Systems-Based Practice to Improve Care Within and Beyond the Emergency Department

Marsha Vollbrecht, MS, CSW[a,*], Kevin Biese, MD, MAT[b,c],
Susan Nicole Hastings, MD, MHS[d], Kelly J. Ko, PhD[e],
Laura Ann Previll, MD, MPH[f]

KEYWORDS

- Emergency department • Care transitions • Geriatric • Culture change
- Implementation science • Leadership buy-in • Alternative approaches

KEY POINTS

- There is abundant evidence that an emergency department (ED) visit signifies a period of vulnerability for older adults, especially as they transition back to the community.
- There are essential elements for improved transition of older adults from the ED back to the community.
- Starting a new program for ED transition requires buy-in from leaders, the clinical team, and the community.
- Following implementation science and frameworks will increase the success of program implementation and dissemination across a health system.
- There are many examples of successful alternative approaches to older adult transitions within health systems.

CARE TRANSITIONS PERILS

There is abundant evidence that an ED visit signifies a period of vulnerability for older adults, and the transition between the ED and community care can be fraught with

Disclosure Statement: The authors have nothing to disclose.

[a] Senior Services, Aurora Health Care, 1020 North 12th Street, Milwaukee, WI 53233, USA; [b] Academic Affairs, Internal Medicine, Division of Geriatrics, 170 Manning Drive, CB#7594, Chapel Hill, NC 27599, USA; [c] Division of Geriatric Medicine, 170 Manning Drive, CB#7594, Chapel Hill, NC 27599, USA; [d] Center for Health Services Research, Durham VA Health Care System, Duke University School of Medicine, Center for the Study of Aging and Human Development, Duke University, Duke Box 3003, Durham, NC 27710, USA; [e] West Health Institute, 10350 North Torrey Pines Road, La Jolla, CA 92037, USA; [f] Department of Medicine, Division of Geriatrics, Duke University, DUMC 3003, Durham, NC 27710, USA
* Corresponding author.
E-mail address: marsha.vollbrecht@aurora.org

Clin Geriatr Med ■ (2018) ■–■
https://doi.org/10.1016/j.cger.2018.04.005 geriatric.theclinics.com
0749-0690/18/© 2018 Elsevier Inc. All rights reserved.

challenges.[1–4] In particular, providing information to patients who are acutely ill or injured and their families is difficult in a busy ED. Many older adults have cognitive, vision, or hearing impairments and/or low health literacy, making it even more difficult to receive, process, and retain sometimes complicated discharge instructions. Patients with preexisting chronic illnesses, suboptimal medication therapy, and poor understanding of ED discharge information are at higher risk of return visits, underscoring the need to improve ED care transitions.[5–7] This article describes some challenges of care transitions, reviews best practice strategies, provides an example of systems-based improvements at a health care system in Wisconsin, and outlines some lessons learned.

Insuring smooth care transitions for older adults from the ED carries many challenges. Particular emphasis has been on patient safety, preventing unscheduled return visits, and strengthening community partnerships that lie at the core of optimal transitions of care for older adults in both hospital and ED settings.[8,9] During care transitions, "clinicians, including those in the ED, are responsible for ensuring that clinical information is shared across settings and when necessary, direct clinician-to-clinician communication occurs to address time-sensitive questions and transfer accountability of patient care."[10,11]

BEST PRACTICES

For an older adult, an ED visit is generally imbedded in a web of other interactions of the patient with the health care system. The care delivered in this setting has the potential for wide ranging outcomes, leaving much room for improvement (**Figs. 1** and **2**). Essential elements to improving ED transitions of care for older adults include verifying existence of a primary care physician or medical home, engaging with a patient's support system,[12] addressing palliative care needs,[13] completing medication reconciliation, and accessing accurate patient information across care settings.[14] Three areas of transitions of care best practice for older adults receiving emergency room care are discussed.

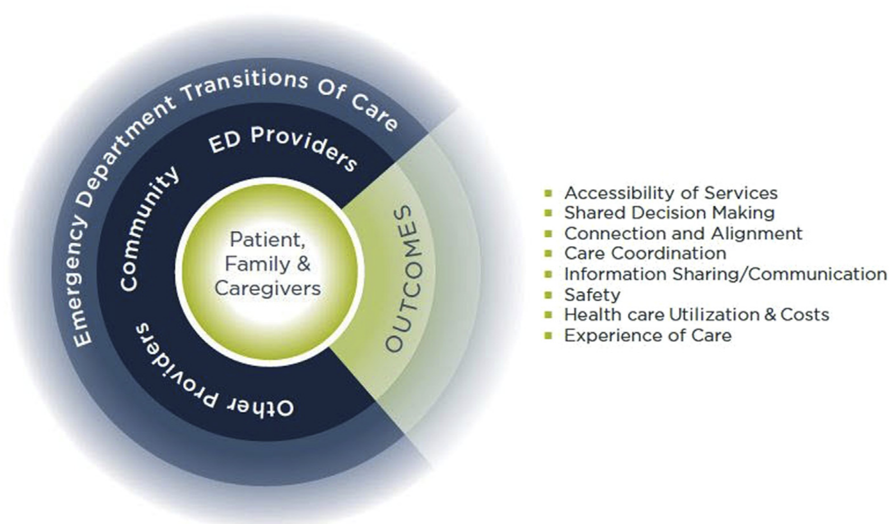

Fig. 1. Dimensions of care.

Download English Version:

https://daneshyari.com/en/article/8732308

Download Persian Version:

https://daneshyari.com/article/8732308

Daneshyari.com