PRIMARY HEALTH NETWORK

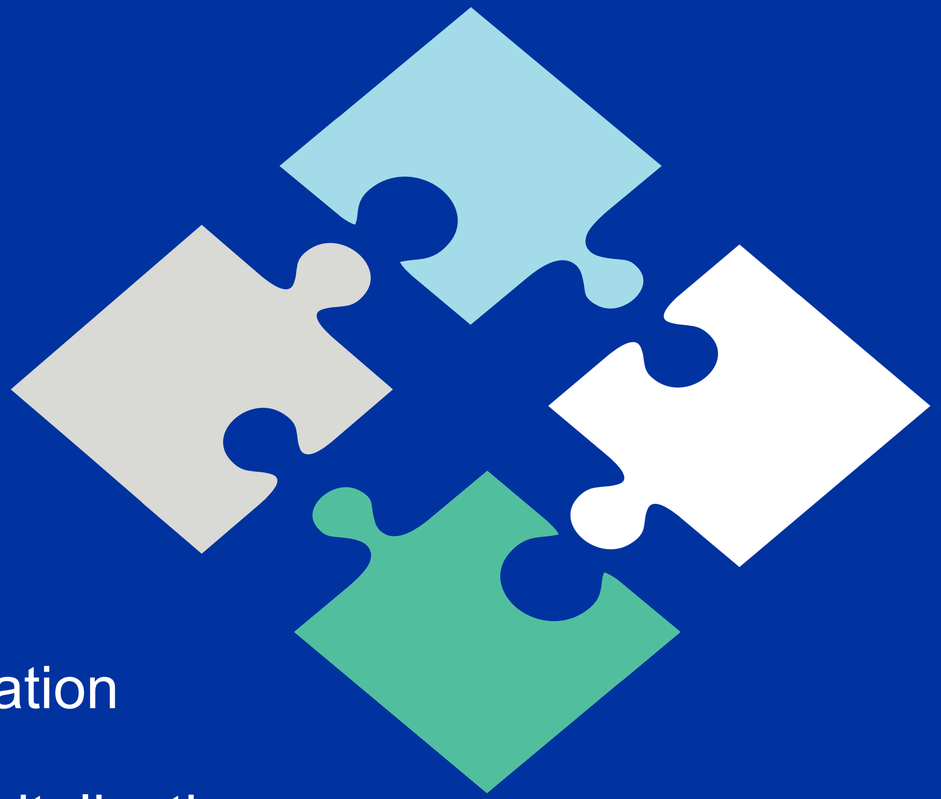
THERE'S NO PLACE LIKE HOME

- HOSPITAL AVOIDANCE STRATEGIES FOR GENERAL PRACTICE

15th September 2021

WE ACKNOWLEDGE THE TRADITIONAL OWNERS & CUSTODIANS OF THE LAND THAT WE LIVE & WORK ON AS THE FIRST PEOPLE OF THIS COUNTRY.

Learning Objectives



Define what constitutes a potentially preventable hospitalisation

Identify common diagnoses for potentially preventable hospitalisation

Recognise who is at greatest risk of potentially preventable hospitalisation

Consider how we can implement hospital avoidance strategies in General Practice

What is a potentially preventable hospitalisation?

Classifying a hospitalisation as “potentially preventable”
does not mean that the hospitalisation itself was unnecessary.

It means that optimal management at an earlier stage might have
prevented the patient’s condition worsening
to the point where they needed hospitalisation.

A strong, accessible primary health care system
keeps people well and out of hospital by supporting them to
manage their health issues in the community and at home.

Why are hospital avoidance strategies important?

RACGP

The role of a GP

The GP plays a central role in the delivery of health care to the Australian community.

In Australia, the GP:

- is most likely the first point of contact in matters of personal health
- coordinates the care of patients and refers patients to other specialists
- cares for patients in a whole of person approach and in the context of their work, family and community
- cares for patients of all ages, both sexes, children and adults across all disease categories
- cares for patients over a period of their lifetime
- provides advice and education on health care
- performs legal processes such as certification of documents or provision of reports

General practice is a medical speciality (in some countries called family medicine).

