

Transitional Care for Older Adults with Chronic Illnesses as a Vulnerable Population: Theoretical Framework and Future Directions in Nursing

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Purpose: Effective transitional care is needed to improve the quality of life in older adult patients with chronic illness and avoid discontinuity of care and adverse events. The aim of this article is to provide an overview of the key features, broader implications, and the utility of Meleis' transition theory intended for the transitional care of older adults with chronic illnesses. We present the role of nurse in the context of transitional care and propose future directions to increase the quality of nursing care. **Methods:** The online databases Cumulative Index of Nursing and Allied Health Literature, MEDLINE, and Science Direct were searched for relevant literature published since 1970 along with textbooks regarding nursing theory. **Results:** An evaluation of the usefulness of transition theory based on transitional care in older adult patients with chronic illnesses is provided. Healthy transition should be the expected standard of nursing care for older adults across all healthcare settings. **Conclusion:** Nurses need to contribute to the development of transitional care for vulnerable populations; however, transition theory needs to be enhanced through additional theoretical work and repeated evaluations of the applicability in areas of transitional care.

Key words: Chronic illness; Nursing; Older adults; Transitional care; Transitional theory

INTRODUCTION

Advances in healthcare have led to a growing number of people living with chronic illnesses. At the same time, the proportion of older adults in the population is also growing, further increasing the number of those with chronic health problems because of accumulated exposure to chronic illness risk factors over their lifetime [1,2].

Hospitalization rates due to chronic illnesses such as heart failure, stroke, chronic obstructive pulmonary disease, cancer, hypertension, and diabetes are highest among individuals aged 65 and over and typically result from an acute change in the health

status of older adults [3]. Older adults with multiple chronic conditions that require close follow-up and early discharge may be prone to an increased risk of re-hospitalization because the decline of cognitive function or physical disabilities [1,3]. Furthermore, when appropriate care or resources are not available in the community, older patients will often remain in high-level care such as intensive care, exacerbating wait times for others in need of a hospital bed [1,3]. Therefore, comprehensive and well-executed discharge plans including the acceptance of changes in functional capacity, reconciliation of medications ordered at admission and at hospital discharge, coordination of follow-up diagnostic tests and appointments, and assessment of community

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resources are required [2,4].

Previous studies have highlighted the concerns related to the peri-discharge period [5]. The results showed that approximately 49% of patients have experienced at least one medical adverse event such as medication duplication, confusing follow-up instructions, or unnecessary testing [5-7].

Transitions are vulnerable exchange points that contribute to unnecessarily high rates of health services use, and they expose chronically ill people to lapses in quality and safety [2]. Moreover, transitions can give rise to adverse clinical events resulting in patients having serious unmet needs and feeling poor satisfaction with the quality of care they receive [1]. Transitional care refers to the multiple transfers that patients make between healthcare practitioners and/or care settings during an episode of illness [5,6]. Transitional care as a part of integrated care encompasses a broad range of services and environments designed to promote the safe and timely passage of patients between levels of health care and across care settings [2,8] and it can be considered as a part of prevention of re-hospitalization programs within care transition programs in chronic care [4]. Transitional care includes pre-hospital discharge planning and immediate post-hospital discharge follow-up at the next location of care [2,9]. Research has shown that older adults are at high risk for negative care outcomes during these transitional periods related to the complex organizational practices and culture differences among settings [5].

Transition theory is widely used in the field of nursing because nursing frequently involve various transitions (e.g., mothering, immigration, health and illness, etc.) and it has been welcomed and adopted in nursing research, education, and practice [10,11]. Transition theory provides an excellent lens through which nursing can be systematically and comprehensively viewed [12,13]. Also, transition theory is particularly applicable for the care of aging families because age-related transitions that may result in hospitalization of an older adult often precipitate the need for nursing care for older individuals [11]. Furthermore, transition theory informs nurses on how to better understand the experience of transitioning from a hospital-to-home or nursing home, and how nurses can develop multifaceted interventions to ease the transition process for older adults [13]. However, more studies are needed to review the utility of applying transition theory

to transitional care for older adults with chronic illnesses.

