

September 29, 2015

Transitions in Care, Community & Residential Care

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Overview

- Transitions defined
- Why are transitions an issue in healthcare?
- How and why transitions break down
- Transitions and patient safety
- The patient and caregiver perspective
- Transitions in context (Hospital, ED, Long Term Care, Nursing Home)
- The Patient and Caregiver Perspective
- Improving Care Transitions
- Work in progress and completed

Definition

- “A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care in the same location” (Coleman & Berenson, 2004. p. 533).
- A successful transition is safe, effective, and efficient (Cummings et al. (2012)
- Transitional care is essential for persons with complex care needs, including the elderly (Coleman, 2003).

Why are transitions an issue in healthcare?

- Too many transitions are poorly executed. A survey of patients with complex care needs in eleven countries, Schoen et al. (2011) found gaps at the point of hospital discharge in all countries, and at least one in four patients reported a lack of follow-up instructions.
- Older patients often experience more care transitions.

Why are transitions an issue in healthcare?

- In the majority of care transitions, the patients and caregivers are the only common thread between sites of care, and by default have the added responsibility of facilitating their care transitions, often without the skills or confidence to do so.
- Poorly executed care transitions can lead to greater use of hospital, emergency departments, post acute, and ambulatory services.
(Coleman, 2003).
- High quality transitions required for success(Jeffs et al., 2013).

Transitions: The Canadian context

- Seniors make up the fastest-growing age group in Canada

<http://populationpyramid.net/canada/2015/>

- In 2011, 5 million Canadians were 65 or older (Human Resources and Skills Development Canada, 2011).
- One in every six seniors receives home care (Canadian Home Care Association, 2013).
- 33% of Canadians over sixty five, and 56% aged 75 and up reported having at least one disability (Canadian Home Care Association, 2013).

Transitions: The Canadian context

- Canadian Population Health Survey: Transition programs can reduce or delay admission to nursing homes. Access to publicly funded home and community-based services would keep people at home longer and reduce likelihood of institutionalization (Sarma, Hawley, & Basu, 2009).
- Hospitals make up the largest component of healthcare spending at 29.6%, nursing homes, 10.3% (CIHI, 2014).
- Timely discharge from hospital and recovery at home means a greater focus on preparation before both admission and discharge and more follow-up at home (Pringle, Hendry, & McLafferty, 2008).

How and Why Transitions Break Down

- Delivery System Level: Practice settings often operate as “silos” without knowledge of the care received (medications, treatments, etc.) in the previous setting (Coleman, 2003).
- Clinician Level: PCPs rarely manage the treatment of older patients across multiple settings (delivery models, staffing) (Coleman, 2003).
- Patient Level: older patients and their caregivers often are not well prepared for the care they will receive in the next setting, or be required to carry out (Coleman, 2003; Macdonald et al., 2013b).

Transitions and Patient Safety

- The more service providers and settings involved, the greater the risk of error (Moreno, 2013, Lang et al., 2009)
- Medication errors: receiving care in multiple settings often means that patients obtain medications from different prescribers (Coleman, 2003).
- The first 30 to 60 days following admission to HC is considered a post-acute transition period to HC. About 8.5% of post acute care clients were readmitted within 30 days of discharge (Macdonald et al., 2013a).
- Communication errors: the sending clinician fails to communicate critical elements of the care plan to the receiving clinician, patients are not adequately prepared for care in the most appropriate setting (Coleman, 2003).

The Patient and Caregiver Perspective

- Patients and caregivers are often unprepared for their role in the next care setting.
- Do not understand the essential steps of managing their condition.
- Caregivers feel trapped in the role without adequate resources or support.
- Caregiving can place a strain on employment, income, and family resources
- Deteriorating health of caregivers due to physical, emotional, social, and financial challenges of caregiving. (Macdonald et al., 2010)
- Cannot contact appropriate healthcare providers for guidance. (Coleman and Berenson, 2004) conditions that cause or exacerbate abuse.

