



Slipping Through the Seams: Optimizing Transitions in Care Settings for People with Serious Illness

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Case example

A middle-aged gentleman presented to the hospital following a severe motor vehicle accident. He suffered from extensive injuries including a severe brain injury and skull fractures.

Upon discussion with the neurosurgical, trauma surgery, and palliative care teams, his family was informed of their loved one's poor prognosis.

After conferring amongst each other, the patient's family decided to pursue organ donation.

They shared with the palliative care team some critical pieces of information needed to honor the patient and his family's Hindu practices. This included ensuring that, after organ procurement, his body be closed with sutures, as opposed to staples, and wrapped in a white cloth during transportation to the crematorium.

This information was shared verbally with members of the primary and consulting teams, as well as the organ donation representative; it was also reflected in a palliative care note.

Unfortunately, after transition from the ICU and into the OR and later to the crematorium, it was discovered that these practices were not honored.

THE NUMBERS

Transitions in palliative care

PATIENTS WHO
EXPERIENCE

1 in 5

**an adverse event
during a transition in
setting**

PERCENTAGE OF
OLDER PATIENTS
WITH

14%

**a medication query
on hospital
discharge**

PERCENTAGE OF
OLDER PATIENTS
WITH

40%

**a pending lab at
hospital discharge**

PERCENTAGE OF
FOLKS WHO
CHANGED CARE
SETTINGS

50%

**at least once in their
final 3 months of life**

PERCENTAGE OF
FOLKS WHO
CHANGED CARE
SETTINGS

10%

**≥3 times in their
final 3 months of life**

THEMES

Transitions as a cause of suffering

Uncertainty about the new care setting

- Knowledge about the new care setting and discharge plan
- Access and availability of care

Biographical disruption

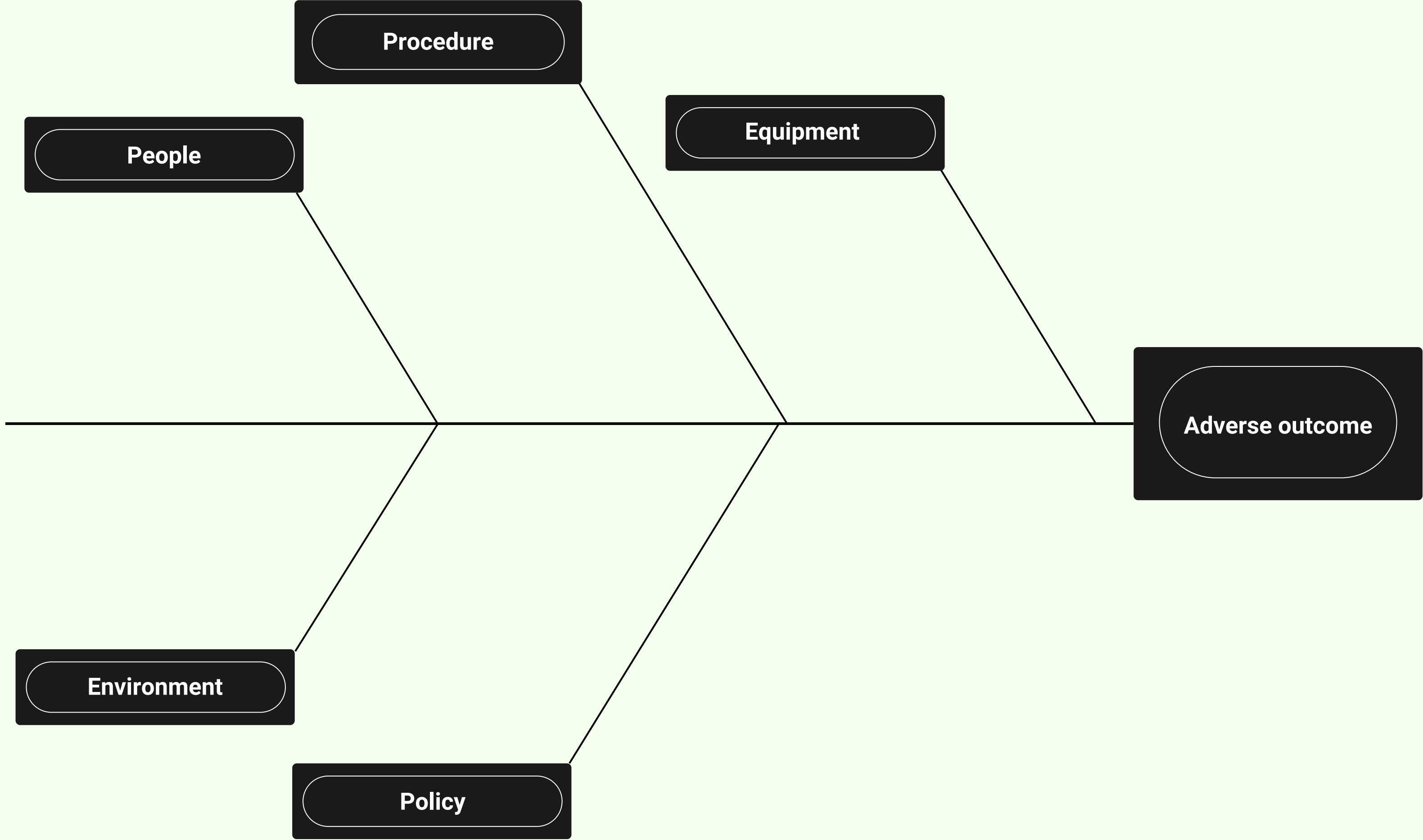
- Adjustment to identity change
- Maintaining normality

