The Transition Navigator: towards co-ordinating care and reducing hospital readmissions in Champlain

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Family Health Team
Équipe Santé familiale

Background

- Poorly executed transitions can have a negative impact on patient health, well-being and safety, caregiver relationships, and unnecessarily increase health care system costs (Rutherford et al., 2013) [1]
- Hospital readmissions can be seen as a signal of system failure: they often occur because of gaps in care and communication, and reflect the complexities of transitions within the health care system (Baker et al., 2011)[2]
- This demonstration project provided Transition Navigators (TN) to facilitate the transition from hospital to home and primary care follow up.
- The same TN visited the patient both in hospital and at home, and worked with patient and caregiver to ensure that the patient's care plan was carried out successfully.
- Encouraged follow-up appointment with Primary Care Provider
- The project's goals included improving communication and understanding with patients and caregivers, strengthening collaboration between hospitals and primary care, improving the patient experience and lowering the number of preventable readmissions to hospital.

Project design

- The TN could have been a professional from any health discipline. The TNs from this project were RNs and Social Workers.
- Potential patients were identified by the care team at the hospital.
- The TN performed a screening using a validated tool called TCM (Transitional Care Model) to select patients who met certain criteria.
- The TN visited the patient in hospital, and gave the patient a discharge binder to house discharge documents, contact information and goals
- The same TN made the home visit, and ensured that all care arrangements were in place, that the patient was able to manage them all, and that the Primary Care visit was arranged
- The TN called the patient at 15 days, and then at 30 days following discharge
- The TN did not provide services. The TN formed linkages and made sure that the appropriate services were accessible and arrangements in place.

Challenges Encountered

- Short term employment — 50% of navigators left the project before completion – reposting required
- Reluctance of some primary care practices to do home visits
- Data collection across agencies with different tools and access requirements

Patients seen (n=353)	
Number	353
Average age	75
Gender	56% female
Diagnosis	39% cardiovascular 40% diabetes 25% hypertension 16% CHF
Living alone	56%
Readmission within 30 days of discharge	20%
An ED visit within 30 days of discharge	31%

Patient Satisfaction (n=130)	
TN role was helpful	89%
Discharge binder helpful	69%
Rated as good or very good on a Likert scale:	
Knowledge of 'red flags'	92%
Understanding medications	95%
Confidence in managing health	86%
Satisfaction with arrangements for care after discharge	86%
Satisfaction with involvement in decision making about care at home	86%

Select Transition Navigator services provided (n=214)	
Teaching	53%
Linkage to pharmacy	52%
Facilitate follow up plans	53%
Family/Caregiver support	52%
Social issues intervention	45%

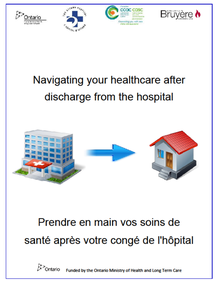
Transition Navigator Observations at first visit (n=214)	
TN concerns about social situation	87%
Discharge summary available	85%
All prescriptions filled	79%
Patient/caregiver understanding about medications	Acceptable 39% Adequate 42% Inadequate 18%
Patient contact with Family Practitioner arranged	65%

Lessons Learned

- Many of the issues facing these complex patients at home were social; (e.g. housing, caregiver stress, financial)
- Patients are overwhelmed in the hospital. At home they are much more settled in their own environments and able to ask questions and plan their health care strategies with the TN
- Patients do not understand the role of the Primary Care Provider as co-ordinator of their health care, and often don't see a need to make contact after discharge.
- Lack of understanding about medications at home is significant (continuing to take previous meds, unsure what has been stopped and started, not sure what they are for, not sure what side effects to watch for)
- The most complex patients often have appropriate services in place and are managing well. The patients who are less complex, or more recently complex, have fewer supports in place and needed more help from the TN

Next steps:

- Project terminated June 30, 2015
- Discussions with the Central Ottawa Health Links project to examine opportunities for sustainability
- Communication of findings to decision makers



The patient binder is given to the patient by the TN before discharge:
contains

- Transition Navigator photo
- Hospital discharge documents
- Discharge checklist
- Contact information for services in place
- Red flags to watch out for
- Healthcare goals list
- Calendar of appointments

Client Comments

- An excellent program. It was the first time I've had anyone follow up with me. Feel more comfortable and confident.
- Very good. I was considered a person. Was nice to have someone follow up. Helped me out when needed (find doctor's phone numbers). It was nice to have someone to talk to. Offered a lot.
- No, this was not essential for me, but I appreciate the help
- Absolutely recommend it, I am very very happy about this, I hope this program lasts awhile because our community needs something like this, I did not know it existed.
- My wife wants this project to continue, it's a wonderful program, especially for seniors for those who do not have a caregiver
- Very professional, it was a great experience
- This program is a good thing, however, this is more useful for those who do not have a caregiver
- Very convenient program, I am feeling more secure to the fact that [the TN] calls me to reassure everything is okay, with appointments etc. I am very happy!
- Very helpful, it was very reassuring, especially as there is no caregiver at the present time

1. Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2013.

2. http://www.health.gov.on.ca/en/common/ministry/publications/reports/baker_2011/baker_2011.pdf

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