Policy and Practice Note / Note de politique et practique

Determinants of Health in Discharge Planning for Seniors: Asking the Right Questions

Lisa J. MacNaughton-Doucet
Dalhousie University School of Nursing

RÉSUMÉ

Les praticiens sont encouragés à envisager un changement de perspective philosophie sur la façon dont les équipes interdisciplinaires interrogent les personnes âgées et leurs soignants au cours du processus de la sortie de l'hôpital. Les équipes engagées dans le planification des congés de l'hôpital peuvent commencer systematiquement à poser des questions qui vont au-delà du mise au point médical traditionnel sur les prescriptions, la réhabilitation et les soins, s'ils sont engagés dans un cadre de la décharge englobant attention aux déterminants sociaux de la santé. Une telle approche pourrait révéler les points forts et aussi pourrait exposer les inégalités sanitaires et sociales que les aînés doivent confronter en arrivant chez eux. Cette information peut ouvrir une porte d'entrée reliant les personnes âgées aux ressources sociales et économiques qui les soutiennes afin qu'elles puissent rester en bonne santé et productives.

ABSTRACT

Practitioners are encouraged to consider a shift in their philosophy regarding the manner in which interdisciplinary health care teams ask questions of seniors and their caregivers in the hospital discharge process. By engaging with a discharge framework that encompasses a social-determinants-of-health lens, discharge planning teams can begin to systematically ask questions that move beyond the traditional medical focus on prescriptions, rehabilitation, and treatments. This approach may reveal strengths and also expose health and social inequities that seniors might face upon their arrival home. This information may open a gateway for connecting seniors to social and economic resources that will support them in remaining productive and healthy.

Manuscript received: / manuscrit reçu : 28/05/12

Manuscript accepted: / manuscrit accepté : 26/11/12

Mots clés : vieillissment, invalidité naturelle, planification de congés de l'hôpital, personnes âgées, déterminants sociaux de la santé

Keywords: aging, chronic illness, discharge planning, seniors, social determinants of health

Correspondence and requests for offprints should be sent to / La correspondance et les demandes de tirés-à-part doivent être adressées à:

Lisa J. MacNaughton-Doucet, R.N., M.N.
Dalhousie University School of Nursing
55 Vancouver Street
Yarmouth, NS B5A 2P5
(Lisa.doucet@dal.ca)

Introduction

Interdisciplinary teams should consider social determinants of health (SDOH) in discharge planning to support the health of seniors transitioning from hospital to home. SDOH could systematically address socio-economic issues by revealing strengths and identifying challenges that seniors might face once home. Left unrecognized, seniors may be discharged home inadequately prepared to cope with activities of daily living (ADL), that may significantly hinder their capacity to maintain optimum health (Canadian Institute of Health Informatics [CIHI], 2009).

This article presents a current profile of Canadian seniors followed by an overview of SDOH, discharge planning

doi:10.1017/S0714980813000342

processes, and application of SDOH to discharge practices. The profile discussion is meant to inspire critical thinking by health care professionals on how exploring SDOH may impact the successful transition from the hospital to the home environment. The principles of SDOH have the potential to enable interdisciplinary teams to bridge gaps in the discharge process by means of a common language. Within an SDOH framework, teams can ask meaningful questions to expose potential health and social inequities. Responses to the questions may reveal opportunities for activating community and social supports not previously recognized. This, in turn, may lead to reduced stress on the health care infrastructure and ultimately promote the health of seniors in the community.

Who are Canada's Seniors?

Seniors in Canada are active members of society late into their retirement years. The population of seniors in Canada aged 65 and older is on the rise and expected to increase from 4.2 million to 9.8 million between 2005 and 2036 (Statistics Canada, 2006). In 2006, seniors in Canada accounted for 13.2 per cent of the population, a number projected to increase to 21.2 per cent by 2026 (CIHI, 2009). As of 2008, Canadians could anticipate a life expectancy of 80.7 years (Conference Board of Canada, 2012).

As seniors advance in age, maintaining health while living at home is often contingent on the availability of appropriate support services. Carrière and Légaré (2000) have reported that the availability and accessibility of health and social services are the most important factors related to quality of life for elderly people. Memory loss resulting in an inability to drive, decreased mobility requiring ambulatory aids, and diminished senses resulting in the need for visual and hearing devices are examples of changes that seniors may experience as part of the aging process.

