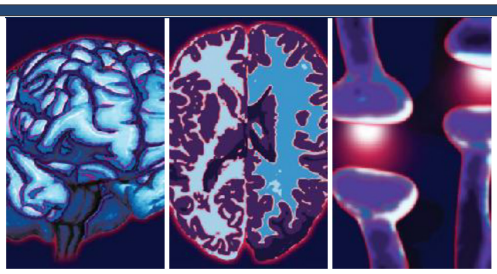
Review Article



The Transition Dilemma: Barriers to Safe Disposition in Older Adults after Hospitalization

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ABSTRACT

The transition of older adults from hospital to home or other care settings is an important element of healthcare that greatly influences patient outcomes. Factors that may delay safe social disposition include clinical, healthcare system and social barriers. Despite advancements in medical care, numerous older adults encounter barriers during the transition process, potentially resulting in adverse health events, readmissions and diminished quality of life. This review examines the challenges associated with safe discharge for older adults following hospitalization and considers possible strategies to deal with these concerns.

Keywords: Disposition, Older adults, Hospitalization, Barriers

Introduction

The aging population is expanding, resulting in a higher incidence of elderly patients necessitating hospitalization. The World Health Organization (WHO) 2024 world report on aging and health indicates that individuals aged 65 and older will surpass the youth population, with projections of 2.1 billion by 2050, up from 1 billion in 2020 [1]. Numerous factors influence the health of older adults, encompassing physical and social environments such as their residences and communities, as well as individual characteristics including gender, race, socioeconomic status and genetic predispositions. Physical and social environments influence health either directly or indirectly by developing barriers or incentives that shape opportunities, decisions and health behaviors. Older patients experience a higher prevalence of morbidities compared to younger patients, resulting in extended hospital stays and greater healthcare requirements [2]. Safe disposition, which involves transitioning patients from hospital care to their homes or alternative care settings, is essential for maintaining continuity of care and enhancing health outcomes. A secure disposition process can reduce errors during care transitions, which are frequently avoidable, thereby decreasing the likelihood of readmissions and adverse drug events post-discharge [3,4]. Numerous barriers can delay this process, showing the need for a thorough understanding of the challenges faced by older adults in the post-hospitalization phase. Efficient discharge planning constitutes a key element of high-quality inpatient care, particularly for older adults with multimorbidity and complex medical requirements [5]. Efficient discharge planning seeks to enhance patient quality of life by facilitating continuity of

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care and minimizing readmission rates and complications, thereby potentially improving the financial burden on the healthcare system [6,7]. This review identifies various barriers to safe disposition in older adults following hospitalization and shows the necessity of coordinated efforts to enhance care transitions.

Barriers to Safe Disposition

▪ Clinical Barriers

Complex medical needs: Multimorbidity, defined as the coexistence of multiple chronic diseases, affects 35% to 80% of older adults [8]. Multimorbidity leads to disability, diminished quality of life and increased health care utilization and costs complicating the discharge process [9]. Furthermore, elderly patients often exhibit dementia which impairs their understanding of discharge instructions, thereby posing a significant challenge for the services provided [10].

Polypharmacy and medication reconciliation: Polypharmacy refers to the use of an excessive number of medications beyond medical necessity, which may encompass medications that are not indicated, ineffective or result in therapeutic duplication. While there is no universally accepted limit for the number of medications, most studies classify the use of five or more drugs as polypharmacy [11,12]. Polypharmacy frequently occurs in older adults because of multimorbidity. Hajjar E et al., conducted a study involving 384 elderly hospitalized patients, revealing that 58.6% of these patients were prescribed one or more unnecessary medications [13]. Polypharmacy results in adverse drug events, elevated healthcare costs, medication non-adherence, functional decline and heightened risks of cognitive impairment and falls [14]. Insufficient medication reconciliation at discharge may lead to medication errors, non-adherence and subsequent health complications [15].

Cognitive impairment: Cognitive impairment and delirium are common in older adults. Hospitalized older patients with conditions such as stroke, heart failure or lung disease exhibit a heightened risk for cognitive decline. Cognitive decline may result in confusion and non-adherence to treatment recommendations. Mental deterioration in hospitalized elderly patients may also result from delirium [16]. Delirium significantly increases the risk of difficulties associated with hospitalization, leading to longer stays, unplanned admissions to the Intensive Care Unit (ICU), transfers to nursing facilities and higher rates of all-cause mortality [17].

