

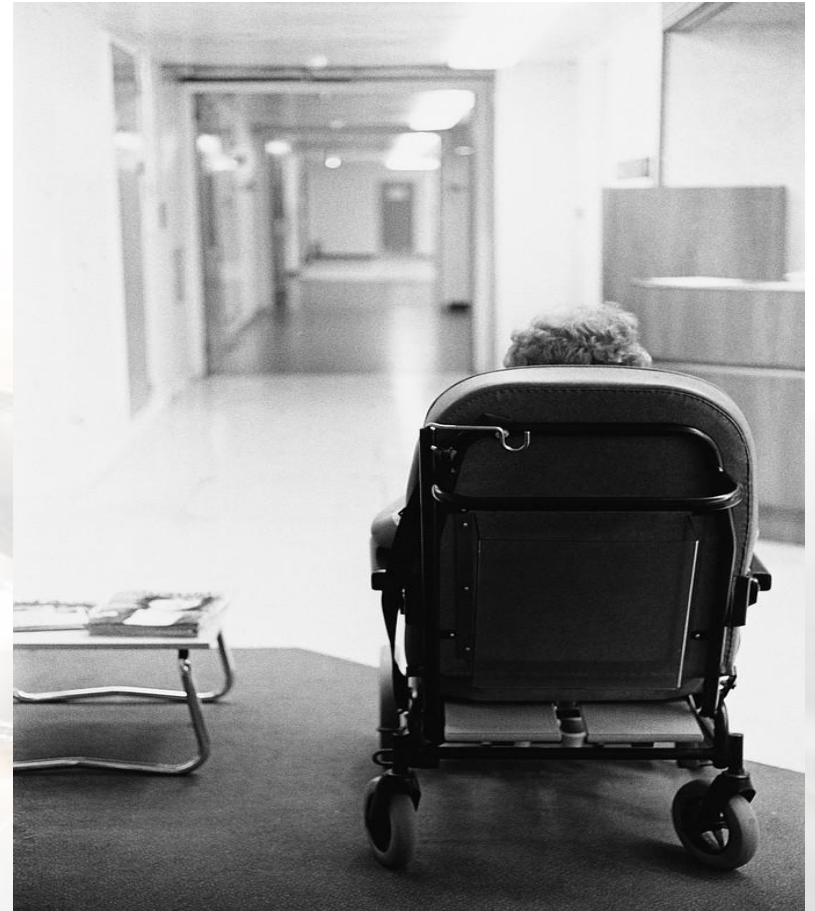


Transitions of Care



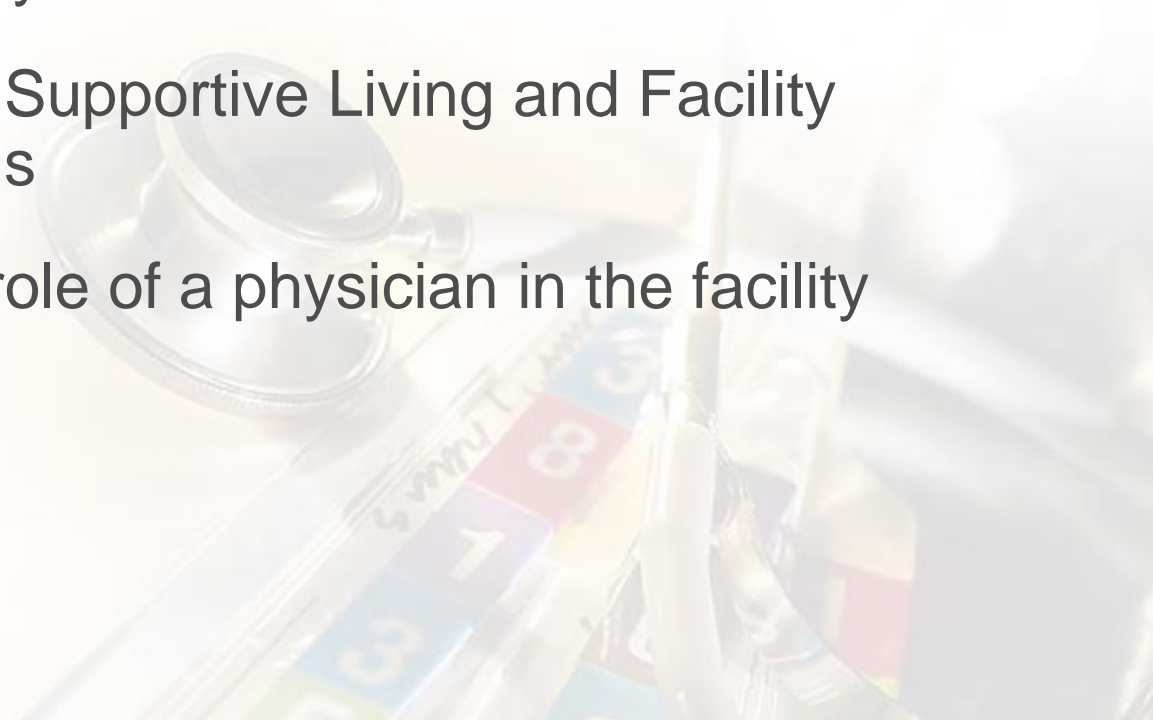


“Hospitalization can be a turning point for older people and their caregivers”





Learning Objectives

- Review the principles of transitions of care with case examples
 - Understand the general components of the continuing care system
 - Home Living, Supportive Living and Facility Living Streams
 - Understand the role of a physician in the facility living stream
- 



