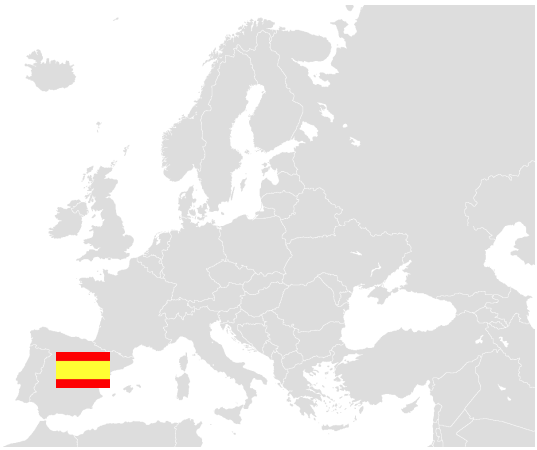
517927-LLP-2011-IT-LEONARDO-LMP

The Health Assistance in Hospital and at Home

The Spanish Situation



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The Health Assistance in Hospital and at Home

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Abstract

In the following lines there are described the main guidelines of the home health care attention provided in the health system of Spain. It is very relevant to understand that in Spain very few data in this area is available as consequence of the way that the characteristics of the system. That means that overall information is not generally available but locally and even there is very difficult to know it. The system implies 17 subsystems with general guidelines provided by the government of Spain.

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1. Introduction

1.1 Spanish National Health System

Spanish National Health System is complex and has its roots in the Spanish Constitution of 1978 which recognizes the right of all Spaniards to the protection of Health. Moreover, article 43 of the Constitution states that “is is competence of the Public Powers to organize and to have the charge of the public health through preventive measures and the arrangement of the necessary services”. The General Health System Act of 1986 stated the decentralization principle and, from the basis of a decentralized State sated the basis of the existence of 17 Health Sub-systems that work together, as the rest of the Welfare System sub-systems, on a coordination and cooperation basis. In 2002 the process of transference of health competences from the State to the Autonomous Communities finished and now in Spain there are 17 health sub-systems and a general framework. The National Health Service is now based on the equity and the fact that every Spaniard has the same right to health with independence of the work, social or personal situation of each one of them. So this State Service is aimed to maintain equality in health assistance over the differences that can arise from the existence of that multiplicity of systems, involved authorities and legal competencies. The principles of this system are:

- Universality of attention: The provision of health services covers to the whole Spanish population with independence of their work situation. Health services also cover foreigners as far as they are registered in a municipal register. The attention is Universal because of a mixed funding, that is, through social security contributions and taxes.
- Desconcentration: On the basis of the necessity of coming closer to the population and avoiding the concentration on urban nucleus.
- Decentralization: That means to imply Autonomous Governments in the provision of health services and in fact nowadays they are the main suppliers of health services in Spain.

The System is organized in different levels of organization and attention. With regards to the territorial organization there exists

- Health Department: This department is aimed to establish the general framework and policies for the Spanish National Health System.
- Autonomous Communities: They have also legal competencies on Health Services Organization and overall they can take decisions with regards to the expenditure level, priorities and management system of their own systems. But the can not reject to assist any person who needs assistance. According to the General Health System Act, and the deconcentration principle established, the Health Services have to be organized in Health Areas and Health Basic Zones integrated in them, and the responsible of defining their territorial limits are the Autonomous Communities. Those are defined having into account geographic, cultural, social, infrastructural and other proximity criteria besides demographic criteria (Health Areas comprehend between 200.000 and 250.000 people while Health Basic Zones comprehend between 5.000 and 25.000 approximately).

With regards to the Services Organization the Spanish Health System has different Assistance Levels.

- a) Primary Assistance: It is the first level of attention and its objective is to see the more common health problems of the population, to be in charge of the main preventive actions and to filter and re-direct the cases to the next level of attention. This level is the closest to the citizen because it is the more accessible and, moreover, it goes as far as the patient home, providing urgent and regular domiciliary attention. The master piece of this system is the so called “Family Doctor”.
- b) Specialized Assistance: It is the second level of the system and it is only accessible from the Primary Assistance. This level counts with methods and techniques for

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diagnosis much more specialized and complex. The specialized attention takes place in the Hospitals of which there is, at least, one per Health Zone. Both levels are coordinated with the aim of providing a best Health Assistance and making a more efficient use of the Health System Resources.

