POLICY NOTE :: HOSPITAL DISCHARGE

Strengthening Hospital Discharge to Improve Patient Care and Health System Sustainability in Moldova

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APRIL 2024

Health, Nutrition and Population Global Practice

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EXECUTIVE SUMMARY

- **In its National Development Strategy 2030, the Government of Moldova made addressing noncommunicable diseases (NCDs) a key priority.** As part of the effort to lessen the burden of NCDs, the Ministry of Health (MoH) launched several ambitious initiatives focused on optimizing the national hospital network, regionalizing stroke care, and modernizing rehabilitation services.
- **The hospital discharge process is a critical step in ensuring that a patient's needs are fully met in order to achieve the best possible health outcomes after an acute episode.** This step is especially important - and challenging - for patients who have more complex needs such as those associated with chronic diseases, or who need additional post-discharge care such as rehabilitation services.
- **In fragmented health systems, such as Moldova's, suboptimal discharge processes can significantly impact treatment adherence, continuity of care and health outcomes, increasing the risk of rehospitalization and adverse events** (which studies have found can affect 19% to 23% of patients within three weeks of discharge).
- **Key areas for improvement identified with regards to the hospital discharge process in Moldova include insufficient information sharing and coordination between hospitals, primary health care and social care;** a lack of incentives for hospitals to improve continuity of care; and limited infrastructure for post-discharge care, especially with regards to rehabilitation services and home care, which creates delays or gaps in care that can affect a patient's recovery.
- **The need for a more holistic lens and greater standardization of the discharge process at the national level was raised,** and recommendations include the development of standardized assessment tools and guidelines to support a more systematic and person-centered approach.
- **Digitization is another important element of strengthening the hospital discharge process, and the implementation of several digital health initiatives** (such as e-referrals and e-appointment systems) is already a key priority for the MoH, aimed at improving information sharing and coordination between the different levels of the health system.
- **In addition, expanding workforce skills and developing performance indicators and payment mechanisms were identified as key levers** to promote and incentivize greater continuity and coordination of care in this context.
- **Finally, patients and caregivers must play a central role in any strategy aiming to support safe and effective transitions of care**, and strengthening patient education and support for informal carers was highlighted as a key area of focus.
- **Strengthening the hospital discharge process would result in a more efficient health system,** better equipped to address the rise in complex discharge needs fueled by Moldova's demographic and epidemiological trends and, by improving coordination of care, would also facilitate the effective implementation of MoH's priority reforms and provide a robust foundation to support the delivery of more integrated, person-centered health services, as outlined in the National Health Strategy.

Background

As a crucial point of transition, hospital discharge can be a complex episode in a patient's care pathway (Waring et al. 2014). Strengthening hospital discharge processes offers an opportunity to improve care and increase cost-effectiveness, which are key objectives of the Government of Moldova's National Health Strategy. Beyond Moldova, suboptimal hospital discharge processes have been shown to increase the risk of adverse events (Foster et al. 2003, 2004; Moore et al. 2003), with studies finding that about half of patients experienced a medical error after discharge and 19% to 23% suffered an adverse event within three weeks (Kripalani et al. 2007; Foster et al. 2003). Poor communication between hospitals and post-discharge care providers was found to be the leading cause of half or more preventable adverse events post-hospitalization (Patel et al. 2019). Because such events increase the likelihood of costly hospital readmissions, suboptimal hospital discharge processes can have major financial implications for patients and providers. Moreover, delayed or uncoordinated discharges result in longer hospital stays and beds being "blocked" (Glasby 2003). Increasing cost-effectiveness and quality of care by optimizing discharge processes and reducing the risk of readmission would therefore support the government's efforts to achieve the goals of the National Health Strategy "Health 2030."

BOX 1

Defining hospital discharge

Hospital discharge refers to the formal process by which a patient leaves an acute health care facility after receiving medical treatment or care. Transitions between hospitals and lower levels of care (e.g., care at home or in specialized outpatient facilities) are recognized as high-risk scenarios for patient safety (WHO 2016) because of high rates of medication errors, incomplete or inaccurate information transfers, and lack of appropriate follow-up (Coleman et al. 2006). (See Annex 1 for an overview of the most common issues related to hospital discharge.)

Patients with noncommunicable diseases (NCDs), especially patients with multimorbidity,[1] generally have more complex discharge needs, and they are disproportionately affected by inadequate coordination of care, which increases the cost of their care and lowers its quality. In the UK, the National Health Service estimates that about 80% of patients have simple discharge planning needs and 20% have complex discharge needs (Health Service Executive National Integrated Care Advisory Group 2014). Those needs can include specialized medical equipment, accessibility modifications, rehabilitation, coordination with specialists, multiple medications, home care services, social assistance, and caregiver support. Patients with complex needs typically account for a disproportionate share of health spending, partly because they are at higher risk of rehospitalization.

Moldova's demographic and epidemiological trends are fueling an increase in complex discharge needs. The share of people aged 60 and over is expected to grow from 24% to 34% of the population by 2050 (National Bureau of Statistics of the Republic of Moldova 2023; IMF 2023), and older age is associated with an increased prevalence of chronic diseases and multimorbidity (Goodwin et al. 2014) (in Moldova, approximately 71% of the elderly suffer from chronic diseases [Holla et al. 2017]). Moldova also faces a rising burden of NCDs, which affect more than half of the population, and the number of people per 100,000 population who die prematurely from NCDs is higher in Moldova than in the World Health Organization (WHO) European region overall (Mosca and Richardson 2022). Heart disease, stroke, cancer, diabetes, and chronic respiratory diseases account for nearly 90% of all deaths and approximately 4 out of 10 primary disabilities in Moldova.[2] Both older people and people with NCDs are at higher risk of repeated hospitalization and avoidable readmissions if their post-discharge care needs are not properly addressed (Laugaland, Aase, and Barach 2011;

1 Multimorbidity is defined as the co-occurrence of two or more chronic conditions.
2 The primary disability is the major or overriding disability condition that characterizes an individual's impairment.

Murray et al. 2021), especially if they suffer from multimorbidity (Griffin et al., 2023). For example, a European COPD Audit carried out across 13 countries found that 35% of patients were readmitted within 90 days of discharge (Hartl et al., 2016), and that the inclusion of a number of interventions into a discharge care bundle were shown to reduce readmission rates (Kendra et al., 2022; Hopkinson et al., 2012). Similarly, the 2021 OECD average rate of hospital readmissions within one year of discharge was 22.4% for patients after an ischaemic stroke, and 32% for patients with congestive heart failure, but these rates varied by country – in the Czech Republic for example they represented 29.5% and 39% respectively (OECD 2023).

