Care transition types across acute, sub-acute and primary care

Case studies of older people with complex conditions and their carers

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Abstract

Purpose – The purpose of the paper is to examine the care transitions of older people who transfer between home, acute and sub-acute care to determine if there were common transition types and areas for improvements.

Design/methodology/approach – A longitudinal case study design was used to examine care transitions of 19 older people and their carers as a series of transitions and a whole-of-system experience. Case study accounts synthesising semi-structured interviews with function and service use data from medical records were compared.

Findings – Three types of care transitions were derived from the analysis: manageable, unstable and disrupted. Each type had distinguishing characteristics and older people could experience elements of all types across the system. Transition types varied according to personal and systemic factors.

Originality/value – This study identifies types of care transition experiences across acute, sub-acute and primary care from the perspective of older people and their carers. Understanding transition types and their features can assist health professionals to better target strategies within and across the system and improve patient experiences as a whole.

Keywords Australia, Older people, Care transitions, Case study design, Sub-acute care

Paper type Research paper

Introduction

The number of older people with multiple chronic conditions is increasing (Mansah *et al.*, 2009) as are emergency department presentations by older people with complex care needs (Ellis *et al.*, 2011). For the older person, a critical health event can precipitate a series of transfers across different settings and levels of care, involving multiple providers (Giles *et al.*, 2009). It can also mark a new level of frailty or vulnerability to functional decline accompanied by a period of uncertainty and lifestyle adjustment (Walker *et al.*, 2015). The care transition involves older people, carers and providers in a process of "negotiation and navigation" (Allen *et al.*, 2016, p. 8) across the system to adapt to changed health and social care needs (Ellins *et al.*, 2012).

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The transition from hospital to home is a time of particular vulnerability. Risks include: delays or lack of information exchange between providers (Dossa *et al.*, 2012; Baillie *et al.*, 2014) or between providers, older people and their carers (Allen *et al.*, 2016; Baillie *et al.*, 2014; Giosa *et al.*, 2014); patient and carer confusion about post-discharge arrangements (Scott, 2010), and access to information and care post-discharge (Dossa *et al.*, 2012); and inadequate patient and carer preparation for new and emerging care responsibilities (Allen *et al.*, 2016; Giosa *et al.*, 2014; Byrne *et al.*, 2011). Frequent transfers and rapid discharges can have a detrimental impact on continuity of care (Toscan *et al.*, 2012). Ownership of the outcome can become diluted as the number of providers increase and older people become disengaged (Toscan *et al.*, 2012) or feel disempowered (Walker *et al.*, 2015). Perceived early discharge from hospital with limited follow-up can result in unmet needs that compromise self-management and independence (Allen *et al.*, 2016) impact on patient safety (Mansah *et al.*, 2009; Coleman, 2003) and increase readmission risk (Mudge *et al.*, 2013).

Interventions to improve older people's care transition experiences and reduce readmission rates and length of stay have shown mixed results. A recent synthesis of international systematic reviews identified the essential components of successful interventions as: more intensive rehabilitation, working more closely with older people and carers, and a dedicated transition provider to advocate for and facilitate care co-ordination and outreach to patients following discharge from hospital (Sahota *et al.*, 2016). Despite this, an intervention utilising these approaches showed no benefit in reducing hospital readmissions or length of stay (Sahota *et al.*, 2017). In Australia, efforts to improve older people's care transitions are focused on implementation of the Geriatric Evaluation and Management (GEM) model of care which promotes comprehensive geriatric assessment and multidisciplinary, coordinated care for older people with complex needs in a sub-acute setting (Foster *et al.*, 2017). While not solely focused on transitions, the purpose of GEM is to lay a foundation for an integrated and coordinated care plan after return to community (Lowthian, 2017). Programmes using the GEM model of care have shown promising results in reducing readmissions and length of stay (Bird *et al.*, 2010; Roberts *et al.*, 2007). However, the dynamic and unpredictable nature of care transitions involving a GEM service has also highlighted the need for early intervention across the system, a more systemic approach to service linkages (Harvey *et al.*, 2016) and support for workers to consistently tailor practice to older people's needs (Foster *et al.*, 2017).