According to the 2001 Canadian census, approximately 93 per cent of seniors resided in private households. Of this percentage, 26 per cent stated they received formal and/or informal support due to long-term health problems or physical conditions that affected their daily activities which included yard work, shopping, transportation, and/or personal care. Of seniors older than age 85, 36 per cent required assistance with bathing, toileting, and/or grooming (Statistics Canada, 2006). The fact that 74% of seniors did not utilize help because of a long-term health problem does not necessarily mean that all those who required help received it. In 2002, about 2% of seniors living in private households experienced unmet caregiving needs (Statistics Canada, 2006, p. 163). They required care because of at least one long-term health problem but reported that they had not received the help required (Statistics Canada). Factors that compounded seniors' inability to receive supports included low income, inaccessibility to health care, and housing costs (Raphael et al., 2011).

Further barriers to self-management frequently include "inadequate social support, difficulties with time management, troubled emotional state, low self-efficacy … personal health beliefs, physical limitations, lack of knowledge about their medical conditions, and the presence of comorbid disease" (Bayliss, Ellis, & Steiner, 2007, p. 396). In addition, Bayliss et al. recognized that depression, compromised health literacy, low self-efficacy, and lack of well-being often negatively impact the quality of life for seniors. With increasing age, diminished senses and compromised mobility and dexterity are common. In 2001, two thirds of seniors over age 75 were physically inactive. In addition, 47 per cent of persons aged 85 or older were unable to walk or required either mechanical support such as a wheelchair or assistance from caregivers to ambulate (Statistics Canada, 2006). Those experiencing multiple health and social challenges may struggle to seek suitable resources to promote independence at home, on the assumption that resources are, in fact, available.

The lack of financial resources is a significant factor in seniors being able to provide for the necessities of life. In 2003, the proportion of seniors in Canada living below the low-income cutoff (after taxes) was 4.4 per cent for men and 8.7 per cent for women. There is also a gender difference in living arrangements and household composition due, in part, to women's longer life expectancy: in 2001, 43 per cent of women aged 75 to 84 lived alone, compared to 18 per cent of men (Statistics Canada, 2006). Immigrant senior women are particularly vulnerable to the impact of poverty. Among female immigrants aged 65 and older who lived alone and who arrived in Canada after 1990, 71 per cent were considered low-income compared to 42 per cent of Canadian-born women living alone (Statistics Canada). Green, Williams, Johnson, and Blum (2008) examined seniors, living on Canada's public pensions in Nova Scotia, and their capacity to remain food secure. Seniors living alone who rely solely on public pensions are more likely to have inadequate funds at the end of the month; this puts them at greater risk for food insecurity than senior couples (Green, Williams, Johnson & Blum, 2008, p. 75). Those who were food insecure were more likely to report ill health and, also, to report having to struggle to pay for necessities such as rent and energy (McIntyre & Tarasuk, 2002).

Seniors are at risk for suboptimal health and well-being due to a complexity of physical and social challenges, chronic illnesses, and economic inequities. Upwards of 80 per cent of seniors in Canada have at least one

chronic condition (CIHI, 2009), and seniors diagnosed with a chronic illness consume a higher proportion of health and social services than the average Canadian. Denton and Spencer (2010) have noted that the number of chronic conditions, rather than age, is a critical factor contributing to seniors' health care usage. In 2007, for example, Canadian seniors diagnosed with two or more chronic conditions accounted for 23 per cent of hospital emergency department visits (CIHI, 2009). This number is anticipated to grow as Canada's population of seniors rises over the coming decades.

Social Determinants of Health: A Conceptual Framework

SDOH refer to a variety of factors that influence our health and well-being. These include environmental factors, support systems, personal lifestyle, and health behaviours (Commission on Social Determinants of Health [CSDH], 2008). SDOH are often associated with public health and policy developments that can influence social justice and reduce health disparities at the community level (Hunter, Neiger, & West, 2011). SDOH take into account the varying degrees of physical, social, and personal resources of an individual "to identify and achieve personal aspirations, satisfy needs, and cope with environment" (Raphael, 2009, p. 1). Personal resources that contribute to successful aging include autonomy in decision making, a positive outlook, a sense of self-worth, healthy routines and habits, being an informed consumer, having social networks and family ties, having a good sense of humour, and spirituality (Bassett, Bourbonnais, & McDowell, 2007; Gadalla, 2009; Hutchinson & Wexler, 2007; Marziali, McDonald, & Donahue, 2008, Molzahn, 2007). Even more broadly, SDOH encompass macro-level factors such as the political climate, economic distribution, and the allocation and accessibility of health services.