1.2 Spanish National Home Health System.

The Spanish National Health System includes within the framework of the Primary Assistance the so called “Domiciliary Assistance”. This kind of action will be developed by Family Doctors and nurses within the scope of the Health Basic Zones (including attention given by phone or with the assistance of Information and Communication Technologies-ICT´s). Both Family Doctors and Nurses are responsible of this kind of health care but are Nurses the professionals more deeply involved in this kind of activity. The Act of 1986, of the General Health System establishes which as a basis of the reforms that introduces the health domiciliary visit. This act understand it not only from the point of view of the care to patients but also from the point of view of the preventive actions. This kind of attention, within the scope of primary attention, has the following aims: Research (on the heath situation of the population and patients; Assistance to the different possible health necessities; Heath Education; or a mixture of the three of them. So the intention of this kind of assistance is not only the attention to patients but the integral attention that goes from the prevention to the palliative care. For being well implemented there has to be an activities registry in order to know what, when and in order to what is done. Moreover, this attention and care has to be developed around the following principles: Universal as far as every single person entitled to health care is entitled to this kind of care; Decentralization having into account the different demarcations for the health providing; Participation of the patients; Racional in the appropriate use of the appropriate resources for each kind of intervention; and Normalization in the sense of not isolate the patients but providing the attention in the most normal environment possible. Beyond the strictly sanitary approach there is a socio-sanitary approach that was established by the Act of the General Health System of 1986 and was stressed by the Dependency Attention Act of 2006. This Act has an approach defines dependency as a matter of health and social questions, considering that dependency is related to the limitations on the participation provoked by limitations on the function and body structures and by this means following the International Classification of Functioning. Different issues made that Act necessary in a country where ageing of the population is bigger than in any other country of the world. Dependent people are those that need the help of another person for developing essential activities of self-care in their lives. The coordination between social services and home health attention (be it the attention provided by primary attention services or hospital - specialized services) is vital in order to provide an integral attention that improves the situation of the patients in a general ground. So in this area social services have the task of provide the access to the necessary and available state services and resources, in the quantity and quality necessary, which help to improve the situation of the patients. And all of that has to be done in accordance with the following principles which the Constitution of 1978 and the General Health Act provide: Universality; Public expenditure rationalization having into account a cost – profit planning approach; Accessibility in the sense that the population have to have access to this kind of services and: Decentralized Action. This law has put the focus on disabled and chronic patients considering them as subjects of and integrated scope of action that includes both kind of services, social and health services. Beyond the scope of the public health services, that are coordinated with social services, the attention is provided by a wide range of institutions and companies that provide social care attention to this population within the framework provided by the Dependency Attention Act. Actually, and beyond other questions, in Spain there are only two National Programs of Health Care Attention. It is due to the way in which the system is built. Each Autonomous Community organises their own health service because of the Spanish territorially decentralised model. That means that it is very difficult to talk about homogeneous programs or trends or figures. With regards to the national programs, as said above, there are two of them. The program, delivered to immobilised people, gives to those who cannot go to the doctor´s office because they cannot move health attention in their homes. And the program for

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Terminally ill people that provides terminally ill patients and their families care in the final moments of the patient´s life. Those two programs are part of the primary attention services chart of services and take place all over Spain. Other services of primary attention can be established by the Regions. Those other services, like palliative attention, or attention to concrete illness like AIDS or EPOC, are part of specialized attention and can be different depending on the region of Spain.

