EHMA 2024

Shaping and managing innovative health ecosystems

Enhancing coronary patient recovery through digital integration

" +closetoyourheart"

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Introduction

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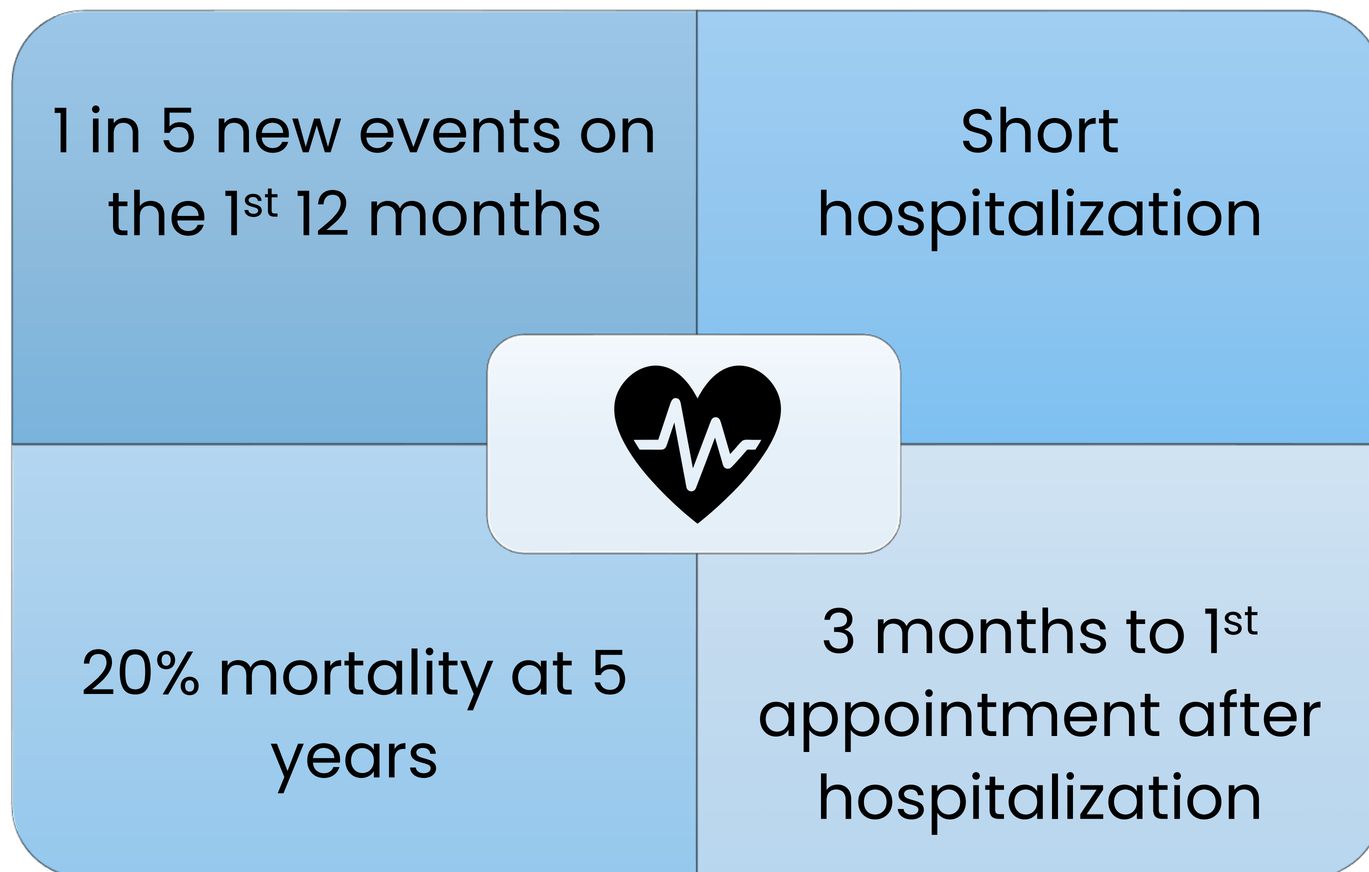
UNIDADE LOCAL DE SAÚDE
COIMBRA

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



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

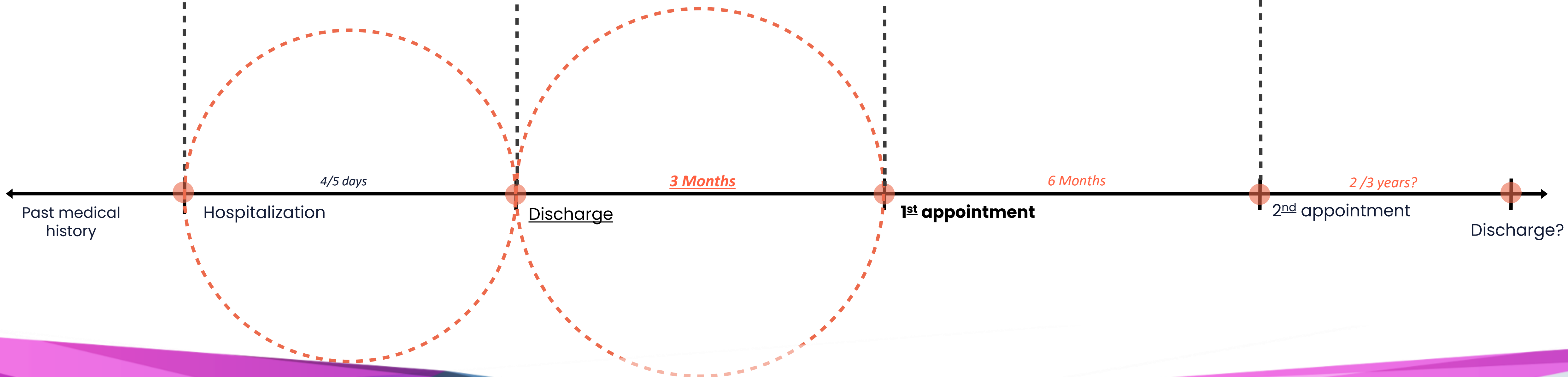
- **Difficulty** coordinating with the **Family Medicine**;
- **Difficulty contacting the hospital**;
- Patient leaves **without the first appointment** scheduled.

First appointment

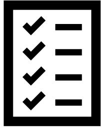
- **Medical exams not performed**, delaying the appointment;
- **Poor medication adherence** or failure to **change habits**;
- Lack of available **first appointment** slots.

Follow up

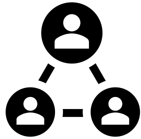
- **Disparity in discharge** sumaries;
- **Lack of clear criteria** or protocol for discharge from the clinic;
- **Difficult coordination with Family Physicians.**



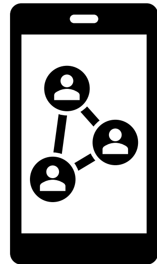
Innovation



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

1. **Remote nursing consultation**
2. Create a **dedicated contact for the Family Physician;**
3. **Flowchart** for the patient with the **expected course**;
4. **Scheduling of the first appointment** at discharge.

First Appointment

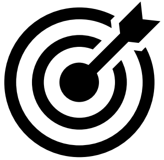
1. **First Post-ACS Reassessment Appointment**
2. **Performing blood tests on the same day** as the hospital appointment;
3. **Nursing consultation**
4. Increased number of **first appointments.**

Follow up

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

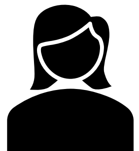
Impact

- Disease perception an 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

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Thank you

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