Transitional Care

Methods and processes for transitioning older adults with cancer in a postacute setting

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BACKGROUND: The concept of transitional care and the methods and processes to efficiently and effectively transition patients between a variety of care settings remains a continuous healthcare goal. Despite the numerous transitional care models that have been developed and implemented in a myriad of healthcare settings, increasing healthcare costs and substandard patient outcomes persist.

OBJECTIVES: This article will examine the topic of older adults with cancer when transitioned to a skilled nursing setting and the challenges they may face along the care continuum. In addition, it will look at the continuity of care between the hospital and skilled nursing facility, as well as explore some of the clinical difficulties experienced by older adult patients with cancer in the postacute care setting.

METHODS: Keyword searches were conducted in a selected literature review of CINAHL®, Ovid, PubMed, and Google Scholar databases.

FINDINGS: Successful transitional care models are built around effective communication and often include an interprofessional team approach and/or a nurse navigator to aid in the effective execution of medical treatment and patient care plans.

KEYWORDS
transitional care; care coordination; older adults; skilled nursing facility

DIGITAL OBJECT IDENTIFIER
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A RECENTLY RETIRED 68-YEAR-OLD DIVORCED WOMAN NAMED J.S. presented to the emergency department after two days of experiencing diffuse abdominal pain and a decrease in appetite. J.S. has a past medical history of hypertension, hyperlipidemia, hypothyroidism, and gastroesophageal reflux disease. A computed tomography scan of the abdomen was performed in the emergency department and revealed cholelithiasis, wall thickening, and fluid around the gallbladder. J.S. was taken to the operating room to undergo a laparoscopic cholecystectomy and lymph node biopsy. The pathology report showed an approximately 1 cm well-differentiated gallbladder adenocarcinoma with involvement of two nearby lymph nodes. J.S. was given a diagnosis of stage IIIB gallbladder cancer.

After an uncomplicated surgical course and five-day hospital length of stay, it was determined by the hospital medical team that J.S. was medically stable and physically independent in all areas of her care and would, therefore, be appropriately discharged from the hospital directly to her home where she lives independently. At the time of her discharge, J.S. was given appointment dates and times to follow up with her primary care provider, as well as an oncologist whom she would now establish care with to begin chemotherapy treatment for her diagnosis of gallbladder cancer. J.S. met with the oncologist within one week of the hospital discharge and was given a six-month systemic chemotherapy treatment to be administered via IV, once a week for three continuous weeks, followed by a three-week recovery period.

J.S. believed that her first week of chemotherapy went well and she only experienced some generalized weakness without any other complaints or concerns. However, after the second week's treatment, J.S. began experiencing extreme fatigue and developed a fever along with severe diarrhea, nausea, and vomiting. J.S. was transported to the emergency department and ultimately required a three-day hospital stay for severe dehydration and bacteremia from sepsis secondary to urinary tract infection. While in the hospital, J.S. was ordered a 14-day course of IV antibiotics; she also received IV hydration and total parenteral nutrition because she was now experiencing symptoms of anorexia. Although the treatments received during this hospitalization significantly improved the side effects J.S. was experiencing from the chemotherapy and infection, she remained weak and still required 11 additional days of IV antibiotics as well as cautious advancement of an oral diet. Based on current Medicare guidelines and the necessity of her medical needs, J.S. met the criteria to transfer from the hospital to a skilled nursing

facility (SNF) for continued antibiotic treatment and physical rehabilitation to strengthen her from deconditioning prompted by her medical condition.

J.S. shared with her hospital medical team that, although she lives alone and would prefer to go home, she agreed that a temporary stay at the SNF would allow her to complete her course of IV antibiotics and also receive additional therapies to improve her function. As the hospital medical team was preparing for her transfer to the SNF, J.S. recalled that she had previously scheduled an appointment date and time for her third chemotherapy treatment. Given the severity of her symptoms and her weakened clinical state, it was unclear at the time of hospital discharge if J.S. would be physically strong enough and medically cleared to undergo the third chemotherapy treatment. J.S. attempted to get the uncertainty of her pending treatment resolved, but her hospital medical team assured her that this would be addressed by the medical team that would now be assuming her care at the SNF. J.S. was transferred that afternoon from the hospital to the SNF. On her arrival, J.S. told the admission nurse that she had an upcoming chemotherapy appointment in four days, and the nurse replied, "I will let the doctor and the case manager know."