> The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. (CSDH, 2008, p. 1)

Numerous policies and socio-economic factors beyond the individual's control have a significant impact on health. Indeed, "the primary factors that shape the health of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience" (Mikkonen & Raphael, 2010, p. 7). Mikkonen and Raphael identified 14 categories of cultural, environmental, social, and economic influences that impact one's health. These are as follows: gender, disability, housing, early life, income and income distribution, education, race, employment and working conditions, social exclusion, food insecurity, Aboriginal status, social safety net, health services, and unemployment and job security.

In 1974, the Canadian government introduced the landmark work *A New Perspective on the Health of Canadians: A Working Document* (Lalonde, 1974). This provided the foundation for reconceptualising how health care practitioners understood the causes of good or ill health. Lalonde contended that optimal health must be attained through a variety of biological, environmental, and lifestyle factors. Since then, research and evidence-informed practice across multiple health sectors have verified Lalonde's work. Health care practitioners often are able to recite what social determinant of health mean or recognize the implications of these determinants on poor health at a conceptual level. However, there is little evidence that SDOH concepts are integrated into typical discharge planning which would indicate a knowledge-to-practice gap, leaving the use of SDOH an unexplored area in the hospital environment. Davis (2011) contended that 37 years after Lalonde's report, there indeed continues to be disengagement between recommendations and action. It is essential to impress upon health practitioners that they must examine more carefully seniors, and their respective circumstances, before discharging them to home.

Hospital Discharge Processes

Discharge planning is the systematic identification and organization of services to assist patients to self-manage in the community once they are discharged from hospital to their home (Grimmer, Moss, Falco, & Kindness, 2006). Effective discharge planning can lead to a successful transition home with resources to support quality of life and to enable seniors' participating as fully functioning members of society (Hunter et al., 2011; Mukotekwa & Carson, 2007). Such planning is based on a comprehensive plan of care designed by health care practitioners who have current, specific information about the patient's goals, preferences, and clinical status (Coleman & Boult, 2003).

To result in maximum benefit, discharge plans must address key socio-economic issues. Health care practitioners, even while sincerely striving to support seniors' health as they transition home, may have difficulty uncovering relevant socio-economic issues while the patient remains in the safe, predictable hospital environment. Billings and Kowalski (2008) have noted that "hospital-based nurses who have not practiced in home health care may find it difficult to anticipate

patients' needs during the transition from hospital to home" (p. 198). Discharge plans made by hospitals, with limited human resources, are often dictated by the medical diagnosis and the pure economics of needing to fill the next bed (Lattimer, 2011). In a task-oriented and medically focussed environment, patients' specific socio-economic factors can easily be overlooked. One study of 89 seniors indicated that their discharge plans often did not take into account their usual routines or concerns, nor consider realistic ways to ease the transition from illness to wellness (Grimmer et al., 2006).

Contributing factors leading to poorly orchestrated discharge processes included a breakdown in verbal and written communication, shorter hospital stays, time constraints, and knowledge gaps of health care personnel (Maramba, Richards, Myers, & Larrabee, 2004; Nosbusch, Weiss, & Bobay, 2010). Fabre, Buffington, Altfeld, Shier, and Golden (2011) further reported that consequences of inadequate hospital discharge preparation of seniors have led to medication errors, challenges in completing discharge instructions, increased caregiver burden, and increased costs to the health care system. Chen, Tang, Wang, and Guan-Hua (2009) reported results of their longitudinal study on the nutritional decline of seniors at post-hospitalization: namely, that it took up to three months for the majority of seniors discharged home to return to their baseline nutritional status. An additional 21.3 per cent of seniors, post-discharge, remained below their nutritional status at hospital admission.

Hospital readmission rates have implications for the health of seniors and also for the health care system. Between April 2010 and March 2011, over 2.1 million readmissions to hospitals and emergency departments occurred in Canada, costing an estimated $1.8 billion. Seniors aged 65 or older accounted for 37.2 per cent of these costs (CIHI, 2012). In a 2011 systematic review of interventions designed to reduce 30-day re-hospitalization rates, researchers acknowledged the challenge of health care professionals to address social factors, concluding that discharge interventions "did not adequately adjust for contextual factors at both the hospital and the community level" (Hansen, Young, Hinami, Leung, & Williams, 2011, p. 526). An earlier, 2007 study reported that nearly 16 per cent of medical patients in six Toronto hospitals were readmitted within 30 days of discharge; these patients had a median age of 71 (Gruneir et al., 2011). In 2008–2009, a total of 73,190 Canadian seniors experienced a fall causing hospitalization (CIHI, 2010). One study of 311 seniors discharged from hospital was conducted to evaluate their fall rate 90 days post hospitalization and associated risk factors. The results of this study indicated that fall-related injuries accounted for 15% of hospital readmissions one month after discharge. Contributing prehospital risk factors associated with the falls included dependence on ADL's, poor balance, 2 or more falls, and more hospitalizations in the year prior. Post hospital contributing risk factors included further decline in balance, probable delirium, and use of antipsychotic medications (Mahoney et al., 2000).

