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WHAT ARE THE FIRST QUALITY REPORTS FROM THE TRANSITION CARE PROGRAM IN AUSTRALIA TELLING US?

ABSTRACT

Objective: Transition Care is a new program in Australia, jointly funded by the Commonwealth and State/Territory Governments. Implementation is undertaken by State Health Departments, in some cases through Aged Care Organisations, against a set of Key Requirements. This paper examines reports from providers to reveal enablers and barriers to compliance with the requirements and to highlight emerging patterns of practice.

Method: Content analysis of the first 23 self reports was undertaken against the Key Requirements of the Transition Care Program.

Results: Person-centred and goal oriented care was evidenced. General practitioner, pharmacist and geriatrician involvement in care planning and review was low. While service agreements between Transition Care services, referring hospitals and community providers improved the efficiency of information transfer and discharge arrangements these were rare, hindering entry and discharge from the Program.

Conclusions: Transition Care offers older people a flexible model of care. While the flexibility of the model is a strength service providers are struggling to achieve integration with existing services.

The authors acknowledge the Australasian Journal on Ageing, the Australian Council on the Ageing (ACOTA) and Blackwell Publishing for disseminating this work.

Citation:

Masters S, Halbert J, Crotty M, Cheney F. What are the first quality reports from the Transition Care Program in Australia telling us? Australas J Ageing. 2008;27(2):97-102, available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1741-6612.2008.00285.x/abstract

Introduction

The Transition Care Program (TCP) targets older Australians at the conclusion of an acute hospital episode who require more time and support in a non-acute setting to complete their restorative process and optimise their functional capacity. A particular objective is to prevent inappropriate admission to residential aged care by delaying the decision point on entry until the care recipient's functional capacity has been optimised. At 30 June 2007, 2,000 Transition Care places had been allocated and 1,594 were operational around Australia.

The key objective of Transition Care is to optimise client independence. This is to be achieved through the provision of goal oriented, individualised, time limited care and low intensity therapies and services delivered in an appropriate setting. Transition Care services are characterised by multidisciplinary teams who apply age-friendly principles and practices [1] and engage in collaborative service delivery and learning. Care is expected to be timely, seamless and provide flexible and reliable support linked to other services. [2] A full description of program requirements is available at Appendix D of the TCP Guidelines and at www.health.gov.au.

The TCP objectives, strategies and service characteristics provide the conceptual framework for a set of Key Requirements against which services are required to self-assess in their first year of operation. Self-assessment is part of a broader approach to quality improvement and monitoring, which also involves the selection of Transition Care service providers, a Plan-Do-Check-Act cycle of continuous quality improvement and an external complaints mechanism. The *Transition Care Quality Improvement and Monitoring Framework* [2] proposes external assessment and stakeholder feedback as additional checks of compliance with the requirements, although strategies to implement review team visits have yet to be agreed.

The key requirements focus on those aspects of care specific to TCP. Transition care services are provided by health and aged care organisations and subject to various accreditation and external regulatory processes. Although most quality reports have two or more signatories and are reviewed by State/Territory *Approved Providers* before submission to the Australian Government Department of Health & Ageing, there is currently no mechanism for direct external peer assessment.

Methods

Content analysis of the first 23 self reports was undertaken against the key requirements. Quality Reports were provided in hardcopy or electronic format. Responses to each key requirement were extracted from the individual reports and grouped for analysis. Content analysis was used to elicit information regarding compliance with each of the key requirements and to identify gaps in the evidence provided. Content analysis focuses on the characteristics of language as communication and pays close attention to both the content and contextual meaning of the text.[3]

A systematic process of coding, sorting and review was applied to the text. First, complex and multi-faceted responses were broken down into discrete pieces of text and coded according to their content. The second step involved sorting text by the coding structure. The third step required a careful review of all text similarly coded. This process revealed subtle patterns and differences amongst responses and assisted in the identification of enablers and barriers to compliance with the key requirements. Ethics approval was obtained from the Australian Department of Health & Ageing and the Flinders Clinical Research Ethics Committee.

Results

The 23 Quality Reports that comprise the sample for this evaluation were received between 15 March and 7 June 2007. The reports were completed between 28 September 2006 and 18 May 2007, an average of 9 months following service commencement (range 5 – 13 months).

