Building Bridges: Successful Transitions in Care

A Senior Friendly Approach to Avoiding Hospital Readmissions

Care Transitions: The set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or levels of care.

Coleman & Berenson, Ann Intern Med, 2004, 140: 533-536

Those at Risk for Hospital Readmission

- Older age
- Male
- Living alone
- No family doctor
- Acute care admissions in last 6 months
- Heart failure or COPD
- Functional decline
- Change in cognition
- Multiple chronic diseases
- Marginal social support network/ socioeconomic status
- Frailty
- Patient unable to successfully “teach-back”
- Dementia
- Literacy issues
- Language barrier
- Abbreviated or protracted length of stay

Pitfalls for Successful Care Transitions

- Under-recognition of geriatric syndromes
- Fragmented care (poor hand-offs)
- Silos of care
- Inadequate communication between health care providers
- Poorly coordinated discharge planning
- Limited access to discharge resources

Senior-Friendly Hospital Framework applied to transitions in care:

Processes of Care

- Book follow-up appointment with family doctor prior to discharge (and ensure a way of getting there!)
- Provide written and “warm” verbal handoffs
- Reconcile medications
- Provide written instructions and use “teach-back” (medications, early warning signs that flag a worsening condition and how to respond)

Emotional / Behavioural Environment

- Begin conversations about discharge on admission
- Strengthen patient involvement
- Include caregiver
- Review available supports

Physical Environment

- Ensure a pre-discharge senior-friendly hospital environment, (eg. promote vision, hearing, mobilization)
- Consider living situation and supports
- Prepare discharge environment
- Follow-up phone call or visit

Ethics in Research/ Clinical Care

- “Do No Harm” while in hospital, i.e. prevent disability (loss of self-care ability): mobility, falls risk, nutrition, delirium, pressure ulcers, promote ADLs
- We are all responsible for successful discharges
- Differentiate between functional and decisional capacity
- Study this phenomenon—there is little research

Organizational Support

- Provide interprofessional approach
- Know your resources
- Engage community organizations

What can you do?

Discharge transition bundle:

- Identify patients at high-risk for readmission
- Teach-back
- Follow-up visit with CCAC Rapid Response Transition Team (R2T2) on day one if high risk
- Written discharge instructions
- Discharge summary at discharge
- Discharge checklist (eg. medications, referrals, appts)
- Arrange follow-up with primary care (2-5 days for high risk)
- Warm hand-off
- Medication reconciliation

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RGP central

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