Nurses play a key role in transitional care as they advocate for older patients with chronic illnesses and their families and provide direct care on a continual basis [14-16]. To stimulate discussion on the transitional care literature, an extensive review of the literature on transitional care in nursing for older adults with chronic illnesses is presented in this article. In addition, the usefulness and significance of Meleis' transition theory is critically compared with other conceptual models suggested for chronic care. How to improve transitional care in nursing areas is also discussed.

BACKGROUND

1. The impact of an aging population with chronic illnesses on the nursing workforce

With populations increasing in age, many countries are facing increased pressure on the allocation of healthcare resources [8]. Older adults with chronic illnesses are the fastest growing segment of the population and are the heaviest healthcare users, accounting for up to four times more hospital days than the rest of the population [17]. In South Korea, 60.5% of older adults aged 65 and over had more than two chronic conditions in 2011 [18]. Multimorbidity, the occurrence of three or more chronic illnesses in one individual, affects over 50% of older adults [9]. Exacerbations of chronic illnesses are the primary cause of over one-third of hospital admissions and potentially complicate another 35% of in-patient stays [3].

Older adults transitioning between hospital units often experience inconsistent nursing care and more adverse care incidents such as nosocomial infections, delirium, falls, and medication errors [5]. Kanak and colleagues [19] surmise that minimizing transitions during hospitalization can result in improved quality of care, shorter hospital stays, and lower overall costs. Improving the quality of care of older adults during healthcare setting transitions may help to decrease these readmission statistics [16]. Moreover, when the transition involves a move from the hospital to the patient's home, evidence suggests that the intervention should start prior to discharge, possibly as early as during admission [20]. Assessment of discharge readiness, discharge preparation and education, and community resource coordination

should be considered as significant nursing interventions that should be provided to support a patient and family through the hospital-to-home or nursing home transition process [4].

2. Meleis' transition theory and other conceptual models in chronic care

Transitions is defined as a passage from one fairly stable state to another fairly stable stage and it is a process triggered by a change and is characterized by different stages, milestones, and turning points [11]. These changes or transitions can be assisted or managed by nurses. Transitions are central to the nursing discipline as nurses are often the primary health professionals that handle transitional encounters with patients and their families. These transitional periods are commonly periods of instability that are precipitated by situational, developmental, or health-related illness changes [10].

Meleis' transition theory is widely applicable and provides a comprehensive guide that considers cultural and social diversity. It was developed from multiple studies among very diverse groups of people during many types of transitions. Transition types are subdivided into developmental (changes in the life cycle), situational (change in roles), health/illness (change from a healthy condition to an illness condition), and organizational (change in the social, political, and/or economic environment) [11]. This theory is based on four key concepts, which are characterized as follows: nature (type, patterns, and properties of transition), transition conditions (process facilitators or inhibitors and related to the person, the community, and society), patterns of response (process indicators and outcome of the transition, conductors of the nursing therapeutics), and therapeutic interventions in nursing [13]. Transition theory provides a framework for understanding the complexity of the post-hospital transition experience on older individuals, their families, and their support systems [13]. This theory conceptualizes transition as both a process and an outcome and provides a theoretical construct for the development of nursing therapeutics that meet the individual needs of patients and families [10]. Because aging is characterized by multiple changes in the physical and cognitive function, and roles of older individuals and those within their social networks, transition theory is particularly applicable in the

care of aging families [13]. Age-related transitions that result in hospitalization often precipitate the need for nursing care for both older individuals and their families [11].

Hospitalization of an older adult potentially creates a multidimensional transition experience for the individual, family members, and social supports [4]. Daves et al. [21] tested transition theory by applying it to the experiences of family members while moving their older relatives to nursing homes. They concluded that the 3 domains of transition theory (nature of transitions, transition conditions, and patterns of response) could be helpful in explaining the range of factors that circumscribe each individual's transition and the various experiences that individuals encounter. There were a few studies using Meleis' transition theory for critically ill patients in Korea [22,23]. However, transition theory should be evaluated as being clear, simple to understand, and easily generalizable to various types of transitions.

