Title:

Care transitions as street-level work: Providers' perspectives on the dilemmas and discretions
of older people's transitions across acute, sub-acute and primary care

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Abstract

Purpose: The complexity of older people's health needs often brings them into contact with a myriad of services and service providers that can extend across primary, secondary and sub-acute care sectors. Consequently, the right response is critical to quality and safety. This paper explores the experiences and perspectives of hospital health professionals and community service providers to provide a whole-of-system view of transition of community dwelling older people.

Design: Focus groups were conducted with 23 hospital health professionals and community service providers involved in care transitions of older people across acute care, sub-acute care and primary care. A thematic analysis derived two key themes which capture critical interface issues and how front-line providers manage these.

Findings: The first theme *Tipping points, targets and timing* exposes the possibility of critical opportunities in transitions but the chances that these will be missed due to systemic forces at particular points. In this case, system targets can be a deterrent to early intervention, while entrenched divisions between different levels of service can create displacement of responsibility across the system. The second theme, *Discretionary tactics* highlights the embedded nature of front-line practice and how local pressures are assimilated into practices and decisions surrounding transitions. It describes the various practices adopted by providers to manage unspecified referral pathways and complexity.

Implications: The study reinforces the need for standard ways to monitor and identify critical tipping points at the interfaces, supported by systemised approaches to care coordination and capacity building across the system as a whole.

Key words: Care transitions, sub-acute care, older people, qualitative study, focus groups, Australia

What is known about this topic

- Care transitions of older people are often compromised by information deficiencies, confused responsibilities, lack of preparation and poor communication.
- There's good knowledge about transition interface issues including at hospital/community or within single settings.
- Less attention is devoted to a whole-of-system perspective on care transitions

What this paper adds

- This study offers a whole-of-system perspective of care transitions by integrating the viewpoints of front-line providers to depict transitions across primary, secondary and sub-acute care.
- It focuses on interface challenges, provider responses and uncovering the heightened risks for patients during care transitions
- It identifies critical tipping points across the system that help to address transitions as a systemic rather than interface issue

Introduction

Care transitions of older people, to different locations or levels of care, are a practice and policy priority in the health care system because a poor response risks quality and safety. Poorly managed transitions can have a detrimental effect on patients' health, their trust in staff (Uhrenfeldt, 2013) and quality of care (Arora and Farnan, 2008) and increase readmission risk (Mudge *et al.*, 2013). Unfortunately, extensive research on care transitions emphasises continuing problems and interface challenges. Frequent transfers involving multiple teams can dilute responsibility and disrupt continuity of care (Toscan *et al.* 2012). Information delays (Baillie *et al.*, 2014; Toscan *et al.*, 2012), patient and carer confusion about post-discharge arrangements (Scott, 2010) and information access (Dossa *et al.*, 2012), and poor preparation of patients and carers (Goisa *et al.*, 2014) are other commonly cited interface problems. Poor quality transitions mean that gains made in one setting can be lost in transition and contribute to patient dissatisfaction and carer burden (Coleman, 2003). Consequently, integrated responses are increasingly promoted in policy and practice. These include holistic care assessments and care planning (Goodwin *et al.*, 2014) at the micro-level; and systemic strategies targeting information sharing and communication across organisational boundaries (Beech *et al.*, 2013), better care coordination (Goodwin *et al.*, 2014), and integrated care skills and practices in education and professional development (Howarth *et al.*, 2006). Key worker roles have also emerged to ensure safe and effective care transitions through self-management education, needs assessment and service brokerage (Bird *et al.*, 2007; Coleman, 2004; Roberts *et al.*, 2007).

In Australia, efforts to improve care transitions for older people have focused on national policy reforms such as hospital performance targets, including length of stay targets,

preventing and reducing hospital readmissions and more scope for sub-acute services (National Health and Hospital Reform Commission, 2009). Among the reforms, the Geriatric Evaluation and Management (GEM) service model, which was given a substantial boost under \$1.6 billion of government funding in 2010-2011, promotes a multidisciplinary, coordinated response to older patients with multiple conditions and complex health care needs who present at the hospital ED (Council of Australian Governments, 2011). When delivered in a dedicated ward it is effective in reducing functional decline, mortality and discharge to residential aged care (Ellis *et al.*, 2011).