Bowles and Cater (2003) observed that seniors' ability to perform typical ADL (such as ambulating, eating, and bathing) once discharged home were important considerations to any discharge plan. These considerations take on added significance when we realize that, in fact, rural seniors experience higher readmission rates than their urban counterparts. Goodridge, Lawson, Rennie, and Marcinuik (2010) reported that these higher rates could be due, in part, to the lack of availability in rural home care settings of health professional offerings, for instance, palliative care and physiotherapy. In a meta-analysis of six studies, Mukotekwa and Carson (2007) reported that patients, seniors in particular, who were discharged home with inadequate supports and information, had a higher incidence of hospital readmissions within 6 to 12 weeks after discharge. Additional risk factors included increasing age, low education attainment, co-morbidities, health illiteracy, and poverty (CIHI, 2012; Dhalla, O'Brien, Ko, & Laupacis, 2012). These findings suggest that the ability of patients to resume ADL post-hospitalization is influenced by discharge processes.

Interdisciplinary Responsibility

It is the responsibility of an interdisciplinary discharge planning team to strive for a seamless transition from hospitalization to home. Yet, to effectively achieve this goal, a number of hospitals may lack the requisite complement of professional health services (such as social work, rehabilitation services, physiotherapy, occupational therapy dietetics, pharmacy, nursing, home care coordination, physician, respiratory therapy, recreation therapy, and clergy). By engaging multiple disciplines, a discharge planning team has a wider lens with which to problem-solve discharge matters, keeping seniors and their families as their central focus for effective patient-focused care.

Interdisciplinary teams experience challenges in discharge planning due to organizational policies and protocols and administrative pressures to turn over beds. Connolly et al. (2010) conducted a cross-sectional study of 455 health professionals to determine patient, process, and system factors that affect the quality of discharge preparation. These authors reported that 44 per cent of study participants felt there was inadequate staffing on the discharge team; 66 per cent felt that the discharge team could benefit from further training; and 80 per cent felt that the administrative

https://doi.org/10.1017/S0714980813000342 Published online by Cambridge University Press

demands to limit length of stay caused inadequate and rushed discharge planning (Connolly et al.). Other barriers to effective patient discharge included a lack of continuity of care, role confusion, lack of key members on the interdisciplinary team, competing priorities, and perceived power differentials (Maramba et al., 2004; Nosbusch et al., 2010). Dedhia et al. (2009) reported that, often, individual health care disciplines on their own did not offer comprehensive discharge strategies. Navigating services for seniors with complex diagnoses and social issues can challenge even the most seasoned team, yet it is essential to address barriers that impede effective discharge planning and strive to improve processes.

Medical Model in Practice

Hospital-based care is closely aligned with treating the acute phases of disease with interventions focused on improving or maintaining clients' status (Stanhope & Lancaster, 2012). These systems are increasingly taxed by shorter hospital stays, deepening budget cuts, and readmissions to acute care (CIHI, 2012; Livadiotakis, Gutman, & Hollander, 2008). Lalonde (1974) had cautioned against the economic risks of remaining entrenched in a medical mind-set that focuses on the diagnosis: "The consequence of the traditional view is that most direct expenditures on health are physician-centered, including medical care, hospital care, laboratory tests, and prescription drugs" (p. 12). Increasingly, hospital administrators, managers, and health practitioners are challenged with fewer resources to provide optimal care and to do so by utilizing resourceful and creative approaches to "think outside the box". Hunter et al. (2011) stated that despite the challenges of incorporating SDOH considerations, the necessity for doing so is "a reality which local health professionals can no longer ignore" (p. 23). It is timely to consider how to enhance discharge practices using SDOH concepts that will build economic sustainability in the health care system and support the long-term health of Canadian seniors.

Application in Practice: SDOH as a Conceptual Framework

A number of existing discharge planning tools do have a measure of effectiveness in preparing patients for discharge (Lattimer, 2011). Nonetheless, there continue to be fundamental gaps in most discharge planning processes. The literature provides little evidence that discharge planning teams "accurately identify genuine patient needs in a manner that takes account of patients' usual living arrangements … [and] how hospital staff can encompass this information into appropriate and realistic discharge plans" (Grimmer et al., 2006, p. 1). Checking off the list of medical-related needs is only part of the solution in order to discharge seniors safely to home.

