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Transitions of Care—Leaving the hospital: the concerns of complex chronic disease patients

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Background

Chronic Disease

- Chronic disease makes up 60% of the global disease burden (WHO, 2005)
    - 70% of the population over the age of 45 has two or more chronic conditions in Ontario (MOHLTC, 2007)
    - Chronic disease is estimated to be 55% of total health care costs (MOHLTC, 2007)

- Complexity Challenges
    - Long-time illness with ongoing care needs
    - Heavy users of health care system
    - Health problems related to multi-morbidities, functional impairments, mental health problems, addictions and social vulnerabilities (Lyons et al., 2012)

Background

Transitions of Care

- Bridgepoint Hospital, Toronto, ON
  - Bridgepoint Study: mixed-method large scale study, 2011, analysis of in-patient population's characteristics, needs and experiences
  - **Transitions are problematic—patients need more support during admission and discharge** (Lyons et al., 2012)
- Transitions of care is a vulnerable process for patients (Kuluski et al., 2013)
  - Adverse events, low satisfaction of care, re-admission (Naylor et al, 2008)
  - Interventions: discharge checklists, questionnaires, provider-to-provider handoff tools (Coleman & Chalmers, 2006; Doran et al., 2013; Graumlinch, Novotny & Aldag, 2008; Halasyamani et al., 2006; Weiss & Piacentine, 2006)

Objective:

Determine the key themes about discharge concerns from the perspective of complex chronic disease patients

Research Question:

What are the issues and concerns complex chronic disease patients have about hospital discharge?

Methods

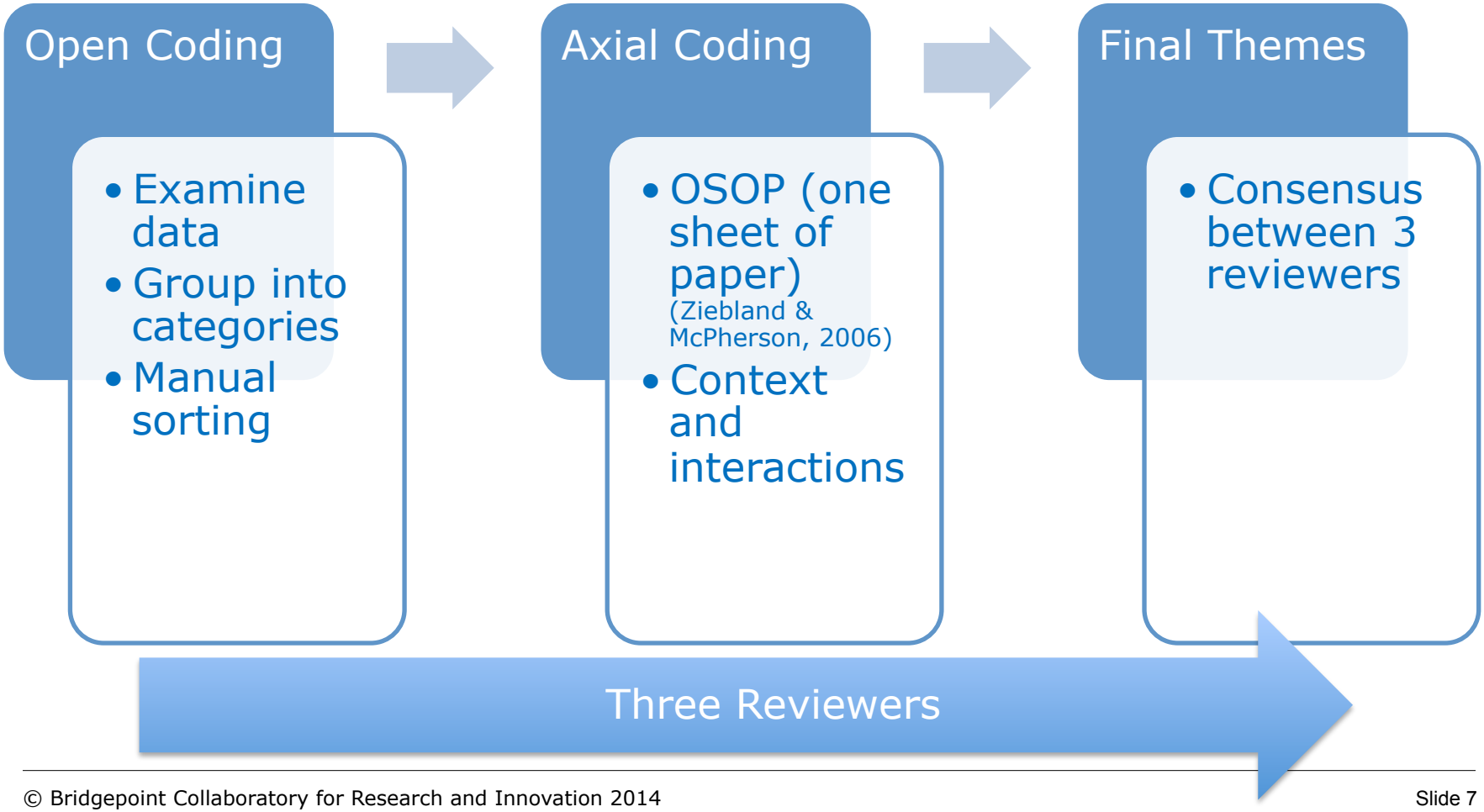
- Setting:
  - Bridgepoint Hospital (Toronto, ON)
- Purposeful sampling
- N=116
  - 42% male
  - 13% under 44 years old, 52% between 45-64 years old, 46% older than 65 years old
  - Mean age=63, Range=19-96
  - 89% Caucasian
  - Average of 5 health conditions (25% had 7-12 conditions)
  - Average length of stay (at time of interview)=162 days

