Hôpitaux Universitaires Genève

smig service de médecine interne générale

UNIVERSITÉ DE GENÈVE
FACULTÉ DE MÉDECINE
Département de médecine interne générale, de réhabilitation et de gériatrie

Transition hôpital-domicile: Risques et opportunités!

Pr Martine LOUIS SIMONET

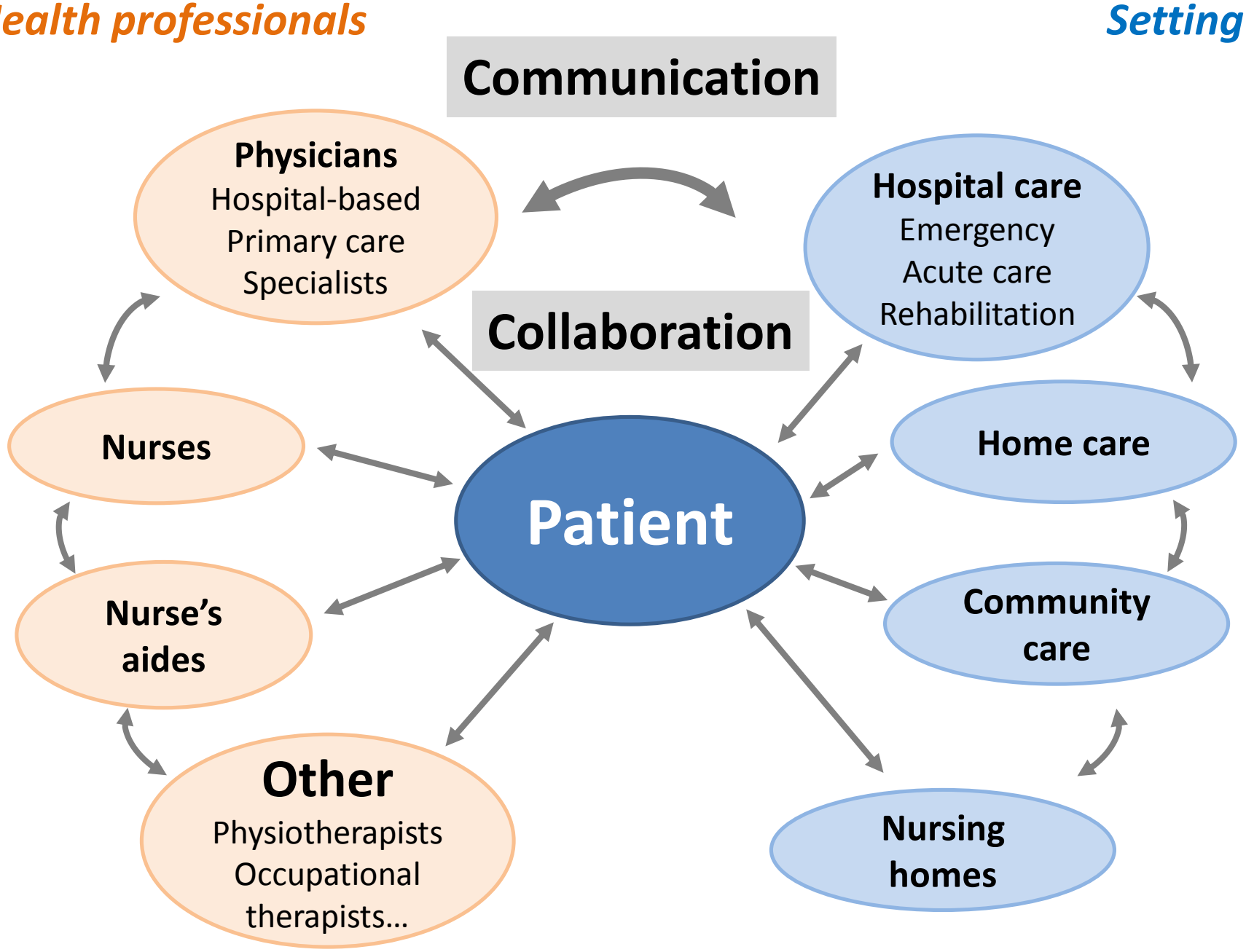
Formation Continue Médecins de Famille Genève

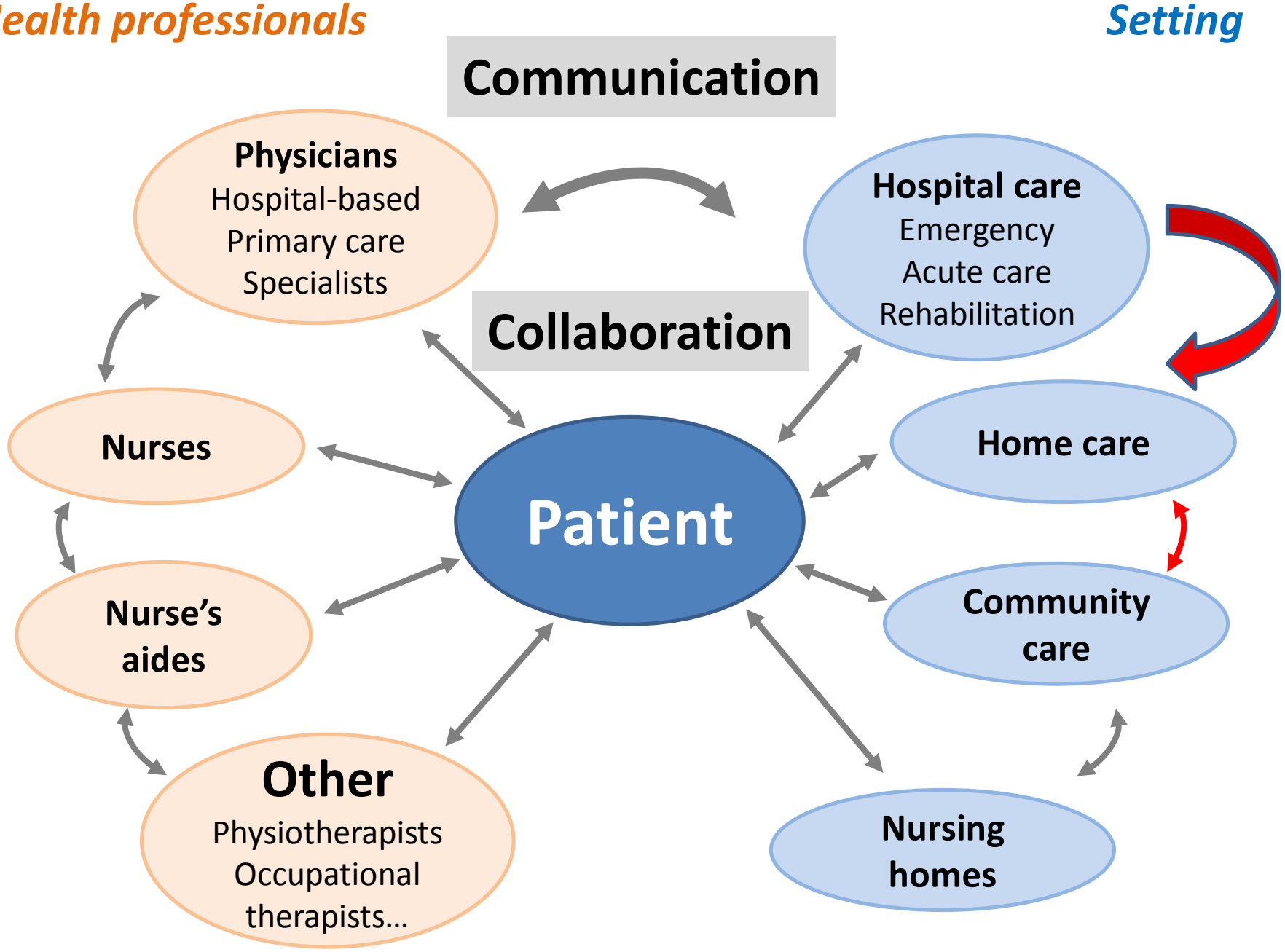
14 avril 2016

"Transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location."