While the emphasis on the hospital community interface seems justified in terms of risk, self-management in the community can be precarious (Harvey *et al.*, 2016) and there is strong evidence that better health outcomes can be achieved through intervention early in older people's illness trajectory (Beswick *et al.*, 2008). This suggests the need to examine the sequence of care transitions experienced by older people living in the community. The purpose of this analysis is to distil the types and commonalities of care transitions of older people by examining the individual experiences of older people, and their carers, who transitioned from community through acute and sub-acute care to home as a case study of transition. Through this approach, a more nuanced understanding of care transitions as both a series of discrete transitions and a whole patient journey, with unique patient and systemic features can be obtained. Findings from the larger study are presented elsewhere (Harvey *et al.*, 2016).

Methods

Design

A qualitative case study design was used, which is ideally suited to in-depth investigation of complex social issues (Yin, 2014) such as care transitions (Toscan *et al.*, 2012; Beech *et al.*, 2013). The study was conducted in regional Australia within a 531-bed public hospital with an Older Persons Evaluation Rehabilitation and Assessment (OPERA) unit which utilises

the GEM model of care. The OPERA unit is a 32-bed dedicated sub-acute ward within the hospital. Within the OPERA ward, the GEM model of integrated interdisciplinary care is well embedded and fundamental to the success of the programme. However, integrative care across health services in and out of the hospital is more limited. Ethical approval was obtained from the Local (HREC/12/QCH/76-802) and University Ethics Committee (H5460).

Participants and recruitment

Eligible participants were hospital patients with a Mini-Mental State Examination score $\geqslant 20$ and their nominated carer (excluding paid carers). Patients were approached personally on the ward by the research team and invited to participate. Carers were approached either in-person or by telephone. In all, 20 patients were recruited, one withdrew and one patient and a carer were unavailable for a follow-up interview. A criterion sampling approach was used to commence recruitment. Data were reviewed and purposive sampling was used to identify varied transition experiences. All participants provided written consent.

Participants were 19 people between 64 and 95 years and their carers. The mean age of older people was 83. In all, 12 were male, seven female. Four participants (two patients and two carers) were Aboriginal and/or Torres Strait Islander people. Five were eligible for intensive short-term transition care following discharge. Carer relationships were wife ($n = 4$), husband ($n = 2$), daughter ($n = 8$), son ($n = 2$), niece ($n = 1$), partner ($n = 1$) or friend ($n = 1$). The average length of stay in sub-acute care was 14 days.

Data collection

The "case" for analysis in this study was older people's care transitions across acute, sub-acute (OPERA ward) and primary care. Each transition case study involved semi-structured interviews with the older person on admission to the OPERA ward, before discharge and one month after discharge; and semi-structured interviews with the carer, before and one month after discharge. Interviews explored events preceding the emergency department presentation, acute and sub-acute experiences, hospital discharge and post-discharge experiences. Each interview was conducted by members of the research team who had no clinical contact with participants. To build rapport and enhance data quality, the same interviewer completed all interviews for each case. Data collection ceased when no new themes could be identified from the data and the analysis showed depth and variation of experiences.

In total, 93 interviews were conducted, 56 with patients and 37 with carers. The majority of interviews were conducted face to face ($n = 89$). Post-discharge interviews were conducted at a participant's home, workplace or at the hospital. Interviews were recorded, transcribed and stored for analysis using NVivo version 9 (QSR International) software. Function and service use data were collected by a post-discharge medical chart review.

Data analysis

Two researchers read interviews for the first five cases several times to familiarise themselves with the data. The same two researchers independently coded the interviews for these five cases (25 interviews) line by line. This yielded a number of descriptive codes that were discussed until an agreed coding framework was developed. The coding framework was applied to all interviews by two researchers and illustrative text segments were recorded. Where gaps and new insights emerged, the framework was modified by agreement. The codes were grouped into a smaller number of themes and subthemes. A single page descriptive account of each case which synthesised relevant data from a medical chart review and analysis of the semi-structured interviews was created to integrate the analysis (Creswell, 1998; Baxter and Jack, 2008). The summaries were compared,

noting patterns and contrasts with a focus on identifying overarching types of transition experiences and distinguishing themes.

Several strategies were implemented to achieve trustworthiness (Lincoln and Guba, 1985) and thereby enhance study quality. These were congruence between the research question and design, purposeful sampling for a variety of experiences, thick descriptions from participants through repeat interviews, multiple data sources, and an accurate audit trail of analytic methods. Coding of data by multiple researchers enhanced the dependability of the analysis (Baxter and Jack, 2008).