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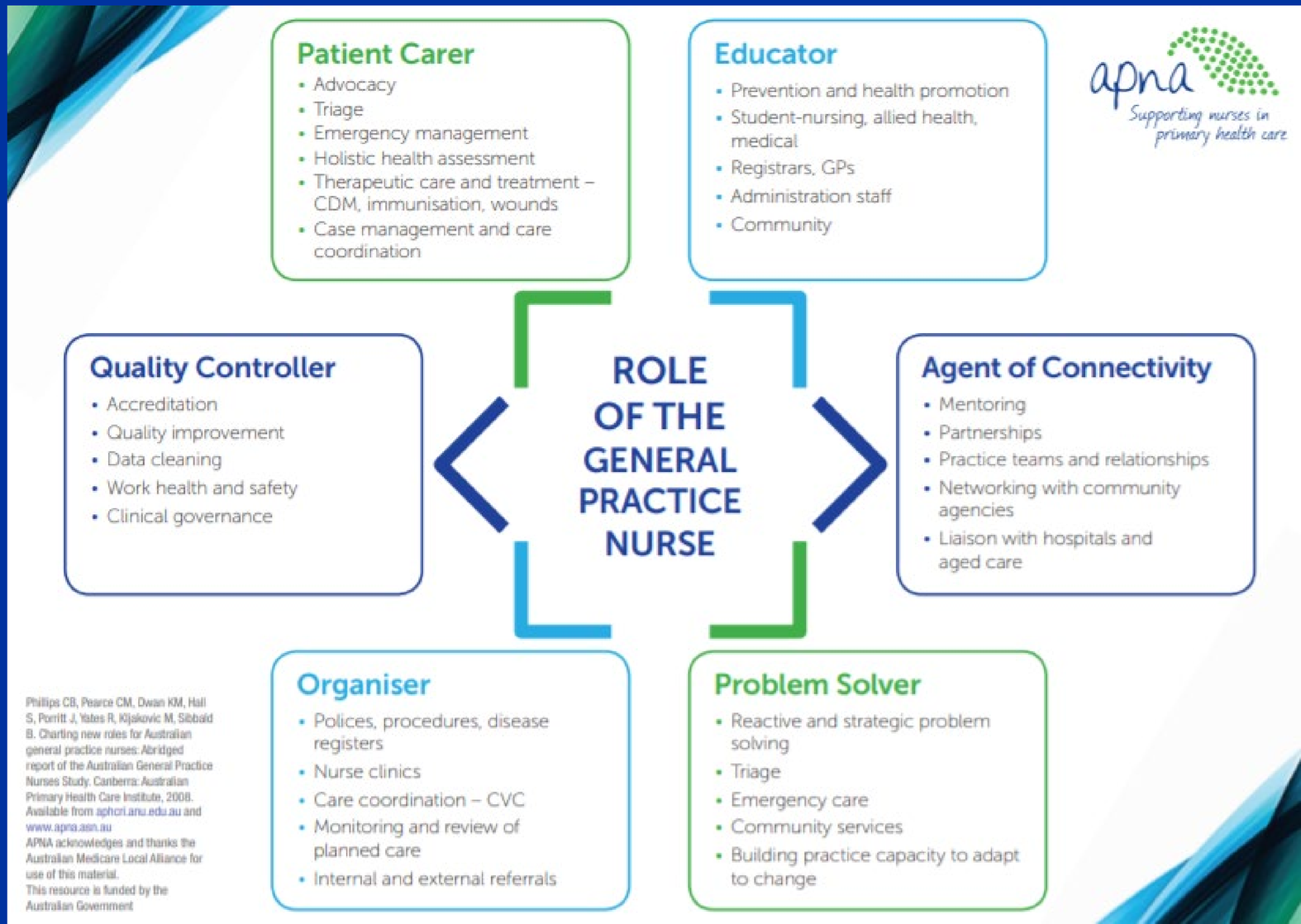
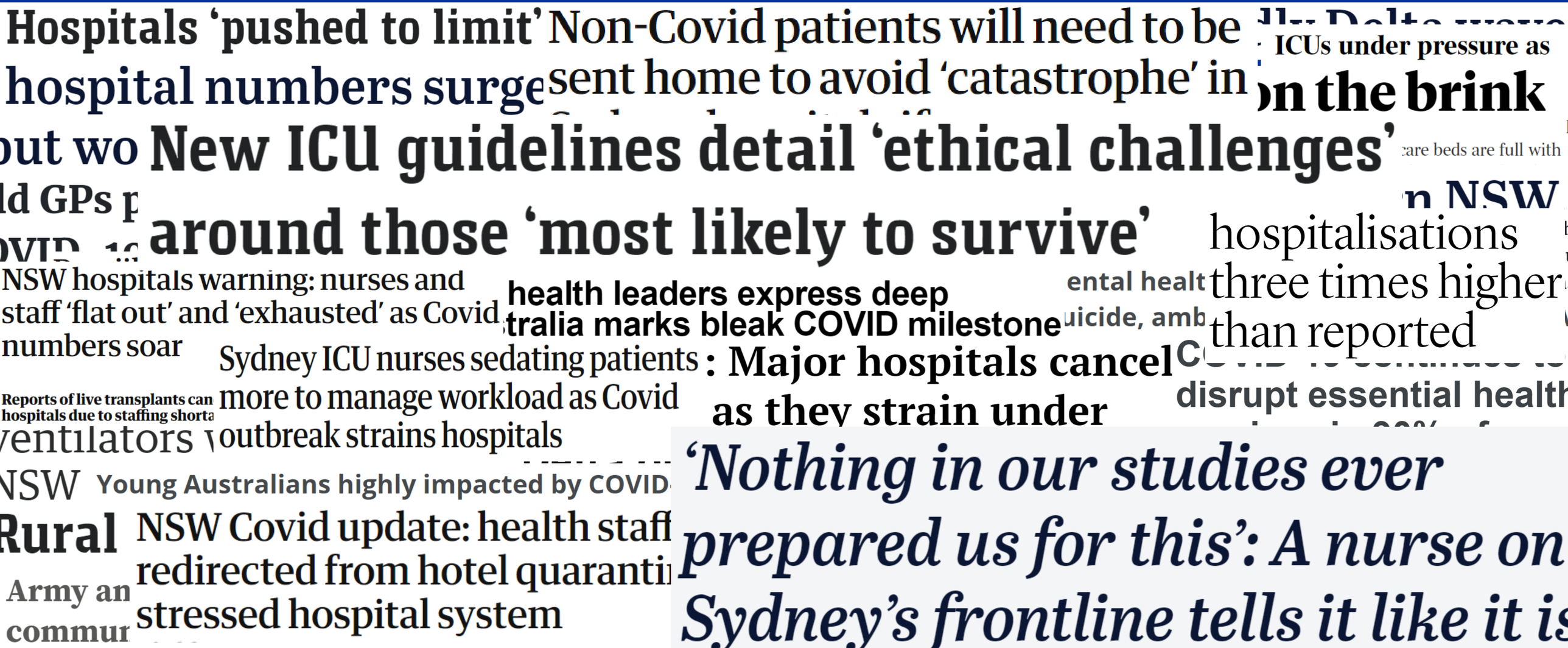
Why are hospital avoidance strategies important?



