


The Experience of Transitional Care for Non-Medically Complex Older Adults and Their Family Caregivers

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Abstract

Transitional care research has mainly focused on the experiences of older adults with complex medical conditions. To date, few publications examine the experience of transitional care for non-medically complex older adults. In this article, we draw on and thematically analyze interview and audio-diary data collected at three hospitals in Eastern England, and we explore the experience of transitional care of 18 older adults and family caregivers. Participants reported mixed experiences when describing their care transitions, which indicated variations in care quality. To achieve independence and overcome the difficulties with care transitions, participants used a range of interrogative techniques, such as questioning and information seeking. We contend that the existing transitional care interventions are inappropriate to address the care needs of non-medically complex older adults and family caregivers. Implications for frontline health care staff and health services researchers are discussed.

Keywords

discharge planning, lived experience, qualitative analysis, older people, transitional care

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Transitional care is important for all patients, as it ensures that their care needs are met when they move across care settings (i.e., from secondary to primary care or vice versa); it includes hospital discharge, post-discharge support at the next level/location of care, and the engagement of the patient and caregiver in these processes (Bauer, Fitzgerald, Haesler, & Manfrin, 2009). Transitional care research has mainly focused on the experiences of older adults with chronic illnesses or those with complex medical conditions, such as people with heart failure or stroke, as these patients tend to have high levels of ongoing care and frequent transitions across care settings (Allen, Hutchinson, Brown, & Livingstone, 2014; Baillie et al., 2014; Copley, Fisher, Chouliara, Kerr, & Walker, 2013; Coleman & Boulton, 2003; Doos et al., 2014; Enderlin et al., 2013; Naylor & Keating, 2008; Storm, Siemsen, Laugaland, Dyrstad, & Aase, 2014). While it is important to explore and improve the experience of transitional care for such patients, the administrative pressure to free up hospital beds coupled with the emphasis on shorter hospital stays and shrinking social care budgets (Hau, 2003; Hesselink et al., 2012; Ismail, Thorlby, & Holder, 2014) can impact the quality and experience of care delivered to other patient groups. It is unclear how non-medically complex older adults (>65) experience transitioning from hospital to home. Although the care needs of such patients

may not warrant complex discharge planning and frequent care transitions, they may require a well-planned and executed discharge and/or follow-up support post-discharge. Such actions, if well planned and executed, can improve patient experience and reduce the risk of rehospitalization.

To our knowledge, there are few publications that address the issue of care transitions from the perspective of non-medically complex older adults and family caregivers. This literature gap is significant for two reasons: (1) unplanned hospital admissions and readmissions have a particularly high financial cost and negative impact on both the individual and the health system (Billings et al., 2012), and (2) person- and family-centered care are pivotal elements of quality health care (Allen et al., 2014; Institute of Medicine, 2001), and examining the experiences of non-medically complex older adults and their family caregivers can offer a more nuanced understanding of quality in transitional care. To address this gap, we draw on data collected as part of a larger

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mixed-methods study to examine how non-medically complex older adults and their family caregivers experience transitioning from hospital to home.

Background

Transitional Care

Transitional care is described as a set of actions, both pre- and post-hospital discharge, designated to ensure the continuity and coordination of health care when patients transfer between levels of care and across care settings (Coleman & Boulton, 2003). The persisting focus of health care systems on acute, episodic care has made care transitions particularly problematic for older adults and other patient groups with complex needs (Baillie et al., 2014; Doos et al., 2014; Fuji, Abbott, & Norris, 2013; Ham, Imison, Goodwin, Dixon, & South, 2011). Difficulties with accessing information about health and diagnosis (Christie et al., 2016; Ellins et al., 2012), poor communication between patients and care professionals around medication and symptom management (Doos et al., 2014; McMurray, Johnson, Wallis, Patterson, & Griffiths, 2007), limited involvement in discharge-care preparations (Baillie et al., 2014; Bauer, Fitzgerald, Haesler, & Manfrin, 2009; Foust, Vuckovic, & Henriquez, 2012), and problems with continuity of care post-discharge (Benzar, Hansen, Kneitel, & Fromme, 2011; Brown, Craddock, & Greenyer, 2012; Foust et al., 2012; Fuji, Abbott, & Norris, 2013) are problems associated with transitional care for older adults with medically complex needs. Such problems are linked to lengthy hospital stays (Lim, Doshi, Castasus, & Lim, 2006), increased rates of rehospitalization (Yam et al., 2010), increased hospital costs (Guerin, Grimmer, & Kumar, 2013), and compromise patient satisfaction and safety (Kripalani et al., 2007).

