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Creating a sustainable assessment tool and follow-up plan to improve care transitions for the frail elderly patient population: The TPRAS project

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ABSTRACT

A variety of health care professionals effectively collaborating is often required to successfully coordinate care transitions of complex, frail older adult patients who are experiencing co-morbidities and cognitive decline. This paper describes an interprofessional approach using quality improvement methodology to iteratively develop and improve an acute geriatric medical unit's discharge planning and care transitions processes. The approach has shown early signs of positive outcomes at the patient, provider, and organizational levels. Health care leaders may use a similar approach in their efforts to improve patient, family and provider experiences and outcomes associated with discharge and care transitions planning for the older complex adult patient population.

1. Introduction

Frail elderly patients are often subject to multiple care transitions across various care settings that puts them at a higher risk of experiencing poor post hospital discharge outcomes.[1–7] These negative outcomes include returning to the Emergency Department (ED) and/or being readmitted to the hospital[7]; experiencing a medication error[8]; a decline in function and dissatisfaction with their in-hospital care.[1,9] To mitigate frail elderly patients experiencing negative outcomes during transition points, health care professionals need to effectively collaborate, plan, and coordinate their transitions in care.[3,4,10] This type of collaboration requires health care professionals to work as an interprofessional team communicating and interacting with each other to enhance continuity of care from the initial assessment phase to the discharge from the hospital.[10–12]

As part of the collaborative efforts, early identification of frail older patients at risk for poor post-discharge outcomes enables the engagement of patients and their support person(s) earlier in the transitions planning.[13,14] Further, older patients who have caregivers or family involved early in their discharge planning process are less likely to be readmitted to the hospital.[13,14] In this context, hospitals are undertaking efforts to improve care transitions of the frail elder population by assessing and engaging patients and their caregivers earlier in the discharge planning process.[15] This paper describes the planning and piloting of one hospital's approach to improving the discharge and care transition planning process and associated outcome measures. First an overview of the clinical unit and patient population is provided. This is followed by a description of the need for improvement, the quality improvement initiative undertaken and the associated outcomes and lessons learned.

2. Acute Care for Elders unit at [organization]

Over the last decade, several hospitals have created Acute Care for Elder (ACE) units that are dedicated to caring for the acutely ill, frail elderly patient.[16] An ACE unit's focus is on managing acute medical conditions while simultaneously focusing on preventing the potentially adverse effects hospitalization can have on an older adult. ACE units utilize an interdisciplinary team framework where in-hospital clinicians work collaboratively, in conjunction with community partners, to

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develop patient-centered care plans that support the patient's care during their hospital stay and for their discharge and transition out of hospital. The unit involved in the implementation of a new discharge and care transitions planning process is a 28-bed unit located at the [organization].[17] The average age on the unit is 83.2 years and patients often present from the ED with a myriad of acute medical conditions, multi co-morbidities, and varying levels of cognition and function.

3. Transition planning risk assessment screen (T-PRAS) initiative

3.1. Impetus for improvement

Given the complexity and frailty of the ACE patient population, there can often be limitations in transitioning the individual to his/her pre-admission destination. As a result, many ACE patients can reach a point in their hospital stay where their intensity of service requirement can be provided in an alternative care setting and are therefore designated as Alternative Level of Care (ALC). ALC designation is a provincial designation that is determined by the health care team when the patient's level of care can be supported in an environment other than the acute care setting. Historically, ALC numbers at [organization] remained stable with little variance and with a small percentage of the patients being ALC for long-term care. However, in July 2015 the ALC numbers started to rise and by May 2016 the number of patients in the hospital designated to be transferred to an alternative care setting was at an all-time high of 40 patients and nearly 40% were awaiting a long-term care bed. On the ACE unit specifically, the number of patients with ALC designation occupied close to 75% of the total beds, well beyond the baseline of below 25%. The nursing staff experienced frustration and diminished morale associated with the large proportion of ALC patients with lower inpatient acuity needs and the length of time it took to coordinate complex transition plans.

At the time of the increase in intra-hospital and unit ALC numbers, there was simultaneously a system-wide surge where acute and post acute institutions in the regional Local Health Integration Network (LHIN) saw a 23% increase in ALC numbers from 2015 to 2016. This increase prompted individuals from the [organization], other acute and associated post-acute institutions to develop a working group mandated to reduce ALC numbers within the LHIN. The activities of the working group included: collecting and interpreting data, sharing best practices, and developing new strategies to address the growing numbers of patients with ALC designation. A key best practice for influencing timely discharges and ALC avoidance is the use of a standardized tool by hospital clinicians to identify and flag patients who are high risk for being designated ALC. A self-assessment undertaken at [organization] indicated a gap and thus presented an opportunity to explore and develop a plan to utilize a standardized tool.

