



Beyond the Borders: Care Pathway Hospital to Home

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Today, non-communicable diseases, including diabetes, cardiovascular diseases, strokes, chronic respiratory diseases, and cancers, are considered a global health priority (1, 2). Research indicates that patients with chronic illnesses face a heightened risk of disease recurrence and complications following hospital discharge. This reality emphasizes the necessity for continuous monitoring and specialized care within home settings (3). As the number of chronically ill patients requiring hospitalization continues to rise, the healthcare system is increasingly adapting to provide specialized services that cater to these patients' unique needs. In response to the growing demand for specialized care, healthcare professionals are undergoing significant changes to improve the quality of care provided to chronic patients. One notable development is the establishment of multidisciplinary teams composed of physicians, nurses, nutritionists, and psychologists. These teams aim to deliver comprehensive and coordinated care, addressing the diverse needs of chronic disease patients during their hospital stays. The complexity of managing chronic diseases often presents challenges for healthcare systems, including shortages of specialized personnel and escalating treatment costs. A lack of cohesive care plans following discharge can lead to increased treatment expenses and higher rates of readmission, thereby placing additional strain on healthcare resources (4). Evidence-based treatments and care approaches have proven effective in addressing these challenges. Studies demonstrate that implementing evidence-based care can enhance patients' quality of life and reduce complications associated with chronic

conditions. Such approaches are essential in mitigating the risks faced by patients after discharge.

In recent years, there has been a notable shift in the provision of services for chronic illness management from hospital settings to community environments (4). This transition reflects the need for a caregiving approach that actively responds to patient needs while incorporating family education to facilitate better disease management at home. Many patients requiring specialized care in hospitals continue to need ongoing attention after discharge (4, 5). This highlights the importance of high-quality services and care that extend beyond hospital walls. Developing educational programs for patients and their families can play a crucial role in preventing disease recurrence and ensuring effective management at home. In developing countries, the demand for specialized services at home and within communities has seen significant growth in recent years. This trend not only alleviates financial burdens on healthcare systems but also enhances patients' overall quality of life. In Iran, for instance, there has been a concerted effort to address these issues, with innovative technologies such as telenursing facilitating medical service delivery at home.

Several initiatives have emerged to enhance healthcare delivery for chronic disease management. These include establishing health education clinics, implementing patient follow-up programs post-discharge, revising educational curricula for medical students to align with societal needs, activating home healthcare service centers, and launching specialized disciplines focused on individual, community, and elderly health. Such initiatives represent a cultural shift within Iran's health system aimed at improving care

quality from hospitals to homes. Policy-making and the development of research programs related to chronic diseases are essential priorities for health systems worldwide. These efforts aim to generate the necessary evidence for providing comprehensive and holistic care from the moment a patient is hospitalized until their ongoing care continues at home. Research indicates that integrated care models can significantly reduce complications and treatment costs, further emphasizing the importance of coordinated healthcare strategies. Qazvin University of Medical Sciences is committed to its goals by launching the "Care Pathway: Hospital to Home" journal to realize this objective. This journal aims to fundamentally advance evidence-based practices concerning the stated goal on both national and international levels.

Footnotes

AI Use Disclosure: The authors declare that no generative AI tools were used in the creation of this article.

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