

Geriatric Care Transitions

Addressing the Complex Needs of Older Adults



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KEYWORDS

- Transitions • Patient • Care transitions • Patient handoffs
- Continuity of patient care • Geriatric care

KEY POINTS

- Older adults experience numerous types of care transitions, including between home and health care settings and within health care settings.
- These transitions are made more complex by co-occurring multimorbidity, polypharmacy, frailty, and other situations that complicate transitions for older adults.
- While many interventions to improve transitions of care among older adults have been tested, many are disease-specific or setting-specific, and additional work is needed to improve care transitions.

INTRODUCTION

Care transitions for older adults are common, complex, and challenging. Emergency department (ED) visits, hospitalizations, and readmissions are among the most common types of care transitions: older adults who are 65 years old and older account for more than 15% of all emergency department visits each year¹ and over 40% of all hospitalizations.² Of those hospitalizations, 5% to 80% will result in a readmission.^{3–6} Transitions of care also have negative downstream effects, for example,; within 3 months of an ED visit, nearly a third of older adults will experience an adverse event such as an inappropriate prescription.⁷ **Fig. 1** illustrates the types of care transitions that older adults may experience. These include transitions between home and health care settings, transitions between health care settings (eg, hospital to skilled nursing facility), and even transitions within settings of care (eg, inpatient ward to intensive care unit [ICU]).

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Abbreviations	
ACP	advance care planning
ADEs	adverse drug reactions
ED	emergency department
HIE	health information exchanges
ICU	intensive care unit
MCCs	multiple chronic conditions
SNF	skilled nursing facility

The goal of this article is to review the current landscape of geriatric care transitions, to highlight the specific challenges faced by older adults when they move between settings of care, and to identify recent interventions to support effective care transitions in this population.

Why Do Older Adults Undergo Care Transitions?

In addition to the myriad factors driving care transitions in health care, there are several situations unique to older adults that may make care transitions more common and more impactful in this population. The first is clinical complexity, often encapsulated by multimorbidity. As of 2015, nearly three-quarters of older adults reported 2 or more chronic conditions,⁸ making multimorbidity or multiple chronic conditions (MCCs), the most common chronic condition among older adults. MCCs are more common in older adults than in younger adults.⁹ Managing multiple, intersecting medical conditions that each have their own treatment plan is complicated and is likely part of the reason that older adults are more likely to have hospital admissions and readmissions,^{10,11} and are more likely to be discharged from the hospital to a skilled nursing facility (SNF),¹² among other care transitions.

MCCs frequently lead to polypharmacy. Polypharmacy is very common among older adults, with 30% to 40% taking 2 or more medications and 44% taking 5 or more medications.^{13,14} Polypharmacy is associated with challenges with medication adherence, increased adverse drug reactions (ADEs),¹⁵ and increased rates of prescribing errors, which can lead to more transitions of care.¹⁶ A 2012 study analyzing the prevalence of unplanned hospitalizations caused by ADEs in a cohort of Veterans Affairs patients found that 10% of hospitalizations were attributable to ADEs, over a third of which were preventable.¹⁷

In addition to multimorbidity, several discrete chronic conditions that are more common in older adults also increase the risk of care transitions. Foremost among these is dementia, which impacts at least 4% of older adults in the United States.¹⁸ Prior work

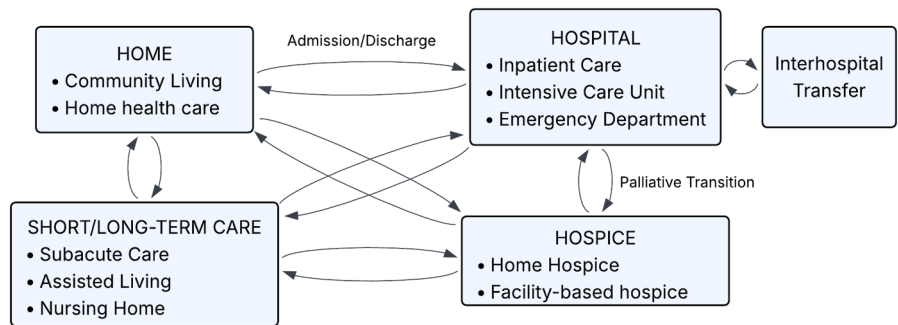


Fig. 1. Health care transitions among older adults.

suggests that patients with dementia experience more care transitions than patients without.¹⁹

Diagnoses such as heart failure, chronic obstructive pulmonary disease, and cancer, many of which increase in prevalence with age, can also increase the risk of hospitalization and subsequent care transitions.

CHANGES IN STATUS LEADING TO CARE TRANSITIONS AMONG OLDER ADULTS

Acute Illness

Care transitions such as acute care hospitalization, ICU admission, and emergency room visits may beget subsequent transitions for older adults.²⁰ A recent meta-analysis suggests that rates of hospital-associated disability in older adults following acute care illness are as high as 30%,²¹ placing many at increased risk of nursing home admission after discharge.²² Even visits to the emergency room that do not result in hospitalization bring risks of functional decline.¹

Critical illness requiring ICU admission further escalates risk of death, nonhome discharge, and prolonged functional disability. Multiple prospective cohort studies suggest that ICU admission is associated with high rates of inpatient and 1-year mortality, as well as with functional decline.^{23–25} Both noncritical care and critical care admissions are associated with development of dementia, suggesting that the impacts of hospitalization have longitudinal effects on neurocognitive as well as physical function,²⁶ leading to reduced functional independence and a higher probability of discharge to a nonhome care facility.²⁷

Frailty

Frailty often drives care transitions in older adults, who may manage daily life but lack the reserve to recover from injury or illness. Estimates of frailty vary due to patient age and assessment method; recent work estimates that between 4% and 59% of community-dwelling older adults experience frailty.²⁸ Frailty puts older adults at increased risk for many kinds of care transitions—both from community to acute care settings, but also to long-term care and hospice if they are unable to recover their function following a change in their medical status. For example, frailty is a specific risk factor for poor outcomes following surgical and trauma admissions in older adults,²⁹ including increased rates of transition from hospital to SNF.³⁰

Social Isolation and Loneliness

Social isolation, defined as *physical isolation, reduced size, and diversity of social network*³¹ and loneliness are common in older adults: before the COVID-19 pandemic, 24% of community dwelling older adults in the United States were isolated, with 4% reporting severe social isolation.³² Social isolation and loneliness are associated with increased rates of health care use among older adults, including more ED visits and hospital readmissions.^{33–35} Social isolation has also been associated with adverse outcomes such as disability and mortality following critical illness,³⁶ and with nursing home entry after discharge.³⁷

End-of-Life/Hospice Care

End-of-life care can lead to additional care transitions for older adults. Over the past 2 decades, the proportion of older adults who die in hospitals has decreased from roughly one-third to approximately 20% of Medicare beneficiaries, whereas deaths at home or in a community setting have increased from 30.7% to 40.1%.³⁸ This shift toward dying outside of health care facilities has had a variable impact on care transitions at end-of-life over time: as of 2015, 10.8% of Medicare fee-for-service

beneficiaries experienced a care transition within the last 3 days of life.³⁸ This transition from hospital-based deaths to deaths in the community is in part attributable to increased utilization of hospice services, which can be delivered at home/in the community as well as in nursing homes, inpatient hospice facilities, and even hospitals. In one study of Medicare beneficiaries, 10.2% experienced at least one care transition after hospice enrollment; over 50% of these individuals experienced transfer to or from a hospital.³⁹

Even in acute care settings and nursing homes, hospice medical teams are generally distinct from medical care teams, meaning that hospice enrollment automatically involves a transition in care provider, even if physical location remains stable. Those older adults who transfer home for hospice care or to a different care settings thus may face both geographic and medical care transitions, and their associated risks and challenges.

CHALLENGES OF CARE TRANSITIONS FOR OLDER ADULTS

Fragmentation of Care

Fragmentation of care is defined as care that is spread diffusely across physicians⁴⁰ or settings of care. Prior work has found that fragmented readmissions, that is, readmissions to a different hospital than the initial admission, are associated with increased mortality during^{41–43} and following hospitalization,⁴⁴ increased length of stay (LOS),⁴² higher odds of discharge to a SNF,⁴⁵ and higher odds of subsequent readmissions^{46,47} among older adults. When patients have fragmented ambulatory care no one provider may be accountable for providing continuity of care.^{48,49} Prior work has found that primary care providers (PCPs) and practices with less fragmentation have fewer ED visits, ambulatory-care sensitive admissions, and readmissions⁵ among older adults.

Goal-Discordant Care Delivery

Care transitions can also lead directly or indirectly to delivery of undesired or goal discordant care, defined as care such as life-prolonging measures that does not or is unlikely to achieve a patient's goals (eg, functional independence, cognitive clarity, or comfort). Goal-discordant care for older adults admitted to the hospital is not uncommon, in 1 study occurring in 46.1% of cases.⁵⁰ Risk factors for goal-discordant care include patient and surrogate decision-maker characteristics and dynamics⁵⁰ but also patient health status and even disagreement regarding goals of care between patient and clinician.^{51,52} High-intensity and/or high-cost care, which often includes transitions in care (eg, admission or readmission to an acute care facility), has been inversely associated with perceived goal-concordance of care.⁵³ Transitions in care may lead to goal-discordant care through undesired escalation or de-escalation of care but also through care fragmentation: limited documentation and/or availability of patient goals and preferences may lead to undesired treatments and/or interventions.⁵⁴

Disparities in Care Transitions

Racial/ethnic health disparities have been observed in care transitions among older adults. In a study using 2011 Medicare claims data, nearly 40% of Black older adults had 4 or more care transitions in a year, compared with 32.5% of White older adults.⁵⁵ Older adults who are racial minorities are more likely to be admitted and readmitted to the hospital⁵⁶. Black older Medicare beneficiaries with dementia had 37% higher odds of a 30-day readmission compared to White beneficiaries with dementia.⁵⁷ Older

adults from minority groups have been observed to have higher rates of discharge to skilled nursing facilities than to home with home health.⁵⁸ These differences have been attributed to a variety of factors, including higher burdens of chronic disease, poor communication between nursing staff and patients,⁵⁹ and higher postacute care needs.⁵⁸ The inverse distribution is true for interhospital transfer: Black older adults have a reduced probability of undergoing interhospital transfer when compared to White and Hispanic Medicare patients,⁶⁰ even when hospitalized with a diagnosis associated with mortality benefit from transfer.⁶¹

INTERVENTIONS TO SUPPORT CARE TRANSITIONS

The medical and scientific community has long recognized many of the challenges surrounding care transitions for older adults and has developed numerous interventions to improve patient and family experiences of care transitions, outcomes associated with them, and to measure the quality of transitions of care systematically (Table 1).

Interventions to Reduce Readmissions

Several evidence-based interventions to improve care transitions have been developed (see Table 1). While these interventions are broadly applicable to all hospitalized patients, many of them are targeted toward older adults at increased risk of readmissions. A 2020 systematic review of interventions and randomized controlled trials for transitions of care found that high-intensity multicomponent and multidisciplinary interventions are the most likely to be effective at reducing readmission rates among older adults after hospital discharge.⁶² However, clinician-level interventions are likely insufficient to have a large impact on the quality of care transitions. System-level interventions, backed by incentives and policies, will likely be required to see real

Table 1 Types of interventions to improve care transitions for older adults		
Intervention Type	Target (s)	Potential Components
Improved discharge services and follow-up	Hospital readmissions and nursing home admissions	- Care coordination to facilitate discharge - Supplemental home services
Communication	Medication-related adverse events Hospital readmissions Goal-discordant care delivery	- Education about medications and treatments - Predischarge medication reconciliation - Increased engagement of social supports - Integration of advance care documents into electronic medical record (EMR)
HIE	Communication gaps between care settings (eg, acute care hospital to skilled nursing facility)	Improved communication between electronic medical records
Multicomponent	Hospital readmissions and discharge associated adverse events	Any of the previous components

change. Some examples of such policies and programs exist. The Hospital Readmission Reduction Program is a value-based program that incentivizes hospital systems to optimize postdischarge communication and care coordination to reduce readmissions.⁶³ Similarly, the Joint Commission has enacted a requirement for hospitals to complete medication reconciliations for older adults after admission.⁶⁴ Additional efforts to incentivize broader adoption of practices to reduce and improve transitions of care among older adults should continue.

Disease-specific interventions to improve transitions of care are also an emerging area of research. Because of advances in stroke care, the number of stroke survivors—who often need outpatient rehabilitation following hospitalization—has dramatically increased. A systematic review of transition of care interventions for acute stroke highlighted the value of *early supported discharge*, that is, discharge with more intensive home supports and follow-up, which seems to have reasonable evidence in stroke.⁶⁵

Interventions to Improve Communication

In 2007, Kripalani *and colleagues* reviewed several high-level issues that inpatient physicians can consider when discharging patients to improve their transition out of the hospital. These included optimizing communication between inpatient and outpatient physicians and improving communication between clinicians and patients/families. Strategies to improve clinician-patient/family communication included, improving education about new medications, performing accurate medication reconciliation, and engaging with social support systems to ensure adequate support after discharge.⁶⁶ These communication strategies at the time of hospital discharge are particularly important for older hospitalized adults because of multimorbidity, polypharmacy, and changes in clinical status that can occur with hospitalization, which increase the risk of a subsequent readmission. Another systems-level intervention to improve transitions of care is leveraging electronic data exchange to address communication gaps among different clinicians and between clinicians and patients around transitions of care. Health information exchanges (HIE), systems that electronically exchange patient data between settings of care, are available in 92% of hospitals and 53% of outpatient clinics.^{67,68}

Despite advances in HIE in various health care settings, critical gaps in information exchange in transitions of care for older adults remain, including lack of interoperability between PCPs and specialists, PCPs and hospitals, and hospitals and postacute care. SNFs in general have a lower level of interoperability than hospitals; as of 2018, although 2/3 of SNFs have EHRs,⁶⁹ 40% of facilities had zero interoperability capabilities while 25% had just one interoperability capability (send, receive, query, or integrate)—mostly receive/query—and only 12.4% could integrate data from outside facilities. Similarly, few home health agencies participate in HIE. A 2022 analysis found that only 5% of home health care classes that are required to be reported to CMS are required to be interoperable by law. These gaps will likely require policy-level solutions to address them.

Improved health care communication should also incorporate facilitation and documentation of older adults' wishes and preferences for their care. Efforts to promote advance care planning (ACP), a process of discussing and documenting older adults' wishes and preferences for future care,⁷⁰ as a means of guiding decision-making around care transitions are frequently hindered by limited availability of these documents between electronic medical records and facilities. Existing studies suggest that ACP documents are rarely accessible for older adults who present to the emergency department.^{71,72} Even in single-system electronic medical records such as the Veterans Health Administration,⁷³ ACP documentation is often limited, inaccurate,

and decontextualized, limiting its utility in guiding discussions about care preferences. Expanding efforts to incorporate these documents into EMRs, to make them more accessible and modifiable by patients and clinicians, and to allow interfacility sharing of advance care planning documents may improve care transitions for older adults by improving delivery of person-centered care.⁷⁴

SUMMARY AND FUTURE DIRECTIONS

Older adults may be faced with a variety of care transitions, all of which may have longitudinal implications on health and wellbeing. Care transitions can also have significant implications in terms of patient and caregiver and systemic costs, both through direct care expenses and through fragmented care causing redundancy and duplication. Efforts underway to improve these care transitions include the development of health information exchanges, of decision aids to guide decision-making for families and for clinicians, and strategies to improve discussion and communication of older adults' care preferences. However, additional efforts are needed to define and understand unnecessary care transitions and to engage and guide older adults and their families to improve these transitions when unavoidable.

CLINICS CARE POINTS

- Care transitions are common and represent a vulnerable time for an older adult and their family.
- Preventing care transitions starts with high quality care, communication, and a clear understanding of a patient's goals of care.
- Leveraging tools to help communicate and transmit goals across settings of care is important to support care transitions that are aligned with a patient's wishes.

DISCLOSURE

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