

Managing the Seams: Care Transitions for Older Hip Fracture Patients

Paul Stolee, Jacobi Elliott, Bert Chesworth,
Joanie Sims-Gould, Dorothy Forbes
and the InfoRehab Team

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IRT Team

Investigators

- Dr. Dorothy Forbes, U. of Alberta
- Dr. Christine Ceci, U. of Alberta
- Dr. Joanie Sims-Gould, UBC
- Dr. David Hogan, U. Calgary
- Dr. Katherine Berg, U. of Toronto
- Dr. Bert Chesworth, Western U.
- Dr. Mary Egan, U. of Ottawa
- Dr. Susan Jaglal, U. of Toronto
- Dr. Claire-Jehanne Dubouloz, U. of Ottawa
- Dr. Ann Cranney, U of Ottawa
- Dr. Jennie Wells, Western U.
- Dr. Kerry Byrne, U. of Waterloo
- Dr. John Hirdes, U. of Waterloo
- Dr. Richard Cook, U of Waterloo
- Dr. Mu Zhu, U. of Waterloo
- Dr. Jeff Poss, U. of Waterloo

IRT Team

Graduate Students

- Jacobi Elliott, Helen Johnson, Justine Toscan/Giosa, Brooke Manderson, Heather McNeil, Joshua Armstrong, Emily Piraino, Christine Glenney, Jordi McLeod, Eric Sadowski, Liz Lusk

Undergraduate Students

- Katelyn Godin, Stephanie Hinton, Claire Lafortune, Kavitha Spriparamanathan, Heather Drouin, Geoff Hooper, Andrew Noakes, Sarah Jiwa, Kayla Bilodeau, Samantha Black, Allie Harrison

Staff

- Sheila Bodemer, Selena Santi, Josephine McMurray, Katie Mairs, Brandie Steeves, Stephanie Filsinger, Beth Hicks, Thea Franke, Sheila Cook

Outline

- **Background:**
 - Complex Patients & Complex System
- **The InfoRehab Transitions Study**
- **Study Results**
 - Patients, Families, Health Care Providers
- **Where to from here?**

Complex Patients

- Frail older patients, such as those who have had a hip fracture, are high users of the health care system
- Complex medical conditions, multimorbidities, cognitive impairment, and stressed caregiving networks are common

Complex System

Falling Through the Cracks

(Coleman, 2003)¹



- “Although patients with complex acute and chronic care needs experience heightened vulnerability during these transitions, systems of care often fail to ensure that the essential elements of the patient’s care plan that were developed in one setting are communicated to the next....Indeed, practice settings often operate as ‘silos’” (pp. 549-50).