Posing questions that address SDOH may offer solutions to narrow the gap between patient needs on discharge and the services they receive once they are home. It is time to ask what else needs to be considered. Questions that address seniors' socio-economic situations may expose shortfalls such as inadequate monetary resources to fill prescriptions, buy groceries, and access transportation. For example, asking the patient "Do you have your prescriptions?" is a common question asked to patients on discharge. This will most likely be answered with a yes/no response which does not give an opportunity to explore socio-economic concerns in actually getting the prescription filled. However, questions that explore how the patient will fill the prescription once discharge will more likely reveal potential concerns such as "How will you be getting your prescriptions filled?", "Do you have adequate money to purchase the medications or do you have insurance?" or "How will you be getting to the pharmacy to fill your prescriptions?". These questions are more comprehensive because they include elements of determinants of health that may reveal underlying socio-economic barriers to filling the prescriptions. These types of questions are meant to forge a critical pathway to bridge the hospital-to-home link. Discussions stemming from the SDOH lens can identify strengths and also uncover social, economic, and/or environmental concerns potentially missed during hospital admission.

Figure 1 provides an illustration of how one might consider SDOH in discharge practices. This framework offers a consistent guideline in which to pose questions regardless of what discipline is part of the planning team. It is not practical to capture every situation in this framework due to the fluidity and complexity of the human condition. Therefore, questions asked will vary depending upon the senior's circumstance and diagnosis. For example, under the SDOH regarding "social isolation", the senior who lives with a family member and has multiple children living in the neighbourhood may be asked different questions than the senior who has no family and lives alone. Some categories may not apply. If the patient is identified as Caucasian, for instance, then addressing social and health concerns associated with Aboriginal status is unnecessary.

Case Study: John Williams

Health care practitioners involved in hospital discharge planning can appreciate this scenario. Although it is simplified for purposes of this article, the consequences mimic real situations for many seniors living with chronic illness in an already compromised situation.

Patient is 86-year old John Williams who lives alone and has no family. He was discharged home from a 14-day hospitalization for a primary diagnosis of "fractured right hip" after

https://doi.org/10.1017/S0714980813000342 Published online by Cambridge University Press

