that provide access to health care professionals with a strong community link and rapid response time
    d. Implementing infrastructure for monitoring social care
    e. Implementing educational programs for patients regarding their own health and disease self-management[4]
    f. Developing personalised health care programs for people who are regularly seen as medical outpatients and frequently admitted to hospital
    g. Testing proactive management tools for people with long-term conditions, focusing mostly on Elderly
    h. Implementing effective tools for integration of, and communication between, the multidisciplinary teams involved in healthcare delivery, including primary/secondary care as well as health/social care
    i. Demonstrating value for telemedicine for remote monitoring, and the use of 'virtual wards' (for multidisciplinary case management) in reducing hospital admissions[4].

Outcomes

Activities run in this focus area need to demonstrate major contributions to achieving one or several of the outcomes below. Any proposed solution needs to be scalable in a sustainable manner.

1 Strong home-care structured services that, through technological innovation:
    a. Integrate social and health services
    b. Support delivering needed care
    c. Improves patient, family, caregivers and HC professionals experience
    d. Impact positively on objective health parameters
    e. Demonstrate efficiency
    f. Coordinate healthcare and social institutions, professionals and actors
    g. Contribute to patient independency

2. Tested and proven gold-standard measures for home-care system outcomes regarding:
    a. Better integration of operations, data and technology
    b. Quality: deliver the needed care, patient / HC professionals experience, Objective measurements of chronic disease (disease control)
    c. Efficiency: N° of new admissions, N° of readmissions, days of hospitalization, professionals needed
    d. Replicability: Key facts that are / are not due to the concrete characteristics of the set and the positive / negative impact to the project

3. Improved training and education for carers that support the efficiently integrated home-care service delivery structure

References

1. Eurostat. Population structure and ageing, 2017. http://ec.europa.eu/eurostat/statistics-explained/index.php?title=Population_structure_and_ageing
2. Population ageing in Europe: Facts, implications and policies. European Commission. 2014.
3. eHealth Action Plan 2012-2020 - Innovative healthcare for the 21st century. European Commission; 2012
4. Purdy S, Shantini Paranjothy CU, Huntley A, Thomas R, Mann M, Huws D, et al. Interventions to reduce unplanned hospital admission: a series of systematic reviews. University of Bristol; 2012.