"Les soins de transition sont définis comme un ensemble d' actions visant à assurer ***la coordination et continuité des soins*** *lorsqu'un patient est transféré entre différents lieux ou différents niveaux de soins dans le même lieu****."***

Coleman, J Am Geriatr Soc, 2003
Position Statement of the American Geriatrics Society Health Care Systems Committee


Health professionals
Setting
Communication
Physicians
Hospital-based
Primary care
Specialists
Hospital care
Emergency
Acute care
Rehabilitation
Collaboration
Nurses
Home care
Patient
Nurse's aides
Community care
Other
Physiotherapists
Occupational therapists…
Nursing homes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Nurse's aides
Community care
Other
Physiotherapists
Occupational therapists…
Nursing homes

Transition from hospital to home

IT MATTERS

- Increasingly recognized as a time of heightened vulnerability in safety and quality of patient care
- It is a process and not a unique procedure with increasingly recognized lapses in the key stages of the discharge process
- Improvements are definitely needed and feasible
- It is a real challenge for acute care services

AND IT IS EXCITING !!!

Transition from hospital to home

Forster et al. Ann Intern Med 2003; CMAJ 2004; J Gen Intern Med 2005

- **Adverse events** in the 5 weeks following hospital discharge
  - 1 patient out 5 (20%)
  - 70% are due to medication

- **Higher risk** if:
  - Treatment changes in the hospital
  - High number of medications
  - No knowledge of side effects
  - High-risk class: antibiotics, cardiovascular, anticoagulants, corticosteroids, analgesics

- **62% preventable or ameliorable….**

Transition from hospital to home

Forster et al. Ann Intern Med 2003; CMAJ 2004; J Gen Intern Med 2005; Jenks et al.N Engl J Med 2009

- **Consequences on both health and costs**

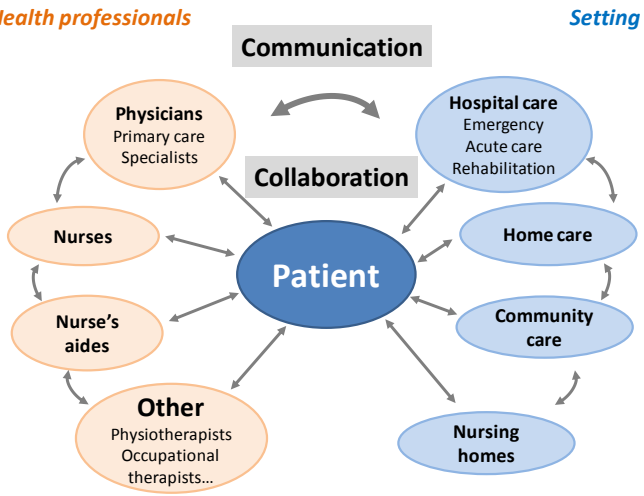
• **Additional medical consultation**	**21%**
• **Emergency consultation**	**12%**
• **Readmission (30 days; 90 days)**	**20%; 30%**
• $12 billion !!!	
• **Patients/caregiver satisfaction**	**↓**

Transition from hospital to home

Forster et al. Ann Intern Med 2003; CMAJ 2004; J Gen Intern Med 2005; Jenks et al.N Engl J Med 2009

- **Ineffective communication/information transfer of critical elements of the care plan**
  - **Patient-caregivers/practitioner/home health services**

- **Ineffective anticipation, planification, preparation and coordination of the care plan**

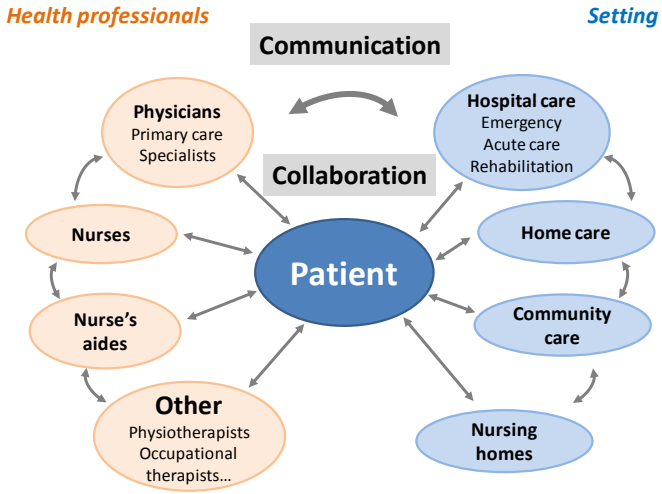


Transition from hospital to home

Forster et al. Ann Intern Med 2003; CMAJ 2004; J Gen Intern Med 2005; Jenks et al.N Engl J Med 2009

- **Ineffective communication/information transfer of critical elements of the care plan**

- **Ineffective anticipation, planification and coordination of the care plan**



Deficits in communication between hospital-based and primary care physicians

JAMA. 2007;297:831-841

Item	Proportion
Direct communication between hospital and primary care physicians	3%-20%
Availability of a discharge summary	
• at the first postdischarge visit	12%-34%
• at 4 weeks	51%-77%
Discharge summary quality, lack of:	
• diagnostic test results	33%-63%
• treatment or hospital course	7%-22%
• discharge medications	2%-40%
• Test results pending at discharge	65%
• patient or family counseling	90%-92%
• follow-up plans	2%-43%

Deficits in communication between hospital-based physicians and patients

HUG-patient satisfaction questionnaire 2014

Information/explanation	No/few
At discharge	
Reason of medications	18%
Adverse/side effects	32%
Precautions/alerts to be aware of	44%
When to resume normal activity	43%
Well organized discharge	29%

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Deficits in communication between hospital-based physicians and patients

Forster et al. Ann Intern Med 2003; CMAJ 2004; J Gen Intern Med 2005; Jenks et al.N Engl J Med 2009

- → **Low adherence to treatment**:
  - Errors in dosage, quantity, time..
  - Unintentional or intentional discharge medication discontinuation
  - Spontaneous introduction of new medication
  - Resuming previous treatment
  - Duplication of medications
- **↑Risk**
  - Low health literacy, cognitive deficits, self-efficacy

Coleman; Arch Intern Med 2005;Am J Med Qual 2013

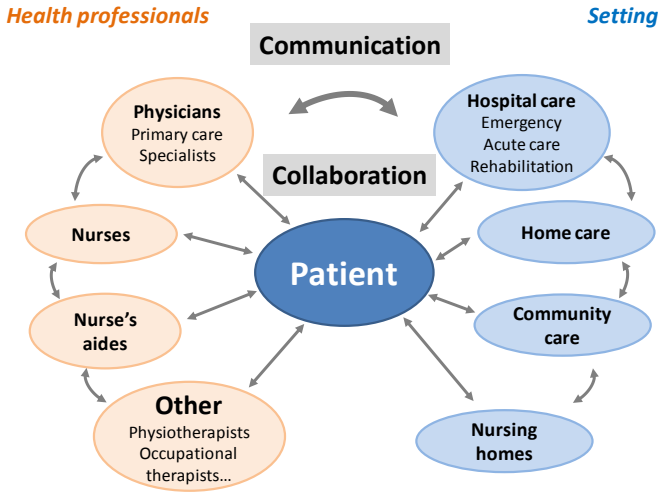
Transition from hospital to home

Forster et al. Ann Intern Med 2003; CMAJ 2004; J Gen Intern Med 2005; Jenks et al.N Engl J Med 2009

