

Transition Care (TC): its place in
the aged care service puzzle

TRANSITIONAL CARE FOR
OLDER PEOPLE CONFERENCE

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Summary

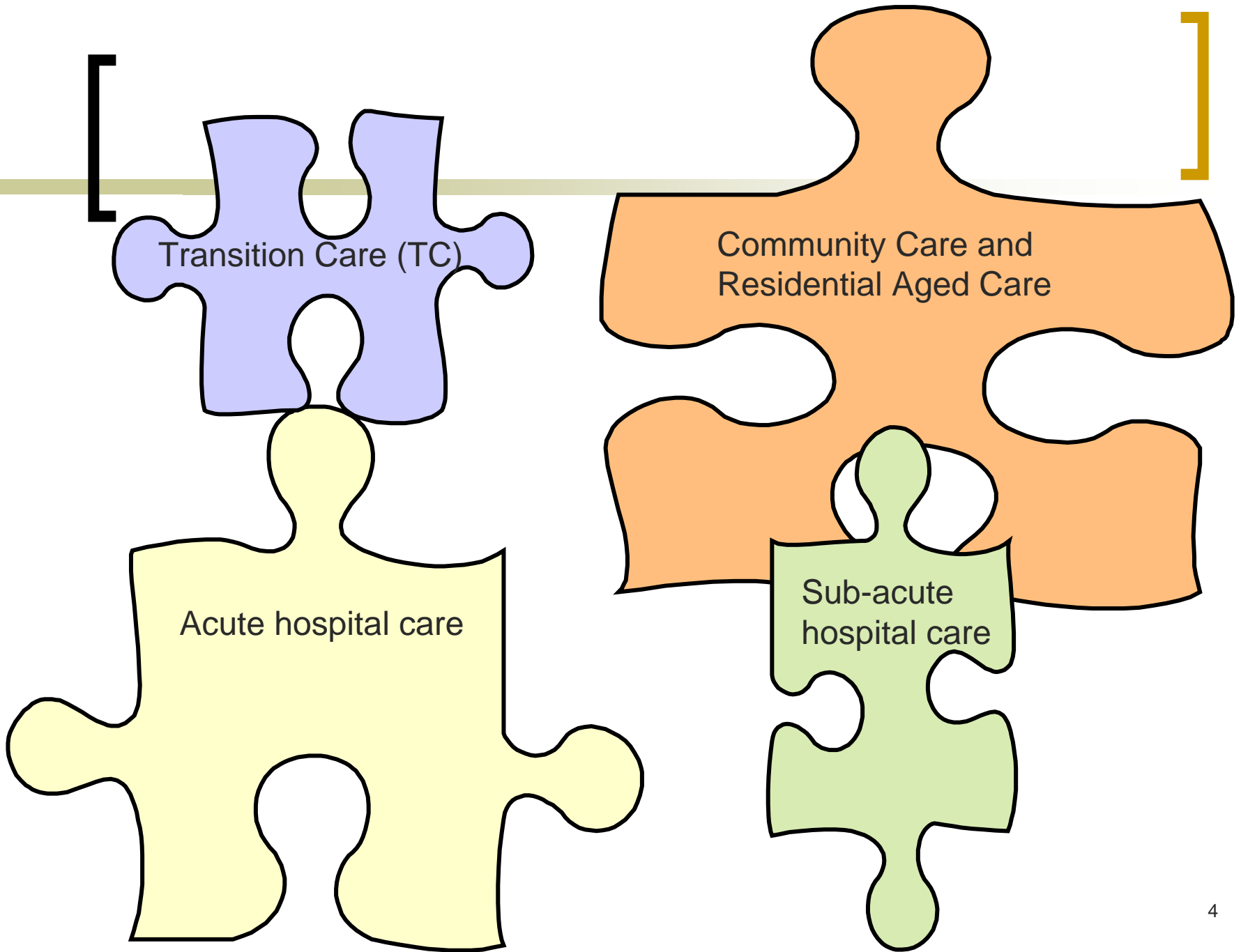
The Transition Care (TC) Program

- Background
- Client studies
- TC audits
- National Evaluation of TC
- Aged care service puzzle issues
- Developments
- Unanswered questions
- The future

