PHCRIS RESEARCH ROUNDup

Transitions from hospital to primary care

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ISSN 1839-6348

Issue 46
May 2016

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For older Australians, transitions from hospital to primary care (i.e. general practice, community and/or aged care) are frequently accompanied by discontinuities in medication management, delays in follow-up care, duplication of tests, adverse events and readmissions to hospital. This *RESEARCH ROUNDup* describes factors affecting smooth transitions and provides examples of best practice.

Introduction

Between 1995 and 2015, the proportion of Australia's population aged 65 years and over increased from 12% to 15% and is projected to increase to 22% by 2061. The proportion of Australians aged 85 years and over is also projected to grow rapidly, from 2% in 2015 to 5% by 2061.[1,2]

Older Australians are at greater risk of admission to hospital. In 2014–15 approximately 41% of hospital separations were for people aged 65 years and over; and 63 432 patients were discharged for the first time to residential aged care (RAC).[3] As hospitals focus on patients with higher acuity and average length of stay for less serious conditions decreases, an array of post-acute services have been introduced to support older adults who are medically stable but have ongoing care needs. Broader changes in the way health care is delivered (e.g. outpatient or same-day admissions for chemotherapy) also contribute to the experience of multiple transitions,[4] particularly for older adults with complex and chronic health problems.

Older adults with chronic health problems are at high risk for adverse events during transitions[5] including problems with medications (e.g. inappropriate, suboptimal, discontinuity or duplication)[6] and delays or lack of community support[7] or follow-up medical care. General practitioners (GPs) are often unaware that their patient has been admitted to, or released from, hospital, with challenges related to the receipt and legibility of discharge summaries;[6] though shared eHealth records may improve care coordination in this area.[8]

Policy context

The separation of responsibilities for health care, whereby State Governments fund hospitals and sub-acute care and the Federal Government funds primary health and aged care, can impact on transitions. Joint funding of services to bridge the gap between hospital and home (or RAC), such as the Transition Care Program[9] is one approach to address problems arising from differing governance arrangements.[10]

The recently established Primary Health Networks (PHNs) aim to improve coordination of primary and hospital services by working closely with Local Hospital Networks to "strengthen and promote regional collaboration in commissioning services to support local and out of hospital care [and] to develop or build upon locally relevant hospital admission and discharge approaches or protocols, including locally relevant patient health care pathways".[11, p.8]

Factors affecting transitions

Models of care

The Transition Care Program, implemented in 2005–06, provides short-term allied health, nursing and/or personal care for older adults following a hospital admission.[9] From 2005-06 to 2012-13, more than 75% of recipients who completed their planned care were discharged with an improved level of functioning.[9]

Effective discharge plans and services have demonstrated shorter length of hospital stay and reduced risk of readmission (e.g. early supported discharge;[12] tailored discharge plan;[13] follow-up services[14]). Discharge counselling by pharmacists is cost-effective, particularly for high-risk, elderly patients.[15]

Since older Australians often need access to multiple health services, partnerships between general practice and other parts of the health sector are required to support good quality, coordinated team-based care. A trial of the patient-centred medical home (PCMH) has been recommended,[11] building on the model's international successes.[16] The PCMH has demonstrated reduced costs through lower inpatient and emergency department use for older and sicker patients.[17] The model emphasises access to a personal physician (through patient enrolment); physician-led team-based care; care coordination and/or integration; a systems-based approach to quality and safety; enhanced access to care; and practice payment reform.[18] A systematic review of challenges to PCMH implementation identified the importance of resources, internal capabilities and expert consultants.[19]

Information technologies

ICT plays an important role in both primary care and hospital systems as effective connections between the various parts of the health system are expected to offer better continuity of care. However, the interface between ICT systems presents many challenges. The personally controlled electronic health record (PCeHR), renamed *My Health Record*, provides Australians with choices about the information that is uploaded to their record and visibility to others. This has obvious trade-offs in terms of the completeness of the information that is available to care providers. Uptake of the PCeHR by patients and GPs has been sluggish and an 'opt out' system is being trialled.[20] New eligibility requirements for practice incentive payments for e-health are also expected to increase uploading of shared health summaries.[20]

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The commissioning role of PHNs presents opportunities to trial new models of care. Advancing the role of care coordinators and commissioning for post-acute care needs are possibilities. Broader reforms to health care financing can also impact on the quality of transitions. For example, bundled or episodic payments for hospitals that cover the period of admission and the first 30 days post-discharge (including unplanned readmissions) provide a financial incentive to improve discharge planning and medication management during the transition period.[21] In Australia, the potential for PHNs to fund community-based health care services for 90 days following discharge has been discussed.[22]

Support

Advanced/specialist roles for nurses such as the community matron role in the UK[23] improve patient satisfaction, however evidence to support an associated reduction in hospital admissions is lacking.[24] The Australian Coordinated Veterans Care (CVC) Program utilises patient enrolment and nurse coordinators to enhance relationships and care continuity and provides practical support for older adults with chronic and complex needs through reminder calls and assistance with transport. CVC coordinators are expected to provide transitional support[25] but few hospitals routinely notify GPs that their patient has been admitted.