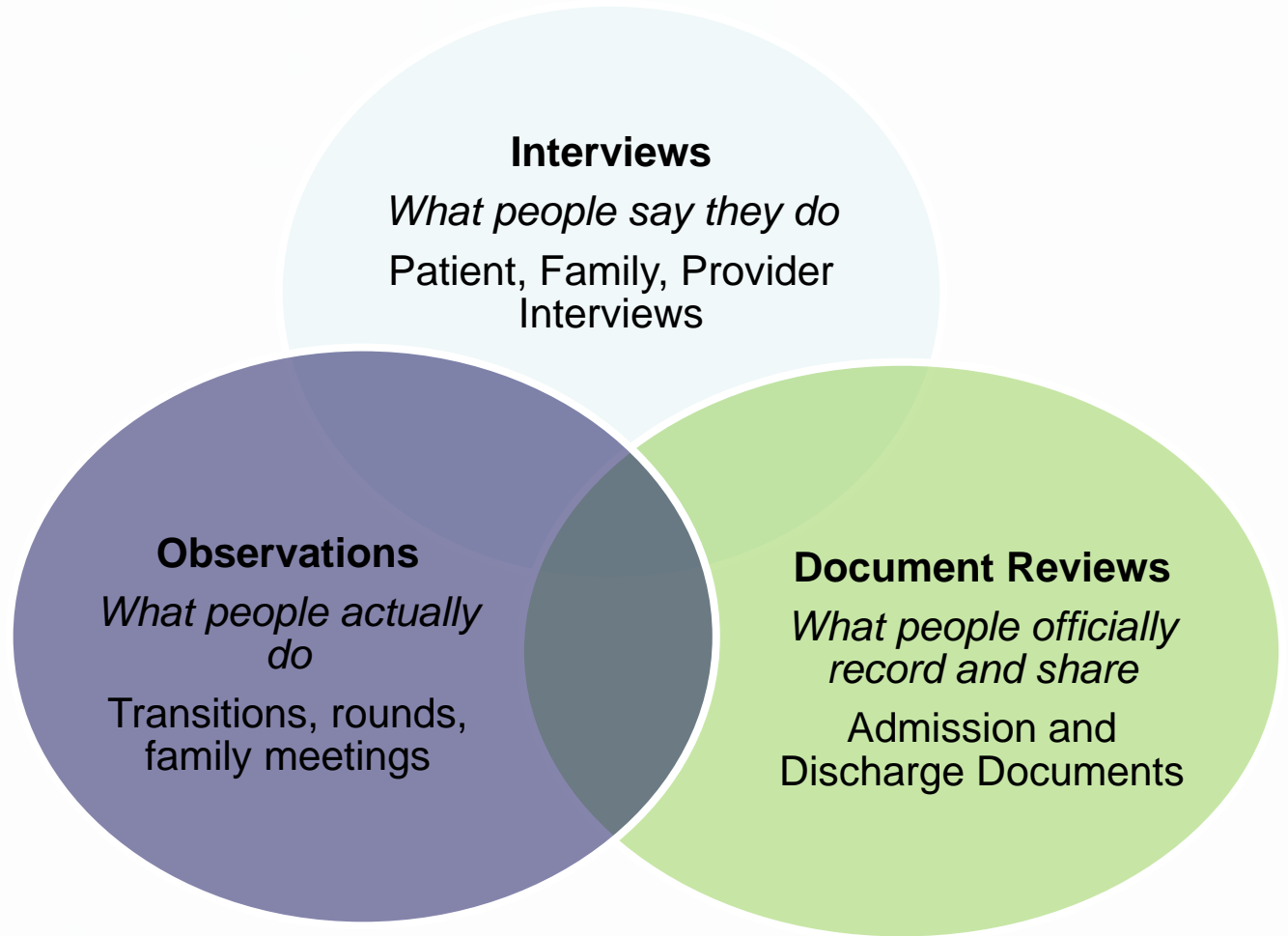
The InfoRehab Transitions Study



Methods

- **Objective:** Explore information need, use, and sharing at points of transition across the health care system from the perspective of patients, their families, and health care providers
- Ethnographic approach
- Focus on hip fracture patients

