Regione Toscana

The regional model to support frail people and caregivers at hospital discharge

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Vulnerable Patient Management after discharge from the hospital

Objective: to coordinate the discharging process by setting up the necessary actions when taking charge of the patient in relation to their needs by ensuring an interchange with the local integrated services.

Recipients: Patients who at the time of discharge require a short period of convalescence to recover their physical capacity and autonomy

The type of operation that the project intends to develop

- In modern health systems we are witnessing the following phenomenon:
  - reduction of beds in hospitals for acute care patients
  - low levels of hospitalization for those that are not acutely sick
  - early discharge from hospital.

- This requires the organization of safeguards for patients that are no longer acute but who are discharged from the hospital in a vulnerable condition.

- Through reinforcing the role of a local agency that liaises between the hospital and the local services

The District areas

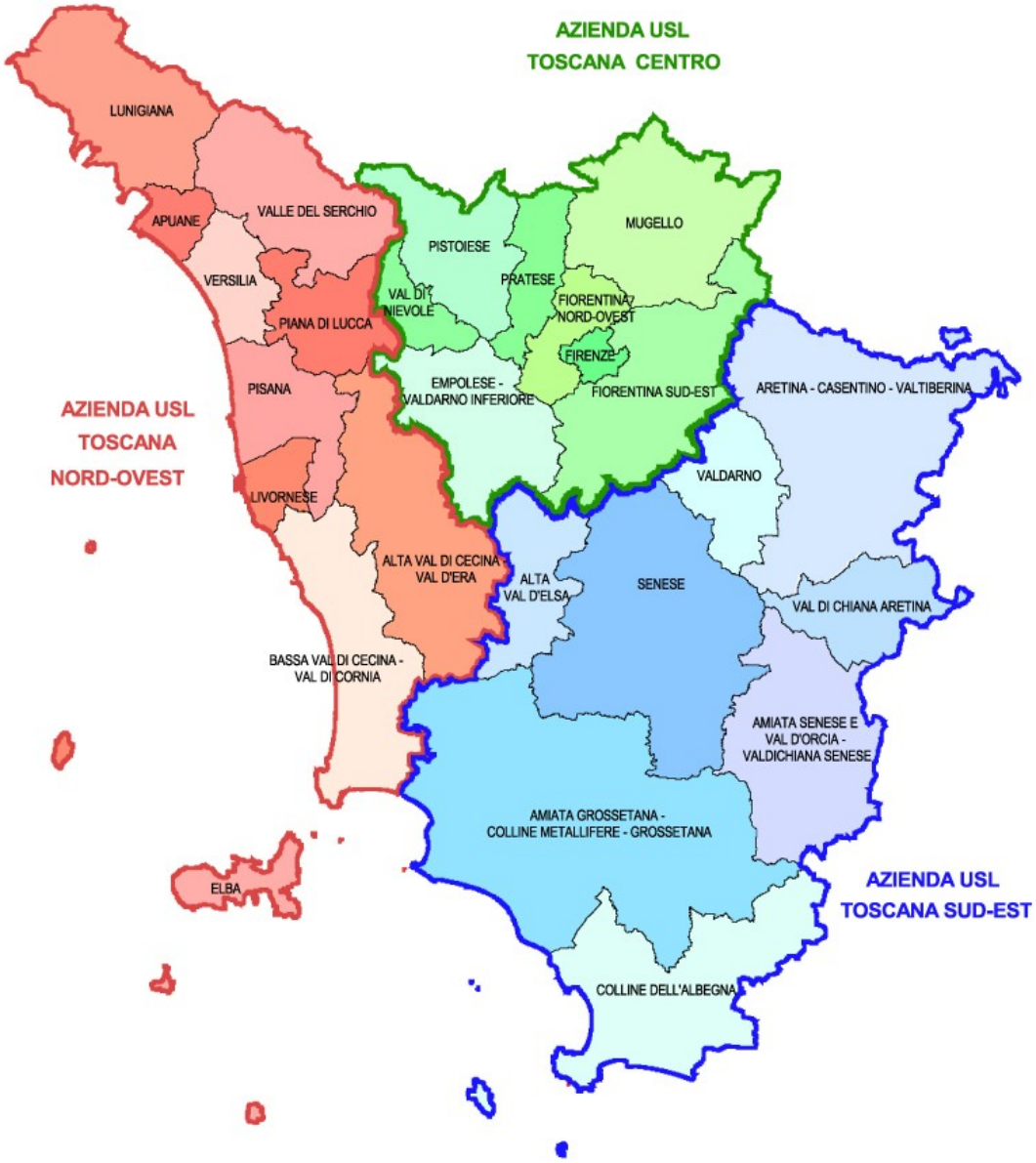
The region is divided into 26 District areas (public consortia)