Strengthening hospital discharge processes is a vital part of optimizing the Ministry of Health (MoH)'s investments to strengthen rehabilitation services. As a result of Moldova's high NCD burden, current and future demand for rehabilitation services is substantial,[3] with the WHO estimating that 1.6 million Moldovans had at least one condition that would benefit from rehabilitation services (WHO 2022). Yet, due to limited provision, Moldova faces substantial unmet demand for rehabilitation services, which limits patients' ability to recover, and rejoin the workforce after catastrophic health events, in turn impacting the country's human capital. In response, the MoH has embarked on an ambitious program to strengthen rehabilitation services. However, findings from site visits and interviews suggest that inefficiencies in patients' transition from hospital to rehabilitation services affect continuity of care and risk undermining the benefits of rehabilitation services, and patient recovery more generally. Strengthening hospital discharge processes is therefore important to support the government's efforts to modernize rehabilitation care.

Strengthening hospital discharge processes will also support the government's efforts to optimize the national hospital network. The reorganization of the hospital sector led by the MoH aims to develop regional "centers of excellence" to reduce bottlenecks at tertiary-level (republican) hospitals located in the capital, and to reroute health services away from low-performing, low-volume district hospitals in order to improve the efficiency of the hospital sector and free up resources in a challenging economic context (see Box 2 for more details). With hospitals located further away from local communities and post-discharge care providers, there will be a greater need to improve discharge processes and to strengthen coordination between providers to ensure continuity of care.

BOX 2

Overview of context

Moldova faces economic challenges despite two decades of solid performance. The economy is largely dependent on agriculture, with wine production being a significant sector. Moldova's GDP per capita was US$5,714 in 2022 (World Bank, 2023), reflecting a continued increase since 2015, yet issues such as high unemployment and extensive emigration have impacted social conditions, contributing to poverty and inequality. In addition, recent factors such as the impacts of the war in Ukraine and the influx of refugees have created a challenging socioeconomic environment in the medium term (World Bank, 2023).

Moldova saw a rapid increase in public health spending since the introduction of mandatory health insurance in 2004, with public health spending as a share of GDP remaining below EU average but above average compared to countries with similar income levels. Current health expenditure (CHE) grew in absolute terms from US$21.4 in 2000 to US$306.6 in 2020, representing a fifteenfold rise, while the share of public health expenditure also grew, accounting for nearly 65% of CHE in 2020. Public spending on health increased from around 2.9% of GDP in 2000 to a peak of around 5.8% in 2009, fluctuating in following years to 3.8% in 2019 and 4.8% in 2020 - below EU average but above the average of lower middle-income countries in the WHO European Region (Mosca and Richardson 2022). In 2021, the share of the population covered by the National Health Insurance Company (CNAM) was 87.7% (Mosca and Richardson 2022).

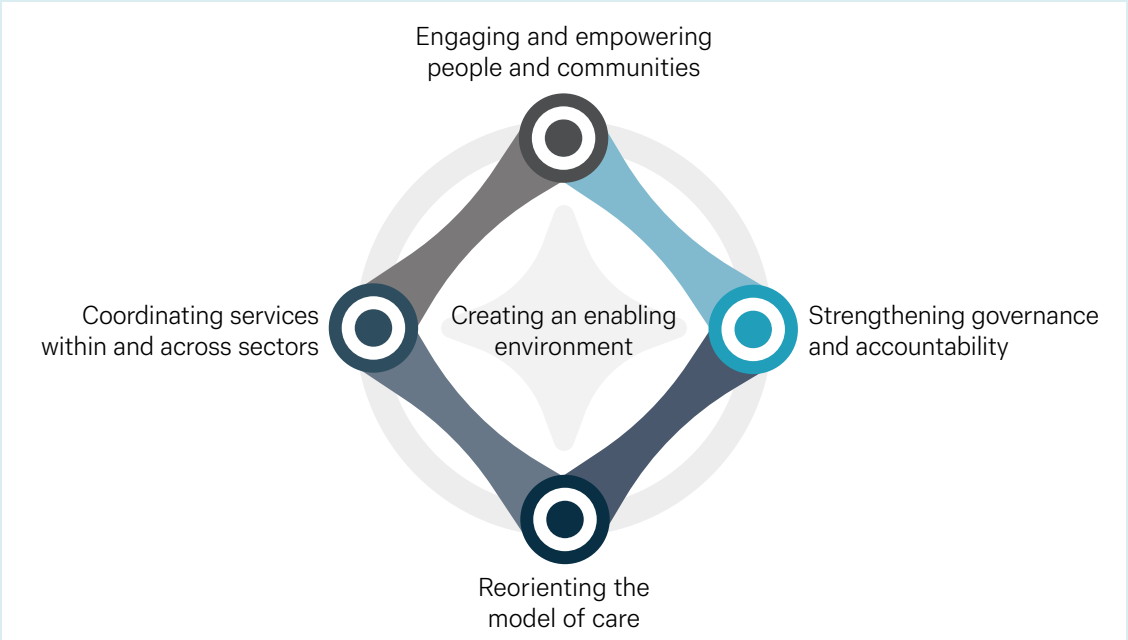
3 WHO (2023a) has defined rehabilitation services as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment."

More broadly, delivering "integrated, person-centered, equitable and accessible health services across the lifespan" is an overarching priority of Moldova's National Health Strategy "Health 2030", and optimizing hospital discharge would facilitate the implementation of the country's integrated care goals. The strategy notes that the health system is constituted of a "fragmented group of service providers", and that the delivery of well-coordinated health care services and the "organization of health activities from a beneficiary perspective" would improve health outcomes and access to care for the population.

State of play and good practices

This section assesses the current state of hospital discharge in Moldova through different lenses, adapted from the five strategies of the WHO's Framework on Integrated People-Centered Health Services (IPCHS). WHO's IPCHS framework (see Figure 1) provides a useful structure for understanding how to improve hospital discharge processes in Moldova and support the delivery of integrated people-centered health services as outlined in "Health 2030". The following assessment is based on findings from a comprehensive desk research, key informant interviews with hospital directors, family doctors, academics, and government representatives, site visits to hospitals and rehabilitation centers (in Chișinău and Hîncești), as well as meetings with representatives of the Ministry of Health (MoH), the Ministry of Labour and Social Protection (MoLSP) and the National Health Insurance Company (CNAM) all of which were carried out between September 2023 and March 2024. Selected examples of good practices are highlighted where relevant.

FIGURE 1. The five interdependent strategies of the WHO Framework on Integrated People-Centered Health Services (IPCHS)



Source: WHO 2018.

Coordination of services

Paper-based discharge limits information sharing between hospitals and primary health care (PHC) in Moldova, compromising patient care and opportunities for cost-effective service delivery. Despite efforts to improve integration within the health system, coordination between

hospitals and primary care remains very limited, and separate electronic systems hinder the transfer of information between hospitals and PHC providers.[4] As a result, discharge processes are paper based. The template for the discharge letter is standardized,[5] based on a form approved by the MoH that interviewees suggested had not been updated since 1991. The discharge letter is given directly to the patient upon discharge, and it is the patient's or carer's responsibility to share the discharge letter with the family doctor; there is no other mechanism to alert the doctor of the patient's stay in hospital. In some cases, for example in more rural areas, the hospital might have a closer or pre-existing relationship with local PHC providers, in which case the hospital might inform the family doctor directly of the need for a follow-up for certain patients, but such coordination is not systematic.

