KEY MESSAGES

Implementing care coordination plus early rehabilitation in high-risk COPD patients in transition from hospital to primary care

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Policy context

Problems associated with the transition between hospital and primary care in people with chronic obstructive pulmonary disease (COPD) have a high personal and public health cost. Problems that have been identified include: patient and carer dissatisfaction with experience; poor identification or concern for patient health goals; high incidence of adverse events including early re-admission; declines in physical activity, function and quality of life (QOL) after hospitalisation.

In order to address the documented problems with transition, this pilot study implemented care coordination plus early rehabilitation in people with COPD at the time of transition from hospital to home.

Key messages

➤ This pilot intervention generated a positive experience of both the process and outcomes of transition for COPD patients and their carers.

➤ Patient-centred problem identification and goal setting was followed by significant and meaningful progress toward achieving those goals.

➤ Patient-centred care planning by the care coordinator was highly comprehensive and valued by patients, carers and general practitioners.

➤ This intervention avoided adverse events including emergency department presentations by patients in the early post-transition period.

➤ Only 1 in 10 (10%) of patients in the intervention group were readmitted within 28 days for a respiratory reason compared with 6/19 (32%) of controls.

➤ Objectively measured physical activity increased (time spent standing and walking) and time spent sitting decreased as a result of early rehabilitation in the context of transition care coordination. These improvements were not seen in the control group.

➤ Commitment of this program to gain collaboration with the patient’s general practitioner (GP) proved challenging but did effectively prompt care continuity at the time of transition.

   o Evidence for this lay in the generation or review of GP management plans by the patient’s usual practice resulting from the intervention in all cases where a current plan had not previously existed (9/10 cases).