Mental health issues: Approximately 15% of individuals over the age of 60 experience mental health disorders, including depression, anxiety, loneliness and substance abuse, with depression being the most common [18,19]. Suicide rates among older adults are comparable to or exceed those of younger individuals, with primary contributing factors including physical illness, functional impairment and stressful life events [20]. Lin P et al., conducted a study revealing that 78% of older hospitalized patients experience mental health issues, while 53.8% of older patients with chronic diseases employ negative managing strategies that may impair the adverse effects of their conditions [21].

Functional decline: Functional Decline (FD) refers to the loss of independence in one or more basic Activities of Daily Living (ADLs) and represents a significant issue among hospitalized older adults. Approximately 20%-30% of older adults exhibit functional decline upon hospital discharge, resulting in heightened dependency on ADLs, extended inpatient length of stay, increased hospital readmission rates and elevated mortality the oldest demographic shows the greatest functional decline [22,23]. A meta-analysis conducted by Geyskens L et al., identified several significant risk factors for functional decline, including residing in a nursing home, impairment in Instrumental Activities of Daily Living (IADLs), a history of falls, cognitive impairment, dementia, delirium, malnutrition, hypoalbuminemia, comorbidity and the presence of pressure ulcers [24].

▪ Healthcare system barriers

Barriers within healthcare systems, such as fragmented communication and resource mismanagement, disrupt the continuity of care. These issues contribute to delayed treatments, higher costs and poor patient outcomes.

Fragmented healthcare systems: Inadequate communication with patients and caregivers, poor coordination among healthcare providers and misallocation of resources relative to patients' actual needs can lead to disjointed care and unsafe transitions. This results in diminished patient

satisfaction, extended lengths of stay, heightened healthcare costs and increased mortality [25-27].

Insufficient involvement of social workers: Insufficient involvement of social workers significantly impacts the discharge process for older patients. Social workers are essential in assessing the social, emotional and economic needs of these patients. They collaborate with healthcare teams to formulate discharge plans, link patients and caregivers to community resources and advocate for the rights and needs of older patients. Additionally, they provide education to patients and families regarding the discharge process and organize follow-up visits to ensure the patient's well-being [28]. Insufficient involvement of social workers can create barriers to hospital discharge.

Inadequate discharge planning and coordination: Complete discharge planning is an essential component of healthcare systems. The objective is to enhance the coordination of services from the hospital to the community, facilitating seamless patient discharge which leads to a reduced length of hospital stay and a lower rate of readmissions [29]. Older adults exhibit more complex needs, frequently present with multiple comorbidities and typically experience prolonged recovery periods after illness, necessitating more targeted discharge planning for their transition to home or long-term care facilities [30]. Discharge summaries often experience delays, exhibit inadequate quality in follow-up plans and demonstrate improper medication reconciliation. These issues contribute to confusion among patients and caregivers, potentially resulting in decreased treatment compliance and increased readmission rates [31,15].

Social barriers

Limited social support or housing instability: Older adults often seek assistance from their families, followed by neighbors and eventually depend on formal social support systems, including social workers, in the context of limited social support and housing instability. Family members can assist older patients by delivering care and working with the healthcare team, thus facilitating a safe discharge [32]. Elderly patients often exhibit insufficient social networks or family support systems, which are essential for maintaining safety and compliance with post-discharge plans. Isolation may delay recovery and elevate the possibility of readmission. Unsafe living conditions, homelessness, overburdened caregivers, financial strain on caregivers and geographic distance from the patient contribute to prolonged hospitalization, increased healthcare utilization and unsafe discharge [33].

Health literacy: Insufficient health literacy is identified as a more significant predictor of adverse health outcomes than age, income, employment status, education level or race and serves as an independent factor influencing 30 days hospital readmission following discharge [34,35]. Patients exhibiting low health literacy may struggle to adhere to medical instructions given at hospital discharge. This noncompliance, along with difficulties in attending follow-up visits and delays in seeking medical care, can result in elevated all-cause mortality rates [36,37]. Older patients exhibit a significantly higher prevalence of inadequate health literacy compared to younger patients, likely due to declines in memory and word recognition abilities [38]. A study conducted by Shahid R et al., indicated that among patients aged over 65 years, 45.6% exhibited inadequate health literacy, while 22.8% demonstrated marginal health literacy [39].

