TRANSITIONS IN CARE: THE ABC'S OF ALC TO LTC

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Faculty/Presenter Disclosure

- Faculty: Dr. Maureen Gottesman

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Learning Objectives

- Describe the process of patient transitions from acute care to ALC to then LTC
- Identify common challenges during transitions of care leading to LTC
- Explore solutions to improve patient care upon admission to LTC

PATIENT TRANSITIONS

the transfer of a patient between different settings and health care providers during the course of an acute or chronic illness

(HQO, 2012)

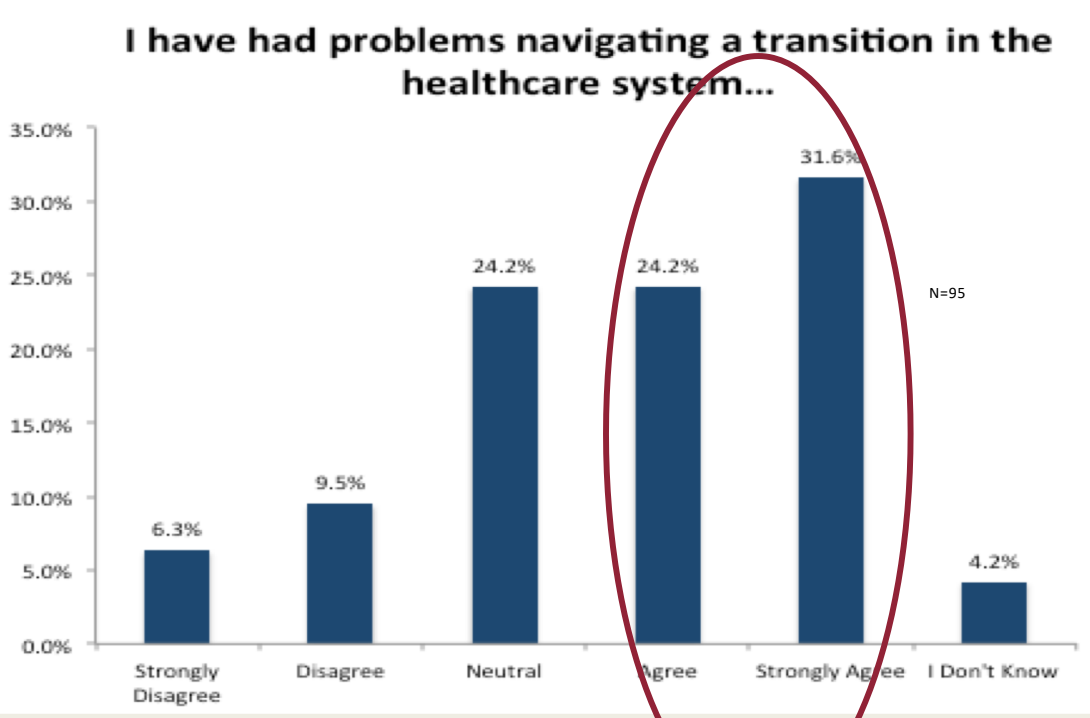
Hearing From Seniors – The Change Foundation

- Six focus groups across Ontario with patients and caregivers
  - *Tell us about your experience*
  - *Tell us what worked well*
  - *Tell us what didn't work well*
  - *Tell us what could be done to improve*

