# Effective Care Transitions to and from Acute Care Hospitals

## MODULE 10

LAKE ERIE INTEGRATED GERIATRIC HEALTH TEAM

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# Outline

- Transitions for persons living with dementia (PLwD)
- Transitions between home and hospital
- Discharge planning

# Learning Objectives

After completing this module, participants will be able to:

- Identify the risks associated with care transitions for persons living with dementia (PLwD).
- Identify basic post-discharge information needs for persons living with dementia discharged from a hospital.
- List immediate actions that should be in place upon discharge from the hospital.
- Describe how to minimize potential post-discharge setbacks.

# Key Take-Home Messages

- Transitions are challenging times. Communication is critical.
- Smooth transitions between home and acute care hospitals require a modest amount of information about PLwD—but require the information immediately.
- Referring organizations/facilities have a responsibility for good communication.

# Outline

- **Transitions for persons living with dementia (PLwD)**
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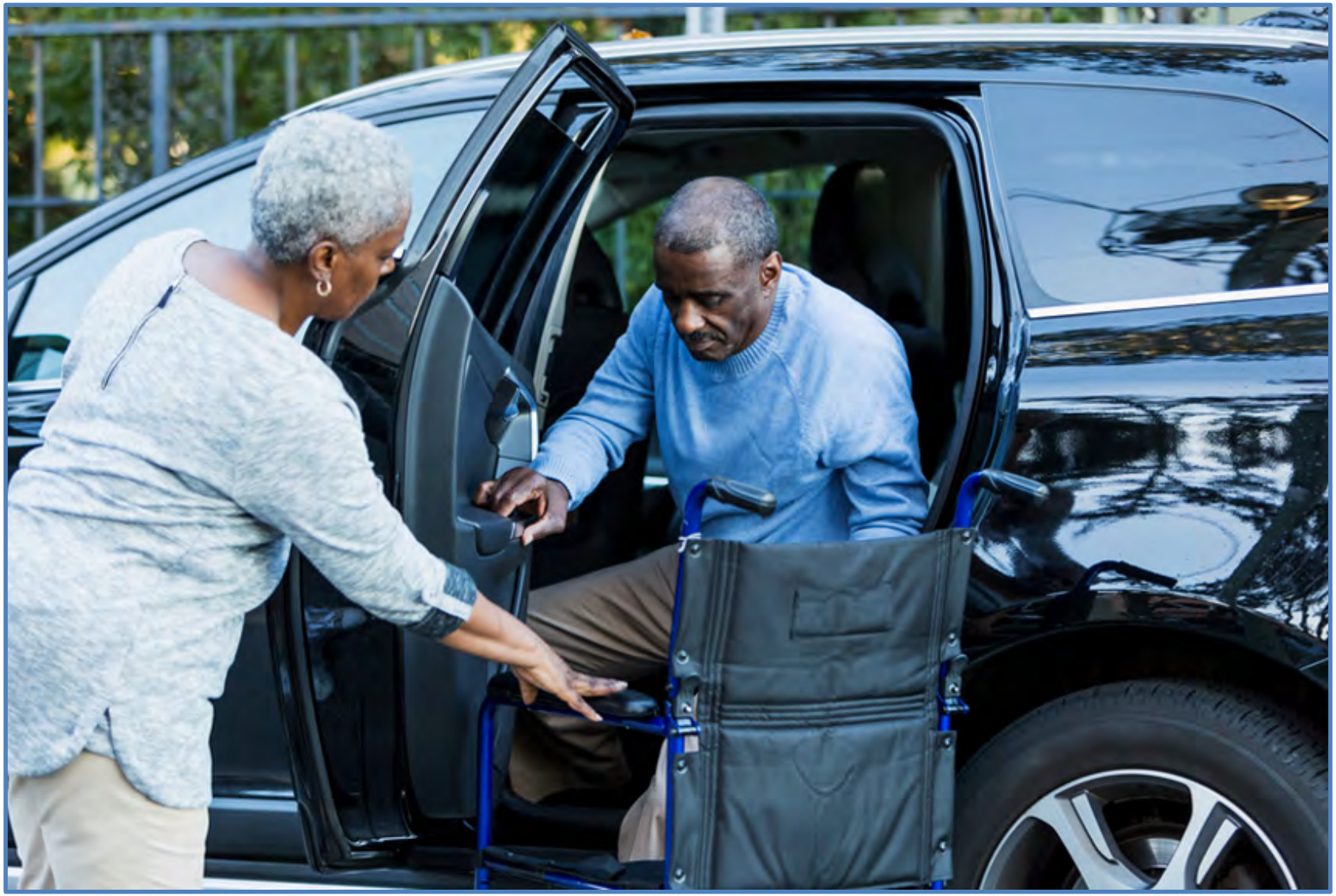
# Levels of Care for PLwD

- There are many different levels of care for PLwD.
- Many PLwD remain at home, in their community, but may require home and community-based services, and sometimes use emergency care or hospitalization.
- Some PLwD will require care at some form of long-term care facility (e.g. nursing home) over the course of the dementia.
- Hospice care can be provided at home or in a care facility.



