Adaptarte: social innovation project

What is **Adaptarte**?

Adaptarte is a social innovation project led by the Faculty of Nursing and Rehabilitation of Universidad de la Sabana that provides a service to people who, as patients or family caregivers, are in a transition process between a health institution and their home, to improve their adaptability to care.

Where does this initiative come from?

The care people receive when they transition from a health care setting to another is called transitional care. This change can happen within an institution, between different health institutions or between the institution and the patient's house.

Changing settings during health care makes people vulnerable. It is estimated that patients present complications in one in five discharges from the hospital to their homes1. Social determinants of health also have an important impact on these transitions[2].

The transition between health care scenarios has shown good results when it is properly planned, directed at specific processes and users, systematized, followed-up, accompanied by motivation strategies so that people add care, and when it has organized support networks.[3] [4] [5]. Structuring transitional care reduces adverse events such as mortality and hospital readmission[6] and is also a cost effective strategy[7].

Several nursing-led strategies in Latin America are reported to strengthen transitional health care. These include better planning for hospital discharge, anticipating the care required, educating the patient, strengthening their capacity for self-management, strengthening adherence to medication, guaranteeing complete information, and accompanying users in the discharge processes[8]. However, these address the patient once they are close to being discharged, and not from the moment of admission to the health institution, and they don't reflect a joint approach to the patient-family caregiver dyad as the subject of care either.

There is often a lack of quality intra-institutional information in the field, and a lack of structured connections between the networks or the different services that make up

social security systems at a global level. Colombia is no exception. Although institutionally there are hospital discharge processes, there are no solid mechanisms that facilitate intra- and inter-institutional transitional care, nor care between health institutions and the home[9]. This in addition to the low competence in caring for patients and caregivers evident in the different macroregions of the country. [10]. In this context, the transition between the health institution and the home is a process of high vulnerability and overload for patients and their caregivers, and it creates unnecessary costs for the system.

Adaptarte is an initiative that responds to the support needs of a growing number of people who face the transition between the health institution and home. It also responds to the commitment of the professional nursing discipline to improve the health care experience of people. And finally, it responds the institutional commitment to serve society through the development and transfer of new knowledge created as part of academic activity.

Who are we?

We are the research group “Nursing Care-Unisabana”, attached to the Faculty of Nursing and Rehabilitation, Universidad de la Sabana. We are currently categorized with an A by the Colombian Ministry of Science (2021). The focus of our projects are the health and well-being of people in vulnerable conditions. Through the **Adaptarte** social innovation macroproject, we carry out national and international interdisciplinary and intersectoral projects to generate an impact on the health and well-being of people who are experiencing transition processes between a health institution and their home. We have several active teaching-assistance alliances to improve the service in this field. We also involve undergraduate and graduate students interested in the topic in our projects, as well as graduates as young researchers, in order to guarantee the sustainability of our work.

What do we look for?

Adaptarte's mission is to improve the adaptive capacity for health care of dyads (patients and caregivers) in transition processes between a health institution and their homes. This project also creates new knowledge for health and education services, it is supported by different media, and it strengthens the construction of public policy that supports transitional health care.

What conceptual model guides us?

The transition between a health institution and a patient's home is a complex process that starts when the person begins to receive health care in the institution and continues during their transit through it and until the person returns home, where, alongside their caregiver, they must assume the responsibilities of caring for their health.

To understand this dynamic, we turn to the philosophical and scientific bases of two nursing models: the first: transitions[11] that seek to guarantee a healthy transition in processes such as hospitalization and when a patient returns home. The second, adaptation [2] that expects people to adapt to the new demands that this process generates for them.

What do we do?

Adaptarte has a strategy called **Plan Adaptarte** that supports the transitional care of the patient-family caregiver dyad through a systematized health care intervention, advised and validated by international experts on the subject. This facilitates care for the person and their family caregiver in the transition, from their admission to a health institution, to 30 days after their return home.

The **Plan Adaptarte** has been used for people with different health needs, differentiated by the name of the respective condition. For example, **Plan Adaptarte - HTA** is meant for people diagnosed with high blood pressure (Hipertensión Arterial in Spanish) and their caregivers, and **Plan Adaptarte - DM2** is meant for people diagnosed with type 2 diabetes mellitus and their caregivers.