Patients are expected to navigate post-discharge care and may face real or perceived barriers in following up with their family doctor. This arrangement places too great a burden on the patient and increases the likelihood of complications and low adherence to treatment.

Family doctors are responsible for prescribing medication and providing any referrals needed by the patient after discharge (for example, referrals for rehabilitation care must be provided by the family doctor). However, interviewees suggested that patients do not always comply with instructions to follow up with the family doctor upon discharge from hospital, which means that family doctors may often not have the necessary information to ensure adherence to treatment. Compliance with follow-up appointments varies between patient groups [6] and might be affected by concerns over additional costs (real or perceived), lack of time, poor access to transportation, and poor understanding of the importance of the follow-up. In addition, this process poses additional challenges in areas where there is a shortage of family doctors (e.g. in rural areas), which can cause delays in the provision of post-discharge care. Hospitals also lack incentives to follow up with patients to ensure that their post-discharge needs are appropriately addressed, even though such interventions have been shown to be effective in reducing hospital readmissions, especially among patients with complex needs (see Box 3).

BOX 3

Multidisciplinary care programs and follow-up calls post discharge have been shown to be effective strategies to reduce hospital readmissions.

In Poland for example, a programme of multidisciplinary care after discharge for patients with heart failure (HF) led to a 37% reduction in overall hospital readmissions and a 48% decrease in readmissions due to HF, as well as reduced lengths of stay, compared to HF patients cared for by their primary care physician only. It involved follow-up visits, patient and caregiver education, telephone counselling and in some cases home visits by a HF nurse (Wierzchowiecki et.al., 2006). Most successful programs aimed at improving transitions of care highlight the importance of conducting timely patient follow-ups, and simpler interventions such as follow-up post-discharge calls can also significantly reduce 30-day readmission rates (Mwachiro, Baron-Lee, and Kates 2019), and represent a relatively low-cost intervention that can be initially implemented at a small scale for a specific group of patients. While such interventions are often delivered by nurses, there are examples of hospitals tasking nonclinical staff (such as trained graduate interns) to initiate post-discharge follow-up calls.

Some examples of follow-up coordination exist in Moldova—for example, in the case of maternity care, the hospital will inform the family doctor after discharge (if information about the family doctor has been appropriately recorded), who will then be required to follow-up with the patient. A similar mechanism exists in some cases for emergency care.

4 A few hospitals have a fully electronic system including patient files, but this is not uniformly the case: district and municipal hospitals for example might collect some basic patient data electronically on admission, but patient records and notes are typically paper based, and even large hospitals are not able to share discharge instructions electronically with other facilities.

5 The discharge letter typically contains basic patient data, reason for hospitalization, information about the diagnosis, tests performed, treatment, and recommendations for follow-up care.

6 For example, employed persons are required to visit the family doctor to obtain compensation for sick leave, which increases the likelihood that the patient will follow-up, but this is not necessarily the case for other categories of persons, such as self-employed people, pensioners or children.

While disease-specific clinical protocols exist, there are no overall guidelines for the hospital discharge process. National clinical protocols, which are based on international guidelines, include protocols for the diagnosis, treatment, and discharge of patients with specific conditions. However, such single-disease protocols do not consider the multifaceted challenges faced by patients with complex discharge needs, and Moldova is missing an opportunity to better support such patients.[7] Examples of interventions targeted at patients with complex discharge needs could include promoting a more systematic and consistent approach to medication reconciliation (see Box 4), which has been shown to be an effective and cost-effective strategy to reduce medication discrepancies, especially for patients with polypharmacy and multimorbidity.

BOX 4

Medication reconciliation interventions to improve hospital discharge.

Medication errors are a leading cause of patient harm in most contexts. A systematic review across 26 countries found that a median rate of one in two patients were affected by at least one medication error (ME), one in two by at least one unintentional medication discrepancy, and one in five by an adverse drug event (ADE) post-hospital discharge, with the median rate of ME and ADEs being higher in the elderly population (Alqenae et.al., 2020). In addition, more than 40% of medication errors are believed to result from inadequate reconciliation in handoffs during hospital admission, transfer, and discharge (WHO 2016). In Croatia, a study conducted to evaluate the impact of medication reconciliation practices found one or more unintentional medication discrepancies in 35% of participating patients, with 60% of these having the potential to threaten patient safety (Marinović et al., 2016). This study shown clinical pharmacist-led medication reconciliation to be an important tool in preventing adverse patient outcomes, and standardized medication reconciliation processes could be widely applied across settings. Additional guidance and resources (e.g. specific training and tools) to strengthen this process for high-risk patients during discharge could therefore yield significant benefits.

In addition, a more systematic approach to identifying complex patients and assessing their needs would also facilitate the implementation of other targeted interventions to support them, such as assigning a discharge coordinator to patients at greatest risk of complications or rehospitalization (see Box 5). The need for a more holistic approach to manage the transition from inpatient care to post-discharge care (including social assistance) and for greater standardization at the national level was a recurring issue raised by interviewees.

BOX 5

Assigning a discharge coordinator to improve efficiency, reduce length of stay, and increase the likelihood of successful self-care at home.

One of the key benefits of a discharge coordinator is the early identification of obstacles to discharge. The responsibility for discharge coordination can be split across a multidisciplinary team, often including both clinical (e.g., nurse) and nonclinical (e.g., peer coach) staff; or it can be assigned to designated staff, including nurses, social workers, or nonpermanent volunteers such as medical students.

In Slovenia, assigning a discharge coordinator to patients with COPD led to significant reductions in both COPD and all-cause hospitalizations during the 180 days after discharge. The main role of the discharge coordinator was to assess patient situation and homecare needs, actively involve

7 In a context of limited resources, interventions to strengthen hospital discharge processes should be targeted at patient groups with the greatest risk of rehospitalization. These groups include patients using high-risk medication; patients with polypharmacy (five or more medications) and specific clinical conditions (e.g., advanced chronic obstructive pulmonary disease, diabetes, heart failure, stroke, and depression); patients with low health literacy, reduced social network, low cognitive status or functional status; and patients having issues with the suitability of the home, availability of support from carers and family, access to social services, or availability of appropriate transportation.

patients and caregivers in the discharge planning process, liaise with care providers (e.g. general practitioner, community care, home care, social services, etc.), and follow-up with the patient post-discharge (Lainscak et.al., 2013).

In the case of mental health reform in Moldova for example, the responsibility for coordination and monitoring of the patient was assigned to the community mental health center.

The lack of standardization also contributes to variation in the quality of discharge information, which undermines the quality of care. Interviewees noted that quality of information provided by hospital physicians in the discharge letter varies, and anecdotal information suggests that quality might be worse in smaller hospitals or in rural areas. They also indicated that the information provided was not always specific enough to enable family doctors to effectively supervise the patient's treatment.[8] Greater standardization and training could improve the quality of follow-up care.