Cathy Fooks, The Change Foundation, 2012

Problems navigating healthcare transitions

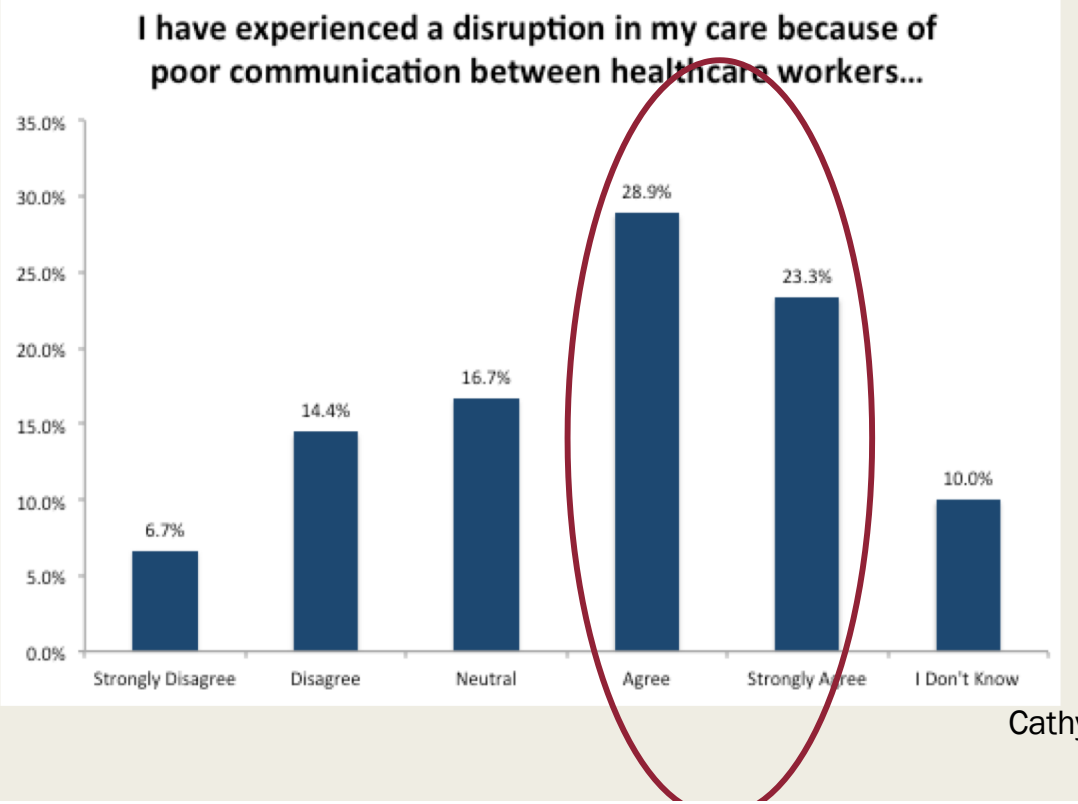
The majority (55%) of the participants in our in-person and online engagements told us that they had experienced problem navigating transitions; less than one-fifth (16%) said that they had not.



Cathy Fooks, The Change Foundation, 2012

Disruptions in care due to poor communication

Over half of participants said they had experienced a disruption in their care because of poor communication between health workers (about 20% did not)



Cathy Fooks, The Change Foundation, 2012

Transitions in Care: RELEVANCE for LTC Clinicians

- Info we have vs info we need
- Info we have access to vs info we access
- Our role vs the roles of others
- Other…

ALC

Alternate Level of Care

Alternate Level of Care - Defined

- "when a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting … the patient must be designated ALC at that time by the physician or her/his delegate" (CCO 2017).

TYPES of Inpatient Services where patient can be designated ALC (CCO 2017)

- Acute Care
  - *ICU*
  - *Non-Surgical*
  - *Surgical*
- Complex Continuing Care
- Rehabilitation
- Mental Health

FROM Alternate Level of Care TO... (CCO 2017)

- Short Stay
  - *Rehabilitation*
  - *Convalescent Care*
  - *Transitional Care*
  - *Complex Continuing Care*
    - Slow stream Rehab (LTLD)
    - Non Low Tolerance Duration (NLTLD)
- Long Term
  - *Palliative Care*
  - *Home (with/without services/programs)*
  - *Supervised/Assisted Living*
    - Retirement Home/Shelter/Supportive Housing/Group Home
  - *Long-Term Care Home*

Eligibility for Long-Term Care

(https://www.ontario.ca/page/about-long-term-care)

To live in a long-term care home, you must:

- be age 18 or older
- have a valid Ontario Health Insurance Program (OHIP) card
- have care needs including:
  - 24-hours nursing care and personal care
  - frequent assistance with activities of daily living
  - on-site supervision or monitoring to ensure your safety or well-being
- have care needs which cannot be safely met in the community through publicly-funded community-based services and other care-giving support
- have care needs which can be met in a long-term care home

Ontario LTC Utilization Report Feb 2019

(https://www.oltca.com/oltca/OLTCA/Public/LongTermCare/FactsFigures.aspx)

- 626 homes in Ontario
  - *58% privately owned, 24% non-profit/charitable, 16% municipal*
  - *About 40% LTC homes are small, with <96 beds*
    - 45% of small homes are located in rural communities - limited home care or retirement home option
- Bed Allocations:
  - *77,257 long-stay beds*
  - *669 convalescent care beds*
  - *321 respite beds*
- Approximately 300 LTC homes are older and need to be redeveloped (> 30K beds)

- **Average time to placement in LTC = 161 days (As of Feb 2019)**
- **Wait List for long-stay beds = 34,834 (As of Feb 2019)**

CHALLENGES & SOLUTIONS

Related to patient transitions

COMMUNICATION CHALLENGES

- Admission/readmission orders
- Past Medical History
- Vaccination history
- Goals of Care/Levels of Intervention

How to improve transitions: Communication

How can we better access information available to us?

