Enabling GP integration with rehabilitation services

Initiative Type

Model of Care

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Deliver

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Summary

Data from the Australasian Rehabilitation Outcome Centre (AROC) indicates > 17000 people participated and were discharged from 51 inpatient Rehabilitation (21 public, 30 private) Units across Queensland in 2018. Over 15,000 people returned to the community and ongoing medical care with General Practitioners (GPs). Safe quality patient care, both during the period of inpatient

Rehabilitation and on discharge requires timely accurate clinical handover between Rehabilitation Services and GPs. There is no set definition for integration and integrated care. Aspects of integrated care (Children's Health Queensland, 2018), include:

- Broad care provision – physical, psychological and social
- Person and family centered
- Delivered in partnership

Unfortunately, GPs frequently only know that their patient has undertaken rehabilitation at the point of discharge, either having to provide ongoing medical care based on short discharge summaries or having to digest extensive medical and allied health discharge summaries in an initial 15-30-minute appointment post inpatient rehabilitation. GPs are involved with coordinating referrals, ongoing specialist appointments and ongoing medical management of these patients often without having been involved with any discussions with rehabilitation teams. Rehabilitation pathways post discharge have been demonstrated to be complex and diverse and GPs may not be aware of some specialist allied health services or rehabilitation pathways that may be appropriate for their patients.

Key dates

Jul 2019

Jun 2020

Implementation sites

Children's Health Queensland, Cairns Base Hospital, Gold Coast University Hospital

Key Contacts

Melanie Mildenhall

5477

Anonymous

Network coordinator

Statewide Rehabilitation Clinical Network

07 3068 2950

Melanie.Mildenhall@health.qld.gov.au

Aim

This project aimed to identify key points in the inpatient rehabilitation pathway where integration with General Practitioners (GPs) is most beneficial and to describe the best approach in order to maximise outcomes during transfer of care from the hospital to the community setting. Implementation of the new model of care was developed and trialed at three pilot sites; Cairns and Hinterland Hospital and Health Service, Gold Coast Hospital and Health Service and Children's Health Queensland Hospital and Health Service.

Benefits

Strengthen patient care, both during the period of inpatient rehabilitation and on discharge by enabling timely accurate clinical handover, coordination and communication between rehabilitation services and GPs. Improve support for patients that have complex medical conditions requiring rehabilitation (stroke, acquired brain injury, spinal cord injury/illness, deconditioning, fractures etc.), often accompanied by comorbidities as they return to the community and ongoing medical care with GPs. Improve support for young people transitioning to adult rehabilitation and health services.

Background

It is commonly accepted that any transition of care is a high risk time for adverse events (Belleli, Naccarella & Pirotta, 2013). This includes all points of transition including internal transfers, transition from acute to sub-acute care and then to community care (Mahfouz, Bonney, Mullan & Rich, 2017). Although it is accepted that patients are generally better off in their own home environment, patients with complex care needs are often hospitalised for long periods of time due to a complicated discharge process (Carter et al., 2016). Transition from hospital to community care is a high risk time for patients and many factors must align to make this a safe and successful transition time (Hirschman, Shaid, McCauley, Pauly & Naylor, 2015). Factors relating to hospital healthcare providers, community healthcare providers and patients/families all play an integral part in transition of care. It is also true that technology, timeliness of information sharing, GP knowledge and effective handover processes all impact on the transition from acute hospital to community based care. Risks lie in medication errors, unclear medication plans, unclear follow up plans and patients not utilising community healthcare providers (Escobedo, Kirtane & Berman, 2012). Successful integration of GPs in the discharge of patients from acute to community care is more than just an

efficient discharge summary, it involves integration in aspects of care throughout the whole inpatient stay. Communication

Effective and clear communication is the key to successful handover during any transition of healthcare provision (Belleli et al., 2013). Ineffective communication during discharge is said to attribute to, on average, almost half of all patients experiencing an adverse event during their post acute care (Mahfouz et al., 2017). Providing incorrect, incomplete or hard to decipher clinical handovers to GPs upon discharge can lead to GPs spending great lengths of time trying to extract relevant and correct information (Australian Commission on Safety and Quality in Health Care, 2019). This can lead to frustration, poor use of time, unsafe follow up care and missed vital information. Quality communication between acute care professionals and GPs can help negate frustrations around unclear follow up plans, poor use of resources and unnecessary travel and appointments (Beaton, O'Leary, Thorburn, Campbell & Christey, 2019). Quality of handover

Receiving an accurate and timely handover from acute inpatient healthcare providers is key in ensuring patient safety post discharge (Hewner, Sullivan & Yu, 2018). Medication errors in discharge reports, prescribing and ongoing medication plans continues to be an ongoing issue in healthcare, both in acute and community settings (Escobedo et al., 2012). This remains one of the key areas of risk when patients are discharged from acute settings into GP care as GPs are often receiving patients with incorrect medication information. Belleli et al., (2013) conducted research around how and when hospital discharge reports were received by GPs. It is noted that 88-100% of discharge reports were completed by the hospitals but only 55% of reports were received by the patient's GP prior to their first appointment post discharge (Belleli et al., 2013). This is thought to be due to administration error, no GP listed on hospital records, delayed discharge summary completion or technological issues (Belleli et al., 2013). GPs are often not experts in the complexities of all post acute care, relying on quality information and care plans from acute care settings (Bench, Cornish & Xyrichis, 2016). Therefore, GPs prefer an outline of key points to be highlighted at the top of a discharge report (Lockman et al., 2018). The use of a framework for effective handover is promoted in healthcare, for example, ISBAR; introduction, situation, background, assessment and recommendation (Beaton et al., 2019). Expectations