In response to this gap, a smaller in-hospital working group was established, aimed at developing a strategy that would move to reduce the number of ALC patients on the ACE unit initially with the aim of scalability long term throughout the organization. This working group consisted of the senior director for health disciplines, who also sat as a representative on the ALC avoidance committee, the ACE unit manager, the senior manager of rehabilitation and respiratory therapy, and the manager of social work and clinical nutrition. Early on, the working group established their goal to develop a multi-component process to screen and flag patients who require complex transition planning, and to coordinate a patient care meeting early in the patient's admission to promote early discussion and preliminary planning. Anticipated outcomes associated with the strategy included: 1) reduce the total number of ALC patients on the ACE unit, including the number waiting for long-term care; 2) reduce the total number of ALC days; 3) improve length of stay (LOS), and 4) increase discharge rates. An early and major component of the strategy was an agreement to adopt or develop a standardized tool that would identify patients at high risk for being designated ALC.

3.2. Plan and pilot phase

Initial efforts to develop a standardized tool included the working group reviewing the literature and other organizations' approaches to enhance patients' discharge and care transition planning processes with a focus of minimizing acute care LOS beyond a patient's medical and functional requirements. Although existing risk assessment tools such as the Blaylock Discharge Planning Assessment Screen developed by Alberta Health Services,[18] the Assessment Urgency Algorithm developed by interRAI CA,[19] and the Senior Friendly Hospitals' Discharge Guide were identified and some trialed as part of the pilot process, they were deemed too time consuming to integrate into the busy workflow of staff on the unit.

The working group, in collaboration with the ACE unit's social workers, developed a self-designed tool that captured similar risk identifiers as the aforementioned tools, but in a more condensed format. This home-grown tool was deemed to be too sensitive as 62% of the ACE unit patients were identified as being high risk for complex transition planning. The high sensitivity and poor specificity required the group to go back and further review the literature. Upon second review, the South West Local Health Integration Network's (SW LHIN) Hospital Discharge Planning Toolkit (2014) was located.[20] The screening tool embedded in this document was believed to meet the purpose and goals of the TPRAS initiative, while representing a more condensed version of the previously trialed tools. Minimal changes were made to the SW LHIN tool, to reflect organizational practices and working group goals. The most notable changes included: the tool was to be completed on the inpatient unit (not ED), quantifying “frequent ED visits”, and a SW referral for positively scored patients. The final risk assessment tool was entitled the Transition Planning Risk Assessment Screening (T-PRAS) (Fig. 1).

In addition to the T-PRAS tool, the working group identified that patient care meetings needed to be a part of the discharge and care transitions planning process. The initial pilot phase launched in July 2016 included the TPRAS risk assessment screen and patient care meetings for positively screened patients. The pilot occurred over a six weeks period utilizing Plan Do Study Act (PDSA) cycles to modify and adapt the screening tools, patient care meeting template and processes that met the interprofessional teams’ needs and workflow. Small tests of change are used in the PDSA cycle and involve small iterations of change often to adapt existing or newly created tools and work flow processes. The PDSA cycle is a widely used quality improvement methodology for testing change on a small scale that involves collecting and interpreting data, testing the change and collecting date, analyzing the results and acting on what is learned.[21,22]

During the pilot, the unit's social workers completed the screening of all newly admitted and transferred patients to the unit. The two social workers were used during the initial PDSA process as a way to facilitate rapid tests of change and modifications to the tool and processes. This decision was based on the social workers' experience with complex transition planning, their consistent role and availability on the unit, and the challenges with educating over 40 RNs on a tool and process that were rapidly evolving through the PDSA process.

The registered nursing staff were engaged early on about the working groups' efforts to develop and trial a risk assessment tool on the unit and the impetus for the initiative. Specifically, nursing staff were provided updates on the tool's design and well informed that the responsibility of completing the tool would be theirs once the final tool had shown to have a positive impact. Nurses on the unit were appreciative of being included but not responsible for the rapid tests of change and PDSA, and voiced understanding as to why the tool would ultimately be part of their Nursing Admission Assessment (e.g. round the clock presence and availability to complete the screening tool).

To support project success, the General Internal Medicine (GIM) staff physicians, responsible for the care of the patients and the chief medical resident were engaged and informed of the pilot early on its