Smooth Transitions: How to Avoid Complications When Discharging from Hospital to Home

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Hospitalization in Older Adults

- Older adults (65 years and up) are three times more likely to be hospitalized than younger adults
- 40% of all patients in the hospital are >65
- 40% of patients 85 and older who come from home end up discharging to skilled rehab

Reasons for hospitalization

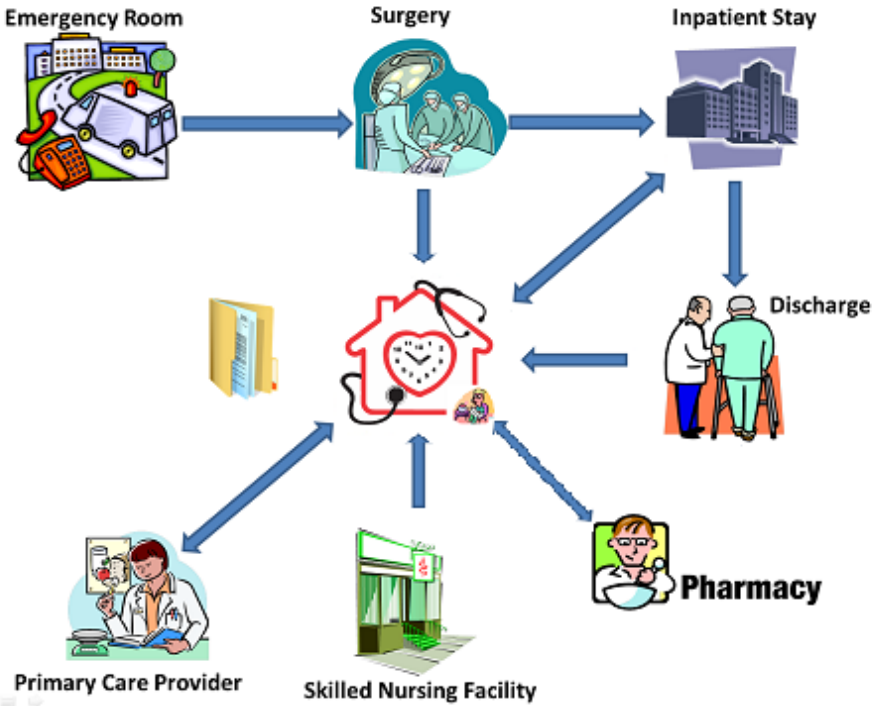
- Heart problems
- Infections
  - Pneumonia, UTI, sepsis
- Stroke
- Trauma (falls especially)

Common Complications of Hospitalization

- Delirium
- Pressure ulcers
- Significant functional decline
- Malnutrition (up to 50%)
- Falls with injury
- Adverse drug reactions
- Sleep alterations
- Blood clots
- Infections

The Discharge Plan?

Actual Flow Cart



Potential complications that occur around transitions to and from the hospital

Medication Errors

How many Medication Related Problems (MRP)are occurring?

- 6 MRP per patient in New Mexico hospital study from 2012-2013
- 30% patients had errors on their discharge medications in study from 300 bed teaching hospital in 2015
- Estimates range 40-75% medication error rate for patients who come from nursing home to hospital and back to nursing home

Which medications?

- Important ones!
  - Most common:
    - Opioids
    - Cardiovascular agents
    - Anticoagulants
  - 39% of people sent on IV antibiotics had errors in the IV antibiotic order

