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Primary care-based approaches to reduce readmissions: older patients' perspectives on the transition of care from secondary care to primary care

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Abstract

Purpose – Readmissions to the hospital are expensive and can have negative health consequences for patients. Older adults are at greater risk of readmission. Patient perspectives are valuable in identifying areas for improvement in the transition of care. The purpose of this qualitative study is to increase our understanding of patients' perspectives on the transition of care from hospital to primary care.

Design/methodology/approach – This study employs a qualitative methodology to conduct semi-structured interviews with patients who have been discharged from hospitals in the Ireland East Hospital Group region. Remote interviews were conducted with 18 participants from eight general practices. Transcripts were analysed using thematic analysis as described by Braun and Clarke.

Findings – The three main themes identified were communication, outpatient supports and patient education. Gaps in communication do occur, but patients are often too external to comment. Patients benefit from a wide variety of outpatient supports including general practice, family, carers, allied health professionals and voluntary organisations. Access and cost are barriers to these supports. Participants were generally positive towards proposed primary care-based interventions such as follow-up appointments with general practitioners (GPs) and education sessions.

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Originality/value – This study highlights a number of areas for improvement in the transition of care in current practice including communication between services and access to outpatient care. It also suggests directions for further research, such as explorations of healthcare provider perspectives and pilot studies of readmission reduction interventions.

Keywords Readmissions, Older patients, Transition of care, Patient perspectives, Primary care

Paper type Research paper

Introduction

Being readmitted to the hospital is an issue which affects patients, families and healthcare professionals globally and is often considered a performance indicator of hospital-based healthcare. Recent research indicates that up to one-fifth of patients discharged from hospitals are readmitted within 30 days and up to one-third are readmitted within three months (Fu *et al.*, 2023), and readmission is associated with adverse health outcomes, such as increased length of hospital stay, morbidity, functional decline and mortality (Cakir *et al.*, 2017). In addition to being economically unfavourable, increased rehospitalisation also suggests suboptimal continuity of care. Continuity of care is a fundamental characteristic of general practice; associated with a range of better health and care outcomes including adherence to treatment, uptake of preventative care, decreased emergency department use, hospitalisation and mortality and patient satisfaction (Tammes and Salisbury, 2017; Chan *et al.*, 2021). Recent research indicates that patients who perceive higher levels of continuity of care experience a higher perceived level of control of their condition(s) and perform self-care to a greater extent, reducing the risk of hospital readmissions (Säfström *et al.*, 2023).

Some patient groups are more likely than others to experience readmission. Numerous risk factors have been identified for readmission and include increasing age, male sex, length of hospital stay greater than seven days, number of previous admissions and certain diagnoses (chronic obstructive pulmonary disease (COPD), myocardial infarction, heart failure and alcohol-related conditions) (Kidney *et al.*, 2017; Gorman *et al.*, 2010; Glans *et al.*, 2020). Research indicates that older adults are at elevated risk of readmission and indeed may account for the majority of readmissions. Donnan *et al.* (2008) found that 66.3% of readmissions occurred in the over 65's (in a study of patients over 40). Therefore, it can be expected that costs related to readmissions will rise in countries with ageing populations.

A large cross-sectional study by Busby *et al.* (2017) highlighted that ambulatory care sensitive conditions (ACSCs) account for one in five unplanned admissions. ACSCs are conditions where general practitioners (GPs) can potentially reduce admissions by ensuring that patients receive high-quality disease management, timely treatment and an appropriate referral. However, the study found that large interpractice variations were commonplace, with differences in excess of 150% found for diabetes complications, iron deficiency anaemia, hypertension and COPD. Furthermore, the highest interpractice variations were found among conditions that disproportionately affect deprived patients. For example, 40, 31 and 45% of patients admitted for alcohol-related diseases, diabetes complications and schizophrenia, the three highest variation conditions, resided in the most deprived quintile of areas.