Findings

All care transitions examined could be classified as three types: manageable, unstable or disruptive (Table I). Notably, the transition types are not fixed as analysis indicated that older people can have different types of experience across acute, sub-acute and primary care due to variations in health status, system responses, local care arrangements and temporal factors. Participant quotations labelled as either P (patient) or C (carer) in chronological order of recruitment are included to illustrate key findings from the analysis.

Manageable care transitions

Most transitions from home to acute care and almost half of transitions from acute to sub-acute care and back to community were typically manageable transitions. These featured the willingness and acceptance of the older person, active engagement and trust in the system, and organised continuous support. In a manageable transition, the older person and their carer generally acknowledged the need for transition from home to acute care. This included acknowledgement that a health threshold had been reached which signalled the need for change, being receptive to making a transition and acceptance of the timing of the transition:

> I wasn't too good at home and had this pain in the back […] and then my daughter who is my carer and her brother came and he said "Mum, I think we better get the ambulance" and I didn't object. I said Ok. Alright. Because I got to the stage where I felt that I did need help (B02P).

Where the transition was associated with trauma such as a fall, there was ready acceptance of the need for timely transfer to a more appropriate level of care, for example, by activating a medical alarm "I went to turn around and sit down and I was on the floor before I knew where I was […] I've got a medical alarm system and just press the button and the

Transition	Manageable	Unstable	Disruptive
Home to acute care via emergency department	Reaching a threshold Active engagement and trust in the system Organised, continuous support		Losing control of decision making Avoidant or delayed help seeking Delayed system response
Acute care to sub-acute care	Being part of the care process Trusting in system response Developing confidence	Hesitancy and uncertainty at discharge Being rushed through the system Older person and carer as recipients of care	
Sub-acute care to home	Reclaiming independence Adjusting to change Predictable and uninterrupted care	Experiencing unmet needs Floundering in the system Increasing despondency	Relinquishing independence Overwhelming need Breakdown in continuity of care

Table I.
Types of transition experiences and distinguishing characteristics

ambulance comes" (I09 P). Other participants who typified a manageable transition willingly accepted the recommendation of a trusted GP to present to hospital "I had an appointment to see the doctor and when I saw him he said 'I think we better get you into hospital' " (R18P).

A manageable transition from acute to sub-acute care generally involved active engagement of the older person and trust in the recovery process. This was exemplified by engagement in goal setting and therapy "I have a goal that I want to reach to get home. If you don't work hard you will never get anywhere, you will be there for longer still" (E05 P). Trust in the system response was underpinned by information sharing "They (OPERA staff) answered lots and lots of questions. One of the physios showed us a DVD about how to look after [older person] when he comes home" (A01C).

Both active engagement and information sharing were part of a preventive approach that featured in manageable transitions. From sub-acute care to home this was characterised by system support to adjust to change, avoid risk and resume independence. Most participants who experienced manageable transitions valued being able to resume at least some elements of their former lifestyle as a result of sub-acute care " […] they taught you at OPERA how to avoid or try to avoid falling over and that sort of thing and so far it has worked. I haven't fallen over since I came home" (L12 P). Most also reported timely and anticipated commencement of arrangements planned on the OPERA ward, which indicated that manageable transitions featured well-organised continuity of support:

> It's marvellous, They sent someone home with me a couple of days ago to see how I would cope at home and what would be needed, whether I could manage, but she found that I could manage very well indeed (G07 P).

In some instances, however, planned services or arrangements proved unsuitable or inflexible. In these cases, making changes, often negotiated by the carer, led to a smoother transition to home:

> I had all these people from the hospital coming to care for him but my father was overwhelmed with so many people coming so I had to stop it all […] So it was very stressful and the transition care did say that we are upsetting your father more by coming here so its best that we just cut this all out […] (N14C).

Interestingly, participants who experienced a manageable transition from hospital to home had varied experiences earlier in their journey. Only some received short-term support from the Transition Care Program. While most had supportive and inclusive experiences of the GEM service, others did not. A consistent characteristic of a manageable transition from hospital to home was the timely adjustment to new or emerging needs, often due to active involvement and advocacy by the carer.

Unstable care transitions

Unstable transition was the second typical type. These types as a whole featured more uncertainty and despondency for older people and their carers and disruptions in the continuity of support. Ten case study transitions from acute to sub-acute care and nine from sub-acute care to home showed the features of unstable transitions.