It is unrealistic to rely on the patient or their family to give accurate and complete medical information to their GP upon discharge (Belleli et al., 2013). Patients transferring care form inpatient rehabilitation units to community services are usually complex and often have a new diagnosis. Therefore, clinician to clinician handover is necessary. There are often unintended expectations that patients and families take on the role of 'care coordinator' post discharge which often is an unsafe outcome due to a multitude of barriers (Allen, Hutchinson, Brown & Livingston, 2018). It is an expectation from the GP that discharge summaries they receive are clear and accurate. Belleli et al., (2013) found that information regarding medications, referrals and tests completed during inpatient stays were often missing or inaccurate. This is a concern for patient safety and follow up care. Accurate and effective discharge summaries are a requirement for accreditation through the Australian National Safety and Quality Service Standards (Mahfouz et al., 2017), therefore, this is not just an expectation of healthcare providers but mandated by their facility. Patients expect a clear point of contact for follow up concerns as well as ongoing assessment by hospital staff, not their GP (Beaton et al., 2019). This can often clash with the hospitals expectation that follow up care will be provided by the GP, leaving the GP in a difficult position of trying to ensure patients are provided all follow up care that is required. There are often unclear guidelines as to which health professional is responsible for which aspect of ongoing care, leading to confusion and missed follow up requirements (Bench et al., 2016). Technology

The best ways in which to use current and future technology in the effective discharge from inpatient to community care is a significant theme noted in the literature. As the capability and capacity of technology improves, an increase in uptake of technology can be seen in the healthcare sector (Hewner et al., 2018). It is widely accepted that effective technology plays a vital role in successful

transition to community care (Hirschman et al., 2015). Through positive and improved transitions of care, patients remain healthier, hospital admissions are decreased, and consumers experience a higher perceived satisfaction with their healthcare (Escobedo et al., 2012). Technology was also cited as one of the barriers to effective communication and handover between acute and community teams (Pellett, 2016). Lack of access to information about the inpatient stay as well as an informative and accurate discharge summary can lead to problems for the GP in providing appropriate, efficient and timely care for the recently discharged patient (Escobedo et al., 2012). Providing electronic discharge summaries to GPs may improve the timeliness or receipt, however, it is suggested that a hard copy is also provided to patients in the case of technological issues or it not being received by the GP prior to their first GP appointment (Belleli et al., 2013). Ensuring technology is cost efficient, secure and user friendly can ensure it is utilised by more healthcare professionals in both the acute and community settings (Escobedo et al., 2012).

Collaboration:

Promoting the collaboration of the patient, family, rehabilitation team and GPs in the discharge planning from acute to community care promotes consumer satisfaction, patient safety and improved quality of care (van Beusekom et al., 2019). Collaboration between acute and community healthcare providers is often difficult due to time constraints and clinical workloads. However, this initial investment of time and resources will lead to an improvement in health outcomes, clear follow up plans, establishment of shared mutual goals and a decrease of burden on patients and families (Hirschman et al., 2015). Through collaboration, all involved parties can learn from each other and gain a greater sense of investment (Hanley, Doyle, Fagan & Mulligan, 2014). This will allow the GP to learn expertise from the acute care staff, facilitating a more effective use of community resources, empowerment of GPs to manage ongoing care requirements and improve communication between all healthcare professionals involved (Hanley et al., 2014). Support provided by senior hospital medical staff to junior medical staff could assist in the quality of discharge summaries provided to GPs (Belleli et al., 2013). Ensuring accurate information, specifying what is important in discharge summaries and eliminating omissions are all skills that senior medical staff can support junior medical staff to develop (Bench et al., 2016). There are several frameworks that have been developed to support health care professionals in the transition of care from one setting to another, these include the Care Transitional Intervention and the Transitional Care Model (Allen et al., 2018). These both include the need for collaboration between all healthcare professionals involved in the patients care, as well as involving the patient and their family in the discharge process. The goal is to provide accurate, timely and effective discharge care as the standard practice (Hewner et al., 2018). The complexities that are associated with acute and ongoing care of rehabilitation and complex care patients requires a clear and comprehensive approach (Bench et al., 2016). The GP is often the gateway between the patient and other healthcare professionals (van Beusekom et al., 2019), therefore, the GP needs to be informed of all available resources and follow up requirements to be able to do this effectively. More research needs to be completed about how the GP can be more involved in the inpatient stay and if this would support faster discharge, more effective follow up care, improved patient outcomes and improved consumer satisfaction (van Beusekom et al., 2019). The importance of starting the discharge process at the point of hospital admission has been highlighted as a key aspect of successful transitional care (Goncalves-Bradley, Lannin, Clemson, Cameron & Shepperd, 2016). This should involve integrating the patients GP as a member of their healthcare team throughout the inpatient admission, not exclusively upon discharge.

Solutions Implemented

A new model of care, with recommendations for GPs and Rehabilitation Clinicians to support GP integration.
Associated resources for Consumers, GPs and Rehabilitation Clinicians.

Evaluation and Results

An Environmental Scan was conducted as part of the project. A short SurveyMonkey survey was disseminated through the Statewide Rehabilitation Clinician Network, GPLO Network and the Rehabilitation Clinical Nurse Consultant Interest Group. A total of 45 responses were received, across various healthcare settings in Queensland and interstate. The results of the Environmental Scan suggest the need for the following supportive practices:

- Clear expectations for content and timeframe for completion of inpatient rehabilitation discharge summary
- Clear processes and contacts for multi-modal communication with Rehabilitation Units
- Education for Rehabilitation Clinicians on the GPLO role, including building awareness that the role exists (and where) and their role in supporting patients to identify a GP
- Education for GPs on available rehabilitation services
- Further exploration of novel practices (such as a Community Registrar) already in place at other facilities
- Further exploration around the use of technology, including health software platforms for communication

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