In addition to transition theory, several conceptual models guide transitional care in older adults with chronic illnesses. First, the Transitional Care Model (TCM) is advanced nurse practitioners-led, multidisciplinary approach to care for older adults with multiple chronic conditions [2]. The TCM includes comprehensive in-hospital patient assessment, active engagement of patients and their family, and continuity of medical care between hospital and community follow-up in partnership with the patient and family [5]. A second hospital-to-home model is the Care Transitions Intervention (CTI) which is part of the Care Transitions Program is designed to encourage older patients and their caregivers to assert a more active role during care transitions [15]. This care transitions model include a hospital visit, followed by a home visit, and three follow-up calls. The nurse coach meets the patient in the hospital, visits the patient at home 48-72 hours after discharge, and performs three follow-up telephone calls [24]. A third model Better Outcomes for Older Adults through Safe Transitions (Project BOOST) was developed by the Society of Hospital Medicine [17] and was designed to help reduce unplanned hospital readmissions and improve information flow between inpatient and outpatient providers. This model provides resources to optimize the hospital discharge process and minimize many of the problems incurred by older patients discharged from the hospital [5,17]. The final model is the Chronic Care Model (CCM) is a physician-designed, patient-centered,

systems approach for providing safe and effective care to older adults with chronic diseases and fluctuating health statuses. The CCM includes both care coordination and case management, and has been applied most frequently in outpatient clinic settings [17]. These conceptual models regarding chronic care are utilized in a variety of settings that include hospital-to-home (CTI, TCM, and BOOST), outpatient clinic-to-home (CCM). These models promote patient-centered care and report reduced hospital readmissions and reduced overall healthcare costs [5]. Nevertheless, these models are mostly focused on one specific transition period and expensive to apply to medical settings. Especially, BOOST and CCM are both physician-led models. On the other hand, Meleis' transition theory as a nurse-led framework extensively used to explain health and illness transitions such as the recovery process, hospital discharge, and diagnosis of chronic disease. The literature shows that transition theory in nursing practice has been used with diverse groups of people including geriatric, psychiatric, and maternal populations as well as family caregivers, menopausal women, Alzheimer patients, immigrant women, individuals with chronic illness, new nurses, and others [10,13,23]. In addition, Meleis et al. [10] developed this middle range theory based largely on qualitative research. Long-term changes in health and illness create a process of transition, linked to shifts in self-care ability [1]. Nurses working alongside their patients can help them identify changes forced by illness and seek new possibilities from disruptive experiences. Understanding transition enables nurses to move towards a more holistic approach to the provision of care.

3. Significances of transitional care in chronically ill older adults

Transitional care is a broad term for care interventions that promote the safe and timely transfer of patients between levels of care and across care settings [2]. Coleman and Berenson [15] proposed transitional care should cover admission, transfer, and discharge procedures. The main goal of transitional care is optimal patient care and safety [14].

Older patients over the age of 75 utilize approximately 25% of all hospital encounters [25,26]. The rate of hospitalization for adults over the age of 65 has shown an upward trend over the

past 30 years, while rates of all other age groups have significantly declined [25]. Transitions such as the hospitalization of an older adult ultimately affect people who live within multifaceted family systems. In addition, frail older patients with complex healthcare problems appear to be a group particularly at risk for adverse events during the periods of health-illness transitions across medical locations and providers [13].

The physical and mental health of older adults may deteriorate after hospital discharge. They may experience changes in their treatment regimen and discontinuities during their transitions. The type and incidence of adverse events reported in the literature relate to adverse drug events, procedure related events, diagnostic test follow-up errors, nosocomial infections, and falls. Ineffective care processes, poor communication, and deficient documentation represent the major risk factors associated with these adverse events [6,8,25]. According to prior studies [5,14,23,25], poor transitional care led to serious complications including hospital re-admission and increased emergency treatment. Poor outcomes may be attributable to duplicated, omitted, or incomplete care provision. During the discharge and home recovery transition periods, in particular, patients and family caregivers often struggle to redefine their self-concepts, resume prior roles, and employ the new knowledge and skills required to manage condition-associated changes in health [25]. Nurses are often the primary providers of interventions that support patients and families during these vulnerable periods.