Research indicates that patients' accounts of the pathway from their discharge to readmission(s) may differ from those of their healthcare providers, as highlighted in a study by Smeraglio *et al.*, which reported that patients identified system issues as contributors to their readmission in 58% of cases, while providers identified system issues as the contributor to a patient's readmission in just 2% of cases. Further research by Jones *et al.* found that patients identified inconsistencies in care transition processes and highlighted multiple opportunities for improvement, including providing reliable, systematic care transition processes for all and scheduling and helping patients attend follow-up appointments (Jones *et al.*, 2022). A study of patient and caregiver views on individuals admitted with COPD or congestive heart failure (CHF) revealed four main themes on the role of the primary care physician in follow-up post-hospital discharge (Griffiths *et al.*, 2021). First, participants valued visiting their primary care provider after discharge to build upon their longitudinal relationship. Second, primary care providers played a key role in coordinating care. Third, there were mixed views on the ideal time for follow-up, with many participants expressing a desire to delay follow-up to stabilise following their acute hospitalisation. Fourth, the link between the post-discharge visit and preventing hospital readmissions was unclear to participants, who often self-triaged based on their symptoms when deciding on the need for emergency care. Further research by Cakir *et al.* also showed that patients believed that if they had greater involvement in their discharge planning, it would help reduce hospital readmissions (Cakir *et al.*, 2017).

Hospital admission and readmission issues have also been apparent in Ireland, with Ireland's Health Service Executive reporting that 11.3% of people admitted for acute medical conditions were readmitted to the same hospital within 30 days of discharge (Health Service Executive, 2018). The Sláintecare reform strategy, first proposed via the "2017 Sláintecare Report" (Department of Health, 2019), has been developed in Ireland to address these issues, with a focus on ensuring high-quality, accessible and timely care for the public with a focus on reducing pressure on the hospital system through improving care in the community (Lewis *et al.*, 2020).

The aim of this study was to conduct semi-structured interviews to qualitatively explore patients' perspectives on the transition of care from a hospital to a primary care setting.

Methods

Setting

The study was conducted with GPs within the Ireland East/UCD Practice-Based Network. University-affiliated primary care-based research networks are now an established element of research infrastructure internationally, and their role in enhancing care delivery and monitoring health outcomes has been demonstrated (Rhyne and Fagnan, 2018). Associated general practices in this region serve both rural and urban patients and are funded by a mixture of private and public means.

Sample and recruitment

GPs belonging to the Ireland East Hospital Group (IEHG)/University College Dublin (UCD) Practice-Based Research Network ($n = 10$) were asked to identify 10 patients (aged over 70) at each practice who were discharged from hospital (following treatment as an in-patient or at the acute medical assessment unit) for the period 1/07/21–30/09/21. GPs sent a participant information leaflet outlining the study to identified patients ($n = 82$), asking them to return a signed consent form to a member of the research team if they were interested in participating in the study. From those patients who returned a signed consent form ($n = 28$), patients were contacted to participate in a semi-structured interview with a member of the research team to explore their experiences of the transition of care from hospital to community and their perceptions of proposed interventions which might reduce hospital readmissions.

Interviews

Semi-structured interviews were carried out by two members of the research team (LSP and GM) via telephone between February and June 2022, and each interview lasted between 10 and 15 minutes. Data saturation was reached after 18 interviews, with no new themes emerging. All interviews were audio recorded, transcribed verbatim and checked for accuracy prior to analysis.

Data analysis

All participants were given a code (e.g. P1) and thematic analysis was carried out as informed by Braun and Clarke (2006) using NVivo V.12 software. Key themes were determined according to whether they referenced something important in relation to the overall research question. Similar concepts from the transcripts were identified and grouped, and then overarching themes were identified by examining the similarities and relationships between different concepts. The coded data were analysed until it was determined that the themes identified were an accurate reflection of the participants' experience of the intervention. The "keyness" of a theme was not necessarily dependent on quantifiable measures, but in terms of whether it captured something important in relation to the overall research question (Braun and Clarke, 2006). Similar themes from each transcript were identified and grouped, and then overarching categories were identified through examining the relationship between the themes. Reliability was enhanced by two authors (LSP and GM) independently analysing the transcripts, followed by a discussion about codes, themes, charted summaries and interpretations. The senior author audited the final analysis.

Results

Three key themes and sub-themes were identified from the analysis of the data, which are illuminated with exemplar quotes for each theme:

1. Communication;
2. Community supports;
3. Patient education.

    1. Communication

Participants talked about their experiences of healthcare service communication between the hospital and their GP and the hospital and pharmacies in relation to post-discharge prescriptions. There were positive and negative experiences for both of these communication channels.

Most participants felt that the hospitals kept their GP well informed about the details of their inpatient stays. A few reported confidently that their GP received correspondence about their hospital care. On other occasions, they expressed a general sense that their GP's were aware of any recent admissions without having to be updated by the patient.