Functional Decline

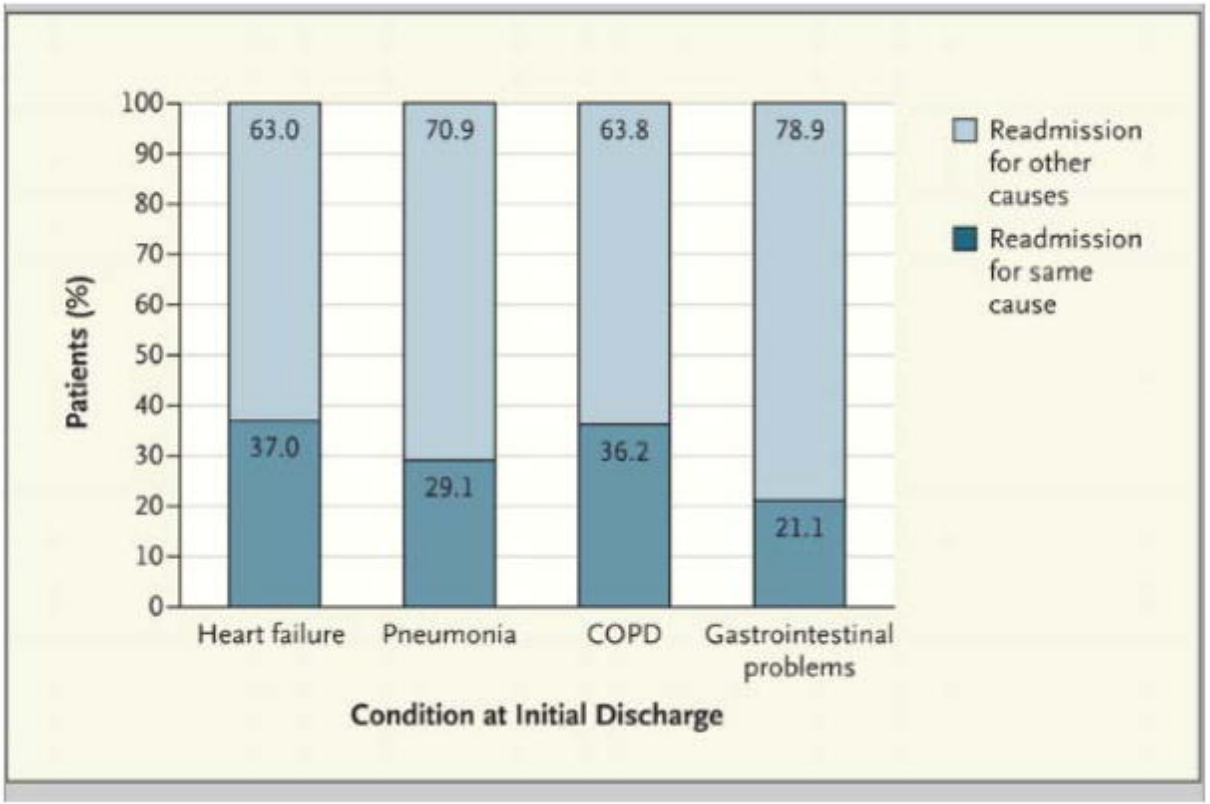
- 40% of patients 70 and over have worsened functional ability (decline in IADLs and ADLs) after hospitalization
- 46% of patients 70 and over have worsened functional ability 1 month after hospitalization

Hazards of Hospitalization

- Accumulating evidence suggests that hospitalized patients face functional decline, debility, and risk for adverse events despite resolution of the presenting illness, implying perhaps that the hospital environment itself is hazardous to patients' health. In 1993, Creditor hypothesized that the "hazards of hospitalization," including enforced bed-rest, sensory deprivation, social isolation, and malnutrition lead to a "cascade of dependency"

Hospital Readmission

- 1 in 6 elderly patients who are discharged will be readmitted to the hospital within 30 days
- Death rates within 30 days EXCEED hospital death rates for many conditions including heart failure


Patients (%)
100
90
80
70
60
50
40
30
20
10
0
63.0
37.0
70.9
29.1
63.8
36.2
78.9
21.1
Heart failure
Pneumonia
COPD
Gastrointestinal problems
Condition at Initial Discharge
Readmission for other causes
Readmission for same cause

Post Hospital Syndrome

What is PHS?

- Post Hospital Syndrome is a hypothesis that says that the hospitalization itself creates a syndrome of temporary frailty that makes an elderly person more susceptible to other health problems beyond the initial problem causing hospitalization

Post Hospital Syndrome

- Dr. Harlan Krumholz, a cardiologist at Yale University, coined the phrase “post-hospital syndrome” in a New England Journal of Medicine article in 2013.
- Definition: An Acquired, Transient Condition of Generalized Risk

- Significant research going on currently about the underlying mechanism as well as possible interventions
  - Pituitary-hypothalamic-adrenal axis
  - Autonomic nervous system
  - Similar mechanisms to stress disorders (acute traumatic and post-traumatic stress disorders)