Providing quality transitional care is important because during care transitions, people are vulnerable to risks that can affect their health (Coleman & Boulton, 2003; Meleis, Sawyer, Im, Hilfinger-Messias, & Schumacher, 2000). For transitional care, the main elements of quality are (1) communication between providers about the discharge assessment and plan of care, (2) preparation of the person and caregiver for the care transition, (3) reconciliation of medications at transition, (4) preparation of a plan for follow-up, and (5) patient education about self-management (Coleman & Boulton, 2003).

Transitional care interventions have emerged as a convincing alternative to traditional hospital discharge care (e.g., hospital staff responsible for preparing discharge plans and referring to community services, either via phone or written communication) for improving health and care outcomes (Altfeld et al., 2012). For instance, the Transitional Care Model (Naylor et al., 2004) and the Care Transitions Interventions Models (Coleman, Parry, Chalmers, & Min, 2006) have been found effective in reducing health care costs

and readmission rates (Altfeld et al., 2012). Both are nurse-led, team-based models of care that aim at implementing a streamlined care plan that is executed and supervised by trained project personnel. They include in-person hospital visits, followed by home visits, and follow-up for several weeks after discharge (Coleman et al., 2006; Naylor et al., 2004). Another model that has showed promising results in reducing readmission rates and decreasing costs is the Project RED (Re-Engineered Discharge) (Jack et al., 2009). This model employs nurses as advocates to provide discharge-related information to patients and family caregivers and uses post-discharge telephone contacts for following up patients in the community. The Enhanced Discharge Planning Program (EDPP) is a telephone-based intervention implemented by social workers that aims at addressing psychosocial issues and resolving access problems to community services (e.g., transportation, social support services). EDPP has been found effective in facilitating patients to communicate and follow up with their physicians on a timely basis (Altfeld et al., 2012). Although these models have been found to have a positive impact on readmission rates and health care costs, they have been developed with the aim of addressing the needs of older adults with complex needs. It is unclear whether these models can have similar benefits for non-medically complex older adults and their family caregivers. The research question that this article sought to address is as follows:

Research Question 1: How do non-medically complex older adults and family caregivers experience transitioning from hospital to home?

Method

Ethics

Ethical approval was obtained from the National Health Service regional research ethics committee (NHS REC Nottingham) and the local Research and Development offices. We negotiated access to the hospital wards with the senior management teams at three hospitals. All participants provided their informed consent, and they were briefed about issues of confidentiality. We compensated participants for their participation in the study (£20 voucher).

Data Collection Procedure

This article is based on a larger multi-method study that aimed to gain a comprehensive understanding on how patients, family members, and health and social care professionals experience the discharge planning process and care post-discharge (Corrigan et al., 2016). Figure 1 presents the three-lens approach and associated methods that we used. In Lens 1, we gained a “snapshot” of patient experience as it was articulated on the day of discharge, whereas in Lens 2,

