CH Research day

Transitions in Care

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Background

Edmonton Zone has a patient access and flow strategy that aims to facilitate timely patient access and flow across the continuum of care while supporting quality patient care delivery and safety. This involves integrated care planning and patient centered care. Much research has been done on how to smooth the transition home from hospital. This involves identifying patients at high risk for readmission and coordinated discharge with community supports. Interventions such as post discharge phone call follow ups have been proven to help with continuity of care and bridge discharge home.

Objective

To facilitate smoother discharge from the medicine units at the Grey Nuns Community Hospital, (GNCH) Edmonton for high risk discharges and prevent hospital readmission.

Method

Phase 1 utilized expert consensus from the Covenant Transition Steering Group and a Covenant Transition Working Group to design a risk assessment tool, and determine the cohort of patients who would benefit from this intervention, and the components of a scripted telephone call with a comprehensive evaluation framework. This was supplemented by literature review. The work was also guided by the experience of Providence Health, BC, GNCH geriatrics pilot, and South East Edmonton Primary Care Network (PCN) transitions work.

A pilot was undertaken to validate the efficacy of the risk assessment tool in June 2016.

Phase 2 includes the intervention of the risk assessment tool and follow up telephone calls 48 hours after discharge which includes support as needed from research coordinator (with nursing/transition coordinator background) tobridge any gaps in medications/equipment/homecare/physician appointments identified in the telephone calls.

This study was funded by the Network of Excellence in Seniors Health and Wellness (NESHW).

The study was given an exemption for the Health Research Ethics Board, University of Alberta.

Results

The pilot used a modified LACE tool. N=40. Using 19 as a cut off it identified 19 patient as high risk. When the original LACE was applied with a cut off of 13, 13 patients were identified as high risk. Thus the added length of the modified LACE did not yield much and the decision was made to use the original LACE in Phase 2. The scripted telephone call was developed focusing on whether the patient : understands the discharge instructions, picked up medications**,** if referred for equipment picked up**,** and

if referred to home care have heard from them. The study has partnered with home care, the local PCN and primary care physicians (PCP) as well as pharmacy to support the patients. An appointment will be made with their primary care physician by the hospital prior to their discharge. A copy of the telephone call documentation will be faxed to their PCP and homecare where involved. Data and Decision Support supplemented the evaluation framework which will focus on outcomes, including emergency visits and readmission rates.

Conclusion

The initial phase 1 of this study has helped inform the risk assessment tool and telephone call/supports needed to facilitate smooth discharge home for high risk patients. It is anticipated that the intervention of provision of post discharge follow up to complex patients and/or care supports will support the cross continuum seamless transition planning.