

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.

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Healthy People, Healthy Communities

Learning Objectives

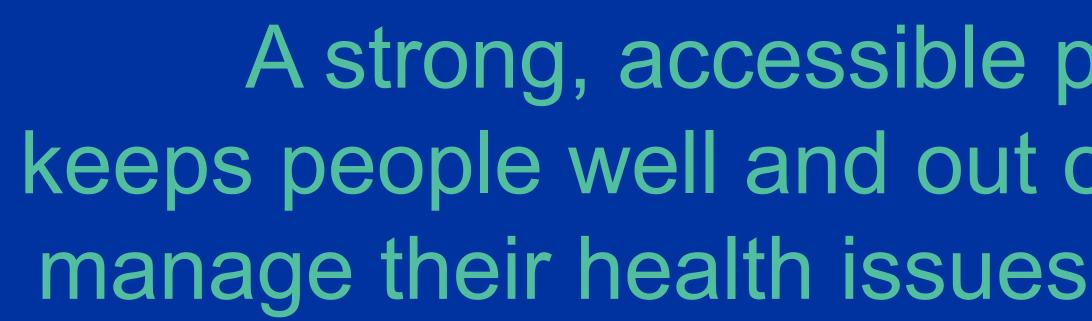
Define what constitutes a potentially preventable hospitalisation Identify common diagnoses for potentially preventable hospitalisation Recognise who is at greatest risk of potentially preventable hospitalisation Consider how we can implement hospital avoidance strategies in General Practice



Solution with the second secon

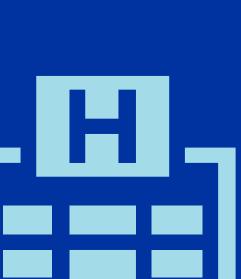
Classifying a hospitalisation as "potentially preventable" does not mean that the hospitalisation itself was unnecessary.

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?



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).







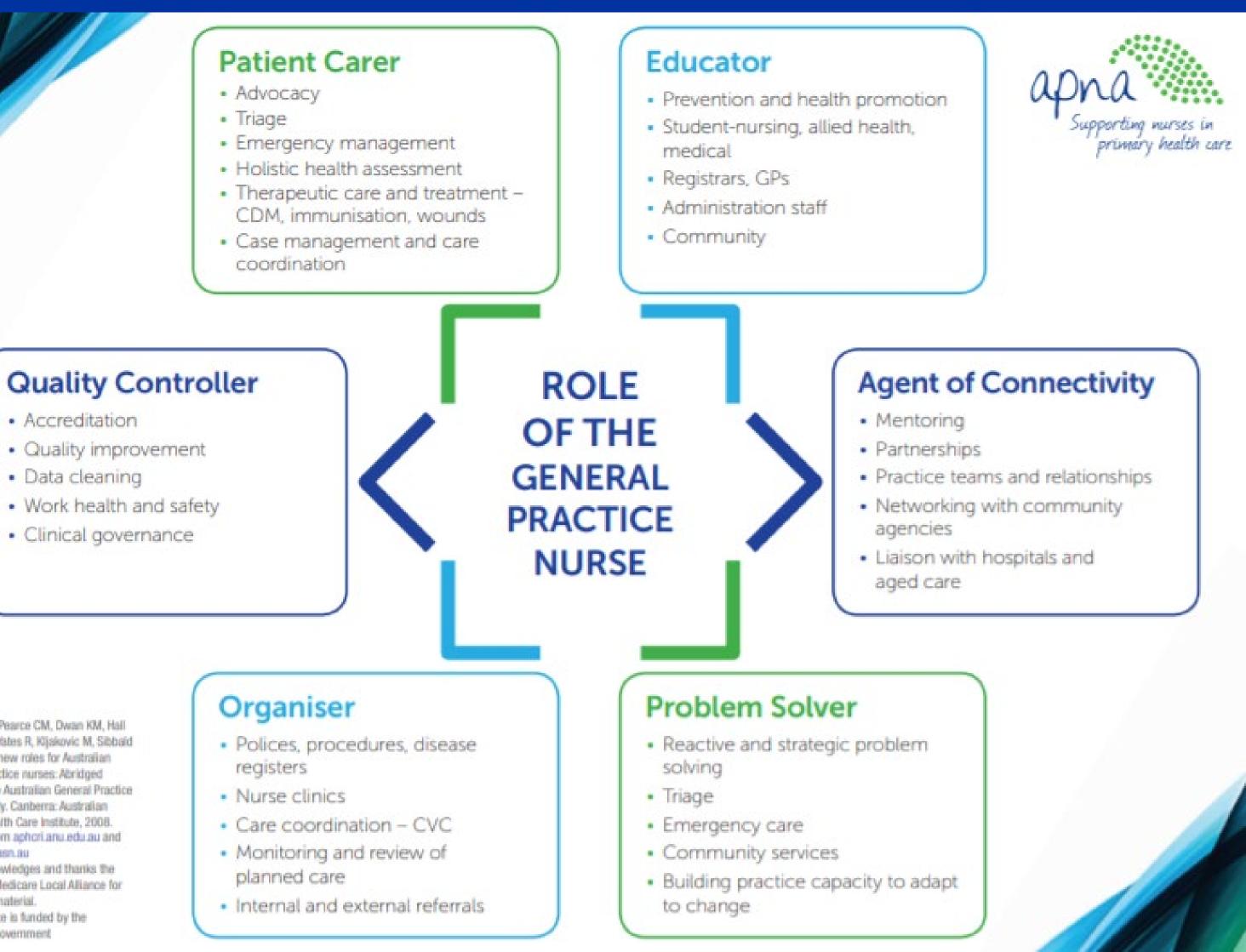
§Why are hospital avoidance strategies important?