# Introduction to Transitions

- "Transition" is defined as a physical move from one location to another involving at least one overnight stay (Aaltonen et al., 2012).
- Transitional care encompasses those actions designed to ensure coordination and continuity of health care through transitions (Coleman & Boult, 2003).
- PLwD have frequent transitions, particularly between home and hospital or emergency department (ED) (Callahan et al., 2012).

# Timing of Transitions for PLwD

- PLwD have more overall transitions compared with those without dementia (Callahan et al., 2012).
- For PLwD, transitions are most likely to occur during year of diagnosis, year before death, and year of death (Aaltonen et al., 2012; Sivananthan & McGrail, 2016; Teno, 2013).
- Factors associated with hospitalizations include older age, use of benzodiazepines or antipsychotics, overall poor health, or comorbidities (Sivananthan & McGrail, 2016).
- Organizations serving persons with intellectual disability may initiate a transition to acute care when the PLwD care needs exceed what the organization can offer (NTG, 2012)

From Home To Hospital

# Trends in Transitions

- More persons dying in their homes (vs. out of the home) (Hall et al., 2013)
- Between 2000 and 2009: decrease in proportion of deaths occurring in acute care hospitals; increased use of ICU in last month of life; and increased use of hospice (Teno et al., 2013)
- Dementia diagnosis associated with earlier time to first nursing facility use, earlier time to death vs. persons without dementia (Callahan et al., 2015)
- Data from Health and Retirement Study: more frequent transitions for PLwD vs. those without dementia, especially between home and hospital (Callahan et al., 2015)

# Why Transitions Are Particularly Difficult for PLwD

- Good dementia care stresses continuity, familiarity, and coordinated care—all often absent in transitions (Callahan et al., 2015).
- PLwD have difficulty processing new information; transitions are disruptive and can cause anxiety and agitation.
- Transitions are difficult for PLwD and care partners.
- Older persons generally visit emergency departments (EDs) more than younger persons and are at increased risk of harm from errors (Parke et al., 2013).
- Persons living with dementia and intellectual disability may be disadvantaged as staff may be unfamiliar with intellectual disability and be untrained in communication and special care practices (NTG, 2012)

# Transition Challenges

- Transitions are times of high risk for medical errors, added burden, and medical treatments not concordant with plans and goals of PLwD (Callahan et al., 2015).
- All transitions increase risk of undesirable outcomes for PLwD (Ray et al., 2015).
- Successful transitions for PLwD require additional time, resources, and information.

# Impact of Dementia on Care Transitions

- PLwD are not necessarily identified as such when first admitted to ED or hospital (Deeks et al., 2016).
- Increasing severity of dementia among PLwD hospitalized for hip fracture is associated with higher 12-month mortality and less functional recovery (Tarazona-Santabalbina et al., 2015).
- While hospitalized, PLwD often receive care that is incongruent with their preferences (Catic et al., 2015).
- Greatest risks of poor outcomes are associated with hospitalized PLwD who also have delirium (Bellelli et al., 2007) that can appear during hospital stay.
- Care transitions for person living with dementia and intellectual disability can be eased if familiar staff from the person's organization accompany them and remain to help the hospital care staff (Jokinen et al., 2013; NTG. 2012).

