Transitions from hospital to primary care

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,6 particularly for older adults with complex and chronic health problems.

Older adults with chronic health problems are at high risk for adverse events during transitions5 including problems with medications (e.g. inappropriate, suboptimal, discontinuity or duplication)6 and delays or lack of community support7 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;8 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 Program9 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”.11,12

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;10 tailored discharge plan;11 follow-up services12). 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 (PcEH), 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.21
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Funding
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. In Australia, the potential for PHNs to fund community-based health care services for 90 days following discharge has been discussed.

Support
Advanced/specialist roles for nurses such as the community matron role in the UK improve patient satisfaction, however evidence to support an associated reduction in hospital admissions is lacking. 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 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. As part of the HMR programme, a hospital referral pathway is currently being trialled in Australia.

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. 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.

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

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