- Accreditation

Phillips CB, Pearce CM, Dwan KM, Hall S, Porritt J, Yates R, Kijakovic M, Sibbald B. Charting new roles for Australian general practice nurses: Abridged report of the Australian General Practice Nurses Study, Canberra: Australian Primary Health Care Institute, 2008. Available from aphori anu edu au and www.apna.asn.au

APNA acknowledges and thanks the Australian Medicare Local Alliance for use of this material. This resource is funded by the Australian Government

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Solution with the second strategies and the second §important right now?

Hospitals 'pushed to limit' Non-Covid patients will need to be 'ICUs under pressure as hospital numbers surgesent home to avoid 'catastrophe' in 'n the brink out wo New ICU guidelines detail 'ethical challenges' are beds are full with ld GPs p a correction of the second those 'most likely to survive' hospitalisations NSW hospitals warning: nurses and ental healt three times higher NSW hospitals warning: nurses and staff 'flat out' and 'exhausted' as Covid tralia marks bleak COVID milestone^{uicide, amb} than reported numbers soar Sydney ICU nurses sedating patients : Major hospitals cancel Reports of live transplants can more to manage workload as Covid hospitals due to staffing shorta disrupt essential health as they strain under ventilators voutbreak strains hospitals NSW Young Australians highly impacted by COVID 'Nothing in our studies ever Rural NSW Covid update: health staff prepared us for this': A nurse on redirected from hotel quarantia stressed hospital system Svdnev's frontline tells it like it is