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From Hospital To Home

# Common Reasons for Hospitalization or Re-hospitalization for PLwD

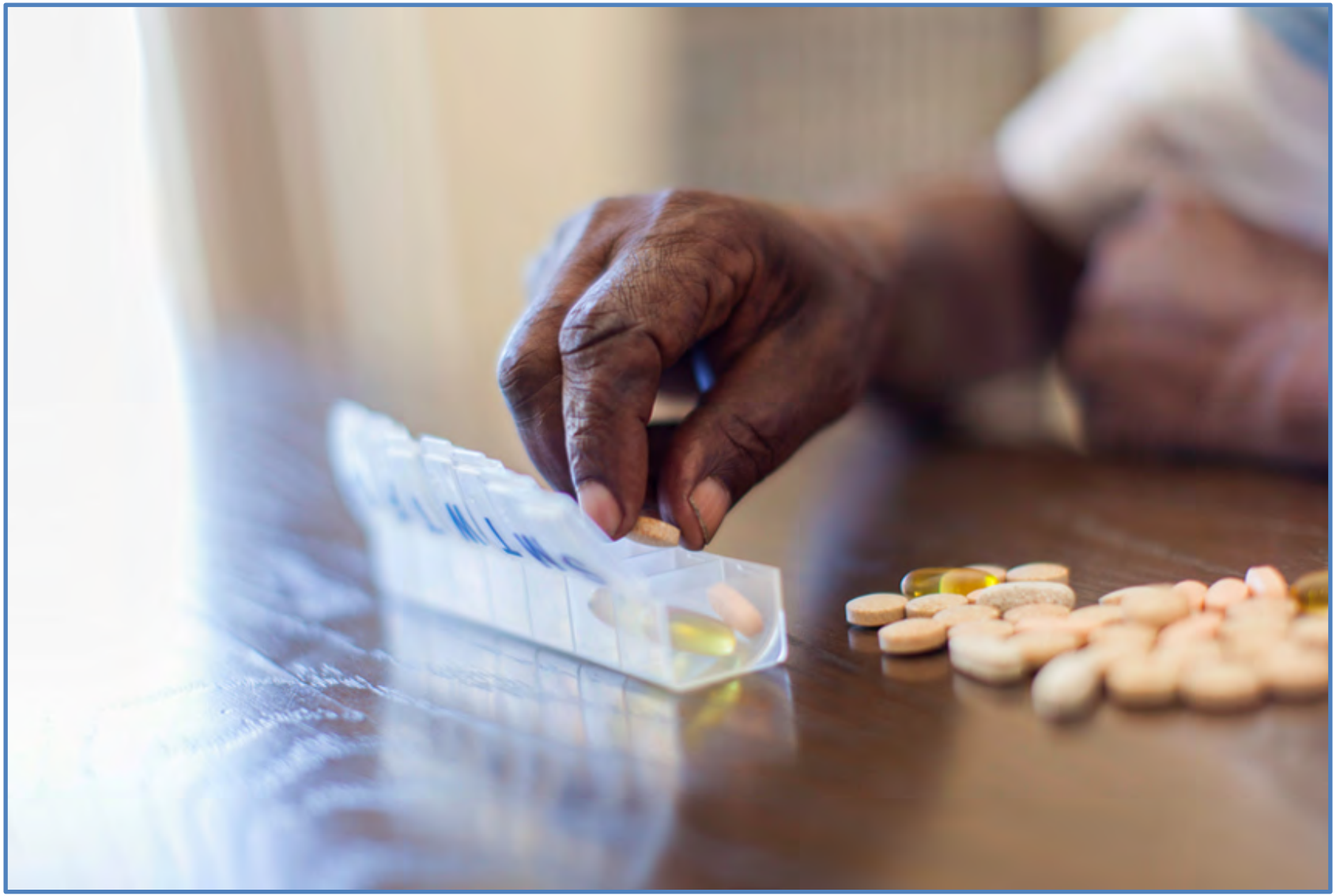
- Many medical reasons necessitate hospitalization for PLwD.
- Risks for re-hospitalization for PLwD include poor communication and lack of understanding or adherence with the discharge instructions.
- Contributing factors for re-hospitalization may include medication mismanagement,  mismanagement of medical care, and care partner burnout.

# Facilitating Smooth Transitions in Care

- PLwD or care partners need to be able to provide medical, legal, and other information about PLwD during transitions.
- PLwD or care partners need to receive specific information about anticipated care that will be provided by the transitional site and/or what care will be available at home.
- Persons living with dementia and intellectual disability should be accompanied by records of preferred care and by staff from the sending organization who are familiar with the person (Jokinen et al., 2013).

# Facilitating Smooth Transitions for PLwD

- PLwD, family/care partners, and hospital staff can implement simple strategies to smooth the transition for PLwD.
- Ask the family/care partners to provide familiar touches, such as blankets, photographs, and pajamas.
- Review current routines of PLwD and try to maintain them.
- Persons living with dementia and intellectual disability should be accompanied by records of preferred care and by staff from the sending organization who are familiar with the person (Jokinen et al., 2013).



# Medication Management Across Transitions

- Facilitating consistent medication management is vital to all transitions.
- PLwD may not be aware of all medications, vitamins, and/or supplements they take (Deeks et al., 2016).
  - It is important to verify the list while the PLwD remains hospitalized.
  - It is important to provide comprehensive instructions regarding medications upon discharge.
- PLwD and intellectual disability may be on numerous medications designed to treat both medical needs and address behavior (Jokenin et al., 2013).
  - It is important to obtain a full list of medications being taken and for what reasons.

# Medication Management Across Transitions (continued)

- Older persons with risk for delirium or currently on anti-dementia medications are discharged with an average of nearly 15 medications, with up to 3 medication changes while hospitalized (Paquin, 2015).
- Medication changes need to be communicated and explained to PLwD and care partners. Involving the primary care provider and pharmacist may be of great benefit (Paquin, 2015; Deeks et al., 2016).

