

# **Transitions of Care**

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## **Introduction**

As the population ages, physicians will increasingly care for older adults with complex and often chronic health concerns. Providing a continuum of care for these individuals becomes the main responsibility of contemporary medicine. Over the last decade there has been significant growth in continuing care and the notion of “transitions in care”. As the trend continues, options for the care and residence of the aged become an even more important issue for government, families and the elderly themselves.

In their 1999 report, the Alberta Government appointed a Long Term Care Review Policy Advisory Committee and emphasized the need for continuing care services based on assessed needs. They recommended a single point coordinated access to continuing care services, supportive housing, and expanded home care services. This would require regeneration and creation of long term care centres, the development of models of care for special needs groups such as Alzheimer’s patients and the generation of incentives to elevate the numbers and value of competent human resources in continuing care.

Continuing care is the continuum of healthcare services delivered in three general streams in our region: home living, supportive living and facility living streams. Continuing care refers to a wide range of medical, social and personal care services that are needed by the elderly. Patients may require increased care needs during times of transition around hospitalization, injury, exacerbation of chronic illness or change in social support network. Community based services for the elderly have an important role to play and can delay or prevent a move to a higher level of care (e.g. facility living stream).

The concept of a continuum of care linking the community and institutions should be encouraged. Examples of community based services or programs available include home care, adult day support programs, day hospitals (START psychiatry) and CHOICE (Comprehensive Home Option of Inclusive Care in the Elderly).

The setting in which care is eventually provided is best determined by the patient’s preferences, their medical, social, financial needs and the family’s ability to meet these needs. The challenges and the complexity of providing care in continuing care settings demands that a physician possess a special clinical skill-set. Great medical acuity can arise in the context of less opportunity for diagnostic support, less available personnel for inter-current medical management and sometimes less ability for patients and residents to direct their own care.

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### “Discharge” Planning

Increasingly, “discharge planning” is viewed more as a continuum along a spectrum. For example, thinking of simply discharging someone from hospital versus transitioning from one setting to another (e.g. home to community). Thus, “transitions in care” is increasingly used in the language and should be considered in any situation of change.

This requires a certain level of knowledge of your patient: You need to know their social circumstances: where they are living and with whom and their primary and formal supports. You will also want to know if their primary caregiver is experiencing their own health issues or increased levels of stress. Safety, of the patient and caregivers is always an important component.

Secondly you need to know their function: BADL's and IADL's. Thirdly you will decide if the patient is likely to go home from the acute care setting where most of your exposure to discharge planning will occur. They may return home with or without home care services or additional programs, they may require follow-up by geriatrics or a family physician in a clinic setting, they may need additional rehabilitation or may require relocation directly from the hospital.

Quite often, in your training, the transition will be one from hospital to a variety of possible settings: home, home with home care (+/- lodge application, special programs), home with a plan for relocation from the community or relocation from hospital to supportive living, facility living or palliative care.

If a person is relocating to a higher level of care from hospital, the transition coordinator in that hospital will assess their level of care and make recommendations. The social worker and other team members will also be involved and the physician will complete an AAPI form. Certain tests such as urinalysis, recent CXR and mantoux testing are required. If a person is suitable for a Lodge this information will often be given by the social worker during hospitalization.

If a patient is relocating from the community, they would access home care (496-1300) and the community care management team (assessor = transition coordinator) would assess their level of care and make recommendations. Information about the private options can be obtained from a variety of sources (e.g. social worker, transition coordinator, home care, SAGE etc)

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### **Geriatric Outpatients**

Outpatient geriatric assessments are offered around Edmonton and the surrounding areas: UAH, GRH, MCH, GNH, NECHC, Westside PCN, St Albert, Sherwood Park, Leduc, Westview and the Good Samaritan's Seniors clinic. Their core component is a comprehensive geriatric assessment using our database. Different clinics will also take on management (GEM geriatric evaluation and management – MCH, NECHC, Westview, Westside PCN, Sherwood Park) and in home assessment (NECHC, Westside PCN, Sherwood Park, Westview, Good Samaritans). The Good Samaritans Seniors clinic also offers primary care. Most teams comprise of a dyad – physician and nurse with varying access to PT/OT/social work/pharmacist/dietician. These are accessed via a referral to central intake.

### **Rehabilitation**

There are inpatient and outpatient programs offered around the city. The Glenrose has 3 units where patients are transferred for more extensive rehabilitation after their medical issues have stabilized (4-6 weeks). Access to the Glenrose is via a consult to the Geriatric Consultation Service from the acute care site. The MCH and GNH have units where patients may have acute medical issues and be admitted from the emergency but are in the majority stable and require rehabilitation and assessment. Patients tend to spend 14-21 days on these units.