Causes:

- Ineffective communication/Information of critical elements of the care plan

- **Ineffective anticipation, planification and coordination of the care plan**



Ineffective anticipation and planification

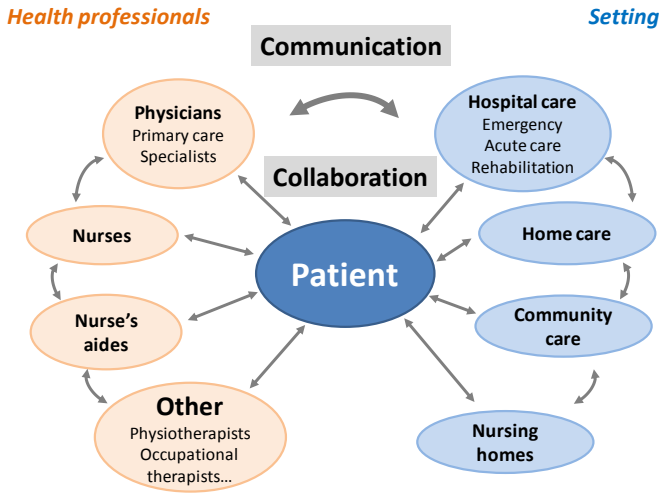
Chopard et al, Int J Epidemiol. 1998

- **Inappropriate hospital days (AEP protocol)**
- 35% of hospital days of which **50% related to the discharge process**
  - Awaiting for post-acute care facilities (50%)
  - Medical indecision; Absence of the care plan; Patient and caregiver poorly informed;
  - Awaiting for discharge organisation

- **↑ Risk if**:
  - Inappropriate admission
  - > 80 years; comorbidities++

Transition from hospital to home

- **How to improve?**



Recommendations for improving care transitions at hospital discharge

J Hosp Med 2007;2:314-323

Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key Issues for Hospitalists

Sunil Kripalani, MD, MSc[1]
Amy T. Jackson, PharmD[2]
Jeffrey L. Schnipper, MD, MPH[3]
Eric A. Coleman, MD, MPH[4]

[1]Emory University School of Medicine, Atlanta, Georgia

[2]Emory Healthcare, Atlanta, Georgia

[3]Brigham and Women's Hospital, Boston, Massachusetts

[4]University of Colorado Health Sciences Center, Denver, Colorado

The period following discharge from the hospital is a vulnerable time for patients. About half of adults experience a medical error after hospital discharge, and 19%-23% suffer an adverse event, most commonly an adverse drug event. This article reviews several important challenges to providing high-quality care as patients leave the hospital. These include the discontinuity between hospitalists and primary care physicians, changes to the medication regimen, new self-care responsibilities that may stress available resources, and complex discharge instructions. We also discuss approaches to promoting more effective transitions of care, including improvements in communication between inpatient and outpatient physicians, effective reconciliation of prescribed medication regimens, adequate education of patients about medication use, closer medical follow-up, engagement with social support systems, and greater clarity in physician–patient communication. By understanding the key challenges and adopting strategies to improve patient care in the transition from hospital to home, hospitalists could significantly reduce medical errors in the postdischarge period. ***Journal of Hospital Medicine*** **2007;2:314–323.**

How to improve?

J Hosp Med 2007;2:314-323

Ineffective communication/information transfer

- Educate and train students and physicians for effective communication
- Educate and inform patients and caregivers
- Inpatient-outpatient physician continuity
- Medication reconciliation

Ineffective anticipation, planification and coordination

- Early identification of high risks patients
- Standardize the process and content of transitional care
- Involve all partners
- Improve instruments

How do we improve?

Ineffective communication/information transfer

- **Educate and train students and physicians for effective communication**
- **Educate and inform patients and caregivers**
- Inpatient-outpatient physician continuity
- Medication reconciliation

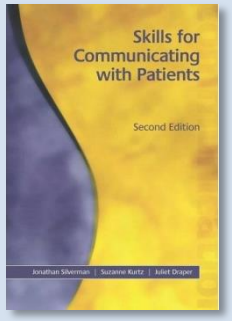
Ineffective anticipation, planification and coordination

- Early identification of high risks patients
- Standardize the process and content of transitional care
- Involve all partners
- Improve instruments

Educate physicians and students
Communication skills-based curriculum for **effective communication**

Teaching

- Undergraduate
  - Preclinical years (bachelor)
    Cinical compentencies
    - 2nd- 3rde year
  - Clinical years (master):
    - 4th – 6th year
- Postgraduate
  - Residents SMIG
  - Residents SMPR



Issues

- Medical consultation
  - Comprehensive repertoire of basic communication skills
  - Patient-centered approach
- Complex settings
  - Discharge interview
  - Difficult physician-patient relationship
  - Breaking bad news
  - Conducting interview with families
  - ….

Educate the patient

Effects of a Structured Patient-Centered Discharge Interview on Patients' Knowledge about Their Medications

Martine Louis-Simonet, MD, Michel P. Kossovsky, MD, MSc, François P. Sarasin, MD, MSc, Pierre Chopard, MD, MSc, Victor Gabriel, Thomas V. Perneger, MD, PhD, Jean-Michel Gaspoz, MD, MSc

Am J Med. 2004;117:563–568.

Reason for medication

Precisions and precautions

Side effects

Carte de traitement pour le patient

Hôpitaux Universitaires de Genève
Service de médecine interne générale

Nom du patient
Nom du médecin

Date 15.12.2009
Unité 7-FL

Nom du médicament	Présentation et dosage	Posologie et fréquence				Schéma particulier et précautions	Raison du traitement	Effets indésirables
		matin	midi	soir	coucher			
Irfen (ibuprofène)	400 mg	1	1	1		en réserve is fièvre ou douleurs	etat grippal	douleur estomac
Tamiflu (oseltamivir)	75 mg	1		1		fin le 18.12	grippe H1N1	nausées
Dafalgan (paracetamol)	1000 mg	1	1	1	1	en reserve si fièbre ou douleurs	etrat grippal	
Prednisone (prednisone)	40 mg	1				fin le 18.12	asthme	nervosité
Seroquel (quétiapine)	25 mg	1		1			dépression	sécheresse buccale
Sertraline (sertraline)	25 mg	1		1			dépression	constipation
Nicotinell TTS (nicotine)	14 mg/24h	1					tabac	palpaitations
Seretide Diskus (fluticasone + salmétérol)	500 ug fluticasone, 50ug salmeterol	1		1			asthme	palpitations
Ventolin (salbutamol)	1 push	1		1		à réévaluer par Dr. Neesseer	asthme	tremblements
Ventolin (salbutamol)	1 push	1	1	1	1	en réserve si dyspnée	asthme	palpitations

Educate the patient

Am J Med 2004;117:563-8

Intervention

- Structured patient-centered discharge interview (done by 73% of the residents)

Results

Increased

- Patient knowledge on:
  - Reason for each medication
  - Precautions to be observed
  - Potential side effects
- Likelihood of the patient receiving information OR: 3.6 (95% IC: 1.5 à 4.4)
- Increased patient satisfaction (card very useful, 90%; used every day, 50%)

Decreased

- Likelihood of patients interrupting their medication

How to improve?