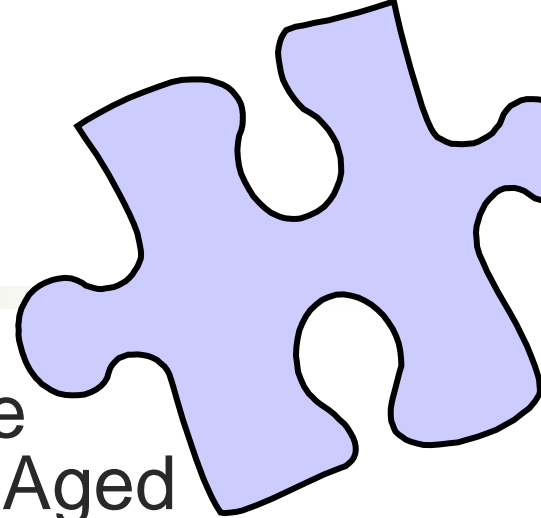
Supported by the National Health and Medical Research Council of Australia, “Transition Care: Innovation and Evidence” Research Program Grant
<http://www.rehab.med.usyd.edu.au/tie/>

[Disclaimer]

- Ian Cameron works with a regionally based Aged Care and Rehabilitation Service in a well resourced part of Northern Sydney
- Ian Cameron has accepted funding from the Australian Government to conduct research with older people
- Ian Cameron has parents who are now both over the age of eighty
- Ian Cameron has a wife who is a geriatrician



[Transition Care Program



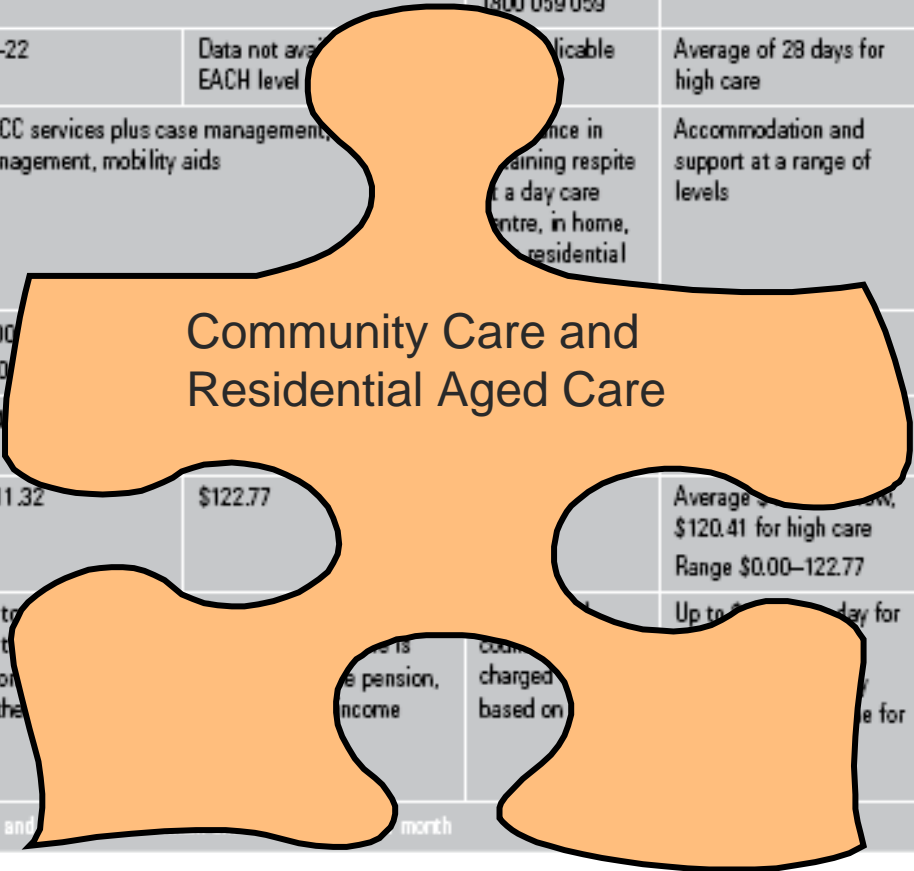
- In the 2004 announced as part of the Government Investing in Australia's Aged Care: More Places, Better Care package.
- Transition Care is a form of flexible care provided to an older person at the end of an inpatient hospital episode in the form of a package of services that includes at least low intensity therapy and either nursing support or personal care
- Transition care is product of the difficulties in coordination between State and Commonwealth government programs

[Aged Services Jigsaw]