The **Plan Adaptarte** makes the care of the dyad more adaptable during their transition between the health institution and their home, by identifying and strengthening 7 basic conditions:

1. Facing the responsibility of care with the greatest willingness and confidence, based on their ability.
2. Discerning the particularities of the health situation they experience and the care it requires.
3. Supporting the identification, search and harmonization of the available resources required in each phase of the hospital – home transition.
4. Preventing risks that may negatively affect health by identifying them and taking early action.
5. Transferring therapeutic and care instructions to make them an operational plan.
6. Adhering to the instructions prescribed by the therapist or professional caregiver and incorporating them into daily life.

7. Recording essential information to monitor the health condition and facilitate decision-making.

The Project has the **Adaptar Tool** to assess, monitor and evaluate the adaptation capacity for the care of the dyad.

Adaptarte also prioritizes people by ensuring the best possible clinical outcomes and experiences with the health services. It considers the routines and workload of health professionals to support and facilitate their work, develops and uses the best available technology to strengthen the health and well-being of people in the transition between the health institution and their home, and helps improve the cost-effectiveness of health services by avoiding unnecessary complications stemming from admissions or re-admissions.

What studies does **Adaptarte** include?

Adaptarte was developed through the following professorial research projects:

- The effect of an “anticipated and structured care plan at hospital discharge” regarding the burden of caring for people with chronic non-communicable diseases.

- The effect of a technology-mediated health intervention care competence at home, with therapeutic adherence and hospital readmission of people with chronic illness during hospital transition.

- The effectiveness of the “Plan Cuidarte – US” intervention during the home hospital transition in patients with arterial hypertension and diabetes mellitus II in Colombia and Mexico.

- The **Adaptarte Tool** : validation study of a new scale to evaluate the adaptation of the hospitalized person-family caregiver dyad during the hospital-home transition.

- The effect of the CUIDARTE PLAN on the care competence of people with heart failure and their caregivers: execution of the research protocol (U. Caldas).

In addition, **Adaptarte** includes 27 research projects distributed in the different geographic macro regions of Colombia.

1. Preliminary version of requirements for the in-hospital promotion and prevention program at the Clínica Universidad de la Sabana (Finalized).
   Joylen Arlenys López
   Beatriz Sánchez
   Chía (Cundinamarca)

2. Preliminary version design of an in-hospital health promotion and disease prevention program (arterial hypertension and type II diabetes mellitus) (Finalized).
   Laura María Rodríguez, Rudy Castro
   Beatriz Sánchez
   Zipaquirá (Cundinamarca)

3. Preliminary proposal for a health promotion and prevention program for people with chronic illness and their family caregivers – high blood pressure (Finalized).
   Juliana Castellanos
   Beatriz Sánchez

4. Preliminary proposal for a health promotion and prevention program for people with chronic illnesses and their family caregivers – COPD (Finalized).
   Neider Jair Cruz
   Beatriz Sánchez
   Bogotá (Cundinamarca)

5. Preliminary proposal for a health promotion and prevention program for people with chronic illness and their family caregivers – diabetes mellitus (Finalized).
   Luisa Fernanda González
   Beatriz Sánchez
   Chía (Cundinamarca)

6. Preliminary proposal for a structured and anticipated care plan at hospital discharge for people with Type II Diabetes Mellitus and High Blood Pressure and their family caregivers (Finalized).
   Julián Villamil
   Luz Marina Camelo
   Beatriz Sánchez
   Zipaquirá (Cundinamarca)

7. Effect of the “Adaparte plan” in the hospital-home transition for caregivers with a preterm newborn on their competence for care (Finalized).
   Jorge Alexander Jerez Molina
   Alejandra Fuentes Ramírez
   Medellín (Antioquia)

8. Effect of the “Adaparte Plan” on home care competences for people with hematological cancer undergoing chemotherapy treatment, compared with a conventional discharge plan in an oncology hospitalization service in the city of Manizales. (Finalized). Natalia Ospina Álvarez
   Alejandra Fuentes Ramírez
   Manizales (Caldas)

9. Effect of a systematized nursing intervention during the hospitalization transition for the care competence of people with type 2 diabetes mellitus or their family caregivers, 2020.
   Maritza Pérez
   Beatriz Sánchez
   Bogotá (Cundinamarca)