Why are hospital avoidance strategies especially important right now?



Management of patients with mild COVID-19 at home

Guidelines for the GP & Practice team
Patient triage and clinical care
Developing a management plan
Managing symptoms and medicines
Monitoring symptoms
Escalating care

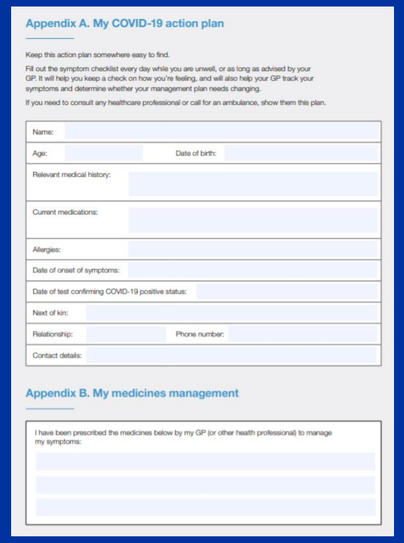
Telehealth consultations
Face-to-face consultation
Advice for pregnancy or breastfeeding

www.racgp.org.au/yourracgp/faculties/nswact/events/

www.racgp.org.au/clinical-resources/covid-19-resources/other-health-issues/home-care-guidelines-patients-with-mild-covid-19

Management of patients with mild COVID-19 at home

Guidelines for patients
Managing symptoms
Isolating at home
Stopping the spread of the virus
Taking care of your mental health
Advice for caregivers and other people in the household



Appendix A. My COVID-19 action plan

Keep this action plan somewhere easy to find.

Fill out the symptom checklist every day while you are unwell, or as long as advised by your GP. It will help you keep a check on how you're feeling, and will also help your GP track your symptoms and determine whether your management plan needs changing.

If you need to consult any healthcare professional or call for an ambulance, show them this plan.

Name:

Age: Date of birth:

Relevant medical history:

Current medications:

Allergies:

Date of onset of symptoms:

Date of test confirming COVID-19 positive status:

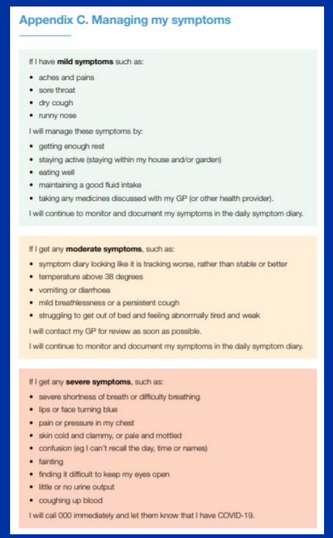
Next of kin:

Relationship: Phone number:

Contact details:

Appendix B. My medicines management

I have been prescribed the medicines below by my GP (or other health professional) to manage my symptoms:



Appendix C. Managing my symptoms

If I have **mild symptoms** such as:

- aches and pains
- sore throat
- dry cough
- runny nose

I will manage these symptoms by:

- getting enough rest
- staying active (staying within my house and/or garden)
- eating well
- maintaining a good fluid intake
- taking any medicines discussed with my GP (or other health provider).

I will continue to monitor and document my symptoms in the daily symptom diary.

If I get any **moderate symptoms**, such as:

- symptom diary looking like it is tracking worse, rather than stable or better
- temperature above 38 degrees
- vomiting or diarrhoea
- mild breathlessness or a persistent cough
- struggling to get out of bed and feeling abnormally tired and weak

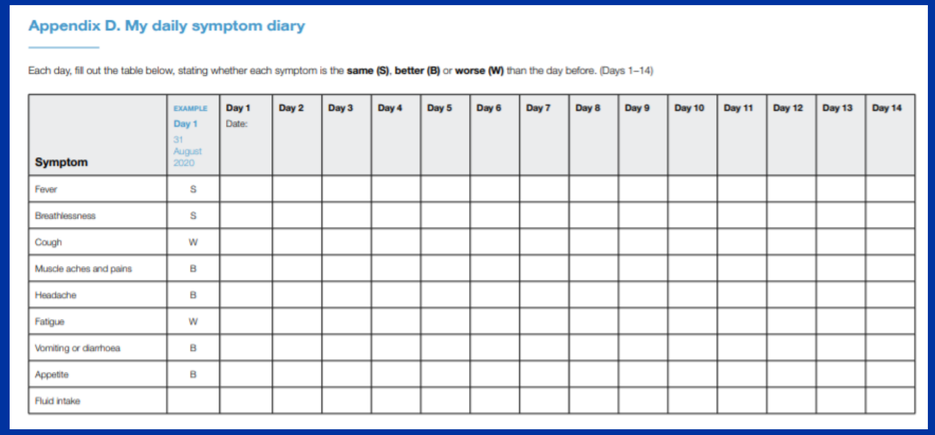
I will contact my GP for review as soon as possible.

I will continue to monitor and document my symptoms in the daily symptom diary.

If I get any **severe symptoms**, such as:

- severe shortness of breath or difficulty breathing
- lips or face turning blue
- pain or pressure in my chest
- skin cold and clammy, or pale and mottled
- confusion (eg I can't recall the day, time or names)
- fainting
- finding it difficult to keep my eyes open
- little or no urine output
- coughing up blood

I will call 000 immediately and let them know that I have COVID-19.