- *Access old records from Fam Doc, From Ontario system*
- *Direct communication with families*
- *Engaging families along the way to be stewards in keeping records*
- *Best Practices in Medication History (aka- get all the info!) ** Compare Meds to Dx list!*
- *Other?*

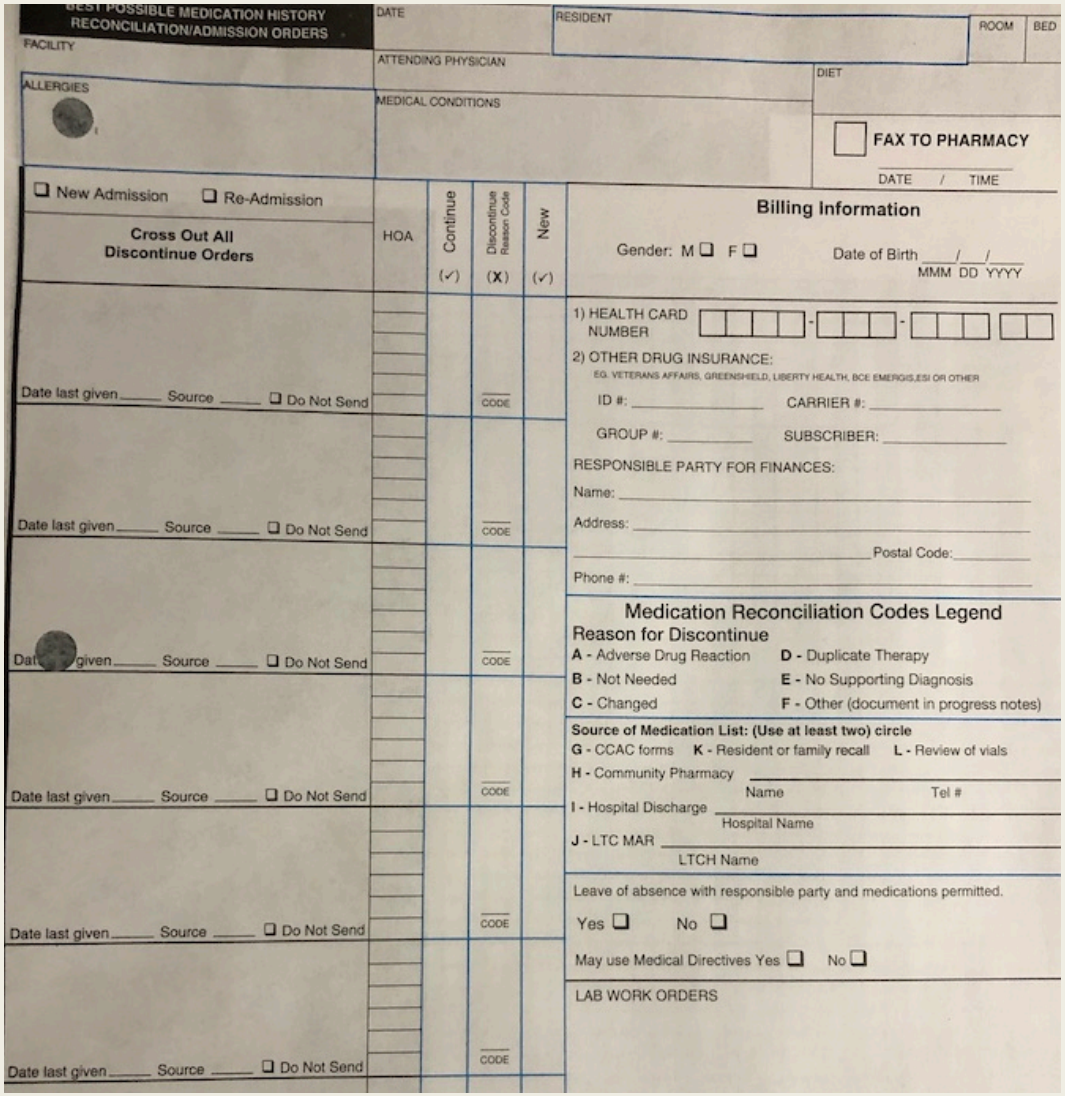
Best Possible Medication History (BPMH) (MOHLTC, 2011)

