P004

The CHARM Study - Coordinating transitions from hospital for older adults with fractures: An interventional mixed methods study

Summary

- Fall-related injuries, such as fractures, are increasing amongst older adults in New Brunswick, leading to hospitalizations and negative health effects.
- Transitions in care can be complicated and overwhelming for patients and families. Effective communication and coordination of care during these transitions are crucial.
- To improve inpatient care and the transitions in care, a Patient Navigator program was implemented. Trained professionals, Patient Navigators, helped to guide patients through the healthcare system.
- Older adult patients who were admitted with a fracture to a New Brunswick hospital's Orthopedic Unit, along with their family caregivers, were approached to participate. Those patients who consented were randomly assigned to receive the Patient Navigator intervention (37 patients, 8 caregivers) or standard care (39 patients, 7 caregivers).
- This project evaluated the impact of the Patient Navigator program on: length of stay in acute care; unscheduled healthcare utilization post discharge; patient and family caregiver experience and satisfaction with care; and HCP experiences working with Patient Navigators.
- A total of 76 patients aged 65+ (83% women) and 15 family caregivers (93% women) were recruited.

HSPP Focus Area	Developing innovative care pathways
Project Start & End Date	June 2022 – March 2024
Organization/Agency	Horizon Health Network
Location	Saint John, New Brunswick
Principal Investigator(s)	Dr. Pamela Jarrett

Indicator	Impact / Outcome / Result	Quote
Health Care System Barriers	According to interviews, patient navigators positively impacted the acute care experiences of patients and their family caregivers as well as their satisfaction with care after discharge from acute care. Interviews showed that Patient Navigators **advocated** for patients and improved **support** for and **communication** with families.	"*Oh, excellent [experiences with Patient Navigator], yeah. Good, good job she was around there, 'cause, you, you know, to figure out all that stuff on your own, you'll be, kind of, lost in the dark, or something [laughs]. With nowhere to go [laughs]… Yeah, just, uh, get all these people gathered up that we needed to help mum. Yeah. Took a lot of different things off our shoulders, so we wouldn't have to worry about it.*" (Family Caregiver, Patient Navigator Group)
Use of In-Home Services	The patient navigator program shows promise for improving patient care transitions and post discharge care experiences by providing information, support and assistance to coordinate and access necessary services.	"*Like, she kind of put it all together, because all of them had their separate things, right. Like, OT came to talk about OT, and the physio were doing their own thing. And, but, er, yeah. [Patient Navigator] was great, getting it all together for me. And, like, I think she signed me up for that extramural programme, because I didn't really have to call people at all. And I get home on the Friday, and they started coming on Tuesday. Like, it was amazing.*" (Patient, Patient Navigator Group)
Repeat Usage	Results suggested that program benefits were greater among patients who were frail and/or who had less family support available.	

Methods and Comparison

60 patients and 15 caregivers were interviewed to capture their experiences from acute care to three months after discharge. Quantitative measures of patients' length of stay in acute care; patient and family caregiver satisfaction with care, and patient healthcare utilization after discharge from acute care were collected using medical records and follow-up calls.

Conclusions and Lessons Learned

- According to interviews, patient navigators positively impacted the acute care experiences of patients and their family caregivers as well as their satisfaction with care after discharge from acute care.
- Results suggested that program benefits were greater among patients who were frail and/or who had less family support available.
- The patient navigator program shows promise for improving patient care transitions and post discharge care experiences by providing information, support and assistance to coordinate and access necessary services.

Recommendations

- Integrate patient navigator services into the care and recovery pathway for older adults after a fracture, focusing on those who have higher levels of frailty and fewer familial/social supports.
- Address budgetary constraints for the hiring and training of patient navigators.
- Include patient navigator positions within clinical department reporting structures.

Next Steps

The project has not secured further funding to scale up or sustain the project. This project has demonstrated the importance of exploring patient and family experience as part of health care outcomes. More work is needed to better understand how to successfully measure these outcomes. This project has also inspired the need for further work in this area and the need for better research in the area of the role and impact of patient navigators. Further work is being planned.

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