Older patients discharged from hospital are at high risk of medication misadventure and a timely home medicines review (HMR) can reduce the risk of adverse drug events and related readmissions.[26] As part of the HMR programme, a hospital referral pathway is currently being trialled in Australia.[27]

Given that people with dementia and family carers often have poor experiences of hospital care and dementia prevalence is increasing, a role for specialist dementia nurses in handover from hospital to primary care has been proposed.[28] In Sydney, a pilot service to support people with dementia for up to 12 weeks following a hospital admission or emergency department presentation is being commissioned.[29]

Conclusion

Transitions from hospital to primary care are associated with multiple risks for older adults with complex needs. Efforts to reduce these risks include reforms to the financing and organisation of health care as well as implementation of new models of care, ICT, and relational support to enable better connectivity, coordination and continuity of care.

References

1 Australian Bureau of Statistics (ABS). (2013). *Population Projections, Australia, 2012 (base) to 2101*. Canberra: ABS.

2 ABS. (2015). *Australian Demographic Statistics June Quarter 2015*. Canberra: ABS.

3 Australian Institute of Health and Welfare (AIHW). (2016). *Admitted patient care 2014–15: Australian hospital statistics.* Canberra: AIHW.

4 American Hospital Association. (2013). *Issue Brief: Moving towards bundled payment*. Washington: AHA.

5 Russell L, et al. (2013). *Patient safety – handover of care between primary and acute care: Policy review and analysis.* Canberra: Australian Primary Health Care Research Institute.

6 Belleli E, et al. (2013). Communication at the interface between hospitals and primary care. A general practice audit of hospital discharge summaries. *Aust Fam Phys*, 42, 886–90.

7 Masters S, et al. (2008). What are the first quality reports from the Transition Care Program in Australia telling us? *Australas J Ageing,* 27 (2), 97–102.

8 Richardson JE, et al. (2015). A needs assessment of health information technology for improving care coordination in three leading patient-centered medical homes. *J Am Med Inform Assoc*, 22, 815–20.

9 AIHW. (2014). *Transition care for older people leaving hospital: 2005-06 to 2012–13.* Canberra: AIHW.

10 Cameron ID, et al. (2010). Whither transition care. *Australas J Ageing*, 29, 147–9.

11 Primary Health Care Advisory Group. (2015). *Final report: Better outcomes for people with chronic and complex health conditions*. Canberra: Department of Health.

12 Fearon P, et al. (2012). Services for reducing duration of hospital care for acute stroke patients. *Cochrane Database Syst Rev*, 9, CD000443.

13 Goncalves-Bradley DC, et al. (2016). Discharge planning from hospital. *Cochrane Database Syst Rev*, 1, CD000313.

14 Verhaegh KJ, et al. (2014). Transitional care interventions prevent hospital readmissions for adults with chronic illnesses. *Health Aff (Millwood),* 33, 1531–9.

15 Chinthammit C, et al. (2012). A cost-effectiveness evaluation of hospital discharge counseling by pharmacists. *J Pharm Pract*, 25, 201–8.

16 Nielsen M, et al. (2016). *The patient-centered medical home's impact on cost and quality, review of evidence, 2014-2015: Patient-Centered Primary Care Collaborative*. Retrieved 5 May 2016, from https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-2014-2015

17 Williams JW, et al. (2014). *The patient-centered medical home closing the quality gap: Revisiting the state of the science*. Rockville (MD): Agency for Healthcare Research and Quality.

18 Braddock CH, et al. (2013). The Patient-Centered Medical Home: An ethical analysis of principles and practice. *J Gen Intern Med*, 28, 141-6.

19 Janamian T, et al. (2014). A systematic review of the challenges to implementation of the patient-centred medical home: Lessons for Australia. *Med J Aust*, 201(3 Suppl), S69-73.

20 Australian Government Department of Health. (2016). *Trials: Another million Australians to have a record*! Retrieved 1 April 2016, from http://www.bsphn.org.au/wp-content/uploads/2014/06/My-Health-Record-News_FEB2016.pdf

21 Silow-Carroll S, et al. (2011). *Reducing hospital readmissions: Lessons from top-performing hospitals: Synthesis report.* New York: The Commonwealth Fund.

22 Australian Healthcare and Hospitals Association. (2015). *Pathways to reform: Health funding and the reform of Federation.* Deakin: AHHA.

23 Gravelle H, et al. (2007). Impact of case management (Evercare) on frail elderly patients: Controlled before and after analysis of quantitative outcome data. *BMJ*, 334, 31.

24 Stokes J, et al. (2015). Effectiveness of case management for 'at risk' patients in primary care: A systematic review and meta-analysis. *PLoS One*, 10, e0132340.

25 Australian Government Department of Veterans' Affairs. (2011). *Coordinated Veterans' Care Program: A guide for general practice.* Retrieved 1 April 2016, from http://www.dva.gov.au/sites/default/files/files/publications/providers/cvc/GGP.pdf

26 Huynh K, et al. (2014). *Home Medicine Reviews: Recent changes and potential implications. RESEARCH ROUNDup* Issue 39. Adelaide: PHCRIS.

27 The Pharmacy Guild of Australia. (2015). *Home Medicines Review*. Retrieved 5 May 2016, from http://6cpa.com.au/medication-management-programmes/home-medicines-review/

28 Griffiths P, et al. (2013). *Scoping the role of the dementia nurse specialist in acute care*. Southhampton: Centre for Innovation and Leadership in Health Sciences.

29 Northern Sydney PHN. (2016). *Hospital discharge follow up service for people with dementia: Request for proposal 2016*. Retrieved 2 May 2016, from http://sydneynorthhealthnetwork.org.au/about-us/commissioning/grants-tenders/

Acknowledgement: Thank you to expert reviewer Professor Christopher J Poulos for his comments on a draft of this paper.