However, in the case of care transitions, one cannot predict the courses of action that practitioners will take in a dynamic practice setting (Geary and Schumacher, 2012), which might explain why no specific transition intervention is consistently successful (Kansagara *et al.*, 2015). Geary and Schumacher (2012) argue that the bulk of transition research to date has been largely descriptive, neglectful of context and lacking in theoretical depth. This amplifies the need to know more about how transition perspectives and practices are unique to and emerge out of the local context. To that end, this paper offers a novel perspective by using the concept of street-level bureaucracy (Lipsky, 1980) to develop an understanding of street-level transition practice. The benefit of a street-level perspective is that it uncovers the complexities of negotiating patient and organizational demands that are otherwise not easily captured. The aims are to: 1) examine the work of care transitions from the perspectives of hospital and community providers involved with community dwelling older people admitted to sub-acute care; and 2) illuminate the distinctive practices that emerge from the dynamics and dilemmas of local settings.

Method

Approach

Lipsky (1980) proposed Street-level Bureaucracy (SLB) as a way to understand and examine the dilemmas and coping strategies of front-line public service workers responsible for implementing welfare programs. Although not originally focused on health workers, its relevance to this area has been increasingly highlighted (Bergin and While, 2005; Cooper *et al.*, 2015; McDonald, 2002). The significance of policy and organisational structures for how front-line health work is performed has also seen a revival of Lipsky's work (Hoyle, 2014). A key assumption is that street-level workers develop a logic of practice to manage the work tasks and competing demands of the local setting (Brodkin, 2011). Of relevance to this project on care transitions, a fundamental dilemma faced in street-level work is the tension of managing demands for efficiency while endeavouring to meet client needs (Lipsky, 1980). Moreover, it is commonly assumed that tight schedules and fragmented systems make it difficult for workers to meet their responsibilities for clients (Lipsky, 1980). Consequently, front-line workers exercise discretion in various ways creating a particular form of practice (Bergin and While, 2005; Hoyle and Grant, 2015). Assuming that risks to quality transitions increase with the frequency of transitions and numbers of providers involved (Toscan *et al.*, 2012), care transitions across the acute, sub-acute and primary care interface will generate competing pressures and perspectives, which must be negotiated at the local level (Lowthian, 2017). The present paper explores this with front-line health workers in relation to care transitions of older people using concepts of street-level theory.

Design and setting

This qualitative study was conducted in one hospital and health service (HHS) in far north Queensland, Australia. The study setting was the only major public hospital in this HHS, which also included a sub-acute service comprising a 16-bed older persons' evaluation, rehabilitation and assessment (OPERA) unit. Three focus groups were conducted with 23

representatives purposively selected from primary care, acute and sub-acute care, and community-based services. The focus groups were part of a larger longitudinal exploratory case study on care transitions of community dwelling older people who received a GEM service. The larger study examined care transition of older people and the patient and systemic factors influencing transitions by drawing on 93 semi-structured interviews with older people and their nominated carers interviewed on three occasions, analysis of medical record data and focus groups with providers. Full details of the larger study have been reported elsewhere (Harvey *et al.*, 2016). A key finding of the larger study was the disrupted nature of care transitions, which was complicated by poor linkages and system complexity (Harvey *et al.*, 2016). The focus groups in this study were intended to provide a system-level view of transitions and to explore the systemic tensions impacting transitions thereby complementing the patient case studies. The study reported in the present paper complements the larger study by focusing specifically on a street-level view of providers' work of care transitions. Ethical approval was obtained from the Far North Queensland Human Research Ethics Committee (HREC/12/QCH/76-802) and relevant university ethics committee (H5460).

