Position Statement 25

Transitional Care

Healthcare systems in many developed countries have special services to support older people who often have multiple comorbidities, complex social situations and high care needs requiring assistance with activities of daily living in the immediate post hospital discharge period. These services enable timely, coordinated and supported discharge with continuity of healthcare in an effort to reduce risk of readmission and premature institutionalisation and promote functional restoration in the community. The term transitional care program refers to such services which have also been described as intermediate care, subacute care, early supported discharge and post-acute care (1). The Australian Transition Care Program is an example of such a program. Though different terminology is used to describe these services there are important fundamental principles that should underpin their design:

1. Transitional care programs are an important component of support for older people at the completion of hospital care and should be accessible by patients at all hospitals that treat older adults.

2. Such programs have multiple aims:
   i. Minimisation or avoidance of lengthy acute or sub-acute hospital stay.
   ii. Enhancement of the recovery process and support during convalescence.
   iii. Optimisation of functional capacity.
   iv. Reduction of the risk of early readmission to hospital.
   v. Support of carers in assuming new caring roles for patients with major new disability.
   vi. Reduction of early and premature admission to permanent residential care.

3. The target population should include:
   i. Individuals where there is an opportunity to improve function and ameliorate dependency.
   ii. Individuals where there is little capacity for functional gain who can be re-integrated into their usual domestic context by assisting them and their carers during adjustment to new circumstances and new roles after an acute illness.

4. A shared approach with families and older people in goal setting and decision making should be adopted.

5. The potential for functional gain should not be the only key goal or the only criterion for admission. It should however be one of the criteria when the program is able to accelerate or increase the extent of functional gain.

6. Consistent with these principles, people with dementia should not be excluded. The high risks of re-hospitalisation and institutionalisation associated with this condition make them a special target population.

7. The programs should primarily be focused on benefits for the older person and their carer(s). Any systemic efficiency or cost-savings are an important but secondary focus of the program, and evaluations in these areas can further guide improvements in the efficient delivery of care to older persons.

8. Transitional care programs should offer a range of in home, centre and residential care based interventions, administered under a single organisational structure.

9. Transitional care programs, whether community or residential based, are not a substitute for appropriately configured and adequately resourced inpatient rehabilitation and geriatric assessment and management programs, where these have the potential for greater benefit to the older person. They are complementary programs which should coexist in every jurisdiction.

10. The primary focus of residential care based transitional care should be on provision of restorative care, for persons requiring extra community support, which cannot be safely
provided at home, and functional maintenance while finalising long term discharge arrangements. Opportunities for community discharge should be identified and enabled.

11. Transitional care where offered to patients awaiting decisions on residential care should be appropriately resourced to ensure that function is improved or maintained, morale and quality of life of the older person is promoted, and that any opportunity to reduce dependence is embraced.

12. Transitional care programs should be integrated interdisciplinary teams, with medical, nursing and allied health components. These services are offered to older patients with multiple comorbidities and should therefore have regular geriatrician input. Effective and timely communication both within the team and with other health care providers is essential and should include both verbal and written discharge summaries.

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BACKGROUND

Appropriate management of the interface between hospital and community care at discharge has the potential to maximise functional recovery and support the patient and carers, with consequent reductions in hospital length of stay and reduced transfers to permanent long term institutional care. Australia and New Zealand, like many other developed countries, are faced with an increasing proportion of older people who are likely to have more than three chronic conditions, greater levels of disability and higher healthcare service and hospital utilisation than their younger counterparts (2-4). Increasing age is associated with a greater length of hospital stay for acute care episodes and a higher proportion of non-acute care utilisation: Older persons (aged over 65 years) account for 30% of admissions and 43% of bed day use in Australia (2). There are a significant number of older patients being discharged from acute and subacute hospital care requiring additional support to allow them to remain in the community. The risk of institutionalisation is high following acute hospital admission and the majority of high level care residential care admissions occur as transfers from hospital (5, 6).

Post-acute Care Services

A variety of inpatient and outpatient programs are available to patients in Australia and New Zealand on completion of acute hospital stay. These include inpatient sub-acute services such as rehabilitation, and geriatric evaluation and management (GEM), ambulatory services such as outpatient day hospital and home based rehabilitation programs, and Australia has the Australian Transition Care program (TCP).

Coordinated discharge planning and provision of post-acute care services with additional case management improves quality of life and reduces hospital bed day use (7). Integration of acute care and long term care services has also been shown in systematic reviews to reduce institutionalisation and can be cost effective if well set up (8). It is important for these services to be linked to provide continuity of care to patients who require ongoing support.

Australian Transition Care Program (TCP)

The Australian Transition Care Program was announced in 2004 by the Australian government with a focus on assisting older persons after a hospital stay and facilitating transitions between hospital and aged care systems (9, 10).