10. Effect of a nursing educational intervention to reduce pain in patients with myocardial revascularization during the outpatient postoperative period.
    (Finalized).
    Débora Álvarez
    Gloria Carvajal
    Cúcuta (Norte de Santander)

11. Effect of the “Cuidarte Plan” on the care competence of patients with heart failure and their caregivers (Finalized).
    Marcela Vallejo
    Alejandra Fuentes Ramírez
    Bogotá (Cundinamarca)

12. Effect of the Cuidarte Plan on the care competence of patients with acute myocardial infarction, or their family caregivers, during the transition from the Intensive Care Unit to their homes (Finalized).
    Sury Carreño
    Gloria Carvajal
    Cúcuta (Norte de Santander)

13. Evaluation of the effect of the “Cuidarte-US Plan” intervention compared to the conventional discharge plan on the care competence of people with gastrointestinal elimination ostomies in a tertiary institution (in progress).
    Liz Adriana Álvarez
    Alejandra Fuentes Ramírez
    Bogotá (Cundinamarca)

14. Effect of the Cuidarte plan on the care competence of patients with hypertensive crisis during the transition from the emergency department to home (In progress).
    Jennyfer Carolina Ramírez
    Gloria Carvajal Carrascal

15. Adaptation for the care of pregnant women with hypertensive disorders in outpatient follow-up: Case Series Study (In progress).
    Sara Esther Lizarazo
    Lucy Muñoz
    Tunja (Boyacá)

16. Effect of the "Cuidarte-US" plan in the hospital-home transition on care competence in parents with premature children (In progress).
    Yenny Antolínez
    Lucy Muñoz
    Floridablanca (Santander)

17. Early and structured nursing intervention at hospital discharge for care competence in parents of children with congenital heart disease during their transition to home (In progress).
    Evelin Mileidy Suarez Arévalo
    Jimmy Mendieta- Alejandra Fuentes
    Bucaramanga (Santander)

18. Nursing intervention for people in the process of diagnosis of gastric cancer and their family caregivers during their hospital-home transition (In progress)
    Jesús Hernán Arévalo Terán
    Beatriz Sánchez Herrera
    Pasto (Nariño)

19. Nursing intervention for care competence in patients with chemotherapy in their transition to their home (In progress).
    Liberlis Gómez Pineros
    Jimmy Mendieta- Alejandra Fuentes

Montería (Córdoba)

20. Adaptation for care during the hospital-home transition of the person with DM-2 and their family caregiver (In progress).
    Liseth Marcela Aldana Argel
    Beatriz Sánchez
    Sincelejo (Sucre)

21. Adaptation during the hospital-home transition of people undergoing hip joint replacement (In progress).
    Marlene Helena Chávez Velandia
    Karen Tatiana Roa Lizcano
    Chía (Cundinamarca)

22. Effect of the Adaptarte plan compared to a conventional discharge plan on home care competence in mothers and fathers of newborns with a history of prematurity during the transition from a neonatal intensive care unit (In progress).
    Clara Rocío Niño Gómez
    Viviana Robayo
    Cúcuta (Norte de Santander)

23. Effect of a nursing educational intervention based on coping strategies during the postoperative period of myocardial revascularization (In progress).
    Jorge Eliecer Rodríguez Marín
    Débora Álvarez
    Manizales (Caldas)

24. Effect of a nursing intervention for adaptation during the transition of patients with chronic kidney disease on dialysis (In progress).
    Cilia Yaneth Corredor Corredor
    Karen Tatiana Roa Lizcano
    Cúcuta (Norte de Santander)

25. Effect of a nursing intervention on the adaptation of the dyads of people with DM2 and their caregiver in the hospital-home transition (In progress).
    Carlos Saul Corredor Pineda
    Beatriz Sánchez
    Cúcuta (Norte de Santander)

26. Adaptarte Plan to promote competence in the care of patients with hemophilia and their caregivers (In progress). Yuri Stefanía Díaz Mosquera

Gloria Carvajal
Neiva (Huila)|

27. Effect of the Adaptarte plan aimed at parents in the transition from the NICU to their home, in infants with a history of hypoxic-ischemic encephalopathy.
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