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2. Main National Trends

Actually in Spain there are several ways of home health service public and private. Having into account the public sector the General Health Act gave way to a Royal Decree which establishes the general portfolio of common services of the National Health System (R.D. 1030/2006 of 15th of September). In this Royal Decree a group of services can be found that are common to all Autonomous Communities. Between those services one can find in the area of the primary attention in the first place what is called Health Attention on demand, whether programmed or urgent, in the office or in the patient's house. In the Spanish Health system is also considered Home Hospitalization in those cases that this will be necessary. The system is, as said before, universal so everyone has access to that kind of attention. But nowadays one of the main problems faced by the National Health System is the problem of the Socio Sanitary attention. This issue is related to the general ageing of the Spanish population. Many authors talk about the necessity of integrate both kind of actions in order to improve the attention given to the patients (on the basis of a comprehensive and socio-sanitary approach) and to save money trough the avoiding of double and not coordinated actions. It is considered that in Spain there are 20.000.000 of chronic patients. Those patients mean the principal demand to the Health System in Spain. Actually those kind of diseases are object of the 80% of the surgery hours in primary attention and 60% of surgery hours in specialized attention. In economic terms they are thought to imply a 70% of the Total Health Expenditure in Spain and a 6.7% of the GDP. The home attention is about 40% of the whole attention provided by primary attention doctors. An important part of those 20.000.000 of people are considered dependent people (around 4.000.000 people). That means that they are not able of developing some of the so called activities of the daily life (such as taking care of their personal hygiene or getting dressed that are meant to be those that a person needs to do by itself in order to live autonomous) and need the help of another person to perform those. Of those 3.874.900 people lived in their own house (by their own or with family or relatives) and only 269.139 were institutionalized. If we have into account the people that live in their own houses, 2.088.200 received any kind of external help, being prevalent help provided by family and relatives (1.413.000 had informal carers) while the rest were formal and professional carers. So Spain is within the so considered Mediterranean Welfare State Model in which care is essentially provided on a familiar basis and system. Informal care is the one provided within the social network of the patient and in a completely altruistic way (without any kind of intermediate organization or remuneration). Formal care is the one provided by public services or bought in the market by the families. In Spain it has been estimated that the 88% of the health care is provided by informal carers. Actually one of the main trends is leaded by the Act of 2006 that establishes a system of attention for the dependent people. This act divides dependent people into different categories and provides different kind of services in relation with the degree in which people are limited in their autonomy. This law establishes a homogeneous social services system for the Spanish territory trying to overcome the differences existing due to the fact that Social Services are one of the competences of the Autonomous Communities. Nowadays, thanks to this act, there is a common framework for the social assistances to non autonomous people in Spain. But there can still be differences between the 17 Social Services Systems due that the National System only establishes the minimum of the attention provided in the different Autonomous Communities. So, actually, in Spain one of the main concerns about the health care developed in the house of the patients is that it has to be developed in a socio-sanitary framework. There has to be a connection between the health services and the social services. Only by this means it will be possible to develop a comprehensive attention to this people that are the main part of the people that receive home health care. This attention has to have into account the social environment and conditions in which the life of the dependent person takes place as well as his/hers health circumstances. The principal users of those services are diverse but the most important group is formed by old people that suffer any kind of pluri-pathology and functional deterioration, that experiment difficulties with their autonomy, or terminally ill people who need palliative care in their own house. The estimate prevalence of people who need this attention is about 14% between people older than 65 years. In those cases the effort has to be delivered in order to satisfy the care necessities of the patients and to educate and support their principal

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carers within the family. With regards to the pathologies that can be treated at home, be it in a palliative phase or in a critic ones. The most general ones are chronic processes with frequents exacerbations, acute processes in a stabilization phase (it is used to finish treatments).

- Oncologic
- AIDS
- Surgical: for the care of the inmediate post-surgery treatment.
- Specific lines of work like enteral nutrition, early rehab of C.V.A.
- Neuronal Diseases (meningitis, multiple sclerosis).

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3. National Bodies in charge of the home health service

In Spain, as it has been said, the Health Services are provided, in their main part by the Social Security and is funded by taxes. So every national, child and non-national but municipally registered, is enabled to obtain attention from the Public Health Agencies.