Participants and recruitment procedure

A purposive sampling strategy was used to recruit medical, nursing and allied health professionals from the hospital Emergency Department (ED), acute and sub-acute care units (henceforth hospital participants), and primary care providers, including General Practitioners (GPs) and non-government health and social care services (henceforth community participants). Participants were recruited with the assistance of professional networks based on their involvement with older patients across community, sub-acute and acute care settings. All eligible participants were provided with an information sheet and voluntarily signed a consent form. Details of focus group participants are shown in table 1. Of note, the hospital

participants included the core disciplines of the OPERA unit where older people are admitted for sub-acute care and front-line practitioners from the key interface areas such as ED. The community participants included all key agencies within this HHS that link with the hospital and provide services to community-dwelling older people.

Table 1 Focus group participants

Discipline	(n=23)	Practice area
Hospital participants		
Nursing	2	Acute care
Occupational Therapy	1	Subacute ward
Social Work	1	Subacute ward
Physiotherapy	1	Subacute ward and community
Physiotherapy	1	Acute care
Nursing	1	Subacute ward
Medicine	1	Subacute ward
Community participants		
Medicine	2	Primary Health
Nursing	1	NGO
Nursing	1	Subacute in Community Health
Social Work	1	Acute care and Community Health
Coordinator	1	NGO
Nursing	1	Primary Health
Community participants		
Medicine	2	Primary Health
Nursing	2	Community Health
Care coordinator	2	NGO
Physiotherapy	1	Community Health
Nursing	1	NGO

NGO, nongovernment organisation

Data collection and analysis

One focus group of hospital participants and two focus groups of community participants were conducted. Discussions were based on a topic guide, which included perspectives on coordination of care transitions across interfaces; capacity of specialist services to facilitate

transition; and capacity across the system to optimise care transitions. The focus groups were audio-recorded and transcribed for analysis.

Guided by the principles of thematic analysis (Braun and Clarke, 2006), focus group data were coded, classified, sorted and synthesised by the first author to derive major themes and sub-themes. The amount of data was manageable in a word document and hand-coded (Patton, 2002). First, transcripts were read and openly coded using the discussion topics. During this process, patterns and exceptions within and across focus group transcripts were considered and interesting text segments recorded. This process yielded multiple descriptive codes that were then examined and refined into a coding framework. The refined coding framework was then applied to all data, with patterns and contrasts in the emergent themes and sub-themes considered as the analysis progressed. With reference to the study aims and SLB concepts of practice logic and street-level dilemmas and discretion, the emergent themes were interrogated further to capture the nature of street-level transition work. Representative extracts were selected to illustrate the themes and show overall patterns in the findings.

Findings

Three main themes were derived with reference to the aims. The first theme, *risk logics of care transition* depicts the rationale of care transitions and how this relates to key work tasks and local demands. The second theme, *dilemmas of fragmentation* reveals the criticality of particular touch points and provider responsibilities in care transitions. The third theme, *discretionary tactics* highlights how these local logics and dilemmas might open or close opportunities in care transitions. The illustrative extracts from focus group participants are

labeled with unique codes to indicate the focus group in which the participant was involved (FG1 and FG3 were community groups and FG2 the hospital group).

Theme 1: Risk logics of care transitions

Care transitions of community dwelling older people could be sudden and unpredictable, particularly if associated with trauma such as a fall. Participants agreed they were also unpredictable because of the *complex nature of...health issues*, [and patients] *don't maintain a steady course of health* (FG2). Even with continuous care, the risk for front-line practitioners was not knowing the crucial turning point.

If you're a GP for a long time, you may have been seeing somebody from age 65 to 70 and you might see them every six months or so. But you're not aware of the crucial period when actually they are deteriorating. (FG 3)

Unpredictability engendered a *risk management* (FG 2) logic which influenced care transitions. One participant highlighted the tendency for community providers to be more cautious, while another suggested that GPs were risk averse and encouraged hospitalisation if problems became too complex.

I know the NGOs will say if anything goes wrong go straight to ED. (FG 2)

We're more and more risk averse, perhaps, as a group of practitioners in encouraging people if...they think they've got a really bad problem, they go to hospital and not bother you. (FG 3)

However, the divergent views of some community participants was that where possible complex problems were best managed locally. These views emphasised the advantage of management by providers who had good knowledge of the patient.