The RAH and UAH also have units whose main function is acute care of the elderly. Thus while emphasis is always on early rehabilitation they also focus on acute medical care and assessment. The admission criteria may vary slightly on each unit (e.g. admissions directly from ER).

Subacute offers an inpatient rehabilitation option. Patients usually complete their stay within 30 days. There is slow stream sub acute for longer stays (60/90). It generally caters to the less complicated elderly with few comorbidities and little cognitive impairment. The intent is for the patient to return home once the rehabilitation is complete. They are medically stable. Subacute is accessed mostly from acute care hospitals via Transition Coordinators.

The newest program is a 45 bed unit at Norwood called the Restorative Care Unit. The desired length of stay is 28 days and will provide rehabilitation for patients with potentially undifferentiated discharge location who need rehabilitation and convalescence.

Transition units are located within both acute care and community settings. They are accessed primarily by hospital patients and assessed by transition coordinators. Situations where someone

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may be appropriate for TU include medical stability but inability to return home (i.e. lengthy course of antibiotics, awaiting guardianship/trusteeship or awaiting arrangements for private care or modifications to home).

There are also outpatient rehabilitation options: SROP (Glenrose), CRIS program (Misericordia Hospital), community rehabilitation and homecare.

### **Day Programs**

The CHOICE (Comprehensive Home Option of inclusive Care of the Elderly) program is long term and aimed at the complex frail elderly who are bordering on needing nursing home or are high medical service users (repeat ER visits). The program physician becomes the family physician offering continuity for these complex patients. Home care services are also taken over by the program. There is access to a nurse 24 hours. They have respite and treatment beds again facilitating continuity of care. These beds are housed in long term care with limited access to lab/diagnostics, thus there is a limit as to what they can handle. However, uncomplicated cellulites, CHF, COPD etc can be treated. Patients can attend the CHOICE program up to five days per week. The program is accessed via home care (community) and transition coordinators (hospital).

Adult day support programs offer a 2 day a week program. There are 3 major types: medical/nursing, medical/rehabilitation (maintenance as opposed to active) and health maintenance/social. Information can be obtained from home care (case manager in community) or various team members in hospital (e.g. SW or transition coordinator).

The above programs have fees associated for transportation, meals etc.

### **Home Living Stream**

In our region, home living stream is the most independent and includes homes, senior's apartments and lodges +/- additional home care. The majority of seniors reside within this stream. More than 40,000 seniors in AB receive home care with more than 11,000 in Edmonton.

There are 2500 units in Edmonton with varying price ranges. Some are culturally oriented and you must be capable of independent living (e.g. transfers, mobility). Seniors apartments may or may not offer a central cafeteria and homemaking services. It often depends what other facility they may or may not be paired with. There is a current emphasis for there to be differing levels all

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in one place so patients can age in place. Lodges provide additional support with meals and housekeeping. Other services are often available for a fee. Additional home care can be obtained if needed. The Greater Edmonton Foundation operates the vast majority of Lodges. Rents are means assessed and can start as low as \$800. Lodges will often not accept patients directly from hospital. Patients are expected to be independent and they wish to see them regain that post discharge. Ultimately as patients decline at the lodge more and more services are offered to support them but they will not accept patients like this on entry as they will likely need another transition within a short space of time. Lodges have a separate application form that can be obtained from SW (in hospital) or various sources in community (e.g. home care, GEF, SAGE). A physician is often required to do a medical assessment.

Home care is available to those with specific care needs. All the services below are free. They are accessed via the Community Care Access line: 496 1300. They can be referred by a health care professional, caregiver or self refer. Home care can be short term (< 3 months), long term (> 3 months) or palliative/end of life.

Various team members provide scheduled services within home care (see below):

The main services provided are by HCA (health care aids) on a scheduled basis. They may provide am/pm care for washing and dressing, on a daily basis. They also provide bathing assistance, one or two times a week. They provide medication assistance up to four times daily. They can provide meal escorts for patients living in group environments developing visuospatial issues or reduced mobility. Lastly they provide respite for up to eight hours per week, usually four hours twice a week. RNs or LPNs may assist with medication, teaching, wound or stoma care.

Each patient is assigned a case manager. This role is filled by nurses, OTs and social workers. They perform an initial assessment with patients and their families and determine their needs. They may request assessments and treatment from other team members - occupational therapist (e.g. bathroom equipment, seating, home safety assessment), physiotherapist (e.g. gait assessment, pain, rehab) social worker (e.g. support programs, PD/EPOA counselling) or respiratory therapist (e.g. oxygen needs). Additional consultations can be made to nurse practitioners, enterostomal nurses, pharmacists, dieticians, regional mental health or regional palliative care.