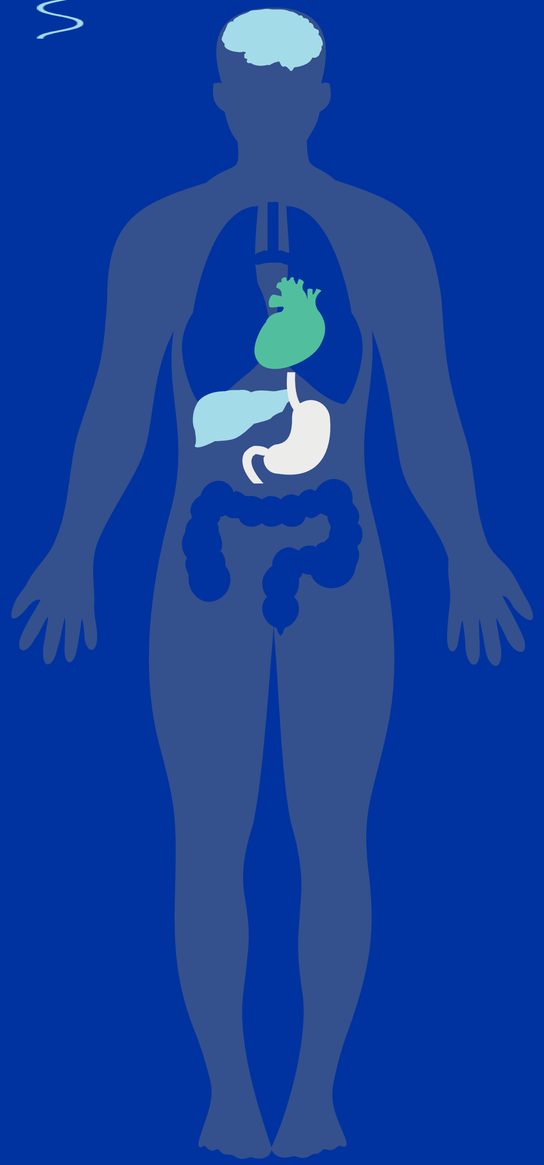
Appendix D. My daily symptom diary

Each day, fill out the table below, stating whether each symptom is the **same (S)**, **better (B)** or **worse (W)** than the day before. (Days 1–14)

Symptom	EXAMPLE Day 1 31 August 2020	Day 1 Date:	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Fever	S														
Breathlessness	S														
Cough	W														
Muscle aches and pains	B														
Headache	B														
Fatigue	W														
Vomiting or diarrhoea	B														
Appetite	B														
Fluid intake															

www.racgp.org.au/clinical-resources/covid-19-resources/other-health-issues/home-care-guidelines-patients-with-mild-covid-19

Common potentially preventable hospitalisations



Vaccine preventable conditions

- pneumonia
- influenza
- other vaccine preventable diseases (e.g. chickenpox, measles, polio)

Chronic conditions

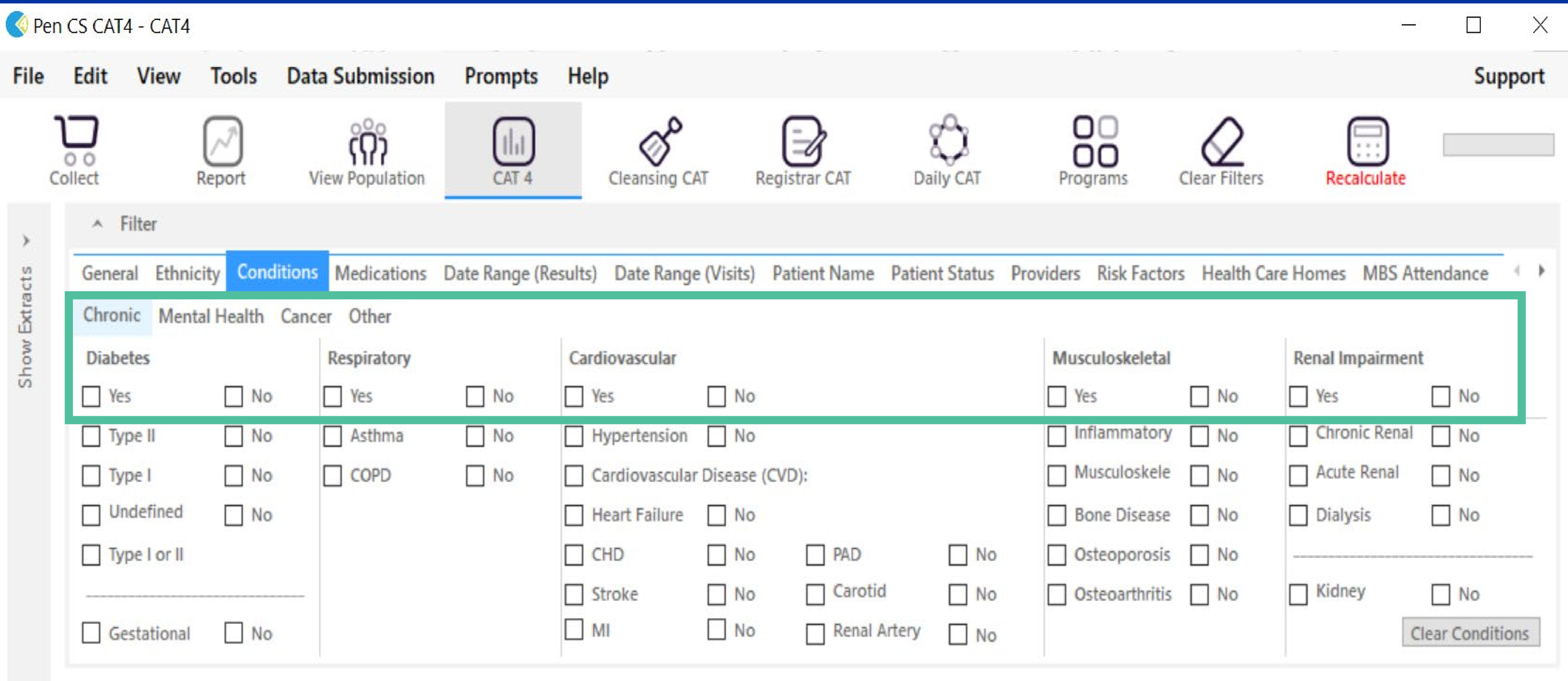
- angina
- asthma & COPD
- bronchiectasis
- congestive cardiac failure
- diabetes complications
- hypertension
- nutritional deficiencies
- rheumatic heart diseases