Language barrier: Limited english proficiency among patients results in inadequate knowledge of follow-up visits and medications after discharge. This results in extended hospitalizations and increased rates of readmission [40,41]. The interplay of low education and health literacy alongside language barrier places numerous patients in a state of 'double jeopardy' limiting their understanding of essential information and elevating risks at the time of discharge.

Transportation challenges: Reliable transportation access frequently constitutes a major obstacle for older adults receiving follow-up care or rehabilitation services. Restricted mobility may delay attendance at appointments and compliance with treatment plans. Each year, transportation barriers delay 3.6 million individuals in the United States from accessing medical care [42]. Transportation ranks as the third most frequently identified problem to health service access for older adults [43]. Studies indicate that older individuals, those with lower levels of education, females, minorities and low-income persons, particularly when these factors co-occur, experience greater difficulties related to transportation barriers [44]. Transportation challenges include limited availability and routes, overcrowding on trains and buses, safety concerns, high fare costs, absence of a personal vehicle, extended travel distances, prolonged waiting times and inconvenient schedules.

Strategies to reduce barriers

Adopting effective care coordination and specified

protocols can help overcome healthcare system barriers and ensure seamless patient transitions.

Enhanced discharge planning: Enhanced discharge planning aims to improve patient quality of life by ensuring continuity of care and reducing unplanned readmissions and complications, thereby potentially improving the financial burden on the healthcare system. Coordination is essential for successful discharge planning. Commencing discharge planning at the time of admission with an innovative team, patients and families ensures careful attention to all facets of a patient's care. This is especially significant for older adults who have a more complex discharge plan and necessitate additional support in implementing the required components [45]. A complete geriatric examination, involving a thorough evaluation of the patient's medical, cognitive, social and functional needs along with the implementation of standardized discharge planning protocols can enhance transition safety [46].

Medication reconciliation efforts: Medication reconciliation is a systematic process that accounts for all medications currently taken and those to be prescribed for the patient when developing a new prescription. Implementing effective medication reconciliation procedures at discharge is essential for ensuring that patients and caregivers comprehend the medication regimen [47]. Incorporating proficient pharmacists into allied healthcare teams facilitates the identification and resolution of medication-related issues [48]. The aim is to reduce medication errors by facilitating the transfer of complete and precise patient medication information among healthcare professionals at every transition in the care continuum.

Effective communication: Effective communication regarding the disease process and discharge planning, along with the provision of education and resources for family caregivers, can empower them to support older adults after hospitalization. This approach enhances acceptance to care plans and improves health outcomes. Furthermore, family members assuming caregiving responsibilities should receive information regarding support systems that can assist them both emotionally and practically. Family meetings should deal with the various aspects of caregiving to assess the family's understanding and readiness for this role [49,50].

Patient-centered care: Discharge safety is an evaluative concept; thus, it is essential to consider a patient's values regarding well-being, risk and a meaningful life. The findings indicate that enhancing patients' knowledge of medication in their preferred language is an essential element of interventions aimed at preventing medication errors and decreasing re-hospitalization.

Community support programs: The establishment of community resources and support networks is essential for reducing social barriers. Interventions aimed at enhancing functional capacity and promoting independence, gradual rehabilitation process, case managers for caregiver support and home health services and resolving issues related to transportation, housing and food security are some of the services that community support programs must provide [51].

Telehealth and remote monitoring: The implementation of telehealth services provides a cost-effective approach to follow-up care, allowing elderly patients to interact with healthcare providers without the necessity of transportation. Telehealth enhances health outcomes, particularly regarding readmission rates, mortality rates and quality of life among older adults at elevated risk of readmission [52].

Conclusion

The safe transition of older adults following hospitalization presents numerous barriers that can substantially affect health outcomes. Recognizing the clinical, healthcare system and social challenges faced by older adults allows healthcare providers to implement targeted strategies that improve the transition process. Reducing these barriers enhances patient safety, decreases readmission rates and promotes an improved quality of life for elderly patients. Ongoing studies and policy initiatives are vital for developing effective interventions that promote safe transitions within this at-risk population. Coordinated efforts from healthcare providers, social workers and community organizations are vital in developing a seamless transition process.

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