# Care Transition Management for Elderly Patients: A Case Study

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Care transitions are defined as "the movement of patients between one care setting or care provider and another" (Golden & Shier, 2012, p. 6). This movement of patients is a common occurrence in modern medical care in the United States, as patients move from primary care to specialists to surgery and acute care and back again. Obviously, the settings, providers, and their interactions vary depending on the individual patient and the circumstances surrounding their health/medical condition. But regardless of the variables, skilled and coordinated management of care transitions can lead to improved patient health outcomes and quality of life.

Due to the many common factors found in elderly individuals, care transition management is especially beneficial for elderly patients. According to Lowthian (2017), hospitalization is a common cause of decline in level of function and physical condition for elderly patients. This puts them at higher risk for adverse health events and potential re-hospitalization. Pugh et al. (2014) state that careful assessment of frailty could prevent hospital readmission, while Toles, Colón-Emeric, Naylor, Barroso, and Anderson (2016) explain that care transition management results in "decrease[d] complications during transitions in care" (p. 1). Decreased complications lead to better health outcomes, resulting in improved quality of life and decreased healthcare spending. These benefits clearly show the need for skilled management of care transitions. This paper investigates the case of Mrs. S, an actual elderly patient, and the benefits she would gain from having well-managed care transitions.

## Meet Mrs. S

Mrs. S is an elderly, widowed woman with significant risk factors for adverse health events. These include her age, residence, frailty status, comorbidities, medications, and

frequency of hospitalization. Although many individuals are involved in Mrs. S's care, care transition management is unfortunately not being provided.

**Age, Residence, and Assistance**

Mrs. S is 75 years old, a factor that alone puts her at risk for experiencing multiple care transitions as she approaches the final stages of her life (Wang et al., 2016). She lives alone in a two-story house, though she has several adult children living within a 15-mile radius. Her children check on her regularly, purchase her groceries, and take turns transporting her to and from appointments. Mrs. S has a caregiver who spends two hours every weekday assisting her in her home, a housecleaner who comes twice a month, and a cook who prepares and freezes meals two to three times monthly.

**Frailty Status**

Bandeen-Roche et al. (2015) discuss frailty status as a measure of "slowing, fatigue, and decreased muscle mass, strength, and physical activity" (p. 1428). They explain that frailty status helps identify elderly patients who are at greater risk for adverse medical events. According to their measuring scale, individuals qualify as "frail" if they meet three or more of the criteria discussed above and "pre-frail" if they meet one or two of the criteria (Bandeen-Roche et al., 2015, p. 1428). Mrs. S falls under the "frail" categorization, increasing her likelihood of experiencing further negative health effects such as "mortality, falls, disability, and adverse events following surgery" (Bandeen-Roche et al., 2015, p. 1428).

**Comorbidities**

Mrs. S has multiple comorbidities. These include congestive heart failure, morbid obesity, osteopenia, severe peripheral edema of the lower extremities, obstructive sleep apnea, osteoarthritis of the hips, a torn rotator cuff, recurrent kidney stones, intermittent unexplained

vaginal bleeding, and depression. Because Mrs. S has so many conditions, she sees several health care providers at multiple clinics associated with multiple health care systems. Communication between the providers is difficult and slow, requiring Mrs. S to request updates be sent to other providers after every visit. Mrs. S does not always successfully remember to request these updates, and even when she does the requests are not always filled.

**Polypharmacy and Medication Concerns**

Mrs. S's comorbidities are managed with multiple medications. She also supplements her nutrition with over-the-counter vitamins and minerals. Her varying medications require differing administration times, which means Mrs. S needs to take pills up to four times daily. She finds this very difficult to coordinate and remember, especially since she does not follow a consistent sleep/wake pattern.

Mrs. S sometimes brings to her medical appointments a hand-written sheet of medications (usually omitting her supplements), though she is frequently unaware of the dosages of each medication and often forgets to remove medications she no longer takes from the list. It is not uncommon for Mrs. S to misplace the list of medications and attempt to recreate it from memory on the way to her appointments. This understandably causes confusion when she is questioned by medical staff about her current medications.

**Frequent Hospitalizations**

Mrs. S experiences frequent hospitalization because of her many health conditions. Her recurrent kidney stones require surgical intervention, after which she is routinely hospitalized for heart complications. Mrs. S also frequently presents to the emergency department because of pain, falls, or heart concerns. Because of her many comorbidities and medications, she is typically admitted from the emergency department for observation while hospital staff attempt to

sort out her diagnoses and medications. According to Mudge et al. (2016), these hospitalizations may be a result of Mrs. S's many care providers and their lack of communication. In addition, Mudge et al. (2016) state that "[r]ecent hospitali[z]ation and multimorbidity are also potent risk factors for hospital readmission" (p. 87). This indicates that simply being admitted increases the likelihood of Mrs. S being readmitted within a short time after her discharge.

## Mrs. S's Actual and Expected Care Transition Points

Mrs. S experiences numerous care transition points. These include primary care to specialist (cardiologist, urologist, and gynecologist), emergency department to the med/surg floor, surgery to the med/surg floor, the med/surg floor to inpatient rehabilitation or home (depending on her health status at the time of discharge), the rehabilitation facility to home, back to her primary care physician, and from inpatient rehabilitation to outpatient rehabilitation. In addition to these actual care transition points, it can be expected as Mrs. S advances in age that she will eventually require transition of care to either an assisted living facility or a skilled nursing facility. At every juncture in her care, Mrs. S has multiple children involved (frequently not the same ones from one event to another or even within the same event) as well as her personal caregiver and cook.

## Benefits to Mrs. S of Care Transition Management

Given the large number of care transition points Mrs. S experiences, skilled management of these care transitions by a single individual or entity would provide many welcome benefits to Mrs. S, her children, and her care providers (both medical and in-home). These benefits include improved communication between providers and caregivers; a more appropriate management of her medications, supplements, and diet; and a reduction in Mrs. S's risk of being readmitted to the hospital.

**Communication Between Providers and Caregivers**

Communication is a vital and often neglected part of care transitions. According to Lowthian (2017), "a key element is effective communication and transfer of relevant information with relatives, carers and community service providers including the primary care physician" (p. 3). Having everyone on the same page, including Mrs. S and her children, would greatly streamline her care. Currently, Mrs. S is reluctant to burden her children with her many needs. As a result, she alternates among when she calls for her many needs and concerns. This means that there is no one caregiver (medical or otherwise) who is aware of all Mrs. S's conditions, needs, concerns, medications, and appointments. This can lead to conflicting instructions for Mrs. S from differing providers, leaving her and her family confused about what is of highest priority. In addition, each of her children is only aware of the certain aspects of her care with which they have been involved, and therefore family members frequently clash when it comes to determining what is best for Mrs. S.

**Medications, Supplements, and Diet Management**

Improved communication between providers and caregivers would also lead to improvement in the management of Mrs. S's medications, supplements, and diet. Having a single individual aware of all the health conditions and concerns relating to Mrs. S's multiple conditions and providers would enable communication between providers regarding the timing and amounts of Mrs. S's medications. Additionally, it would enable a thorough evaluation of the necessity and compatibility of Mrs. S's many medications and supplements, their timing for administration, and restrictions on her diet and fluid intake. This is important because, as Mudge et al. (2016) point out, a high incidence of "inappropriate medication use" has been noted in elderly adults and may contribute to their frequent hospitalization (p. 89).

Dietary concerns regarding medications and medical conditions are vital for Mrs. S's cook to be aware of. Mrs. S has been given differing diet restrictions from each of her care providers (for example: no salt, no sugar, no dairy, no wheat and gluten, no meat, no dark leafy greens, low cholesterol, fluid restriction, and no acidic produce), which have ultimately left her with very little she can eat. This results in increased work for the cook, who must attempt to find recipes that fit all Mrs. S's dietary needs while still meeting her nutritional needs and flavor preferences. Having an individual managing all this dietary information would allow for consultation among physicians regarding what Mrs. S can and cannot eat. It would also allow the care transition manager to communicate with the cook on a regular basis throughout all care transition points regarding Mrs. S's current dietary requirements.

**Reduced Risk of Re-hospitalization**

Improved communication between providers combined with attention to medication and diet management would decrease Mrs. S's risk of re-hospitalization because her nutritional needs would be met, she would be on an appropriate medication schedule, her risk of kidney stones could be reduced, and her providers would communicate with each other and her in-home caregivers about what her risks are. In addition, having a specific individual in charge of managing care transitions means Mrs. S would have someone to contact whenever she had a health concern or status change. This individual would be able to communicate with Mrs. S's varying providers and determine whether hospitalization or presentation to the emergency department was indeed necessary. This would decrease the likelihood that Mrs. S would require as many hospitalizations, and significantly decrease the number of times she was admitted from the emergency department while providers attempted to determine the interactions of her current medical conditions and medications.

## Interventions to Manage Mrs. S's Care Transition Points

Interventions to manage Mrs. S's care transition points are necessary if her care is going to improve. Some beneficial interventions include designating a care transition manager; putting structures and procedures in place that support care transition management; educating providers, caregivers, and Mrs. S about the importance of care transition management and processes; and teamwork among all individuals involved in Mrs. S's care.

### Designating a Care Transition Manager

The first step in managing Mrs. S's care transition points is to designate a care transition manager. This could take the form of an individual (such as a nurse case manager) or an organization (such as a patient centered medical home). Regardless of the individual or organization chosen to manage Mrs. S's care transitions, all interventions will need to be coordinated and managed by this entity.

### Structures and Procedures

Once a care transition manager has been selected, that entity can begin coordination of Mrs. S's care by implementing structures and procedures to allow the efficient communication and transfer of information between medical providers and care providers. Such structures could include standardized forms to be filled out at the completion of a medical interaction and returned to the care transition manager. A patient-centered intervention might incorporate a binder for Mrs. S including information on all her medical diagnoses, doctors, medications, and dietary restrictions. This binder could be kept up-to-date by the care transition manager and Mrs. S could take it with her to medical appointments. It would also be available in her home for Mrs. S's children, personal caregiver, and cook to consult as necessary.

Procedures that may be beneficial could include regular meetings (with frequency determined depending upon Mrs. S's current medical acuity) between Mrs. S, her family, caregivers, and the care transition manager. In addition, regular review of Mrs. S's binder and communication with her many medical providers by the care transition manager would be an important procedure to put in place. Finally, procedures for who to contact when Mrs. S is experiencing medical concerns or emergencies would be a vital addition to the plan of interventions. This information could also be kept in Mrs. S's binder.

Specified structures and procedures allow all members of the care team to follow standardized processes. This improves the likelihood that such interventions will be consistently followed (Toles et al., 2016).

**Education**

After structures and procedures have been implemented, it is vital to educate all members of the care team on their use and importance. Toles et al. (2016) noted that "gaps in staff knowledge were associated with omissions in transitional care services" (p. 7). Clearly, to properly carry out appropriate care transitions, all members must be aware of and invested in their implementation. Of utmost importance is the education of Mrs. S about the significance of the interventions so she can encourage their use with all her caregivers.

**Teamwork**

The final vitally important intervention in appropriately managing Mrs. S's care transitions is teamwork. A willingness to work together, to help with tasks as needed, and a commitment to the goal of improving Mrs. S's care and quality of life through care transition management is the element that will ultimately determine the effectiveness of all other interventions (Toles et al., 2016). Members of the care team (including Mrs. S and her family)

who recognize the importance of teamwork will provide more consistent and comprehensive care and ultimately display more confidence in their own abilities to participate in improving Mrs. S's health and quality of life.

## Conclusion

It can be seen from the case of Mrs. S that care transition management for elderly patients can have a profound impact on improving their care and quality of life. The many commonalities among elderly patients predispose them to experiencing vast improvements in health status from care transition management. Clearly, specific interventions are needed to ensure the success of such management, and several appropriate interventions were suggested in the case of Mrs. S. With commitment, dedication to improving care, proper education, and consistent teamwork led by a designated care transition manager, many unnecessary adverse events could be prevented in the lives of elderly individuals. But even more importantly, their health and quality of life could be greatly improved. High-quality care transition management for elderly patients should become the rule – not the exception.

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