This kind of services are provided, into the national level, by the following bodies and agencies:

- Primary Home Health Attention: is given by the primary attention doctors and nurses and can consist on urgent or programmed attention. This attention can be provided as primary attention for critic situations (before delivering to a critic hospital) or can be provided as a primary attention.
- Home Health Teams: In some Autonomous Communities there are Home Health Teams that provide attention for people who are not able to go to the regular primary health centres (because of their circumstances). In those cases the team (compound by doctors, nurses and social assistants) goes to the house of the patient and provides in there the necessary attention.
- Health Attention for Terminally Ill people: is given by the health care system to those people who are in the final stages of a Terminal Illness. It helps the patient and the family to make the process easier and provides attentions that can be provided out of an institutional (hospital) environment.
- Finally we can find what is called Home Hospitalization: it is considered as a group of Health actions and protocols that are provided in the patient´s house and that have an intensity, complexity and duration similar to those that would be delivered in a conventional hospital. For those cases there is a specific team made of doctors, nurses, health auxiliaries, physiotherapists and social workers that develop the proper actions in the field. These units depend of a Hospital of Reference and are directed by the Hospital´s direction team and make urgent and programmed home interventions. These programs pretend to reduce the medium stay in the hospital maintaining, at the same time, the necessary attention and improving the quality of life and reducing the amount of inappropriate hospitalizations.
- And in the area of the Social Services we can find Home Social Services. They consist in assistance actions given through auxiliary home staff in order to do the housekeeping job, and some basic personal care as hygiene, mobilization, regular shopping, cooking, etc. This is a kind of attention that relies on the non Sanitary Social Services and is complemented with the informal help provided by patient´s family. In Spain are the municipalities the responsible of implementing those services and putting them at disposal of the people who need them.

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4. National policies implemented to promote and improve the home health service.

One of the most challenging realities for the Spanish health system is the fact that our population is ageing and that increases the number of cases in which assistance, whether in the office of the doctor or at home, is necessary. That is why it is one of the most important reasons to improve the health care provided to people over 65. This have a very strong relationship with home health care as far as those people are more prone to suffer multiple pathologies and therefore to need an attention that can, very well, better provided at home because of different reasons. Between them it is considered much better not institutionalize people when not needed having into consideration two groups of questions: It is better for their social life and environment (as far as it makes life easier in many ways for families) and therefore for their own health; It prevent, in many cases, the necessity of being hospitalized (so it releases hospital resources for other cases). Therefore the increasing pressures over the system related with the ageing of the population make necessary a change in the home health services in order to cope with those realities. Actually there is a political trend that is stated in the “Framework for the improvement of Primary Attention on Spain 2007-2012” as part of its strategic vision, developed by the State Department on Public Health as guidelines for the whole country. More specifically its strategic line number 26 is described as it follows: To promote the health home activities and the involvement of sanitary professionals in the attention of people with dependency problems. Its purpose: To improve home health care. In accordance with this framework, with this purpose, the action lines that are developed are the following ones:

- To promote home health assistance plans, implemented within the primary attention scope, in which the goals of health assistance delivered to dependent people and their carers.
- To promote and increase the coordination of those plans with other sanitary measures (like home hospitalization) and with social services.
- To include in home health assistance, the necessary care for dependent patients, for people with serious mental disorders and terminally ill patients.
- To spread the activities of health promotion, of prevention of dependency situations and, any other focused on the maintenance or recovery of capacity and autonomy for de performance of daily life activities, from the Primary Attention.
- To include, in home health care programs, the necessary activities for psychosocial attention for the carers of dependent people.
- To incorporate, in home health care programs, the necessary activities for people that need enteral nutrition, the application of breathe therapy and other physiotherapist techniques.

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5. Strategies and Initiatives developed to promote and improve the home health service.

