Gaps in Seniors' Transition from Rehabilitation to Home

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Purpose

A review of the literature revealed three primary areas that affect the success of transitioning home from a rehabilitation facility: the client, the caregiver, and the community (Graham, Ivy, & Neuhauser, 2009; Grant et al., 2013; Gustafson & Bootle, 2013; Wodchis & Bourgeault, 2015; &Young, Lutz, Creasy, Cox, and Martz, 2014).

The purpose of this study was to examine the three areas identified in the literature in greater depth, in order to identify gaps and limitations in the transition of care for clients discharged from acute care, inpatient rehab, and skilled nursing facilities to home with home health care. Bringing awareness to these deficits will help facilities recognize areas to improve which will improve client outcomes.

Methods

Participants of this IRB approved study were provided informed consent prior to responding to an online survey. No personal identifiers were collected. This study utilized a mixed methods design to obtain quantitative and qualitative data. Data analysis was performed utilizing a descriptive statistical analysis of quantitative data and a thematic analysis of qualitative data.

Participants: 31 occupational therapists (OTs) who either currently work or have previously worked in home health care with persons over the age of 65 who transitioned from acute, inpatient, or skilled nursing rehabilitation to home.

Participants completed a 42-question survey which focused on influential areas of transition pertaining to three major areas: client, caregiver, and community resources.

References

Graham, C. L., Ivey, S. L., & Neuhauser, L. (2009). From hospital to home: Assessing the transitional care needs of vulnerable seniors. *The Gerontologist, 49*(1), 23-33. doi:10.1093/geront/gnp005

Grant, J. S., Clay, O. J., Keltner, N. L., Haley, W. E., Wadley, V. G., Perkins, M. M., & Roth, D. L. (2013). Does caregiver well-being predict stroke survivor depressive symptoms? A mediation analysis. Topics in Stroke Rehabilitation, 20(1), 44-51. doi:10.1310/tsr2001-4

Gustafsson, L., & Bootle, K. (2013). Client and carer experience of transition home from inpatient stroke rehabilitation. *Disability and Rehabilitation, 35*(16), 1380-1386. doi:10.3109/09638288.2012.740134

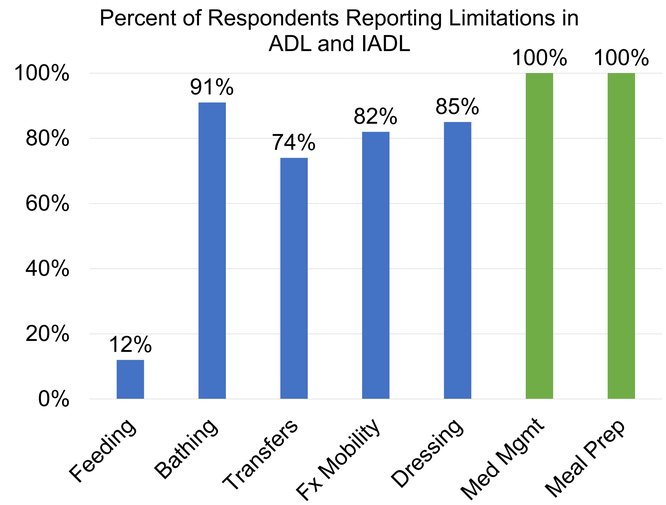
Wodchis, W., & Bourgeault, I. L. (2015). Experiences of older adults in transition from hospital to community. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement, 34*(1), 90-99. doi:10.1017/S0714980814000518

Young, M. E., Lutz, B. J., Creasy, K. R., Cox, K4. J., & Martz, C. (2014). A comprehensive assessment of family caregivers of stroke survivors during inpatient rehabilitation. *Disability & Rehabilitation, 36*(22), 1892-1902. doi:10.3109/09638288.2014.881565

Results

The results came from 30 different home health therapists reporting on behalf of clients transitioning from acute care (15), inpatient rehabilitation (3), skilled nursing facility (11), and hospital (1). Diagnoses included orthopedic (7), CVA (4), cardiopulmonary (11), debility (3), multiple diagnoses (4), and other (1). The thematic analysis yielded four different themes including: **(1) limited independence with ADL and IADL completion, (2) insufficient home modifications, (3) caregiver preparedness**, and **(4) under utilization of community resources**. These themes corroborated findings from the literature review. These themes are represented in the graphics below:

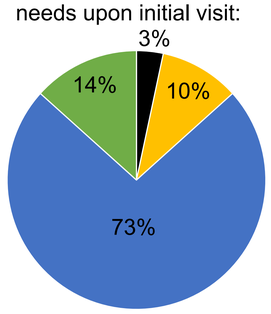
1. Limited Independence with ADL and IADL Completion



Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree

2. Insufficient Home Modifications

The home was modified to meet clients' needs upon initial visit:

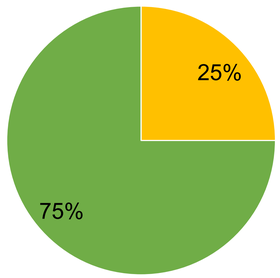


86% of therapists reported that their clients' homes were not typically modified in accordance to their post-hospital needs and suggested that transition should include:

"Discharge planning to include home visits prior to discharge to allow caregiver to implement (rehab) instructions"

3. Caregiver Preparedness

Caregiver was prepared:



Challenges experienced by caregivers:

"...some anticipate that they can provide care while working a job away from home, or by dropping in a few times/day, which is usually inadequate"

Lack of caregiver education:

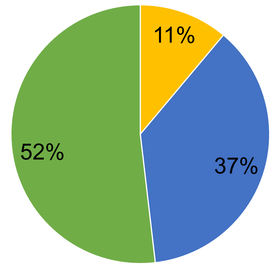
"Lack of prior education from previous setting regarding what they can do to support the patient..."

Learned helplessness:

"...Upon discharge to home, families are completing tasks for patients instead of encouraging patients to perform (them) on their own"

4. Under Utilization of Community Resources

Clients typically have been set up with access to appropriate community services:



89% of therapists felt as though their clients were not adequately connected with community resources at the time of their transition to home.

When asked which community resources were underutilized by their clients and their caregivers, two therapists replied:

"All"

Discussion

Limited ADL/IADL

- Clients with higher levels of dependence were not ready to transition home, especially 100% assistance need for medication management
- Initial dependence with ADL/IADL may indicate a lessened rehab potential

Home Modifications

- Lack of needed DME or home modifications increase dependence with ADL/IADL

Caregiver Preparedness

- Increased dependence creates undue stress for client and caregiver alike and correlates with reduced caregiver preparedness

Community Resources

- Resources not known or utilized adding to burden and stress of caregivers and clients

Overall

- Responsibility not clear who should address each gap in transition care: the discharging OT or the home health OT
- Communication between the rehabilitation facility and the home health OT may improve the continuum of care

Limitations

- While this study identified client level of assistance, it did not identify whether or not the level of assistance was appropriate for the client. The level of functional independence needed to return home with home health services is heavily dependent upon numerous factors such as living situation, availability of caregiver support, capability of caregiver support.
- This study did not draw a distinction between home modifications and DME that were absolutely necessary upon return home and those that would improve functional independence, but were not vital upon initial home health evaluation.
- The study does not define what is entailed within each IADL.

Recommendations

- Further studies can help determine what aspects of home modifications, DME, and medication management should be addressed at each level of rehabilitation.
- Larger sample size will allow comparison between diagnoses and settings.
- Survey clients to obtain client perspectives and gather greater detail.
- Greater focus on relationship between levels of independence at discharge and caregiver and community support.