Acute conditions

- cellulitis
- convulsions
- dental conditions
- ear, nose and throat infections
- pelvic inflammatory disease
- perforated/bleeding ulcer
- urinary tract & kidney infections

Source: Australian Institute of Health & Welfare
Last updated 21/01/2020 v7.0

Who is most at risk in our practice?



Cancer screening and early identification of cancer for Hospital avoidance

Bowel cancer is Aust. **second** biggest cancer killer. If detected early, bowel cancer can be successfully treated in more than 90% of cases
Target audience: 50 – 74 yo males and females
Call to action: remind patients to complete iFOBT kit or reorder if required*

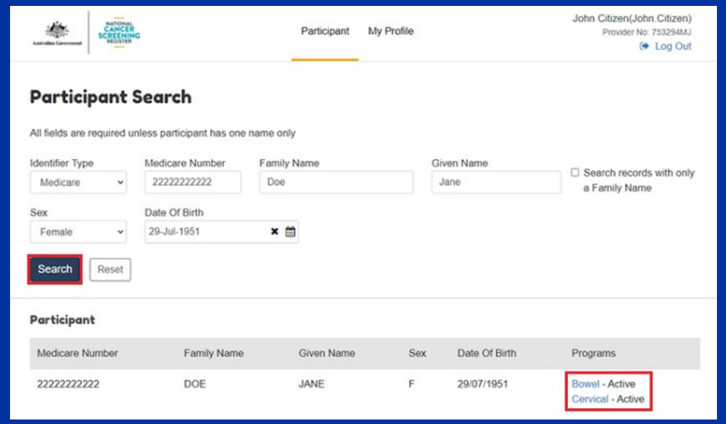
1 in 7 women will develop breast cancer in their lifetime.
Target audience: 50 – 74 yo females
Call to action: encourage women to be breast aware, to contact you if they notice any changes

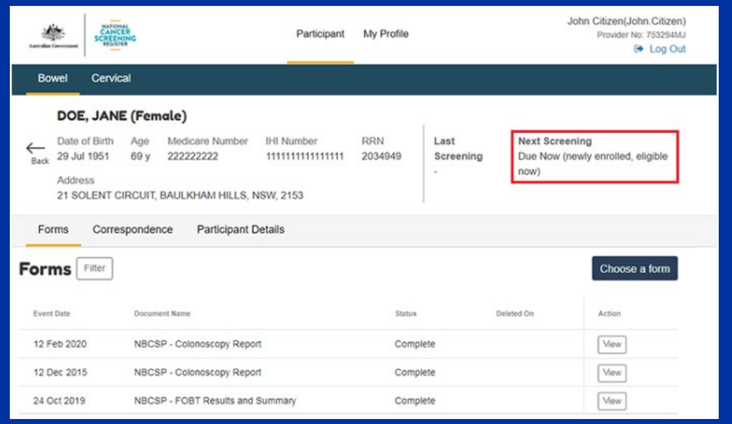
Most cervical cancers occur in people who have never screened or do not screen regularly
Target audience: 25 – 74 yo females
Call to action: continue to recall and remind women to attend cervical screening

Cancer screening and early identification of cancer for Hospital avoidance

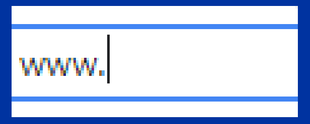
PRODA
Provider Digital Access

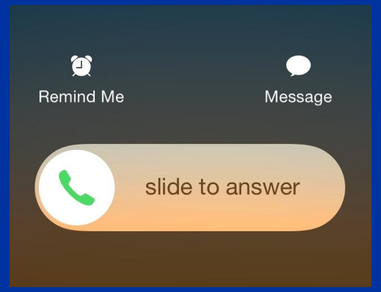
NATIONAL CANCER SCREENING REGISTER

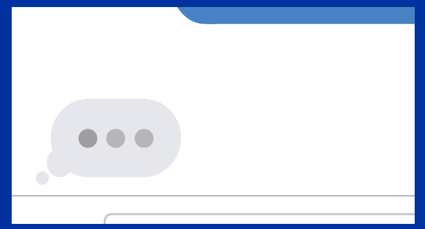




Where are the opportunities to encourage your patients to screen and maintain their health?