In Spain, as said before, the system is composed by 17 subsystems, as many as regions, what makes that almost any initiative has to be a regional or local one. But there is common ground for some of them. One of the most commonly used in this case is what is called Domiciliary Attention Program that is planned and carried out within the area of the Primary Attention. In those areas, but also in the hospitals, is being more and more common what is called “linking nurse” or “Case manager”. This is an attention model that is addressed to tread each case in a singular way in order to improve the care given. Those nurses have the responsibility of management and coordination of the different health services provided to the user of domiciliary attention (e.g. primary attention, specialized attention…). By these means the case manager, knowing the situation and Medical Records of the patient, is able to reduce the fragmentation and to avoid the duplications in the health services provided to each singular patient. And the case manager, when does that, prepares a attention domiciliary plan adapted to each situation. The conclusion is that this figure helps to improve quality and cost-efficacy ratio of the health services. Those case managers have within their scope of responsibilities: to attract actively patients for the home health care service, when they need it, to assess patients and their necessities and families and informal carers and to prepare a care comprehensive and continuous plan for each singular patient. This figure, the case manager, has been introduced in Spain by the Health Service of the Autonomous Community of Andalucía in 2002 and the rest of the Autonomous Communities are introducing this professional, not without problems, progressively. By the characteristics of its job those professionals have a very important social working dimension which can be conflictive if the activity areas are not well defined between social and health care services, this is the opinion of important researchers as Mariano Sánchez Robles from CSI in Spain. But, on the other hand, their work is justified because of the different languages used by Social Services and Health Services. Those differences make easier for a case manager the contact and coordination with the different kind of health services. Another line of work is the improvement of the Home Hospitalization. This is still infrequent because of the resources needed in those cases. As said above it was born because of the lack of places in the hospitals for some specific cases in which health attention can be provided, in a controlled way, at home. Sometimes it is even better that being at the hospital because the nature of the pathologies treated. And, with regard to the comfort of the patient, patients normally feel better when they are in their own environment with their family and friends. This kind of attention, that in Spain in provided within the scope of the specialized attention, is meant to be provided by a multidisciplinary team that will include doctors, nurses, psychologist (both for the attention of the patients and the carers), social assistants, infirmary auxiliaries and physiotherapists, among others. The resources, techniques and care provided are, all of them, within the scope of specialized health care. The attention would be the same that would be provided in the hospital but at the house of the patient and always be delivered by a limited amount of time until the patient is finally cured or his/her attention is transferred to the primary attention services. This kind of hospitalization in very helpful, as said above, but It is important to mention that it is also very expensive because of the costs of the team and equipment that has to be joint in order to implement this kind of home health care in the proper way. And in relation with this kind of care, it is to be mentioned that in Andalucía, in the south of Spain, there are also “care managers” at the hospitals related with this kind of hospitalization. So this kind of action is always related with public health services and is relatively modern so, as said before, it is not very extended in Spain. The lack of common plan and the decentralization in health services brought as consequence that this kind of attention has not been homogeneously developed over the whole territory of Spain. Up to 2011 there were 100 units (only 3 of them were private) in Spain that provided this kind of attention in 15 of 17 Autonomous Comunities. With regards to the results It is important to mention that this kind of care is not always cheaper that traditional hospitalization, sometimes it is even more expensive. But from the point of view of patients (who feel that this kind of hospitalization fulfil their demands of accessibility, continuity, adaptability and personalization of health care) and health professionals and managers (who are capable of manage the resources in a more efficient way, reducing the