An unstable transition for the participants was characterised by a sense of being rushed through the system. Some expressed frustration with "being moved from one room to another, to another" (M13C) through acute wards when it was perceived to be due to system problems, such as bed shortages, rather than patient need. In these cases, participants were generally keen to return to their home environment, but were concerned about their readiness for discharge from OPERA and self-management capacity:

> Even though I was getting better according to them, I felt that I could have stayed a little bit longer because the treatment – the care they were giving me was good. The people, nurses working 24hours and they give blood pressure and really look after you […] because I wouldn't be getting that kind of care here [at home] (K11P).

Carers too expressed concerns about readiness for discharge home:

> She won't have raised that concern. She won't have told anybody […] I think it's that she's going to be lonely, and it's having to do things for herself again. Being in hospital for over three weeks, she's absolutely become institutionalised […] I thought she should have had more Physio, more Occupational Therapy. I don't think she's had very much of that (M13C).

Older people and carers experiencing an unstable transition from sub-acute care to home reported floundering in the system, experiencing unmet needs and a feeling of despondency. These experiences were also associated with minimal, medically focused discharge planning, gaps in implementation of health and social care services in the community and a lack of awareness of how to address emerging needs. One participant who described himself as "just hanging on" recounted his experience one month following discharge from sub-acute care:

> I'm finding it very painful to walk. I'm getting a lot of pain at night […] And it has gotten me worried and I don't know really what to do about it (A01P).

There was a lack of systemised linkages between sub-acute and primary care "I don't know what's happening or if anything is going to happen or if they're just going to leave it to the GP" (J10C) and often an assumed reliance on carers who were also unprepared for a more proactive and demanding role in navigating local services "At the moment I don't know if that's gone ahead because I haven't spoken to Dad for a couple of weeks. I have been really full on at work" (J10C).

Disruptive care transitions

A small number of care transitions across the system were characterised as disruptive. Four of these were transitions from home to acute care. Key features of these transitions were losing control of decision making, avoidant help seeking and delayed system response.

Generally, disruptive transitions were crisis driven. In part this was linked to older people's responses to a change in status. In these cases, participants valued their independence highly and avoided or resisted seeking help until it was absolutely necessary. Together with delays in accessing a GP service at short notice, this resulted in crisis-driven transitions. After experiencing chest pain for over three days and being advised of a two hour wait to see a GP, one participant asked family to call an ambulance saying "I can't wait that long just go to the […] Hospital" (K11P).

In other cases, an older person's strident resistance to presenting to the emergency department conflicted with the carer's preferred response:

> On the Sunday morning I phoned and she [older person] wasn't even out of bed. I went around and just said "This is it, I can't do this" so pressed her alarm button and the ambos came. She [older person] was yelling at them "For god's sake just leave me alone" (M13C).

Two transitions between sub-acute care and home were disruptive. Unlike unstable transitions where participants experienced a sense of floundering trying to address unmet needs, disruptive transitions could involve overwhelming needs due to a deterioration in health, a breakdown in continuity of care and relinquishing of independence. In one instance, planned home visits by a therapist and home modifications had not yet commenced when:

> He couldn't walk much. He just sat in the chair. If he wanted to go to the toilet then my brother had to carry him. But we just rang the ambulance to come (K11C).

In the other instance, a carer described the situation shortly after discharge:

> He still staggers and he still has pain. Actually he went into hospital one day this week and he couldn't stand the pain and they monitored him and then he came back late at night but the pain hasn't gone yet (S19C).

She also expressed concern about options for management of care in the community as "His GP, I don't think he can do much more. He says if he is bad just call the ambulance and go into hospital" (S19C). In both these instances the breakdown in continuity of care left older people and their families stranded between sub-acute and primary care.

Discussion

This study provides an important insight into care transition experiences both at specific transition points and across the whole patient journey. Many of the issues including communication breakdowns and rushed or ineffective discharges have previously been identified in respect to the transition from hospital to home. The findings of this study extend current knowledge by analysing experiences at three transition points within each patient journey and across all cases. This uncovered common types of transition experiences and associated personal and systemic factors. These findings will enable health and social care providers to plan and adjust interventions to optimise care transitions for older people accessing sub-acute care.