Methods

- Data collection:
  - Self-designed survey, closed and open ended questions (Kuluski et al., 2013)
  - NVivo Node Report

- Study Design:
  - Secondary Analysis
  - Qualitative Description (Sandelowski, 2000)

Methods
Data Analysis



Results

Process

- Uncertainty in the care plan
- Friction in the provider-patient relationship
- Premature discharge

Consequences

- Loss of comforts and security in the hospital
- Care burden on family
- Adverse events at home
- Uprooting Life

Needs

- Home care supports
- Accessible home
- Management of daily activities

Results

Patient Characteristics

- No apparent demographic trends in any of the themes
  - Different age groups, both sexes, different martial status groups, range of number of health conditions, length of stay, represented across three themes
- Some patients had multiple concerns represented in two or more themes
- A small proportion of patients reported **no concerns**:
  - Tended to be younger, fewer health conditions, shorter lengths of stay (at time of interview), more likely to have a partner

Theme 1: Process

Theme 1: Process

Example Quotes

Uncertainty in the care plan:

"I'm scared of the fact that I don't know what I'm anticipating when I come home….Scared of the fact that just in general, that I honestly don't know what's going to happen to me after May 16 when this cast comes off."

Friction in the patient-provider relationship:

"…in one ear and out the other"

" ...what I'm saying is that I am getting a strong kind of a push out of here by the doctor, and down from there."

Theme 1: Process

Example Quote

Premature discharge:

I: "Do you feel ready to go home?

R: "Not ready but you know, the doctors say you are ready so I am going to go home. But I don't think I'm ready."

I: "Why do you feel that you're not ready to go home?"

R: "I got the impression that they brought me here, and they say, okay, physiotherapy, they will make you walk and you will go home. So no, I think I'm going to go that way. I think I'm going to go back home with my crutch and come back and take physio…"

Theme 2: Consequences

Theme 2: Consequences

Example Quotes

Loss of comforts and security of the hospital:

"In the sense of having people to talk to all the time, yes. Because I talk to a lot of people around here, and I'm going to miss that. Of course I prefer to be healthy and have a nice place to live but the atmosphere here is pretty good, and I'm going to miss it."

Adverse events at home:

" And the possibility of slipping, and because I live alone, nobody would even know I have fallen. So that is the big issue for me…I'm afraid of falling, yes."

Theme 2: Consequences

Example Quote

Burden on family:

"And I'm not sure my partner can cope with the strain of looking after me."

"My father, he can't 100% do this for me. He's way too old and he's too weak. He can't bend down or anything. My mother has cognitive issues. So sometimes she's there and sometimes she isn't."

Theme 2: Consequences

Example Quote

Uprooting Life:

R: *"I was upset. I didn't want to go to an old aged home. I mean who would? I don't feel like I belong there. I don't feel that's the place I belong."*

I: "Remind me how old you are."

R: "56"

Theme 3: Needs

Theme 3: Needs

Example Quotes

Home care supports:

"Well, I've had a tremendous amount of stress attempting to get one home service that's coming to bath me once a week."

Accessible home:

"So there are a lot of stairs. So that was my main worry going home, is like can I do the stairs?"

Theme 3: Needs

Example Quote

Management of daily activities:

"And now they are sending me home at the end of the month and I'm completely alone. And I don't know, the daytime I am not afraid but at night, how am I going to the bathroom? I am unable to stand, unable to walk."

Conclusions

- Patients did not feel like active participants in the care planning process
  - Anxiety about being "pushed" out of hospital
  - Lack of clarity in communication from care providers

- Patients anticipated major life changes after discharge
  - Relocation (i.e. long-term care placement)
  - Loss of independence, relying on others for daily support

- Patients felt secure in the hospital and leaving was a uneasy prospect
  - Particularly for people without a support network (live alone)
  - Concerned about managing daily activities at home

Future Research

- How can this framework (process, consequences, needs) be applied to discharge planning?
    - Patient-centred care plans (Perkins et al., 2012)
    - Increasing home and community supports

- New models of care to address complex chronic disease population
    - System Navigator (TCM (Naylor et al., 2013), TDM (Forchuk et al, 2007))
    - Integrated Care (GRACE model (Aliotta et al., 2008))

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