METHODS

The material for this article was derived from electronic databases: Cumulative Index of Nursing and Allied Health Literature, MEDLINE, and Science Direct and a search of literature published since 1970. Additionally, relevant literature published in English was found using the terms "transitional care", "transition of care", "continuity of care", "transition", and "chronic care" in combination with the terms "aging", "older", and "older adults". Titles and abstracts from the searches were first screened for their relevance to the discussion's aim, and then any publications deemed relevant were examined for inclusion in this article. We read and reread articles to elicit their relevance to transitional care for older adults with chronic illnesses.

DISCUSSION

1. Importance of healthy transitions for chronically ill older adults

Nursing Science has become proactive in the study healthy transitions [10]. A healthy transition that has received considerable attention is the move from hospital-to-home [26]. Nursing interventions for complex healthcare transitions have been examined recently [14,23,25]. The transition from having independence to requiring professional help to manage daily self-care may bring upon various types of distress and vulnerability in an individual. To accept the professional support needed in such situations, a healthy transition is vital [15].

Older patients typically leave the hospital with residual recovery needs and often must elicit the support of family, friends, or formal resources to optimize transition outcomes [8]. Better understanding of the evolving needs of older patients in the early and later stages of transition is needed. It may assist in identifying older patients who are at risk for or are already experiencing an unhealthy home recovery transition and developing time-appropriate interventions that address the complexity of individual patients and their families is necessary [23]. The frequency of early hospital readmissions increase when patients are discharged to an inappropriate setting, are prematurely discharged, when caregivers are excluded from the discharge plan, and when patients are inadequately prepared to resume self-care [26]. Establishing an effective process of transitioning patients from one setting to another or from one provider to another will lead to improved outcomes and satisfaction [6]. The extent and consequences of poor transitions for older individuals are temporary disability, psychological stress, and sometimes death [2]. Therefore, to improve care transitions, a shift in emphasis from provider-centered to patient-centered care is required.

It is critical that nurses identify healthy transition outcomes to facilitate research on transitions and the evaluation of clinical interventions. Three indicators of healthy transition such as subjective well-being, role mastery and well-being of relationships appear relevant across all types of transitions [13]. Thus, it is appropriate to assess these indicators periodically throughout the transition and not simply at the end of the transition period.

2. Effects of the transitional care program using meileis' transition theory on improving patient outcomes

Transitional care is clearly capable of reducing hospital readmission rates and costs [15]. Preventive home visits, chronic disease self-management, caregiver support, transitional care, and comprehensive inpatient care can improve patients' quality of life and functional autonomy [16]. Positive outcomes of these interventions include fewer unplanned readmissions, longer median event-free survival reduced mortality rates, and lower health-care costs [7,19,27].

Geary and Shumacher [28] presented an interesting look at the integration of transition theory with concepts of complexity science. They argued that the complexity of many transition situations encountered by nurses today is better described when the theories are integrated. Integration encourages recognition that transition effects are widespread and include patients, caregivers, healthcare providers, and the healthcare system [28]. Moreover, structured post-discharge follow-up of recently hospitalized older adults may be more effective if it is driven by individual patient assessment rather than condition-specific protocols [14].

Several studies using transition theory have focused on the experience of caregivers. One study [12] was an extensive review of the literature to examine the transitions encountered by patients with cancer and their caregivers. The intent was to develop a more focused intervention and better allocation of resources to assist caregivers during this change. Research findings have shown that involvement of an advanced practice nurse or social worker significantly improves transitional care outcomes. Interventions that include assessment of older adults for discharge readiness and structured follow-up interventions may be particularly beneficial in identifying those that are at-risk for poor home-recovery transition outcomes [2,5,16]. Telehealth interventions that incorporate inclusion of mobile technologies such as Facebook, tablets, and mobile videoconferencing such as Skype may provide assistance in post-discharge support.

