Improving Care Transitions for Older Adults

Goal of Care Transitions

1. To assist older adults coping with multiple chronic conditions to successfully transition from acute care into other less-intensive settings or the home
2. To address root causes of poor outcomes and to prevent re-hospitalizations
3. To effectively COMMUNICATE with providers and share clinical information across settings

Role of the Care Transitions Clinical Team

1. Maintain open COMMUNICATION and collaboration of care between different settings and professionals leading to individualized plans of care
2. Ensure the coordination of discharge planning to include discharge services and the engagement of the patient and caregiver(s)
3. COMMUNICATE discharge instructions that are easily understood by the patient
4. Set date and time for a follow-up appointment with PCP and other healthcare members

Care Transitions Models

1. Dr. Eric Coleman - "Four Pillars"
   a. Medication = Self-Management
   b. Dynamic Patient-Centered Record
   c. Provider Follow-up
   d. Red Flags: Patient is unable to identify worsening symptoms and understands how to respond
2. Dr. Mary Naylor - "4 Key Components"
   a. Focus on patient and caregiver understanding
   b. Help patients manage health issues and prevent decline
   c. Reconcile and manage medication
   d. Concentrate on transitional care, not ongoing case management

Poor Care Transitions Causing High Utilization Costs

1. Breakdown of COMMUNICATION and accountability:
   a. Patient and caregiver distress, confusion, and dissatisfaction with care
   b. Lack of coordinated discharge planning
   c. Delayed transfer of discharge summary
   d. Unknown test results
2. Ineffective transitional care management:
   a. Failure of the care teams to identify problems early—psychosocial, behavioral, and cultural
   b. Deficient living environment and affordable community resources
   c. Medication errors and/or discrepancies
   d. Lack of follow-up with PCP or specialists
   e. Low health literacy
   f. History of readmissions
3. Deviation from evidence-based care:
   a. Suboptimal chronic illness management
   b. Poor self-care skills and decline in health and functional status
   c. Inadequate care leading to avoidable hospitalizations

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