APPCARE

APPROPRIATE CARE PATHWAY

Polibienestar

VNIVERSITAT DE VALÈNCIA

APPCARE Model implementation – **VALENCIA pilot site**

APPCARE Model – **Valencia pilot site**

Hospital care

Patients +75 years coming from E.R. or admittance area

ASSESSMENT: Comorbidity, Functional Status, Risk of pressure ulcer, Dementia, Discharge Planning

FURTHER ASSESSMENT AND INTERVENTION

Up to one week after hospital discharge

Continuity of care

ASSESSMENT/FOLLOW-UP: Functional Status, Risk of pressure ulcer, Dementia **+** Frailty, Disability, Physical performance, Risk of falling, Polypharmacy, Health-related QoL, Loneliness and Living conditions

INTERVENTION: 6 months

FOLLOW-UP: Post-intervention

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Hospital care

INCLUSION CRITERIA: Patients +75 coming from E.R. or admittance area, with NO severe cognitive impairment and NO living in residential care facilities

ASSESSMENT OF MEDICAL VARIABLES:

Comprehensive Geriatric Assessment →

Medical variables	***Measures***
Comorbidity	CIRS
Functional Status	Barthel Index
Risk of pressure ulcer	Braden Scale
Dementia	SPMSQ
Discharge Planning	Brass Index

Routine physiological measurements:
Mean arterial pressure; Heart rate; Respiratory rate; Sodium (serum) *(if available in patient file*), Potassium (serum) (*if available in patient file*); Creatinine (i*f available in patient file*); Hematocrit (*if available in patient file*); White blood cell count (*if available in patient file*)

DISCHARGE including:

- Diagnosis (according to International classification ICD9)
- Indication on where the patient is addressed

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Continuity of care

Up to one week after hospital discharge further assessments will be conducted to all participants at their homes

CONTINUITY OF CARE ASSESSMENT:

Hospital care assessment: Follow-up after 1 week →

VARIABLES	*MEASURES*
Risk of pressure ulcer	Braden Scale
Dementia	SPMSQ
Functional Status	Barthel Index
Frailty	Tilburg Frailty Index
Disability	Groningen Activity Restriction Scale (GARS)
Physical performance	Short Physical Performance Battery (SPPB)
Risk of falling	Falls Self-efficacy Scale (FES-I) - Did you fall in the past 12 months? - Are you afraid of falling?
Polypharmacy	Medication Risk Questionnaire (MRQ-10)
Health-related QoL	SF-12v2 Health Survey
Loneliness	Jong Giervel (6 item)
Living conditions	Living Standards Capabilities for Elders (LSCAPE)

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Continuity of care

Based on the Hospital care + Continuity of care assessment participants will be referred to care interventions according to their needs

INTERVENTION

Total duration of 6 months

MEDICAL PATHWAY

PHYSICAL THERAPY PATHWAY

COGNITIVE STIMULATION PATHWAY

SOCIAL CARE PATHWAY

FOLLOW UP: The variables measured at the beginning of the intervention (Continuity of care assessment) will be evaluated again at the end of the intervention (after 6 months) in order to know the impact of the intervention in each participant.

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Continuity of care

INTERVENTION

MEDICAL PATHWAY

Inclusion criteria: All participants

Aim: To follow-up:

- Medical variables (those assessed at the Hospital care)
- Routine physiological measurements (Temperature, Mean arterial pressure, Blood glucose if diabetes, etc.)
- Medication management

Professional in charge: Nurse

Duration: At 1 month, 3 months and 6 months after hospital discharge

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Continuity of care

INTERVENTION

PHYSICAL THERAPY PATHWAY

Inclusion criteria: Participants assessed as suffering from **frailty, disability and/or risk of falling**

Aim: To improve functional status, physical performance, risk of falling and physical frailty through **custom designed physiotherapy program or physical exercise program** according to each participant needs

Professional in charge: Physiotherapist

Duration: Once a week during 6 months

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Continuity of care

INTERVENTION

COGNITIVE STIMULATION PATHWAY

Inclusion criteria: Participants assessed as suffering **moderate cognitive impairment**

Aim: To enhance participants' **memory** and cognitive function through brain games, imagery, and other dynamics

Professional in charge: Psychologist or educational psychologist

Duration: Once a week during 6 months

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Continuity of care

INTERVENTION

SOCIAL CARE PATHWAY

Inclusion criteria: Participants assessed as suffering **loneliness and/or unmet social needs**

Aim: To improve participants' social needs, living conditions and loneliness feelings through:

- SOCIAL PARTICIPATION PROGRAM: **Individual home visits or group meetings** where social participation will be enhance through a motivational approach. And for those that don't want attend the groups, **information on the available social activities and resources** at the community level (such as painting classes, walking groups, etc.) will be provided.

- SOCIAL ASSISTANCE PROGRAM: To **inform**, and if convenient to **offer assistance** to perform the required procedures, on the **existing social benefits, aids and resources** for older people (such as household assistance services, home telecare, aids for home adaptation, etc.) in order to improve their living conditions.

Professional in charge: Social worker; *Duration*: 6 months

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Thank you for your attention