This theme will address the distinctive care transition needs of patients who may have complex care needs requiring specialized knowledge and expertise and/or social needs that are typically considered beyond the traditional purview of the health care system. Such needs may include housing, social support, addictions and/or mental health concerns, low income, literacy or others. Examples of topics within this theme include:

- Challenges in care transitions
- Issues of equity and marginalization
- Transitioning to rural and remote communities
- Care transitions for patients with multiple co-morbidities
- Patient engagement

**Presentation 1**

**ID. 69 Prompt and Sustained Primary Care Contact As Care Transition Priority**

*Agnes Kulinek, Toronto Western Hospital*

**Background:** Two thirds of the health care system is utilized by 5% of the population living with multiple complex medical conditions requiring intensive, well-coordinated care. To achieve this, a single point of contact with primary care provider (PCP), to address the patient’s complex healthcare needs is required.

**Objectives:** The Transitional Care Specialist (TCS) role at Toronto Western Hospital was implemented as a one year trial role in July 2014 to promote smooth care transitions for complex Medicine patients returning home in an effort to reduce avoidable readmissions. Arranging an appropriate PCP for unattached patients and encouraging their 7 day post discharge contact is an active priority of the TCS role. The goal is that 100% of patients have an appropriate PCP pre discharge and for 80% to have ongoing contact with this provider for up to 3 months post discharge.

**Methods:** The TCS explores each individual patient’s needs and level of care required to make relevant connections with appropriate contacts for primary care. To promote contact with primary care post discharge, several steps are put in place such as booking appointment pre discharge and inclusion of details in discharge summary. Attendance is encouraged in TCS post discharge follow up calls.

**Results:** In the first year of the TCS role, 96% (74/77) of unattached patients were connected with a PCP. In a random sample of newly attached patients, it was found that 57% (13/23) of patients saw their PCP within 7 days. At 1 month post discharge, 78% (18/23) of these patients had contact with the PCP. At 2 and 3 months, 57% (13/23) of patients had continued to see their arranged PCP.

**Conclusions:** The results suggest that the TCS in the acute care setting is successful at connecting complex patients with an appropriate PCP and can be utilized elsewhere. Further investigation is required to identify why some patients did not sustain contact with a newly attached PCP.

**Presentation 2**

**ID. 88 Identifying Effective Nurse-Led Care Transition Interventions for Complex Older Adults**

*Using a Structured Expert Panel*

*Lianne Jeffs, Sharon Straus, Monika Kastner, Madelyn Law, Kerry Kuluski, Sherry Espin, Chaim Bell, Ella Ferris, Jane Merkley, Brenda Dusek, Vera Nincic, Maria Maione, Marianne Saragosa*

**St. Michael's Hospital/Li Ka Shing Knowledge Institute, Brock University, Lunenfeld-Tanenbaum Research Institute, Sinai Health System, Ryerson University, Registered Nurses Association**

**Background:** Poorly executed care transitions involving older patients with complex care needs results in medication errors, care delays, avoidable re-admissions, and increased healthcare costs. Nursing plays a central role to facilitating care transitions for complex older adults, however there is no expert consensus of the components of nurse-led care transitions interventions among complex older adults.
Objective: To address the aforementioned gap, a project was undertaken to delineate from the evidence and expert opinion on the optimal nurse-led care transitions.

Methods: This project involved a realist review of the literature and a modified Delphi panel. Panelists (n=23) part of the Delphi panel were asked to individually rate a series of statements derived from the literature for relevance, feasibility and likely impact. Statements receiving an aggregate score of ≥75% (7/9) were then reviewed and revised at a face-to-face consensus meeting. A second round of rating following the same process as round 1 was used, followed by a final ranking of the statements.

Results: As part of the Delphi panel results, the five highest ranked intervention components and contextual factors were: 1) educating and coaching patients, their family members, and/or their caregivers about self-management skills; 2) ensuring patients, their family members and/or caregivers are aware of follow-up medical appointments and post-discharge care plan; 3) using standardized documentation tools and comprehensive communication strategies during care transitions; 4) optimizing nurses’ roles and scopes of practice across the care transitions spectrum; and 5) having strong leadership, strategic alignment and accountability structures in organizations to enable quality care transitions for the complex older person population.