> Yeah. He always gets it. He gets a report on what was wrong and what they did. He might ring me and speak to me or I might make an appointment to go and see him and we go through it all. p11

> They'd write to the doctor and tell him what happened. He'd have it on a computer. When I'd meet him the next time, he'd know I had been in the hospital and what they treated me for, and what they done. p1

Some did not know what communication their GP's received or were not sure about it. Lack of patient–GP communication was stated by many patients as one of the reasons why patients themselves are unaware of what information GP has (or has not) received from the hospital from which the patient was discharged.

> Now, you would have to ask the doctor that. p2

> I don't know that but I've a feeling she [GP] didn't because I was talking to her a short time after around the Christmas, I was talking to her and she never mentioned anything [. . .] Unless the doctor told me, I wouldn't know from that hospital, they wouldn't tell you. p3

> I don't know now. See I haven't been talking to [GP] lately and I never said anything to him about it. p4

> I don't know. I don't think he [GP] did. You see he didn't refer me to the hospital. He was on holidays when I went to see the doctor that time and it was [another GP] that referred me to the hospital. I only went up there with an infection and he wouldn't let me home. p6

There was less evidence for effective communication between hospitals, pharmacies and GPs relating to post-discharge prescriptions.

One participant described a "rigmarole" where there was a clash between the prescription written by a GP and a hospital doctor, which led to a delay in being dispensed. Reportedly, this issue could not be resolved over the phone to maintain the patient's confidentiality. Another participant felt communication regarding prescriptions could be improved and suggested that a centralisation of information would improve the system.

> Well, the one I got from the hospital I brought it into the pharmacist. But then there was something that wasn't on it that the doctor had prescribed and I asked the chemist to ring them but they wouldn't give them the information over the phone or something. There was a whole big rigmarole about it anyway. p3

> I think it could be improved a bit, yes, definitely. I think to centralise that so that everybody knows what they're talking about. Because my pharmacist said that he had a prescription from one place and a bit of a prescription from another. And there was no communication between the hospital and the doctor as to what medication I was on, you know. p12

Many participants' commentaries on communication were limited, as they were often external to the communication channels being discussed. The below quote relates to the information a participant's GP received from the hospital.

> I don't know directly that he has received it, but I generally understand that he does receive information, because he's pretty well aware of all my hospital activities. p7

2. Community supports

Participants described various supports which they had benefited after being discharged from hospitals. These supports could be grouped into general practice-based support, home-based support and community supports.

General practice-based support

Few participants reported having a follow-up appointment with their general practitioner after being discharged from the hospital. Most reported making an appointment with their GP at a later date, while some patients didn't contact their GP as they reported being happy with their condition. However, many expressed positivity to the concept of an automatically organised follow-up appointment and thought that this appointment could be reassuring and would help remind them of the advice received while in the hospital.

> No, there was no follow up appointment unless I'd go to him myself with something wrong with me. p17

> Sometimes I'll contact him and sometimes he'll contact me, you know. Well, we'll say within a couple of weeks when things had settled down and I could say to myself, things are looking good, and then I'd go and I'd ring [GP] and I'd say can I come and see you or can we talk on the phone? p11

> I really didn't need him because I was home and I was better at that stage. Medically there wasn't an awful lot they could do for me, I just needed rest and recuperation. Medically I was fine. p12

> Well, it could have been made better if they had arranged some sort of follow up support at home, which wasn't arranged. Also, I would have enjoyed having a sit down with my GP and discussed

> what had happened. But they're just so busy, we can't even get them on the phone. They're so busy. You ring and the number and you're 16 in a line on a call. p16

Due to the study being conducted during the COVID-19 pandemic, majority of GP services in Ireland transitioned to offering teleconsultations. There were mixed opinions about whether, after being discharged from the hospital, follow-up appointments via telephone or via Zoom were appropriate. Some felt that most problems were easily dealt with on the phone but acknowledged that it is necessary to be seen in person if one is particularly unwell. These participants indicated that they were more comfortable with this form of communication since the restrictions related to the pandemic.