Of the 23 services in our sample, 15 were located in New South Wales (NSW). Transition Care services in NSW and Queensland (QLD) provided residential or community transition care places, but not both. In contrast, Transition Care services in Victoria (VIC) and Western Australia (WA) provided both residential and community places. The South Australian (SA) sample comprised one residential service and a second Transition Care service with flexible places that could be residential or community as required. NSW and QLD services ranged in size from a minimum of four Transition Care places to a maximum of 51 places. The SA, VIC and WA services were generally larger, ranging from 20 to 50 places.

The relative numbers of Quality Reports submitted from each state, in part, reflected the length of time that services had been in operation. Tasmania submitted two quality reports but these were not available to the evaluation team in time for inclusion in the study. Table I provides a summary of responses against the key requirements.

Timely, seamless care (entry)

The key requirement related to the period between Aged Care Assessment Team (ACAT) assessment and admission to Transition Care was stated as follows: *Transfer and admission to transition care is at the very latest within 4 weeks of ACAT approval for transition care, but preferably much less*. Transition care services reported a high level of compliance with this requirement, with only one service reporting that transfer times had exceeded the guidelines on one or more occasions. Several transition care services reported transfer times of around 48 hours. In QLD, the integration of community and aged care services enabled a coordinated approach to ACAT assessment and entry to Transition Care. Co-location, common reporting and organisational structures and funding of ACAT assessors as part of the Transition Care team were factors that appeared to expedite transfer.

There was evidence that the new transition care services were struggling to set up effective communication systems with the hospitals. The key requirements state: *Each transition care client has a current care plan, which is informed by hospital and discharge assessment and planning*. Excerpts from the TCP Guidelines suggest that responsibility for the development of the care plan is shared between the referring hospital and the transition care provider. Case management is one of the services that must be provided, when required, to all transition care recipients and includes: *ensuring that a comprehensive care plan is available at the time of discharge from hospital*. [2] The TCP Guidelines also articulate a clear role for hospitals, with specific attention to planning for the client's rehabilitation needs: *the hospital geriatric rehabilitation service or equivalent will also need to play a key role in developing the care plan that will apply for the therapy services delivered through transition care.* [2] Although Transition Care services reported having access to the Aged Care Client Record (ACCR) and other documentation to *inform* care planning, only one service reported that the hospital discharge summary included a basic care plan.

Several Transition Care services described routine visits and consultation with patients and clinicians prior to the patient's discharge from hospital. In this way, transition care staff took the lead to ensure that the service had access to relevant information for care planning. This strategy enabled personal contact with the prospective transition care recipient and an opportunity to seek clarification regarding health and personal care needs. Other services reported ongoing challenges, including inconsistent provision of discharge documentation and system barriers such as the provision of generic discharge letters with little information concerning the recent episode of care. Strategies aimed to facilitate information flow from the acute/ sub-

acute sector to Transition Care were associated with variable levels of success. Transition Care services that had established formal protocols or agreements with hospitals reported less problems associated with the timeliness and adequacy of information provision.

Client Independence is Optimised

A high level of commitment to the goals of optimising clients' functional capacity and independence was evidenced. However, there was recognition that personal care staff who had worked in residential aged care settings were less familiar with the restorative/rehabilitation focus of Transition Care. Several services reported on initiatives to enhance the educational preparation and development of personal care staff for transition care settings. Service initiatives included: a) discussions with Technical & Further Education (TAFE) institutions regarding the development of an additional module as part of Certificates III and IV in Community Services, and b) supernumerary placement of Transition Care staff in acute rehabilitation wards for experience/ training in the rehabilitation model of care.

Collaborative learning

Collaborative learning was evident at local, regional and state/territory levels. Transition Care providers highlighted their efforts to network, share practice, provide joint or cross sector training opportunities and advance leading practice. Local and regional initiatives were most often described although the extent of linkage was reported to vary across regions. Two state-level initiatives were described. At a service level, multi-disciplinary forums were identified as contributing to staff learning in addition to ensuring optimal client care and outcomes. Learning opportunities were enhanced by the integration of a range of acute, sub-acute and community based services, enabling staff to work across clinical and community areas or in close proximity to ACAT, rehabilitation, aged care or other expertise.

Services were asked to detail evidence based practice and included professional development, membership of professional bodies, registration/certification and clinical supervision but did not describe how the selection and use of therapies was informed by evidence based research.