I'm sure the emergency department do the best they can but seeing a young [Principal House Officer] compared to seeing [their GP] who knows someone for 30 years and knows all those social-emotional psychosocial stuff as well as their medical problems, far better that person presents to their GP to have things sorted out than they present to the emergency department. (FG 1)

However, risk management was reliant on the front-line worker being proactive. In one example, providing case management even though *we don't case manage, there might be some clients we might want to...* (FG 3). In other examples, it could mean deliberate action to identify patients who needed additional monitoring.

If we know you've got something that is recoverable we'd expect you to improve in a short period of time. You have to be a little bit careful and the ones that often you might monitor to see if they do pick up but then there's still that period of time. (FG 3)

Performance targets, specifically in the Emergency Department (ED) and more broadly about length of stay, were another dimension of the local logic of care transition. In this case the work was about balancing patient and system risks, specifically in response to a nationally imposed four-hour target for processing patients through ED and pressures to reduce length of stay across acute care. The inherent dilemmas were identified by one

participant who was concerned about targets displacing the goal of patient care.

...the patient lobs in A&E and already they are saying when is their expected date of discharge. It shouldn't be that, it should be caring for the client first and foremost and worry about fix them first and then start thinking about it. (FG 2)

For some community participants *the need to get clients out in a timely fashion under the bed days* (FG 3) risked providers missing the *holistic nature* of older people's needs (FG 3).

The contrasting stance was that targets encouraged efficiency. However, the inherent challenge of balancing patient needs and system risks is apparent in this example.

See I disagree with that...we need to be planning what their journey is going to be through the system. And it's not saying that we're not focusing on patient care...but we do need to define the length of stay otherwise the patient could just stay in the system for months...it's really important that we do set the [Expected Date of Discharge] for our patients. (FG 2)

This theme makes clear how the different logics of front-line work reflect the intersection of tasks and local constraints. However, the divergent views from hospital and community participants also emphasise how front-line providers in different locations and settings are orientated to different goals and organisational priorities and assimilate these into the rationales for action. This has particular relevance to the second theme about dilemmas faced across a fragmented system.

Theme 2: Dilemmas of fragmentation

From all focus groups it was evident that participants were dealing with immense complexity and fragmentation across the system. There were comments about disconnected transitions with the journey being *very dislocating for people right from the beginning and across the wards* (FG 1), complicated by an *unknown referral pathway* (FG 2) and inferior communication: *there's no discharge summary, there's no communication at the hospital whatsoever* (FG 1).

Fragmentation created *a lot of double handling of the patient* (FG 2) and fears about *how accurately the information is being transferred from one place to another, one service to another* (FG 3). A dominant dilemma was the constantly changing service system which in turn created more work for front-line providers to appropriately match the service to client needs.

We were learning new pieces of information just last week about a service provider we've known for a long time and that happens all the time. The service providers this year are different to the ones last year and the year before and they all do different things. In keeping up with that to match your patients with what's available is really challenging. (FG 2)

Notably, these conditions convinced participants about critical touch points and responsibilities of *getting people to the effective touch points so that they're not having to do all the useless ones* (FG 1). An agreed critical point was ED. However, the dilemma in a busy context with performance targets was often identifying the important *red flag* and acting to

enhance linkages with community based providers, in many cases GPs.

I don't honestly expect a busy resident or RN or anybody else to call me at each and every presentation to ED. Some people's medical history is relatively slender... as soon as you've got somebody with complex care or as soon as you've got a range of medical problems...it's obviously a red flag to get in contact with the general practitioner. (FG 3)

The role of the GP was a prominent discussion across focus groups, particularly in relation to their responsibilities for coordination and role in reducing unnecessary transitions to hospital. One viewpoint from the hospital focus group was that GPs *need to take a little bit more interest...*

I know that sounds critical but so often these people are left to fend for themselves with limited input from the GP ...the best we've got is a good local GP. (FG 2)

On the other hand, discussions among community participants reinforced the importance of stronger integration across acute and primary care to engage the GP.