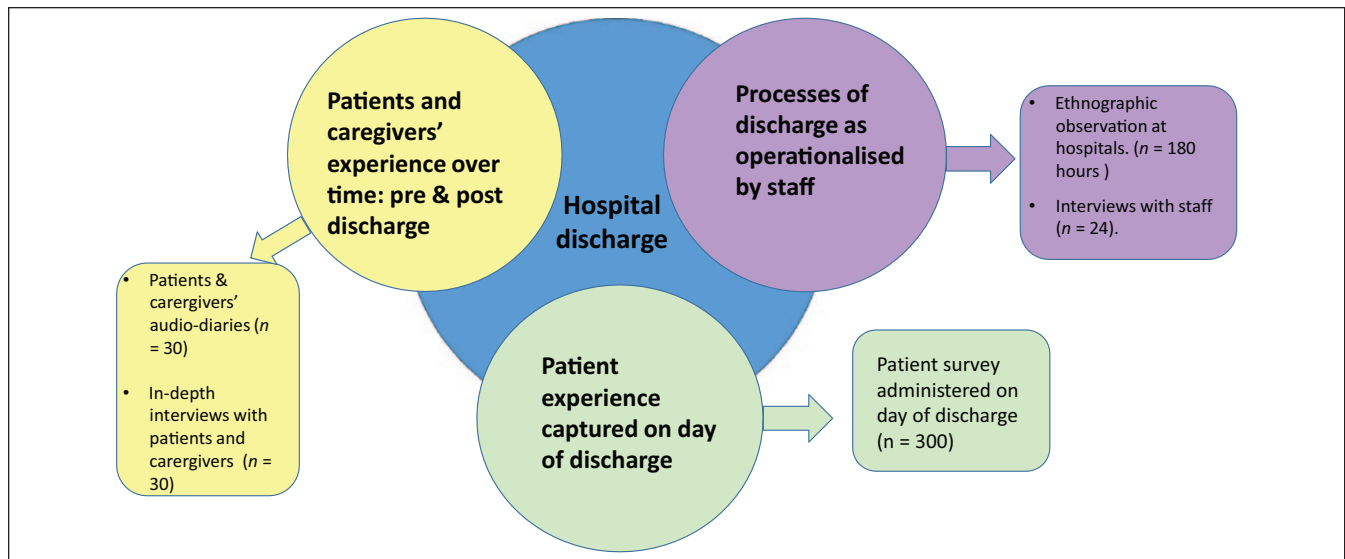


Figure 1. Three lens approach and associated methods for studying transitional care.

we examined the real-time events that make up discharge-care preparations and staff experience of these events. The aim of Lens 3, which is the focus of this article, was to gain an in-depth understanding of the factors that influence transitional care experiences from the perspective of non-medically complex older adults and family caregivers.

Studying the “lived experience” involves the detailed examination of participants’ “lifeworlds,” their experience of a particular phenomenon, how they make sense of these experiences, and the meanings they attach to them (Husserl, 1901/1970). Our study is located within the wider phenomenological tradition (Husserl, 1901/1970), where scientific understanding of the social world cannot be undertaken by merely collecting “objective facts,” but research needs to engage in a deep and empathetic way with those involved in an attempt to get as close as possible to the everyday world as experienced by those individuals.

Previous research highlighted transitional care as an issue of great concern in Eastern England (Hughes-Hallett & Probert, 2013); however, owing to capacity issues, the research team could not conduct the study across all the county hospitals. We selected three hospitals with the largest catchment areas. We aimed to recruit a purposive sample of 30 older adult patients (10 at each hospital) and/or family caregiver who were able (physically and cognitively) to participate in the study. Initially, we aimed at recruiting patients with complex care needs, that is, patients whose discharge required detailed assessments by multi-disciplinary teams. However, it was difficult to recruit such patients because they were too frail to participate. Therefore, we changed the focus of the study and worked with ward staff across the hospitals to identify and recruit older adult patients with non-medically complex illnesses. These patients were experiencing comorbid illnesses, but their care needs were

not complex to require the involvement of the multi-disciplinary team to be discharged from hospital. We recruited 18 participants (six from each hospital), with a mean age of 65.94 ($SD = 17.15$). From these, 12 were patients and six caregivers of patients. Time constraints and capacity issues did not allow us to recruit a larger number of participants or to expand the recruitment phase. All participants reported their ethnicity as white British; this is typical of the recruitment area where approximately 85% of the population in these areas are described as white British (Office for National Statistics, 2011). All participants were admitted to one of the hospitals as an emergency due to bone fractures (e.g., ankle or hip) or because of a medical problem such as gallstones, urinary tract infection (UTI), and chest infections.

