Care transition

Hospital discharge follow-up in a general practice setting

What?

Patients can receive critical support to improve transitions between inpatient and outpatient care, when followed up post hospital discharge. This ultimately translates into improved patient health outcomes. General practices are uniquely positioned to support their patients who have been recently discharged from hospital, and can help prevent unnecessary and costly re-admission.

Practice nurses can play an important role post discharge as they are often familiar to the patient, have knowledge of the social supports the patient may require, and have expertise in community care coordination.

This diversified approach where a practice nurse works to the top of their scope, strongly aligns with the principles of the Patient Centred Medical Home (PCMH) model of care. This model of team-based care is rapidly evolving to become the future of primary health care in Australia and internationally.

Why?

When patients are discharged from hospital it can be a vulnerable time, with risk of re-hospitalisation. Elderly patients are at a greater risk of returning back to hospital after an acute episode, or people with chronic conditions. Re-admissions can occur when patients don't receive appropriate follow-up care or ongoing outpatient management of their medical condition. Hospital readmissions can have a negative impact on patient outcomes and are costly to the health system.

As the primary contact reaching out to recently discharged patients, the practice nurse can perform a comprehensive assessment identifying and addressing any issues, needs, or gaps in care. Some of the benefits include:

- patients are provided a smoother transition from hospital to home and they benefit from ongoing pain and acute clinical needs management (eg. wounds), scheduling and reminder of follow-up appointments, and engagement of appropriate community services
- continuity for the GP across the inpatient and outpatient setting which allows medication reconciliation, referrals to specialists, as well as engaging patients and their carers to develop patient-specific goals and care plans
- practices are able to offer more enhanced coordinated care in their broader medical neighbourhood. This has potential to reduce fragmentation, improve communication across providers, and provide a local primary health service that genuinely places emphasis on the needs of their patients and community.

How?

Sharp Street Surgery's care transition project was one of 13 initiatives supported by COORDINARE. It was part of a project designed to build the capacity and capability of our region's general practices to move towards a PCMH model of care.

With funding from COORDINARE, a designated practice nurse was assigned time and responsibility to follow-up recently discharged patients. Using their practice software, the nurse identified patients and made phone calls to the patient or their carer. The nurse was able to confirm any post discharge needs the patient had and assist with any appointments, medication issues or community care liaison.

"Being on the front foot in caring for our patients by contacting them in times of need before they contact us, is a very empowering position as a health provider and is the reason why I wanted to become a nurse in the first place."
- Ann Douglas, Practice Nurse.

Want to get involved?

At different times COORDINARE offers funding to support initiatives such as this. Practices which do not apply or are not selected for funding can still work with us and explore other opportunities. If we are outside of a funding round, we have resources to support practices on their change journey.

For further details on the steps involved to implement this model of care, visit http://bit.ly/MOCcaretransition. For more information or support contact your Health Coordination Consultant, or phone 1300 069 002.

This initiative is supported by funding from COORDINARE – South Eastern NSW PHN through the Australian Government's PHN Program.

Outcomes

Figures sourced from Sharp Street Surgery PCMH final report

Patient engagement

79% of discharged patients were contacted by the practice nurse

100% of contacted patients were assisted by the practice nurse

Hospital re-admission

5 patients required re-admission, all relating to the original admission

44% of contacted patients subjectively reported the practice nurse intervention had helped to prevent re-admission

Practice nurse intervention

69% of contacted patients required medication reconciliation

9% of contacted patients were provided with additional pain management support

93% of contacted patients required facilitation for follow-up appointments

7% of contacted patients required the initiation of new referrals to community services

Perspective profiles

GP
- Dr Brian Tugwell

"We are a busy rural general practice and are fortunate to have responsibilities that extend beyond the typical GP patient scope. All of our staff live in Cooma, raise families here and are active community members - so providing a health service that truly meets both individual and the broader community health needs is our genuine mandate.

As a practice, we are constantly re-evaluating our initiatives and resource allocation. Although we felt this telephone support service by our practice nurse was well received, to keep it sustainable we need to refine our approach. The key recommendations we are currently evaluating include extending the patient reach to include emergency presentations not just those that lead to a hospital admission; prioritising our patient catchment to those with a higher risk profile (over 65 years, poly-pharmacy, acute clinical needs, those flagged by the care navigator at Cooma District Hospital); and using an automated technology service to establish contact."

Practice Nurse
- Ann Douglas

"I often put myself in my patients' shoes as a way to evaluate any intervention I am involved in. For this project, that was easy because I could think of my parents and how having someone check-in with them to make sure they have the help they need after what can often be quite a stressful hospital admission, would be so comforting. This was exactly the feedback I received from the patients too.

For some patients it was only a matter of reconfirming a follow-up appointment. Whilst this may not seem vital, forgetting or choosing to not turn-up to a follow-up appointment can often mean the underlying reason for admission is not adequately addressed with behaviour or medication changes, rather just a temporary bandaid solution.

In a rural practice like Sharp Street, it's so important that we continue to be community builders. Helping our patients, many of whom are long-term and have generations on our books, to achieve a smooth transition between care settings, means we continue to put their health needs as our priority."

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