The program was set up with the aim of providing short term support and active management for older people leaving hospital particularly focusing on those who still required support outside a hospital environment to optimise functional capacity and finalise long term care arrangements. The aims are to minimise extended hospital care and premature nursing home admissions. Patients who are stable for discharge are assessed for eligibility by an Aged Care Assessment Team, a multidisciplinary team of health professionals who conduct comprehensive assessments and assist older people to gain access to Australian Government subsidised residential and community services. To be eligible for the program they should meet the requirements to receive permanent residential care. Under current regulations they have to be a hospital inpatient to be eligible for the Program.

Transition care is community based, for example when care is provided in the patient’s home, or residential based when the patient is temporarily discharged to a facility. Available services include nursing support, personal
care, low intensity rehabilitation and case management. The provision of primary medical care to a Transition Care recipient is undertaken by the person’s General Practitioner, in consultation with the Geriatrician or Rehabilitation Medicine Physician, where possible. It is time limited care with support provided for up to 12 weeks. A further 6 week extension can be applied for in special circumstances (1, 10).

In 2010-2011, there were 17,441 discharges from TCP and nearly half of these returned to the community, with a median length of stay in the program of 11 weeks. 23% returned to hospital after a median length in TCP of 3 weeks and 19% went into residential care after a median length of stay of 6 weeks in TCP (9). Recipients of the Australian TCP are often frail older adults with chronic comorbid conditions, geriatric syndromes and disabling symptoms such as pain, dizziness and dyspnoea. Polypharmacy (>10 regular medications) and hyper-polypharmacy (>10 regular medications) are prevalent in these patients (11). Despite this, medical input from specialists in aged care such as geriatricians, psychogeriatricians and rehabilitation physicians is variable and some services have difficulties engaging general practitioners (12).

Several countries have similar post-acute care services and programs. In England the term “Intermediate Care” is used to describe services which provide post-acute care as well as hospital admission prevention programs such as hospital-at-home schemes. Components of rehabilitation, convalescence and respite are delivered through a wide range of settings. Intermediate care aims to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living (13). Key components of intermediate care described by The National Service framework for older people and supported by the British Geriatric Society include a coordinated multidisciplinary approach based on person centred comprehensive assessments, structured individual care plan and appropriate medical input (14, 15). A pilot audit of the services highlighted low input from geriatricians and variations in clinical governance (16).

Home Visiting
Several studies have examined the effect of home visiting strategies for older people. Elkan et al in 2001 performed a systematic review of randomised and non-randomised trials targeting home visits for older persons. The review demonstrated reduced mortality and institutionalisation but no improvement in function, suggesting that functional improvement may require more intensive or different kind of interventions. The analysis included trials with patients post hospital discharge (17). Two previous systematic reviews had shown conflicting results on effectiveness of home visits, with Stuck et al 1993 showing positive effects on mortality and admissions to hospitals and nursing homes and Haastreg et al 2000 showing no evidence of effect on any outcome (18, 19). Stuck et al 2002 revisited the issue and demonstrated modest reduction in nursing home placement, improved function and mortality benefits. The effect on nursing home placement increased with frequency of follow up visits. Functional improvement was associated with multidimensional geriatric assessments and follow up. Mortality benefits diminished as age approached 80 years (20). The heterogeneous nature of trials and variations in interventions make evaluation of benefit challenging but this aspect of patient care can be tailored to individuals to obtain optimum benefit for patients.

Multifactorial Interventions
Various trials have demonstrated older patients including those with a history of recurrent hospital admissions benefit from multifactorial interventions of varying combinations post hospital discharge. Benefits included improvements in health related quality of life, reduction in emergency health care usage, improved ADL performance, reduction in falls and improved mobility (21-23). Beswick and colleagues described combinations of interdisciplinary teamwork as complex interventions. In their systematic review and meta-analysis they demonstrated that these complex interventions with input of varying durations and intensities from a wide range of healthcare disciplines reduced falls, hospital and nursing home admissions and improved physical function, thereby helping older community dwellers continue to live at home. Though the margins of benefit were small, 2-3%, contamination of control groups and intention to treat analysis may have been a factor reducing the effect size. Geriatric assessments and community based post-acute care had a significant impact on living at home (24). In New Zealand, a study assessing resource usage in a Facilitated Discharge service providing multidisciplinary support to frail older people leaving hospital showed that, despite the patients being frail, 80% were alive and living at home at 90 days post discharge,
although there was a high readmission rate of 32% (25). These multifactorial interventions are most likely to benefit those at high risk of institutionalisation, including those with dementia (26, 27).

Inpatient Rehabilitation
Functional decline among older patients in hospital is common as a result of acute medical conditions, exacerbation of chronic conditions and deconditioning. Inpatient geriatric assessments and rehabilitation have been shown to reduce death and institutionalisation and improve physical and cognitive function (18, 28). There is a strong evidence, in the form of randomised controlled trials and systemic reviews, for intensive inpatient rehabilitation, particularly for older adults, stroke patients, acquired brain injury, rheumatoid arthritis and hip fracture patients (29, 30). Deconditioning with resultant decline in the ability to perform basic activities of daily living often occurs in hospitalised older adults. These patients can be successfully treated by an inpatient rehabilitation program (31).