The District area has the task of ensuring that the regional population has both local healthcare and health and social care integrated care

It is also the task of the District area to oversee all the continuity between the hospital and local integrated services up to the in-home support of citizens

The ACOT are operational instruments of the District areas

Each District area has at least one ACOT that deals with the local hospitals of reference.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MUGELLO
FIORENTINA NORD-OVEST
FIRENZE
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ARETINA - CASENTINO - VALTIBERINA
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AMIATA GROSSETANA - COLLINE METALLIFERE - GROSSETANA
ELBA
AZIENDA USL
TOSCANA SUD-EST
COLLINE DELL'ALBEGNA

Services at the disposal of the ACOTs

The continuity Agencies can initiate:

- home care
- residential Intermediate Care (Low Care)
- residential and/or home rehabilitation
- temporary care in social and healthcare facilities

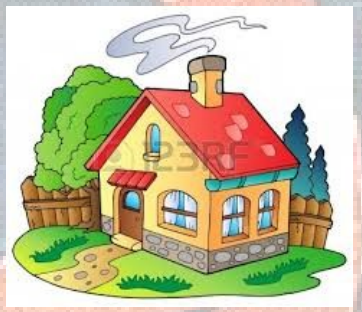
Integrated territorial services – Hospital – Integrated territorial services

Acuteness

warning

discharge

Hospital-region continuity agency (ACOT)



HOMECARE ASSISTANCE

INTEGRATED HOMECARE ASSISTANCE

Post-Acuteness

Intermediate care

Post-Acuteness

Rehabilitation facilities

Post-acute care

Financing

Reinforcing of the ACOTs, which were already part of the health and social care regional system, was included into the ESF Programme 2014-2020 through:

- A 9,000,000.00 € budget for two years to be used for :

- The strengthening of human resources employed in the ACOTs (for case managers) and training
- Implementing technological systems and computer systems to support care paths
- Provision of vouchers to families with which they can take advantage of home or residential services (low care) for 7,500,000 €

The beneficiaries and the suppliers of services

- The project is aimed at people over 65 years with temporary limitation of autonomy or at risk of not being self-sufficient when discharged from a hospital or other healthcare rehabilitation facility

- As a result of a joint-planning process, there were selected :
  - Accredited economic operators
  - Healthcare Professionals

- Beneficiaries may spend their vouchers with these operators, based on their personalized plan drawn up by the ACOT

Planned interventions

The individualized plan established by ACOT's multidisciplinary group may provide a combination of the following interventions, depending on the needs and the seriousness and up to a maximum of 1,500.00 € per cycle:

Level	intervention	operator	programme	budget
minimum	Basic tasks of hygiene and mobilization	Social-healthcare	15 accesses in 3 weeks	330,00€
low	Simple treatment, and care assistance and reinstatement	Nurses and physiotherapist	5 accesses in 3 weeks	190,00€
medium	Medication, therapies, dressings and rehabilitation	Nurses and physiotherapist	10 accesses in 3 weeks	780,00€
residential	Low care	hospitalization	12 days	1.428,00€

Prospects

- The programme provides for a second edition of the project for a further two years
- The aim is to consolidate the regional multidisciplinary work and the processes of taking in charge of the beneficiaries from the hospital toward lower intensity care facilities and/or towards home
- This approach allows patients to quickly regain their autonomy to improve their quality of life and the recurrence in the short/medium term of hospitalization
- The working method experimented with this project can thus be extended to other types of beneficiaries (the frail elderly, chronically ill and disabled)
- At the end of the support period with ESF funds, the programme foresees the use of regional resources for this type of assistance.

Thank you