



# BUILDING BRIDGES: SUCCESSFUL TRANSITIONS FROM HOSPITAL TO HOME FOR OLDER ADULTS

Senior's Month Education 2013

Sponsored by Regional Geriatric Program central (RGPC)

Committee for the Enhancement of Elder Friendly Environments (CEEEE)

# Outline of our talk

## **Content**

- ▶ Definition
- ▶ Importance
- ▶ Scope
- ▶ Who is at risk
- ▶ Prevention – two successful examples
- ▶ Best practices for transitions - our LHIN discharge bundle with emphasis on teach back, warm handoff
- ▶ Adaptations for seniors and those with dementia
- ▶ Conclusion
- ▶ Submit your quiz !

# Definition of Hospital Readmission

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- patient admission to any hospital within 30 days after being discharged from an earlier hospital stay *for the same condition*

# Hospital re-admission: significance

- Ontario population increased by 16% in past decade, BUT number of Ontario hospital beds remains constant
- Readmission rates are a measure of institutional quality of care and regional care co-ordination
- Increased burden to patients and families.
- Patient satisfaction scores on discharge co-relate with lower readmission scores (Boulding , 2011)
- Cost to Canadian health system 1.8 billion yearly, 700 million Ontario (CIHI,2012)
- ***We need to do things differently in order to create better patient outcomes and more capacity within existing resources.***

•CIHI ,2012.All Cause Readmission to Canadian Hospitals :

•Boulding, W et al. (2011). Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. American Journal of Managed Care, 17(1), 41-48.

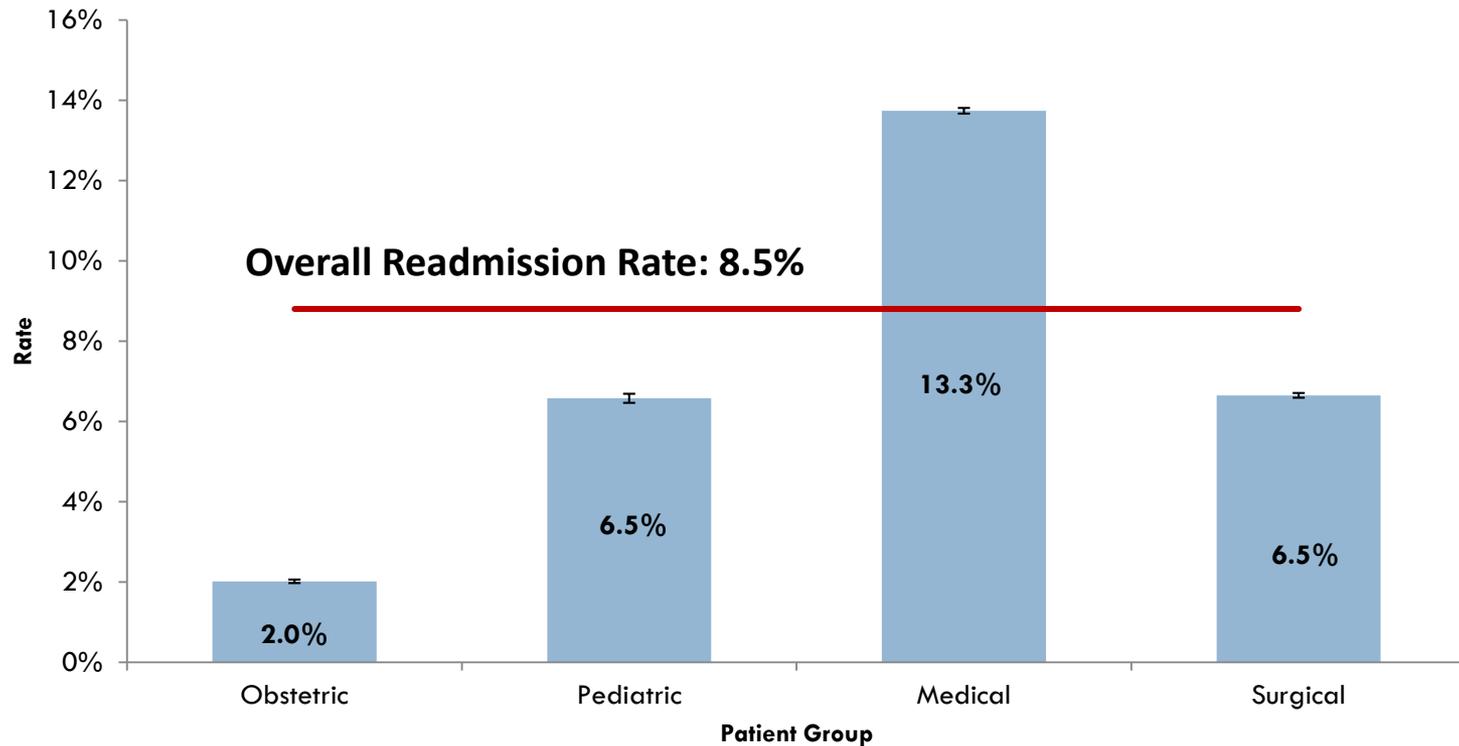
# Scope of the problem:

- 1 in 12 patients are readmitted within 30 days in Canada (8.5%)
- 180,000 readmissions within 30 days of discharge
- Older adults are at higher risk
- Older adults with dementia at even higher risk

## Sources

Discharge Abstract Database, 2010–2011, Canadian Institute for Health Information; Fichier des hospitalisations MED-ÉCHO, 2009–2010, ministère de la Santé et des Services sociaux du Québec; *All-Cause Readmission to Acute Care and Return to the Emergency Department*, CIHI, 2012.

# 30-Day All-Cause Unplanned Readmission Rates in Canada

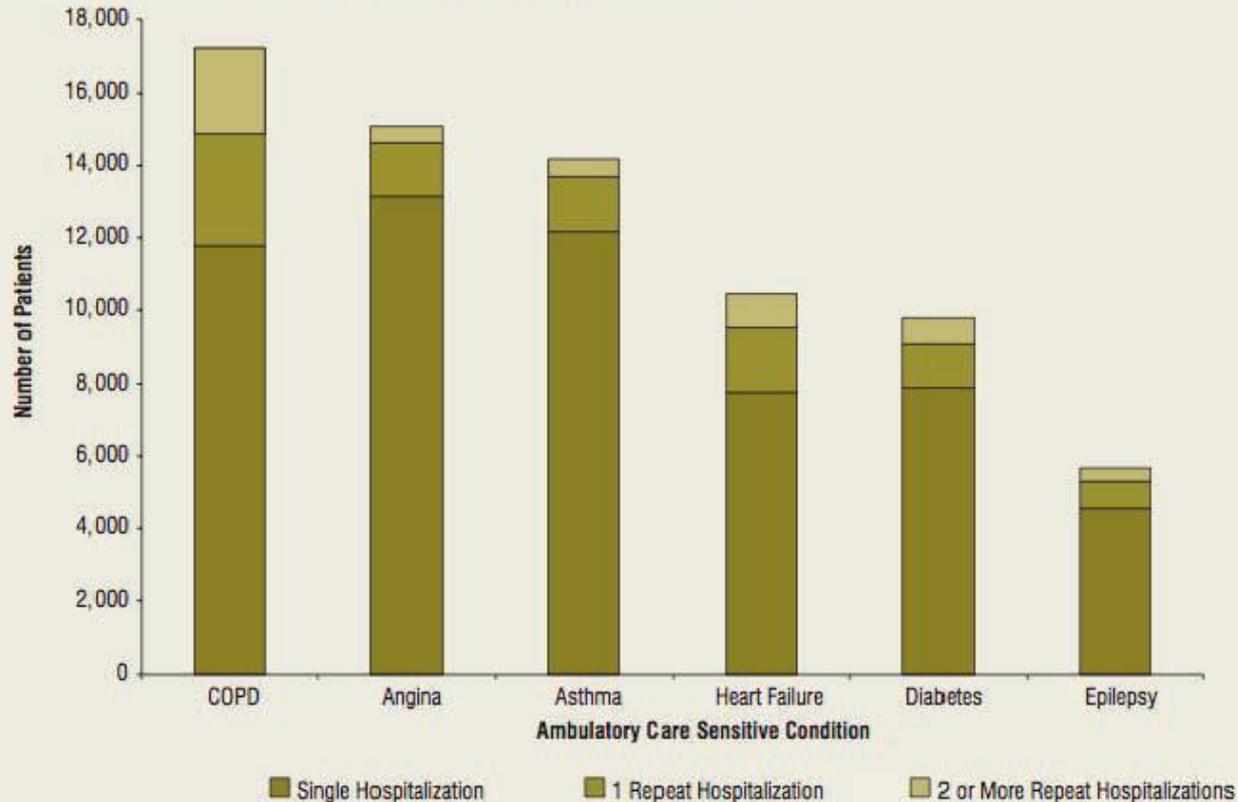


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# Repeat Hospitalizations by Condition

The graph below shows the number of patients, outside Quebec, with a single hospitalization, one repeat hospitalization and two or more repeat hospitalizations by ACSC at first admission.