Engagement and empowerment of people and communities

Patient education at discharge is a cost-effective way to improve adherence to treatment, improve patient satisfaction and reduce readmissions (see Box 6). Feedback from interviewees suggests that the level and quality of patient education provided by hospitals in Moldova varies, and that in many cases the information patients receive might be incomplete or insufficiently understood. For example, patients might not have sufficient information to fully understand the importance of following up with the family doctor or the recommendations provided for post-discharge care, especially if the recommendations include the provision of specialist services. This issue is not specific to Moldova, as studies across different contexts have found that many patients could not recall discharge instructions and reported a lack of information on managing their health condition on their return home, impacting their recovery (Sanderson et al. 2009).

In particular, patients with low health literacy were found to be at a significantly higher risk of hospital readmission than peers with higher health literacy (Bailey et al. 2015; Kanejima et al. 2021). However, the fact that patient and carers' associations are underdeveloped in Moldova does present an additional challenge as such associations often play a crucial role in promoting patient education and advocating for patients in other European countries. Therefore, patients in Moldova are more dependent on hospital or primary care providers to obtain the necessary education to manage their conditions. The level of available resources seems to vary between conditions, for example it was suggested that the development of additional patient guidelines and resources for diabetes in Moldova had been supported by an internationally funded initiative and that these were therefore comparably more comprehensive.

BOX 6

Benefits of interventions to improve communication and patient education.

Communication interventions (e.g., pre-discharge counseling on medication, self-management programs, nurse-led education, information leaflets or videos, family consultation, and tailored written information about health, risk factors, or prescribed medication) have been highly effective in reducing hospital readmissions: a 2021 systematic review across 18 countries showed such interventions leading to a combined 31% lower readmission rate, 9% higher adherence to treatment, and 23% higher patient satisfaction (Becker et al. 2021). Patients with chronic conditions benefited the most from such interventions.

In Croatia, the addition of individual pre-discharge pharmacotherapeutic education about discharge prescriptions for patients with Type 2 diabetes led to a 23% increase in medication adherence compared to patients who received the usual diabetes education (Marušić et.al., 2018).

8 Specificity is especially important with regard to medication because it enables the family doctor to monitor treatment adherence.

Insufficient patient education impacts treatment adherence and increases the risk of hospital readmission (Baily et al. 2015) and mortality (McNaughton et al. 2015), especially for persons with NCDs, multimorbidity, advancing age, or disability. Non-adherence to medication is a pervasive issue, as rates of non-adherence to treatment for patients with chronic diseases are estimated to reach 50% on average in developed countries, and to be even higher in developing countries (WHO, 2003). In the European Union, it has been associated with almost 200,000 premature deaths and €80-125 billion of potentially preventable costs every year (Khan and Socha-Dietrich, 2018). Low treatment adherence is a driver of preventable hospital admissions and was raised by interviewees as an issue in Moldova, particularly for patients who suffer from conditions where strict adherence to treatment and long-term self-management are required to avoid complications and rehospitalization, such as patients recovering from strokes or other cardiac events. One study carried out in Moldova examined this issue in the case of uncontrolled hypertension, which is a leading risk factor in the country, with high systolic blood pressure estimated to account for 37% of all deaths in 2019 (Mosca and Richardson 2022). Yet daily adherence rates to long-term antihypertensive treatment have been found to be as low as 27% (Skarphedinsdottir et al. 2014), despite the fact that this medication is included in the reimbursed drug list of the National Health Insurance Company (CNAM).

Discharge decisions in Moldova appear to be driven primarily by clinical factors and financial considerations, and there is little evidence of a systematic process for shared decision-making. There are no standard criteria for discharge, and discharge decisions are generally taken by the treating physician and the head of the department in which the patient is being treated, based predominantly on clinical factors and length of stay considerations. In the case of patients with complex needs, a committee of physicians might be involved in the decision. Interviewees suggested that controlling the use of resources is a key consideration in discharge decisions. Hospitals are not compensated for stays extending beyond a certain number of days following an acute event, resulting in pressure on hospital staff to release beds. Patients and relatives might be involved in the discharge planning at the discretion of individual physicians, but there does not appear to be a systematic process for shared decision-making. Yet, variability in patient and family member involvement in discharge planning increases the risk of post-discharge care not meeting patients' needs and preferences (Hesselink et.al, 2012, Philibert and Barach, 2012). In addition, health systems with limited infrastructure for post-discharge care, such as Moldova's, rely disproportionately on informal care to support patients through recovery, and it is important to offer carers the training and resources they need to provide quality care and act as advocates for patients. In addition, studies from other European countries have highlighted the impact of caregiving responsibilities on the welfare, professional occupation and family and social relationships of informal carers of patients with chronic diseases and higher levels of dependence, and the importance of efforts to improve support for caregivers (Miravitlles et.al., 2015). Therefore, interventions to improve transitions of care also have the potential to significantly benefit informal carers, for example by reducing caregiver depression (Bryant-Lukosius et.al., 2015). Specific interventions to promote patient activation[9] (see Box 7) and support informal carers could therefore be highly beneficial in fostering greater continuity of care and better treatment adherence.

BOX 7

Patient activation as a tool for developing a patient-centered model of care.

In a fragmented system, patients and caregivers are often the only common thread moving across a complex network of care providers, which means that the roles and responsibilities of patients and caregivers are central to any strategy aiming to support safe and effective transitions of care. Interventions to enable them to be active participants in the care process and ensure that their needs are met during care transitions (for example, discharge coaching for chronically ill older patients and their caregivers) can significantly reduce the rates of rehospitalization at 30 and 90 days, as well as costs, and data suggests that patients were able to sustain the benefit from the skills learned and tools used over the longer term (Coleman et al. 2006).

9 Patient activation entails providing patients with the knowledge, skills, and confidence to be active participants in their own care. It has been shown to support patient-centered care models (Dumitra et al. 2021).

Reorienting the model of care

Moldova's health system remains largely hospital centric (WHO European Region and European Observatory 2022), and underinvestment in home care and rehabilitation services has limited the availability of post-discharge care services. Often, patients remain in the hospital because there is no appropriate facility available to discharge them to, or because family members are unwilling or unable to take on the burden of care. In addition, interviewees indicated that hospital physicians generally appear to have little knowledge of the resources available to support patients post-discharge (e.g. there is limited information on the type of rehabilitation services available) and that there is limited communication with patients about their options. Navigating a fragmented post-discharge care ecosystem with scarce information can therefore be very challenging for patients and their families.

The lack of rehabilitation services means that more people are experiencing impairment or a decline in functioning for substantially longer periods of their lives than would otherwise be the case. Years of underinvestment have resulted in a lack of appropriate facilities and equipment, lack of defined clinical protocols and pathways, and insufficient numbers of health professionals. The provision of outpatient rehabilitation services is extremely limited, and restorative rehabilitation services, which are essential for limiting long-term disability following an acute event, are currently provided in only four overburdened hospitals, with patient waiting times of up to three months. Lack of service provision and long waiting times result in enormous unmet needs for rehabilitation services, estimated at 70% (WHO 2022). Patients are often discharged immediately after being stabilized without having access to the rehabilitation services they need; as a result, it is estimated that a substantial share of these patients do not return to the workforce, representing a significant loss to Moldova's human capital, with far-reaching implications given the country's existing challenges in the labor market. Even if patients eventually obtain a place in a rehabilitation facility, long waiting times will likely have disrupted their recovery and increased the risk of a communication gap. Interviews also raised concerns regarding the inefficient use of limited rehabilitation resources, as patients with the highest needs are not always prioritized.