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amount of time that the regular hospitalization takes, or releasing resources as beds for more urgent regular hospitalizations) this kind of measure is appropriate in many cases. That are the conclusions of a review of the situation in Spain after more than 25 years of this kind of service which began to provide services in 1981 in Madrid for the first time. Other great course of action that is being undertaken, in many of the autonomous communities in accordance with social services, is the care provided to the informal carers. It is due many of those carers have very delicate situations when taking care of their relatives. The implication they have with the situation that is taking place, in most of occasions, at their own homes is personal. It is considered that 80% of informal carers devote time every single day of their week to care of their parents, children, dependent relatives, etc. And between them 50% are considered to take tranquilisers. Many of the have what is called syndrome of the principal carer. As established in an studio (Programa de intervención multidisciplinaria para cuidadores de pacientes en atención domiciliaria) made over the consequences of a program of attention to principal carers, when somebody is overburdened with care charge his/her quality of life can diminish and his/her risk of morbidity and death increases. That overburden depends on subjective experiences and social support than on the real assistance they give to the patients. One of the main risks is psychological morbidity and a part of the home health care programs are aimed to reduce this risk. The study mentioned above took multidisciplinary home health care actions with regard to the care of carers during a period of 15 months with 79 patients and relatives (using 39 of them as control group). The conclusion was that this kind of attention does not reduce the overburden that those people experiment but do reduce their psychological morbidity. The proposal that arises from the conclusion of this study, as from many other studies in the field, is that this kind of actions is necessary in home health care and that should be provided by doctors and nurses in their regular home visits to the patients. But when talking about this kind of actions we should not forget that we are in the fringe between health and social care and that can bring problems if the scopes of action of both systems are not well defined. In the same sense we need to talk about the general discussion right now in Spain as consequence of the approval of the Dependency Attention and Autonomy Promotion Act in 2006. That is the integration of the social and health care for the attention to dependent people. Having into account the dependency criteria defined in the law it is very important to have into account the environment of the patients. Those patients have always a double dimension they have a pathology that reduces their autonomy and they are part of a social reality. So patients are assessed with regards to their autonomy in their own houses as far as they reality is considered as a whole. And this assessment produces a qualification of their dependency degree of other people. But the reality is that with independence of the assessment made at home, the Law establishes a service charter in which there are not provisions for socio-sanitary integration. The consequence is that people that need of both kind of services need to duplicate their efforts in order to get them. This coordination is responsibility of the respective Autonomous Communities in their territories. That is what the Dependency Act establishes in its article nº 11 saying that is responsibility of the executive bodies of those entities to create the necessary units for coordination. Very few Autonomous Communities have regulated socio-sanitary coordination up to now On December 2011 has been published the white book for socio-sanitary coordination by the National Institute of Elderly and Social Services. This document analyzes the situation with regards to that kind of joint actions. In the white book it is established that there is a general and positive tendency to develop ways to promote integral attention and coordination between health and social sectors. Some actions that reveal a real and explicit politic commitment and a important bet for this model of attention (both at national and regional levels). But the implementation and development rhythm of those measures is very different between regions. Acts, protocols, organizational models, and financial commitments... have been undertaken in many Autonomous Communities in relation with the necessary coordination, but even though there are protocols to transfer out patients to other hospitals, primary services, residences or programs... they are still very few with regards to social home assistance and home health care. Only 3 autonomous communities have this kind of protocols in a model that, following the white book, has to give special importance to this kind of coordination. To establish a joint chart of socio-sanitary services, to match social services and health services maps in the territory and protocols to transfer out patients between services are

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among others the key that the book provide to improve the home health care attention in the sense of coordination with social services. Finally it is important to have into account that some services already provided by the social attention system have a health dimension. It is very important in Spain a measure denominated tele-assistance. This assistance consists in an alarm device that is connected to an emergencies service. When a disabled, or an old or chronic patient live alone can request from the social services that they install one of those devices in his/her home. If the patient falls down or have any kind of sudden problem that makes him/her need external help, he/she can use this device (is like a button that hangs from a necklace) and the connexion is quick and effective. On the other hand is important to remark that technology is making easier home health care in different ways: It can help the case manager in the management activity, the use of different devices by patients (PDA or Tablet PC), monitoring of patients, administration of medicines... Those can be very helpful in the development of the home health system.

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6. Description of Training Courses for Professional Health Carers on the Issue.

6.1 Training Courses.

With a base on the Dependency Act and the increasing care provided on the patient´s house there is a important tendency to increase the number of courses developed in Spain. Many of them are delivered by private institutions (in the area of social care services) to train future workers. The content of those courses are both social and health care. One of the most common courses, in that sense, is a course on “Hygiene and Home Health Assistance”. This course is authorized by the International Commission of Training of UNESCO. This is aimed to set the principles and bases of the specialized intervention with dependent people. It pretends to transmit the necessary knowledge, skills and competencies that allow people to develop activities of attention and promotion of the autonomy of elder, disabled and convalescent people in their homes. The following one is developed for people who do not have competencies in this area and try of give a response to a socio-sanitary model that is more and more demanding of The training program includes the following modules:

- IIdentification of the characteristics and necessities of dependent people.
- Specification of the scope of home attention.
- Techniques for the hygiene of dependent people.
- Menu planning.
- Use of feeding techniques.
- Stools Disposal.
- How medicines should be taken at home.
- Mobility of dependent people.
- How to check vital signs.
- First Aid Techniques.