So, somebody who could contact the GPs and say, I'm so and so from [the hospital], could we talk about this patient... just some constant re-education that goes on and I think it needs to be done face-to-face and personally as well. (FG 1)

While not disputing the role of GPs, other discussions highlighted the challenges of

fragmentation preventing GPs from fulfilling their responsibilities: *GPs are very unaware of a lot of programs* (FG 1). Some participants reinforced that everyone had a responsibility to ensure *the service provider and the GP are both aware...of what's going on actually in the home* (FG 3)

As highlighted by this theme, fragmentation places immense pressures on street-level transition work and frustrates the goals of efficiently matching patient needs and services. It also shows the inherent tensions surrounding responsibilities across the system. Importantly, while this theme indicates some of the ideal practices proposed by participants, the third theme discretionary tactics captures how front-line providers might actually respond when there is immense uncertainty.

Theme 3: Discretionary tactics

The theme of *discretionary tactics* captures how discretion interacts with risk logics and dilemmas to create local care transitions practice. As identified above, performance targets had to be managed along with patients' needs. Some discussions highlighted the struggle of dealing with delays: *in between that time frame of who do we refer to, to that person actually picking them up sometimes can be an extremely ridiculous amount of time and delay* (FG 2). In response, hospital participants had a strategy of making multiple referrals to ensure transition to another destination as soon as possible, while recognising that this could be inefficient.

Whereas at the moment you hedge your bets or...what some people do, is cast a wide net for all of them which annoys the people on the receiving end of the referrals when

you get one and it's also gone to rehab and [Transitional Care Program] and [Aged Care Assessment Team...it can be inefficient. (FG 2)

With the system fragmented and pressures on care transitions, community participants confronted challenges *getting information out of the hospital* as there was no *clear avenue* (FG 1). Rather, it was up to the community provider to create mechanisms such as good relationships to facilitate this aspect of transition work.

...the issue is information, getting information out of the hospital. Where we've actually developed relationships with units, information is much better and flows a lot easier but where we don't have a relationship, a good working relationship, the information is quite hard to get. (FG 1)

Similarly, discretionary practices to deal with fragmentation and breaks in transitions were evident across the groups. From one community focus group, going beyond routine practice to provide a more extensive service was one way of developing better service coordination for the patient, and indirectly, a strategy to maintain care in the community. In this example, a GP captured the option of using practice nurses more extensively.

I think we are prepared to use our practice nurses a great deal or more than we are and there's a couple of our nurses who are very keen to go out and do home visits and do health assessments at home but extend their role and extend their clinical role and provide some sort of cohesion. (FG 1)

Likewise, in dealing with transitions and the complexity of the service system some participants talked about choosing to allocate time to find out the range of providers involved.

I guess we do a lot of research, a lot of checking other people's databases or going to contact [Home and Community Care] to see whether they're involved, [Aged Care Assessment Team] to see whether they know the client. (FG 3)

Although these examples indicated a willingness to go beyond the scope of practice, they also show how front-line discretion can be used to implicitly ration resources at the local level. Similarly, this was exemplified by the reported variability of GP behaviours despite national policy efforts to encourage more consistency. In this case, providing financial incentives did not necessarily curtail front-line discretion.

I mean, there's a tremendous spectrum of behaviour and attitude amongst general practitioners. We're a very, very diverse group of people, of course. Some people will do very good at being a coordinator of care and there are a lot of Medicare incentives and things to try and take on those roles. (FG 3)

On the other hand, discretion can be the mechanism for practices to become more routine and this was evident in discussions about the role of OPERA in care transitions. For hospital and community participants transition to OPERA brought *a brief sigh of relief* (FG 1). For hospital participants it relieved pressures *on medical wards...with very limited allied health...and allowed them to concentrate on other acute patients* (FG2). For community participants it could provide a better journey for the slow to recover patient in a pressured acute care environment and in some cases, avoid transition to residential aged care:

There can be a lot of clients that want to return home but medical or surgical teams might think it's too hard or the preferred safer option is just to steer them towards institutional care. I think OPERA are affording clients more choice. (FG 3)

The embedded nature of this transition practice was made clear in the hospital focus group: *now they are being funnelled to OPERA where they should so they are definitely on a better journey (FG 2).*

Potentially people can go straight onto a community service that is available from [multidisciplinary assessment unit] but it's just easier to take it to OPERA and sort it out there. (FG 2)

This theme reveals that rather than entrenched or systemic responses to local problems, the discretionary tactics that were used by participants to balance competing issues in the local setting. While it shows some discretionary practices becoming preferred routines, it also reveals the types of decisions taken in the course of local practice which reflect implicit rationing of time and resources.