“Discharge” Planning

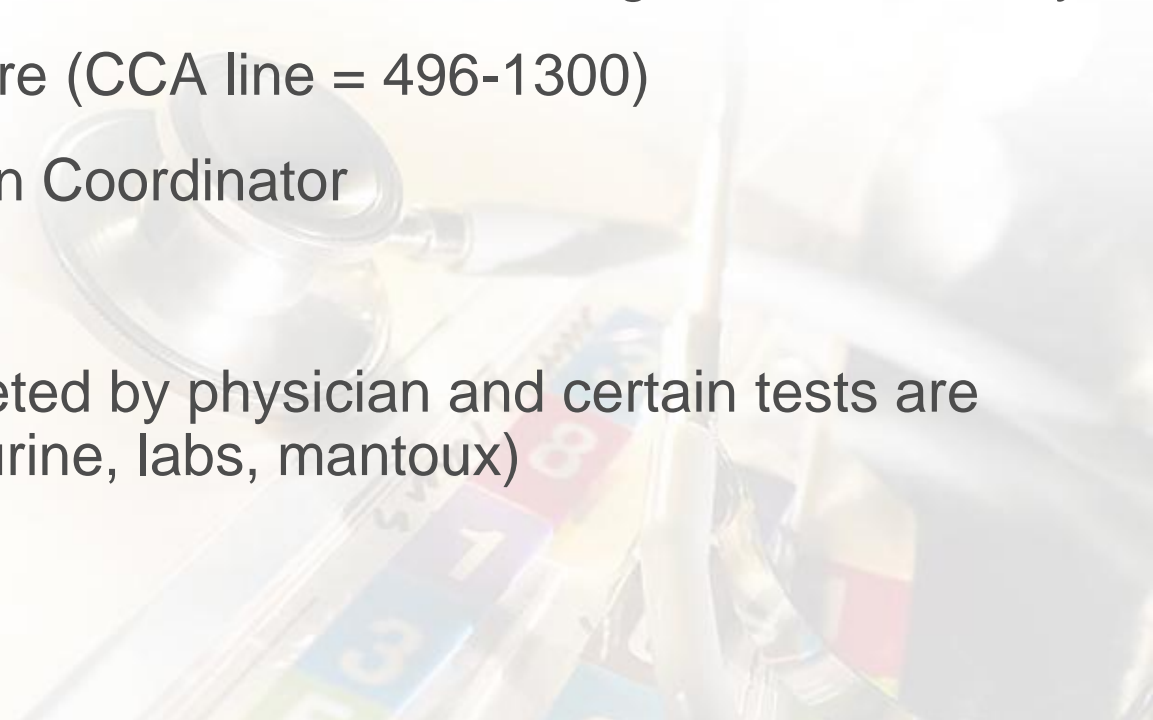
- First need good social history – where living and with who, primary support, formal supports, safety, caregiver burden
- Second need to consider their function
 - BADL - washing, dressing, bathing, feeding, toileting, ambulation
 - IADL – shopping, cooking, cleaning, medications, finances
- Third the decision is made if the patient can go home +/- OPD follow up or rehabilitation versus requiring an increased level of support



Transitioning From Where?

- Acute Care Management Team if relocating from hospital
 - Transition Coordinators and team (i.e. social worker)
- Community Care Management Team if relocating from community
 - Access via Home Care (CCA line = 496-1300)
 - Assessor is Transition Coordinator

An AAPI form is completed by physician and certain tests are required (e.g. CXR, urine, labs, mantoux)





“Discharge” Options from Acute Care

- Home
 - Home with Home Care
 - +/- Day Hospital/Day Programs
 - Consideration of Lodge
 - Assisted Living (private)
 - Home with Home Care and consult to Community Care Management Team for relocation
 - Supportive Living
 - Facility Living
 - Palliative Care or Home Hospice
- 



Discharge Planning

Assessment and Rehab

Transition

Care

INPATIENT

Acute

ACE (RAH, UAH)

CONSULTS

MCH

GNH

RAH

UAH

SGH, Leduc

Stable

GRH

GAU (MCH/GNH)

Subacute

Transition Unit

Restorative Care Unit

OUTPATIENT

Day Hospitals/Programs

START Psych

Adult Day Support Programs

CHOICE

Clinics

Interdisciplinary

- Senior Clinics (UAH)

Other Clinics

- GRH, MCH, Westside PCN

- GNH, Health First

- Good Samaritans

GEM Model – “Outreach”

- NEHC, Westview

- SAS PCN

Facility Living

Auxiliary

Nursing Home

Dependent

Supportive Living

Designated SL (AHS)

Personal Care/

Family Care Home

Home Living

Assisted Living (private)

Lodge Care +/- HC

Senior Apt +/- HC

Dwelling +/- HC

Independent

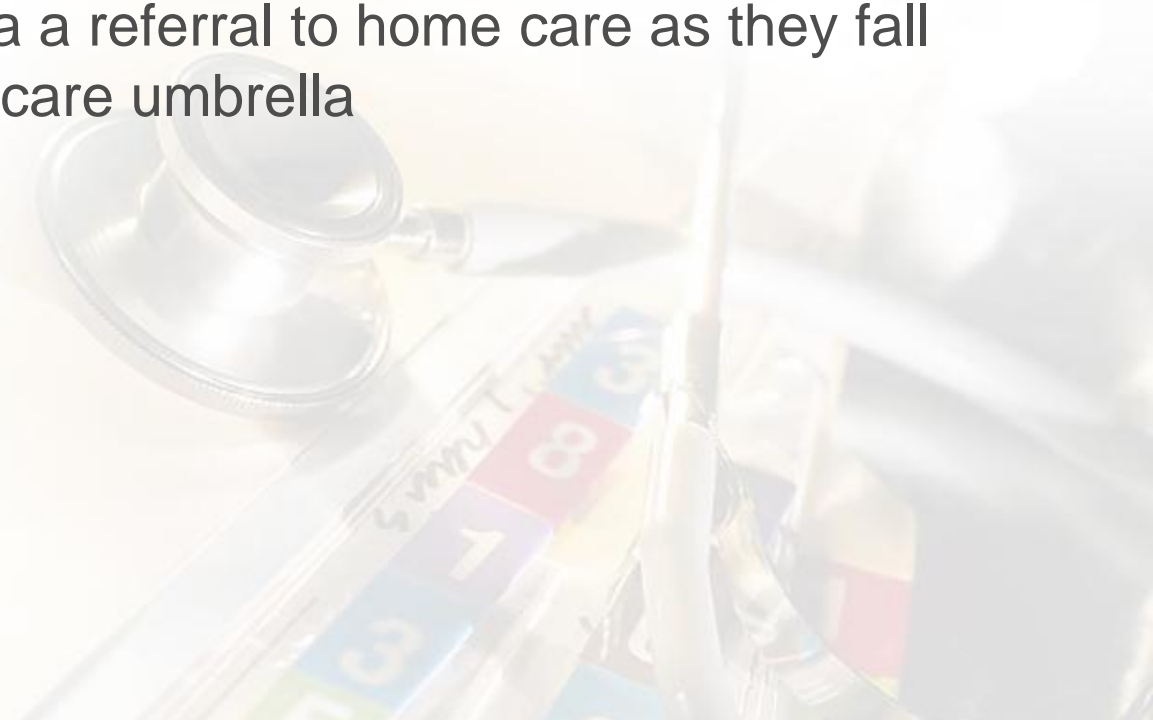


Rehabilitation

- Inpatient
 - GRH (3 units)
 - GAU (MCH/GNH)
 - ACE (UAH/RAH)
 - Subacute (30/60/90day)
 - Restorative care (28 day)
- Outpatient
 - SROP
 - CRIS program
 - Community physiotherapy
 - Homecare physiotherapy