Transitional Care

Transitional care can be defined as "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" (Naylor & Keating, 2008, p. 58). In addition, care continuity and coordination of transitional care is for patients of all ages who move throughout any healthcare setting, both inpatient and outpatient locations, and include (but are not limited to) hospitals, subacute and postacute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities (Coleman, 2003). As transitional care relates to older adults, the American Geriatrics Society's 2003 position statement describes it as "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location" (Coleman, 2003, p. 549). In addition, the establishment and maintenance of high-quality transitional care is of particular importance because older adults most often have numerous complex and chronic conditions that require frequent movement among multiple healthcare providers and between various care settings (Naylor & Keating, 2008).

Care transitions are not always seamless. In addition, frequent instances occur when the communication between care settings is inconsistent and inadequate, ultimately leaving the projected care plan vulnerable and subject to failure (Coleman, 2003). Studies report that RNs from various care settings want better communication and coordination to make more appropriate clinical care decisions required by medically complex older adult patients (Kirsebom, Wadensten, & Hedström, 2013).

"Frequent instances occur when the communication between care settings is inconsistent and inadequate."

Since conceptualization in the 1990s, several transitional care models have been researched. Trial implementation periods have demonstrated that some are effective, advancing adoption of the models in practice (Academy Health, 2017). In addition, some transitional care models have explored a variety of care settings among patients with a myriad of specific conditions and disease states to include various cardiac conditions (e.g., congestive heart failure, arrhythmias, coronary artery disease, stroke), chronic obstructive pulmonary disease, diabetes, spinal stenosis, hip fracture, peripheral vascular disease, deep venous thrombosis, and pulmonary embolism, among others (Kripalani, Theobald, Anctil, & Vasilevskis, 2014). Despite ongoing research efforts associated with transitional care and an overarching quest to improve health care as a whole, healthcare spending and costs continue to rise and interventions do not necessarily prove to reduce healthcare costs (Golden, Ortiz, & Wan, 2013).

Care Considerations for Older Adult Patients

Although some transitional care models are promising, older adults with cancer in the setting of postacute skilled nursing care is an under-researched model of transitional care. This article explores the complexities of care transitions of older adults with cancer to postacute settings, also referred to as SNF. In addition, the author will seek to address the following topics: continuity of care between hospital and SNF medical providers with specialists involved in patient care, coordination of care between SNF clinical and facility staff, and patient expectations of the projected plan of care against the executed plan of care as determined by the oncology diagnosis and the frequent fluctuations of their medical condition based on the ultimate prognosis of disease.

Transition to Skilled Nursing Care

SNFs are part of Medicare's hospital services (Medicare Part A) in which a person requires professional and skilled services typically "for an ongoing condition for which the beneficiary had also received inpatient hospital services" (Centers for Medicare and

Medicaid Services [CMS], 2017, p. 3). In addition, these skilled services may include qualified health personnel (e.g., RNs, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists or audiologists) and must be ordered and deemed appropriate by a physician (CMS, 2017). In addition, a stay at the SNF is not intended to be permanent. The goals are to address rehabilitation in efforts to return the patient back to the original care setting (Coghill, 2014). Physicians who specialize in the full-time care of skilled nursing home patients may be referred to as *SNFists*, and they have responsibility for guiding the medical care and treatments while the patient is at the SNF.

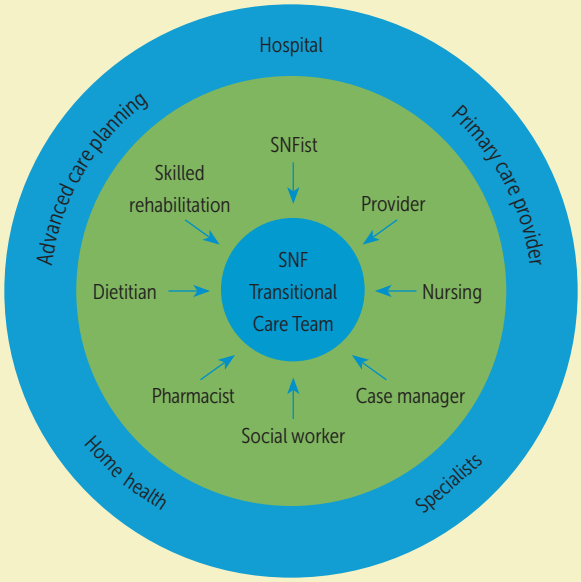
When patients like J.S. transition from the hospital to the SNF, managing their care needs can be complex and may require the expertise of a number of skilled providers in which the communication and sharing of information is necessary for successful care transitions and high-quality care (Dicicco-Bloom & Cunningham, 2013). The precise care needs at the time of discharge from acute hospital to SNF may not always be clear and are often uncertain, as in the case of J.S. Similar to the hospital structure, the SNF also has an interprofessional approach to the patient that involves the SNFist or doctor, providers (e.g., nurse practitioners, physician assistants), RNs or licensed vocational nurses, case managers, social workers, rehabilitation therapists (e.g., physical, occupational, or speech therapists), dietitians, and pharmacists (see Figure 1).