Discussion

This research offers an important yet understudied approach by analysing and integrating the experiences and perspectives of front-line workers from community and primary care, acute care and sub-acute care that might otherwise be latent. Many of the systemic issues identified have been identified in previous research (Fuji *et al.* 2013; Toscan *et al.* 2012). In this case

the themes of risk logics, dilemmas of fragmentation and discretionary tactics provide insight into how providers navigate multiple tensions by creating local practices that are consistent with their rationales and organisational orientations. By examining care transitions as street-level work, the study highlights several key findings about the dynamics and context of front-line practice.

The findings as a whole are consistent with a central tenet of SLB with participants in this study constantly faced with many tensions balancing their work demands and meeting patient needs. Lipsky (1980) argued that this can induce providers to engage in people processing rather than comprehensively dealing with their needs. Likewise, in this study there were perceived trade-offs and a sense of lost opportunities to intervene appropriately. This is best exemplified by the four hour targets of ED, which some thought displaced opportunities for thorough assessments and early intervention. Similar to a study by Sujan and colleagues (2015), performance targets can create conflicting priorities for front-line providers and generate trade-offs. However, the findings also challenge Lipsky's (1980) contention that competing local tensions mean front-line workers never achieve their ideal practice. In this study, hospital participants were incorporating OPERA into their routines as a way of conciliating the need for system efficiencies and comprehensive assessment of client needs. This was also favourable practice according to community participants.

A further assumption of SLB is that fragmentation makes it difficult for front-line providers to fulfil their responsibilities to clients (Lipsky, 1980). The findings uncovered the predicaments of responsibilities in a system that was both pressured and fragmented. One such example was the responsibility of GPs to do more, while the alternative view was that

hospital providers had an obligation to engage GPs at critical points. By explicating the responsibilities of key agents in this way participants were highlighting where notions of ideal practices and responsibilities might not be fulfilled. Importantly, the findings also show how structural factors shape responsibilities. In this case, system complexity could negatively impact GP awareness. On the other hand, structural incentives could have mixed results for GP involvement as indicated in the variability of GP behaviour in care coordination.

Improving care transitions depends on clear understanding of roles and responsibilities of different professional groups (Fuji *et al.* 2013), and systemic mechanisms to enable integrated working (Goodwin *et al.* 2014). In this case, the findings raise questions about system level strategies that will support rather than deter providers in their responsibilities and coordination efforts.

Discretion according to Lipsky (1980) is the way that front-line workers ultimately reconcile competing demands with the task of meeting client needs. Certainly the findings reinforce the significance of discretionary tactics in managing both system efficiencies, complexities and patient transition. The practice of some hospital participants of making multiple referrals to manage performance targets, delays and patient needs was an explicit example, although it also generated other types of inefficiencies. In that sense, transition work is complicated by dual roles that front-line workers often occupy within the system (Lipsky, 1980). On a more positive note, participants also had the scope to translate discretionary actions into routine practice. This is best exemplified by the tendency to incorporate OPERA into transition practices to relieve pressures and to provide more space and time for comprehensive assessment in transition planning.

These examples in particular show the importance of maintaining space for discretion and

more so, reinforce the argument that where there is greater ambiguity such as with fragmentation and system complexity, bottom-up discretion is not only important but essential (Ellis, 2011). However, as other examples show, discretion can also involve implicit rationing of time and resources in both positive and negative ways. The dilemma of managing patient needs that are at odds with organisational needs is not an uncommon feature of street-level work (Finlay and Sandall, 2009). The ultimate challenge is identifying when discretion fails to support quality care transitions for all patients.