J Hosp Med 2007;2:314-323

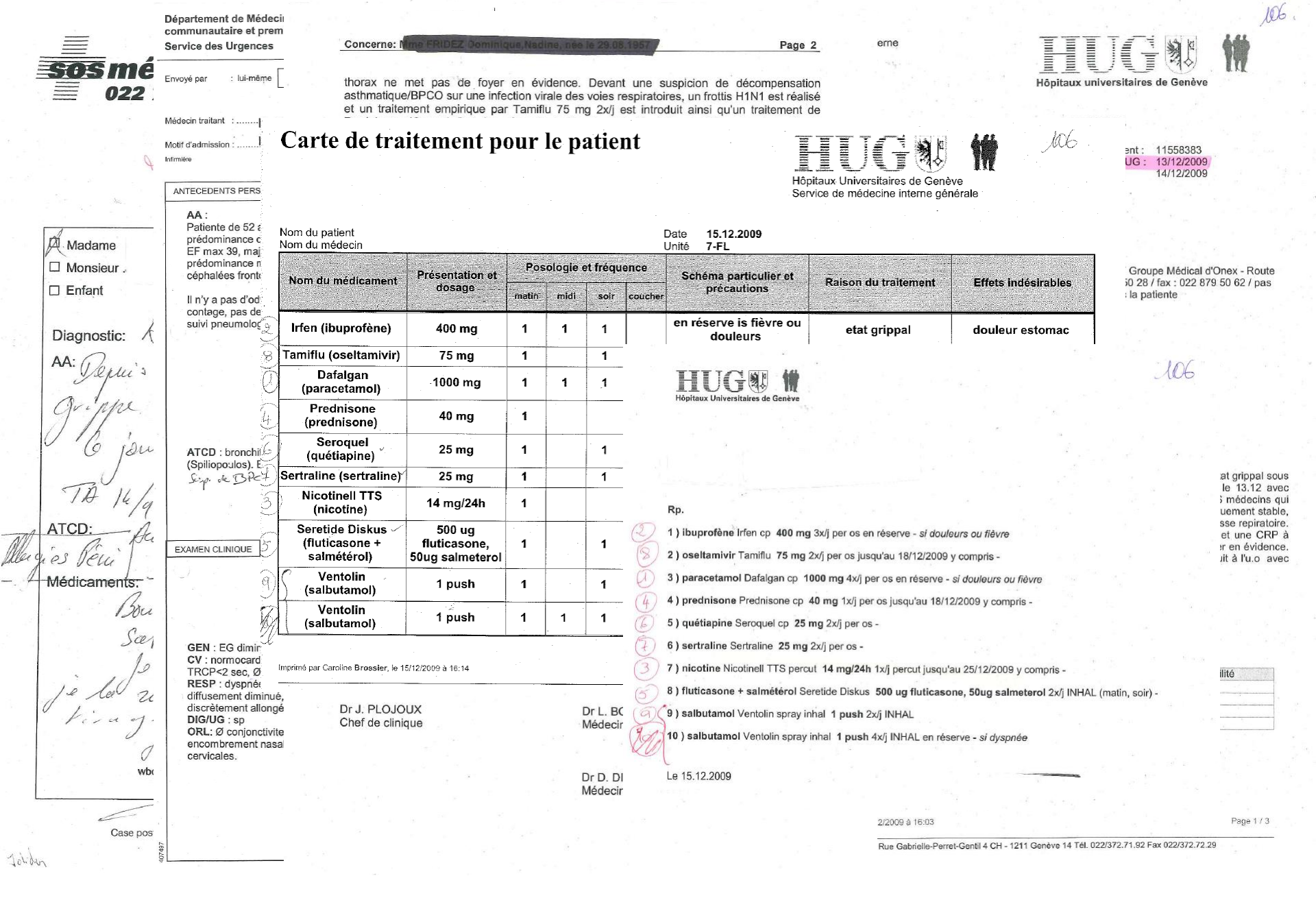
Ineffective communication/information transfer

- Educate and train students and physicians for effective communication
- Educate and inform patients and caregivers
- **Inpatient-outpatient physician continuity**
- **Medication reconciliation**

Ineffective anticipation, planification and coordination

- Early identification of high risks patients
- Standardize the process and content of transitional care
- Involve all partners
- Improve instruments

Medication reconciliation



Département de Médeci
communautaire et prem
Service des Urgences

Envoyé par : lui-même

Médecin traitant : .....

Motif d'admission : .....

Infirmière

ANTECEDENTS PERS

AA :
Patiente de 52 a
prédominance c
EF max 39, maj
prédominance n
céphalées fronti

Il n'y a pas d'od
contage, pas de
suivi pneumolog

ATCD : bronchi
(Spiliopoulos). E
Sep. de BPCO

EXAMEN CLINIQUE

GEN : EG dimin
CV : normocard
TRCP<2 sec, Ø
RESP : dyspnée
diffusement diminué,
discrètement allongé
DIG/UG : sp
ORL: Ø conjonctivite
encombrement nasal
cervicales.

☑ Madame
☐ Monsieur
☐ Enfant

Diagnostic:

AA:

ATCD:

Médicaments:

Case pos

Concerne: Mme FRIDEZ Dominique,Nadine, née le 29.08.1957 Page 2

thorax ne met pas de foyer en évidence. Devant une suspicion de décompensation asthmatique/BPCO sur une infection virale des voies respiratoires, un frottis H1N1 est réalisé et un traitement empirique par Tamiflu 75 mg 2x/j est introduit ainsi qu'un traitement de

Hôpitaux universitaires de Genève

Carte de traitement pour le patient

Hôpitaux Universitaires de Genève
Service de médecine interne générale

ent : 11558383
UG : 13/12/2009
14/12/2009

Nom du patient
Nom du médecin

Date 15.12.2009
Unité 7-FL

Nom du médicament	Présentation et dosage	Posologie et fréquence				Schéma particulier et précautions	Raison du traitement	Effets indésirables
		matin	midi	soir	coucher			
Irfen (ibuprofène)	400 mg	1	1	1		en réserve is fièvre ou douleurs	etat grippal	douleur estomac
Tamiflu (oseltamivir)	75 mg	1		1				
Dafalgan (paracetamol)	1000 mg	1	1	1				
Prednisone (prednisone)	40 mg	1						
Seroquel (quétiapine)	25 mg	1		1				
Sertraline (sertraline)	25 mg	1		1				
Nicotinell TTS (nicotine)	14 mg/24h	1						
Seretide Diskus (fluticasone + salmétérol)	500 ug fluticasone, 50ug salmeterol	1		1				
Ventolin (salbutamol)	1 push	1		1				
Ventolin (salbutamol)	1 push	1	1	1				

Imprimé par Caroline Brossier, le 15/12/2009 à 16:14

Dr J. PLOJOUX
Chef de clinique

Dr L. BC
Médecin

Dr D. DI
Médecin

Groupe Médical d'Onex - Route
50 28 / fax : 022 879 50 62 / pas
: la patiente

Hôpitaux Universitaires de Genève

Rp.