- Home and Community Care Program
- Veterans Home Care
- Community Aged Care Packages
- Carer Respite Program
- Extended Aged Care at Home
- **Transition Care**
- State 'transitional programs'
- Residential Aged Care
 - Low care
 - High care

Table 1. Aged care services in Australia^{45,10-18}

	VHC	HACC	CACP	EACH	EACH -D	NRCP	Residential care
Eligibility criteria	Having needs and a veteran or their widow/widower	Moderate, severe or profound disability, or carer	Disability equivalent to low level residential care	Disability equivalent to high level residential care	Disability equivalent to high level residential care and having BPSD that impacts on ability to live in the community	Carers needing respite	At disability level requiring low or high level residential care
Eligibility assessor	Service provider	Service provider	ACAT	ACAT	ACAT	Service provider	ACAT
To refer	National VHC hotline 1300 550 450 for regional service	Aged Care Information Line 1800 500 853 for regional service	Local ACAT www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-contacts-acat-cd1.htm			Commonwealth Carer Respite Centres 1800 059 059	Local ACAT
Average hours of care per week	0.6	1–2	6.1	18–22	Data not available at EACH level	Variable	Average of 28 days for high care
Services available	Personal care, domestic help, home and garden maintenance, respite	VHC services plus nursing, allied health, meals on wheels, day care, home modification, social support, transport	VHC services plus case management, meal preparation, social support, transport	HACC services plus case management, management, mobility aids		Respite in community, day care centre, in home, residential	Accommodation and support at a range of levels
Number of places	63 823 (2005–2006)	744 197 (2004–2005)	36 000 (2006–2007)	2700 (2006–2007)			
Annual government funding per place	\$1432	\$2016	\$11 500	\$34 000			
Current daily government subsidy rate	N/A Payments based on the type and hours of services delivered		\$33.30	\$111.32	\$122.77		Average \$120.41 for high care Range \$0.00–122.77
Client contribution	Up to \$5 per hour	Based on services used and income level	Up to \$6.02 per day for those whose income is equivalent to the pension Up to 50% of any income above the maximum pension rate	Up to \$10 for those whose income is above the pension, to the maximum of \$10		Up to \$10 per day for those whose income is above the pension, to the maximum of \$10	Up to \$10 per day for those whose income is above the pension, to the maximum of \$10



[Case Study – Mrs Taylor]

- 80 yo widow
- Lives alone, family interstate
- Frail
- Cognition normal
- Physically frail
- “Just managing”
- Fall
- Admitted to hospital
- Wrist fracture
- Sub-acute hospital admission for rehabilitation
- Fatigued and short of breath – heart failure diagnosed

[Case Study – Mrs Taylor (cont)]

- Some improvement but continued to have difficulty with daily living tasks
- Considered residential care, but preferred not
- Referred for and accepted to TC

[Case Study – Mrs Taylor (cont)]

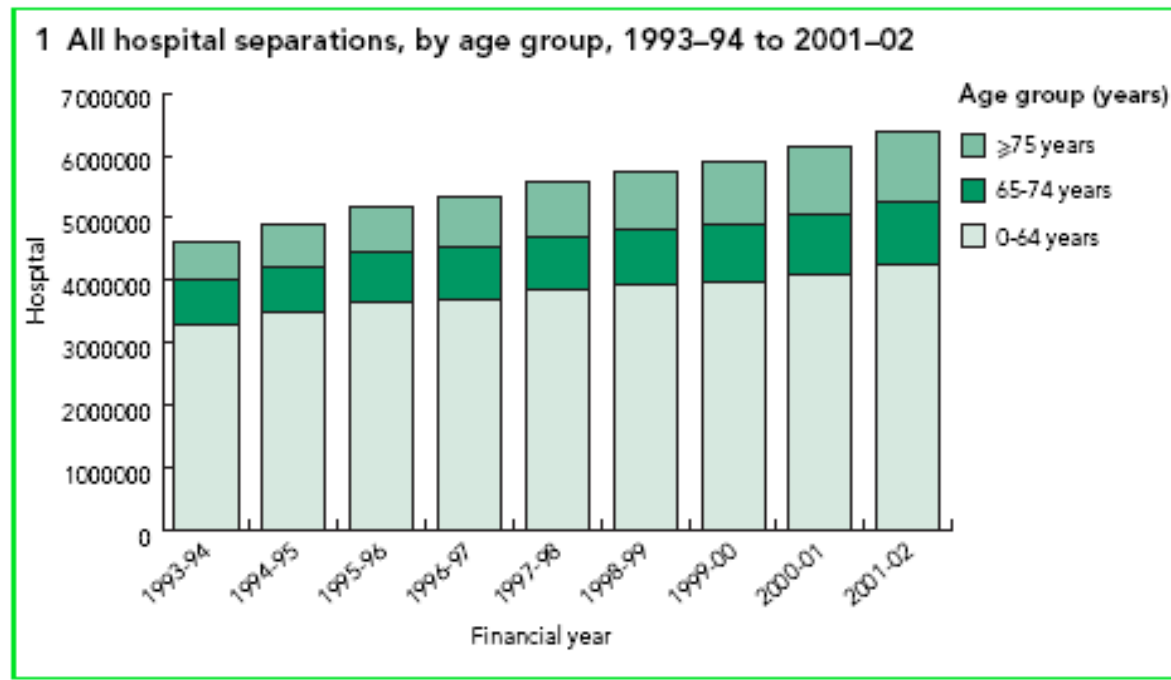
- Some improvement but continued to have difficulty with daily living tasks
- Considered residential care, but preferred not
- Referred for and accepted to TC
- Supported effectively by TC (personal care and restorative / rehab program)
- Still fatigued and frail
- Decided to move to low care residential aged care