Other Programs

- Adult Day Support Programs – medical (nursing), rehabilitation (maintenance) and social
 - CHOICE – long term – interdisciplinary support for complex frail patients
 - both are accessed via a referral to home care as they fall under the continuing care umbrella
- 



CHOICE

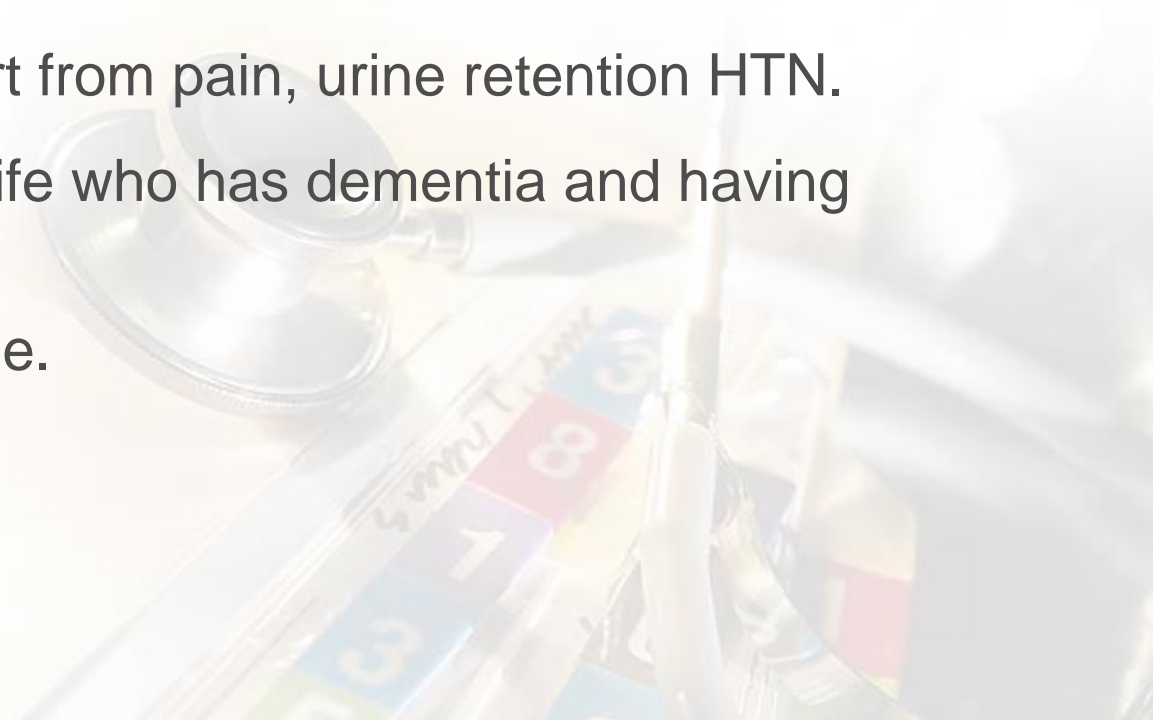
(Comprehensive Home Option of Integrated Care for the Elderly)

- For frail elderly with multiple medical problems at risk for institutionalization
- Access via Home Care (Community Care Management Team) in community or Acute Care Management Team in hospital
- Transportation provided to program
- Services include home support, day program, respite, admission to CHOICE beds short term
- Professional services : MD, nursing, OT, PT, SW, recreation
- On call service for emergencies (e.g. RN)
- Client goes under Choice program physician
- Continue to live at home and attend program (1-5X/week)



Geriatric Outpatient Services

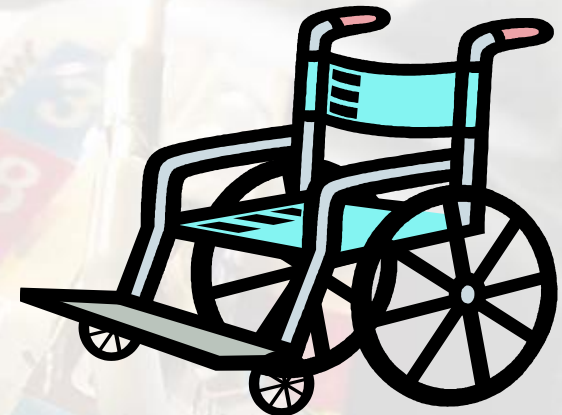
- Variety of models throughout the region for outpatient geriatric assessment, common themes include:
 - use of geriatric database
 - Access via Regional Central Intake
 - Provide consultation for geriatric syndromes
 - Often run as a nurse / physician dyad
 - Capability for home visits in many areas of the city
 - Some provide primary care in addition (e.g. Good Samaritan Seniors Clinic)
 - Various levels of interdisciplinary team member involvement

- 94 yo man admitted with back pain and falls. Compression fracture found on top of chronic disc disease.
 - Difficulty mobilizing due to pain but slowly getting better. Needs 1 PA for 50m
 - Stable medically apart from pain, urine retention HTN.
 - Lived at home with wife who has dementia and having some stress.
 - Wishes to return home.
- 



What Would You Do?

- A) Consult Geriatrics for Glenrose Rehabilitation Hospital
- B) Consult Care Coordinator for Subacute
- C) Consult Care Coordinator for Transition Unit





Continuing Care System

- **Three Levels of Care and How to Access Them**
- From community – Home Care referral, case manager identified and referral made to community care management team (transition coordinator)
 - except lodges and private facilities (private assisted living)
- From hospital – Transition Coordinators in partnership with team

Facility Living : Heavy

- Auxiliary
- Nursing Home

Supportive Living : Intermediate

- Designated SL 1 – 4 (AHS)
- Care Homes

Home Living: Light

- Lodge Care +/- HC
- Senior Apt +/- HC
- Dwelling +/- HC



Provincial Framework (AHS – www.albertahealthservices.ca)