The study involved participants producing audio diaries (and also written diaries) documenting their experiences from admission through to approximately 8 weeks post-discharge. An audio recorder, and instructions on how to use it, were given to participants after they agreed to participate in the study. Participants were asked to use the audio diaries to record their feelings and thoughts about discharge, in particular, following instances where being discharged was discussed with them by the healthcare staff, family, friends, and other patients. This captured recordings of patients’ and, whenever possible, family members’ thoughts and feelings “in real time” as patients moved through the discharge process and adjusted to arrangements after discharge. The researchers did not give any specific instructions about how often participants had to record their thoughts; instead, they advised participants to use the audio-recording device when they wanted to record their thoughts about their transitional care experience, during and/or after their hospitalization.

Audio diaries, compared with written or word-processed diaries, are under-utilized in contemporary qualitative

research (Williamson, Leeming, Lyttle, & Johnson, 2015). However, audio diaries can be used at any convenient time or context, and, therefore, they offer a practical way to capture real-time data regarding participants' experiences of a phenomenon (Bolger, Davis, & Rafaeli, 2003). In addition, the flexibility that the audio diaries offer to both the researchers and the participants make them particularly appealing to research studies that involve participants with constrained mobility and/or health (Johnson & Blytheway, 2001). The audio-diary format facilitated us to capture a "live record" of their experiences, including participants with limited manual dexterity or literacy skills.

To further explore the evidence produced through the audio diaries, follow-up interviews with the participants were held approximately 8 weeks after discharge. At that point, the researchers also collected the audio-recorders from the participants. The interview schedules were developed and based upon the wider literature on transitional care. They were primarily reflexive and aimed at examining participants' overall experience of transitional care, such as communication with health professionals, involvement in the hospital discharge decision-making process, readiness for discharge, and post-discharge care and support. The combination of the two methods allowed us to gain an in-depth understanding of non-medical older adults and family caregivers' experience and understanding of transitional care. Recruitment in the hospitals took place from June 2015 to October 2015.

Analytical Approach

The interview, audio, and written diary data were transcribed and subjected to an inductive thematic analysis (Braun & Clarke, 2006). Braun and Clarke (2006) argue that thematic analysis does not need pre-existing themes, and, therefore, every statement is considered as valid in gaining a deeper insight into a single or multiple concepts. Furthermore, thematic analysis is not embedded in any ontological or epistemological paradigm, which makes its use more flexible. The data were entered into NVivo 11 for analysis. Early in the analytic process, Alexandros Georgiadis realized that participants' talk was focused on the difficulties they had faced both inside and outside the hospital. In the first instance, the codes related to participants' readiness (or not) to be discharged (e.g., premature, delayed, or unexpected discharges) and their ability (or not) to manage their medications and symptoms. In the second instance, the codes related to participants' difficulties with post-discharge care (e.g., failed follow-up appointments in the community or outpatient clinics). Through continual re-immersion in the data, it became evident that participants' talk was focused on the limited information they had exchanged with staff during the discharge process and the limited support they had received after they had left the hospital. The data were re-coded based on these two emerging themes, which were further defined

and refined based on Braun and Clarke's guidelines. Given our phenomenological approach, we adopted an emergent strategy, allowing the method of analysis to follow the nature of the data itself. Data saturation was reached within eight interviews. Our concern in revealing the "lived experience" also reflects our role as researchers working for an independent, statutory organization (Healthwatch Essex) concerned with gathering people's lived experiences to directly inform improvement in local service provision, and so the themes described are presented with health and social care providers and commissioners in mind.

The interviews lasted approximately 30 minutes and were carried out at participants' homes. All interviews were audio-recorded and transcribed verbatim by a professional transcriber.

Trustworthiness

Oonagh Corrigan, the second author and principal investigator of the study, acted as a second coder to ensure inter-rater reliability following Noble and Smith's (2015) guidelines on rigor in qualitative research. In addition, to improve transparency, Alexandros Georgiadis kept a research audit trail, comprised of memos and a research journal, to document the development of the analysis (Creswell & Miller, 2000; Koch, 2006). We resolved the limited number of disputes (90% inter-rater agreement) over different interpretations through discussion and re-examination of the data.

Findings

Limited Involvement in Discharge-Care Preparations

For many participants, being discharged involved a number of practical and mental processes. For example, they had to organize their transport from hospital to home, they needed time to understand their illness(es) and their impact on their lives and ability to perform daily activities. Therefore, not participating in discharge-related decisions involved missing the opportunity to process mentally and organize practically their lives after leaving the hospital.