1) **ibuprofène** Irfen cp **400 mg** 3x/j per os en réserve - *si douleurs ou fièvre*
2) **oseltamivir** Tamiflu **75 mg** 2x/j per os jusqu'au 18/12/2009 y compris -
3) **paracetamol** Dafalgan cp **1000 mg** 4x/j per os en réserve - *si douleurs ou fièvre*
4) **prednisone** Prednisone cp **40 mg** 1x/j per os jusqu'au 18/12/2009 y compris -
5) **quétiapine** Seroquel cp **25 mg** 2x/j per os -
6) **sertraline** Sertraline **25 mg** 2x/j per os -
7) **nicotine** Nicotinell TTS percut **14 mg/24h** 1x/j percut jusqu'au 25/12/2009 y compris -
8) **fluticasone + salmétérol** Seretide Diskus **500 ug fluticasone, 50ug salmeterol** 2x/j INHAL (matin, soir) -
9) **salbutamol** Ventolin spray inhal **1 push** 2x/j INHAL
10) **salbutamol** Ventolin spray inhal **1 push** 4x/j INHAL en réserve - *si dyspnée*

Le 15.12.2009

at grippal sous
le 13.12 avec
médecins qui
uement stable,
sse repiratoire.
et une CRP à
r en évidence.
it à l'u.o avec

ilité

2/2009 à 16:03 Page 1 / 3

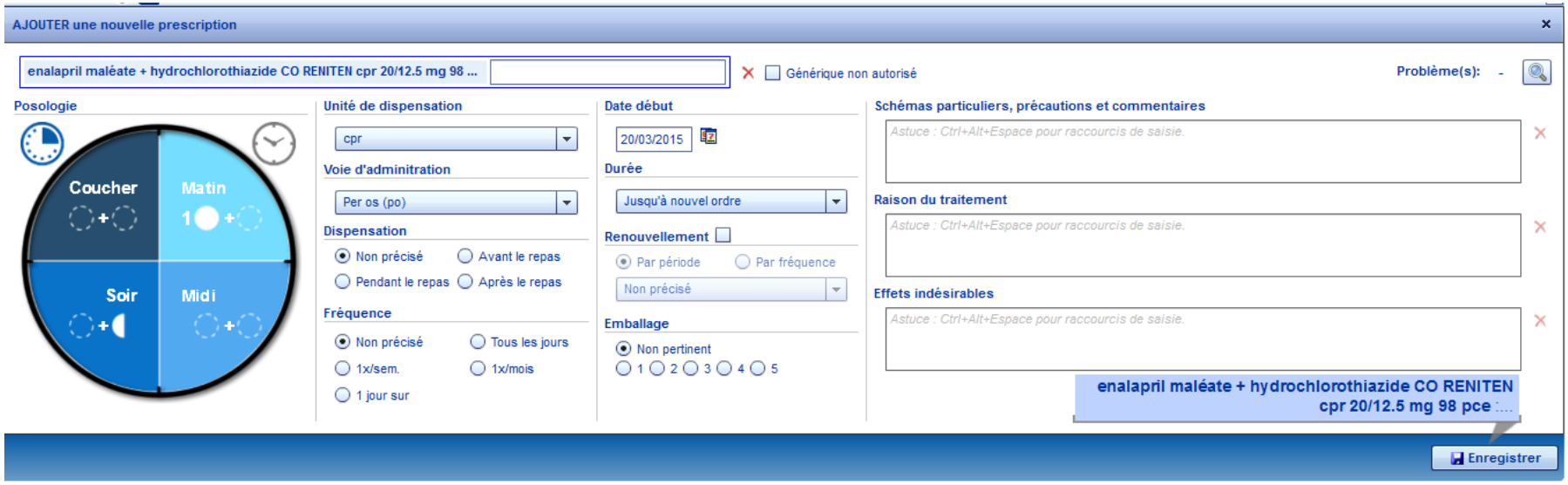
Rue Gabrielle-Perret-Gentil 4 CH - 1211 Genève 14 Tél. 022/372.71.92 Fax 022/372.72.29

Dossier informatisé accessible

Accès à tous les documents relevant pour la santé du patient

- Accès réglé par le patient (carte clé)
- Deuxième clé nécessaire pour le prestataire de soins
- Données décentralisées
- **Plan de traitement partagé**

MonDossier Medical.ch
Connecté à ma santé



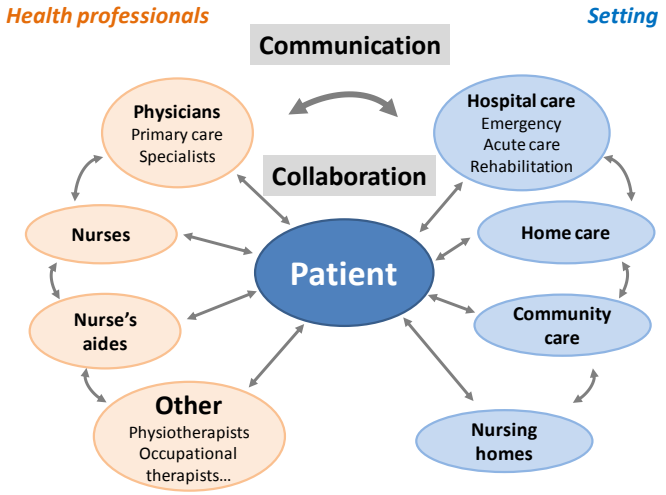
Transition from hospital to home

Forster et al. Ann Intern Med 2003; CMAJ 2004; J Gen Intern Med 2005; Jenks et al.N Engl J Med 2009

- Ineffective communication/information of critical elements of the care plan

- **Ineffective anticipation, planification and coordination of the care plan**

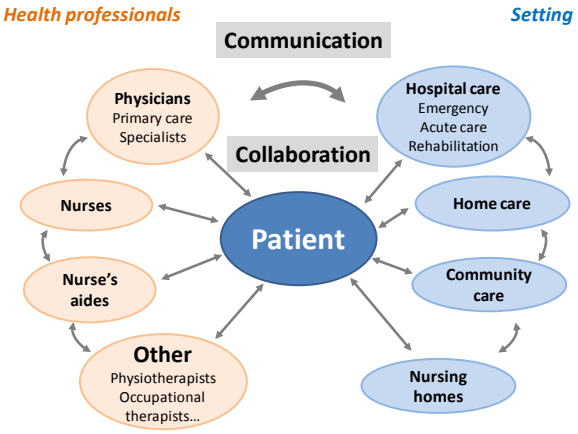
How do we improve?



Ineffective anticipation, planification and coordination of the care plan

- **Early identification of high risk patients**
  - Predictive score

- **Standardize the <u>process and content</u> of transitional care** (involving all partners and improving instruments)
  - Institutional quality improvement project *(« P9 »..!)*



BMC Health Services Research BioMed Central

Research article Open Access

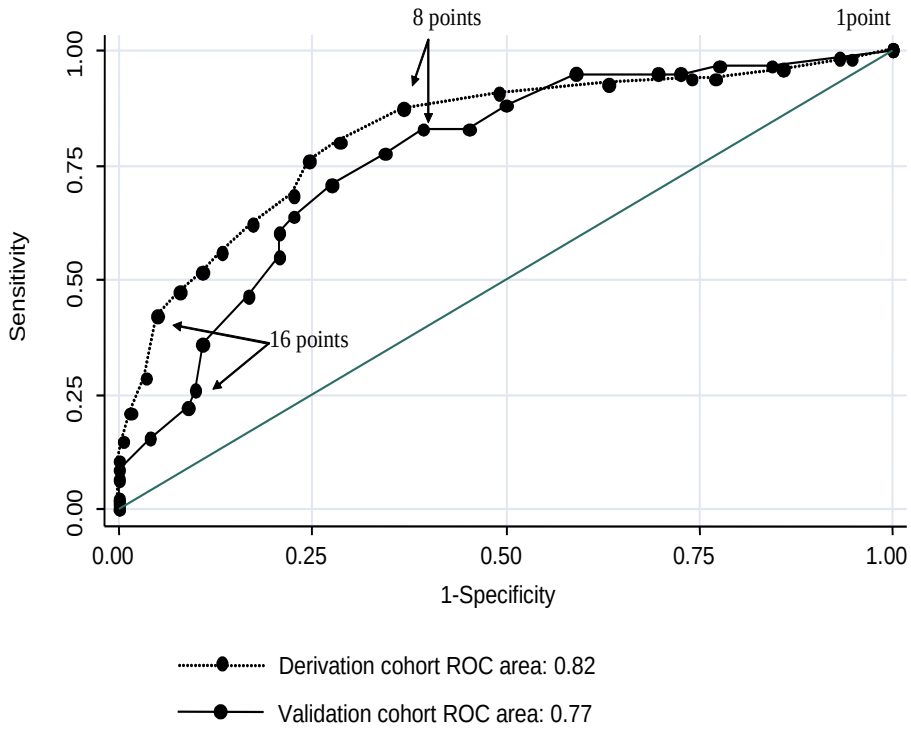
A predictive score to identify hospitalized patients' risk of discharge to a post-acute care facility