Continuing Care System		
Home Living	Supportive Living	Facility Living
People who live independently in their own homes, including:	Combines accommodation or housing, hospitality and / or health services	Includes long-term care facilities (nursing homes / auxiliary hospitals)
<ul style="list-style-type: none"> • Single family dwellings • Apartments • Condominiums • Seniors Independent Living options 	Targets individuals who require support with nursing and personal care services. Numerous levels and service combinations exist	Targets individuals with the highest and most complex health care needs
Home Care Community Based Services	Basic services include meal(s); housekeeping, laundry, life enrichment, safety and security, etc.	Requires 24-hour registered nursing care for scheduled and unscheduled needs
Individual choice determines building features	Building features vary based on level but typically include private suite / unit and common areas including dining room	Has specialized physical design and infrastructure to address highly complex needs
Various residential acts; regulations & bylaws	Licensed under Supportive Living Accommodation Licensing Act	Governed by Nursing Home Act



Home Living Stream

Home +/- Home Care
Lodges
Other services in home





Home Living

- Majority of seniors live at home
- Most elderly prefer to stay at home even with complex care needs
- Home care services can be received in many settings (e.g. home, apartment, lodge, AL)
- >40,000 Alberta Seniors are receiving Home Care. In Edmonton about 11,000 are receiving home care.
- Services are offered on a *scheduled* basis




Senior's Apartment and Lodges

- Must be capable of independent living (independent transfers/ mobility).
- Lodges provide meals and housekeeping.
- Can get home care services.
- Other service options are available for varying cost
- 20,000 supportive housing units and senior's apartments in Alberta (2,500 in Edmonton).
- Rent range from \$800-\$2,750/ month.
- Some places are culturally oriented.



Types of Home Care

- STIT (short term intervention team)
 - Anticipated service need for < 3 months
 - LTS (long term)
 - Service requirement > 3 months
 - Palliative – end of life care
 - Access via CCA line (496-1300)
- 



Home Care Professionals & Consult Services

Registered Respiratory Therapist (RRT)
Physical Therapist (PT)
Occupational Therapist (OT)
Social Worker (SW)
Nursing (RN, LPN)
OT/ PT Assistant
Health Care Aide (HCA)




Consult Services

Home Living Geriatric Consult Team
Nurse Practitioner (NP)
Enterostomal Therapist Nurse (ET)
Pharmacist
Registered Dietician (RDT)
Regional Mental Health
Regional Palliative care

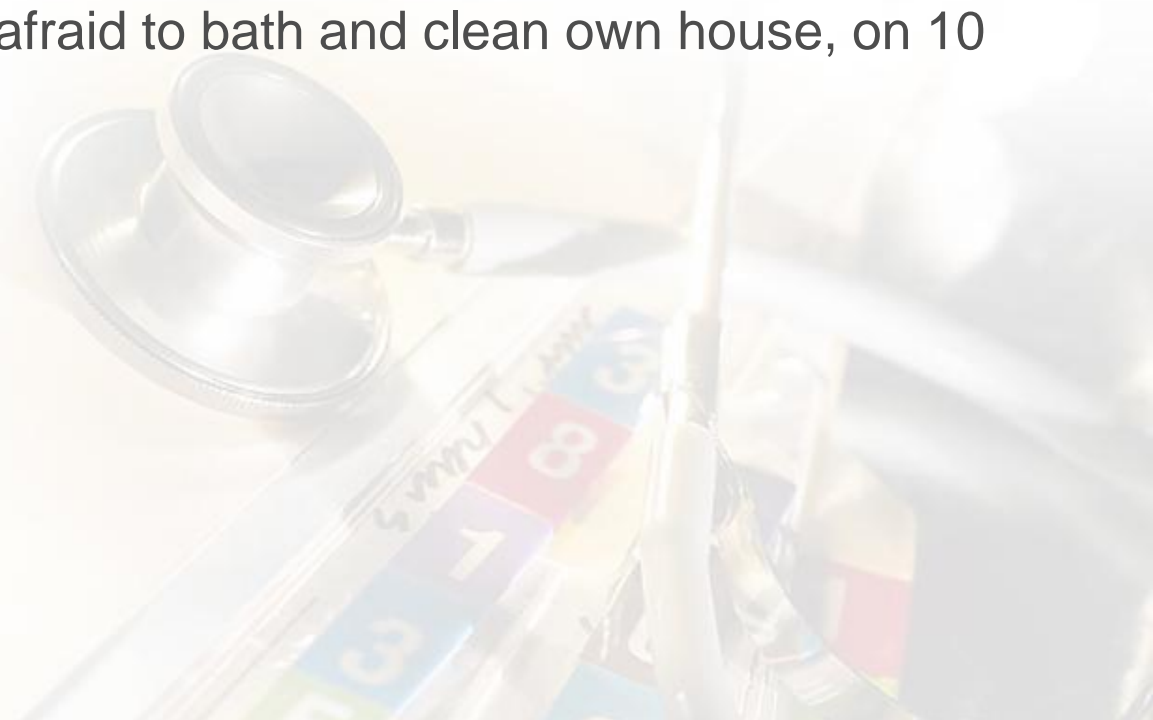


Additional Resources

- Additional services that may maintain patients in their own home (for an additional cost):
 - Meals on Wheels
 - Shopping delivery
 - Lifeline/Telecare
 - DATS or Driving Mrs Daisy
 - Homemaking
- 




Mrs. HC

- 76 yo lady, living alone in a bungalow, with no prior home care services, admitted with new CHF
 - Looks after own BADL. Family assist with shopping but otherwise patient looks after own IADL.
 - Now she is weaker and afraid to bath and clean own house, on 10 new medications
 - Wishes to return home
- 



What Would You Do ?

- A) Refer to Geriatrics
 - B) Refer to Social Work
 - C) Refer to Home Care
- 



Assisted Living (private)

- Privately funded and operated
 - Up to \$4000/month and “Informed shopping”
- Staff on site 24 hrs/day for personal and/or professional care
 - Additional care may be supported by home care
 - Accessed by application to individual site
 - As with DSL, patient pays for medications and furniture within suite



Hospital to Home Care Referral

Page 1 of 2

- Cross Cancer Institute
 GRH
 GNCHHC
 MCHHC
 RAH
 SCHHC
 UAH

Patient Name _____

Date of Birth _____

TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL IF PATIENT IS REFERRED TO HOME CARE.

1. MEDICAL INFORMATION

Discharge Diagnosis _____

Is patient aware of diagnosis? yes no

Is family aware of diagnosis? yes no

Surgical Procedures _____

Please explain _____

DOCTOR'S ORDERS: Must be written and signed for the following: dressing and wound care; medication administration including preloads / dosettes; catheter insertion; respiratory therapy treatment (include oxygen litres per minute and hours per day); and physical therapy treatment (include instructions re: weight bearing and precautions).