# Role of the Care Partner During Transitions

- PLwD require continuous care and support during transitions.
- Care partners are often overlooked during the decision-making process (Coleman et al., 2015; Jamieson et al., 2014). They report rarely receiving advance information regarding discharge (Jamieson, 2014).
- Care partners are often not prepared to handle post-discharge medication management (Coleman et al., 2015) and other post-discharge instructions.

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# Post-Discharge Planning

- Post-discharge planning to home should start at the time of hospital admission. It may necessitate home health care or personal care.
- Resources are available for clinicians to help PLwD and their care partners.
- Access to and open communication with primary care are critical.
- Many PLwD and their families are not prepared for discharge.
- Because of the 30-day re-admission rule, hospitals have a strong incentive to improve transitions.

# Discharge Planning For Persons Returning Home

- Discharge planning should include the PLwD and any care partners (as appropriate) (Deeks et al., 2016).
- Discharge planning involves thoughtful decisions.
- Discharge plans should be written, clear, comprehensive, and reviewed with PLwD and care partners.
- Because the needs of PLwD can change on a daily basis, discharge plans should be constantly reviewed and amended.
- All providers involved in the care of PLwD while hospitalized should provide guidance in the discharge plan.

# Information in a Discharge Plan

- Ideally, discharge plans should be jointly developed by providers and PLwD/care partners.
- Discharge plans should include:
  - Medication instructions
  - Need for home health services and/or home and community-based services
  - Dietary considerations
  - Instructions regarding exercise and physical or occupational therapy
  - Information regarding connecting PLwD with necessary community support services, including support for the family care partner
- Discharge plans should identify potential concerns upon discharge, include suggestions for addressing any problems, and be written in plain language.

# Facilitating Smooth Transitions Home

- All providers should provide information to PLwD and care partners prior to discharge.
- When appropriate, PLwD or the care partner should be trained on any new therapy plans or medications.
- A care coordinator can be recommended if PLwD do not yet have one.
- The care partners should be involved as much as the PLwD desires, and in accordance with privacy rules and legal arrangements.
- For persons living with dementia and intellectual disability it is important to involve the sending organization in all steps of care and discharge planning (Bishop et al., 2015).

# Distinguishing Home Health Care From Home Care

- PLwD may require home health care as well as home and community-based services.
- Home health care is provided by a skilled professional after an ED or hospital stay.
  - Finite duration if paid for by Medicare or health insurance based on eligibility rules
  - Addresses specific medical concerns
- Home and community-based services can be provided by direct care workers, and focus on quality of life, community integration, and assistance with function.

# Potential Post-Discharge Setbacks

- There are many challenges to coordinating care between hospital and primary care providers (Jones et al., 2015), including time limitations, poor, communication processes, and interrupted information feedback loops.
- It is important to enable continued and consistent care across transitional sites to minimize disruption to the care of PLwD.
- PLwD and care partners should be educated about strategies to minimize anxiety and agitation upon discharge, including maintaining old routines and identifying signs of delirium or pain.

# Transition Models to Optimize Transition Outcomes

- Numerous models have been proposed to help facilitate optimal transitions across health care settings (Coleman et al., 2015; Hirschmann et al., 2015; Hirschmann et al., 2015; Naylor et al., 2007; CMS, 2016).
- Few available transition models specifically address the needs of PLwD.
- Available models involve health care providers providing information and care to PLwD and any care partners.

# Community Resources

- Online and in-person support groups are available for PLwD, their care partners, and their families/children.
- Online support groups are widely available and are especially helpful for persons living in rural areas who do not have in-person groups.
- The resource segment of this module lists many government- and non-government-funded resources.

# Evaluation

1. **For persons living with dementia, why are transitions between home and acute care hospitals particularly difficult?**
   a. Persons living with dementia have a difficult time processing new information and stimuli.
   b. Any change in the environment can be difficult and trigger agitation.
   c. Medical records may not be readily available to identify the person as having dementia.
   d. All of the above

# Evaluation (continued 1)

**2. To minimize risk of re-hospitalization, what information should be provided to persons living with dementia and the care partners upon hospital discharge?**

a. Recommendations for necessary follow-up therapies

b. Clear instructions for all medications

c. List of providers who cared for persons living with dementia while in the hospital

d. Additional reading materials on depression and delirium

# Evaluation (continued 2)

**3. What should be included in discharge plans?**

a. Need for home health services
b. Dietary considerations
c. Instructions regarding exercise and physical or occupational therapy
d. All of the above

**4. Optimal discharge planning:**

a. Should be initiated at least a day prior to discharge
b. Should always involve the care partner
c. Should involve a home visit prior to the person being discharged
d. Should focus specifically on the abilities (or lack thereof) of the person living with dementia

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