Martine Louis Simonet*[†1,2], Michel P Kossovsky[†2,3], Pierre Chopard[1,2,4], Philippe Sigaud[2], Thomas V Perneger[2,4] and Jean-Michel Gaspoz[1,2,3]

BMC Health Services Research 2008, 8:154

> 8 points
> Sensibility 87%
> Specificity 63%

Variable	Point score
Active medical problems (per additional problem)	+1
No help provided by spouse/partner	+4
Inability in medication self management before admission	+4
Dependent for transfers bed/chair on Day 3	+4
Dependent for bath / shower on Day 3	+4



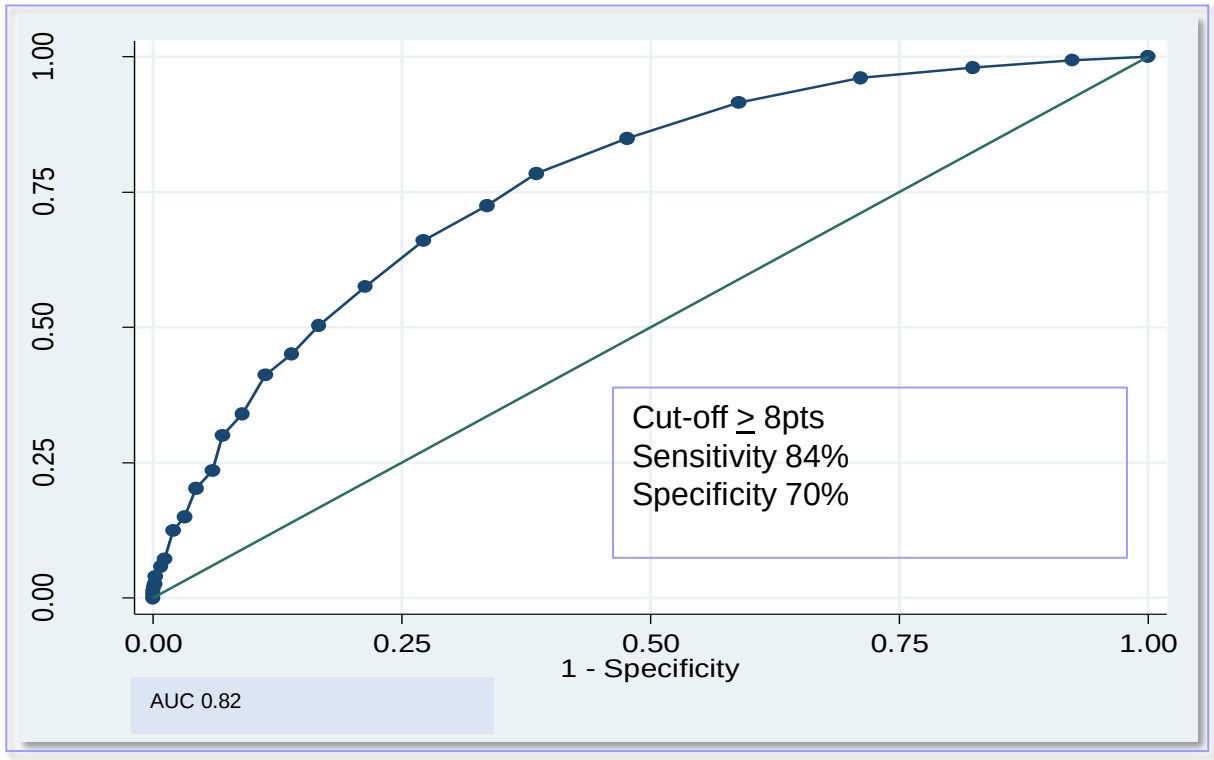
Validation of the Day 3-score in an other cohort

Tertiary swiss hospital (Aarau)

A Conca, A Gabele, Philipp Schuetz , M.Louis Simonet et al , 2015 submitted

1432 medical patients

- Day 3-Score

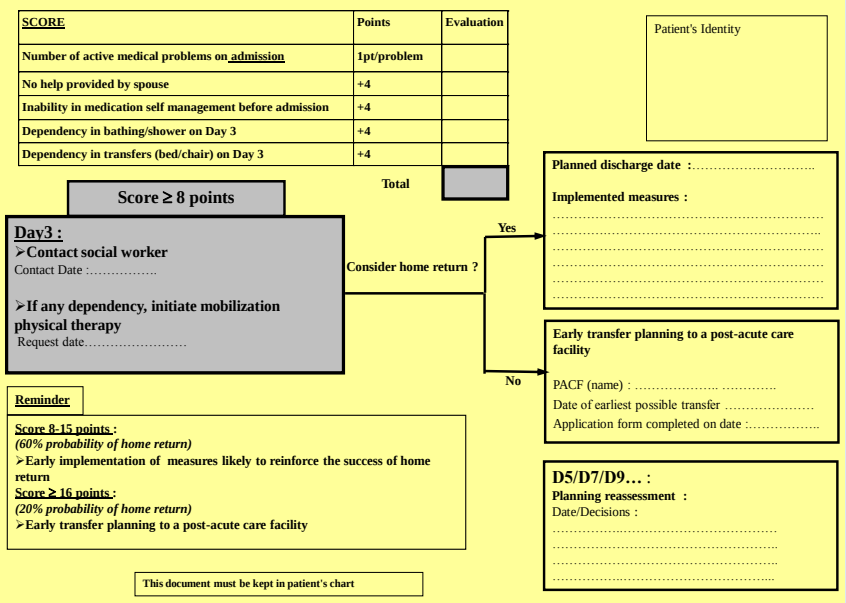


Early identification of high risk patients

M.Louis Simonet et al, BMC Health Services Research 2008

Intervention

- J3- Score



SCORE	Points	Evaluation
Number of active medical problems on admission	1pt/problem	
No help provided by spouse	+4	
Inability in medication self management before admission	+4	
Dependency in bathing/shower on Day 3	+4	
Dependency in transfers (bed/chair) on Day 3	+4	
	Total	

Patient's Identity

Score ≥ 8 points

Day3 :
➢**Contact social worker**
Contact Date :…….

➢**If any dependency, initiate mobilization physical therapy**
Request date……

Consider home return ?

Yes

Planned discharge date :……

Implemented measures :
……
……
……
……
……
……

No

Early transfer planning to a post-acute care facility

PACF (name) : ……. …….
Date of earliest possible transfer ……
Application form completed on date :……..