Discharge medications? none other (please list below)

Drug	Dose	Frequency	Drug	Dose	Frequency

Date _____ Physician's Signature _____

Physician contact(s) for Home Care for immediate post-discharge issues:

Name _____ Phone _____ notified

Name _____ Phone _____ notified

Has the patient / family been instructed re: medications / treatments? yes no

Do you anticipate the patient / family will have any difficulty managing medications / treatments at home? yes no

If yes, please explain _____

Follow-up Appointments _____ Date _____

_____ Date _____

2. HOSPITAL CONTACT PERSON(S)

Discipline	Name	Phone	Discipline	Name	Phone
Nurse			Social Worker		
OT			Dietitian		
PT			Pharmacist		
RT			Other (specify)		

**Hospital to
Home Care Referral
Page 2 of 2**

Patient Name _____

Date of Birth _____

3. PHYSICAL FUNCTION / ADL		Independent	Independent with equipment	1 person standby	1 person assist	2 person assist	Equipment used or individual who assists	Comments
Ambulatory	indoor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	outdoor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Transfers	toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	tub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	bed mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Personal Care	bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Household Management	meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Equipment ordered _____ Suppliers _____

4. HOME CARE REFERRAL

Anticipated Discharge Date _____ Time _____ Initial Home Care Visit Date _____ Time _____

Discharged to address on demographics sheet? yes no Care Map yes no

If no, please indicate where the patient is being discharged to:

Name _____ Phone _____

Address _____

Type of service Required	Treatment / Teaching Required
Nursing	
Occupational Therapy	
Physiotherapy	
Respiratory Therapy	
Social Work	
Personal Care / Homemaking	
Other (specify) _____	

5. SPECIAL CONCERNS (eg. safety, family involvement, pets)

Unit Designate for Confirmation of Home Care Services _____ Phone _____

Date _____ Completed by _____ Signature _____



Supportive Living Stream

- ~ 22,000 people live in approximately 600 supportive living facilities (Alberta stats)
 - designated supportive living, group homes, family care homes





Supportive Living Care Homes

- Personal Care Homes
 - Small number of clients (4-6), on site care 24hours (HCA)
 - An example of SL3 level
- Special Care Homes
 - Client with challenging behaviors/complex needs
- Family Care Homes
 - Caregiver is live-in family/homeowner
- Mental Health Approved Homes
 - Family home environment, clients with severe mental illness

Designated Supportive Living

- Developed for people who require
 - Accommodation
 - Domiciliary support (i.e. food, laundry)
 - Social activity
 - On-site 24 hour access to *scheduled & unscheduled* care by HCA +/- LPN
- Types:
 - SL 1 & 2
 - SL 3
 - SL 4
 - SL4D (safe living)

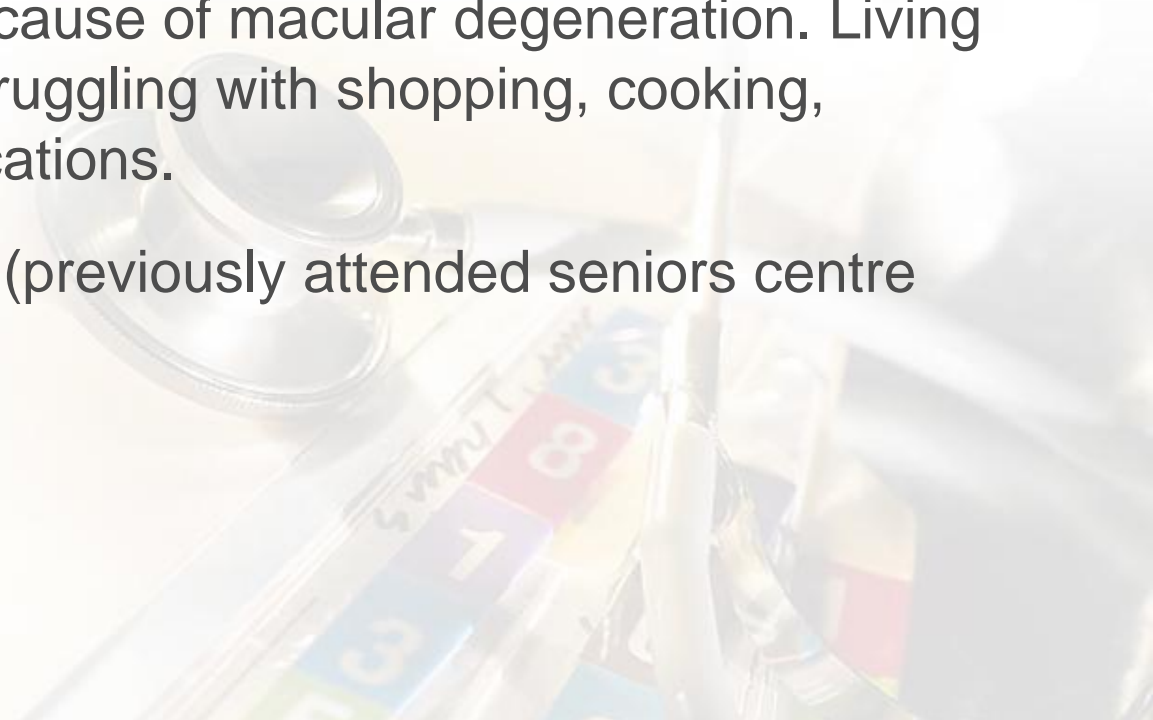


Kensington Village




Designated Supportive Living

- ~ 4,000 DSL spaces in Edmonton Zone
- Accommodation and service needs managed by operator
- Care plan & health care needs supported by AHS
 - On site Case Manager
 - Off site interdisciplinary team (via consultation)
 - GEM team (geriatric evaluation and management)
 - Geriatric psychiatry
 - PT, OT, SW, dietician, RT, SLP, NP, kinesiology etc.
 - On call RN availability
 - Nurse educators
 - Specialty clinics (i.e. wounds, incontinence)

- 71 yo man recently widowed comes to you for check up
 - Independent with BADL except bathing and dressing due to vision
 - Gave up driving because of macular degeneration. Living in own home but struggling with shopping, cooking, cleaning and medications.
 - Isolated and lonely (previously attended seniors centre with wife as driver)
- 



What Do You Suggest?