Courses in the area of Life Long Learning with the idea of continuous training are the following one. There are specialized courses for professionals related with the different possible areas of intervention in domiciliary attention. But nowadays this is the kind of courses that is being developed in the area. Those courses have a very good acceptation because of the existence of a wide range of private companies that provides home health care in relation with social services. The private health companies provide a minor amount of the home health care.

6.2 Competencies.

With regards to the necessary competences, in the socio-sanitary (having into account that home health attention has always a social dimension) professionals, some studies have been developed. A professional in this area should be, in accordance with Bienvenida Gala Fernández, Sergio Romeo López Alonso and Rosa María Pérez Hernández:

- Close professional: with regards to the presence in the territory and with regard to his/hers identification as part of the health care system that provides the service.
- Competent: capacity to integrate knowledge, skills and attitudes associated to professional good practices.
- General Vision: in order to asses properly the different necessities to the patients.
- Anticipation capacity: having into account the proximity to the population.
- Capacity to manage the shortage because of the lack of resources.

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7. Identification of best practices.

7.1 REPOCA® Proyect.

Universitary Hospital Dr Peset with VitalAire, has developed an Domiciliary Attention Program for people who have COPD. This is a continuous attention domiciliary program that includes programmed domiciliary attention, telephonic monitoring and medical and nurse attention on demand, besides of educative sessions in which the professionals work together with patients and carers on questions like vaccines, pollution, nutrition, sexuality or tobacco detoxification. The attention equipment was supported by a pulmonologist in ambulatory regime. The main objective of this program was to assess the efficacy of the domiciliary attention, in patients with serious exacerbations of COPD, in order to reduce the necessity of hospital attention and hospitalization. This program has been very successful. They have worked for a period of 6 months in the region of Valencia Autonomous Community and they have reduced the hospitalizations in 83%. They have assisted to 25 patients with mild (8), serious (8) and very serious (9) COPD. The program has also reduced the medium number of exacerbations that those patients suffered in relation to the previously same period of time. The quality criteria of this practice are that:

- They have delivered a new domiciliary attention program.
- They have accomplished their objectives, they wanted to reduce the number of hospitalizations of their target population and the number of the crisis of exacerbation of COPD that they have.
- And they did it through a program based on prevention and sanitary education which improved quality of life of their patients and families. I think that this is the main criteria of success of this program besides the fact that the patients felt safer knowing they could turn to the program for help.

More info in http://www.vitalaire.es/es/rss/vitalaire-presenta-los-primeros-resultados-del-proyecto-repoca-en-el-ii-simposium-internacional-epoc-y-tabaco-que-tendra-lugar-en-caceres-los-dias-10-y-11-de-noviembre.html

7.2 Telephonic Communication Plan for Carers.

This is a program that is being tested right now in one of the Centres of the Public Health Service of the Autonomous community of Andalucía. The program is aimed to provide a telephonic attention to the informal carers of the patients that are dependent or are immobilized, present a special fragility or risks in their own houses. It gives the carers the possibility of consulting and obtaining advice from their nurses or case managers about the problems and situations related to the patient´s situation. The case manager will provide the carer with the necessary contact information and in the primary services there will be the proper coordination in order to transfer the calls received in this program to the proper professional (be it the nurse, the doctor...). The specific objectives of this program defined by it are: to avoid or reduce complications on the immobilized patients; to provide answer to the questions and doubts presented by informal carers; to provide information to informal carers; to avoid the necessity or reduce the frequency of the urgent assistance; and to manage health resource avoiding unnecessary trips. This practice has been chosen because of the innovation that implies to have a very good protocol for telephonic attention to carers. The program began on 1st September 2011 and has to finish at the end of 2012.

For more info: www.saludinnova.com/practicas/view/942

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