Despite reforms to prioritize home-based care, demand continues to exceed supply. Government policies over the last three decades prioritized support for families and the provision of services in the home (resulting in limited capacity for institutional care, such as nursing homes), yet the provision of home-based care services has been slow to develop. It has been challenged by a lack of resources at the local government level and emigration of the working-age population, which has reduced the availability of carers. A personal assistant service funded by social care exists for patients with the highest levels of need, but expansion of this service is constrained due to its high cost. In addition, models of multidisciplinary mobile teams to provide care services in the home (including for example kinesiotherapists, psychologists, speech therapists, and social workers) exist in several municipalities and are in high demand. In Chișinău for example, this service caters to patients with severe or very severe disabilities (primarily patients recovering from a stroke), and in addition to facilitating patient recovery, it also aims to support better coordination of care, provide training for carers, and improve access to social assistance where appropriate. However, due to limited funding (which also impacts staff retention), there is high unmet demand. Beyond that, home care is mainly provided by private institutions and voluntary organizations or nongovernmental organizations (NGOs), and constrained public funding in this area means that service provision varies across the country and that needs far exceed available supply.

In addition, the provision of social assistance plays a key role in ensuring that the needs of complex patients can be appropriately addressed post-discharge, but Moldova's social care system remains under-resourced. While Moldova's social care system provides a range of services for citizens across their life course, there is a need to support and strengthen its capacity (EC 2023). Access to social care services—such as assistance with activities of daily living, home adaptations, or services related to adequate and affordable housing—directly impacts people's quality of life and ability to recover and maintain overall health, especially among those with multiple or chronic conditions, functional or cognitive impairments, frailty, or mental health challenges (Kuliski et al. 2017). For example, the lack of appropriate transportation services to transfer patients safely out of the hospital, and to support patients with disabilities in attending follow-up appointments was raised repeatedly as a significant issue. Interviewees mentioned that examples of such

services exist in some municipalities including Chișinău but that there is a need to expand this offering across the country. In addition, the provision of assistive technologies remains a challenge due to limited resources and procurement issues.

Despite past integration efforts, health care and social care are governed by different financing mechanisms, protocols, and processes — an arrangement that can hinder the streamlined delivery of services. Feedback from interviewees suggests that fragmentation between health and social care services remains high and that collaboration at a local level can be challenging and generally relies on interpersonal relationships. Only a limited number of hospitals employ social workers, and a lack of information sharing and communication between primary care and social care was raised as an issue. While community social workers and social assistants are placed in municipalities, they are hired and paid by territorial social assistance structures, which can lead to a misalignment in priorities and incentives. In addition, the lack of integration between health and social assistance regarding the development and implementation of in-demand services such as home care also affects the delivery of post-discharge care.

Governance, accountability, and creating an enabling environment

Substantial improvements in interdisciplinary collaboration and cooperation, both within the health care system and across sectors, are needed to strengthen the hospital discharge process, and their realization requires structural change. The development of a digitalized health system is a key step that is already being prioritized by the government, but one that must be part of a wider approach. Recent investments in information system infrastructure have led to the development of some elements of eHealth platforms, data-gathering systems, and digital solutions. The development of an interoperable health information system would significantly facilitate the sharing of information and coordination across different levels of care. In order to promote a patient-centered hospital discharge process, there is also an opportunity to design this system to support greater integration of services across sectors, by promoting greater alignment and information sharing with the social care sector as well. It is important to note that some research suggests that for patients with complex needs, automated discharge instructions can be inaccurate or incomplete, causing confusion and increasing the risk of adverse events (Pollack et al. 2018). Therefore the development of electronic solutions should be seen as an enabling component of a wider strategy to drive process improvement and increased cooperation.

Promoting greater interdisciplinary collaboration and a systematic emphasis on patient engagement and education will require practitioners to acquire knowledge and skills that are not part of the traditional curriculum. While interviewees noted practitioners' interest for increased collaboration across sectors and disciplines, they also highlighted the perception that hospital practitioners have limited knowledge and understanding of the issues faced by PHC, other care providers, and patients. Research findings across different contexts show that curricula typically reflect the fragmentation of the wider system and emphasize the diagnosis and treatment of acute diseases, while interprofessional teamwork, effective communication, and patient education and coaching for example are generally a neglected aspect of physician or nursing training (Barış et. al. 2022). Strategies to improve coordination and transitions of care should address this gap through workforce training, such as specialized training in patient education and care coordination. Examples of such initiatives that could be further built on and expanded include the accreditation in 2018 of a training program for therapeutic patient education[10] in diabetes schools for both physicians and nurses in Moldova (WHO, 2023b).

The current funding structure limits hospitals' willingness to invest in interventions to improve coordination of care and discharge planning and management (Jack et al. 2023), and there is a need to develop additional accountability mechanisms to foster shared planning and coordination. Payment mechanisms should be revised to incentivize coordination and continuity of care between hospitals and PHC facilities — for example, through specialized funding or

10 Therapeutic patient education, as defined by the WHO, is "a 'structured person-centred learning process' that supports individuals living with chronic conditions to "self-manage" their own health by drawing on their own resources, supported by their carers and families". It is carried out by trained health professionals and comprises several types of self-management support interventions. (WHO, 2023b)

adjusted reimbursement structures. Greater coordination of care will require the strengthening of the MoH's stewardship role, including with regards to nonstate actors such as the voluntary and private sectors. The implementation of a multidimensional intervention such as optimizing the hospital discharge process could be an opportunity to create or strengthen platforms for more comprehensive planning across sectors.

The effectiveness of reforms — e.g., new policies and tools to strengthen the hospital discharge process — relies on the participation and buy-in of all actors within the health care system, but civil society and the NGO sector are underdeveloped in Moldova and lack resources. While the MoH has a mechanism to systematically inform and engage external stakeholders in policy formation, civil society and NGOs often lack sufficient resources and time to appropriately provide input (World Bank Group 2023; Bump and Mendy 2024). Moldova has few professional associations of physicians and health care providers, and health-focused civil society groups, such as patient and carers' associations, are underdeveloped, which reduces their opportunities for participation and influence in policy making. In addition, professional associations in the health care sector have historically tended to be of a specialist or academic nature and have not played an active role in influencing policies. For example, the family doctor association collaborated with the WHO on consolidating Moldova's NCD programming at the PHC level, but interaction with the government on policy issues remains limited. This is a barrier to successful reforms within the health system. Such organizations have the potential to play a key role by strengthening the voice of health professionals and patients in the policy development process, and their involvement and development should be encouraged.

