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Transitioning from Hospital to Home: White Paper

Coming home from the hospital is not easy, especially for older adults who may face unexpected challenges. In a study of hospital discharges, 83% of patients had problems identified during the first 2 days after discharge.[1]

The Breakdown.

Finding themselves back at home after a hospital stay, many older adults struggle to manage their medications and make followup doctor's appointments as well as obtain the physical assistance and inhome support they may require, at least on a temporary basis. As a result, many older adults do not successfully make the transition home well and end up returning to the hospital.[2]

Elderly patients are at increased risk for poor outcomes in the transition from hospital to home. Factors associated with poor outcomes include breakdowns in communication between providers across health care agencies, inadequate patient and caregiver education, poor continuity of care, and limited access to services.[3]

Developing a Strategy for a Succesful Transition Home.

Because elders are released from the hospital after shorter stays and in weaker conditions, there is an even greater need for discharge planning and post-discharge services at home.[4]

Transition programs that include short-term in-home services for transportation to doctor appointments and shopping, light housekeeping, meal preparation, and laundry may see further beneficial outcomes.[5] One study found that regular in-home assistance was needed about 50% of the time to help with informal support with ADLs during the first few weeks after discharge. The in-home assistant helped to catch potential risks earlier, identify developing health problems, and prevent re-hospitalizations.[6]

Private duty homecare is the only post-acute provider who can be in the home consistently with the patient after discharge. Trained, Licensed Certified Nursing Assistants are available through Private Duty Home Care agencies to help with common tasks that can be difficult during this time, including: transportation to home/errands/ follow up doctor visits, medication pick-up and reminders, grocery shopping and meal preparation, mobility/ambulation assistance, bathing/toileting/hygiene assistance, light housekeeping/laundry/linens, and more.

Private duty homecare is the best way to ensure continuous assistance in the home post-discharge and to increase the success of a transition from hospital to home.

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1 The Illinois Transitional Care Consortium: the Bridge Model of transitional care (2011)
2 EldercareLocator (2011) Hospital to Home: Plan for a Smooth Transition
3 Naylor M. D., Brooten D., Campbell R., Jacobsen B. S., Mezey M. D., Pauly M. D., Swartz S. J. (2010). Comprehensive discharge planning and follow-up of hospitalized elders: A randomized clinical trial. Journal of the American Medical Association, 281(7), 613-620
4 Brown-Williams H. (2006, April). Dangerous transitions: Seniors and the hospital to home experience. In: Perspectives Health Research for Action (Vol. 1, No. 2, pp. 1-7). Berkley: University of California
5 Watkins, L. MSPT, PT, Hall, C., MSW, and Kring, D., PhD, RN (2012). Hospital to Home: A Transition Program for Frail Older Adults, Professional Case Management, Vol. 17, No. 3, 117-123
6 Ibid.