The Transitions of Care Story from a Community Perspective

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What's on my book cover

- Lived Experience
- Research

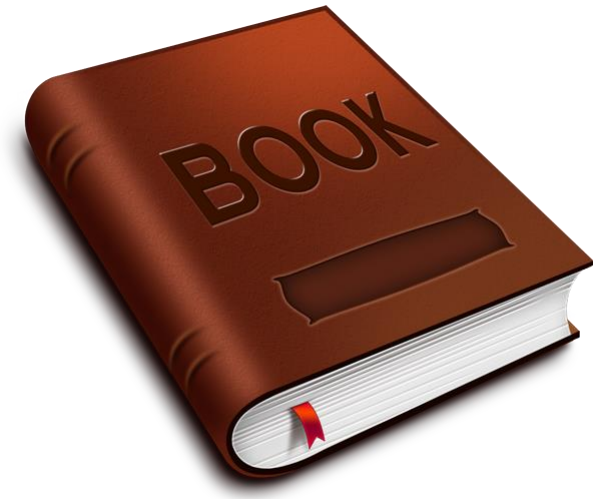

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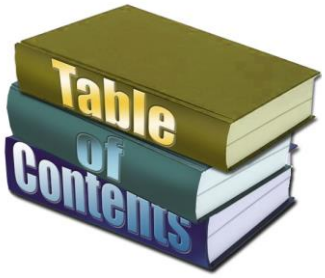
Table of Contents

- **Transitions of care** increase risk of adverse health events among older adults, resulting in costly readmissions to hospital care, where the individual's goals and preferences may not align with what happens.
- A **gap in understanding** exists between the healthcare approach and the human experience. Community organizations have implemented programs to bridge the gap, but they are generally unknown.
- Critical to learn about the **community perspective** to understand the multiple contextual elements that impact transitions.



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First interview

Partners have formal and informal programs and processes to support transitions of care primarily through:

advocacy

- walking alongside, making connections, supporting self-care, relationships

services

- transportation, care coordination, food security

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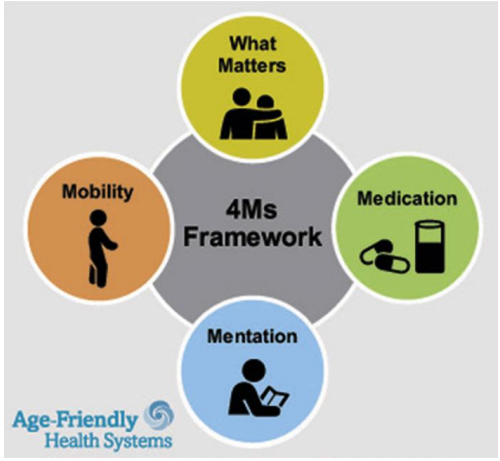
Chapter Two – Second Interview

4Ms Framework	Interview Questions
What Matters (Know and align care with older adult's specific health outcome goals and care preferences)	1. What do participants say matters to them? 2. Where do referrals come from, and what initial assessments do you complete? 3. How do you connect with families – who are the caregivers? 4. How do you identify and address health inequities, the need for advocacy? 5. What assets and challenges exist when your program intersects with healthcare systems? 6. How does the greater community support what you do? How are your interventions funded? 7. What resources do you have (or need) to accomplish the work? Who are your partners in the neighborhood – family, CHWs, churches, etc.? 8. What are the most common needs of seniors – referrals, services? 9. What works – where do you find success? What are the biggest barriers to delivery of services?
Medication (Use age-friendly medication that does not interfere with what matters, mentation or mobility)	1. What are your challenges in assuring access to medication? 2. What are the priority concerns of clients/families related to medication? 3. What community-based supports are available to assist in medication management?
Mentation (Prevent, identify, treat and manage dementia, depression and delirium)	1. How do you identify concerns about mentation? 2. What community-level preventive strategies are there and what is needed? 3. What challenges are there to assuring access to services when they are needed? 4. What are the priority concerns of clients/families related to mentation?
Mobility (Ensure that older adults move safely every day to maintain function and do What Matters)	1. What barriers in our community's structural environment challenge mobility? 2. What are the priority concerns of clients/families related to mobility? 3. What community-level prevention/wellness activities would you like to see available? 4. What mobility needs do you identify most frequently?



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Third interview (participatory findings – knowledge-building and suggestions before creating new program):

- Seniors are not prepared for new limitations after hospital
- **Loneliness and isolation is very real**, not just COVID
- Funding for programs is challenging – always stretching to do more with same resources
- **Technology can be limiting** – data literacy, even using phones
- Decision making, person-centered care
- Caregivers are key
- Access to resources and recommendations
- When you ask what matters, be well prepared and authentic

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Connect with under-resourced seniors – asking about what matters related to **technology** and **isolation** using 4Ms Framework.
(FIRE grant CU-CON: Faculty Innovation, Research, and Education Seed Fund)

Networking to participate in Age-friendly initiatives.

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Next chapters start with knowing:

- Transitions of care may initiate in the hospital, but they play out in the community.
- Age-friendly, community engaged approaches hold potential to reveal what matters most to older adults during times of transition. Without this contextual knowledge, health systems will struggle to provide client-centered care leading to desired health outcomes.
- Healthcare and community services should collaborate to support older adults experiencing transitions of care. Innovative, well-resourced programs in the community can support interventions that impact complex issues such as hospital re-admissions while also addressing “what matters” to older adults.

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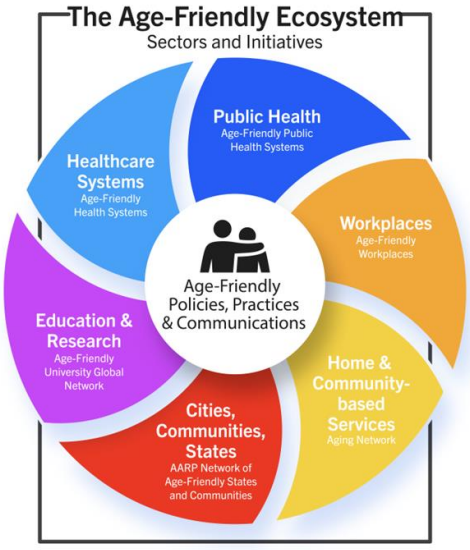

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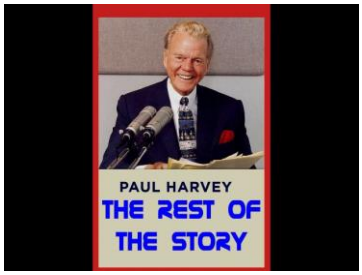
The Rest of the Story – thank you to:



- My Community Partners
- Creighton University – College of Nursing
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