Difficulties were reported with the requirement that: *Each client leaves transition care with a refined care plan and discharge summary…which records: a list of pharmacist-checked discharge medications*. Only two services described processes for pharmacist review of medications as part of discharge from Transition Care. Both services provided transition care in a residential setting and identified hospital and visiting

pharmacists as the providers of this service. In a residential Transition Care setting, medical care may be provided by the recipient's General Practitioner (GP) and/or medical staff employed by provider or partner organisations. In this context, one or more doctors may initiate medication changes and the transition care provider has additional responsibilities regarding the supply, storage and administration of medications. For recipients of community based transition care, medical care and medications are the responsibility of the GP. Moreover, access to a Home Medication Management Review (HMMR) funded under the Medicare Enhanced Primary Care (EPC) program requires a referral from the GP. The requirement for pharmacist review of discharge medications for recipients of community based transition care would benefit from strategies to meet the requirement.

Two of the key requirements included a reference to the involvement of geriatricians or other geriatric specialists in assessment and care planning. The first requirement was worded as follows: *Each Transition Care client has received in hospital a multi-disciplinary assessment, preferably involving a geriatrician or another geriatric specialist*. Responses to the quality report highlighted regional variations in access to specialist input, with a few services reporting that geriatrician involvement was restricted to clients with complex health needs. In one jurisdiction, routine interRAI assessment for hospital inpatients aged 70 years or older was noted to facilitate geriatrician input but generally this did not occur.

The second requirement stated: *Care is informed by discussions with and between the relevant Geriatrician and the client's GP, where possible, and/or other appropriate medical input*. Only five of the 23 Transition Care services included a geriatrician in the description of their staffing profile (21.7%) and a further three services reported that a geriatrician consult was available on referral from the client's GP. Geriatrician input was most often reported in terms of participation at regular case conferences. Most respondents reported difficulty in engaging GPs and some services described plans to develop links with Divisions of General Practice and nurses working in general practice. EPC items were recognised as providing support for GP involvement in multi-disciplinary care planning but there was little evidence of usage in the transition care setting.

Timely, seamless care (discharge)

Discharge from the program required careful management. Case management and early discharge planning were identified as critical factors in ensuring clients had access to care and equipment at the conclusion of Transition Care. Waiting times for Home and Community Care (HACC) services, Community Aged Care

Packages (CACP) and Extended Aged Care at Home (EACH) packages and financial subsidies for long-term equipment needs were reported to present challenges, both for timely discharge from Transition Care and the provision of optimal services to meet ongoing client needs. Methods for managing this challenge included early referral and maintenance of close links with ACAT staff. One service described the development of *business agreements* with providers of community aged care services. A small number of Transition Care services purchased and maintained their own aids and equipment. For these services, the development of an equipment policy and acquisition of business software were identified as contributing to efficient and equitable access to equipment. Other services described brokerage and joint care agreements for the provision of equipment.

A key requirement related to timely and seamless care is that: *Collaboration between acute/sub-acute care, aged, community and primary care is reflected in protocols and agreements, such as those areas covered by Appendix 1 of the Age-Friendly Principles and Practices*. Only three responses referred to the Age-Friendly Principles and Practices and there was little evidence that Appendix 1 was used to inform the development of protocols and service agreements. Nine of the 23 Transition Care services described having service agreements with partner or brokered organisations. Less commonly reported were formal agreements between the transition care service and acute/ sub-acute services. Services which reported having negotiated minimal hospital discharge documentation requirements and timeframes, for example, reported less difficulties in obtaining relevant and timely information compared to their counterparts.

Discussion

Internationally, the risks associated with transfers between institutions and systems of care are high enough and occur frequently enough for the terms ‘falling through the cracks’ and ‘transfer trauma’ to have entered the literature.[4, 5] A 2003 position statement from the American Geriatrics Society on Care Transitions called for testing of patient centred systems of care to optimise transfers [6], urged monitoring of adverse outcomes and the introduction of standards for transfer information. Most recently in the US a ‘pay for performance’ strategy for managing transfer information has been suggested. Nevertheless, work from the US suggests that the most promising strategies are those that focus on the patient and carer who are moving across sectors, rather than institutions.[7]

There was good evidence that service delivery was goal oriented, time limited and incorporated low intensity therapies aimed at maximising client independence. Individualised care planning inclusive of the client,

family members and other stakeholders involved in the client's longer term care was evidenced. It was apparent that the requirements of Transition Care, which centre on teamwork, case management, a restorative model of care and efficient management of allocated Transition Care places, require considerable adjustment for staff trained in clinical and residential aged care models.