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



Managing mild COVID-19 at home with assistance from your GP

A guide, action plan and symptom diary for patients

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	Appendix C. Managing my symptoms														
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:	If I have mild symptoms such as: • aches and pains • sore throat • dry cough • runny nose I will manage these symptoms by:	Appendix D. My d	aily syn	nptom	diary										
Age: Date of birth: Relevant medical history:	 getting enough rest staying active (staying within my house and/or garden) eating well maintaining a good fluid intake 		below, stating whether each symptom is the same (S), better (B) or worse (W) than the day before. (Days 1–14)												
Current medications:	 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. 		EXAMPLE Day 1	Day 1 Date:	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day
Allergies:	If I get any moderate symptoms, such as:		31 August												
Date of onset of symptoms:	 symptom diary looking like it is tracking worse, rather than stable or better temperature above 38 degrees 	Symptom	2020												
Date of test confirming COVID-19 positive status:	vomiting or diamhoea	Fever	s												
Next of kin:	 mild breathlessness or a persistent cough struggling to get out of bed and feeling abnormally tired and weak 	Breathlessness	s												\square
Relationship: Phone number:	I will contact my GP for review as soon as possible.				<u> </u>	<u> </u>	<u> </u>	<u> </u>			<u> </u>			\vdash	\vdash
Contact details:	I will continue to monitor and document my symptoms in the daily symptom diary.	Cough	w												\vdash
	If I get any severe symptoms, such as:	Muscle aches and pains	в												
Appendix B. My medicines management	 severe shortness of breath or difficulty breathing lips or face turning blue 	Headache	в												
I have been prescribed the medicines below by my GP (or other health professional) to manage	pain or pressure in my chest side celd and another and motified	Fatigue	w												
my symptoms:	 skin cold and clammy, or pale and mottled confusion (eg i can't recall the day, time or names) 	Vomiting or diarrhoea	в												
	fainting finding it difficult to keep my eyes open little or no urine output	Appetite	в												
	coughing up blood	Fluid intake													
	I will call 000 immediately and let them know that I have COVID-19.									1					

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



12	Day 13	Day 14



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

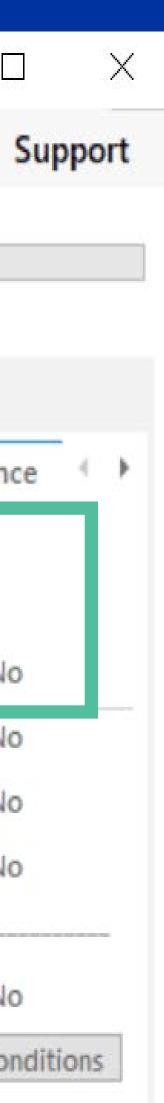
Source: Australian Institute of Health & Welfare Last updated 21/01/2020 v7.0



§Who is most at risk in our practice?

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	Genera	al <mark>Ethni</mark> o	city Cond	itions Medications	Date Range (Re	esults) Date Rang	e (Visits)	Patient Name	Patient Status	Providers Risk Fact	tors Health Ca	re Homes MBS A	ttendan
Extracts	Chron	ic Ment	al Health	Cancer Other									
world	Diabe	tes		Respiratory		Cardiovascular				Musculoskelet	al	Renal Impairmen	nt
S	Yes	5	No	Yes	No	Yes	No			Yes	No	Yes	N
	П Тур	oe II	No	Asthma	No No	Hypertension	No No			Inflammato	ny 🗌 No	Chronic Renal	I N
	🗌 Тур	pe I	No	COPD	No	Cardiovascula	r Disease ((CVD):		Musculoske	le 🗌 No	Acute Renal	N
	Un	defined	No No			Heart Failure	No No			Bone Diseas	se 🗌 No	Dialysis	N
	Тур	pe I or II					No No	PAD	No No	Osteoporos	is 🗌 No		
						Stroke	No	Carotid	No No	Osteoarthrit	tis 🗌 No	Kidney	N
	Ge	stational	No			MI	No No	Renal Ar	tery 🗌 No				Clear Co



Solution Solution</p



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

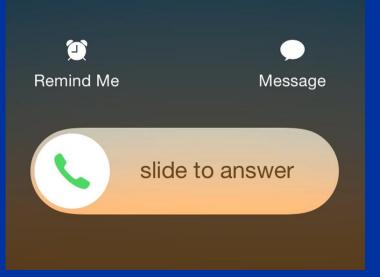


Sof cancer for Hospital avoidance

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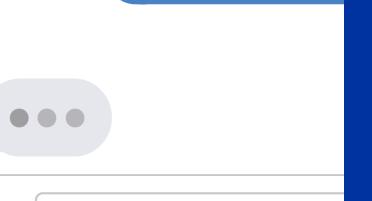
Where are the opportunities to encourage your patients to screen and maintain their health?