Recommendations to enhance the hospital discharge process and improve continuity of care in Moldova

Policy recommendations

Improved discharge processes have been associated with fewer hospital readmissions, better treatment adherence, enhanced patient experience, increased workforce satisfaction, and reduced cost of care. For this reason, improved discharge processes have been a consistent recommendation of policy and research for decades (Glasby 2003). This section describes five interventions that could be undertaken by the Government of Moldova to strengthen hospital discharge processes and improve continuity and coordination of care.

1. Develop person-centered guidelines for hospital discharge and introduce a standardized tool for assessing the complexity of discharge needs using a holistic approach.

IPCHS strategies	• Coordinating services within and across sectors • Empowering people and communities • Reorienting the model of care
What	Hospital discharge is a multidisciplinary process that should be person-centered and start at admission with a systematic, multidimensional (physical, psychological, functional, socioeconomic) assessment of patient needs and the development of an individualized care plan to guide care coordination. The definition of new guidelines for hospital discharge would support a shift away from a single-disease focus toward a greater standardization of person-centered transitions of care. Patients and carers should be active participants in discharge planning, and patients with complex discharge needs should be given additional support to ensure effective continuity of care.
Why	Health equity and integration of care are stated objectives of "Health 2030" and Moldova's National Development Strategy 2030, and implementing a person-centered hospital discharge process would contribute to their achievement, by improving health outcomes for all patients (especially those with complex needs who are disproportionately affected by the current fragmentation of care) and laying the foundation for further integration of care.

How

- **Establish a multidisciplinary working group to assess current performance and develop clear evidence-based and person-centered guidelines and protocols for the discharge process.** A comprehensive study should be conducted to assess the main gaps in more detail and inform the development of these guidelines, which should include the definition of discharge criteria and instructions, clear roles and responsibilities for each component of the discharge process, including coordination, medication reconciliation, patient education, referrals, information sharing, and follow-up, and provide an overall framework that could then be contextualized by each facility. Such guidelines should build on existing disease-specific protocols related to hospital discharge and could focus on patients with more complex needs who are at higher risk of handover failures (Groene et.al., 2012)

  The definition of holistic discharge guidelines could include the development of simple checklists to ensure that key tasks are performed in a standardized manner. The use of such tools should be evaluated and defined collaboratively by the MoH with hospitals and CNAM, as well as with professional and patient associations or civil society where possible.

- **Develop and implement a multidimensional assessment or screening tool to assess the complexity of patients' needs with regard to hospital discharge.** Examples of existing tools that could be adapted to the local context include the Blaylock Risk Assessment Screening Score or LACE index (Mennuni et al 2017).

Examples

- The Welsh government's (2023) "Hospital Discharge Guidance" aims at supporting safe, timely, and efficient discharge of patients. It sets out guidance on hospital discharge standards for health, social care, and independent sector partners in Wales, and outlines key tasks, standards, and expectations for each type of care provider. It is part of a wider framework on improving patient flow, hospital outcomes, and experiences for people in hospitals, and it focuses on helping patients and informal carers with the return home or the move to the next stage of care.

- In the United States, the Agency for Healthcare Research and Quality (AHRQ) developed the ReEngineered Discharge (RED) toolkit to assist hospitals in reducing rehospitalizations. The RED toolkit consists of a set of 12 mutually reinforcing actions to ensure a smooth and effective transition of care. Implementation of the RED toolkit was effective at reducing both 30-day readmission rates and post-hospital emergency department visits (Mitchell et al. 2016; Jack et al. 2009). This positive impact was found to be consistent across settings; for example, at a rural community hospital it led to a 32% decrease in all-cause readmission rates over a four-month period, a 44% reduction from baseline during the previous six months, and a positive perception of the discharge process by patients and their families (Adams et al. 2014).

- With regards to improving the quality of discharge information, effective interventions can be implemented at minimal cost. For example, in the case of heart failure patients in England, positioning a 10-point checklist poster providing guidance on assessing the quality of heart failure discharge summaries (developed by a multidisciplinary committee including GPs and nurses) in a medical ward was shown to result in a statistically significant improvement in the quality of heart failure discharge summaries issued, improving communication and safe continuity of care (Bodagh and Farooqi, 2017).

2. Develop resources to promote patient education and self-management and increase support for informal carers.	
IPCHS strategies	• Empowering people and communities
What	There is an international consensus that health care systems should be reorganized to focus on patients and support patients' self-management in order to improve health outcomes and reduce health care costs (Brandberg, Ekstedt, and Flink 2021). Such a change is particularly important in Moldova due to the rising burden of chronic disease and multimorbidity. Patients, relatives, and informal carers should receive adequate information and training (where appropriate) about medical conditions, medication, and continuing treatment and care. Effective patient education is essential to provide people with the necessary knowledge, skills, and confidence to self-manage their health post-discharge.
Why	While some level of patient education is provided as part of the discharge process in Moldova, feedback from interviews suggests that its effectiveness varies, and that in many cases patients do not understand or recall a substantial part of the information shared with them. This is likely a reason why patients do not always follow up with their family doctor post-discharge, and presents significant risks with regards to treatment adherence. In addition, while continuity and coordination of care depend heavily on the contribution of informal carers and family support, only a few NGOs train informal careers, and there is a lack of comprehensive government strategies to support them.
How	• **Emphasize the importance of promoting patient education throughout the hospital stay in guidance documents and protocols for hospital discharge,** and develop specific strategies to ensure appropriate communication and understanding of discharge information. There is an opportunity to leverage digital technologies such as eHealth or mHealth (mobile health) to support patient education and improve self-management, especially since Moldova's population benefits from widespread internet access. • **Develop a comprehensive strategy to strengthen patient education, building on existing resources** (e.g., patient guidelines in the national clinical protocols) and international best practices (e.g. WHO's guide on "Therapeutic patient education" [WHO, 2023b]), with an increased focus on self-management. This could include developing and expanding training programs for health professionals, health literacy programs, and self-management programs that enable individuals and informal caregivers to be fully involved in care-related assessments and decisions, as well as identifying and addressing any potential bottlenecks with regards to how and by whom patient education can be provided. • **Develop dedicated interventions to increase support for informal carers,** for example by strengthening training programs for caregivers, supporting the development of informal carer support networks, expanding caregiver rights to enable them to better balance their professional life with their caregiving responsibilities, and providing additional support such as psychosocial and respite services. Similar initiatives have been implemented in other European countries, such as France, where the government launched an Acting for Caregivers National Plan in 2019, which recognizes the essential and complex role played by family and informal caregivers and their need for greater support.

