Exploring the Transition from Hospital to Home in the older Adult Population

Sharon Saunderson Coffey, MSN, RN, ACNS-BC
College of Nursing

Introduction

- Discharge out of the hospital is a time of vulnerability for most older adults.
- Poorly coordinated care transition is costly at an estimate of $12 billion to $44 billion per year.
- The Acute Care for Elders (ACE) model is an interdisciplinary, patient-centered model that is function-focused and centric to the older hospitalized adult.
- Cognitive impairment increases with age and up to 61% of hospitalized elders suffer some degree of cognitive dysfunction.

Challenges to Transition of Care

- Standardized discharge methods may not meet the needs of elder patients with cognitive impairment.
- The discharge process may need further exploration to develop methodologies that are adaptable to the elder patient with cognitive dysfunction.

Objectives

- Screen the older adult using the Folstein Mini-Mental Screening Examination (MMSE) for cognitive level at time of hospital discharge from an ACE unit and non-ACE unit.
- Compare scores on the Care Transitions Measure (CTM-15) of older adults discharged from a unit using the ACE model and one without to assess for preparation for transition to home from hospital.

Application to Practice: Improving Transition

- Use MMSE evaluation to determine communication needs prior to hospital discharge.
- MMSE score along with functional status prior to admission will assist in post discharge needs.
- Patient-centered discharge instructions may include family to assure informed decision making and successful planning for transition from hospital to home.

Acknowledgements

Special thank you to Dr. Karen Frith & Dr. Susan Alexander of UAH College of Nursing and Dr. Zaheer Khan at the Center for Aging in Huntsville, AL.