> You know, I would say 90% of the time it's all pretty okay over the phone. But there is that 10% of time that you would need to go and see him [GP]. p11

> It wouldn't have to be face to face unless you were feeling very ill and you wanted them [GP] to see you, you know what I mean? You can manage a good lot over the phone. p12

Conversely, some participants indicated that they preferred face-to-face appointments. One indicated that going to the clinic allowed the practitioner to perform a physical exam. Deafness was noted as a challenge by a family member who was assisting another participant with the interview. Someone from the family needed to be present to facilitate any telecommunication in their case.

> I honestly feel you would be more confident after having a face-to-face talk. p9

> It depends on how you are. If there is something you can talk about that you know a little bit about and you understand, yes, you could do it on the phone but other than that I think you would be better off to see a doctor. p6

> No, I think they need to go back down face-to-face just in case he needs to check my temperatures, do you know what I mean, like check my chest and . . . I think. p4

Home-based supports

Participants described a number of examples of home-based support. Many reported getting carers after leaving the hospital to assist with activities of daily living or shopping, cooking and cleaning. Participants were generally positive regarding their experiences of home care, with one indicating that it was "the best way to keep them out of hospital". However, another participant highlighted the long waiting list as a barrier.

> Well I have a good Carer, and she's very good, and she lives beside me, and she does a lot of things for me probably that she shouldn't be doing, you know? But she's just a very good Carer, and so I'm well looked after. I think it is the best way to keep me out of hospital p8

> We did apply to the County Council or whoever you apply to, my daughter applied for a carer. But I'm on a waiting list, I might get one when I'm 90. p15

One participant described a "hospital-at-home" style solution to the administration of intravenous antibiotics. In this case, the participant had actually been readmitted six weeks after their original admission. They had stopped taking their antibiotics due to gastrointestinal side effects and suffered a progression of their infection. Following the second admission, nurses visited their home twice daily to administer the antibiotics. The participant recovered and was resoundingly positive about the experience.

> . . . but this thing, homecare thing I thought was fantastic with the nurses coming to the house. At least I wasn't taking up a bed for someone that was worse than me. p9

3. Patient education

Many participants reported that most of the information they received with regard to their diagnoses, treatment and lifestyle was from the doctors, nurses and allied health professionals during their inpatient stays. It seems that much of the information is communicated verbally, although some patients did recall receiving leaflets or booklets describing their condition. Some reported that they received most of their education from outpatient clinics, such as the heart failure clinic.

> They did. A lady came in, a dietician I think she was . . . And spoke to me about diabetes, type 2 diabetes and what to do. Lose weight, do more exercise and like change my diet a bit. She gave me a couple of booklets and a five or six-page leaflet all about type 2 diabetes. p11

> I got a booklet because I picked up some sort of a bug in the hospital. Now, it wasn't MRSA but it was some other bug in my gut that they told me didn't need treatment but that I had it and I would always have it. And that it would affect future antibiotics or something. I got a leaflet on that. And I did get a leaflet from the heart failure clinic. p5

The concept of post-discharge education often overlapped with that of post-discharge GP follow-up and a number of patients indicated they would prefer that the GP provide them with education.

> I do think that would be helpful on a lot of occasions, and for a lot of people. Because leaving hospital you tend to be told a lot of things, but they may not be within your technical expertise, if I can put it that way. It may not be in human terms. So, I do think that at a bit of reassurance or discussion from your GP would be beneficial. p13

Discussion

Key findings

This study increased our understanding of patient experiences of the transition of care from the hospital and their perceptions of proposed interventions which might reduce hospital readmissions. Based on our findings, gaps in communication between healthcare professionals, healthcare institutions and patients do occur and can result in delayed care. While most patients would value a follow-up appointment, whether in person or teleconsultation, our study shows that they do not often follow up with their general practitioners after leaving the hospital. This can be associated with them feeling well, thus seeing no need for a second appointment or because of the difficulty accessing a busy primary care centre.

Home care is highly valued by those who receive it, but getting home care can be challenging due to cost and limited availability. Patients benefit from a variety of community-based supports after leaving the hospital, including their own families, social workers, daycare centres and various voluntary organisations working with older people. Patients mostly report getting education about their diagnoses and treatments from doctors, nurses and allied health professionals prior to leaving hospital and are supportive of the concept of an education session post-discharge as suggested in previous studies to reduce hospital readmissions (Rosen *et al.*, 2017; Vaillant-Roussel *et al.*, 2016).