Australia Post

MBS Online
Medicare Benefits Schedule

Nurse follow up care for vulnerable patients

Nurse follow up for patients with a chronic disease with a GP Management Plan and/or Team Care Arrangement

Designed to assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP

- checks on clinical progress
- monitoring medication
- self management advice
- collection of information

F2F:10997 VID:93201 PH:93203

Nurse follow up for Indigenous patients with a current 715 Health Assessment

Designed to assist Indigenous patients who have received a health check which has identified need for follow up services between further consultations with the patient's GP

- Examinations/interventions as indicated by the health check
- Education and monitoring of medication
- Checks on clinical progress and service access;
- Education, monitoring and counselling activities and lifestyle advice
- Prevention advice for chronic conditions

F2F:10987 VID:93200 PH:93202

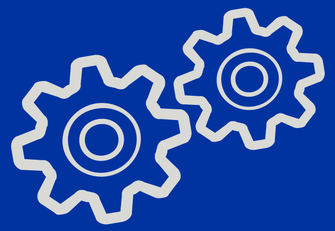
Coordinated Veterans Care

The CVC Program proactively manages Veteran Gold Card holders with chronic conditions and Veteran White Card holders with accepted mental health conditions. Providers and participants work as a team to improve their health care in a general practice setting. It aims to decrease unplanned hospitalisation.

DVA UP03

What can we do?

Empower patients to identify risks

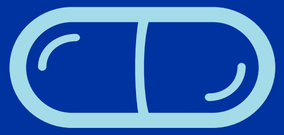


Use a team approach

Talk to patients and practice staff about sick day plans

Plan proactive care

Maintain regular care where possible



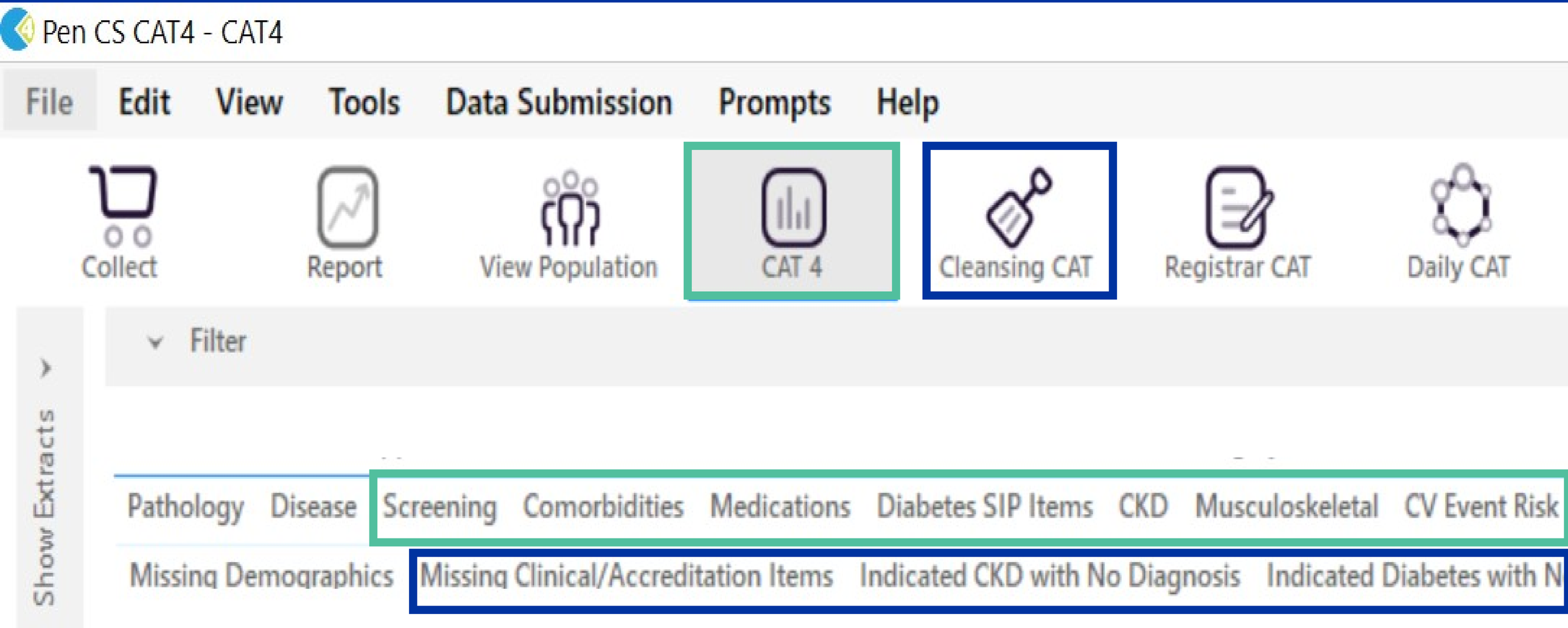
Monitor medication use

Use patient focused SMART goals

Communicate regularly with your team and patients

Ensure timely access to care when it is needed

Monitoring how we are manage patients at risk



Longer term monitoring of hospital avoidance using LUMOS reports

Lumos is a partnership initiative between the Hunter New England and Central Coast Primary Health Network and the NSW Ministry of Health. It is an ethically approved program that securely links data sets across Primary Care, Emergency Department, Hospital Admissions, Outpatient, Ambulatory and Mortality.

Lumos provides practices with an opportunity to see previously unknown data trends focusing on patient journeys through aggregated interaction points with participating practices and the broader health system.

As the Lumos program evolves it is envisioned the information available will support the strategic identification and prioritisation of patient health care across all sectors.