Many participants reported that they had been discharged prematurely. Being discharged without feeling that they had fully recovered appeared to generate feelings of uncertainty in several participants. These participants reported that they were not ready to safely return to their homes and perform daily activities (i.e., go to work, food shopping). Many participants reported that their concerns about being prematurely discharged were rarely heard by the health care teams. A participant reported that he was rehospitalized shortly after he was discharged.

I just turned around and told them. I said to the consultant, "I don't feel as if I'm right for going home." He said, "I think we

can judge that you're all right." They knew best, kind of thing . . . I was annoyed, because I ended up having to go back in for another two weeks.

(Patient 3, interview)

Safety was a key concern for those participants who reported that they had been discharged prematurely. One participant reported that, even though he wanted to return home as soon as possible, he managed to delay his discharge to feel more confident that he could take care of his daughter who needed extra support.

I felt a bit panicky because I thought, "There is no way I am going to be able to go home and look after myself." I hate being a burden. I wasn't breathing right and everything . . . It is just because of my circumstances it made me a bit panicky. I managed to delay it one more day.

(Patient 2, interview)

Owing to his lack of involvement in discharge planning, this participant was not given the opportunity to provide information about his personal circumstances and how they affected his confidence to return home safely. Other participants reported that they received limited information about how to take care of themselves post-discharge, as the ward staff were mainly focused on quickly processing their discharge, rather than explaining how to care for themselves and manage their symptoms.

The only thing about it was they said, "You can go." The doctor said, "Oh, you can go home," never really gave me any clue as to what I had to do, whether I had to go back to my doctor, or whether I just carry on taking the tablets which they gave me . . . I thought it would have been better to have given me a bit more of an idea as to how I would go, but they didn't.

(Patient 1, interview)

Unexpected and delayed discharges were another issue that a few participants talked about during their interviews. In contrast with premature discharges, unexpected discharges appeared to surprise rather than generate feelings of fear to participants. These participants reported that owing to their lack of involvement in their discharge planning, they were unprepared to leave the hospital because they either needed time to arrange their transport or plan their care at home. Family caregivers were frequently responsible for making the necessary arrangements for patients to return home, and, therefore, unexpected or delayed discharges were often problematic for them because they influenced their personal/professional lives.

When I turned up on the Wednesday mum was sitting there ready to come home, in her nightie. They hadn't telephoned me

like they said they would, so I wasn't prepared to take Mum home. I had nothing in place, like Meals on Wheels or a carer. I had no food at home . . . I got back here at five to five, just in time to ring my job and say, "I can't come in tomorrow," and I spent five hours trying to get Meals on Wheels.

(Caregiver 1, interview)

If the ward staff had involved the family caregiver in the discharge planning process, then she might have had more time to plan her mother's care. Participants also mentioned about delays on the day of discharge, often reporting delays for up to 6 or 7 hours until they had left the hospital. Communication problems between the ward staff (i.e., nurses, pharmacists, and physicians) were reported to contribute to these delays.

It is now 3:21. I was told at 9:30 this morning I was being discharged today. A letter for discharge has been done on time. I just happened to see a lady I know who does the pharmacy and I asked her how long she would be before my medication is sorted out. She said, "I don't know anything about it. No one has told me." She checked. She said, "Oh you are due for discharge now." She said with my medication there is a lot to be ordered so another long wait . . . One person doesn't tell the other person what is happening . . . Still here now. It is 4:08 and found out that there has been a mix up with my discharge medication. One is saying they have just ordered it so it is going to be a couple of hours before that will come up which takes it to 8 hours.

(Patient 6, audio diary)

Being involved in discharge planning decisions contributed to participants' experiencing their care as patient-centered; as illustrated when the quotes presented above are compared with a quote taken from another participant's interview who described a positive discharge planning experience.

A thorough consultation took place prior to discharge regarding medication, all of which was listed and administered for use at home . . . I was encouraged to ask questions, given details of follow-up visits and general idea of length of treatment. You weren't kept in the dark.

(Patient 5, interview)

Not being involved in discharge-related care preparations contributed to patients' feeling anxious, unprepared, and not confident to leave the hospital and safely return to their homes—time delays contributed to patients' and families' negative experience of discharge.