According to Naylor and Keating [2], the evidence suggests that nurses play pivotal roles in ensuring that successful care transition occurs. Most interventions in transitional care should be designed to facilitate smoother, safer, and more efficient transitions from the hospital to home or nursing home [27]. In

addition, transitional care interventions should be developed and evaluated for high-risk populations.

3. Nursing roles in the transition process through chronic illness trajectories

Older adults with chronic illnesses and family care providers frequently report unmet transitional care needs as they leave the hospital [2,15,16]. Namely, many older patients are discharged to their home following a hospitalization without proper home-care supervision [3]. Current hospital-based discharge planning processes typically address the immediate relocation needs of the patient within the confines of individual admission [6,8]. These services often occur in isolation and are often ineffective because older patient's health-illness transitions are complex, have profound effects on the individual and their families [7,28]. Furthermore, older patients encountered common post-discharge difficulties in their home setting include; increased dependence on others to meet personal and self-care needs; greater reliance on others to perform household tasks; difficulty with reading medication labels and basic medication management; lack of information on appropriate support services and how to engage them; unmet informational needs; poor understanding of symptom control; social instability; and coping issues including psychological distress such as anxiety, depression, loneliness and hopelessness [26,27]. Therefore, transitional care programs are needed during these vulnerable periods.

There are several reasons why transitions are important in nursing. First, nurses spend a great deal of their clinical time caring for individuals who are experiencing one or more changes in their lives that affect their health [1,9]. Second, patients tend to leave hospitals earlier and continue their recovery and rehabilitation transition at home. The reasons for this early discharge include the benefits of technology, insurance-driven policies related to hospitalization and discharge, and the increasing costs of healthcare. The transition to recovery is somewhat more protracted, and patients need expert and competent care until they complete their recovery transition. When patients and their families are not cared for during these transitions, they may experience complications and possible readmission [26]. Lastly, the increase in the aging population creates a different set of health-

care challenges that require more long-term care from nurses [2]. Nurses are expected to help older patients and families cope with the multiplicity of changes including physical, geographical, spatial, emotional, and mental challenges.

Older adults become particularly susceptible to poor outcomes when transitioning from the acute care setting because they are often discharged with ongoing care demands that exceed those that preceded the hospitalization [25,27]. Therefore, nurses should conduct transitional care according to transition phases such as hospitalization, at discharge, and after discharge.

Specifically, to implement successful transitions it is important for nurses to 1) work in partnership with older patients and their family caregivers; 2) be aware of the pressures the family caregivers are experiencing and attempt to minimize whenever possible; 3) ensure that both patients and family caregivers are well-informed; 4) enable patients to maintain autonomy over their independence and decision-making when possible; and 5) ensure that patients and family caregivers are emotionally supported.

4. Implications and future directions in nursing

1) Nursing education

Changes in treatment plans may increase the risk of medication errors at home; therefore, effective communication between patients, family care providers, and the healthcare team is necessary at the time of discharge [2,13,23]. Better understanding of a patient's pre-admission self-care practices may assist the bedside nurse in developing clear discharge instructions that clarify new or changing elements of care.

Besides the family members who are actively involved in providing care, direct care workers are typically the ones who know the consumer best. They are also most likely to interact with the patient during multiple stages and places along the transitional care continuum.

Finally, there is a need to educate patients and their families about transitions of care. This will provide them with the information and tools necessary to understand their health conditions and care options, and to make decisions that reflect their personal values and preferences [5,13].

In nursing education, professional curriculum should be systematically disseminated before newly trained professionals engage

in transitional care. Furthermore, importance of transitional care for vulnerable population should be understood in undergraduate nursing education system through outcome-based curriculum.

