Improving care transitions for older adults

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Care transitions are the movement of patients between different levels or locations of care, such as from a hospital to a patient's home in the community. Care transitions are a high-risk time for older adults given their complex health and social care needs, with nearly 1 in 5 experiencing adverse events after discharge.[1] In Canada, approximately 9% of patients discharged from hospital are readmitted within 30 days, costing the health care system $2.5 billion annually.[2] The risk of readmission is higher for older adults; 10.6% of people older than 65 years of age who are hospitalized from the community are readmitted within 30 days.[3]

Transitions from hospital to home often cause considerable distress for both patients and caregivers as they grapple with the uncertainty of managing their illness at home and knowing whom to contact for assistance.[4] These occurrences are critical junctures in patient care that require interdisciplinary teamwork, thoughtful coordination, and effective communication among health care providers, patients, and caregivers.[5] In 2020, Ontario Health released a quality standard titled *Transitions Between Hospital and Home* to support this process.[6] Specifically for older adults, a comprehensive assessment of geriatric syndromes, medications, activities of daily living, and cognitive and psychological status throughout admission is expected to guide the transition plan.[6] Furthermore, the essential role of primary care could not be overemphasized. Patients who lack timely primary care follow-up are 10 times more likely to be readmitted and have hospital stays nearly 2 days longer than those who receive timely primary care follow-up.[7] However, there are 2.3 million Ontarians without a family physician, of which an estimated 13% are older than 65 years of age.[8]

Crucial questions in primary care include how to optimize transitions of care for older adults and how to create education and training opportunities for medical learners to develop skills that enable older adults to have safe and timely care transitions.

Role for a new model of care

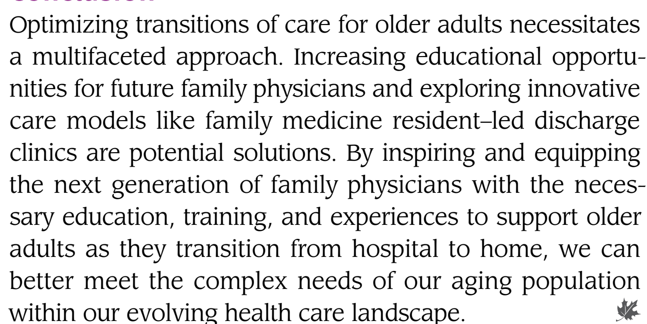
A potential solution to improving transitional care is the establishment of family medicine resident–led discharge clinics. Postdischarge clinics are a common service offered by specialists to provide short-term care following admission for an acute illness; however, a similar model is lacking in family medicine. These clinics could provide short-term comprehensive follow-up care to older patients who do not have a primary care provider, ensuring continuity and addressing any emerging issues promptly from a holistic family medicine perspective. This model offers a structured approach for residents to gain practical experience in transitional care management and increases access to care for patients without a primary care provider. Further, residents would refine their practice management skills while collaborating with interdisciplinary teams involved in the patient's circle of care, all of which are essential competencies as outlined by the CanMEDS roles.[9] A similar model was implemented whereby second- and third-year internal medicine residents arranged and provided follow-up care to unattached patients after hospitalization under the supervision of a staff internist. It was found to be effective in teaching residents about care transitions and improving patient access to posthospital care and, importantly, was described as feasible and easily implemented.[10] Given that most older adults without primary care physicians experience discharge delays,[7] this could present a potential solution to facilitating timely outpatient care, decreasing hospital length of stay, and reducing hospital readmissions.

Role for medical education

Medical education is an important way to stimulate curiosity among learners about the uniqueness of older adult medicine, which blends complex medical, social, functional, and psychological aspects of care. While 14 of 16 family medicine residency programs mandate care of the elderly rotations as per a 2011 survey,[11] residents' exposure to care transitions varies depending on the communities in which they complete training. Currently, there is no essential competency at the University of Toronto in Ontario requiring family medicine residents to demonstrate an effective approach to supporting older adults' transitions between health care settings, indicating a potential knowledge and skills gap. Given that family physicians support these transitions by coordinating services, aiding in patient decision-making, and facilitating continuity of care and communication across settings,[7] training in care transitions should be formally embedded into the curriculum for family medicine residents. A 2-week transition-of-care curriculum designed for internal medicine residents increased confidence in all aspects of care transitions and stimulated ideas for system improvement.[12] This could represent an area for future curriculum development in family medicine where education and training focuses on challenges older adults face when reintegrating into the community

after hospital admission. Providing medical students and residents with exposure to long-term care environments would also be valuable to inform challenges experienced by patients and their care teams when patients return to long-term care homes. Ultimately, there is an opportunity for medical education to increase trainees' exposure to models of care that support transitions in care for older adults and provide opportunities to understand their unique challenges. This would prepare future family medicine residents for the realities of an aging population receiving health and social care across a continuum of health care settings.

Conclusion



Optimizing transitions of care for older adults necessitates a multifaceted approach. Increasing educational opportunities for future family physicians and exploring innovative care models like family medicine resident–led discharge clinics are potential solutions. By inspiring and equipping the next generation of family physicians with the necessary education, training, and experiences to support older adults as they transition from hospital to home, we can better meet the complex needs of our aging population within our evolving health care landscape.

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Competing interests
None declared

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