	• **Support the development of civil society and patient associations** where possible, as an effective platform to create and disseminate resources and provide support to patients and carers.
Examples 	• In Bulgaria, the regional 'Diabetic care' non-profit (DCNPO) programme improved care coordination and patient-centered care by building a community of diabetes patients and health service providers, who are self-empowered and capable of dealing with complex patients' needs. Services are offered free of charge by a multidisciplinary team, and diabetes patients (generally from lower socio-economic groups) are trained and educated in self-management of their chronic condition, and many of them then volunteer as carers, case managers, self-management trainers and health system navigators for other diabetic patients and their family. Internal evaluations demonstrate reduced rates of hospital admissions and avoidable amputations (Struckmann et.al., 2017). • In India, Noora Health is a NGO that aims to equip informal carers with the tools and knowledge to become more competent and confident in providing safe and effective care to patients, easing the transition from hospital to home. Noora Health developed a "train-the-trainer" certification program for hospital staff – usually nurses – who deliver interactive practical health education to patients and their families (WHO, 2018). In 2023, the program reported having trained more than 1.7 million caregivers on cardiac, NCDs, general medical and surgical care conditions (Noora Health, 2023). During a 3-months pilot study with adult post-surgical cardiac patients, a 36% decrease in complications, a 23% decrease in 30-day readmissions and a 55% increase in satisfaction were observed (WHO, 2018). • Mhealth interventions have been associated with a decrease in hospital readmissions (Mashhadi et al. 2021), and have been shown to improve patients' physical activity, adherence to medication, and physical and mental quality of life. Mhealth interventions can range from simple interventions such as check-ins through phone calls and text messages, to more complex interventions using apps, wearable devices, medical platforms, and videoconferencing. Some studies have found that simple interventions were more effective at controlling risk factors (Cruz-Cobo et al. 2022), suggesting that ease of use might be a key consideration in an intervention's effectiveness.
3. In the design of Moldova's health information system, prioritize the development of electronic channels to support two-way information sharing and coordination related to hospital discharge.	
IPCHS strategies	• Coordinating services within and across sectors • Creating an enabling environment • Reorienting the model of care
What	Practitioners emphasize that continued investment in digitalization is a key priority, and that there is a strong need for the MoH to deliver on its objective of developing an electronic health records system with interoperability across sectors and organizations. Such a system would enable information to be transferred between points of care.
Why	Lack of information sharing was identified as one of the most pressing issues related to the hospital discharge process in Moldova. Currently, electronic sharing of discharge information between facilities is not possible, and the flow of information between health care providers during and following hospital discharge depends solely on the patient or on interpersonal relationships.

How	• **The development of a digitalized health system is an ongoing priority for the Ministry of Health and should aim to strengthen all aspects of the hospital discharge process.** The government indicated that the new platform will include an e-referral system aimed at eliminating existing bottlenecks (for example by facilitating direct referrals from acute care to rehabilitation services) as well as information for patients and their families. Given that the hospital discharge process constitutes a key point of connection between different levels of care, the design of the digitalized system should also prioritize elements that facilitate continuity and coordination of care before and after hospital discharge, and foster two-way communication between different levels of care. The development of e-referral mechanisms should also aim to address challenges related to the geographical disparity in the provision of post-discharge care. Its design should be informed by a wide-ranging consultation with care providers at all levels to ensure that it effectively addresses existing issues and to facilitate its uptake. Indeed, accompanying the introduction of a digitalized system with a wider effort to address fragmentation and promote more collaborative ways of working would increase its effectiveness.
Examples	Research has shown that the use of an electronic format significantly improves the quality and timeliness of discharge summaries (O'Leary et al. 2009). However, studies have also suggested that the main limitation of discharge summaries is the failure to recognize that they are often the only communication between hospitals and the next level of care, and hence that they should be treated as handovers. The introduction of an electronic health record system should enable clinicians to generate a prepopulated discharge summary that they then complete with a clear narrative focused on guiding medical decision-making and ensuring continuity of care, by providing useful handover information to the next provider.
4. Expand workforce skills to support a greater focus on patient engagement and education, care coordination, and interdisciplinary collaboration.	
IPCHS strategies	• Creating an enabling environment • Coordinating services within and across sectors
What	Education and training are required to develop the skills and confidence of the healthcare workforce in taking on new tasks and responsibilities related to continuity and coordination of care. They are particularly important to develop competences not traditionally covered in the health care curriculum, such as effective communication, patient coaching and advocacy, interprofessional teamwork, holistic planning, and people-centered care (i.e., the ability to create the conditions for coordinated care centered on the needs of individuals and their families and reflecting their values and preferences).
Why	Curricula typically reflect the fragmentation of the wider system: they emphasize the diagnosis and treatment of acute diseases and tend to neglect for example interdisciplinary teamwork and collaboration, effective communication, and patient education and self-management.
How	• **Collaborate with the education sector to integrate new skills within the core curricula of health care professionals to promote interdisciplinary and cross-sectoral collaboration and a person-centered approach.** These skills should be taught in both core training programs and as part of continuous professional development.

- **Build capacity for more collaborative and person-centered ways of working within the current workforce.** This should include expanding hospital staff's knowledge and understanding of patient care pathways post-discharge, available resources for post-discharge care (incl. social assistance) and common challenges faced by patients and carers, to support greater coordination with other providers and inform more effective patient education and coaching efforts. For example, informal approaches could be encouraged by providing funding and resources for training sessions in hospitals.

Examples

- A study conducted as part of the European HANDOVER project (which aimed to improve transitions of care during hospital discharge) with health practitioners in the Netherlands, Spain, Sweden and Poland found that alertness to vulnerable patient groups, communication skills, knowing what to hand over, and awareness of being responsible for the patient's well-being were the most important topics identified by participants for training on the discharge process. Participants also highlighted the importance of delivering that training in multidisciplinary groups (Kicken et.al., 2012).
- In Germany, the core curriculum for medical training for doctors and nurses (the National Catalogue of Competence-based Learning Objectives in Medicine), emphasizes the principles of therapeutic patient education (as defined by the WHO) and patient education as the standard approach, with compulsory training on doctor-patient communication, communication of diagnosis and shared decision-making (WHO, 2023b).
- The teach-back method is an example of a simple strategy to improve patient education that can be taught to health care professionals in any setting. Studies have shown that health care providers tend to overestimate their own ability to communicate, and that patients often have difficulty comprehending or recalling information given to them: evidence suggests that less than half of the information provided about medication and diet is accurately recalled by patients (Talevski et al. 2020). Teach-back is a simple method that involves asking patients to explain in their own words what a health care provider has just told them. Any misunderstandings are then clarified by the provider, and understanding is checked again until the patient can correctly recall the information that was given. A systematic review of the implementation of the teach-back method reported that 95% of studies across a range of settings and patient groups found the method effective for improving communication and patient education (Talevski et al. 2020).

5. Revise payment mechanisms to incentivize coordination of care and create or expand platforms to foster multisectoral collaboration and mutual accountability.

IPCHS strategies

- Coordinating services within and across sectors
- Strengthening governance and accountability
- Creating an enabling environment

What

The development of national guidelines and protocols is often not enough to drive change in delivery of care and ways of working, and it will be important to introduce performance indicators for hospital discharge that shift the health system toward a more person-centered model. The effectiveness of the hospital discharge process needs to be defined not only in terms of service activity levels, but also in terms of patient outcomes, and introducing performance indicators related to continuity of care post-discharge is an opportunity to foster greater vertical integration between hospitals and PHC providers.

