

## EDITORIAL

# Geriatric Medicine and the Challenges of Transition of Care in the Rural Health Sector

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Geriatric Medicine and Primary Care are the same when an older adult is considered but when a physician is trained in geriatric medicine as well, he/she “knows what *not* to do”. When I first started my practice two years ago in my rural town in northern California, older adult patients who came in for their primary care visit were genuinely shocked when I told them I am trained in geriatric medicine. They were not even aware that geriatric medicine in itself is a separate field of study. Even today, a lot of patients are skeptical about geriatric medicine being its own field and they just want to get their medications refilled or their acute problems dealt with and leave.

It usually takes a few visits to establish trust with the patient and gain their confidence in us physicians. One of the successful methods to do so, as far as I have seen, is to do proper medication reconcili-

ation. It is just mind-boggling how some older adult patients are on at least 10 medications or more for no reason. When asked, they just say it was started by one of the previous providers they saw or from an urgent care visit, and they have been continuing to take the medications since then. Only when you inform them of the harms and side effects of these unwanted long-term medications in the older adult population, do they understand the value of a geriatric medicine-trained physician and they start building their trust in us.

The transition of care is a major obstacle in providing good quality care in the rural health sector for older adults. In rural areas, not all older adults have access to the internet and some do not even have access to phones, mostly because of a hearing disability. Most of the patients who get discharged from

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the hospitals do not make it to the primary care providers (PCPs) within the specified time frame. Also sadly, they are not completely informed of all the medication changes that have been made. Yes, it is the job of the PCP to educate the patients on medications and their proper usage during the post-hospital discharge follows up but sadly the follow-up visit does not happen half of the time.

There have been some good care transition models like Care Transitions Intervention <sup>[1]</sup>, Re-Engineered Discharge (Project RED) <sup>[2]</sup>, Better Outcomes of Optimizing Safe Transitions (BOOST) <sup>[3]</sup>, Transitional Care Model <sup>[4]</sup>, Discharge of Elderly from Emergency Department (DEED) <sup>[5]</sup> and Interventions to Reduce Acute Care Transfers (INTERACT). They have been shown to reduce the 30-day rehospitalization rates in bigger institutions and major metropolitan cities but the real-time experience of these models in the rural health sector is lacking. It is tough to extrapolate the same results in the rural health sector where there is clearly a lack of geriatric medicine-trained physicians and mid-levels.

Patients from nursing homes also suffer from shortcomings in the transition of the care cycle. Working as the Assistant Medical Director of a local nursing home, it is clear that there is a major shortcoming for older adults with their care transition if there is no dedicated physician to take care of the patients, especially in Assisted Living Facilities (ALFs). I currently see patients in the ALF part of our local nursing home and patients in another memory care specialized nursing home and have been able to help with care transitions for the patients once they get discharged from the hospital, especially patients with dementia. Antibiotic stewardship is also a major part of the care transition that can be provided by a dedicated physician.

One way that I have been trying to reach out to the older adult population in my community is by writing a regular column about geriatric medicine and care for the older adult population, in general, in my local community newspaper. It is a biweekly column that discusses the common medical conditions that they are burdened with, simple signs and symptoms that they can look out for in conditions

that are common in older adults like frequent falls, urinary incontinence, frailty, malnutrition, pressure injury, dementia and insomnia. Lots of the patients have provided feedback that it is informative and interesting and I feel it is a good way to reach the community-dwelling older adults as they contribute to the major footfall in newspaper readership.

Working in rural towns brings to light the hurdles that come up in providing good quality care to older adults. If we could have more fellowship-trained geriatricians, and mid-levels trained in managing older adults in this sector, it would be of great benefit to the aging population.

## Conflict of Interest

There is no conflict of interest.

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