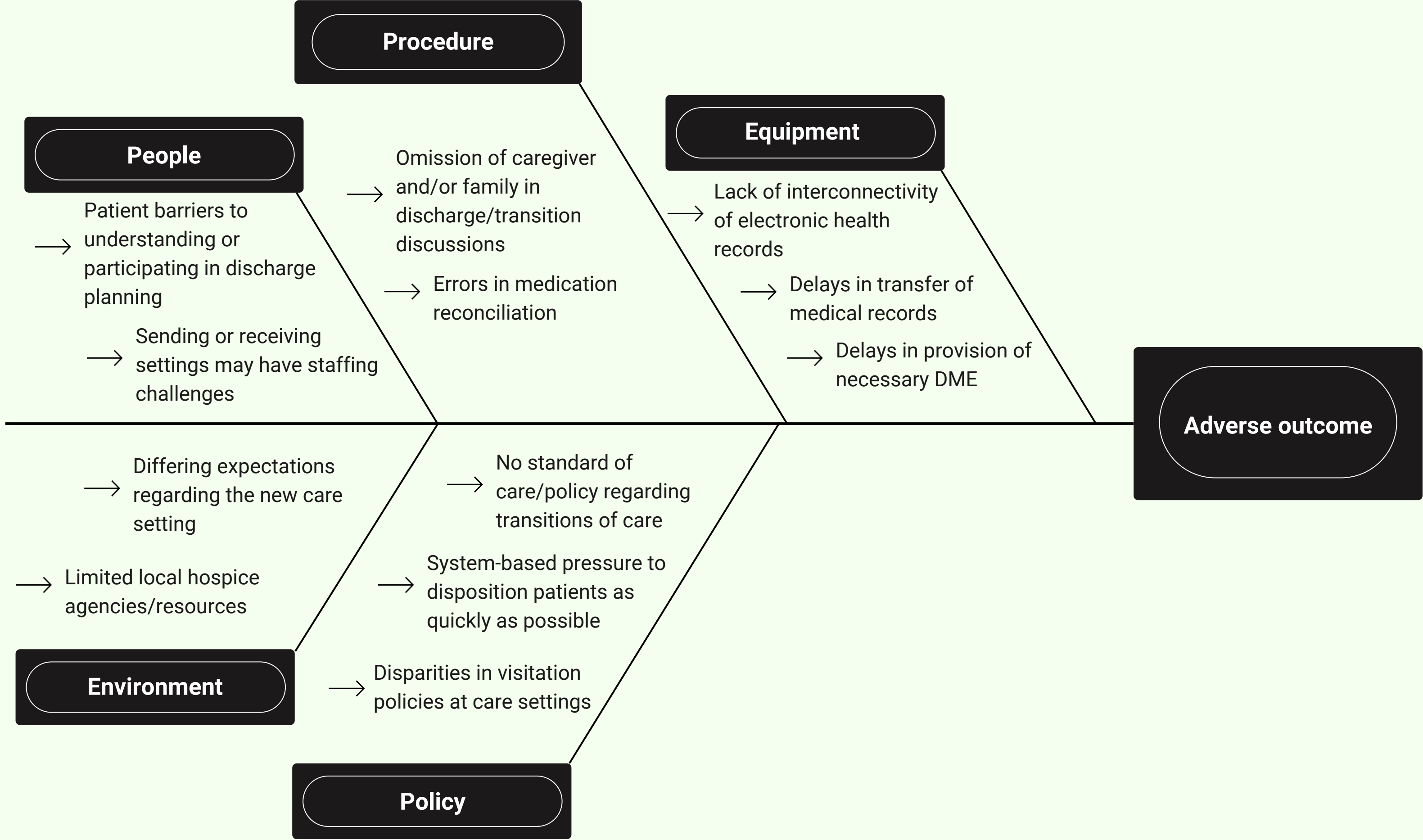
Importance of continuity of care

- Tired of retelling stories
- Feeling unsafe

Need for emotional and practical support

- Support from family and friends
- Isolation





Current tools in use

Project BOOST (Better Outcomes for Older Adults through Safe Transitions)

- 8Ps (risk factors for readmission) including (1) problems with medications, (2) psychological, (3) principal diagnosis, (4) physical limitations, (5) poor health literacy, (6) poor social support, (7) prior hospitalizations, and (8) palliative care
- General Assessment of Preparedness (GAP)
- Patient-centered discharge instructions (PASS, DPET)
- Teach Back method

Project RED (ReEngineered Discharge)

- 12 mutually reinforcing components delivered during hospitalization
 - Need for language assistance
 - Contingency/emergency planning
 - Provide accepting facility with clinical information within 24h of discharge

DISCUSSION

Questions to consider...

- These tools are great for the sharing of clinical/medical information, but how do we best convey goals of care discussions and preferences of care across care settings?
- How do we ensure that information about spiritual and cultural practices is relayed during a transition? Who is responsible for this?
- How do we identify “high-risk” patients that may need a verbal hand-off to another clinician during a transition?
- How do we collect feedback from patients and families about their transitions in care settings?
- What are challenges you are seeing in your region/system?

Thank you

References

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