**Notes:** Data from Quebec were not available for 2006–2007 at the time of publication. Hypertension is not shown due to the small number of patients initially admitted for this condition.

**Source:** Discharge Abstract Database, Canadian Institute for Health Information.

# Why do patients come back?

Patients are readmitted for the same condition they initially came to the hospital with

- **Medical patients:** represent 65 % of unplanned readmissions, with chronic obstructive pulmonary disorder (COPD) and heart failure most common
- **Surgical patients:** post op infection, bleeding or pain main reasons for readmission.

# What Patients say - 2012 Qualitative Study

16 patients and 4 family caregivers of readmitted patients

## **Patients unaware that readmissions are very common or problematic**

- ❑ **Many patients felt they were discharged too soon**
- ❑ **Many did not understand their discharge instructions - tired, afraid, and “in an alien world” in the hospital**
- ❑ **New diagnoses - needed more information, one-on-one time, hands-on training, and more follow-up care**
- ❑ **For some, primary care physicians were missing from the picture.**
- ❑ **Limited or no support once home**
- ❑ **Chronic health conditions for years but were not educated.**
- ❑ **Some were not ready to change behaviors.**

So..... What should we do ?



# We should know who is at higher risk of readmission

## **Patient Factors**

- Age (older)
- Sex (male)
- Lives alone
- Number of Acute Admissions Six Months Prior
- Clinical Conditions (COPD, HF,)

## **System Factors**

### **Hospital Effects**

- Hospital Length-of-Stay Variance
- Hospital Size

### **Community Effects**

- Rural Residence
- Neighbourhood Income-Sociodemographics

# Taxonomy of interventions to decrease readmissions

## **Pre discharge interventions**

- patient education,
- medication reconciliation,
- discharge planning,
- *and booking of a follow-up appointment before discharge.*

## **Post discharge interventions**

- Hospital or community based follow-up telephone calls,
- patient-activated hotlines,
- timely communication with ambulatory providers,
- timely ambulatory provider follow-up,
- and post discharge home visits.

## **Bridging interventions:**

- transition coaches, physician continuity across the inpatient and outpatient setting, and patient-centered discharge instruction.

# The CSHA Clinical Frailty Scale



1 Very Fit – robust, active, energetic, well motivated and fit; these people commonly exercise regularly and are in the most fit group for their age



2 Well – without active disease, but less fit than people in category 1



3 Well, with treated comorbid disease – disease symptoms are well controlled compared with those in category 4



4 Apparently vulnerable – although not frankly dependent, these people commonly complain of being “slowed up” or have disease symptoms