"A medication history obtained by a pharmacist of designate which includes a thorough history of regular medication use (Rx and non-Rx) using some or all of available resources…":

- *pt/caregiver interview*
- *Inspection of vials or med containers*
- *Review of medication list*
- *Community pharmacy*

LTC
Admission Orders

- Med/instructns
- Date Last Given
- SOURCE
- “Do Not Send”
- Cont/DC/New
- Medication Reconciliation Codes
- Sources of Med List



BEST POSSIBLE MEDICATION HISTORY RECONCILIATION/ADMISSION ORDERS

DATE | RESIDENT | ROOM | BED

FACILITY | ATTENDING PHYSICIAN | DIET

ALLERGIES | MEDICAL CONDITIONS

☐ FAX TO PHARMACY
DATE / TIME

☐ New Admission ☐ Re-Admission

Cross Out All Discontinue Orders

HOA	Continue (✓)	Discontinue Reason Code (X)	New (✓)

Date last given ____ Source ____ ☐ Do Not Send — CODE

Billing Information

Gender: M ☐ F ☐ Date of Birth ___/___/___ MMM DD YYYY

1) HEALTH CARD NUMBER

2) OTHER DRUG INSURANCE:
EG. VETERANS AFFAIRS, GREENSHIELD, LIBERTY HEALTH, BCE EMERGIS,ESI OR OTHER

ID #: ____ CARRIER #: ____

GROUP #: ____ SUBSCRIBER: ____

RESPONSIBLE PARTY FOR FINANCES:

Name: ____

Address: ____

Postal Code: ____

Phone #: ____

Medication Reconciliation Codes Legend

Reason for Discontinue

A - Adverse Drug Reaction
B - Not Needed
C - Changed
D - Duplicate Therapy
E - No Supporting Diagnosis
F - Other (document in progress notes)

Source of Medication List: (Use at least two) circle

G - CCAC forms K - Resident or family recall L - Review of vials

H - Community Pharmacy ____ Name Tel #

I - Hospital Discharge ____ Hospital Name

J - LTC MAR ____ LTCH Name

Leave of absence with responsible party and medications permitted.