TC worked well

Background – Older people as hospital users

Trends in the use of hospital beds by older people in Australia:
1993–2002

Len C Gray, Margaret A Yeo and Stephen J Duckett



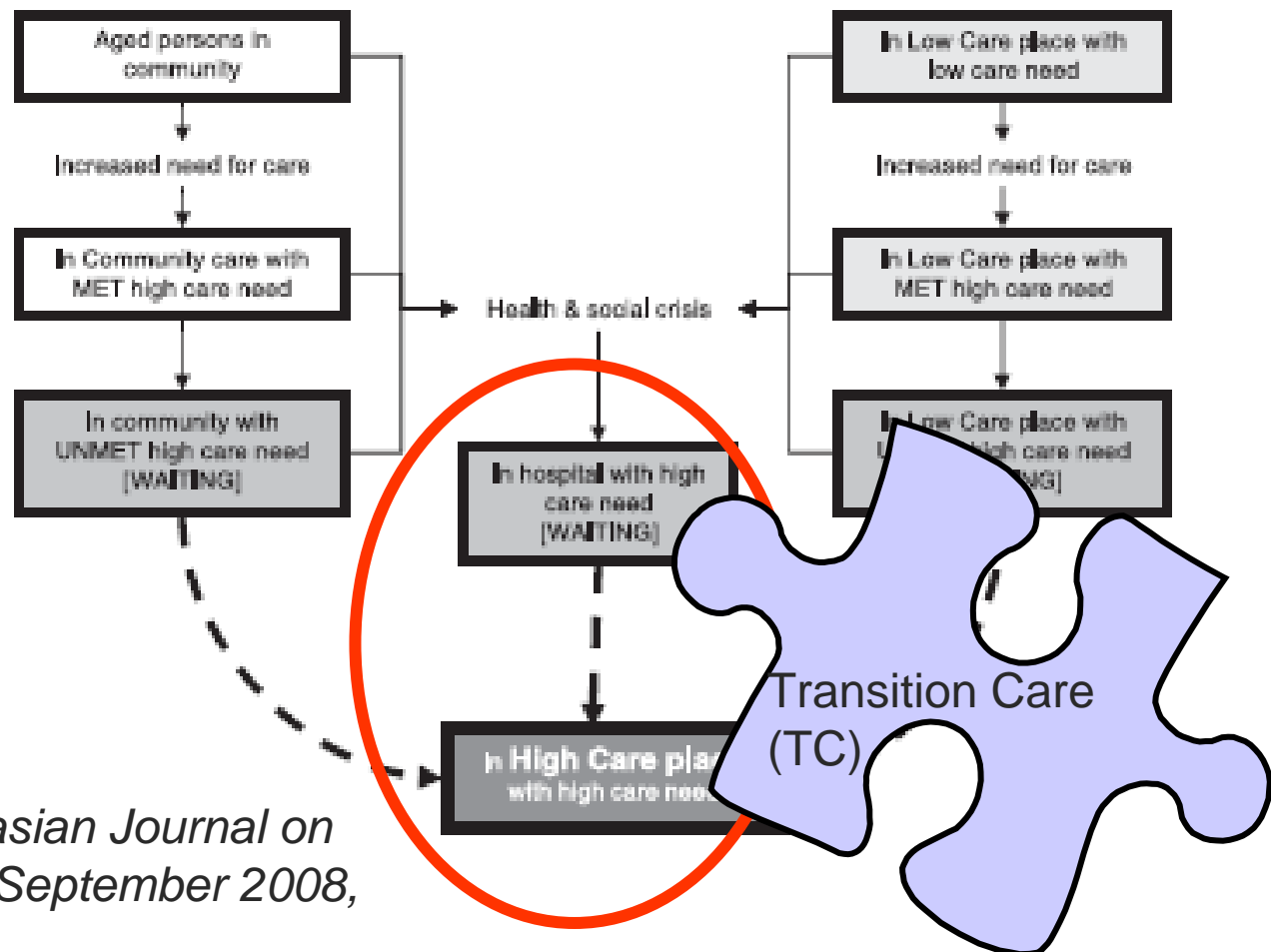
- 
- The most substantial changes were observed in the population aged 75 years and older
 - separations increasing by 89%
 - length of stay reducing by 35%
 - bed utilisation increasing by 23%
 - Rates of bed utilisation (in relation to population)
 - **declined** among older groups (10% decline in per capita use in population 75 years and older)
 - **increased** in the younger population (1% increase in per capita use in people younger than 65 years)