Less well evidenced were GP, geriatrician and pharmacist involvement in care planning and review, although this varied across services and regions. Case managers were identified as having a key role in facilitating GP involvement in care planning and review. The barriers to GP involvement in care planning and case conferencing are well documented [8, 9], although Commonwealth initiatives to enhance GP involvement in residential care have had some success [10, 11]. Home Medication Management Reviews [12, 13] were not evidenced in the 23 quality reports assessed as part of this study. Very few services were systematically involving a geriatrician in transition care.

It was reported that personal care staff were less familiar with the restorative/rehabilitation focus of Transition Care and additional training opportunities were sought. Timely transfer of information from the acute/sub-acute setting was not always achieved. Similarly, waiting lists for HACC, CACP and EACH packages sometimes resulted in less than optimal care at the conclusion of the transition care episode.

Limitations

This study examined the first batch of quality reports submitted to State/Territory *Approved Providers* and the Australian Government Department of Health & Ageing. The reports were completed on average 9 months after commencement of the service and, with the exception of the pilot sites for the Innovation Care Rehabilitation Services (ICRS) program, reflect the early development of service teams and partnership or brokerage models of service delivery.

The key requirements specify the expectations of Transition Care services but do not prescribe how the requirements are to be met. This approach allows for flexibility, innovation and the tailoring of strategies to meet local needs. On the flipside, this lack of prescription contributes to ambiguity in the interpretation of the key requirements, as do subtle differences in the wording of the requirements and relevant sections of the TCP guidelines. Some of the key requirements comprised numerous criteria which presented an additional challenge. Few services responded to the criteria in a systematic way and this detracted from the confidence with which performance against a specific criterion could be reported.

The quality reports comprised the single data source for this study. Additional sources of information such as site visits and discussions with stakeholders are required to expand on the evidence cited in the quality reports, particularly those areas where compliance is currently not well evidenced. Site visits, or an alternative mechanism for external peer assessment would also benefit the program more broadly.

Implications for policy and practice

Transition Care is a new program in Australia. Service providers include state funded health services and aged care organisations. There is heterogeneity in the number and mix of TCP places allocated (residential and community), time since the service became operational, model of service delivery and extent of brokerage arrangements. Some services had been pilot sites for the ICRS program implemented in 2001-02. This experience was reflected in the maturity of service delivery processes and partnerships apparent in responses to the quality report.

Quality in the Transition Care Program is inextricably concerned with care processes to support transfer between locations (hospital to home or alternative care environment); between sectors (acute, primary, community, residential); and between individual states (illness, frailty or disability to optimal independence and quality of life).[14] Responses to the quality report highlight emerging best practice in Transition Care with respect to service agreements with referring hospitals that include protocols for the transfer of client information and agreed processes concerning referral and response times. The review has also noted difficulties in providing for clients' ongoing needs once transition care has finished and suggestions of less than optimal ongoing care arrangements in some instances.

Acknowledgements

This study was co-funded by the Australian and State/Territory Governments as part of the National Evaluation of the Transition Care Program. We would like to acknowledge Lynne Giles, Owen Davies and members of the Transition Care Working Group for their comments on an earlier version of this manuscript.

Key Points

- There is good evidence of collaborative learning at state and regional levels and local service development
- Formal agreements with hospitals and community aged care providers is emerging as best practice in Transition Care

- All staff require training in a restorative/rehabilitative model
- Engaging General Practice in care planning and review remains challenging, while the role of community pharmacists in medication review requires clarification
- Very few teams have succeeded in establishing a working relationship with geriatricians

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Table I: Summary of Key Requirements and Quality of Evidence