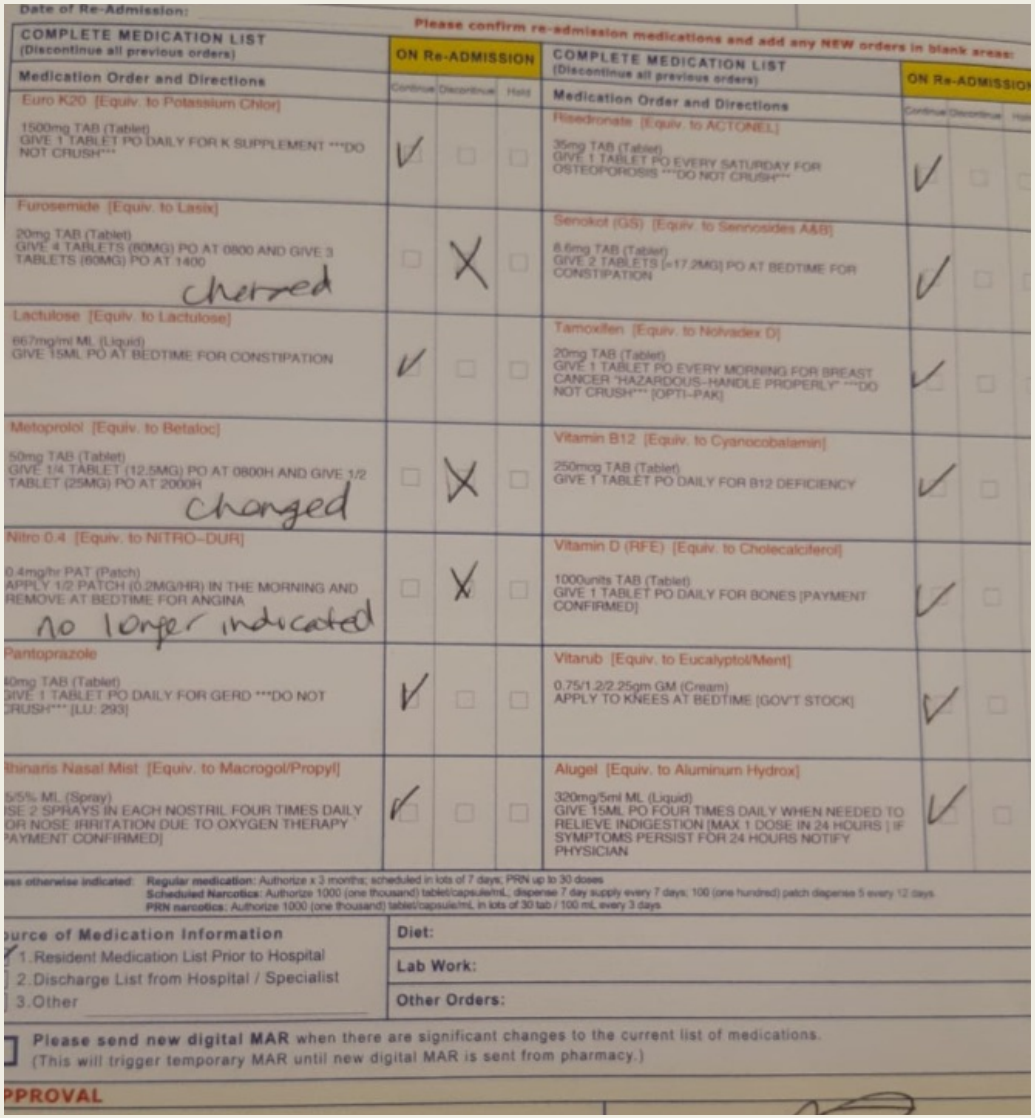
Yes ☐ No ☐

May use Medical Directives Yes ☐ No ☐

LAB WORK ORDERS

LTC Re-Admission

- Cont/DC/Change
- Source of Medication Information
- BLANK boxes for new/changed meds



Date of Re-Admission:

Please confirm re-admission medications and add any NEW orders in blank areas:

COMPLETE MEDICATION LIST (Discontinue all previous orders)	ON Re-ADMISSION			COMPLETE MEDICATION LIST (Discontinue all previous orders)	ON Re-ADMISSION		
Medication Order and Directions	Continue	Discontinue	Held	Medication Order and Directions	Continue	Discontinue	Held
Euro K20 [Equiv. to Potassium Chlor] 1500mg TAB (Tablet) GIVE 1 TABLET PO DAILY FOR K SUPPLEMENT ***DO NOT CRUSH***	✓			Risedronate [Equiv. to ACTONEL] 35mg TAB (Tablet) GIVE 1 TABLET PO EVERY SATURDAY FOR OSTEOPOROSIS ***DO NOT CRUSH***	✓		
Furosemide [Equiv. to Lasix] 20mg TAB (Tablet) GIVE 4 TABLETS (80MG) PO AT 0800 AND GIVE 3 TABLETS (60MG) PO AT 1400 changed		X		Senokot (GS) [Equiv. to Sennosides A&B] 8.6mg TAB (Tablet) GIVE 2 TABLETS [=17.2MG] PO AT BEDTIME FOR CONSTIPATION	✓		
Lactulose [Equiv. to Lactulose] 667mg/ml ML (Liquid) GIVE 15ML PO AT BEDTIME FOR CONSTIPATION	✓			Tamoxifen [Equiv. to Nolvadex D] 20mg TAB (Tablet) GIVE 1 TABLET PO EVERY MORNING FOR BREAST CANCER "HAZARDOUS--HANDLE PROPERLY" ***DO NOT CRUSH*** [OPTI--PAK]	✓		
Metoprolol [Equiv. to Betaloc] 50mg TAB (Tablet) GIVE 1/4 TABLET (12.5MG) PO AT 0800H AND GIVE 1/2 TABLET (25MG) PO AT 2000H changed		X		Vitamin B12 [Equiv. to Cyanocobalamin] 250mcg TAB (Tablet) GIVE 1 TABLET PO DAILY FOR B12 DEFICIENCY	✓		
Nitro 0.4 [Equiv. to NITRO--DUR] 0.4mg/hr PAT (Patch) APPLY 1/2 PATCH (0.2MG/HR) IN THE MORNING AND REMOVE AT BEDTIME FOR ANGINA no longer indicated		X		Vitamin D (RFE) [Equiv. to Cholecalciferol] 1000units TAB (Tablet) GIVE 1 TABLET PO DAILY FOR BONES [PAYMENT CONFIRMED]	✓		
Pantoprazole 40mg TAB (Tablet) GIVE 1 TABLET PO DAILY FOR GERD ***DO NOT CRUSH*** [LU: 293]	✓			Vitarub [Equiv. to Eucalyptol/Ment] 0.75/1.2/2.25gm GM (Cream) APPLY TO KNEES AT BEDTIME [GOVT STOCK]	✓		
Rhinaris Nasal Mist [Equiv. to Macrogol/Propyl] 0.5/5% ML (Spray) USE 2 SPRAYS IN EACH NOSTRIL FOUR TIMES DAILY FOR NOSE IRRITATION DUE TO OXYGEN THERAPY [PAYMENT CONFIRMED]	✓			Alugel [Equiv. to Aluminum Hydrox] 320mg/5ml ML (Liquid) GIVE 15ML PO FOUR TIMES DAILY WHEN NEEDED TO RELIEVE INDIGESTION (MAX 1 DOSE IN 24 HOURS) IF SYMPTOMS PERSIST FOR 24 HOURS NOTIFY PHYSICIAN	✓		