Transitions from Emergency Department (ED) to Home

- Transitions are hindered by short staffing, and comprehensive information not easily available to providers, patients and caregivers (Robinson et al., 2012).
- When frail seniors enter the ED they have more emergent conditions, undergo more tests,, and have longer ED stays (Ryan, Liu, & Wong, 2011).
- The quality and outcomes of ED-based geriatric care can be improved through ED-based interventions with linkages to community based services (McCusker et al., 2012).

Transition from Hospital to Home

- About half of adults experience a medical error after hospital discharge, and 19-23% suffer an adverse event, most commonly an adverse medication event.
- Inpatient-outpatient discontinuity: PCPs do not always follow their patients while in hospital. Discharge summaries often fail to provide important administrative and medical information.
- Changes and discrepancies in medication regimen: providers may not have a complete medical history at time of admission, a patient's medication regimen can be changed several times during a hospitalization, at discharge the current medication regimen must be reconciled with the preadmission medication regimen.

(Kripalani et al., 2007)

Transition from Hospital to Home

- Self-care responsibilities and social support: patients are responsible for administering new medications, participating in physical therapy, and tracking their own symptoms. For some patients, sufficient social and family support is not available to perform these tasks effectively.
- Ineffective patient-provider communication: using medical jargon, relying on verbal communication and failing to provide written instructions. Providers may not point out important self-care tasks.

(Kripalani et al., 2007)

Transitions and the Long-Term Care (LTC) Patient

- LTC patients are at a high risk for complicated transitions of care.
- LTC to hospital readmissions are costly and can be disruptive to patients, families and providers and disrupt the rehabilitation process.
- Risk factors for readmissions: fiscal pressures, lack of health care provider continuity, medication errors.
- Successful transitional care depends on experienced LTC health care providers and developing a comprehensive care plan.
(Oakes et al., 2011).

Transitional Care Between LTC and EDs

- A significant number of LTC initiated ED visits may be avoidable (Oakes et al., 2011).
- There is often a lack of a designated person to take responsibility for coordinating the transition, either in the LTC or ED setting (Oakes et al., 2011).
- A Canadian study of LTC to ED transfers found that informational gaps were noted in 85.5% of these transfers (Cwinn et al., 2009).

Care Transitions and Home Health Care

- Results from the Pan-Canadian HC Safety Study confirmed that the first 30 days post hospital discharge is a high-risk period for HC clients. Many of the risk factors identified have been observed in other studies, particularly with regard to polypharmacy, ADL and IADL decline, increased co-morbidities, unstable disease, and Parkinson's Disease (Doran et al., 2013).
- Many of the AEs could be prevented and healthcare resources conserved if the high-risk clients were identified and effectively transitioned (Blais et al., 2013).

Results from Pan-Canadian Study

- The absence of integrated, interdisciplinary healthcare teams and the absence of communication processes at transition points between hospital and HC providers resulted in the loss of essential information required for consistent care delivery.
- Care was inconsistently planned and delivered because of the ambiguity regarding which healthcare worker had the responsibility and authority to act.
- The episodic nature of HC and the involvement of multiple providers resulted in failures to identify early client deterioration.
(Macdonald et al., 2013a).

Improving Care Transitions

- Communication between the sending and receiving clinicians.
 - Preparing the patient and caregiver for what to expect at the next site of care.
 - Reconciling the patient's medication prescribed before the initial transfer with the current regimen.
 - A follow-up plan
 - Discussion with the patient and caregiver regarding warning symptoms or signs to monitor and who to contact.
- (Coleman, 2003).

Examples of Care Transition Programs

Eric A. Coleman et al., 2004, The Care Transition Intervention.