Outpatient and in-home therapy will be suitable for some patients whose care needs and rehabilitative efforts are able to be met outside of acute care and inpatient rehabilitation wards. In patients where significant doubt exists regarding the capacity to recover, making discharge destination uncertain, then inpatient care in geriatric evaluation and management units or geriatric rehabilitation wards is preferable (32). Transitional care programs should therefore not be a substitute for inpatient rehabilitation but an additional service to deliver care to patients who do not require intensive inpatient care.

Dementia
Hospitalisation can be associated with adverse effects on the health of older frail patients and patients with dementia. Of hospitalised older Australians with dementia, 37% are not discharged to their usual residence, with some having died and some being discharged to residential aged care facilities (2). Older people with dementia are more likely to move into residential care than those without the condition. At the time of ACAT assessment they are much more likely to have been living in the community with others providing care and support (14). Interventions, when targeted to individuals with high risk of institutionalisation, such as those with dementia, can reduce re-admissions and institutionalisation (33). They can be initiated in hospital and followed up in the community by Transitional Care Program providers. Screening for cognitive impairment, which occurs on hospitalised older patients referred to transitional care services, will help identify those who can potentially benefit from these interventions, which include providing a supportive environment for patients with dementia and their carers’, within a more familiar home environment and routine, potentially reducing the risk of delirium, as well as easy access to other health professionals. Patients with dementia who are assessed as able to benefit from services provided by the Australian Transition Care Program are eligible to participate in the program (10).

Transitional Care and Residential Aged Care
Transitional care delivered in RACFs is suitable for various groups of patients, although, compared to home, may share some of the same disadvantages as an acute hospital, such as a new unfamiliar environment, carers and routine. Those who are medically stable and expected to be discharged back to the community after a period of maintenance care, can receive residential transitional care. Other patients require a period of rehabilitation to improve function and promote independence with activities of daily living while finalising care arrangements. Some of these patients will ultimately be admitted permanently to RACFs. Among recipients of the Australian TCP about 20% will be discharged permanently to residential aged care facilities (9, 12). Recipients of residential TCP are more likely to be discharged to RACF (45%) compared to recipients of community TCP (4%) (12). Patients awaiting placement can receive maintenance care and rehabilitation at adequately resourced transitional care centres, resulting in reduced length of hospital stay without any adverse outcomes (34).

Over half of new high level residential care admissions occur as transfers from hospitals (5, 6). Many of these patients receive rehabilitation or maintenance care prior to admission to a residential aged care facility, with a median hospital length of stay of 3 weeks and a 90th percentile length of stay of 10 weeks. The delay is likely to be due to the patients’ multiple comorbidities and the placement process (6). Some of these patients could receive residential transitional care while care arrangements are finalised. Existing recipients of residential aged care can also receive transitional care if they are
assessed as eligible (10). Therefore current residents of aged care facilities and patients awaiting placement can receive transitional care if they are eligible and they have goals which can be met in transitional care.

Cost
Currently in Australia, the states and territories manage the acute hospital system, whereas aged care programs are predominantly the responsibility of the Commonwealth government. Potential problems and financial disincentives can arise at the interface of these systems as older people move between acute hospital and aged care services. The development of the Australian Transition Care program whose cost is shared between the two systems has been viewed as an attempt to minimise these problems, while improving care of older people. Political efforts to limit the length of stay of older people in hospital and to reduce the overall cost of aged care have contributed to the development of post-acute care services. From a societal perspective, the cost of these programs should be offset by savings from reduction in hospitalisation and institutionalisation (26).

Chappell et al demonstrated that the cost of community care was substantially lower than facility care, and this persisted even after taking into account informal caregiver contributions (35). Other studies have demonstrated reduced healthcare costs secondary to reduced hospital utilisation costs as a result of post-acute care multidisciplinary services and case management (7, 22, 36). Hall et al in their case study using the Australian Transition Care Program found that post-acute care services are unlikely to be cost saving to the healthcare system unless additional benefits such as improved quality of life could be demonstrated (37). The heterogeneous nature of these interventions makes cost analysis and comparison between studies difficult and this is reflected in the variable results. Johri et al in their systematic review of community care highlighted the key elements needed to implement effective cost saving integrated community care programmes which result in reduced institutionalisation. These include a single entry point, case management, geriatric assessment and multidisciplinary team involvement, including medical and specialist geriatric medicine components. (8). These aspects have been implemented in the Australian Transition Care Program. Further research into the cost effectiveness of the program is needed but cost saving should be a secondary focus, with the primary focus being the provision of quality care to older adults.

Summary
Transitional care programs are designed to ensure the coordination and continuity of healthcare as patients transfer between different levels of care and among a diverse range of providers, services and settings (38). They are providing much needed support to elderly patients, bridging the gap between hospital and community care and allowing provision of effective and individualised support to these patients who often have complex medical conditions, multiple comorbidities, cognitive deficits, challenging social situations and require support with activities of daily living. As the number of multi-generational households where family support is provided has declined, efforts to make the services more widely available, easily accessible and cost effective will benefit the older patients. They should therefore be accessible by patients at all hospitals that treat older adults.

References