- A) Refer to Home Care for bathing and dressing assistance
 - B) Refer to Glenrose Rehabilitation Hospital for rehabilitation
 - C) Refer to Community Care Management Team
(via Home Care) to assess him for designated supportive living
- 


Facility Living Stream

Nursing Home Auxiliary Hospital



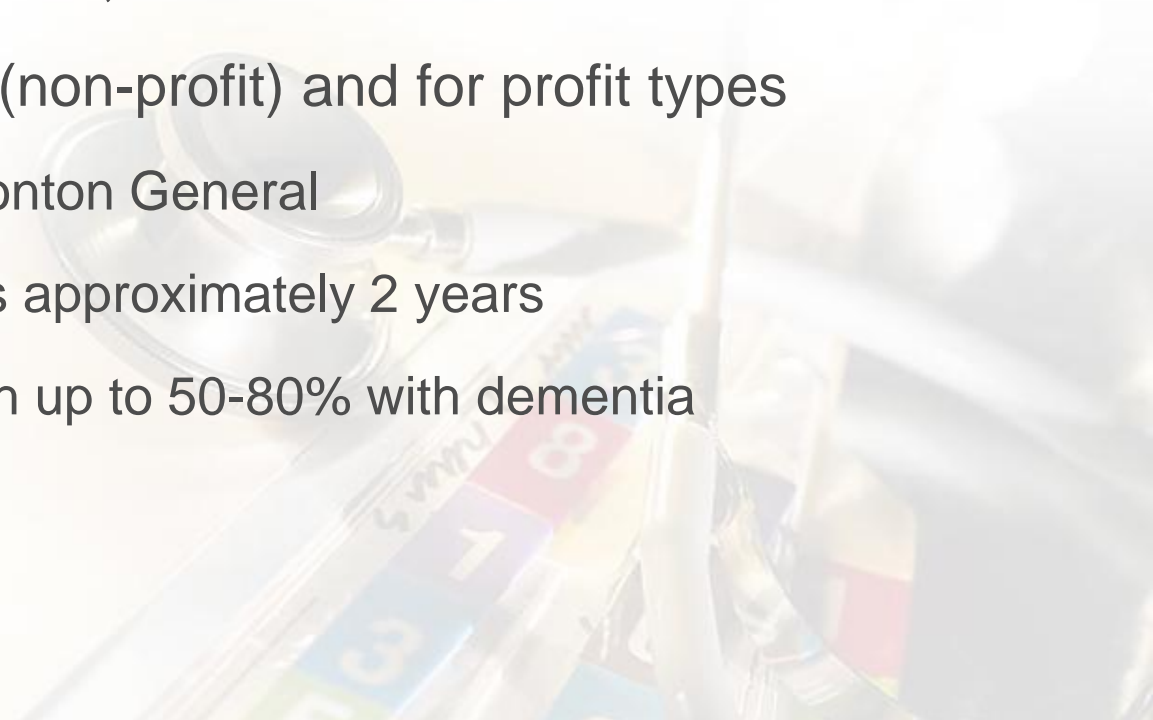


Facility Living

- Care is provided to patients with complex care needs (24 hour, on-site skilled nursing care = RN)
 - Long Term Care settings provide accommodation and health services in facilities
 - Nursing Homes
 - Auxiliary Hospitals
- 




Demographics (Alberta)

- 525, 000 seniors (2007)
 - most live within their own home
 - ~ 200 LTC facilities with 16,400 beds
 - Public, volunteer (non-profit) and for profit types
 - Largest facility is Edmonton General
 - Average LOS in LTC is approximately 2 years
 - Average age 84yrs with up to 50-80% with dementia
- 




Characteristics Predictive of Admission to Facility Living

- Dementia (end stage, immobile, incontinence)
 - BPSD
 - Chronic Comorbid Medical Disease
 - Dependency for ADLs (mobility)
 - Caregiver burden
 - Urine and/or fecal incontinence
 - Terminal illness
- 

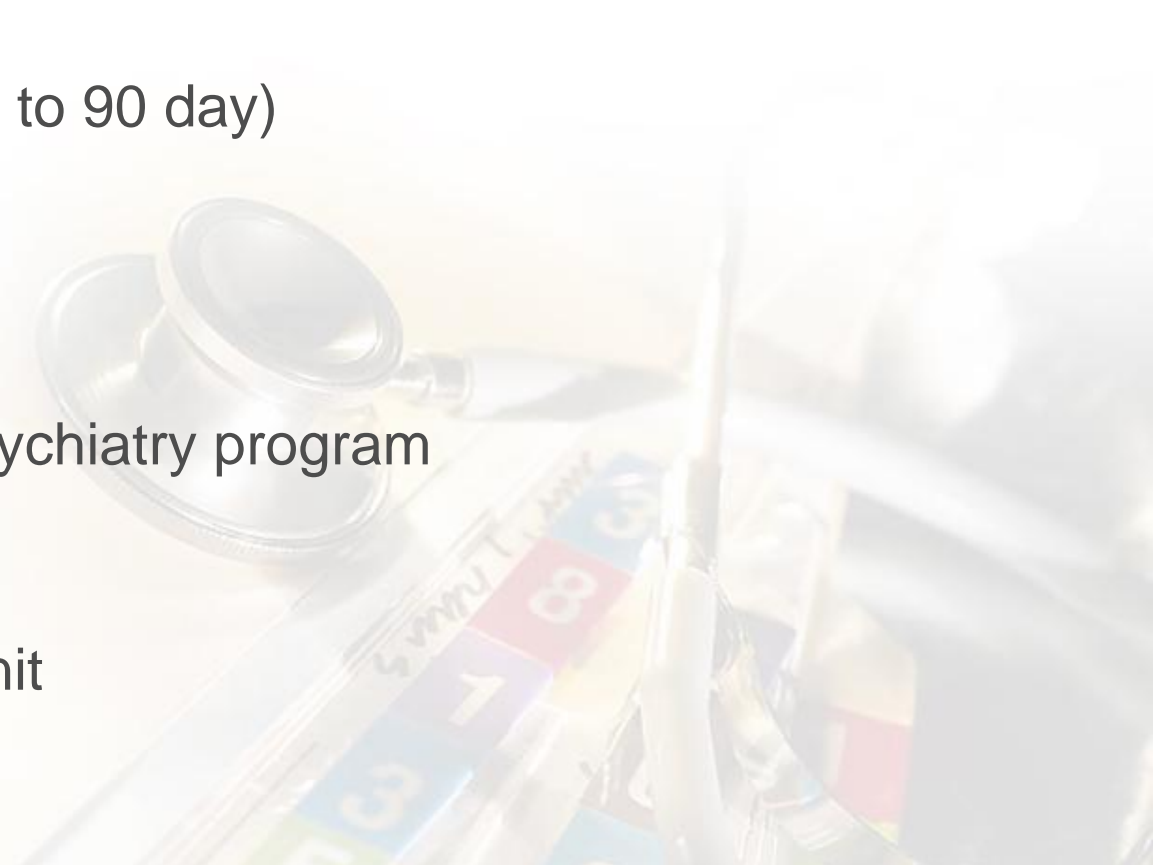


Continuing Care Standards

- Accommodation Standards
 - Health Service Standards
 - Accommodation Fee (e.g. meals, housekeeping, maintenance of buildings) but Health Services are publicly funded
 - Revised in March 2013
 - Case Management
 - All operators (publicly funded) follow these standards
- 