The Home Living Geriatric Consult Team, provides in home specialized geriatric services on an urgent and semi-urgent basis. The home care case manager can request a referral to the team and linkages are made with the patient's family physician.

IADL services may be provided on a discretionary basis. E.g. meal preparation at lunch for a patient living with a working caregiver. However these are usually paid services.

### **IADL supports**

Depending on patients finances and wishes to remain in their own home all IADL's can be supported. Thus any additional services can be provided in the home such as shopping delivery services, meals on wheels, home making services and transportation (e.g. DATS, Driving Miss Daisy). Additional resources for safety can be obtained (e.g. Lifeline/Telecare).

Assisted livings are private, offer an apartment of rooms and usually run from \$1500-4000 or more per month. Private assisted livings have their own individual application forms. We often advise families and patients to do "informed shopping" if looking privately. Some facilities can manage patients with higher care needs (e.g. 1 PA). There is usually staff (i.e. HCA or LPN) on site 24 hours per day. Additional care may be supported by scheduled home care and individuals continue to pay for their medications. .

### **Supportive Living**

This encompasses various settings. There are care homes and designated supportive living facilities (AHS).

Supportive living care homes include: personal care homes, special care homes, family care homes and mental health approved homes. Care is usually 24 hours per day by a HCA and often provided in a family home environment to a small number of clients (e.g. 4-6). They provide IADL support: meals, cleaning, medications and some BADL help such as bathing. However, patients should sleep through the night and toilet themselves. The special care homes are designed for patients with complex needs or challenging behaviours. Mental Health Approved homes serve patients with mental health illness, often quite severe in nature.

The highest level of community based care is designated supportive living. In most cases, there is an LPN on-site available 24 hours for unscheduled care (i.e. personal or professional) in addition to scheduled personal care, often provided by the HCA. The care plan is created in collaboration with the site operator staff (i.e. LPN, HCA) by the Case Manager (AHS). The Case Manager (CM) works on the site during work hours and is most often an RN. If required, an RN is available after

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hours for clinical concerns (AHS) but is off site. The multidisciplinary team (i.e. PT, OT, NP) is available by consultation from the CM and are off site.

According to the new Living Options Guideline (2008), there are 4 levels of DSL. The highest level is SL4. Patients residing in SL4 require medical monitoring for complex comorbidities by LPN staff in addition to assistance with mobility (i.e. 1-2PA). There is an additional level of care (SL4D = Safe Living) for dementia patients who require a safe environment and specialized behaviour management. Many of these levels of care are integrated into large residential settings with various levels within a site.

Additional clinical support is available by consultation, including geriatric psychiatry and specialized geriatrics (GEM = geriatric evaluation and management). Due to medical complexity and limited mobility, many patients are seen by these consultants at the site in addition to their family physician providing home visits. AHS nurse practitioners also provide support for medical care, palliative care and speciality consult clinics (i.e. wound care, incontinence).

DSL is government subsidized (operator managed) and overseen by AHS. Access is through assessment by transition coordinators in hospital or home care.

The Seniors Association of Greater Edmonton (SAGE) provides a useful guide for seniors summarizing these different levels of care and listing the facilities. You can also check on the safety and accommodation standards for each facility.

### **Long term care and DSL accommodation fees in Alberta (Jan 2013)**

<b>Room Type</b>	<b>Rate/day \$</b>
Private	58.70
Semi private	50.80
Ward or Standard	48.15

### **Facility Living Stream**

This stream includes nursing homes and auxiliary hospitals. There are accommodation and health service standards that were revised in 2013. As in home care, a case manager is assigned to oversee care. All publically funded operators follow the standards. The health services are publically funded but fees are charged for accommodation (e.g. meals, maintenance).



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There are approximately 154 long term care facilities with over 16,000 beds. The largest is the Edmonton General. There are publically funded, volunteer (non-profit) and for-profit facilities.

Nursing homes provides 24 hour skilled nursing care in an institutional setting. For every person in the nursing home there are an estimated three persons with similar disabilities living in the community. Women use nursing homes about twice as much as men. This is probably because older women live longer, are much more likely to be single than men and women more readily take on personal care of their spouses. The average length of stay is 2 years with an average age of 84 years old. Estimates reveal that over half of patients have a diagnosis of dementia.

The characteristics predictive of admission to a nursing home include patients requiring 24 hour nursing care (RN): dementia and behavioural disorders (BPSD), dependency for BADLs, living alone, comorbid medical disease and complexity, caregiver burden, incontinence and terminal illness.

