Hospital-to-Home Connections through Transitional Care: Summary Information for Hospital Diversion Projects

(Excerpt "*From Hospital to Home: Improving Transitional Care for Older Adults,* Health Research for Action, UC Berkeley, 2006.)

What is Transitional Care? Transitional Care is provided to a patient as they transition from one care setting to another.

Why is Transitional Care Important? Care Transitions are an increasingly critical health and social problem for seniors and their caregivers.

- Hospitalization can be a turning point in the lives of seniors (and younger persons with disabilities), whose physical and mental health often deteriorate after discharge. Many older adults experience breakdowns in care during the transition from hospital to home. This results in high rates of poor outcomes and re-hospitalization. Patients and caregivers are on the receiving end of a badly fragmented system of care, and both medical and caregiving support during the hospital-to-home transition are inadequate.

Review of Literature: What *Doesn't* Work

- 30 years of hospital-only discharge planning interventions showed no definitive change in patients' status: same mortality, same hospital readmission rates, same cost of care, same length of stay and mixed findings for patient satisfaction (Sheppard et al. 2004).
- Why the intervention showed no definitive change:
  - The interventions used a single discipline/medical framework
  - Availability and type of payment dominates the discharge process

Review of Literature: What *Works*

- Multi-disciplinary team interventions at the hospital led to increased patient satisfaction, quality of life, improved health outcomes, especially for psychiatric diagnosis.
- Supported discharge with post-acute care leads to improved outcomes, and reduced re-hospitalization

Interviews with Providers: Problems with Current Discharge Planning Process

- Lack of care coordination
- Lack of information and training
- Poor training for discharge planning
- Premature/inappropriate discharge
- No services in place before discharge
- No follow-up post discharge

Caregivers and Patients Need More Information and Training

- Inadequate information at discharge (too much volume, not tailored to the care recipient)
- Lack of information about services
- Inadequate training in care of patient, resulting in a sense of insecurity about ability to provide needed care

Seniors at Risk

- Non-English speakers, recent immigrants
- Seniors with multiple, chronic conditions
- Isolated seniors (lack of caregivers and support at home)
- Low-income and middle-income seniors
- Higher-income seniors have trouble fining quality services, face risks from caregiving

Framework for Effective Transitional Care

- Multidisciplinary trams to ensure that services are in place before patient is discharged
- Discharge planning begins at (or before) admission, includes caregiver in unit of care
- Risks/needs of patients assessed at several stages
- Home assessment/modification done before discharge
- Caregiver support
- Follow-up calls and 24-hour telephone support
- Caregiving training
- Information for patients and caregivers
- Provider training in culturally competent, effective transitional care