Specialized programs in Continuing Care

- Subacute - rehabilitation
 - Regular (30 day)
 - Slow Stream (up to 90 day)
 - Palliative
 - Respite
 - Long Term Care Psychiatry program
 - Transition Units
 - Restorative Care Unit
- 

Administrative Issues



Physician's Role



- Facility Living (nursing home)
 - Physician must be assigned to each resident
 - Admission visit within 7 days of admission to the facility
 - Care conference with family, resident and team at 6 weeks (care goals)
 - Medications must be reviewed at least every 3 months
 - Routine visits must occur at least monthly
 - At minimum must be an annual integrated care conference for each resident

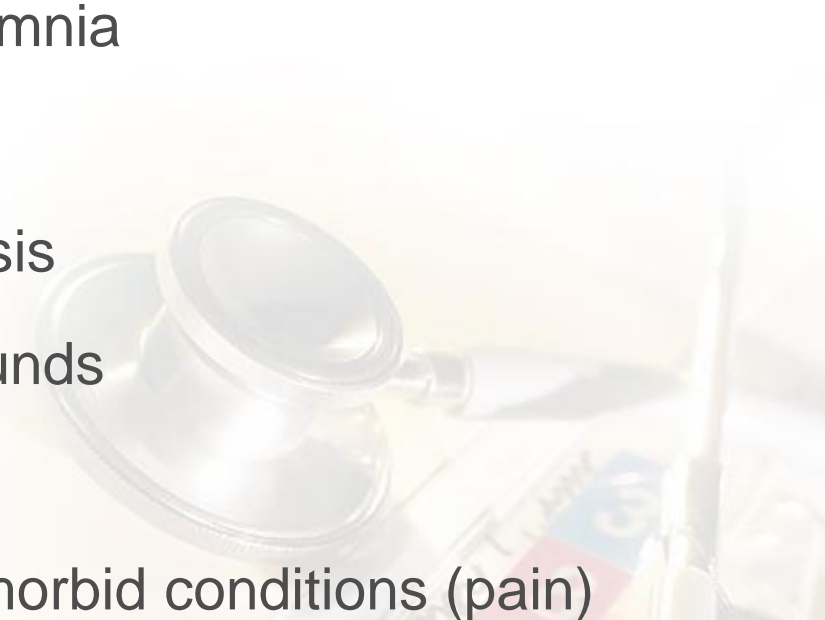
Medication Use

- Regular review by MD and pharmacist every 3 months
- LTC formulary
 - No longer covered by Blue Cross
- OTC and High Cost Medications
 - Guideline Use Medications
 - Special “Requests”
- Medication Reconciliation at admission
 - Goals of Care
 - End of Life Care



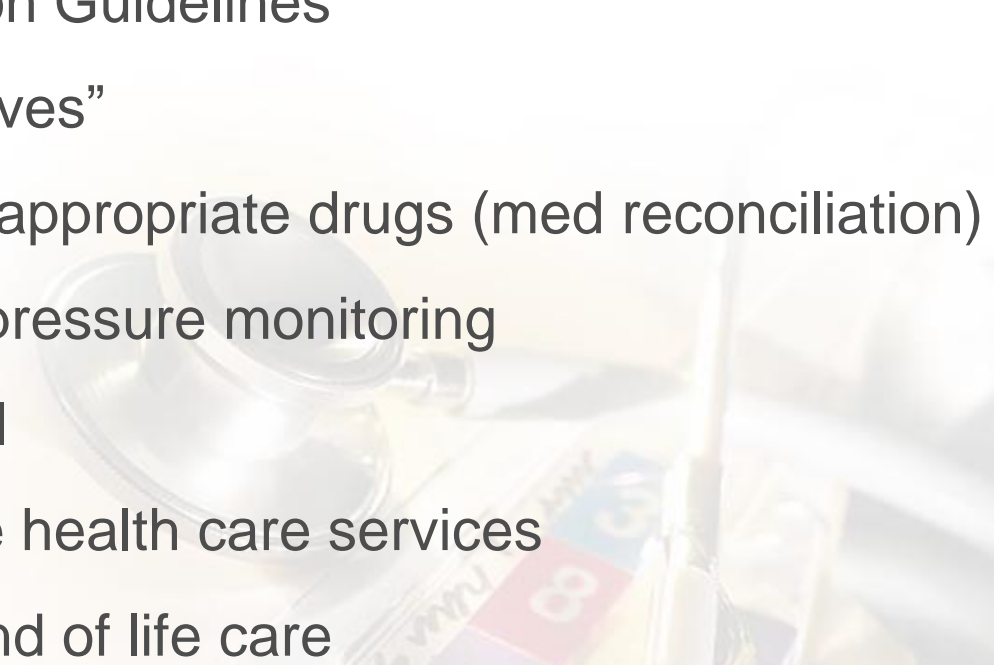


Common Medical Concerns

- Dementia and Behavioral Psychological Disturbance (BPSD)
 - Depression and Insomnia
 - Delirium
 - Falls and Osteoporosis
 - Pressure Ulcers/Wounds
 - Urine Incontinence
 - Multiple Chronic Comorbid conditions (pain)
- 