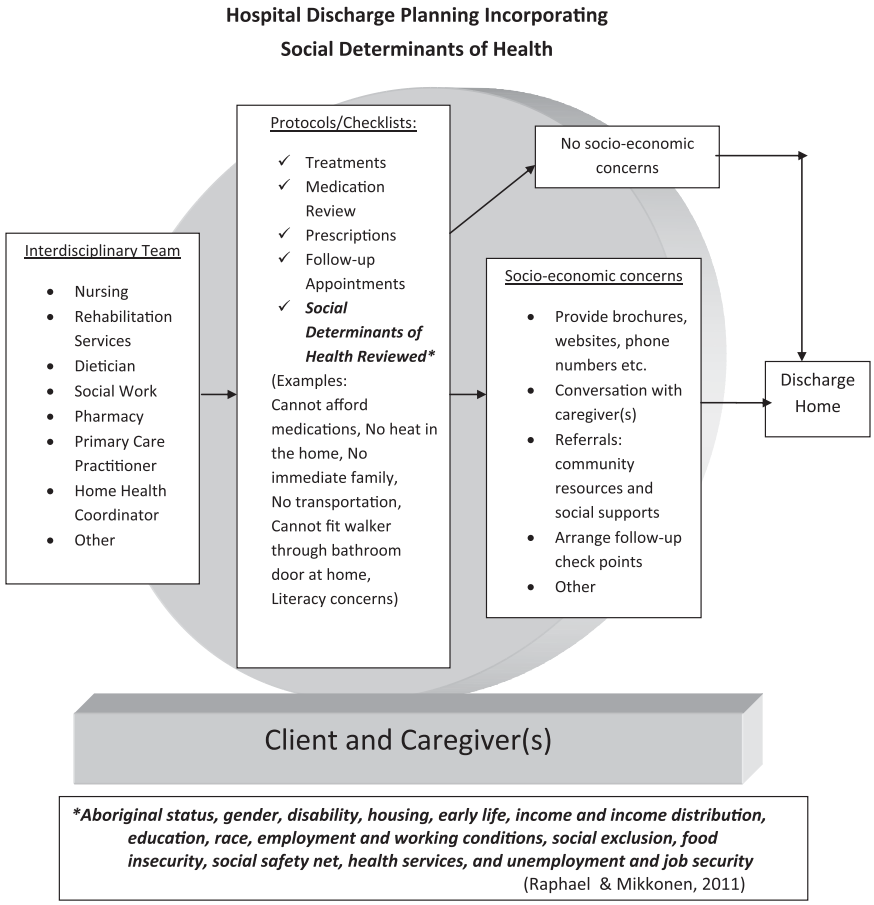

Figure 1: Discharge process using determinants of health

sustaining a fall in his home in which he received a right-hip replacement. He has a secondary diagnosis of vascular dementia. During his hospital admission, the physiotherapist ensured that he was able to ambulate with his walker and sit and stand independently. The registered nurse ensured that his prescriptions were issued and that he received a follow-up appointment with the surgeon. The social worker ensured that his neighbour would provide transportation to his home and would check on him daily as well as place a referral to home care services.

Satisfied that he was progressing towards a successful recovery, John was discharged to his home. Once home, John was not able to easily climb the stairwell, in which he would balance his walker on the steps, to his only bathroom on the second floor. Unfortunately, home care services were delayed due to understaffing. Three days following discharge, the neighbour discovered John had fallen on the floor at the bottom of the stairs and was disoriented, in pain, and in obvious poor hygiene. Where did the discharge plan fail John? Each health practitioner asked the right questions to prepare him for discharge. Or did they?

What were seemingly appropriate questions specific to each health professional's discipline in this case failed to capture the scope of John's challenges on discharge. The focus of the discharge planning team was to optimize John's mobility in light of his primary diagnosis. Collectively as well as separately, they did not ask adequate questions about John's home environment. They did not explore accessibility to essential rooms in his house, access to community services, or communication challenges.

Consider some of the socio-economic-related questions that could have been asked that fall under the umbrella of SDOH. Housing – *How many levels do you have in your home? On what level are your kitchen and your bathroom located?* Income and Income Distribution – *How will you pay for your groceries and your prescriptions?* Social Exclusion – *With whom do you live? If you live alone, do you have relatives and/or close friends in the vicinity? How often do they check on you? Can someone call on your behalf to arrange for regular visits?* Food Insecurity – *Can you drive to the grocery store? If not, who will buy and deliver your groceries? Can you cook your meals independently? If not, can we refer you to a meals delivery service?* Disability – *Do you understand the instructions on the prescription? Can you manage getting washed? Do you know how to call for help if you need it?*

https://doi.org/10.1017/S0714980813000342 Published online by Cambridge University Press

Health Services – *Do you have transportation to the follow-up appointment? Do you need a reminder? Is there someone who can check in with you in a few days and make sure home health services have started?* Socio-economic Status – *Are you able to afford your current household expenses? Have options to supplement your current income been explored?* These questions are not foolproof, but they may have prompted responses that would have revealed critical pieces of information averting John's current predicament by exposing inequities that had not been previously noted.

The intent of this discussion is not to replace existing discharge protocols. It is not designed to generate every conceivable question that could be asked under the umbrella of SDOH. Instead, it is intended to enhance current discharge practices and encourage health practitioners to think beyond medical management. It is hoped this approach will encourage dialogue on how to support seniors' optimal health at home upon discharge from hospital.

Recommendations

Recommendations for future policy, practice, and research arise from this discussion spanning the hospital and the community setting. Enhancing organizational policies that support use of SDOH in discharge protocols may lead to a more comprehensive discharge plan for seniors. Left to an individual practitioner, the discharge process may not be consistent. Consequently, it is important to engage interdisciplinary participation. The degree of effectiveness in asking these questions needs to be explored. Do some categories of SDOH have a greater degree of impact than do others in improving discharge processes? Tracking the relationship between use of SDOH-related questions and the potential increase in community referrals, and/or in reduced readmissions, may also be an opportunity for exploration. Are hospital readmission rates of seniors affected, positively or adversely, when questions related to SDOH are utilized during discharge?

Evaluating the interdisciplinary team's understanding of current referral processes and community services could be explored. If the team does not understand how to access resources or even know what exists in the community, will referrals be activated? This situation can lead to educational opportunities to close the knowledge gap. Intertwined with SDOH considerations, additional education should aim to help health professionals understand how seniors' access to services is influenced by geographical proximity and affordability. This could also expose deficits in community infrastructure that currently may diminish seniors' ability to remain at home.

Conclusion

The proposals made in this article have significant health care policy and practice implications. Effective discharge planning is an increasing priority in health care (Hummel, 2013). Therefore, it may be beneficial to consider SDOH as a guide to expand and improve the quality of questions that discharge planning teams ask of seniors and caregivers. This article challenges both policy makers and practitioners to shift their lens of thinking to ask more socially responsive questions. A gateway could open to more effectively connect seniors to social and economic resources, and ultimately support them to remain productive and healthy members of society.

