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## **CONTEXT**

The lack of continuity of care during the transition from hospital to community has been identified as a problem with serious negative implications for the well-being of individuals in many countries where this has been studied, including Canada, the United States, the United Kingdom, Australia, Sweden, and Japan. Studies examining the experiences of patients and their informal caregivers deal mainly with medical issues and medical uncertainty. The social needs of the patients, such as the availability of supportive family environments, financial stability, and knowledge of community services, are implicitly present as a context for various interventions, but they rarely become a focus of analysis.

## **OBJECTIVES**

This study aims to examine how the care transition was experienced, organized, and coordinated by patients and their informal caregivers at home; to understand how patients and their caregivers experienced the transition to community and which barriers and facilitators they identified on their way to recovery.

## **METHODS**

Participants for the present study were identified from a care transition intervention implemented in South-western Ontario for patients discharged from acute care hospital to home. A risk-screening tool (LACE) was used to select high-scoring patients who were at high risk for acute care readmission, based on hospital length of stay, acuity or urgency of admission, comorbid condition and recent emergency department utilization. Thirty-six interviews with patients and their primary caregivers were conducted in the 2010-2012 time frame. The data were analyzed thematically and the responses of caregivers and patients were compared to identify similarities and differences between these two groups of participants.

## **FINDINGS**

Both patients and caregivers talked about difficulties of adjusting to the transition back home, confusion about organization of care and navigation through the health care system. The majority were overwhelmingly concerned with trying to re-establish order and routine in their daily lives – concerns that often overshadowed their worries about medical problems. Getting to medical appointments was seen as particularly challenging, especially during harsh winter conditions. Personal networks and social support were identified as a crucial facilitating factor for successful recovery. It was easier for individuals who had worked in the health care system as nurses or social workers to navigate the health care system and community services. Many caregivers saw having one person in charge of care as potential facilitator for successful organization of care.

## **CONCLUSIONS**

The study showed that the respondents were mainly concerned with the day-to-day life after discharge from the hospital. Based on the identified barriers and challenges, we propose policy recommendations. First, facilitators for transition in preparing residence after discharge include home safety assessment, coordination of discharge planning with family members and assessment of the availability of the basic necessities at home. Second, in-home services provision could be enhanced by regular visits from Nurse Practitioners, medical testing at home and more home visits by the health care teams including physicians. Lastly, ongoing management could be facilitated by case management approach, consistent care providers and more effective coordination between different providers.

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