Comparison with existing literature

The finding that patients have limited awareness of the communication between their healthcare providers is not new. In a mixed-methods study carried out in Chicago, patients often thought their hospital was communicating with their GP when, in fact, no communication was taking place. Similarly, when the services were communicating, patients were often not aware. Patients who perceived communication between the services were more satisfied with their care (Adams *et al.*, 2016).

Utilisation of and access to services after discharge were highlighted in a number of studies. A recent Australian study also used patient perspectives to identify shortcomings in the discharge process (Considine *et al.*, 2020). Communication among healthcare staff and between staff and patients was a key theme. One patient highlighted the difficulty she had getting information after discharge and proposed that better access would have helped her avoid being readmitted. This experience is echoed in patient interviews and survey data from other studies (Soler *et al.*, 2010; Howard-Anderson *et al.*, 2014, 2016; Horstman *et al.*, 2017). Howard-Andersen *et al.* went on to include "lack of knowledge and/or trust in ambulatory options" as a possible point of intervention in their theoretical "journey on the path to readmission" (2016). These findings are reminiscent of the difficulties patients in our study reported accessing GPs. The burden of providing advice and reassurance to recently discharged patients is significant and cannot be borne solely by primary care services, particularly when some issues will require specialist input. However, in many cases, primary care would be well equipped to convey information that could help keep patients out of the hospital. The concept of a follow-up appointment with a GP after discharge was greeted positively by our participants.

Education on discharge from the hospital is valued by patients as it provides reassurance and a reminder of verbal instruction but is often not fully understood or incomplete. Soler *et al.* found that only 49.4% of the patients they interviewed reported understanding the information "very well" or "perfectly"; almost half of their participants had doubts about their condition or care after 1 week (2010). Berendsen *et al.* (2009) found that their patients appreciated receiving information from additional sources, such as their GP, nurses, pharmacists or patient organisations. This is in line with our findings that patients are not always confident that they understand the information they receive prior to discharge.

Methodological challenges

A strength of the study was using a qualitative approach, which allowed an understanding of the topic from a patient perspective with a sufficient sample of patients to achieve analytical saturation. However, the study also had some limitations. More accounts of participants who were readmitted would have been valuable to this study. While all participants had experienced being discharged from the hospital, few had experienced readmission. Another challenge was that participants often did not have enough information to comment on features of their transition of care. This was particularly apparent in questions related to the communication between hospitals and their general practitioners or pharmacists. In many cases, participants could not know whether their care providers had been contacted by the hospital, and none could comment on the quality of communication that did occur. Improving communication between hospitals and community healthcare services is likely to be a feature of interventions to reduce readmissions. The experiences of the healthcare staff will likely be more useful to guide their development. A final limitation of the study is the lack of data collected on patient variables such as surgical versus medical discharge, post-discharge medication reconciliation and new diagnosis versus exacerbation of an existing diagnosis. The authors acknowledge that this additional information would provide greater context to the reported perceptions of this small sample size.

Implications for further research

This study captures the experiences and perspectives of patients after leaving hospitals. It would be valuable to hear the views of the various health professionals which they then interact with. It is clear that gaps in communication occur between different healthcare services and between the healthcare system and its patients. Patients' accounts of healthcare communication are limited, as they are external to the system. GPs could provide a more intimate account of how much communication they are receiving and the quality of that communication. Furthermore, patients expressed positivity towards the concepts of home care, primary care-based follow-up appointments and post-discharge education sessions. The rapid expansion of virtual ward models of care since COVID-19 (ref) provides a substantive evidence base for hospitals at home and an opportunity to evaluate substantive evidence base for hospitals at home including cost-effectiveness, barriers to implementation and patient and carer experiences. The experience and perceptions of healthcare staff who provide these services are crucial to ensuring the feasibility and acceptability of such interventions. This would lay the groundwork for scaling up to larger populations. Different combinations of intervention components could be assessed to find out what is most effective. These trials would also provide an assessment of the cost and sustainability of such programmes.

Conclusion

This study increased our understanding of patient perspectives on the transition of care in the Irish context. The results suggest that there are multiple areas where efforts can be focused to improve current practice. Among them are communication between healthcare services and the access and cost of outpatient supports such as primary care and home care. A number of avenues for further investigation are suggested. A comparison of patient perspectives with those of healthcare providers would be valuable. Future pilot studies of readmission reduction interventions can be informed and guided by this study's findings.

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