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Solution Number 2018 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 \bullet
- self management advice \bullet
- 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

- by the health check
- \bullet
- access;
- \bullet

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Examinations/interventions as indicated

Education and monitoring of medication Checks on clinical progress and service

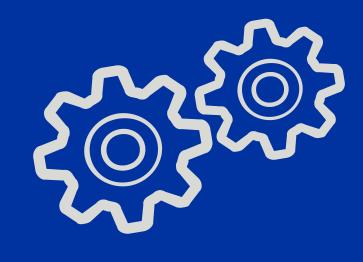
Education, monitoring and counselling activities and lifestyle advice Prevention advice for chronic conditions Coordinated Veterans Care

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





Plan proactive care

Maintain regular care where possible



Use patient focused SMART goals



Use a team approach

Talk to patients and practice staff about sick day plans

Monitor medication use

Communicate regularly with your team and patients

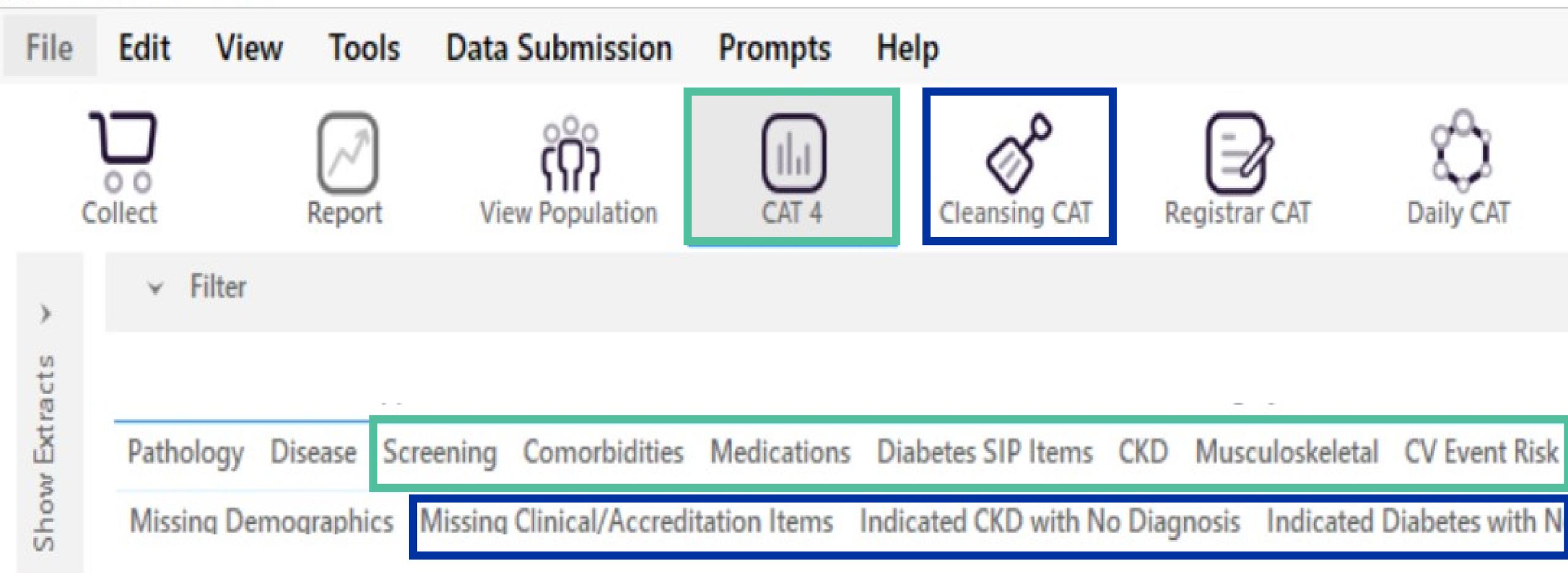


Ensure timely access to care when it is needed





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§Longer term monitoring of hospital avoidance **Susing 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.