Why	Current financing mechanisms focus mainly on the delivery of single services and do not adequately incentivize service coordination. The lack of vertical integration means that hospitals have no incentives to develop strategies to promote continuity of care, as the onus is placed on the family doctor. In addition, hospitals have no incentive to implement interventions to improve post-discharge health outcomes and reduce hospital readmissions.
How	• **Launch a participatory process to define performance indicators** (e.g., rate of hospital readmissions, time between discharge and follow-up appointment, compliance with prescription guidelines, patient-reported outcomes, etc.) **and a specialized funding source or reimbursement structure to incentivize continuity and coordination of care** in the context of hospital discharge. This effort should build on and complement previous pilots implemented by CNAM and the comprehensive work recently carried out by the World Bank with the government of Moldova on the revision of the pay-for-performance (P4P) scheme for the hospital sector, which includes a broad range of quality indicators, including rehospitalization rates (for selected conditions) and patient satisfaction. In addition, opportunities to adjust existing contracting mechanisms to support the expansion of multi-disciplinary delivery of post-discharge care (e.g. multi-disciplinary mobile teams) should be explored, building on existing example and past experience. • **Foster mutual accountability between hospitals and post-discharge care providers,** including PHC providers, rehabilitation services, and social assistance, through the development or promotion of platforms for intersectoral collaboration and planning. Examples could include regular interdisciplinary meetings of providers across levels of care, formal partnerships or shared governance structures between organizations, and development of a shared vision of patient-centered care.
Examples	Emerging models, sometimes referred to as "value-based" payments, aim to adjust or condition payments to providers based on certain cost, quality, or patient experience metrics (Barış et.al. 2022). For example, pay-for-coordination offers lump sums to selected providers to coordinate care for chronic patients across different levels of the health system (e.g. primary care, secondary care, public health, prevention, and health education), while bundled payments incentivize coordination by providing a single payment for an entire episode of care across multiple types of providers in different settings. The latter approach has been adopted by the Netherlands and Portugal for the care of chronic conditions such as HIV/AIDS and diabetes (Barış et.al. 2022). In the U.S., the Hospital Readmissions Reduction Program (HRRP) aims to encourage care coordination and improve communication by linking hospital reimbursement to rates of unplanned readmissions for certain conditions (e.g., COPD and heart failure) (CMS.gov 2023).

Additional considerations

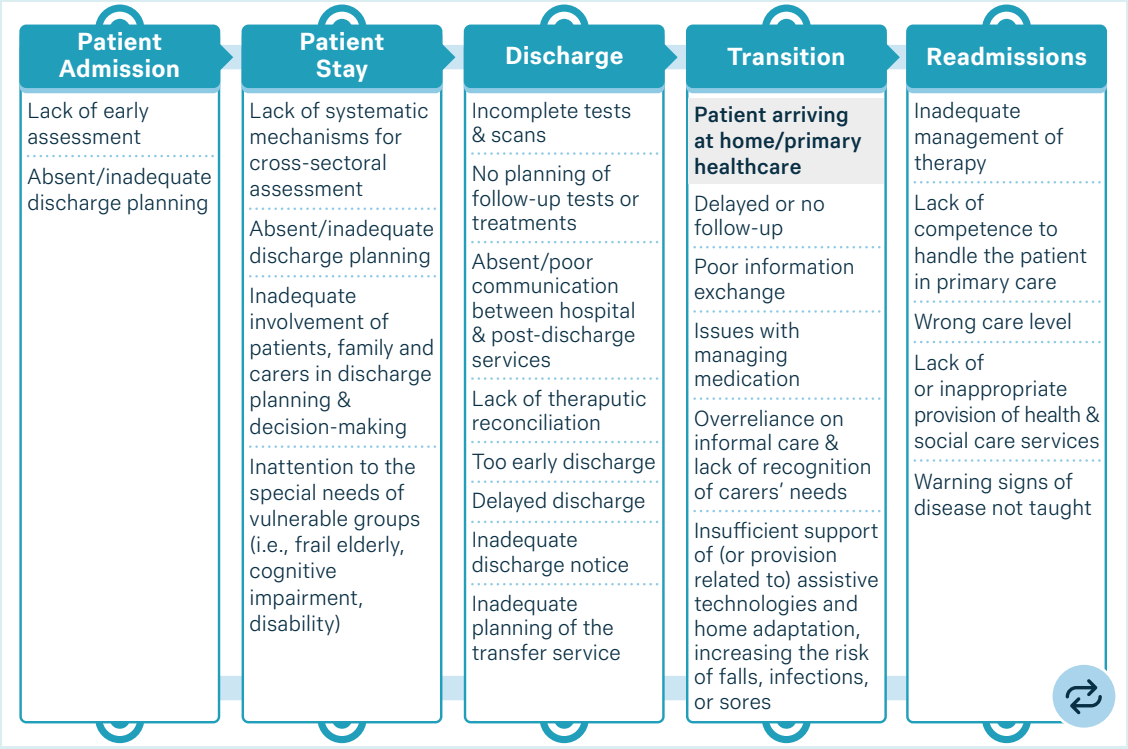
It is important to note that the benefits of increased cooperation and continuity of care resulting from improvements in the hospital discharge process can only be fully realized if the infrastructure for post-discharge care is further developed. To avoid hospital readmissions and ensure that care is provided at the right level, there must be sufficient capacity for alternative forms of care in non-acute settings, especially in rural areas where resources are scarcer. The potential impact of interventions to optimize the hospital discharge process will therefore be constrained by existing gaps in post-discharge care provision, such as in home care and rehabilitation services. In addition, the difficulty posed by the limited infrastructure for post-discharge care is compounded by the overall shortage of health care workers. A key challenge of strengthening the hospital discharge

process will therefore be to carefully manage the addition of any potential new responsibilities on overburdened health professionals, for example by reorganizing existing tasks and responsibilities wherever possible rather than creating the need for additional resources.

However, by bringing together a wide range of stakeholders (across acute care, PHC, rehabilitation, social care, and civil society), interventions to strengthen the hospital discharge process can also provide a platform to explore additional strategies to address these gaps. For example, investments in the development and expansion of community health centers (with capacity for rehabilitation, mental health care, nursing care, and social services support) were suggested as a possible avenue to expand capacity for post-discharge care. Interviewees suggested that both multidisciplinary mobile teams (which is a model that the MoLSP is looking to expand) and the provision of home care more broadly are areas where greater integration between health and social care could yield significant benefits, including by expanding both the reach and the range of services that could be provided. More generally, the large-scale reorganization of the social care system ("Restart" reform) currently being implemented by the MoLSP could provide an opportunity to identify areas for improvement in existing ways of working between the health and social care systems, in order to further strengthen coordination and the provision of care for patients who require support from both sectors. International examples that could inform such efforts include the process of developing patient-centered, integrated home care services in Lithuania, which were scaled up for implementation in all municipalities in 2016 (Kurpas et.al., 2021). Evaluations suggest that the successful development of this integrated service required adopting new ways of working characterized by partnership, open dialog with officials at higher levels and between peers, and participatory program development (Jurkuvienė, et.al., 2016).

Annexes

ANNEX 1. Examples of the most common issues related to hospital discharge



Sources: Knutsen et al. 2019 ; Mennuni et. Al. 2017.

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