Manageable transitions exhibit features consistent with the goals of the GEM model of care (Ellis *et al.*, 2011) and components of successful care transition interventions (Sahota *et al.*, 2016). Numerous studies have reported the importance of active engagement of patients and the need to make adjustments to care plans based on patient experience (Coleman *et al.*, 2004; Walker *et al.*, 2015; Allen *et al.*, 2016; Cheek *et al.*, 2006) As reported elsewhere (Allen *et al.*, 2016; Baillie *et al.*, 2014; Giosa *et al.*, 2014; Byrne *et al.*, 2011) carers in this study had a critical role in optimising care transitions by seeking out information, negotiating with providers and promoting self-management. As reliance on carers can lead to them feeling overwhelmed by their role (Toscan *et al.*, 2012) the expectations imposed by services and the work of carers in care transitions warrant further exploration. Most of the manageable transitions were from home to hospital and characterised by acknowledgement of the need to transfer, active engagement and trust in the system and organised continuous support. The findings highlight the significant role of the GP in discerning tipping points in older people's health and wellbeing and the opportunity to pre-plan for transitions before they occur.

The GEM service was important for engaging patients and carers, creating an coordinated care plan and arranging longer-term follow-up. Despite this, most unstable transitions were associated with experiences during sub-acute care and transfer from sub-acute care to the community. Even a supportive and inclusive GEM service experience could be followed by an unstable transition to primary care which led to despondency as patients and carers floundered in addressing unmet needs. Personal factors such as passive engagement in care, reluctance to complain and hesitancy or uncertainty about discharge timing and capacity played a role, as did systemic factors including a sense of being rushed through the system and a lack of systemised linkages between secondary and primary care. The findings reinforce the tendency of older people to disengage from care when responsibility is dispersed across the system (Toscan *et al.*, 2012) or when they have to juggle multiple provider visits (Walker *et al.*, 2015). Identification of warning signs and rehearsing ways to manage exacerbation of a condition form part of self-management education in some existing care transition interventions (Coleman *et al.*, 2004; Bird *et al.*, 2010). The findings of this study suggest that identifying potentially unstable transitions and implementing specific strategies that ameliorate them maybe warranted.

Disruptive transition was the least successful type of transition from a patient and carer perspective. Although small in number, experiences clustered at the home to hospital and sub-acute care to home interfaces. Avoidant help seeking accentuated by a delayed system response led to a loss of control over the decision to present to hospital. This type of help avoidance can be related to maintaining a sense of independence or fear of loss of

independence such as precipitating residential care (Cheek *et al.*, 2006). Older people may delay seeking help from services, instead asking friends or family for help (Ellins *et al.*, 2012). In this study conflict between patients and carers also played a role with some carers taking control of the decision despite resistance. Carers have a key role in negotiating and advocating for the care recipient in community settings (Cheek *et al.*, 2006; Nahm *et al.*, 2010) and may not feel adequately prepared for their role, particularly in the case of a medical crisis (Giosa *et al.*, 2014). A disruptive transition from hospital to home was marked by overwhelming need, a breakdown in continuity of care and relinquishing independence. Participants in this study preferred to present to the emergency department when a transition broke down. The findings reinforce the key role of primary care, specifically GPs and specialist geriatric assessment in a community setting (Arbaje *et al.*, 2010) in discerning tipping points in health and coordinating care in the community.

Limitations

Each participant experienced a GEM service, and nominated a carer and GP. Five participants accessed intensive short-term post-hospital care. The experiences of older people who access other models of integrated care or transition to aged care facilities may be different. The findings may also reflect the local health service context. Nonetheless, as the focus of the study is on understanding the experiences of populations whose complex needs warrant a combination of services and supports and who typically experience multiple transitions, the study findings may be applicable to populations other than those with the specific characteristics of the study sample and the study context. The study methods have been described in detail so that the transferability of the findings to other contexts and populations with complex care needs can be assessed.

Conclusion

Care transitions are complex processes occurring in a dynamic health and service context and it is not clear how they can be effectively managed. Most care transition interventions focus on service mechanisms within a transition. Identification of types of transition experiences and the factors that influence them can assist clinicians to consider adjustments to optimise care transitions for older people. The concept of transition types, i.e. a thematic description of transition to different levels and locations of care and experiences at different touch points which incorporates influential patient and system levels is a conceptual approach under development. It could be used with other populations to understand experiences and further develop the conceptual categories which allow us to make sense of different transitions in different contexts and to intervene at appropriate points or levels along the transition.

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