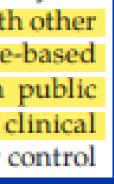
As the Lumos program evolves it is envisioned the information available will support the strategic identification and prioritisation of patient health care across all sectors.

cess to quality-assured general practice data. Linkage with other Lumos practice reports are provided bi-annually. They show patient datasets could enable significant scale-up of primary care-based research in Australia, contributing new knowledge in public encounters with your practice and the linked data sets noted previously. health, health promotion, economics and evidence-based clinical Each report includes a specific 'Condition in Focus' that provides a more care. Technologies that allow consumers to have greater control in-depth review of relevant parameters for the chosen topic – these have PRIMARY included Diabetes and Mental Health



HEALTH NETWORK



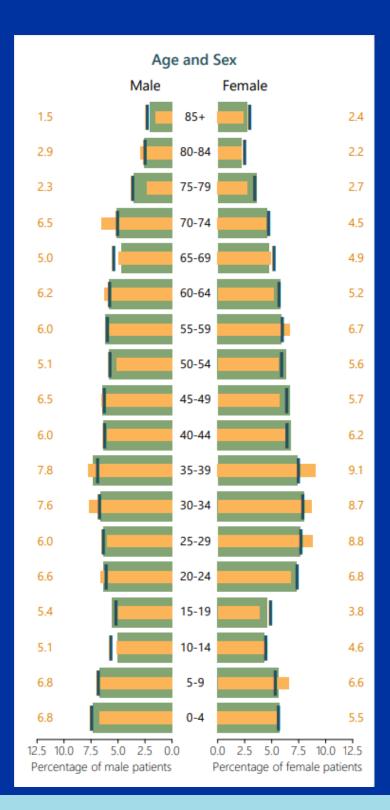




§Longer term monitoring of hospital avoidance **Susing LUMOS reports**

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

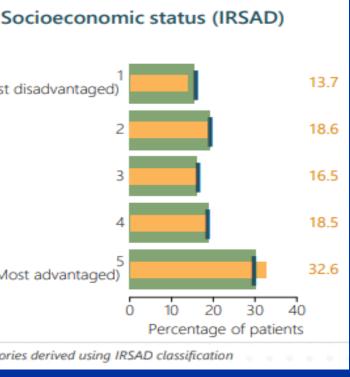
lead clinics for growing cohort of children aged 0-14

(Most disadvantaged

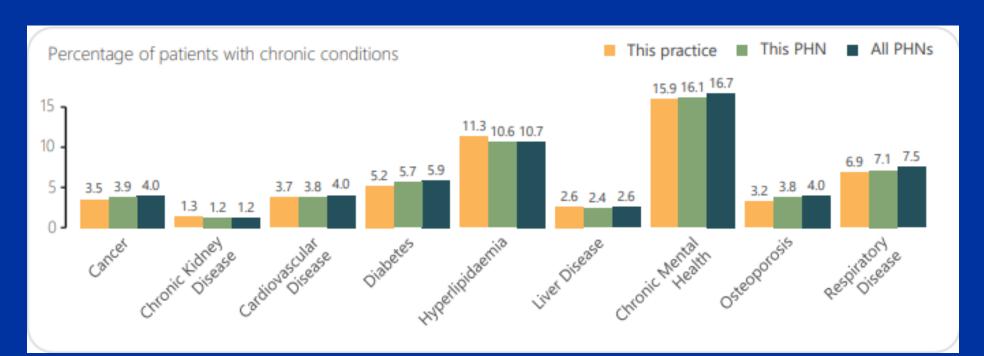
(Most advantaged

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.

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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.



PRIMARY HEALTH NETWORK

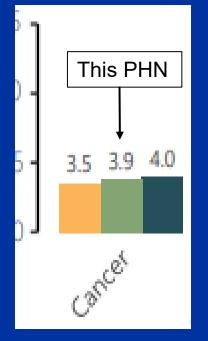




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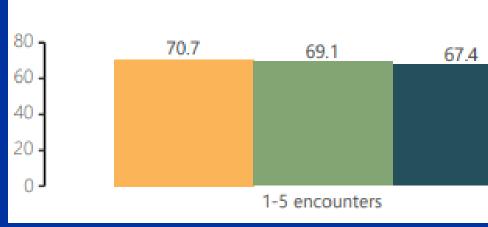
Key insights from Lumos