Conclusion

Ensuring the quality of care transitions across multiple settings and services is paramount to older people's health. Although the findings of this study must be interpreted with some caution given these are derived from a small group of providers within one hospital and health service, nevertheless there are a number of contributions to the literature on care transitions. The current study contributes to the field by exploring care transitions as street-level work and more so, as work that is negotiated across acute, sub-acute and primary care settings. To that end, it provides a better understanding of how front-line providers really operate when doing care transitions and pinpoints critical facilitators and limitations thereby providing a foundation for developing further policy and practice based solutions. Importantly, the findings as a whole suggest that while discretion benefits front-line providers by providing some flexibility to determine how to deal with the dynamics and dilemmas of care transitions, there is also a need for systemic supports to enable providers to more consistently use discretion on behalf of patients. This necessarily involves critical appraisal at the organisation and policy levels regarding the resources required at critical touch points, appropriate incentives to encourage more routine and consistent front-line practices and what

really counts in producing a well-coordinated transition for community-dwelling older.

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References

Arora, VM. and Farnan, JM. (2008), “Care transitions for hospitalized patients”, *Medical Clinics of North America*, Vol. 92, pp. 315-324.

Baillie, L., Gallini, A., Corser, R *et al.* (2014), “Care transitions for frail, older people from acute hospital wards within an integrated healthcare system in England: A qualitative case study”, *International Journal of Integrated Care*, 14, URL:<http://www.ijic.org> 10-1-114776.

Beech, R., Henderson, C., Ashby, S. *et al.* (2013), “Does integrated governance lead to integrated patient care? Findings from the innovation forum”, *Health and Social Care in the Community*, Vol. 21 No. 6, pp. 598-605.

Bergen, A. and While, A. (2005), "Implementation deficit and street level bureaucracy: policy, practice and change in the development of community nursing issues". *Health and Social Care in the Community*, Vol. 13, pp. 1–10. DOI: [10.1111/j.1365-2524.2005.00522.x](https://doi.org/10.1111/j.1365-2524.2005.00522.x)

Bird, SR., Kurowski, W., Dickman, GK *et al.* (2007), "Integrated care facilitation for older patients with complex health care needs reduces hospital demand", *Australian Health Review*, Vol. 31 No. 3, pp. 451-461.

Braun, V. and Clarke, V. (2006), "Using thematic analysis in psychology", *Qualitative Research in Psychology*, Vol. 3, pp. 77-301.

Brodkin, E. (2011), "Policy work: Street-level organizations under new managerialism", *Journal of Public Administration Research*, Vol. 21, pp. i253-i277.

Coleman, EA. (2003), "Falling Through the Cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs", *Journal of American Geriatrics Society*, Vol. 51 No. 4, pp. 549-555.

Cooper, M., Sornalingam, S. and O'Donnell, C. (2015), "Street-level bureaucracy: An underused theoretical model for general practice"? *British Journal of General Practice*, Vol. 377. DOI: 10.3399/bjgp15X685921

Council of Australian Governments. (2011), National Health Reform Agreement - National Partnership Agreement on Improving Public Hospital

Serviceshttp://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf (accessed 6 February 2017).

Dossa, A., Bokhour, B. and Hoenig, H. (2012), “Care transitions from the hospital to home for patients with mobility impairments: patient and family caregiver experiences”, *Rehabilitation Nursing*, Vol 37 No. 6, pp. 277-285.

Ellis, G., Whitehead, MA., Robinson, D *et al.* (2011), “Comprehensive geriatric assessment for older adults admitted to hospital: Meta-analysis of randomised controlled trials”, *British Medical Journal*, Vol. 343, d6553 doi: 10.1136/bmj.d6553.

Fuji, KT., Abbott, AA. and Norris, JF. (2013), “Exploring care transitions from patient, caregiver, and health-care provider perspectives”, *Clinical Nursing Research*, Vol. 22 No. 3, pp. 258-274.