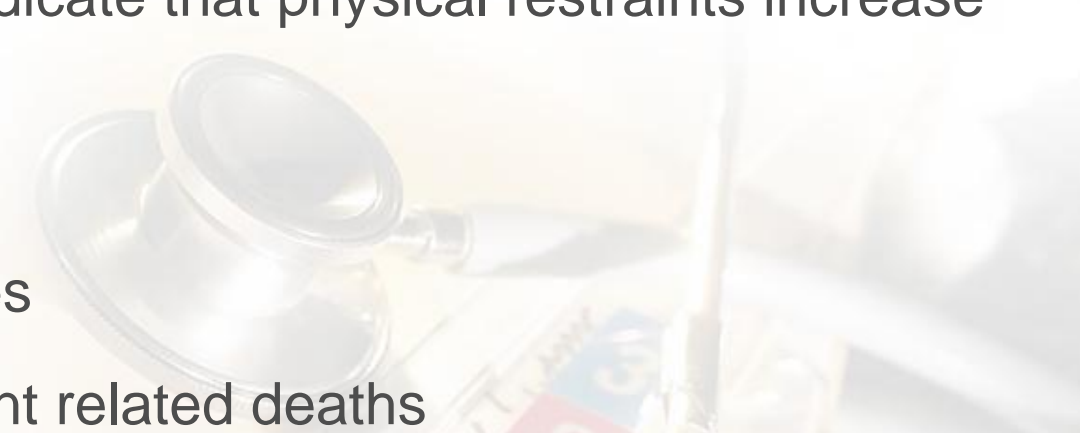


Best Practice Guidelines

- Pneumonia Pathway
 - Urinary Tract Infection Guidelines
 - “Best Practice Initiatives”
 - Use of beneficial/appropriate drugs (med reconciliation)
 - Increased blood pressure monitoring
 - Good pain control
 - Less use of acute health care services
 - Appropriate end of life care
- 

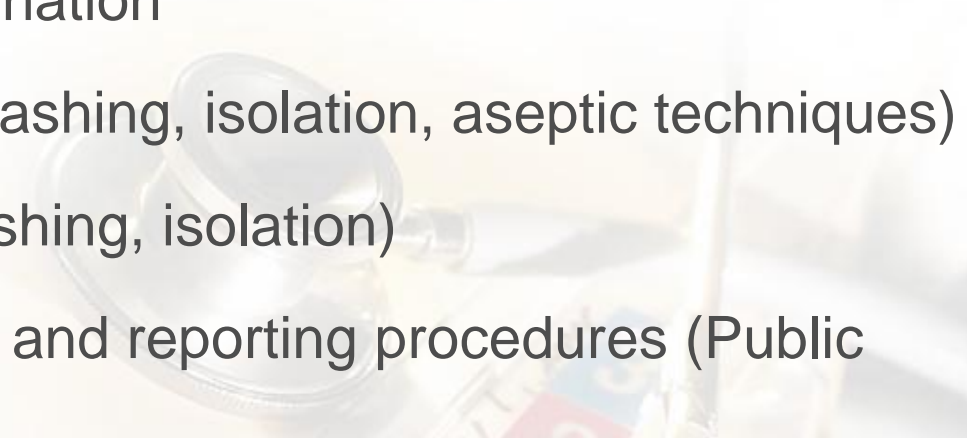


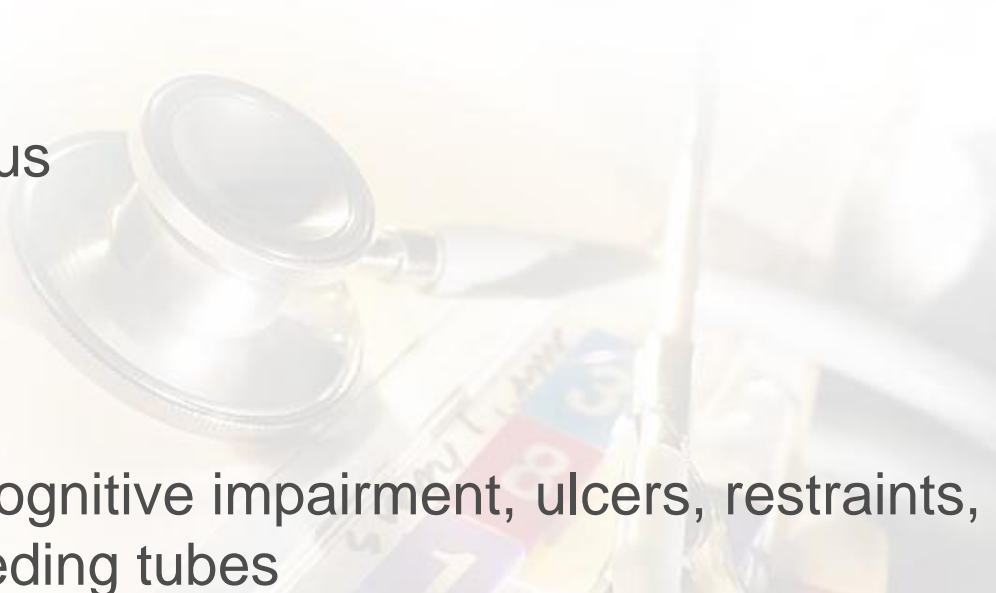
“Least Restraint Policy”

- Includes both chemical and physical restraints
 - Prior assumptions that physical restraints prevent falls and fall related injuries
 - Numerous studies indicate that physical restraints increase incidence of:
 - Falls
 - Fall related injuries
 - Reports of restraint related deaths
- 



Infection Control Issues

- TB (two step mantoux)
 - Influenza (annual vaccination)
 - Pneumococcal vaccination
 - MRSA/VRE (hand washing, isolation, aseptic techniques)
 - C. Difficile (hand washing, isolation)
 - Control of outbreaks and reporting procedures (Public Health)
- 

- Resident Instrument Assessment – Minimum Data Set
 - To be used for collating and comparing data
 - Can look at the following areas:
 - Mobility and Falls
 - Oral/Nutritional Status
 - Disease Diagnosis
 - Incontinence report
 - Assessments with cognitive impairment, ulcers, restraints, weight loss/gain, feeding tubes
- 


Mr. DB

- 89 year old male with severe dementia living in nursing home
- Dysphagia but family and patient expressed wish to “eat at risk”
- Difficult walking due to dementia, arthritis and diabetic neuropathy
- Dependent on nursing staff for BADLs and mobility
- Develops a cough, fever and chest pain





What Now?

- A) Get a Chest Xray and Blood Tests
 - B) Send him to the Emergency Department
 - C) Check his personal directive / goals of care designation
 - D) Speak with him about next steps
 - E) Not sure?
- 



Resources

<http://www.seniors.gov.ab.ca/housing/continuingcare>

<http://www.mysage.ca>

<http://www.srsr-seniors.com>

<http://www.amda.com>

<http://www.cmda.info>

