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A Content Analysis of Inpatients' Referral Consultations for Discharge from a Medical Center Experience

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Background



Despite Taiwan's National Health Insurance with universal coverage has been successfully implanted for 25 years, hierarchical health care system is still under construction.



This study aims to analyze the inpatients' referral consultations to delineate the needs for transiting to community care from one medical center.





Methods



The data was collected from the referral management center (RMC) of in one tertiary medical center in northern Taiwan.



It included

- ✓ the inpatients' and hospital staffs' information about referral consultation,
- ✓ the types of consultation,
- ✓ staff' s primary referral reason,
- ✓ patients' disease severity with their preference,
- ✓ as well as the final disposition of the patients.



Content analysis method was done for statistical analysis.



Result_1/2

From January 2020 to April 2021, a total of 144 consultations were received and categorized into four types:

level	type	n	%
level 0	requiring technical support	38	26.4
level 1	requiring advice by transitional care nurse alone	25	17.4
level 2	requesting transitional care nurse visits supervised by doctors	44	30.6
level 3	requesting physician' s visit	37	25.7





Result_2/2

level 2

including physiological assessment of tube, terminal pain, wound, etc., and care guidance.

Assist patient to find dialysis clinics near their homes, and incorporate cardiology, nephrology and gastroenterology clinics into integrated clinics for medical treatment.

level 3

including family discussion, home emergency treatment, emergency medical treatment, medication adjustment, dying symptoms, etc.

During COVID 19, the terminal patient has been hospitalized for 3 months and wants to go home, but the family members are under pressure to take care of them and worry about urgent medical treatment after discharge.

First, establish a consensus between patient and their families through family discussions, strengthen family care skills and abilities. Finally, connect the Palliative Medicine in the Home, discharge home.

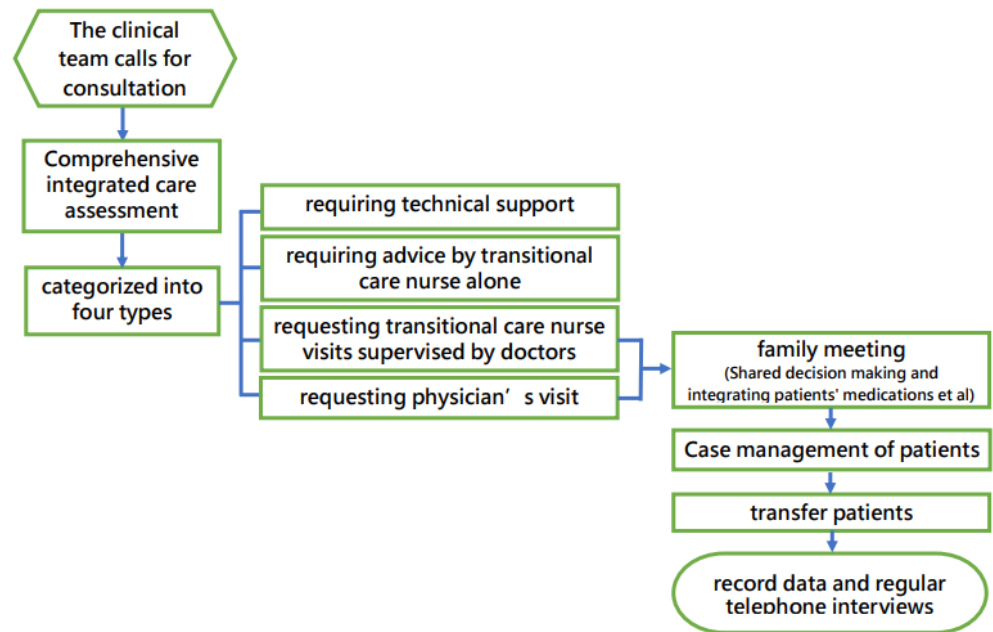




Conclusion

- ✓ **Comprehensive integrated care assessment** with patient-centered approach is mandatory for each referral consultation, which is time-consuming and skillful when initially building up the referral network.
- ✓ **Shared decision making and integrating patients' medications care needs** help properly transfer patients to the appropriate care locations, including community clinics, regional hospitals or nursing home facilities.

Process of case management after discharge from hospital





Acknowledgement: NTUH Referral Management Center Team





Thank you for your attention!

台大醫院 NTUH 分級醫療暨轉銜照護管理中心
Referral Management Center

認識中心 整合門診掛號 星月院所查詢 照護資源 相關活動 聯絡我們 星月通訊季刊 星月院所專區

星月計畫



分級醫療有星月

分級醫療/資源整合/醫界共好

- ✦ 穩定慢性疾病
由社區家庭責任醫師照護
- ✦ 複雜多重重症
由醫院整合照護團隊協助
- ✦ 緩和居家照護
由社區院所在宅醫療介入

轉診照護真專業

聰明就醫123

- ✦ 尋找一個熟悉信任的家庭責任醫師
- ✦ 不要超過兩家醫療院所就醫
- ✦ 不要長期在三個以上慢性病門診拿藥

雙主治醫師

臺大醫院星月計畫

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