References

Bassett, R., Bourbonnais, V., & McDowell, I. (2007). Living long and keeping well: Elderly Canadians account for success in aging. *Canadian Journal on Aging*, *26*(2), 113–126.

Bayliss, E., Ellis, J., & Steiner, J. (2007). Barriers to self-management and quality-of-life outcomes in seniors with multimorbidities. *Annals of Family Medicine*, *5*(5), 395–402.

Billings, D., & Kowalski, K. (2008). Transition from hospital to home care: What gets lost between the discharge plan and the real world? *Journal of Continuing Education in Nursing*, *39*(5), 198–199.

Bowles, K., & Cater, J. (2003). Screening for risk of rehospitalization from home care: Use of the outcomes assessment information set and the probability of readmission instrument. *Research in Nursing & Health*, *26*, 118–127.

Canadian Institute for Health Informatics (2009). *Analysis brief: Experiences with primary health care*. Retrieved July 16, 2013, from http://secure.cihi.ca/cihiweb/products/cse_phc_aib_en.pdf.

Canadian Institute of Health Informatics (2010). *Series on Seniors: Seniors and Falls*. Retrieved July 16, 2013, from http://www.cihi.ca/CIHI-ext-portal/pdf/internet/SENIORS_FALLS_INFO_EN.

Canadian Institute of Health Informatics (2012). *All-Cause Readmission to Acute Care and Return to the Emergency Department*. Retrieved July 16, 2013, from https://secure.cihi.ca/free_products/Readmission_to_acutecare_en.pdf.

Carrière, Y., & Légaré, J. (2000). Unmet needs for assistance with ADLs and IADLs: A measure of healthy life expectancy. *Social Indicators Research*, *51*(1), 107–123.

Chen, C., Tang, T., Wang, C., & Guan-Hua, H. (2009). Trajectory and determinants of nutritional health in older patients during a six month post-hospitalization. *Journal of Clinical Nursing*, *18*, 3299–3307.

Coleman, E. A., & Boult, C. (2003). Improving the quality of transitional care for persons with complex care needs. *Journal of the American Geriatrics Society*, *51*(4), 556–557.

https://doi.org/10.1017/S0714980813000342 Published online by Cambridge University Press

Commission on Social Determinants of Health. (2007). *Achieving health equity: From root causes to fair outcomes*. World Health Organization. Retrieved July 16, 2013, from http://whqlibdoc.who.int/publications/2007/interim_statement_eng.pdf.

Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *Final Report of the Commission on Social Determinants of Health*. Geneva, Switzerland: World Health Organization. Retrieved July 16, 2013, from http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

Conference Board of Canada. (2012). *Health: Life expectancy*. Retrieved from http://www.conferenceboard.ca/hcp/details/health/life-expectancy.aspx#expectancy.

Connolly, M., Deaton, C., Dodd, M., Grimshaw, J., Hulme, T., Everitt, S., et al. (2010). Discharge preparation: Do healthcare professionals differ in their opinions? *Journal of Interprofessional Care*, *24*(6), 633–643.

Davis, K. (2011). Social determinants of health in Canada: A treadmill of progress, (Volume 708). *Ontario Health Promotion E-Bulletin website*. Retrieved from http://www.ohpe.ca/node/12295.

Dedhia, P., Kravet, S., Bulger, J., Hinson, T., Sridharan, A., Kolodner, K., et al. (2009). A quality improvement intervention to facilitate the transition of older adults from three hospitals back to their homes. *Journal of the American Geriatrics Society 57*, 1540–1546.

Denton, F., & Spencer, B. (2010). Chronic health conditions: Changing prevalence in an aging population and some implications for the delivery of health care services. *Canadian Journal on Aging*, *29*(1), 11–21.

Dhalla, I. A., O'Brien, T., Ko, F., & Laupacis, A. (2012). Toward safer transitions: How can we reduce post-discharge adverse events? *Healthcare Quarterly*, *15*, 63–67.

Fabre, V., Buffington, A., Altfeld, S., Shier, G., & Golden, R., (2011). Social work and transitions of care: Observations from an intervention for older adults. *Journal of Gerontological Social Work*, *54*, 615–626.

Gadalla, T. M. (2009). Sense of mastery, social support, and health in elderly Canadians. *Journal of Aging and Health*, *21*(4), 581–595.

Goodridge, D., Lawson, J., Rennie, D., & Marciniuk, D. (2010). Rural/urban differences in health care utilization and place of death for persons with respiratory illness in the last year of life. *Rural and Remote Health*, *10*(2), 1329–1359.