Provides patients and their caregivers with tools to encourage them to actively participate in transition from hospital to home

1. Medication self-management (med-rec)
2. Patient-Centered Record
3. Primary Care and specialist follow-up
4. Knowledge of 'red flags' warning signs indicative of a worsening condition

Results: patients (age 65+) felt confident in their ability to manage their condition, reduced rates of subsequent hospitalizations

Examples of Care Transition Programs

- Manderson et al., 2012, Healthcare navigators (system/patient navigators: healthcare workers who facilitate safe and effective transitions across healthcare settings
- Navigators are beneficial for chronically ill older adults transitioning across care settings.
- Navigator programs focus on a specific disease, population, or role (ex: community care managers, stroke care navigators).

Barriers to Implementing Transitional Care Practices

- Models of care delivery both in institutions and in home and continuing care (institutional versus continuum of care).
- Interprofessional care models not well integrated into the healthcare system.
- Downstream oriented healthcare system.
- Rate of Investment in HC.
- Instituting new roles in a fiscally challenged system (Hennessy & Suter, 2011).

Transitions in Care: State of the Research

- Seven (7) funded projects since 2013
- Two completed (both knowledge syntheses)
- Five (5) in progress



In Progress

- Development and testing of a standardized communication form to improve transitions for nursing home residents (2014-2015)
- Improving the decision process about location of care with the frail elderly and their caregivers (i.e.) decision to move to a care facility 2014-2016

In Progress

- Development of access kits (leveraging mobile devices) that allow the frail elderly to communicate with caregivers, family, the environment (adjust bed controls, lighting) specifically for those who cannot use a touch screen 2015-16
- Post Emergency Department evidence-based interventions for the prevention of frailty and functional decline in injured community-dwellers 2015
- Implementing a risk screening tool in primary care for older frail adults 2015-16

Completed Studies & Key Findings

Hip fracture quality indicators: A Scoping Review

- Several indicators in acute care, not all validated
- Few post-acute care indicators, yet due to rehab needs patients require more post-acute compared to acute care services
- Need is high for post acute care indicators
- <http://bmjopen.bmj.com/content/4/10/e006543.short>

Indicators

Indicator		Acute		Post-acute
Length of stay		√		√
Standardized medical assessment		√		X
Bone health checked		√		X
Mobility, gait, and muscle strength		√		√
Functional ability or improvement		√		√
Mortality		√		X
Pain management		√		X
Diagnosis of delirium		√		X
Health-related quality of life		√		X
Time-sensitive process measures (e.g., time to surgery)		√		X
Standardized fracture and falls prevention efforts		√		X
Pressure sore prevention		√		X
Standardized assessment of nutritional status		√		X
Patient satisfaction		√		X
Readmission rates to hospital		√		√
Access to and assessment from ortho-geriatrician		√		X

Completed Studies & Key Findings

Choosing healthcare options by involving Canada's elderly: The CHOICE knowledge synthesis project

- Engagement of all involved in healthcare decision making
- Engaging older adults in the planning of healthcare research
- Guidelines and recommendations prepared

www.ijic.org/index.php/ijic/article/download/1889/2707

Acknowledgements

Technology Evaluation in the Elderly (TVN)
National Centres of Excellence



Community & Residential Care

Nineteen projects – 5 completed

- User Studies with Intelligent Assistive Robots and Elder Residents Living in LTC
- Communication Technologies for Engaging Patients & Families: A Scoping Review
- Improving Outcomes for frail seniors: Impact of Learning Program for Care Staff
- Rehabilitation for seriously ill elderly: Models of care and Indicators: Scoping Review
- Post-discharge Rehabilitation Interventions

Community & Residential Care

- Incorporating a Frailty Dimension into LOCUS for seniors in a Psychiatric population
- Improving the Quality of Life of Family caregivers at the end of life: The Caregiver Support needs Assessment Intervention
- The e-Dosette study: Optimizing medication use and safety in Community dwelling Seniors
- Measuring Balance and Walking Ability in the Frail Elderly

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