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Lessons learned managing geriatric patients offer framework for improved care

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A large team of experts led by a Johns Hopkins geriatrician reports that efforts to improve the care of older adults and others with complex medical needs will fall short unless public policymakers focus not only on preventing hospital readmission rates, but also on better coordination of community-based "care transitions." Lessons learned from managing such transitions for older patients, they say, may offer a framework for overall improvement.

Nationwide, some 22 percent of older adults experience so-called care transitions annually, moving from and among hospitals, rehabilitation facilities, nursing homes, long-term care, assisted living and their homes. In a report published online in the *Journal of General Internal Medicine* on Feb. 21, 2014, the experts say studies have long shown that fragmented care, incomplete information "handoffs" and poor planning among community-based and home caregivers jeopardize health and safety.

Similarly, the team says, those with traumatic brain injuries, cancer, end-stage kidney failure, complicated diabetes, heart disease, developmental disabilities and cerebral palsy need better coordination of their care across health care settings.

Using a review of research and clinical experience, the authors built their framework and recommendations for improving care on the foundation of what's been learned about caring for aging Americans.

Among their recommendations for health policymakers and caregivers are the need to engage community-based care "receivers" earlier in the transition process, to adopt a palliative care approach with patients and their families that sets realistic care goals, and to focus not only on preventing hospitalization, but also on making out-of-hospital transitions easier.

"In this framework, emphasis is placed on the importance of looking at community, system and regional factors that play into care transitions," says report co-author Alicia I. Arbaje, M.D., M.P.H., director of transitional care research for Johns Hopkins Bayview Medical Center and assistant professor of medicine at the Johns Hopkins University School of Medicine.

Many of the group's recommendations focus on communication among providers. For example, Arbaje says, hospital staff should not only make follow-up phone calls to check on discharged patients, but they should also send written care instructions. Family members and caregivers should be a part of patient education during discharge. Small chores, such as alerting a skilled home health care provider well in advance of a patient's discharge, can make coordinating care and recovery plans more effective.

"Our suggested framework is designed to help providers think ahead instead of reacting during a patient's crisis," says Arbaje. Recovery and emergency contingency plans need to be broader than referring a patient back to a primary care physician and instead include other components of an individual patient's health care system and support.

"These findings shed light on what we can do as a health system and community to reduce readmission rates by looking at more than just the patient. The conceptual framework gives structure to understand problems with care transitions and outlines what and who to consider

when planning and implementing them. It can be a valuable tool for health care systems and policymakers to guide care coordination efforts as part of health care reform," she says.

More information: The full report is titled "Regardless of Age: Incorporating Principles from Geriatric Medicine to Improve Care Transitions for Patients with Complex Needs."

Provided by Johns Hopkins University School of Medicine

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