A Weak Service Interface

Participants reported several disruptions with respect to their care after they had been discharged. Although many of them

were discharged having been told that they would be followed up either by community services or outpatient clinics, they reported that these services rarely contacted them. As a result, participants reported that they relied on their relatives or friends for getting information about their care. The weak service interface between primary and secondary care services had a negative impact on their experience transitioning from hospital to home.

Upon discharge, ward staff informed participants that they would receive an appointment from the outpatient clinic or that they would be visited by community services to monitor their recovery and/or manage their medication. However, many participants reported that they had not been contacted by either care provider.

When the medication came round, on the top of it was written "A nurse will be calling in to see you on the Saturday morning" and I was quite pleased . . . I was pleased but she never came. So if it hadn't been for [Name of caregiver], I wouldn't have known what these tablets were, because they're all different.

(Patient 7, interview)

Such practices compromised patients' safety, as they exposed them to various risks. For example, if this participant had not received the support of her friend, she could have mixed her medication or stopped taking them; both actions could have increased the risk of rehospitalization. Other participants reported that they denied to be discharged unless the ward staff had reassured them that their appointment had been arranged.

He said "We can't get you in on this Tuesday, we can't get you in on this Friday." So I said "What's happening then?" And he said "Well, what we propose is, you go home, and then we'll get you in as quick as we can" . . . I thought that if I was not there, under their supervision, they'd forget about me, and I'd go out, and then each time somebody came in and was in the ward, they'd put them before me . . . we rang up, and I was so pleased, because it was black and white, and we knew we were in.

(Patient 10, interview)

The quote above illustrates some participants' distrust of the fragmented health care system, and their efforts to ensure access to services and continuity of care. In contrast, another participant provided a positive account regarding her follow-up care.

They said to me, "We'll send you an outpatient's appointment but if you don't get it through then you're to ring the secretary and make sure you haven't been lost in the system." I actually got it through yesterday. So, that was the conversation of the follow-up. Yes, so I go back to them in September.

(Patient 8, interview)

Another participant, though, was not so fortunate with regard to her follow-up care.

Seven or 8 weeks Friday. I haven't even had a letter or an appointment. I rang up his secretary a week later saying that it was me, just out of interest to see what was going on. I haven't had an appointment and Mr. whatever his name was said he would see me in clinic in 2 weeks.

(Patient 11, interview)

The weak interface between primary and secondary care services resulted in inequities accessing services, poor patient experience, and increased patients' risk of rehospitalization.

Discussion

In this study, we aimed to examine how non-medically complex older patients and family caregivers experience transitioning from hospital to home. Owing to the qualitative approach and small sample, the findings may not represent how patients living in other areas experience care transitions. Participants' non-medically complex status was determined by the involvement or not of the multi-disciplinary team in their discharge, and not from the number of comorbidities or the number of readmissions in a year, or functional status. Also, participants were mainly white British, and therefore, the findings may not capture the needs of other ethnic groups and how they experience transitioning from hospital to home.

Participants' experiences of transitional care are consistent with other studies involving older adults with complex care needs, which have shown that negative patient experience in care transitions is closely linked to patients' limited involvement in discharge planning discussions (Baillie et al., 2014; Bauer et al., 2009; Storm et al., 2014). In addition to their efforts to adjust their lives after being prematurely or unexpectedly discharged, continuity of care (Holland & Harris, 2007) was problematic for many participants after they left the hospital (Berendsen, de Jong, Meyboom-de Jong, Dekker, & Schuling, 2009; Damiani et al., 2009). Problems with medication and symptom management challenged participants' ability to smoothly adjust their lives post-discharge (Knight, Thompson, Mathie, & Dickinson, 2013). Problems with continuity were not only strenuous for patients but also for the health system as, from the 18 participants, four (22%) were rehospitalized a few days after they had been discharged. This is consistent with previous research on hospital readmissions in the United States, which suggests that almost 20% of patients are readmitted within 30 days of discharge (Hernandez et al., 2010). Notably, the four participants were readmitted either because they were rushed out from hospital before they had fully recovered, or because of an error that occurred during their (first) visit (e.g., communication problems between secondary and primary care services, limited information about symptom management post-discharge).