Lumos practice reports are provided bi-annually. They show patient encounters with your practice and the linked data sets noted previously. Each report includes a specific 'Condition in Focus' that provides a more in-depth review of relevant parameters for the chosen topic – these have included Diabetes and Mental Health

cess to quality-assured general practice data. Linkage with other datasets could enable significant scale-up of primary care-based research in Australia, contributing new knowledge in public health, health promotion, economics and evidence-based clinical care. Technologies that allow consumers to have greater control

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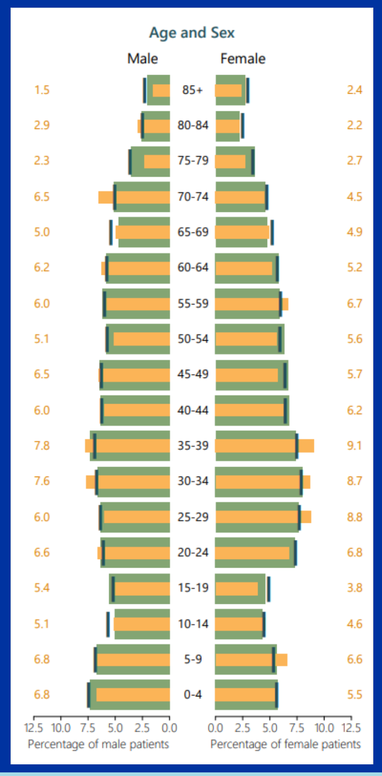
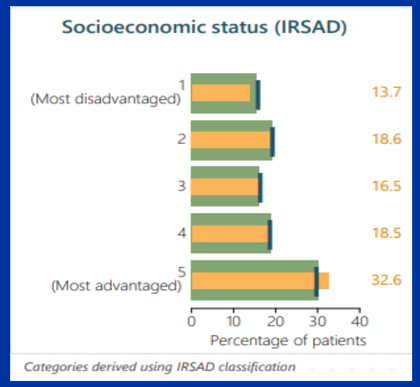
Longer term monitoring of hospital avoidance using LUMOS reports

Key insights from Lumos

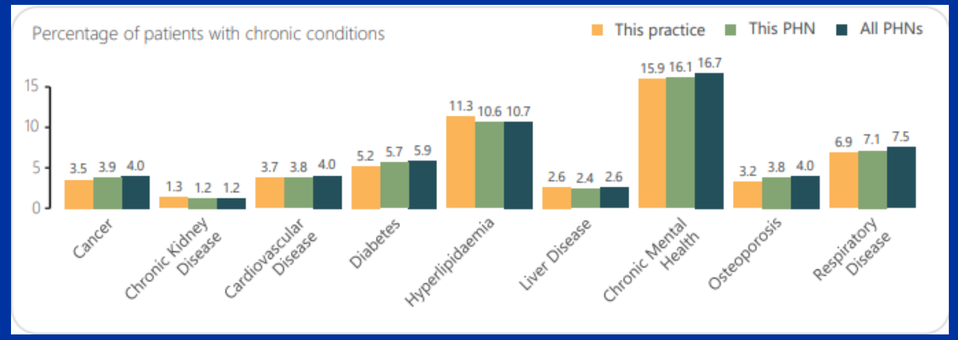


Comparison of Age and Sex data assists in creating a clearer profile of your patient cohort:
* increased focus on preventative opportunities of care for patients aged 40 – 50.
* potential for nurse lead clinics for growing cohort of children aged 0-14



Socioeconomic data can provide broader context to the core patient group accessing the practice:
* Greater concessions for bulk billing.
* Targeted clinics for socially determinant lifestyle risk factors.

The Chronic condition patient profile provides a snapshot of common diseases. The key role of GP's in diagnosis, care and management of patients is well documented – this is especially relevant for minimising presentations at Hospital. The table below can assist with service decisions related to these areas.



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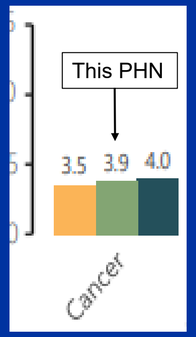
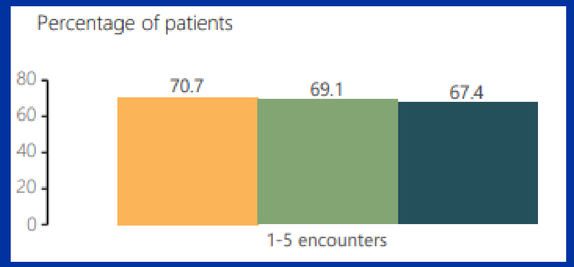
Longer term monitoring of hospital avoidance using LUMOS reports

