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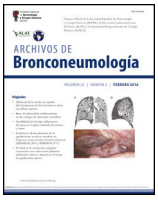

Editorial

Home hospitalization in pulmonology: Efficient management and high patient satisfaction☆

Hospitalización a domicilio en neumología: gestión eficiente con elevada satisfacción de los pacientes

New healthcare models have recently been developed to optimize care and streamline costs in the treatment of patients with respiratory disease. Hospital at home (HH) and early supported discharge (ESD), often evaluated jointly in meta-analyses, avoid admissions and shorten the average length of stay in selected patients, while offering a quality of care similar to that provided by conventional hospitalization (CH), along with lower mortality and readmission rates.[1–4] This approach also increases patient well-being and reduces the risk of nosocomial infection.[5] According to a recent study, the combination of HH and telemonitoring would allow most COPD patients to be treated at home, decreasing emergency visits and reducing the number of patients admitted to CH by 60%.[4] HH and ESD are safe and effective not only for the treatment of acute COPD, but also for other patients with respiratory symptoms, such as decompensated heart failure,[6] respiratory infections in patients with neuromuscular disease,[7] or pulmonary thromboembolism in hemodynamically stable patients.[8] Studies conducted in several countries with different health systems and different HH/ESO organizational structures agree that these solutions are less costly than CH, even in older patients with more serious exacerbations or worse baseline status.[2–5,9] The degree of satisfaction, speed of recovery, and quality perceived by both caregivers and patients treated with HH and ESD is high: a high percentage indicated that they would prefer this type of admission for future exacerbations.[2–4,10]

However, although the advantages of HH/ESD are manifold and this approach is recommended by clinical guidelines as an alternative to CH,[11–14] it is rarely selected as an admission modality. Dismore et al. recently identified possible causes[10]: reasons given by patients include fear of being alone during the night, delayed medical care compared to CH in the event of complications, and perceived stigma associated with receiving support from the social services, while some are concerned about privacy issues associated with the presence of strangers in their home. In contrast, some patients see admission to CH as an opportunity to interact with other people or to try to quit smoking. Furthermore, it seems that clinicians continue to believe that CH is safer for their patients and gives caregivers the opportunity for a break to avoid burnout. The development of referral protocols with clear criteria agreed on by all the departments involved would undoubtedly help to reduce the apparent misgivings surrounding this care modality, and underline the clear advantages that it provides for both patients and family members and for the health system.

Several HH/ESD models that differ in terms of infrastructure, professionals involved, number of visits made, telephone support, and access to services such as rehabilitation or social support are efficient if clear inclusion criteria are followed, certain health and social welfare conditions are met, and families are supported. Continuing care can be guaranteed if responsibilities are shared between primary care and HH teams, provided chronic and acute needs are clearly differentiated in order to avoid conflicting responsibilities and overlap with services already covered by primary care.

Now it is our turn.

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