Stakeholder Perspectives on Patient Experience with Transitional Care after an Acute Neurological Event in Argentina

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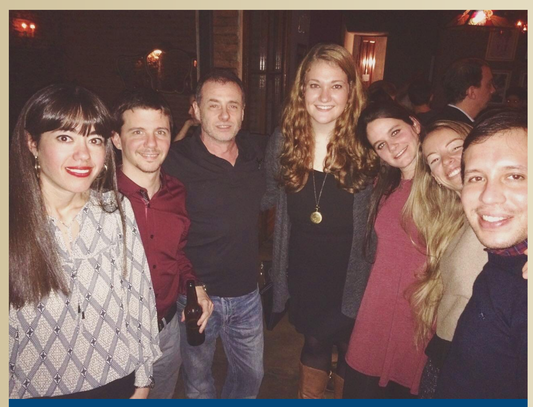
PROJECT SUMMARY: The lack of a hospital to home transitional care strategy represents a gap in services that threatens patients' ability to heal after an acute injury or illness and unduly burdens their caregivers. This study uses Brofenbrenner's ecological systems theory to ethnographically explore perceptions and attitudes of caregivers, healthcare providers, and service leaders about patients' experiences with transitional care after an acute neurological event in Argentina. Findings can inform development and improvement of patient and family-centered care across the care continuum.

PROJECT OBJECTIVES

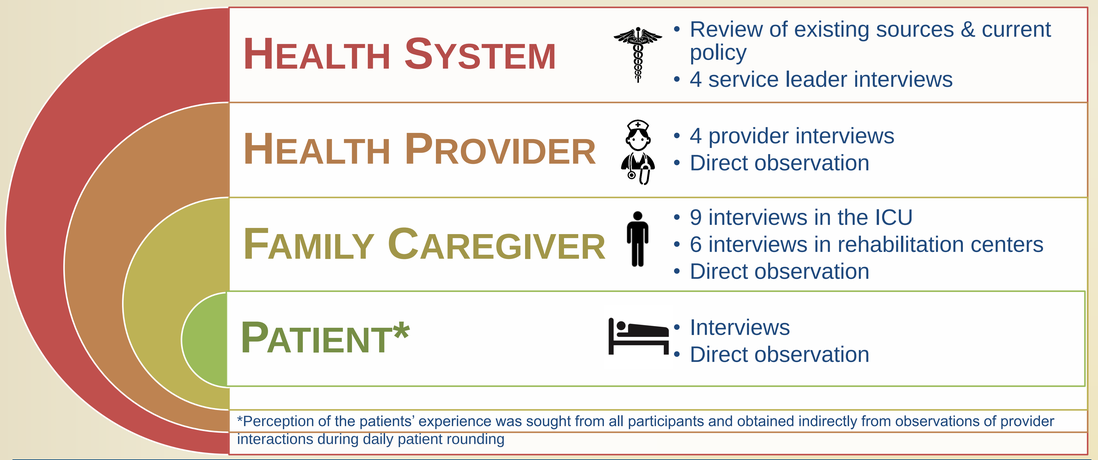
AIM 1: To qualitatively explore patient and family experience with newly acquired disability while transitioning from hospital to home after an acute neurological illness or injury.

AIM 2: To qualitatively explore patient and family experience with newly acquired disability while transitioning from hospital to rehabilitation center after an acute neurological illness or injury.

AIM 3: To understand the Argentinean healthcare system, specifically relating to disability.



Research team in Buenos Aires



Research design based on Brofenbrenner's ecological systems theory

METHODOLOGY

10 weeks of direct observation of daily patient rounds by providers in an Intensive Care Unit

23 qualitative, semi-structured interviews

- 15 family caregivers (unpaid family members)
- 4 providers (front line health professionals)
- 4 service leaders (hospital administrators, community program leaders, and health professionals not providing direct care)

Caregiver interview topics: caregiver experience, patient experience, challenges, coping, anticipated outcome, and obstacles

Provider and service leader interview topics: provider experience and knowledge, attitude, and practice questions regarding patient and caregiver experience

WHAT IS TRANSITIONAL CARE? A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations/levels of care within the same location (Coleman, 2003).

PRELIMINARY RESULTS

Service Leaders

- Providers overwhelmingly identified need for "better" transitional care, continuity of care, and better hospital-based rehabilitation services
- Policy culture (Joint Commission)

Providers

- Some providers identified need for broad systems-level change, while others recognized isolated strategies within individual expertise.

Family Caregivers

- Uncertainty, fear
- Reliance on providers
- Complete life change
- Acknowledgment that patients would never return to previous functionality & redefinition of successful rehabilitation

Members of the Hospital Italiano de Buenos Aires ICU Neurology team at work

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