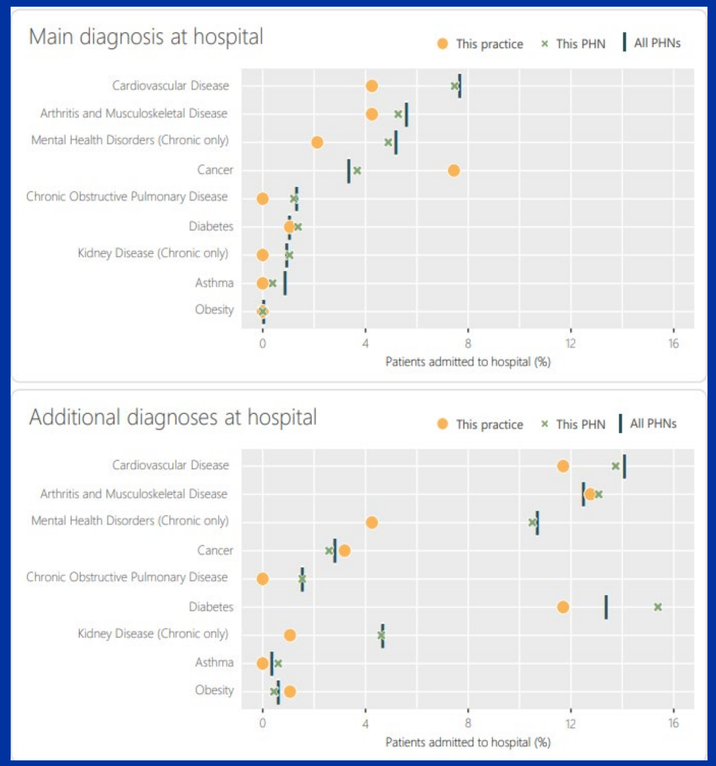
Key insights from Lumos



Comparison data between the 2 previous LUMOS reports found a drop by ½ % across this PHN of Cancer diagnosis.
context: an increase of 46k patients, included the first 4months of the COVID-19 pandemic.

Comparison data between the 2 previous LUMOS reports found a drop by 6% of patients attending practices 1 – 5 times in this PHN.
context: identifies a level of avoidance with General Practices growing in the early pandemic stages GP activity insight - Lumos (nsw.gov.au)





This graph reflects the incidence of main diagnosis at presentation to Hospital compared to Additional diagnosis provided during an interaction at Hospital.
Context: can demonstrate an opportunity to increase focus on a particular area.

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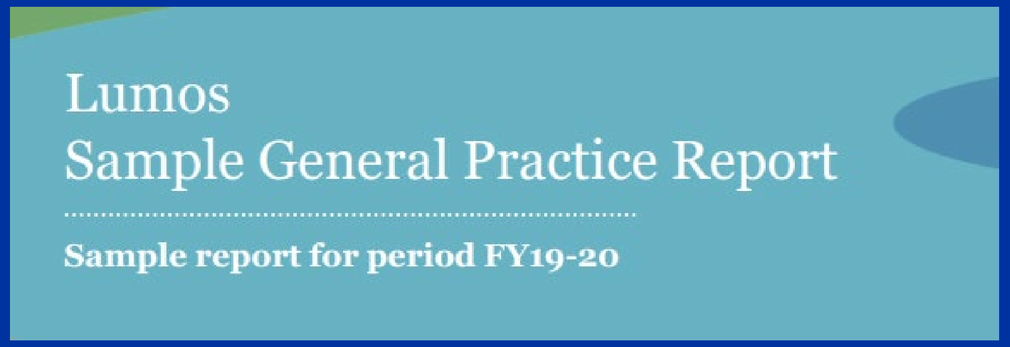
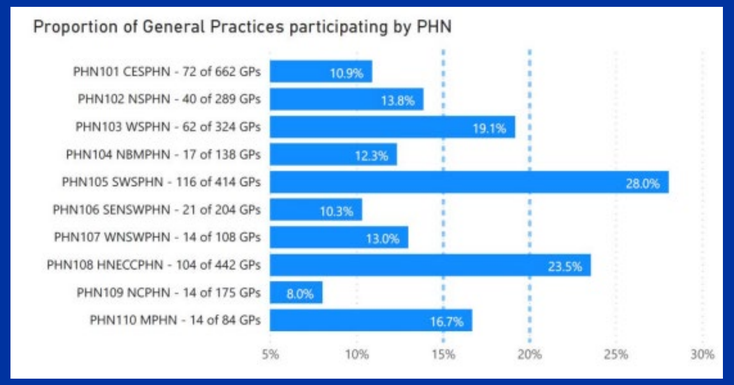
Longer term monitoring of hospital avoidance using LUMOS reports



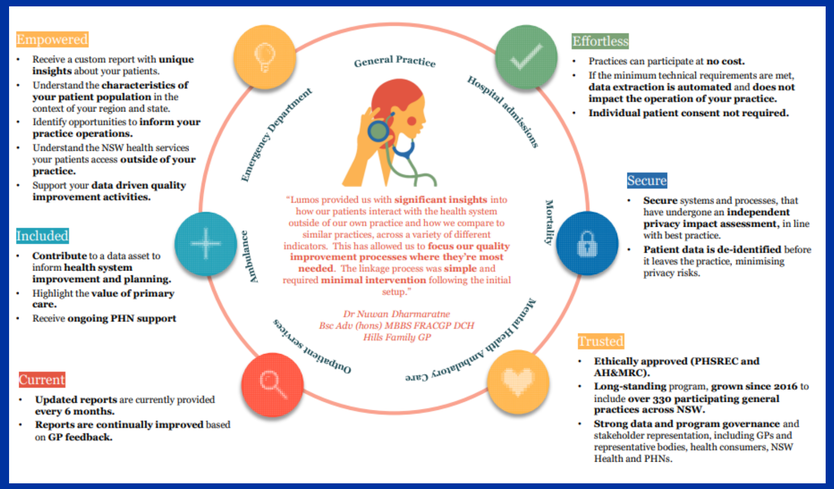
If you would like to access more information you can click here

Additionally, if you would like to access your free **Lumos Practice report** - you only need to contact your local PCIO or James McNeill via email on jmcneill@thephn.com.au



If you are quick, you can still make the next Lumos linkage occurring early October.

Help us get back to leading the state recruitment in this 'first of its kind' initiative.



Stay tuned for more information about *The PHN online Lumos Community of Practice* - COMING SOON

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Questions?

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