2) Nursing practice

Creating an effective healthcare team starts with facilitating a readiness to accept the culture of teamwork and ensuring all members possess the necessary knowledge, skills, and attitudes. To be effective, all members of the transitional care team must go beyond their own area of expertise to be more skilled in interdisciplinary teamwork [27,28]. This requires cooperative efforts to enhance communication, willingness to compromise, and recognition particularly, that communication between patients, family members, and all members of the interdisciplinary team is critically important to the success of transitional care [28]. The need to communicate and coordinate more effectively is increasingly supported by advances in technology, including the use of electronic hospital records [29]. Although technologies improve communication, access to these tools does not guarantee their appropriate or meaningful use. Much is yet to be learned, and standards of use need to be established to optimize the use of medical technologies. In the future, we need to be concerned about these health related technological issues.

To extend coverage and provide needed services to a broader range of diverse populations such as people with mental illness or cognitive impairment will require expanding the scope of practice. Moreover, the transitional care interventions that are implemented will need to be tailored to meet multiple dimensions of diversity including functional age; chronological age; racial, ethnic, and cultural identity; gender identity and sexual orientation; and socioeconomic status [10,13,25].

Most importantly, the ideals of a cooperative and interdisciplinary approach to transitional care need to be carefully reconciled with the risks and responsibilities of effective and ethical patient care. This issue requires further consideration as innovative practices of transitional care move forward. In order to develop interventions that promote healthy hospital-to-home transitions, there is a need to investigate if the care needs and problems experienced at different phases of the home recovery transition vary.

3) Nursing research

There is an absence of literature on the hospital-to-rehabilitation and post-rehabilitation transition experiences of older adults; therefore, there are extensive opportunities for research growth in this area [29,30]. The higher rates of dependency observed in older adults with chronic illnesses should encourage research on the post-hospitalization transitions of older adults who reside in assisted living facilities [27,30].

The field of transitional care research is still in infancy. The role of nurses working in collaboration with other healthcare providers and family members needs to be emphasized in future projects. Finally, studies aimed at translating the findings of best practices in healthcare environments, including home, hospital, adult day care, and long-term care, are needed.

4) Future directions

The successful implementation of transitional care involves a new way of providing healthcare that will require the participation of multiple stakeholders in the process. In turn, these stakeholders represent several pathways through which effective models of transitional care can be adopted and enhanced. To recognize and become engaged in the process, there must be something in the provision of transitional care that stakeholders perceive as relevant and beneficial [26,27]. Identified needs such as information, resources, or culturally relevant services will need to be addressed, and there will be a need to build on existing strengths such as community trust or collaborative organizational culture.

The concepts embodied in transitional care represent a paradigm shift in the delivery of healthcare [30]. As such, the adoption of its principles and program components will likely be an evolutionary process. Incremental change efforts take time and energy, dedicated leadership and staffing, and committed political support, the intensity of which will fluctuate over time [25,26]. To continue to advance effective models of transitional care, it will be critical to engage and mobilize multiple levels of individual and organizational stakeholders to develop collaborative relationships and implement effective mechanisms for the coordination of service delivery.

CONCLUSIONS

With the increasing older adult population and the growing in-

cidences of chronic and end-stage disease rates among those aged 65 and older, monitoring care transitions will remain a challenge. Nurses in key roles across the myriad of healthcare settings will help assure seamless care transitions for their older adult patients.

Transitional care is particularly important for people experiencing serious or chronic illnesses including mental illnesses. Encouraging family members to become active and informed participants in the planning and execution of transitional care has several benefits. Transition theory can provide a more appropriate theoretical fit for the healthcare system because of its inherent consideration of the diversities in patients and its basis in research among various groups of people in transition.

Using Meleis' transition theory as a framework for the development and implementation of clinical and educational approaches, nurses can play an important role in the health and well-being of older patients with chronic illnesses and their family caregivers. Nurses in different practice settings can assist patients in making a healthy transition toward a sense of mastery over their illness and constitute a significant resource in the healthcare available to older individuals.

CONFLICTS OF INTEREST

There are no conflicts of interest.

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