Requirement	Quality of evidence	Enablers	Barriers
Objective: Client Independence is Optimised			
TC is linked to the agreed goals of clients, carers, families & to the promotion of self-sufficiency & self-management	Well demonstrated. All services described individual initiatives to ensure goal attainment.	Service specific activities and strategies were described to ensure family/ carer inclusion in goal setting	Nil identified
Selection & use of therapies is informed by evidence based research & leading practice information	Implementation of evidence based research was difficult to identify. Leading practice examples cited.	Nil identified	Some ambiguity noted in the key requirement ie the difference between leading practice and evidence based research
Service delivery is designed to optimise independent functioning following discharge	Well evidenced	Recognition of the rehabilitative/restorative focus/training required for TC workers; co-location with a rehabilitation facility helpful	No formal training modules were identified for personal care staff
Clients receive timely & appropriate access to care & equipment	Evidence of established networks with services that provide care and equipment, organisation specific policies and documentation.	Early discharge planning essential. Some services itemised strategies to nurture and promote ongoing linkage	Waiting lists for HACC, CACP and equipment
TC Delivery: Goal Oriented, Time-Limited Care; Low Intensity Therapies			
Care plan informed by hospital assessment & discharge planning	Variable	Protocols for transfer of allied health assessments and discharge summary; TC staff visit client in hospital	Delay in receipt of discharge summary; lack of protocol re notification of client discharge
Documentation includes: assessment of function using validated instrument, desired discharge destination, Quality of Life expectations, low intensity therapies, support, counselling & goal review	Functional assessment well evidenced Individualised care planning well evidenced.	Comprehensive assessment developed which incorporates all of the criteria listed	Format of question. Not all services systematically responded to the requirements (n=10); limited access to community-based social workers.
Care plan informs service delivery; periodic review	Evidenced		
Care plan & hospital discharge summary to GP & involved services	GP routinely informed of client admission; Provision of initial care plan not well evidenced		
Residential services provided in a home-like setting	Evidenced	Purpose-built facility	Limitations of existing or temporary buildings
Client leaves TC with refined care plan; d/c summary includes details of ongoing services; list of pharmacist checked medications…	Evidence of discharge information including contact details for services involved in ongoing care Provision of discharge care plan not well evidenced.		
Documentation requirements at discharge from TC	Lack of information about documentation of reasons for non-achievement of client goals		Brokerage of TC places requires monitoring of d/c practices
Transport	Stated compliance		Responsibility not clearly assigned to TC *or* family

TC Characteristics: Aged Friendly Principles; Collaborative Learning			
Requirement	**Quality of evidence**	**Enablers**	**Barriers**
Multi-disciplinary assessment in hospital with geriatrician involvement	Well evidenced; intrinsic to ACAT assessment; the composition of the assessment team was documented on the ACCR – geriatrician involvement variable	Routine interRAI assessment for patients >70yrs facilitates access to geriatrician consult	Limited access to geriatricians in regional areas
Skilled MDT staff assess each client & support care plan review	Evidenced. Composition of MDT's was variable in TC	Skilled case management Co-location within health setting	
Care informed by discussion with & between the relevant geriatrician & GP	Variable	Small number of TC services have medical staff as part of team Case manager has key role in GP involvement	Lack of geriatrician in region or Tele-health access only; variable engagement by GPs
Staff have relevant professional standing	Well evidenced		
Staff work collaboratively with all involved services	Well evidenced	Planned, regular forums	
Annual opportunity for staff to be informed of leading practice in TC	Variable Well evidenced in some states and regions.	Approved Provider &/or TC service provider approval or funding; local initiatives	
Staff utilise other opportunities to be informed of leading practice	Evidence of networking between TC services	Progressive rollout Maturity of TCP and services	Time since inception of TCP
Joint or cross sector training	Developing Some local initiatives	Co-location Community service provider networks	
TC Characteristic: Timely, Seamless Care			
Transfer to TC within 4 weeks of ACAT approval	Well evidenced	Delay ACAT until discharge date is known	High demand for residential TC
Hospital assessment & care plan transferred with client	Not well evidenced	Co-location with acute/ sub-acute health service TC provider visits client in hospital Protocol re minimum d/c information to be provided by referring hospital	Hospital medical records not transferable to community providers
Effective links with all services to optimise goal achievement	Well evidenced		
Equipment & support services arranged for discharge	Well evidenced	Business agreements with community service providers to facilitate access Effective links with ACAT staff	Waiting lists for HACC, CACP, EACH and subsidised equipment
Collaboration reflected in protocols & agreements [Appendix 1 Age-Friendly Principles & Practice]	Ambiguity associated with differentiating the age friendly principles from the guidelines relating to robust service agreements		Service promotion and networking mechanisms used extensively