

Facing the Facts

Issue

HOSPITAL-TO-'HOME' TRANSITIONS FOR PATIENTS/CAREGIVERS

Better co-ordination, communication needed to improve patient experiences/choices

Facts

- Ontario patients often remain in hospital when they should receive care elsewhere. There were 600,000 'alternative level of care (ALC) days' in Ontario in 2005; 36% involved delays with patients waiting to be transferred to a long-term care (LTC) home, and 22%¹ involved delays with patients preparing to return home. The occupancy rate for LTC beds increased to 98% over the last three years.² Discharge delays, driven by a lack of community services, poor collaboration and communication and inadequate information for patient decision-making, affect all patients/caregivers and cause organizational, financial, and system-wide problems.
- From admission to discharge 'home', patients go through more than 230 steps³—interactions with different care providers, LTC assessments, notifying Community Care Access Centres, choosing where to relocate, etc. Along the way, patients/caregivers must repeat their stories over and over again.
- In 2006, there were almost 1 million discharges⁴ from Ontario hospitals: 255,000 patients to in-home care⁵; 44,000² to LTC homes, 10,000 for the first time. Discharge planners spend 80% of their time with 20% of their patients defined as hard-to-place—patients dependent on dialysis, suffering from complex conditions, including chronic mental illness, or seeking culturally-specific accommodation/care. On average, a complex continuing care patient waits for a LTC bed for 62 days.⁶ Some LTC homes accept patients on specific days only or don't take placement requests daily. In other cases, clear communication with patients/families—around discharge times or transportation needs, for example—is missing.
- Sixteen per cent of home-care⁷ and 64% of LTC patients⁸ suffer from Alzheimer's disease, other dementia, or mental disorder and require their family caregivers' active participation in decision-making. Once one of their three preferences becomes available, patients destined for LTC homes have 24 hours to decide and five days to move.⁹
- Resource constraints have led to service reductions, particularly in personal support (fewer hours for palliative patients, home-making, in-home respite, Meals on Wheels, etc.) Without sufficient in-home services, unnecessary readmission to hospital can occur. An estimated 23 % of patients discharged from hospital to home experience at least 1 adverse event; 12% are preventable; 12% lead to hospital readmission; 72% are due to medication errors.¹⁰

Response

The Change Foundation and OACCAC project, *Having their say & choosing their way: helping patients and caregivers move from hospital to 'home'*. It will map transition problems and consult patients/caregivers about their hospital-to-'home' journey. The South East CCAC and Quinte Health Care Trenton Memorial are the first sites.

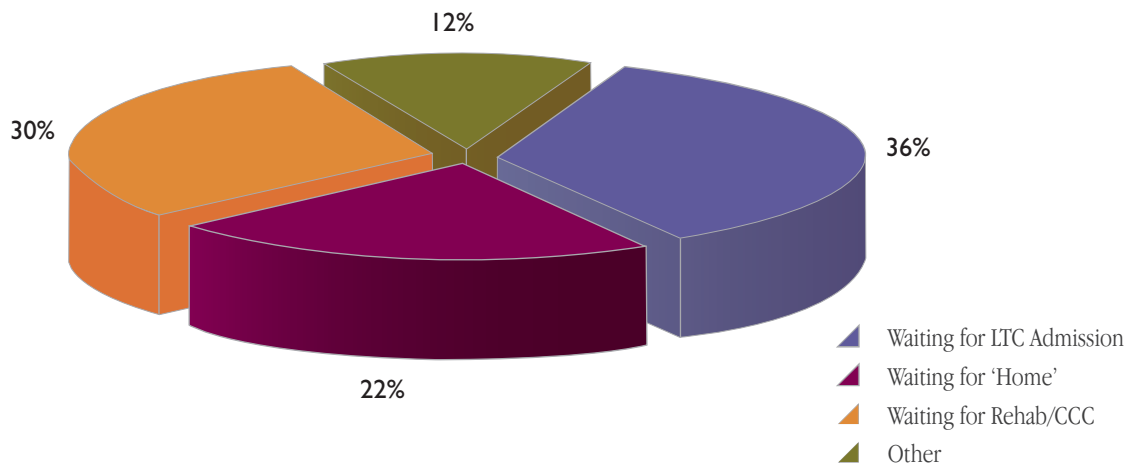
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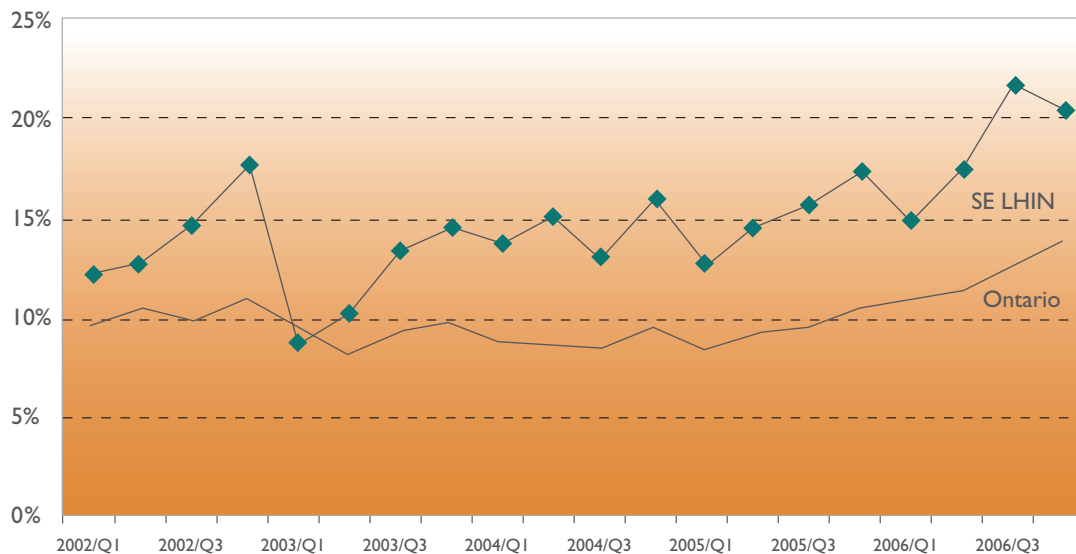
HEALTH CARE DESERVES
OUR FINEST THOUGHT

Figure 1: Transitions from hospital to 'home': The waiting game



Source: Based on Provincial Health Planning Database—2005

Figure 2: Alternative Level of Care (ALC) Days in South East LHIN and Ontario from 2002 to 2006



Source: Based on Provincial Health Planning Database

¹ Based on Provincial Health Planning Database (PHPDB)—2005

² MOHLTC (2007) Community Support Services: Enabling patient flow and supporting hospital avoidance

³ Flo Collaborative (2007) Transforming from Acute Care to Subsequent Care—The Role for Discharge Planning, OHAchieve

⁴ CIHI (2007) Discharge Abstract Database

⁵ Based on Home Care Database, March 2006

⁶ OHA (2006) Alternate Levels of Care - Challenges and Opportunities

⁷ Alzheimer Society Ontario, 2005

⁸ Smith, M. Commitment to Care: A plan for long-term care in Ontario, Spring 2004, Government of Ontario

⁹ www.ccac-ont.ca

¹⁰ Forster, A. (2004). *Adverse Events among Medical Patients after Discharge from Hospital*