Care Coordination and Barriers Encountered

As with any approach to successful transitional care, care coordination is best orchestrated from the time of hospital discharge to the SNF, as well as between the SNF and any additional discipline or specialty involved in the patient's care. In the example of J.S., it is clear that there was no definitive answer at the time of her hospital discharge about whether she would continue with her previously scheduled chemotherapy treatment. At the time of admission to the SNF, the nurse made it clear to J.S. that she would relay this information to the physician and the case manager. Although no studies to date have focused on any barriers of care experienced specifically by the SNFist and outside specialists who are involved in the patient's care, such as an oncologist, DiCicco-Bloom and Cunningham (2013) conducted a qualitative study with 11 primary care providers and 10 nurse practitioners in the community who expressed the frustrations experienced with oncologists in co-managing shared patients. In addition, DiCicco-Bloom and Cunningham (2013) conducted detailed interviews in which five themes emerged: (a) the importance of continued visits with the primary care clinician during cancer treatment; (b) the unsettling differences in communication between the community care clinician and the cancer center oncologists; (c) the identification and remediation for information deficiencies and the inability to secure routine progress reports from the oncologists; (d) the insufficient post-treatment follow-up care plans; and (e) the potential for electronic health records to provide access to patients' care plans. Given the temporary nature of the SNF concerning the patient's stay, it may be fair to assume that these themes could also be shared with SNFists who are responsible only for short-term care of the patient.

Engaging the assistance of other members of the SNF care team is critical in the care coordination of patients with cancer who transition to the SNF. Nurses, case managers, and social workers play important roles in arranging initial visits, as well as follow-up visits with outside members of the patient's medical care team. In an effort to address the importance of care coordination of the patient with cancer, Coghill (2014) highlighted the contribution of a senior cancer care navigation model in Florida that has proven to be effective in the organization and delivery of not only setting up cancer treatments, but also organizing holistic person-centered care. In addition, nurses serve as navigators to assist in the arrangement of appointments, the facilitation of patient education to help patients and families understand available options, and the overall improvement and reduction of time spent prior to receipt of care. Unfortunately, in J.S.'s case, she did not have an assigned cancer care navigator, nor was such a program available in her health plan.

FIGURE 1.
SNF INTERPROFESSIONAL CARE TEAM AND VARIOUS TRANSITIONAL CARE SETTINGS



SNF—skilled nursing facility
Note. Advanced care planning includes palliative care and hospice; skilled rehabilitation includes physical therapists, occupational therapists, and speech therapists; and provider includes nurse practitioners and physician assistants.
Note. Image courtesy of Michelle L. Jackson. Used with permission.

IMPLICATIONS FOR PRACTICE

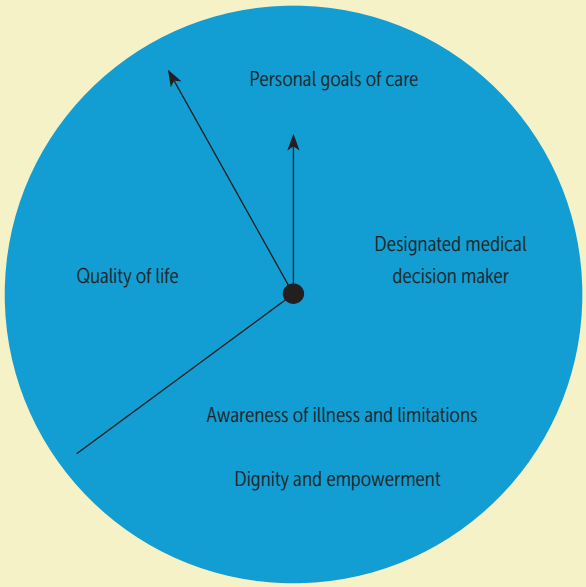
- Encourage and influence stronger collaboration between all disciplines of the healthcare team.
- Assist in bridging the communications gap between various care settings to help ensure appropriate clinical care decisions are made for medically complex patients.
- Initiate and encourage discussions about goals of care as they relate to each individual patient.

The lack of a designated person to coordinate the care of the patient is not uncommon, and other members on the SNF care team are employed with the task of arranging any necessary appointments or treatments for the patient during the SNF stay. Kirsebom et al. (2013) conducted a descriptive study with a qualitative component to examine the frustrations that acute and postacute nurses have concerning decision making and coordination of patient care during transitions between care settings. In addition, nurses in both settings admitted that increased collaboration and communication needs to be improved to reduce the risk of unsuitable medical treatment and nursing care, as well as unwarranted transfers to the acute hospital or even premature discharges to the SNF (Kirsebom et al., 2013). King et al. (2013) conducted a qualitative study addressing the discrepancies found by SNF nurses from the hospital discharge orders and instructions. SNF nurses were frustrated that they often encountered problems with patients' medication orders, lack of psychosocial or functional history, incorrect information concerning patients' current health status, and lackluster discharge communication, which ultimately led to ineffective care transitions (King et al., 2013).