Giosa, JL., Stolee, P., Dupuis, S *et al.* (2014), “An examination of family caregiver experiences during care transitions of older adults”. *Canadian Journal on Aging*, Vol. 33 No. 02, p. 137-153.

Goodwin, N., Dixon, A., Anderson, G *et al.* (2014), “Providing integrated care for older people with complex needs: Lessons from seven international case studies”. The Kings Fund, London, available at www.kingsfund.org.uk (accessed May 2016)

Greenwald, J.L., Denham, C.R., Jack, B.W. (2007), “The hospital discharge: a review of a high risk care transition with highlights of a reengineered discharge process”. *Journal of Patient Safety*, Vol. 3, 97–106. doi:10.1097/01.jps.0000236916.94696.12

Harvey, D., Foster, M., Strivens E., Quigley R. (2016), “Improving care coordination for community-dwelling older Australians: a longitudinal qualitative study”, *Australian Health Review*, <http://dx.doi.org/10.1071/AH16054>.

Howarth, M., Holland, K., Grant, M.J. (2006), “Education needs for integrated care: a literature review”, *Journal of Advanced Nursing*, Vol. 56 No. 2, pp. 144-145

Hoyle, L. (2014), “‘I mean, obviously you’re using your discretion’: Nurses Use of Discretion in Policy Implementation”, *Social Policy and Society*, Vol. 13 No. 2, pp. 189–202.

Hoyle, L. and Grant, A. (2015), “Treatment targets in emergency departments: nurses’ views of how they affect clinical practice”. *Journal of Clinical Nursing*, Vol. 24 No. 15-16, pp. 1211-1218.

Kansagara, D., Chiovaro, J.C., Kagen, D. et al. (2015), “Transitions of Care from Hospital to Home: An Overview of Systematic Reviews and Recommendations for Improving Transitional Care in the Veterans Health Administration”. Washington (DC): DoVA (US)

Kudner, D. and Spreeuwenberg, C. (2002), “Integrated care: meaning, logic, applications, and implications – a discussion paper”. *International Journal of Integrated Care*, Vol. 2 No.14 November ISSN 1568-4156 – <http://www.ijic.org/>

Lowthian, J. (2017), “How do we optimise care transition of frail older people”? *Age Ageing*, Vol. 46, No. 1, pp. 2-4. doi-org.libraryproxy.griffith.edu.au/10.1093/ageing/afw171

McDonald, R. (2002), “Street-level bureaucrats? Heart disease, health economics and policy in a primary care group”, *Health and Social Care in the Community*, Vol. 10 No. 3, pp. 129–135

Mudge, AM., Shakhovskoy, R. and Karrasch, A. (2013), “Quality of transitions in older medical patients with frequent readmissions: Opportunities for improvement”, *European Journal of Internal Medicine*, Vol. 24 No. 8, pp. 779-783.

National Health and Hospitals Reform Commission (2009) A healthier future for all Australians, Final Report of the National Health and Hospital Reform Commission, Canberra ACT. Available at www.health.gov.au (verified December 2014)

Patton, MQ. (2002), *Qualitative Research and Evaluation Methods*, (3rd Edn). Sage Publications, Thousand Oaks, CA.

Roberts, RM., Dalton, KL., Evans, JV *et al.* (2007), “A service model of short-term case management for elderly people at risk of hospital admission”, *Australian Health Review*, Vol. 31 No. 2, pp. 173-183.

Sujan, MA., Chessum, P., Rudd, M *et al.* (2015), “Managing competing organizational priorities in clinical handover across organizational boundaries”. *Journal of Health Services Research & Policy*, Vol. 20 No. 1, pp. 17-25.

Toscan, J., Mairs, K., Hinton, S, *et al.* (2012), “Integrated transitional care: patient, informal caregiver and health care provider perspectives on care transitions for older persons with hip fracture”, *International Journal of Integrated Care*, Vol. 12, URL:<http://www.ijic.org> ISSN 1568-4156.

Uhrenfeldt, L. (2013), “A qualitative meta-synthesis of patients’ experiences of intra- and inter-hospital transitions”, *Journal of Advanced Nursing*, Vol. 69 No. 8, pp. 1678-1690.