UNIVERSITY OF TORONTO
FACTOR-INWENTASH FACULTY OF SOCIAL WORK
Institute for Life Course & Aging

Hospital Discharge Planning for Older Adults

AN ONLINE WORKSHOP FOR HEALTHCARE & OTHER PROFESSIONALS

When: Monday, March 13th to Sunday, April 9th, 2023 (4 weeks) ONLINE weekly at your discretion
Cost: $240 (Students $120) ***Registration Deadline: Monday, March 6, 2023***

Improving transitional care planning increases patient satisfaction and reduces adverse events and avoidable hospital readmissions for older adults. In this workshop, participants will learn about the hospital discharge process, systemic and organizational challenges to effective discharge, how to navigate discharge with vulnerable patients and those with complex needs, and best practices to facilitate smooth transitions out of hospital.

WEEK 1: Overview of the discharge process

- How discharge works
- Roles and responsibilities of the healthcare team; interprofessional collaboration
- Discharge pathways (e.g., to community, bidirectionally to LTC, rehabilitation, CCC, palliative care)

WEEK 2: Discharge readiness, risk and patient centredness

- Post-discharge morbidity, mortality and rehospitalization
- Delayed discharge and premature discharge – systemic and organizational challenges (e.g., quality indicators driving discharge policies) and impact on patients
- Evaluating risk – weighing physical safety against QOL; self-determination
- Patient/family centredness in discharge planning, patient satisfaction with discharge, managing expectations; Patient Ombudsman
- Ethical and legal issues (e.g., informed consent, advanced directives, SDM, family conflict)

WEEK 3: Vulnerable populations

- Addressing transitional care needs for older adults with cognitive impairment
- Addressing transitional care needs for marginalized populations, including ethnic minorities, recent immigrants and those with limited or no English proficiency
- Discharge in the context of addiction, mental health issues or homelessness

WEEK 4: Best practices in discharge planning

- Facilitators to discharge (e.g., intersectoral hospital partnerships, publicly-funded community resources for home-bound patients, interprofessional collaboration, etc.)
- Hospital discharge instructions - comprehension and compliance
- Evidence-based discharge practices to reduce readmission and adverse events (e.g., early discharge planning, discharge templates, medication reconciliation, liaison nurse or pharmacist, teach-back, etc.)
- Innovative models and tools (e.g., community-based discharge planning)

Instructors: Keri West, MSW, RSW & Larissa Teng

Keri West is a PhD Candidate in the Factor-Inwentash Faculty of Social Work, University of Toronto. She has a Master of Social Work from the University of Toronto, with a specialization in gerontology. Keri's work within the Canadian healthcare system spans both policy and practice, in the areas of knowledge mobilization, government relations, and medical social work.

Larissa Teng is a Patient Navigator for the Orthopaedic program at Oak Valley Health-Markham Stouffville Hospital and an Adjunct Professor in the Lawrence S. Bloomberg Faculty of Nursing at the University of Toronto. Larissa has a Masters in Nursing from the Daphne Cockwell School of Nursing at Ryerson University.

Registration and payment available online at https://aging.utoronto.ca/642-2/