Reminder

Score 8-15 points :
(60% probability of home return)
➢**Early implementation of measures likely to reinforce the success of home return**
Score ≥ 16 points :
(20% probability of home return)
➢**Early transfer planning to a post-acute care facility**

D5/D7/D9… :
Planning reassessment :
Date/Decisions :
……
……
……
……

This document must be kept in patient's chart

Results

Decreased (patients score >8 pts)

- Length of stay (3.2)
- Inappropriate days (1.57)
- Inapropriate day due to discharge delays (1)

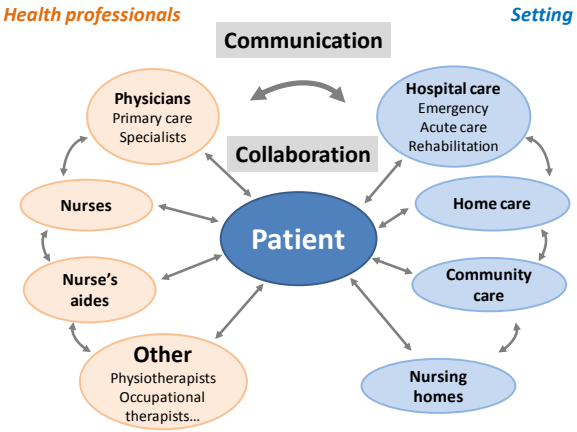
Not increased

- Patients tranfer to a post-acute care facilities

Ineffective anticipation, planification and coordination of the care plan

- **Early identification of high risk patients**
  - Predictive score

- **Standardize the <u>process and content</u> of transitional care** (involving all partners and improving instruments)
  - Institutional quality improvement project (P9)



Standardize content and process

HUG- Institutional Project: Improvement of discharge preparation and anticipation

- Identification, definition and structuration of the process
  - **Key phases** (admission, during hospitalisation, before/at discharge) and **key informations** necessary for the good progress
  - **Roles and responsibilities** of each of the actors at every stage of the process
  - Discharge essential **communicating documents** necessary for transitional care; their **contents; when and to whom**
- Development
  - **Standardized protocol** allowing to start early the process (alerts), to follow it and to document it by **all the involved actors**
  - Protocol **integrated** in the **informatised medical record**

Hôpitaux Universitaires Genève

Discharge planning protocol-Admission

Discharge planning protocol

Discharge check list

PORTFOLIO DE SORTIE

Concerne : Monsieur LAMPI Karlo, né le 23/08/1974
N° EDS : 97015144
Séjour depuis le 06/10/2013

Document et matériels nécessaires à la sortie (portfolio de sortie)

Ordonnances

- Des médicaments : [ ]
- Sur carnet à souche si opiacés / stupéfiants : [ ]
- De matériel particulier : [ ]
- Physiothérapie : [ ]
- Ergothérapie : [ ]

Carte de traitement : [ ]
Avis de sortie : [ ]

Certificats médicaux

- Arrêt de travail : [ ]
- Autres (sport, etc.) : [ ]

Prescription de Soins Aigus de Transition (SAT) : [ ]
Prescription médicale pour soins à domicile : [ ]
Protocole de pansement : [ ]
Carnet de suivi de soins à domicile : [ ]

Summary

- Transition from hospital to home (and vice-versa…) is a **delicate and particularly vulnerable period**, especially for elderly patients and/or with many comorbidities

Summary

To improve Continuity and Coordination of care

- Hospitals must implement standardized discharge procedures to ensure
  - Patients' **effective information** and education at discharge (verbal, written)
  - Patient's discharge at **an appropriate time**, with **adequates notices**; **care needs met and organised**
  - **Accurate, relevant and timely delivery** of discharge informations to community care provider
  - **Medication reconciliation**

Summary

To change the culture

- Discharge planning and procedures should be integrated in the daily hospital care and start on admission
- Hospitals and Faculty must design and implement curricula for physicians and students to develop essential skills in transition care
  - Effective communication
  - Effective handovers
- Strong political, institutional and faculty will is now necessary to make it a definite priority objective

Summary

- Low level of evidence of effectiveness in improving patient outcomes

- **Evaluation direly needed!!**


THANK YOU

- Backup

Transition from hospital to home
Evaluation

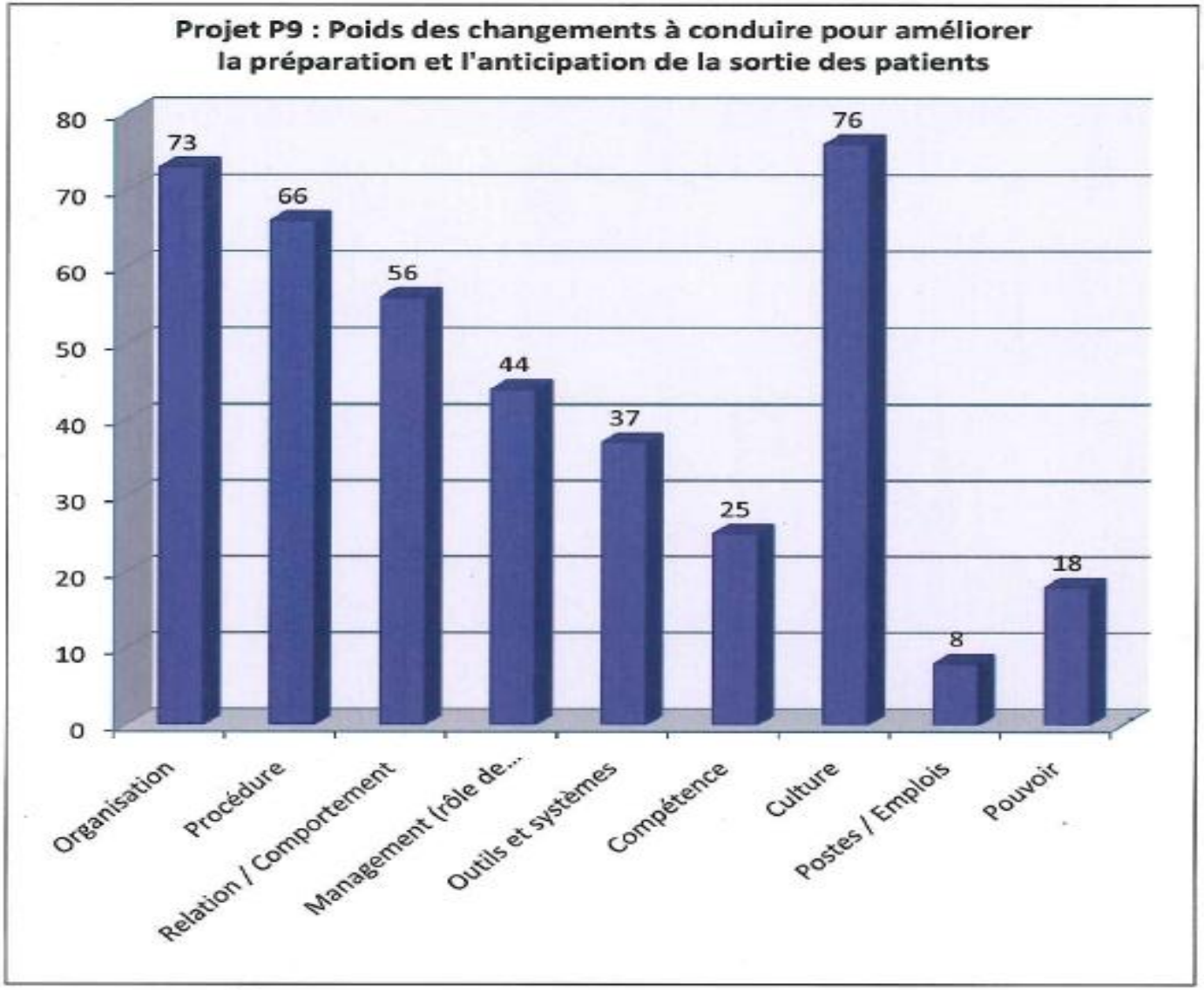
Interventions

- Information/Communication
- Coordination
- Heterogeneity
- Multicomponents
- Non standardized