Green, R., Williams, P., Johnson, C., & Blum, I. (2008). Can Canadian seniors on public pensions afford a nutritious diet? *Canadian Journal on Aging*, *27*(1), 69–79.

Grimmer, K., Moss, J., Falco, J., & Kindness, H. (2006). Incorporating patient and carer concerns in discharge plans: The development of a practical patient-centred checklist. *The Internet Journal of Allied Health Sciences and Practice*, *4*(1), 1–8.

Gruneir, A., Irfan, D., van Walraven, C., Fischer, H. D., Camacho, X., Rochon, P. A., et al. (2011). Unplanned readmissions after hospital discharge among patients identified as being at high risk for readmission using a validated predictive algorithm. *Open Medicine*, *5*(2), e104–e111.

Hansen, L. O., Young, R. S., Hinami, K., Leung, A., & Williams, M. V. (2011). Interventions to reduce 30-day rehospitalization: A systematic review. *Annals of Internal Medicine*, *155*(8), 520–528.

Hummel, P. (2013). Powerlessness. In Lubkin, I. M. & Larson, J. (Eds.), *Chronic illness: Impact and intervention* (pp. 315–337). Burlington, MA: Jones & Bartlett Learning.

Hunter, B., Neiger, B., & West, J. (2011). The importance of addressing social determinants of health at the local level: The case for social capital. *Health and Social Care in the Community*, *19*(5), 522–530.

Hutchinson, S. L., & Wexler, B. (2007). Is "raging" good for health?: Older women's participation in the raging grannies. *Health Care for Women International*, *28*(1), 88–118.

Lalonde, M. (1974). *A new perspective of the health of Canadians: A working document*. Retrieved from http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/1974-lalonde/index-eng.php.

Lattimer, C. (2011). When it comes to transitions in patient care, effective communication can make all the difference. *Generations*, *35*(1), 69–72.

Livadiotakis, G., Gutman, G., & Hollander, M. (2008) Rationing home care resources: How discharged seniors cope. *Home Health Care Services Quarterly*, *22*(2), 31–42.

Mahoney, J., Palta, M., Johnson, J., Jalaluddin, M., Gray, S., Park, S., et al. (2000). Temporal association between hospitalization and rate of falls after discharge. *Archives of Internal Medicine*, *160*(18), 2788–2795.

Maramba, P., Richards, S., Myers, A., & Larrabee, J. (2004). Discharge planning process: Applying a model for evidence-based practice. *Journal of Nursing Care Quality*, *19*(2), 123–129.

Marziali, E., McDonald, L., & Donahue, P. (2008). The role of coping humor in the physical and mental health of older adults. *Aging & Mental Health*, *12*(6), 713–718.

McIntyre, L., & Tarasuk, V. (2002). Food security as a determinant of health. Paper presented at the Social Determinants of Health across the Life-Span Conference, Toronto, Ontario. Retrieved July 16, 2013, from http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf from http://www.phabc.org/modules/Food_Security/files/Food_security_as_a_determinant_of_health.pdf.

Mikkonen, J., & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts*. Retrieved from http://www.thecanadianfacts.org/The_Canadian_Facts.pdf.

Molzahn, A. E. (2007). Spirituality in later life: Effect on quality of life. *Journal of Gerontological Nursing*, *33*(1), 32–39.

Mukotekwa, C., & Carson, E. (2007). Improving the discharge planning process: A systems study. *Journal of Research in Nursing*, *12*(6), 666–686.

Nosbusch, J., Weiss, M., & Bobay, K. (2010). An integrated review of the literature on challenges confronting the acute care staff nurse in discharge planning. *Journal of Clinical Nursing*, *20*, 754–774.

Raphael, D. (2009). Social determinants of health: An overview of key issues and themes. In Raphael, D. (Ed.), *Social determinants of health* (2nd ed.) (pp. 2–19). Toronto, ON: Canadian Scholars' Press.

Raphael, D., Daiski, I., Pilkinton, B., Bryant, T., Dinca-Panatescu, M., & Dinca-Panatescu, S. (2011). A toxic combination of poor social policies and programmes, unfair economic arrangement and bad politics: The experience of poor Canadians with type 2 diabetes. *Critical Public Health*, *1*(19), 1–19.

Stanhope, M., & Lancaster, J. (2012). *Community health nursing in Canada*. Toronto, ON: Elsevier Mosby.

Statistics Canada. (2006). *A Portrait of seniors in Canada*. Ottawa, ON: Statistics Canada. Retrieved July 16, 2013, from http://www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf.