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Sentinel Paper Review: Exploring Care Transitions From Patient, Caregiver, and Health-Care Provider Perspectives

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The Journal of Geriatric Emergency Medicine (JGEM) is happy to feature important articles affecting the emergency care of older adults. We would like to highlight the article from *Clinical Nursing Research* Original Investigation titled "*Exploring Care Transitions from Patient, Caregiver, and Health-Care Provider Perspectives*" by Dr. Kevin T Fuji and colleagues. The article's findings "illustrated provider difficulty in meeting multiple care needs, and the need for patient-centered care to achieve positive outcomes associated with quality measures, reduced readmissions, and care transitions." The following is a commentary by the article's lead author and by a topic expert.

AUTHOR'S COMMENTS: KEVIN T. FUJI, PharmD

Our study described hospital-to-home/community facility transitions of care from the perspectives of patients and their caregiver(s), hospital, and community providers. From the five themes identified, communication is a key concept relevant to emergency physicians in their care of older adults. This includes interprofessional communication and collaboration or patient-centered communication throughout the patient's experience in the emergency department (ED). Communication should begin by setting goals of care with the patient and their caregiver(s). Patients' goals may be more personal in nature (e.g. get well enough to visit their grandchildren in a few weeks) compared to provider-defined goals (e.g. get patient's blood glucose into a normal range). Working within the context of patient-defined goals encourages buy-in and engagement by the patient in their own care. These goals should drive clinical decision-making and be communicated to all members of the patient's health care team, including those who will be caring for the patient after discharge from the ED.

Proactive communication with other health care professionals is essential early on during the patient's time in the ED. Additional assessments or patient education are often an important step in addressing the patient's comprehensive care needs. Some assessments and education may take longer to conduct with older patients who often have more care needs and complexity of care associated with those needs. As transitions out of the ED occur, there is a need to ensure that patients and their caregiver(s) can manage aftercare needs appropriately. This means clearly explaining what to expect once they leave the ED. It involves not just providing information but ensuring that the patient and their caregiver(s) understand what aftercare is needed and evaluating their description of how those aftercare needs will be integrated into the patient's daily routine. If the patient is being discharged to somewhere other than home, all relevant information about the patient's current condition should be sent to the receiving facility and highlighted accordingly, so providers at the receiving facility can readily care for the patient rather than wasting time sorting through what may be a detailed and lengthy patient record.

As emergency situations are high-stress experiences for patients and their caregiver(s), they may not be fully paying attention during these discussions. Therefore, it is important to provide written information (or in the case of a tech-savvy older adult, electronic information via a tool such as a patient

portal) that reinforces the verbal education. This written information is ideally provided in patient-friendly language and includes additional resources that the patient and their caregiver(s) can utilize.

Finally, patients and their caregiver(s) should be provided with a contact person that they can reach out to with questions once they are discharged from the ED. This can either be someone from the ED or the patient's primary care provider (PCP). This is especially useful if that individual has been proactively communicated with regarding their patient's ED visit. The ED should anticipate that important questions may not arise until a day or longer after discharge and can even proactively follow-up with the patient to see how the patient is doing and if appropriate aftercare and follow-up has been initiated.

EXPERT COMMENTARY: BY AARON MALSCH APN, AND PAM MARTIN APRN-BC

The authors illuminate the complexity of ED care transitions for older adults through the perspectives and themes of multiple stakeholders. The dismal track record of emergency department (ED) transitions of care and the complexity of this topic make this study important for emergency providers.

This study highlights:

- The need to incorporate patients and caregivers in the transition process
- How to develop process and communication that reduce variability and increase the success of each patient's transition
- The value of qualitative methods to bolster both the relevance and outcomes of healthcare studies.

We know from personal experience that preplanned admissions are ideal, and this study confirmed that observation. However, most ED visits are unplanned. The article highlighted transition challenges due to incomplete review of systems, past medical history, and medication usage. Inaccurate insurance information limits the available transition resource options and EDs often lack information regarding the patient's managed care insurance product. Can patients go to skilled nursing without the required three inpatient overnight requirements? Does the patient's insurance offer case management resources, social worker, transportation, or resources to discharge patient home?

The Geriatric Emergency Department Guidelines (GEDG)[i], were created to help emergency providers address important issues in emergency care of the older patient, including care transitions. The GED Guidelines incorporate staffing protocols to include transdisciplinary care. GEDs utilize care managers, social workers, physical and occupational therapists, and pharmacists in addition to the medical and nursing team, to enhance the care and outcomes of older adults. GEDs help to ensure older adults receive the appropriate home equipment and level of care needed upon transition. ED presence of a transdisciplinary team enables each team member to focus on their strength each discipline provides and bring recommendations that meet the patient's/family's needs. This study provides valuable information to improve care across all settings and reinforces the GED guideline recommendation for optimal transitions from the ED.

*View the full *Clinical Nursing Research* article HERE.

REFERENCES

1. Fuji KT, Abbott AA, Norris, JF. Exploring Care Transitions from Patient, Caregiver, and Health-Care Provider Perspectives. *Clinical Nursing Research* 2012;22(3):258-274. DOI: 10.1177/1054773812465084

KEY WORDS

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CONFLICT OF INTEREST

The authors have no conflicts to report.

Please visit the JGEM website for other Journal of Geriatric Emergency Medicine publications.

[i] American College of Emergency Physicians; American Geriatrics Society; Emergency Nurses Association; Society for Academic Emergency Medicine; Geriatric Emergency Department Guidelines Task Force. Geriatric emergency department guidelines. Ann Emerg Med. 2014 May;63(5):e7-25. doi: 10.1016/j.annemergmed.2014.02.008. PMID: 24746437.