Pathway Pearls

Discharge Planning

Smoothing transitions in care

2018Jun12

Alberta Health Services
Strategic Clinical Networks

Learning Objectives

- Review practice recommendations
- Discuss past and current community care initiatives with discharged patients (EZ INSPIRED 1.0, 2.0 & Virtual 2.0)
- Discuss challenges and solutions to improving transitions in care
- Identify 2 Pathway Pearls to assist implementation

Outline

- Recommendations
- Beyond the Hospital Doors: The future of discharged patients

  (Shelley Winton, BScN, MPS, RN)
- Group Discussion:

  Challenges and Solutions to transitions in care

  Primary Care Connections
- Wrap Up

2017 Comprehensive Update of the Canadian Cardiovascular Society Guidelines for the Management of Heart Failure (p. 1412)

- Care coordination is integral to the Chronic Disease Management model, which has been recommended as the preferred model for care delivery for CVD by the Canadian Heart Health Strategy Action Plan.

- Proper execution of care transitions from hospital to the community is particularly important, because patients with HF have high rates of readmission. Older patients with multimorbidity, frailty, and previous HF hospitalizations are at increased risk for readmission.

Slide Presentation

Discharge Planning:

Smoothing transitions in care

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Pathway Pearls: Discharge Planning

- A discharge planner within Red Dear Regional Health Complex? They function under the home care portfolio at RDRHC, so their job is to connect people with home care services to address their unmet care needs in order to return home.
- A recent small (104 patients) chart audit revealed that 38% of community family physician are aware that their patient has been admitted or discharged from hospital=not good for continuity of care, chronic disease timely follow up, etc.

Pathway Pearls: Discharge Planning

- Good discharge planning begins with decision to admit to hospital.
- Address concerns with patient and families soon.
- Make connections and familiarize patient/family with services in community that are goal focused, etc.

Discharge Planning: Into Community

Beyond the Hospital Doors:

The future of discharged patients

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INSPIRED 2.0

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Presentation

Alberta Health Services

Canadian Foundation for Healthcare Improvement
Fondation canadienne pour l'amélioration des services de santé

INSPIRED 2.0: Integration Breaths New Life into COPD Care

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INSPIRED

Background

- The **INSPIRED COPD Outreach Program ™** began in Halifax, Nova Scotia.
  - Designed to provide exemplary individualized needs and evidence-based interdisciplinary **support across care transitions** for patients and families living with COPD.

- CFHI facilitated - **INSPIRED 1.0** in Continuing Care – Home Living, Edmonton Zone
  - Results

INSPIRED 2.0 Goal and Eligibility

Goal: Scale and spread INSPIRED™ in the Edmonton Zone

- Identify eligible clients in acute care (Integrate the care pathway)
- Measure the effectiveness of the pathway.

Eligibility:

- Primary Diagnosis of COPD
  AND
- MRC Breathlessness Score 4-5
  OR MRC 3 and LACE score >10

- **OR** at least one indicator of advance COPD in the past year. Admissions for AECOPD: more than 1 admission, admission with ICU stay, or 3 ED visits.

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INSPIRED 2.0 Care Components

- INSPIRED 2.0 invites and engages the client in the planning for and understanding of their disease (Patient-Focused)
  - Care Providers: Case-Managers, Respiratory Educators and other Interdisciplinary Team members as required.
- Care Components match the COPD Discharge Bundle
  - Data elements complement discharge bundle data by adding some information about what actions are implemented.
- Transition and integration across the continuum – in continuous development as we find opportunities to streamline and communicate.

INSPIRED 2.0 Component Details

- COPD Action Plan (including Medication Optimization)
- Patient and Caregiver Education
- Referral to Pulmonary Rehabilitation (where appropriate)
- Advanced Care Planning and Goals of Care Designation
- Most Responsible Provider/ Primary Care Physician attachment and Specialist Collaboration
- Review of Immunization Status
- Review of Smoking Cessation Opportunities

Aims of INSPIRED 2.0 Collaborative

- Aim #1 - Creation of an **integrated care pathway** for COPD patients including:
  - Improvements in care transitions across the continuum of care, and
  - Improvements in quality of life for complex patients (including reductions in readmissions).

- Aim #2 – Evaluation of the effectiveness of the integrated care pathway. The evaluation period is January 2018 to March 31, 2019.

For More Information

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Discharge Planning Documentation

Transition to Community Care

Heart Failure Pathway: Transition to Community Care

Date *(yyyy-Mon-dd)*	**Time** *(hh:mm)*

Consultations (For all consultations, utilize the most appropriate/available health care provider(s) at your site to deliver services)

- ☑ Dietitian for assessment regarding sodium/fluid and malnutrition
- ☑ Pharmacist to optimize heart failure medication therapy
- ☑ Physiotherapy and/or Occupational therapy to screen for the following as necessary
  - Frailty
  - Cognitive status
- ☑ Transition/Discharge services if anticipate need at discharge

Heart Failure Education and Self-Care instructions – use teach-back technique to reinforce learning

- ☑ Provide approved Heart Failure education resources to patient/caregiver
- ☑ Education review prior to discharge
  - Heart Failure medication instruction to patient/caregiver
  - Dietitian to provide or arrange for education regarding sodium/fluid as necessary

Discharge Plan

h) Heart Failure Medicines					
2. Sodium/Fluid Intake ☐ Provider ☐ Dietitian ☐ Other, *specify* _____					
Prior to Discharge ***Review results and ensure appropriate follow-up***					
4. Frailty screen					
5. Cognitive screen					
6. Transition/Discharge services assessment					
7. Review and optimize heart failure medication					
8. Chest X-Ray					
9. Echocardiogram within the past 12 months Ejection Fraction _____ %					
At Discharge					
10. Complete discharge medication reconciliation					
11. Obtain BNP or NT-proBNP within 48 hours prior to discharge *(required for #12)*					
12. Complete 'LACE Index Scoring Worksheet' & 'Risk Stratification Worksheet' *(see Appendix 1 on Admission Orders)*					
13. Complete, review and provide 'Discharge Management Plan' – Reinforce "Red, yellow, green Action Plan" located on the back *(ensure adequate patient understanding)*					
14. Notify Heart Function Clinic or Specialist of patient discharge					
15. Arrange follow-up with Heart Function Clinic or Specialist within recommended timelines as per Risk Stratification Worksheet					
16. Notify Primary Care Provider of patient discharge					

Admission to Discharge Checklist

Participants are encouraged to participate in session talks.

If you would like to email your question, please send to:

hfpathway@ahs.ca