XTend

Supported Discharge Program

What’s happening out there?

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What we know?

- Effective transfer of care from acute to primary care is needed
- 59% of patients in our area see the GP within 2 weeks of discharge [45 Up study]
- High readmission rates for some patients groups [eg heart failure]
- Early access to community based Nurses limited
- Opportunities for integration & building partnerships

[NSW Agency Clinical Innovation sponsored “Building Partnerships” project]
What patients said?

“I cried for a few days”
“As long as I can mange this fluid thing”
“Oh God… don’t talk about the medication. I just have so many of them”
“I cant work them all out”
“It’s scary if I’m on my own

“I get so confused. I was only taking 4 tablets and now I take all these” [19 different medications]
“Scared”
“I don’t know what I’m taking them for”
“I read the referrals but I didn’t understand”

“He is slightly depressed and doesn’t eat anymore”
“We are searching what we are going to do next”
“I want to know what the hospital is going to do”
“I cant deal with the [catheter] bag it makes me vomit”
“He is deflated, he is very upset”
What we did....

We developed the XTend model of care

A pilot program where Community Health Workers [CHWs] under the supervision of Registered Nurses visit targeted patients within 48 hours of discharge to

- Identify and trouble shoot issues
- Check follow up appointments [GP, Specialist, others]
- Facilitate a medication review
- Develop a GP question list
- Early triage and escalation to the community based Cardiac Chronic Care service and GP
What we achieved....

GP Seen Within

5 days: 100%
7 days: 0%
14 days: 0%
Not seen: 0%
What we achieved....

Key Issues

- None: 35%
- Meals: 0%
- Shopping: 0%
- Housework: 0%
- Transport: 0%
- Mobility: 0%
- Personal Care: 0%
- Medication: 50%
- Carer stress: 10%

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What we achieved

- The CHWs sorted and escalated many issues
- Lots of “unmeasurables”
- Readmissions?
- Satisfaction from patients, carers, CHWs, Nursing staff
What were our challenges....

- Change - introducing a new model using CHWs
- Capacity building - CHW’s confidence/navigating community work and becoming ‘social weavers’, understanding the bigger picture
- Evaluation
So- What’s happening out there?

- Post discharge period is a vulnerable time
- Medication is easily and frequently confused
- The patient has more issues than their disease
- Every patient has a different story
- CHWs are effective in connecting, supporting and linking
make every contact count