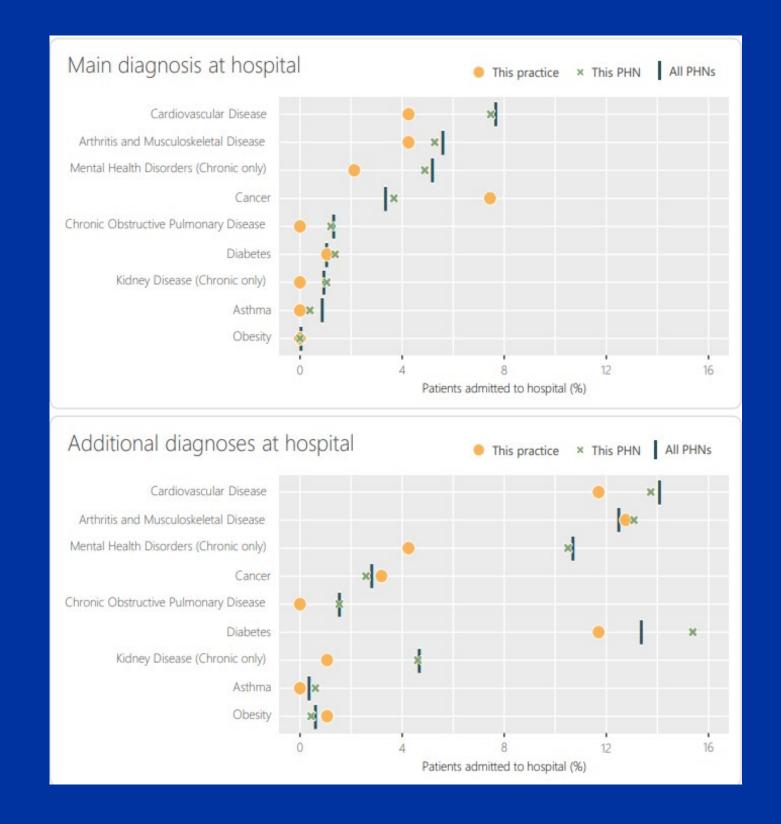
Comparison data between the 2 previous LUMOS reports found a drop by $\frac{1}{2}$ % across this **PHN of Cancer** diagnosis. context: an increase of 46k patients, included the first 4months of the COVID-19 pandemic.

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)



Percentage of patients





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.

PRIMARY HEALTH NETWORK





Solution Sector Sector **Susing LUMOS reports**

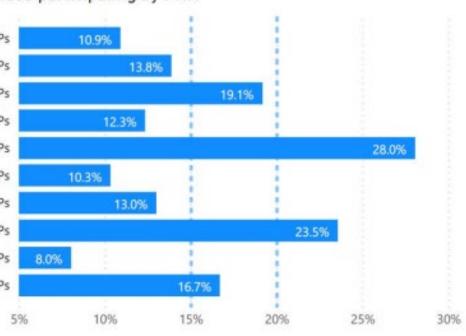
Lumos Sample General Practice Report

Sample report for period FY19-20

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

Proportion of General Practices participating by PHN

PHN101 CESPHN - 72 of 662 GPs PHN102 NSPHN - 40 of 289 GP: PHN103 WSPHN - 62 of 324 GPs PHN104 NBMPHN - 17 of 138 GPs PHN105 SWSPHN - 116 of 414 GPs PHN106 SENSWPHN - 21 of 204 GPs PHN107 WNSWPHN - 14 of 108 GPs PHN108 HNECCPHN - 104 of 442 GPs PHN109 NCPHN - 14 of 175 GPs PHN110 MPHN - 14 of 84 GPs



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 <u>The PHN online</u> Lumos Community of Practice - COMING SOON

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



- Updated reports are currently provided every 6 months. Reports are contin
- on GP feedback

- privacy impact assess it leaves the practice, minimising
- Ethically approved (PHSREC and AH&MRC). Long-standing program, grown since 2016 to
- include over 330 participating genera practices across NSV
- ntation, including GPs and stakeholder renre epresentative bodies, health cons Health and PHNs

PRIMARY HEALTH NETWORK



An Australian Government Initiative

Patient data is de-identified befor

Secure systems and processes, that have undergone an independent



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CHEALTH NETWORK