...us otherwise indicated: **Regular medication:** Authorize x 3 months; scheduled in lots of 7 days; PRN up to 30 doses
Scheduled Narcotics: Authorize 1000 (one thousand) tablet/capsule/mL; dispense 7 day supply every 7 days; 100 (one hundred) patch dispense 5 every 12 days
PRN narcotics: Authorize 1000 (one thousand) tablet/capsule/mL in lots of 30 tab / 100 mL every 3 days

...urce of Medication Information
✓ 1.Resident Medication List Prior to Hospital
[ ] 2.Discharge List from Hospital / Specialist
[ ] 3.Other

Diet:
Lab Work:
Other Orders:

[ ] **Please send new digital MAR** when there are significant changes to the current list of medications.
(This will trigger temporary MAR until new digital MAR is sent from pharmacy.)

...PPROVAL

ASSESSMENT CHALLENGES

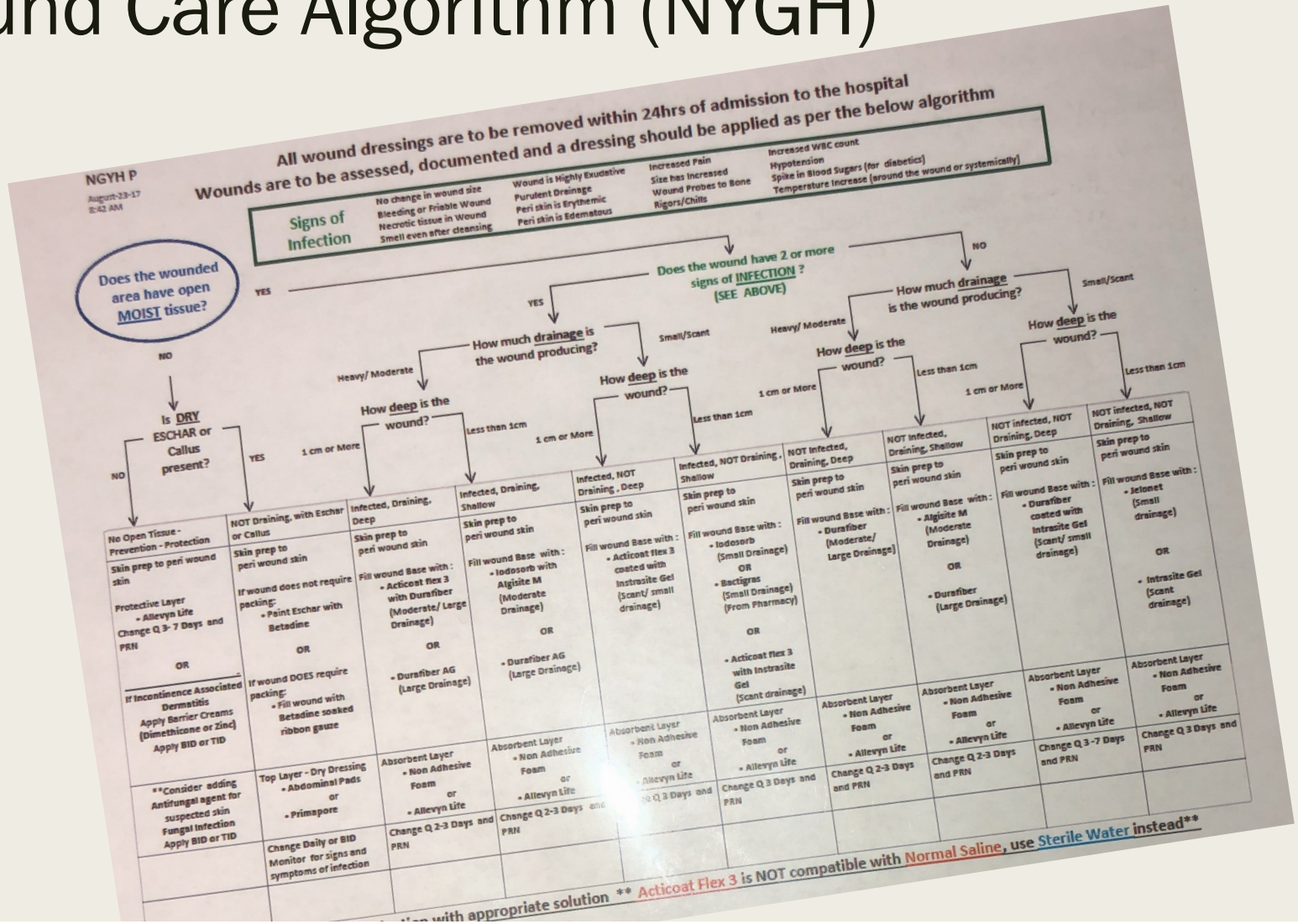
- Specialist consults/follow-ups
  - *When? Where? Who?*
  - *Do they NEED to be seen again?*
- Wound Management
  - *Algorithms for dressing orders*
  - *Tools to monitor progress*
  - *Dressing supply list (equivalence; formulary list)*