Open communication about discharge options and preferences with patients and caregivers are considered vital in ensuring patients receive coordinated and integrated care (Graham, Ivey, & Neuhauser, 2009; Zakrajsek, Schuser, Guenther, & Lorenz, 2013). However, our findings indicate that many participants rarely had discussions with health care staff about their discharge options and personal preferences. As a result, these participants experienced a poorly coordinated hospital discharge process. However, within this context, the majority of participants did not appear resigned to the decisions made by health care staff. They employed several interrogative strategies (Allen, Hutchinson, Brown, & Livingstone, 2016) to negotiate their transitional care. For example, they used questioning to get involved in decisions around their discharge. Some participants challenged the decisions of health care staff to be discharged prematurely; other participants actively sought information from family caregivers, neighbors, and friends for self-management in the community. This was particularly relevant for participants whose questions on self-management were not addressed during their hospital stay by health care staff. Such strategies assisted participants with negotiating their independence after leaving the hospital. There were not gender differences with regard to the strategies that participants used; both female and male participants were equally inclined to use interrogative strategies to overcome difficulties with their discharge and care transition.

Our findings also indicate that the available transitional care interventions may be inappropriate to address the care needs of non-medically complex older patients and family caregivers. These transitional care interventions are based on the assumption that patients experience multiple chronic conditions, whose care may require frequent transitions across care settings; for such patients, care management has been proven to be essential for good health and care outcomes (Naylor & Sochalski, 2010). Such models, though, are inappropriate, and possibly costly, for non-medically complex older adult patients, whose care needs are not complex and, therefore, they would benefit from a well-executed discharge and well-planned follow-up in the community. We contend that such patients require interventions that are less intensive, shorter in duration, and engage them in taking care of their health and care.

Our findings indicate that quality transitional care (Coleman & Boulton, 2003) was not offered systematically and equally across hospitals for all patients; whereas some participants described a safe and personalized transition from hospital to home, the majority of participants did not. These participants reported unsafe practices, such as premature discharges and poor follow-up care post-discharge, which increased the risk of rehospitalization. They also reported negative patient experience, as the care they received either upon or post-discharge was not centered around their needs, values, and preferences. The findings are consistent with previous studies that show wide variations in the quality of care that people receive from different care providers and institutions (Care Quality

Commission, 2014) and sometimes at different times of the week or day in England (Bray et al., 2016; Campbell, 2016). Variation in care quality is desirable when it reflects local needs; however, bad variation, that is, unwarranted and persistent variation that our participants reported, needs to be reduced, as it contributes to inequitable access to services, poor health outcomes, and inefficient use of resources (Appleby et al., 2011). We contend that interventions, such as information technology, the development of explicit care pathways, and the use of guidelines and audit to measure adherence to guidelines (Pearce-Smith, 2011), could contribute to reducing unwarranted variation in transitional care for medical older patients.

This study offers a basis for future research to examine how transitional care could be optimized for non-medically complex older adults and their family caregivers, and what type of interventions could improve their experiences of transitional care. Although care professionals enable quality transitional care for older adults with complex care needs, they might be an expensive intervention to address the needs of non-medically complex older adults. For such patients, we contend that information sheets, pamphlets, and a generic liaison discharge role could be an essential tool for providing information about discharge planning and care coordination across care settings. However, more detailed analysis is required to understand who and what type of information and support do non-medically complex older adults need when they transition across care settings. In addition, further research is also required to understand how such patients and their family caregivers perceive quality in transitional care.

Examining patients and family caregivers' experience is essential to improving transitional care. Frontline healthcare staff should assist older adults with achieving their independence. Practices, such as answering their questions and providing them with the information they need, can facilitate older adults and their family caregivers to navigate through care transitions, release themselves from dependence (i.e., relying on the health system for care), and move toward independence. The available transitional care interventions appear inappropriate to address the care needs of non-medically complex older adults and family caregivers. To improve health and care outcomes for non-medically complex older adults, health services researchers may need either to develop new interventions or to reconfigure the existing transitional care interventions.

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Authors' Note

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