5 Mildly frail – with limited dependence on others for instrumental activities of daily living



6 Moderately frail – help is needed with both instrumental and non-instrumental activities of daily living

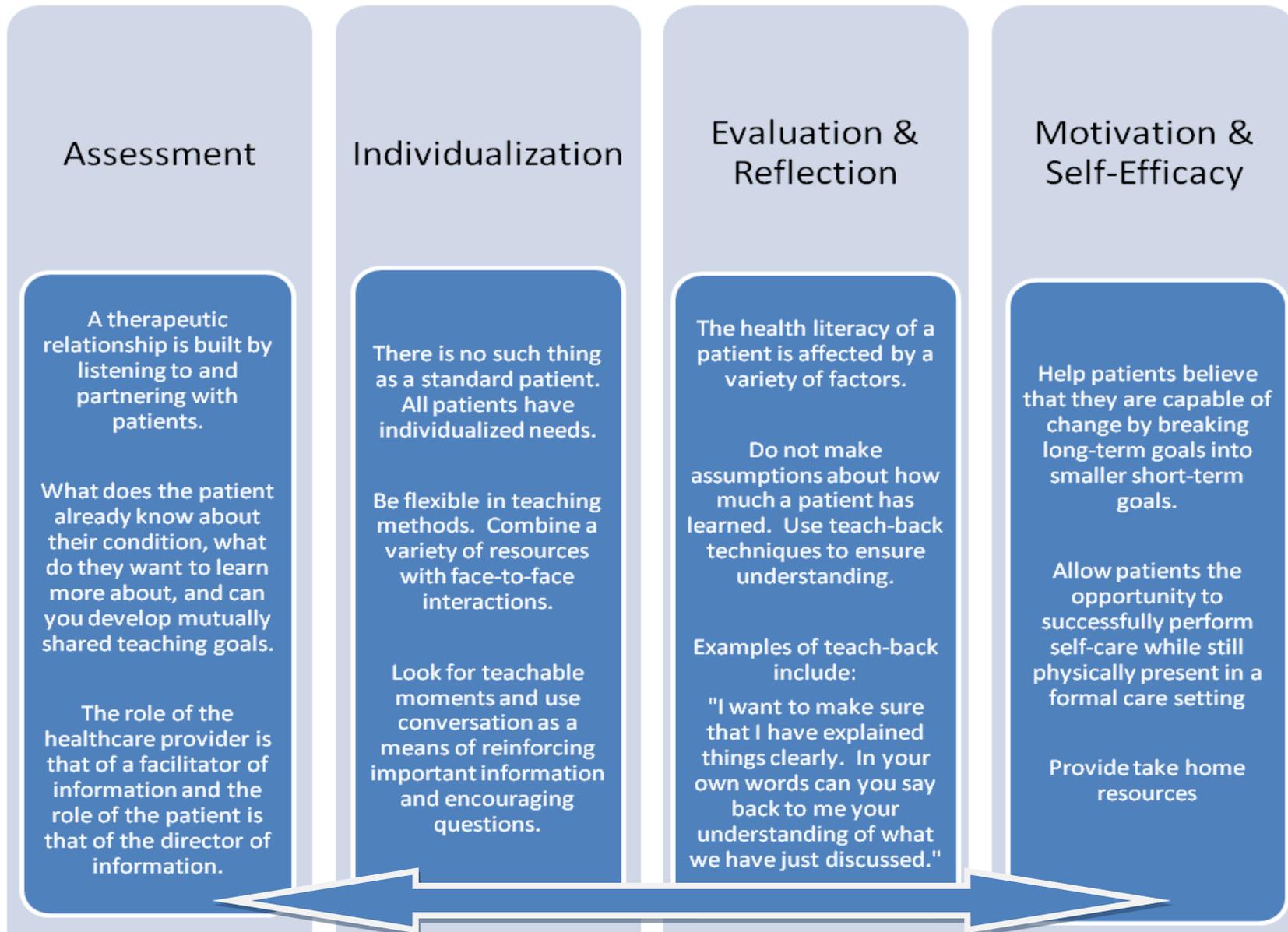


7 Severely frail – completely dependent on others for the activities of daily living

8 Terminally ill

Note: 1. Canadian Study on Health and Aging  
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

# Important Elements of Effective Discharge Teaching- McBride, 2013



# Patients with dementia:

## **Research in Ontario shows that people with dementia are**

- Twice as likely to be hospitalized compared to seniors without the disease
- Twice as likely to visit emergency departments for potentially preventable conditions
- More than twice as likely to have alternate level of care days when hospitalized
- Nearly three times more likely to experience fall-related emergency room visits

# Discharge recommendations for patients with dementia from the UK Alzheimer's Society

- an assessment of the person's needs, living environment and support network
- a written care plan that records these needs
- confirmation that any required services are in place in time for the discharge
- a system for monitoring and, if necessary, adjusting the care plan to meet any change in needs
- an assessment to see if the person qualifies for CCAC

# What can patients with dementia and caregivers do?

## What Can Patients and Caregivers Do?

### 1. Know and understand discharge instructions.

- Do you understand the diagnosis? what to expect? what is normal? What is a sign of a problem?
- Who do you contact with questions? When do you follow up with a doctor(s)?

### 2. Caregivers should make sure all needed equipment and supplies are on-hand. Find out

- what the hospital or home care agency will provide and what you must get.
- the contact information for anyone who will be providing services

### 3. Schedule a follow-up visit with your doctor.

### 4. Understand the limits of what you can do. Ask for help when you need it.

### 5. Home should be comfortable, safe and a good place for care. Caregivers should:

- move out items that can cause falls. Make room for equipment
- create a place for important information

### 6. Find out about local resources such as:

- Help with transportation or financial issues
- Friendly volunteer visits, Counseling or support groups
- Services such as CCAC, day programs , Respite care