Multiple methods of data collection

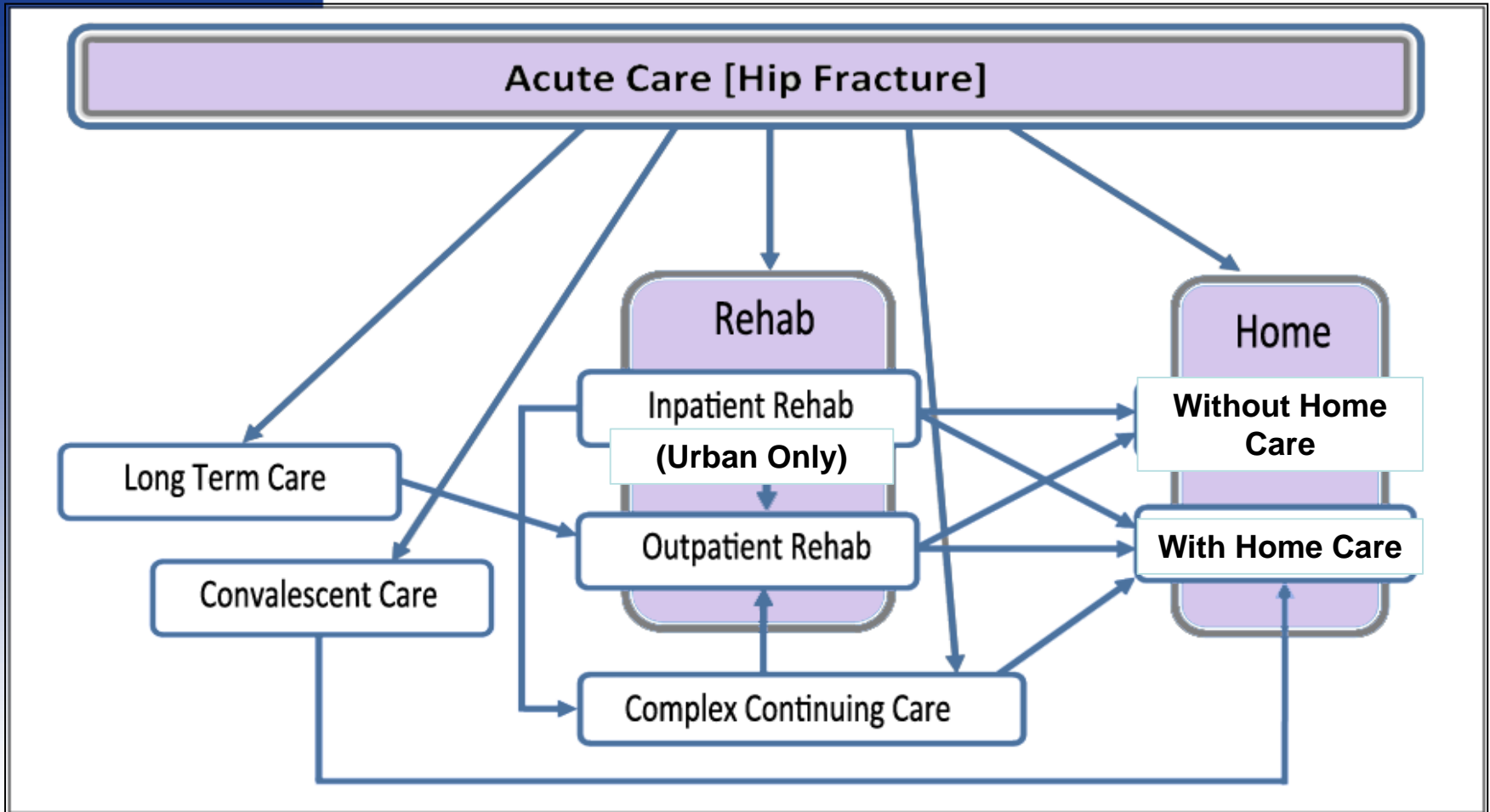


Study Sites

- Mid-Size City
 - Acute Care & Rehab Hospitals
- Rural
 - Small Rural Hospital
 - No rehabilitation unit
- Large Urban
 - Population 600, 000
 - Large Hospital with Rehabilitation Centre



Possible Care Transitions (~2/patient)



Cross-Site Interview Sample

	Urban		Mid-Size		Rural		Total	
Participant group	# of participants	# of interviews	# of participants	# of interviews	# of participants	# of interviews	# of participants	# of interviews
Patients	6	21	6	9	11	21	23	51
Informal Family Caregivers	5	5	6	9	8	10	19	24
Healthcare Providers	32	36	36	36	24	24	92	96
Total	43	62	48	54	43	55	134	171

Participant Characteristics

Patient Demographics

Study Site	Mean Age	% Female	% Living Alone
Waterloo	83 yrs	50%	83%
London	80.4yrs	72%	46%
Vancouver	82.8yrs	67%	67%

Family Caregiver Demographics

Study Site	Mean Age	Family Caregiver Role
Waterloo	40-70yrs (range)	83% Child, 17% Spouse
London	57.5yrs	75% Child, 25% Spouse
Vancouver	41-85yrs (range)	20% Child, 40% Spouse, 40% Other Relative

Participant Characteristics

Health Care Providers

	Urban	Mid-Size	Rural
Physiotherapy	7	5	9
Occupational therapy	7	6	1
Nursing	6	16	9
Primary care physicians	1	1	1
Case management	3	7	1
Social Work	3		
Orthopaedic Surgery	1		2
Rehab Assistants	1		
Administrative	3		
Kinesiology		1	
Care aide			1
TOTAL # of Participants	32	36	24

Data Analysis

- **Emergent Coding:**
 - Line by line coding to identify themes
 - Like-themes grouped together
 - Multiple coders
 - NVivo 8 used for coding data

Findings: Patients

- Patient Complexity
- Patient Engagement

Patient Complexity

- Makes care trajectories uncertain:

“It kind of works out that nobody is for sure going anywhere” (acute care provider)⁵

Patient Complexity

- Expands the circle of care, with benefits & challenges:^{5,6,10}
 - Increased family involvement
 - Multidisciplinary expertise
 - Communication challenges / staff rotations / diluted ownership

***“admitting messed up... so it wasn’t our doing”* (Registered Nurse)¹⁰**

Patient Engagement

- Patients often not involved in decision-making

***“You do what you’re told to do, and they say ‘we’re going to do this’ and they do it:*
(patient)¹⁰”**

***“They gave me a slip yesterday saying you’re going to be discharged on [date]. That’s it you know. The hell with you, whether you want to or not or whether you feel you’re ok...”*
(patient)¹¹”**

- Helps to have a health care background¹³

Patient Engagement

- May be given “the illusion of options”:

“She was a little bit unrealistic” (health care provider)³

“And so the team often has to play the role in helping the family, not convince the patient, but explore with the patient the realities of what they’re facing when they go home. And the other one is where...sometimes we do have families who may not be realistic about their loved one’s abilities or expectations of care, or what we can provide for them.” (health care provider)³

Patient Engagement

- Are often not prepared:

“I know we’ve had people fall through the cracks, kind of waiting to see...what do I do now, I’m home and I have all these medications, I’m starting to have problems with them, who do I go to?” (case manager)¹⁰

Patient Engagement

- And may disengage:

“I was just sort of running on neutral. I didn’t know what to do...I didn’t know what was going on. For somebody that has always been in control, I find that very, very difficult.”

(patient)¹⁰

Findings: Care Providers

- Information sharing
- Information systems
- Working around the system

Information Sharing

- Health care providers didn't always provide important information to patients and families or involve them in care

“I didn't speak with the daughters. They didn't contact me. If they want any information I'd wait for them to ask for it” (Health Care Provider)²

- Information was not always shared with the next care provider

Information Systems

- Electronic systems are generally helpful, but not always available:

“Sometimes we don’t even get a verbal report from the nurse, so all of a sudden the patient just shows up and we’re like, OK, we had no idea that they were coming.” (LTC provider)⁵

“Often when they send a referral over they send it very skimpy thinking we can pick up all our information off the computer. Sometimes we can, sometimes we can’t.” (Rehabilitation provider)⁵

Information Systems

- Are not always popular:

*“I hate it. Oh my god, I absolutely hate it. It’s not that I’m anti-computer because I’m young and I know how to work computers. I feel it’s best to document in handwriting. Yeah, it’s quicker and faster, but I have the biggest fear in the back of my head that these computers are going to crash, and they try to tell you that it’s backed up somewhere, but I don’t know.”
(occupational therapist)⁶*

Information Systems

- May be seen as a challenge to professional autonomy:

“every single nurse documents differently. I find this EMR takes away our autonomy. We want to give the patients autonomy; this is taking away our own autonomy...each person documents different and if you’re just having documentation within defined limits, you’re taking away.” (Occupational therapist)⁶

Information Systems

- May involve duplicate systems:^{6,7}

“I think computer and paper records are fraught with error and I don’t think the two should be used – you should be moving to one, or stick with the other.” (Physician)⁶

- And duplicate assessments:

“If someone admitted my patient I’d go in and do the same thing. Do a complete head to toe and just because they did it and things were fine, doesn’t mean I didn’t see that. So, I’ll do another one.” (Nurse)⁶

Information Systems

- The fax machine is alive and well, and living in health care:

“so we don’t always get everything paperwork wise.... most of the time they send that stuff back with them [the patient]...um, if we need anything we call over there and they will fax us whatever we need” (health care provider)

“They’re not on the computer system yet...we’ll fax through the pre-discharge form to the receiving health unit...there is a lot of faxing that goes on.” (health care provider)⁶

Working Around the System

- For transitions to work well, health care providers often have to be investigators:

“I search for documentation, previous social work notes, or geriatric or geri-psych consult, to get an idea, some background on the patient. And we use Google Map and Street View – that way we can see the building ... so we know what we’re facing for the start.”
(hospital social worker)⁹

Findings: Families

- Goal of both families and health care providers is to receive information rather than provide it:
“there was no history of dementia that I saw from the notes. So I had really no reason to speak with his family members.” (community case manager)²

Findings: Families

- Often need more information than they receive:

“we hadn’t even heard she’d been moved...we had no idea she was being transferred” (family member)

“No booklet or pamphlet...I didn't know about how he was supposed to bend and not bend.”
(family member)⁴

Where to from here?



Transitional Care Programs: Who is Left Behind? (Piraino, et al., 2012)⁸

- Systematic review of 15 RCTs of transitional care programs to identify which patients were included or excluded
- Many studies of transitional care programs exclude (or do not describe) older persons with major risk factors for hospital readmission, e.g., cognitive impairment, multiple comorbidities, polypharmacy, and depression

Where to from here?

- Consider patients and families as part of the care team
- Two-way information exchange, and feedback loops
- “Cross-setting teams” – improve understanding of, and communication with, other care settings

Where to from here?

- System-level solutions which enable consistent information collection and sharing
- Supports for system navigation
 - while we await an integrated system, and to inform development of an integrated system

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Thank You!

- InfoRehab Website:

<https://uwaterloo.ca/geriatric-health-systems-research-group/research/inforehab>