How to improve transitions: Assessments

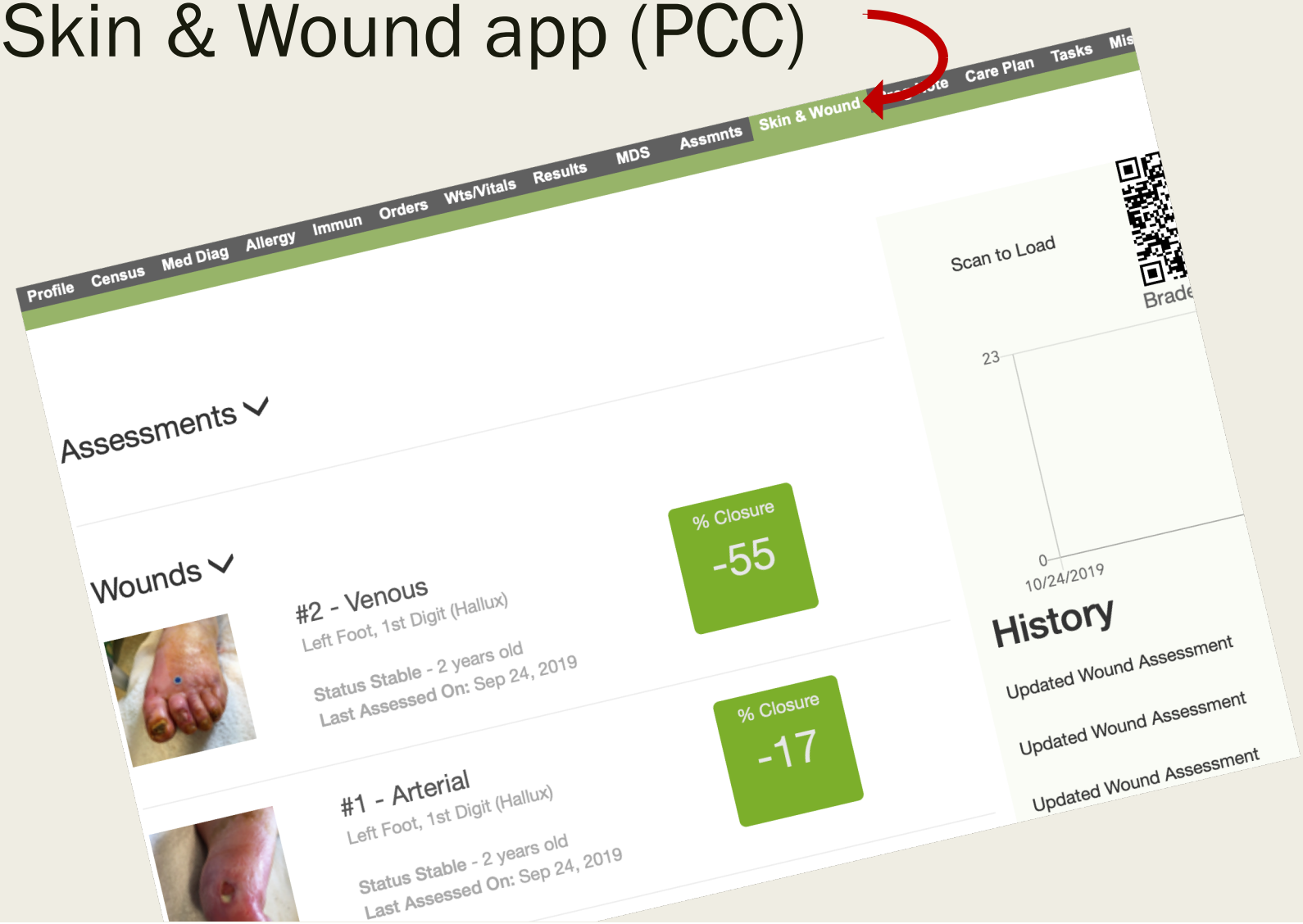
How can we assess patients and family needs better?

