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Inappropriate admissions or inadequate discharges of frail elderly? Implementation challenges in an interprofessional intermediate care intervention

Birgitte Nørgaard1; Helene Skjøt-Arkil2,3; Nina Nissen4; Christian Backer Mogensen5,6
1Department of Public Health, University of Southern Denmark, Denmark. 2Emergency Department, Hospital of Southern Jutland, Denmark. 3Department of Regional Health Research, University of Southern Denmark, Denmark

BACKGROUND AND AIM
Intermediate care interventions are increasingly implemented in health care in order to minimize hospitalization rates for elderly frail patients with complex medical issues, often referred to as inappropriate or unnecessary admissions. This study presents a theory-based stakeholder evaluation of an intermediate care intervention including hospitals, community care and general practitioners with the overall objective to reduce the number of (inappropriate) hospital admissions for frail elderly of 65 years or older.

METHODS
In a controlled design, elderly acutely ill patients were randomized to either a district nursing team with access to various tele health care solutions or to an emergency department – both interventions with a time limit of 48 hours. The intervention took place in a rural district in Denmark and included a regional hospital, four municipalities and 166 general practitioners.

The stakeholder evaluation included stakeholders’ normative theory; situation theory and causal theory (program theories). Data were collected by interviewing stakeholders (managers, nurses, medical doctors and general practitioners (GPs)), literature search and text analysis. A total of four district nursing teams, eight general practitioners, three medical doctors and two project managers were interviewed during January-March 2015.

RESULTS
Health care providers across professions and sectors widely agree on the appropriateness of reducing hospitalization for frail elderly. Yet, GPs were challenged by the overall objective of reducing the number of inappropriate hospital admissions; they would rather reduce the number of inadequate hospital discharges, which in their opinion, inevitably will lead to re-admission. For details on different program theory perspectives, see Figure 1.

ATTENTION POINTS
Attention points crucial for future intermediate care projects or for developing a generic model for intermediate care:
- Ownership and anchoring among all key stakeholders through shared goals
- Unambiguous agreements regarding responsibility, time and resources in relation to specific actions
- Tele-medical solutions should be meaningful, intuitive and simple to use
- Clear agreements on practical matters, including medical equipment, medicines, user fees, transport
- A clear definition of the relevant target group, i.e. not too
comorbid and socially vulnerable to possible benefit from the intervention

Figure 1. A three-step description of program theories presented by stakeholder group.

<table>
<thead>
<tr>
<th>EMBEDDED IN THE ACCESS PROJECT</th>
<th>GPS</th>
<th>MEDICAL DOCTORS/HOSPITAL</th>
<th>DISTRICT NURSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SITUATIONAL THEORY</strong></td>
<td>multiple, short admissions of frail elderly</td>
<td>hospitalization can be necessary</td>
<td>emergency department are constantly under pressure and have reduced bed masses</td>
</tr>
<tr>
<td></td>
<td>risk of delirium and hospital infections during hospitalization</td>
<td>inappropriate discharges</td>
<td>lack of follow-up plan after discharge</td>
</tr>
<tr>
<td></td>
<td>economic incentive for municipalities when admission rates are decreased</td>
<td>inevitable admission</td>
<td>(too) quick admissions of frail elderly</td>
</tr>
<tr>
<td><strong>NORMATIVE THEORY</strong></td>
<td>decreased admission rate for frail elderly</td>
<td>risk of delirium and hospital infections during hospitalization</td>
<td>risk of delirium and hospital infections during hospitalization</td>
</tr>
<tr>
<td></td>
<td>improved inter-sectoral cooperation</td>
<td>hospitals are advanced fast track institutions with low-level care and information</td>
<td>poor supervision and poor diagnostic tools accessible for GPs</td>
</tr>
<tr>
<td><strong>CAUSAL THEORY</strong></td>
<td>intermediate care interventions</td>
<td>buffer capacity for the emergency department</td>
<td>economic advantage for municipalities</td>
</tr>
<tr>
<td></td>
<td>training of district nurses in emergency care</td>
<td>a political agenda</td>
<td>increased cooperation with GPs</td>
</tr>
<tr>
<td></td>
<td>better diagnostic tools accessible for GPs</td>
<td>more optimal discharges</td>
<td>care and rehabilitation can increasingly be taken care of in patient’s homes</td>
</tr>
<tr>
<td></td>
<td>supervision of GPs and district nurses by emergency specialist from hospital</td>
<td>training of district nurses in emergency care</td>
<td>elderly citizens would prefer to avoid hospitalization</td>
</tr>
<tr>
<td></td>
<td>supportive telemedicine</td>
<td>better diagnostic tools accessible for GPs</td>
<td>not too ill patients</td>
</tr>
</tbody>
</table>

binorgaard@health.sdu.dk