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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-admisssion; 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.
    - 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).

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