CPO- Hospital discharge Pathway

Aim

This pathway aims to reduce hospital re-admission rates, support re-engagement with primary care at transition and provide seamless service from secondary to primary care.

Coordinated Primary Options (CPO) funds **1** consultation with the GP/NP in general practice following discharge from the regional hospital.

Entry into Pathway

- Initiated by GP/NP
- DHB Clinician to the GP/NP
- Service must be delivered within **14 days** of discharge from hospital

Access:

Criteria to access the Hospital Discharge Pathway:

1. Hawkes Bay Resident

2. Maori or Pasifika or hold a current Community Service Card, Reside in Quintile 4 or 5 (DEP 7-10) **AND**

3. **The patient will have been an in-patient for 1 night or more AND**

4. The patient will have had an admission for one or more of the following:

    - Cardiac conditions – includes cardiac surgery, myocardial infarction, hypertension.
    - Heart Failure
    - Gastro-intestinal
    - Abdominal surgery
    - Respiratory- asthma, Pneumonia
    - COPD
    - Musculoskeletal
    - Neurological, CVA/TIA
    - Renal
    - Cellulitis & Infection
    - Diabetes
    - Breast Surgery

Exclusions

- Admissions following acute trauma or other ACC covered conditions
- Private hospital patients unless under HBDHB contract
- Maternity Care
- Mental Health

- Treatment at A&M or after hours centres
- Follow up from Outpatients

Process

- On the day of discharge from HBDHB, a discharge summary will be sent to the patients GP/NP. A copy will also be provided to the patient.
- On discharge, DHB staff can advise patients to consult their GP/NP for 1 free visit within 14 days of discharge, if they meet criteria
- If patient meet no obvious criteria and you are unsure of the Quintile, please advise patient that they **MAY** be entitled to a free visit
- On receiving the discharge letter, the GP/NP may also offer the patient a free consultation under the Hospital Discharge pathway if appropriate, within 14 days of discharge
- Patients to have medication review as part of this pathway
- There is no allowance for extended consultations, or post discharge home visits.

Benefits

- Easy transition of care from secondary to primary.
- Beneficial for continuity of care particularly those with long term conditions
- Ensure patient follow up by GP/NP as requested by secondary care.
- Clarifies any confusion with management
- Address's ongoing concerns for the patient
- Reduces the risk of medication errors for the patient.
- Enables early detection of a deterioration in patient condition where early intervention can often avoid re admission
- Removal of financial disincentive for patients to attend a planned GP check as requested by secondary services.

Any queries please contact Clinical Programme Coordinator, on 871 5653