In the example of J.S., the SNF case manager arranged transportation for the follow-up appointment that J.S. was scheduled to have with her oncologist. However, it was only at this time that the oncologist was made aware of her current medical situation and her transfer to the SNF for ongoing antibiotic treatment, dietary advancement, and physical rehabilitation. Given the weakened condition of J.S., the oncologist requested that the SNFist order necessary bloodwork prior to the oncology appointment to better evaluate blood count, renal function, and specific cancer markers to help guide the cancer treatment plan.

After three days at the SNF, J.S. was still weak but stated that she was feeling better and had successfully transitioned to an oral diet with the assistance of the SNF dietitian and a safe swallow assessment conducted by the speech therapist. By this time, J.S. had been informed by the SNF nurse and case manager that transportation had been arranged for her follow-up with the oncologist the next day; although it was still unclear if she would undergo her third chemotherapy treatment, J.S. understood that the bloodwork drawn earlier that morning would be given to the oncologist to help guide that decision. The following afternoon, J.S. arrived for the oncologist appointment and was informed that, because she was still under current IV antibiotic treatment for bacteremia, she would not receive her third treatment. At this time, the oncologist also informed J.S. that, based on the results of her bloodwork, her infection was improving but the bloodwork values with biomarkers indicating her body's response to the previous chemotherapy treatments had nearly doubled when, in fact, they were expected to decline. J.S. asked the oncologist what this meant for her outcome and was informed that her cancer was more aggressive than originally determined. The oncologist suggested that, after she completed IV antibiotics, J.S. would need to schedule an additional follow-up to check the bloodwork and discuss the oncology care plan moving forward.

FIGURE 2.
GOALS OF ADVANCED CARE PLANNING



Note. Establishing goals of care and initiating advanced care planning discussions center around timing. The clock is symbolic of why healthcare providers are encouraged to have discussions with patients and family members in a timely manner, particularly in the setting of advancing chronic and/or acute illnesses.
Note. Image courtesy of Michelle L. Jackson. Used with permission.

Unexpected Changes to the Plan of Care

J.S. was certainly not expecting the information she received at her oncology appointment, but she wanted to remain focused on getting stronger. Similar to J.S., many patients with cancer are given information about the possibility of change concerning their prognostic outcome. Kripalani et al. (2014) encouraged acute hospitals to begin the discussion with patients about advanced care planning as it relates to both long- and short-term prognoses, as well as goals of care that fulfill the patient's wishes and individual preferences concerning medical treatment and care (Kripalani et al., 2014). Using a qualitative approach, Feder, Britton, and Chaudhry (2018) explored the perspectives of physicians from both acute and postacute settings, initiating the discussion of patient goals of care at the time of discharge to the

SNF. The study concluded that the majority of clinicians would rather the hospital staff initiate goals of care discussions prior to the hospital discharge, which may then be continued as necessary when transferred to the SNF (Feder et al., 2018). A retrospective cohort study reported that, in 2009, one of every six Medicare decedents with cancer passed away in a nursing home (Teno et al., 2013). This indicates that patients with cancer who are ultimately transferred to the SNF after an acute hospitalization may have care needs—related to the possibility of futility within their diagnosis—that conceivably extend beyond what rehabilitation services can provide; therefore, the patients may benefit from a goals of care discussion (see Figure 2).

Implications for Nursing

The case study with J.S. represents a common experience for patients with cancer. Although the interprofessional healthcare team approach to care coordination and patient care is invaluable and proves to be effective in various care settings, RNs still make up the largest group of healthcare professionals in the United States with nearly three million nationwide (U.S. Department of Labor, 2018); therefore, they have the potential to make the largest impact on transitional care. As patient advocates, oncology nurses have the ability to help bridge the gap between each care setting that a patient may be transitioned to or from.

Conclusion

Nurses should advocate for effective and accurate communication to help ensure the safety of patients and the effectiveness of medical treatment plans as patients transition between various healthcare settings. Nurses across a variety of disciplines, but particularly in the area of oncology, are in unique positions to encourage and initiate goals of care discussions as they relate to each individual patient. Nurses can encourage and influence stronger collaboration between all members of the patient's healthcare team, ultimately contributing to successful transitional care and positive patient outcomes and experiences.

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