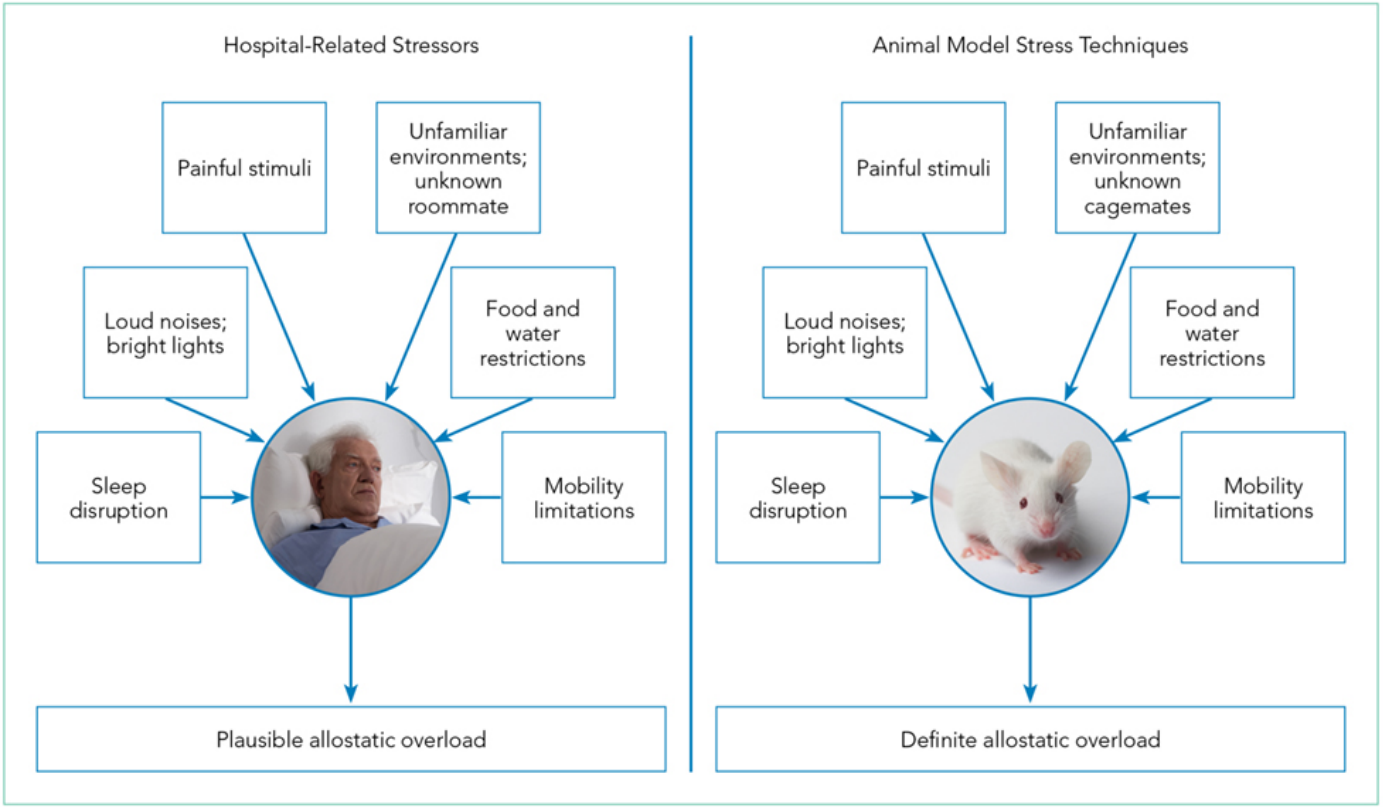


FIG 1. Stress exposure and allostatic overload. The stressors experienced by hospitalized patients are remarkably similar to stress techniques used to generate allostatic overload in healthy animals.

How families/caregivers can help

During the hospitalization

- Make sure your loved one has eyeglasses, hearing aids, walker, dentures, etc.
- Bring in favorite foods to encourage oral intake;
- Plan to eat meals with your loved one
- Take shifts to help with safety/monitoring
- Take your loved one on short walks with permission from health care team
- Proactively ask that staff not wake your loved one in the night unless urgently needed

Understand the reason for the hospital stay

- More than 40% of patients leave the hospital without clear understanding of what diagnoses, test results, and treatments were done
- When you look at patients (or families of patients) who are cognitively impaired, rates as high as 60-90%

Reason for hospital stay

Questions to ask:

1. What did the doctors learn about my loved one's condition?
2. What did the doctors do to treat the condition?
3. Was this a new problem or related to a health problem already known?

Take written notes

Medications

- Bring a list of all medications that your loved one was on before the hospital
- Make sure you get (request if not provided) a list of all medications (include both the brand and generic name) that your loved one should be taking when they go home.
- Ask specifically about medications that are only on one of those lists (medications taken before that are now discontinued – is this intentional?) and Medications ordered to continue at home (is this intentional?)
- Make sure you have either the medication or a prescription for all the medications needed and can afford them
  - If you can't afford them, let the hospital know.
- Ask what time the next dose of medications is due
- Keep the updated list (rewrite or re-type it if needed) and make at least 3 copies.

Follow up Visits

- Make sure you have an appointment before you leave the hospital for follow up with either the specialist or your primary care doctor or both. The hospital can help if you have trouble getting an appointment that is soon enough.
- Ask the hospital to give you copies of any important labs, xrays, or test results
- Request (probably to more than one person) that the hospital send copies of your hospital records to the doctors you are going to be seeing. Give the hospital staff the name, phone number, fax number for that doctor.

Who should I ask about all this?

- Short answer: Everyone – doctor, nurse, social worker or case manager
- Anyone who seems particular motivated to help

Additional care and activity

- Think through the tasks that you have to your loved one do: Bathe, dress, toilet, walk, eat
- Make sure you feel comfortable with the plan to make sure these tasks get handled
- Examples: Home health, equipment (durable medical equipment or DME), hospice, private caregivers, Adult Day Health, meals on wheels

Additional Services

- Make sure you have name of agencies, contact person's name, phone number, and have a delivery or expected start of services date and time before you leave the hospital.

First 30 days at Home

- High risk for rehospitalization
- Rates as high as 1 in 6
- Medication related problems
- Nutrition – eat something; eat anything!
  - Shakes don't help if not eating much
  - Eat together with others for meals (social eating)
- Get back to a regular schedule
- Avoid depression – socialize, visitors, etc
- Anticipate sleep deprivation and recovery
- Fall risk (lower at home than in hospital, but with functional decline and possible worsened cognition, can be worse)

Questions?