Within nursing homes, there are specialized programs. There are palliative care or hospice beds. Some nursing homes have special care units that provide services for specific needs such as Alzheimer's disease or ventilator dependence. Respite beds can be accessed for caregivers who require short term assistance (e.g. vacation, sick time away). This can be arranged via home care. There is also the long term care psychiatry program which offers consultative service to patients in long term care. Additionally, some transitions unit are also located within nursing homes. These units can be accessed via transition coordinators (hospital) for patients requiring additional support before discharge (e.g. wound healing) or with uncertain discharge destinations requiring minimal rehabilitation. They are medically stable.

### **The Role of the physician in the Long-Term Care Institutions (Administration)**

There is an increasing lack of physician involvement in institutions because of the perception of burden of care for individuals, travel time, distraction from office or hospital - based practice, low reimbursement and volumes of paperwork. If physicians adopted the principles of nursing home care, they would soon discover that the professional satisfaction of this activity is substantial and includes opportunities to make a difference in the patient's quality of life (1).

In Alberta, there is a standard that newly admitted patients or residents be assessed by the attending physician within seven days of care centre admission or within 14 days of care centre admission when the attending physician is the patient's or residents regular physician or has attended the patient or resident immediately prior to admission (e.g. in acute hospital setting). It

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is recommended that the attending physician visits his/her patients/residents at least once every month and ad hoc visits as the resident medical condition dictates. The attending physician is expected to ensure that each of his/her patients undergo a complete medical review during each 12 - month period of stay. A care conference occurs at 6 weeks after admission with the team, family and patient and is often used to set and clarify care goals.

Medications are no longer covered by Blue Cross and are under the formulary of the nursing home. Any over the counter or high cost medications may need special requests and guideline use review. Medication reconciliation occurs at admission to ensure goals of care and end of life care issues. Medications are to be reviewed every three months, usually by the physician and pharmacist.

The important conditions common in nursing home population include dementia, behavioural problems, depression, insomnia, delirium, falls, osteoporosis, pressure ulcers and wounds, incontinence, pain, and infections. Often patients have multiple chronic comorbid conditions. There is increasing focus on Best Practice Guidelines appropriate for nursing homes. Some examples are pneumonia pathways, UTI guidelines, med reconciliation, pain control and monitoring tools and appropriate end of life care. In our region there is a least restraint policy for both chemical and physical restraints. Numerous studies indicate that restraints increase incidence of falls, fall related injuries and reports of deaths related to restraints.

With the focus on improved quality of care, tools are to be implemented for data collection. The RIA MDS is the resident instrument assessment – minimum data set. It can be used to collate and compare data. The following areas may be monitored and evaluated (e.g. falls, incontinence, weight, oral and nutritional status).

Another important issue within communal living is infection control. Given the frail nature of this population it is essential to monitor and appropriately treat infection. Examples include influenza, Cdiff, outbreaks and vaccination programs (e.g. pneumococcal).

Wound care:

The pressure wound is the most common type of wound seen and is due to risk factors like limited mobility, diabetes and peripheral vascular disease. The staff should do risk assessment during admission and periodically using Braden scale. (Severe risk <11, moderate 12 - 14 and low risk >14). Management of wound care includes debridement, pressure relief, vascular assessment, antibiotics for infection and dietary management.


Sleep:

In an elderly patient there is less REM or slow wave sleep. Always consider medical and environmental causes for sleep problems, e.g.: pain, reflux, poly pharmacy. Demented patients may have an altered circadian rhythm and less threshold for coping with arousal and will often cause agitation. Sleep disorders include sleep apnoea, restless leg syndrome, periodic limb movement and REM behavioural disorder. Management of sleep problems includes sleep hygiene, avoiding long napping. Abrupt withdrawal of benzodiazepines may cause rebound insomnia. Non-benzodiazepines such as zopiclone and Starnoc can be used for a shorter period.

Pain:

The prevalence of chronic pain is high among nursing home residents. Chronic pain can be an unfortunate consequence of several degenerative diseases associated with aging, such as osteoarthritis, osteoporosis, spinal stenosis, vertebral collapse, sensory neuropathies and vascular insufficiency. People in pain are more likely to develop depression and depression also heightens the suffering caused by pain (2). There is a tendency for care providers to under-recognize and under-treat chronic pain.

**3 levels of care**

<b><u>Heavy care:</u></b>	<b><i>Facility Living</i></b> Auxiliary Nursing Home	 <p>Dependent</p>
<b><u>Intermediate care:</u></b>	<b><i>Supportive Living</i></b> Designated SL 1-4 (AHS) Personal Care/ Family Care Home	
<b><u>Light care:</u></b>	<b><i>Home Living</i></b> Lodge Care +/- HC Senior Apt +/- HC Dwelling +/- HC	
		Independent

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