# What can health providers do? Try this!

- Sensory: glasses and hearing , adjust lighting, limit noise
- Pace your language
- Write down all instructions
- Ensure caregiver is present- often overwhelmed
- Warm hand off to community providers : PICK UP THE PHONE
- Provide written copy of medications
- Follow up appointments made before discharge
- Careful review of available support services—i.e., First Link !
- Don't forget caregivers need support!
- Repeat admissions ? Ensure referral to CCAC Rapid Response Transition Team = R2T2

# Health Quality Ontario transitions bundle - being trialled in our LHIN

## The **discharge transition bundle** includes:

- 1. Identifying patients at high-risk for readmission
- 2. **Teach-back**
- 3. Follow-up visit with CCAC R2T2 at day one if high risk
- 4. **Written discharge instructions**
- 5. Discharge summary at discharge
- 6. **Discharge checklist** (e.g., medications, referrals, appts)
- 7. Arrange follow-up with primary care (2-5 days for hi risk)
- 8. **Warm hand off** (Phone: hospital MRP to primary care)
- 9. Medication reconciliation

# Transition Bundle: The Role of Teach-Back

- Asking people to explain **in their own words** what they need to know or do, in a friendly way
- ▣ **NOT a test of people, but of how well you** explained a concept
- ▣ A way to check for understanding and, if needed, re-explain the information, then check again
- ▣ Can be both a teaching and diagnostic tool-  
**Failed teach back = readmission risk !**

# Asking for a Teach Back - Examples

**Ask patients to show understanding, using their own words:**

- ❑ “I want to be sure I explained everything clearly. Can you please explain it back to me so I can be sure I did?”
- ❑ “What will you tell your family about the changes we made to your blood pressure medicines today?”
- ❑ “We’ve gone over a lot of information, a lot of things you can do to get more exercise in your day. In your own words, please review what we talked about. How will you make it work at home?”

# Want to see teach back in action ?

## You Tube example of teach back

### Bad Example:

- ❑ <http://www.youtube.com/watch?v=MCoIDdFvEu0&feature=related>

### Good Example:

- ❑ <http://www.youtube.com/watch?v=AShv8QdHvJg&feature=related>

# How Warm is your handoff ?

- Person to person
- Succinct
- Diagnosis , treatment , frailty and risk , expected follow up
- SBAR format (situation, background, assessment, recommendation)

# Challenges to our system

- Weekend discharges
- Care silos: redesign will include building bridges between partners and require a culture shift
- Cultural and Language barriers
- Literacy
- No primary care physician – orphan patient
- Transportation!
- Written discharge instructions need to be customized for individual patients
- Socioeconomic challenges
- Competency issues

# COPD Self Management Program (Joseph Brant Hospital)

- In hospital and telephone follow up: all patient's with admitting dx- Acute Exacerbation COPD are seen by the APN. They receive daily self-management training and develop an action plan based on their goals. Each patient is offered a phone call follow-up 24 hours, 1 week, 1 month, and three months post discharge. 92% of patients did not have repeat visits for AECOPD since program began 1.5 years ago.
- COPD Wellness House Program: this outpatient program supports self-management of one's COPD symptoms; provides education on issues of COPD: and improves exercise tolerance. The program runs 2-3 half days per week for 8 weeks or 20 sessions. 83% of all participants have had no repeat hospital admissions for AECOPD.

# Community Services hospitals should know about

- Behavioural Supports Ontario (BSO) 905-945-4930 ext. 4209
- Alzheimer Society First Link 905-529-7030
- CCAC, Rapid Response Transition Team (R2T2)  
hnhb.ccac-ont.ca
- Regional Geriatric Program central Community resource list <http://www.rgpc.ca/oapsd>

## In summary.... many readmissions are avoidable

- Identify those at risk
- Teach back
- Warm handoff
- Written instructions

*We are all responsible for a successful discharge*

# Contributors

Pat Ford, St. Joseph's Healthcare , Hamilton

Trish Corbett, Joseph Brant Hospital

Lily Spanjevic, Joseph Brant Hospital

Anne Pizzacalla, Hamilton Health Sciences

Louise Dayboll, Hotel Dieu Shaver Hospital

Angela John, Hamilton Health Sciences

Esther Coker, Hamilton Health Sciences

Leanne Vanderburg, St Joseph's Healthcare, Hamilton

Sherry Chambers, Norfolk General Hospital

Wendy McPherson, Niagara Health System

Kim Pittaway, Brant County Health System

David Jewell, Regional Geriatric Program central

Anisha Chohan, Regional Geriatric Program central

Dr Christopher Patterson Hamilton Health Sciences