Conclusions: Key insights on optimizing the nurses’ roles and scope of practice during care transitions included having nurses provide “warm hand-offs” and serve as the “go-to person”. The panel identified current challenges to fully optimizing the nurses’ roles and scope of practice across care transition points. Future research is required to determine the optimal components of nurse-led intervention, and in which context do they work or do not.

Presentation 3
ID. 96  Mind the Gap: Improving the Post-Discharge Transition to Reduce Rapid Psychiatric Readmissions
Tara Burra, Gwen Yorston, St Joseph's Health Centre

Background: Rapid psychiatric readmissions stem from a complex interplay between community, hospital, community, health care provider, and patient factors. Readmission within 30-days of a psychiatric hospitalization is a quality of care indicator that assesses both inpatient care and continuity of care in the community. Over the past decade, St Joseph’s Health Centre (SJHC) has had one of the highest psychiatric readmission rates in Ontario. Early readmission represents an opportunity for improving access and integration of inpatient with ambulatory care.

Objective: To enhance access to timely ambulatory psychiatric care at SJHC and improve patients’ post-discharge transition to achieve the broader goal of reduced psychiatric readmissions.

Method: Ambulatory psychiatric services were restructured in 2012 to create the Collaborative Care Clinic (CCC), a team-based, inter-professional approach to patient care. An open-access online appointment scheduler was implemented. Using the Model for Improvement, we introduced the following initiatives: updating patient contact information before discharge, standardizing appointment reminder phonecalls, and implementing patient experience questionnaires. Outcome measures include attendance of the initial post-discharge ambulatory appointment, timeliness of post-discharge appointments, and readmissions within 30 days.

Results: Over 400 post-discharge ambulatory appointments were scheduled for discharged inpatients in 2013 and 2014. In 2013, 63% of patients attended their initial appointment and 78% of the appointments were scheduled within 4 weeks of discharge. In 2014, 73% of patients attended their initial post-discharge appointment and 82% were scheduled within 4 weeks of discharge. The rate of 30-day readmission to SJHC for patients who attended CCC was 4.8% and 17.5% for those who were not referred to the clinic.

Conclusions: We have implemented and sustained an open-access online appointment scheduler. Despite greatly enhancing the availability of appointments, non-attendance remains a concern, and we will continue to implement strategies, guided by patient feedback, to improve the post-discharge care transition. We have preliminary evidence to suggest that the CCC model is reducing psychiatric readmissions; however, data on 30-day readmissions to other institutions, following an index hospitalization at SJHC, is not yet available to inform our evaluation.
Background: The median age of people living with Cystic Fibrosis (CF) is now over 50 years of age. Literature on transition in chronic illness demonstrates the need to provide education at appropriate stages of development to enable young patients to become self-care agents. Newly transitioned patients express frustration and lack of preparation to become independent in their health management. This leads to gaps between individual patient preparedness and health care provider expectations, which impacts ability for patients to self-manage their care.

Objective(s): To improve CF patients’ readiness to succeed in transitioning from paediatric to adult CF care.

Methods: Review of the CF Toronto database and the current transition program provides a background knowledge of our patient population. To assess individual patient readiness, a validated tool (TRAQ) was completed by paediatric patients aged 14 to 17 (n=10) and adult patients aged 17-20 (n=10). Results show gaps in preparedness to transition.

Results: Statistical analysis of the TRAQ questionnaires highlights that young adults are not aware of how they can obtain financial assistance or the importance of asking questions at their clinic visits. Paediatric patients are unfamiliar with their drug coverage, how to make appointments and refill medications. To address knowledge gaps, further patient education in both paediatric and adult CF centres is necessary.

Conclusions: Although we have a well established transition program for patients with CF in Toronto, a detailed assessment has lead us to recognize shortcomings of paediatric patient preparedness prior to transition and their experience of being overwhelmed when joining the adult program. Future directions include the paediatric team addressing education needs and learning gaps throughout each development stage to encourage independence prior to transitioning to adult care. Adult team members can provide adult education and work with patients and families to promote independence and self-care. This joint assessment has confirmed the importance of good communication between paediatric and adult teams to achieve successful outcomes in transition from paediatric to adult CF care.