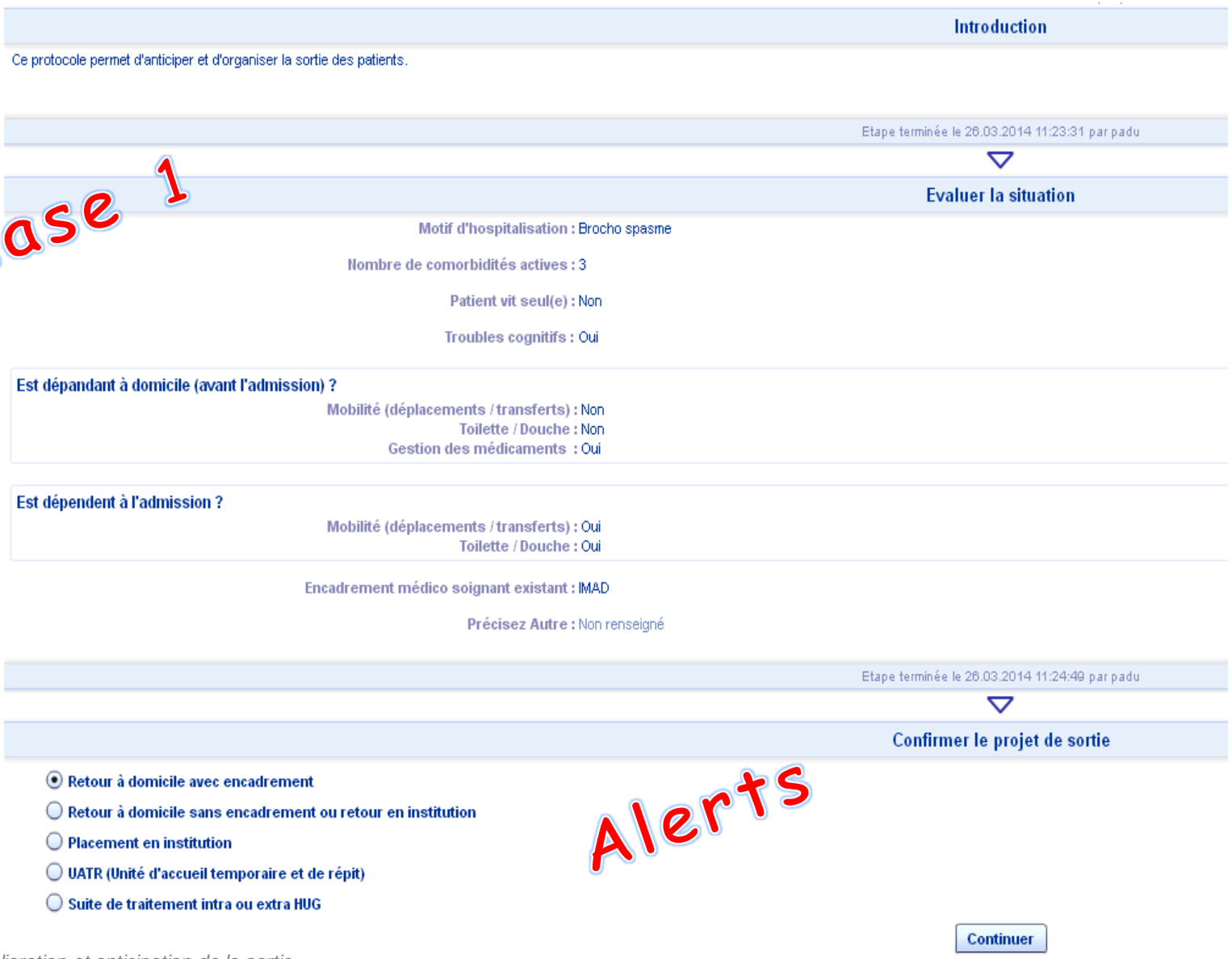
Issues

- System-based outcomes
  - Hospital use
    - Readmission, LOS, ..
  - Continuity of care
    - Medication reconciliation
    - Time discharge summary…
  - Primary care use
- Patient-centered outcomes
  - Mortality
  - Functional status
  - Quality of life
  - Satisfaction
  - Caregiver burden

Changing the culture



Discharge planning protocol-Admission



Annals of Internal Medicine | Review

Improving Patient Handovers From Hospital to Primary Care

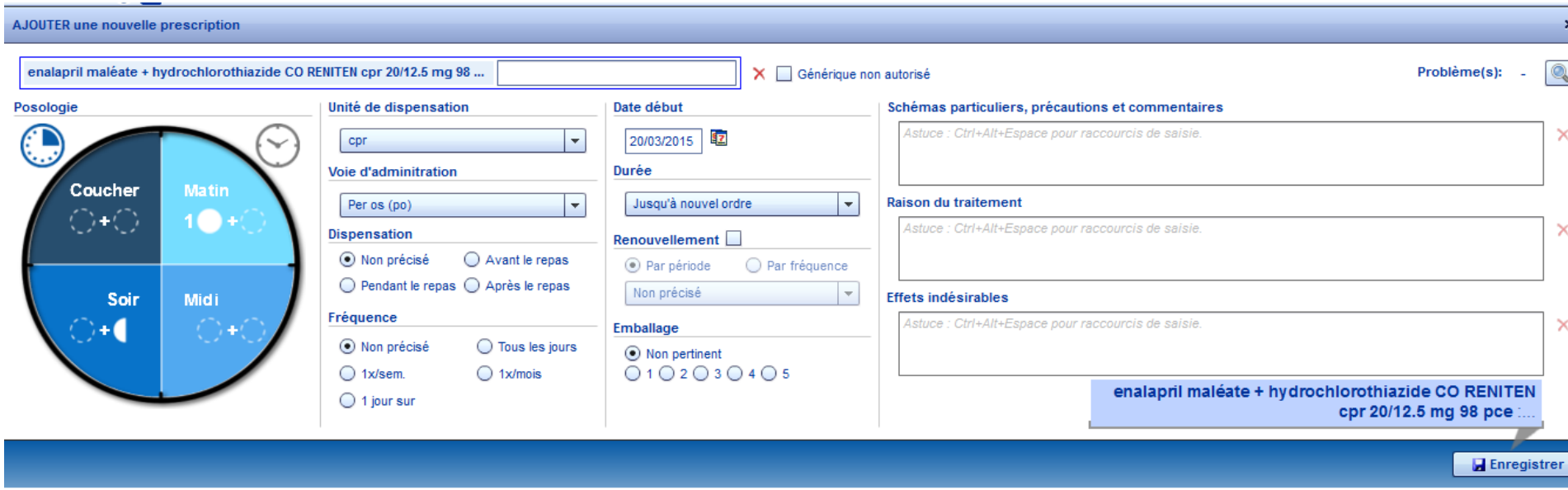
A Systematic Review

Gijs Hesselink, MA, MSc; Lisette Schoonhoven, RN, PhD; Paul Barach, MD, MPH; Anouk Spijker, MA; Petra Gademan, MD; Cor Kalkman, MD, PhD; Janine Liefers, MSc; Myrra Vernooij-Dassen, PhD; and Hub Wollersheim, MD, PhD

Ann Intern Med. 2012;157:417-428.

Réconciliation médicamenteuse

- Rôle des pharmaciens
- Outils informatiques



Dossier informatisé accessible

Accès à tous les documents relevant pour la santé du patient

- Accès réglé par le patient (carte clé)
- Deuxième clé nécessaire pour le prestataire de soins
- Données décentralisées
- Connexion hautement sécurisée

MonDossier Medical.ch
Connecté à ma santé