Enhancing coronary patient recovery through digital integration

“+closetoyourheart”

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#EHMA2024
Introduction
Introduction

- **4000** coronary consultations
- **500** acute coronary syndrome (ACS) admissions

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<tr>
<th>1 in 5 new events on the 1st 12 months</th>
<th>Short hospitalization</th>
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<td>20% mortality at 5 years</td>
<td>3 months to 1st appointment after hospitalization</td>
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Introduction

- The recovery from an ACS is a multifaceted process that involves several stages and interventions but also significant lifestyle change;

- Challenges such as high bed occupancy and rapid patient turnover, coupled with barriers in effective patient awareness and low health literacy influence short and long-term outcomes on these patients;

- Our project seeks to address these issues through the innovative integration of digital tools and telehealth services.
The “regular journey”

Hospitalization
- Information about lifestyle measures: not personalized
- Discharge summary - Separated medical and nursing, delivered only on the last day;
- Patient is not aware of the severity of the situation.

From discharge to 1st appointment
- Difficulty coordinating with the Family Medicine;
- Difficulty contacting the hospital;
- Patient leaves without the first appointment scheduled.

First appointment
- Medical exams not performed, delaying the appointment;
- Poor medication adherence or failure to change habits;
- Lack of available first appointment slots.

Follow up
- Disparity in discharge summaries;
- Lack of clear criteria or protocol for discharge from the clinic;
- Difficult coordination with Family Physicians.

Past medical history
Hospitalization
Discharge
1st appointment
2nd appointment
Discharge?
Innovation

- Personalized multi-professional plan
- Integration of care between hospital and primary healthcare
- Integrated information and communication channels
- Digitally accessible personalized information
- Streamlining the 1st post-discharge contact
Innovation
The “new journey”

**Hospitalization**
1. Individualized plan for each patient;
2. Discharge preparation throughout the hospitalization;
3. Assessment of patients’ knowledge at the end of the hospitalization.

**From discharge to 1st appointment**
- Remote nursing consultation
- Create a dedicated contact for the Family Physician;
- Flowchart for the patient with the expected course;
- Scheduling of the first appointment at discharge.

**First Appointment**
1. First Post-ACS Reassessment Appointment
2. Performing blood tests on the same day as the hospital appointment;
3. Nursing consultation
4. Increased number of first appointments.

**Follow up**
1. Review, clarification, and training on clinic discharge criteria;
2. Prototype of discharge plan
3. Improved coordination with Family Medicine;

Timeline:
- Past medical history
- Hospitalization
- Discharge
- 15 days
- 1 Month
- 2 Month
- 6 Month
- 2 /3 years
- Discharge?
Impact

• Disease perception and awareness of the problem
• Adherence to and management of the therapeutic regimen

• Preparation for discharge
• Empowerment for lifestyle change
• Chronic disease management

• Quality of care provided
• Patients’ and families experience
• Quality of life

• Readmissions rates
• PROM/QALY
• Mortality
Thank you

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