- *Discussing goals of care, values and wishes early on*
- *Reviewing meds/ treatments, specialists etc directly*
  - Use of eConsults
  - Access to In-house specialists/clinics
- *Hands on patient assessment vs by phone*
- *Use of established algorithms/assessment tools*
- *Other?*

Wound Care Algorithm (NYGH)



Skin & Wound app (PCC)



Pressure Ulcers: Classification of Wound Dressings

(SR Tan 2017 myrxfiles.ca)

Dressing	Dressing Characteristics	Wound Types
Transparent film dressings Bioclusive, Opsite, TegaDerm	Semi-permeable, highly flexible dressings that reduce evaporative water loss, provide good antibacterial barriers and reduce shearing forces.	Superficial wounds, abrasions and partial-thickness wounds.
Gauze dressings Adherent: 4×4 Non-adherent: Release, Telfa	These dressings débride, but are painful upon removal unless moistened first. Must be secured in place.	Partial- or full-thickness wounds with necrotic debris or covered with antibiotic ointment.
Hydrocolloid dressings Comfeel, DuoDerm, Restore	Available as composite sheets with a hydrophilic polymer and a water-impermeable vapour-transmitting backing or in paste form. They are occlusive and provide an excellent barrier. Wound exudate is absorbed and a gel is formed that expands into the wound cavity. Promote autolytic débridement. Usually require less frequent changes.	Both partial- and full- thickness wounds, especially superficial wounds.
Hydrogel dressings DuoDerm gel, Intrasite gel	Three-dimensional networks of hydrophilic polymers made from gelatin and polysaccharides. Absorb exudate with medium capacity and provide cooling and pain relief. Promote autolytic débridement and granulation. Can both absorb fluid and hydrate desiccated eschars.	Full-thickness wounds with or without undermining. Consider using as a filler beneath a hydrocolloid dressing in deep ulcers.
Xerogel dressings Aquacel, Kaltostat	Dry dressings with high absorptive capacity that change into a gel-like substance upon contact with wound exudate. After the exudate is absorbed, xerogels act similarly to hydrogels in facilitating moist wound healing. Alginates (xerogels with hemostatic properties) are also procoagulants and can be used to obtain hemostasis in oozing wounds.	Full-thickness wounds with slough, with or without undermining.
Foam dressings Allevyn, Cutinova, Mepilex	Polymeric dressings that maximize absorbency and vapour permeability to provide optimal exudate handling. May be combined with a water-impermeable but vapour-transmitting backing to allow vapour loss. When the exudate contacts the backing, evaporative loss facilitates exudate control. Expansion of the foam as it absorbs exudate creates gentle pressure on the wound, possibly reducing wound edema.	Full-thickness wounds with exudate. Can be used around wound drains and tubes or over incisions.
Enzymatic dressings Collagenase	Enzymatic dressings apply topical débriding agents to devitalized tissue on the wound surface. A clean moist dressing should be applied over the ulcer after enzyme application.	Wounds with eschar.

How to improve transitions: Teams

How can we recognize others in the circle of care to benefit patient care?

- *Trust with front line clinical staff*
- *Collaborate care with pharmacists, other members of team incl. pt/family*
- *Attendings care conference with whole team*
- *Other?*

How to Improve Transitions: 4 Change Concepts (HQO, 2012)

1. Conduct individualized care and discharge planning
2. Assess post-transition risk of readmission and arrange appropriate discharge follow-up
3. **Reconcile medications at key transition points**
4. Strengthen health literacy – help the person develop the knowledge and skills to independently manage their care

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Please remember to
complete your evaluations.

Evaluations can be found on
the Mobile App.

Thank you.