IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)
e-ISSN: 2279-0853, p-ISSN: 2279-0861.Volume 21, Issue 3 Ser.11 (March. 2022), PP 48-49
www.iosrjournals.org

A Short Narrative Review About the Need for Transitional Care

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***Abstract**: Transitional care is the uninterrupted medical attention a patient receives promptly after getting shifted from one health care location to another. It most commonly refers to the transition from hospital to home. Transitional care is especially important in the geriatric population with various persistent health issues. Majority of the elderly people are under the care of different doctors including specialists and subspecialists and it can be overwhelming for the patients and caregivers to tackle the change of patients from hospital to home after discharge. Transitional care bridges the gap between post-hospital-discharge and first visit to the primary care physician. This review focuses on the importance of transitional care and the effect of it in reducing readmissions.*

Keywords: Transitional care, post-hospital care, continuity of care, patient transfer.

Date of Submission: 18-03-2022 Date of Acceptance: 02-04-2022

I. Introduction

Transitional care includes a wide array of services and settings outlined to aid in the smooth and secure transfer of patients between levels of healthcare and across various care settings [1]. American Geriatrics Society defines Transitional Care as "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location" [2]. When patients get released from the hospital or transitioned from another setting, they will be provided with a lot of information and most of the times the patients or their caregivers will not be able to comprehend the vast information provided. This is especially difficult with the Geriatric population. They are particularly susceptible to lapses in care and they remarkably gain benefits from Transitional care [1].

II. Review

Method

Key word searches of Google Scholar, MEDLINE/Pub Med, UpToDate, NICE, TRIP, Cochrane library. Search words included Transitional care, post hospital care, after discharge, continuity of care, readmission.

Results

Keyword searches yielded 20 articles of interest. The articles published from 1990 to 2018 were considered for the review and only the articles published in English were considered.

III. Discussion

The hospital readmission rate in the United States for the year 2018 is 14.9% with Hawaii having a readmission rate of 12.2% and West Virginia having a readmission rate of 15.7 % within 30 days of hospital discharge in Medicare enrollees aged 65 years or more [3]. Hospital readmission rates are used to assess the quality of hospital performance and as a basis for hospital reimbursement [4]. Readmission causes major financial and administrative stress on the hospitals and financial and psychological stress on the patients. Readmissions indicate the failure of the best practice of care [5]. A lot of elements play a role in creating gaps while transitioning from the hospital after discharge to home, thereby causing readmissions [6]. The major factors are inadequate communication, incomplete transfer of information to the patient, insufficient education of the patients and their caregivers [6]. The elaborate medication regimens that elderly people are prescribed on are often changed in the hospital and they are prone to medication-related problems as they restart the responsibility of managing their medications at home [7]. This is where transitional care comes into play. Transitional care specialists identify medication errors and address poor access to after-hospital follow-up care. They coordinate and provide continuous care for the patients, post-hospital discharge, thereby reducing re-hospitalizations. Transitional care serves as the missing link between post hospital discharge and the Primary care access.

A study conducted at St. Joseph's Hospital in British Columbia Canada proved that providing integrative transitional care in the elderly population bettered health outcomes, lessened the time of hospital stay, and improved discharge disposition [8]. Many recognized transitional care programs have exhibited persistent effects in diminishing re-hospitalizations [9]. Another analysis revealed that older patients discharged from the hospital will benefit from directed interventions during transitional care [10]. This showed effective transitional care with appropriate interventions lead to reduction in readmission rates, detrimental drug events, health care exertion, health care costs, and increased patient and family satisfaction [10]. Transitional care also helps in identifying complications early so that appropriate treatment, including rehospitalization, can be ensured before it gets worse. One study conducted among veterans reasoned that in patients with very fragile health, transitional care intervention helped in the early recognition of health issues requiring readmissions [11]. Another evaluation found post-acute care transitional program was beneficial in improving the quality of life [12]. An extensive transitional care intermediation for older patients admitted with heart failure showed an increase in the duration of time between discharge from the hospital and re-hospitalization or death, decreased the total number of readmissions, and minimized healthcare charges [13]. Patient contentment was greatly improved in patients receiving transitional care [14]. An investigation conducted on Heart failure patients unveiled reduced all-cause re-hospitalizations and mortality in patients undergoing a structured transitional program [15]

IV. Conclusion

Transitional care intervention greatly helps in reducing re-hospitalizations, decreasing medication errors, improving follow up care, reducing psychological stress and confusion. A transitional care specialist spends sufficient quality time with the patients and helps in formulating a patient-care. Since the patient's medications are reviewed and their questions answered there will be less chance for adverse drug events or noncompliance of medications. In the future, transitional care is expected to gain more importance especially in the care of the geriatric population.

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Dr. Minu Ambika Rajendran MD. "A Short Narrative Review About the Need for Transitional Care." *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)*, 21(03), 2022, pp.48-49.