Gray et al MJA 2004; 181: 478–481

Exploring the dynamics of ‘bed blocking’ acute / aged interface

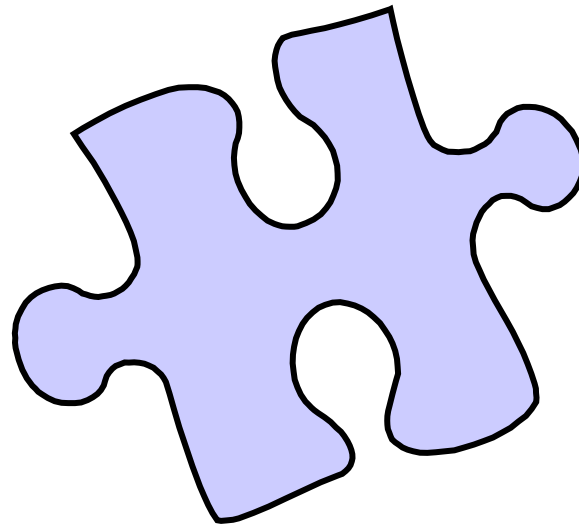
- “The hospital effectively becomes a safety net to accommodate people with high-care needs who cannot be admitted into RAC in a timely manner”

Figure 3: Conceptual framework for entry into permanent high-care Residential Aged Care.



What information do we have about the TC Program?

- Information from the Transition Care Research Program



Transition Care Audit (n=89) 2006 – soon after implementation

- Residential TC and Community TC very different
 - Residential TC lower admission Barthel Index
 - Residential TC much higher discharge to residential aged care
- “TCP is not homogeneous and is substituting for other forms of treatment and care
 - high level residential care as a substitute for waiting for residential aged care in a hospital bed, and
 - community rehabilitation as a substitute for rehabilitation services provided by state health departments.”

Transition Care Audit 2007 (n=395)

- There are differences between different TC services
 - residential vs community based
 - dedicated unit vs individual beds in RACFs
 - metro vs regional / remote
 - access from acute, rehab & private
- There are differences over time within individual TCP services

[TC – where it was in early 2008]

- Evidence of effectiveness of TC still unclear
- TC is expensive (about \$11,000 per episode) - need to compare cost-effectiveness with other programs, eg inpatient subacute services
- TC should be established within the context of overall regional plans for aged care, incorporating
 - hospital acute and subacute inpatient services
 - long-term community and residential care programs

National Transition Care Evaluation – September 2008

- At the individual level positive outcomes were achieved
- Transition Care was valued by patients and carers
- Configured very differently across jurisdictions
- Those who received Transition Care had fewer readmissions to hospital and were less likely to move into permanent residential aged care

National Transition Care Evaluation – 2008

- Interface between Transition Care and hospital rehabilitation services to be clarified
 - Access to rehabilitation and geriatric beds in a region influenced recipient selection
 - In many regions the TC appeared to be fulfilling the traditional role of rehabilitation services. These programs seem less efficient than conventional rehabilitation particularly when providing a substitute for GEM type wards

National Transition Care Evaluation – 2008

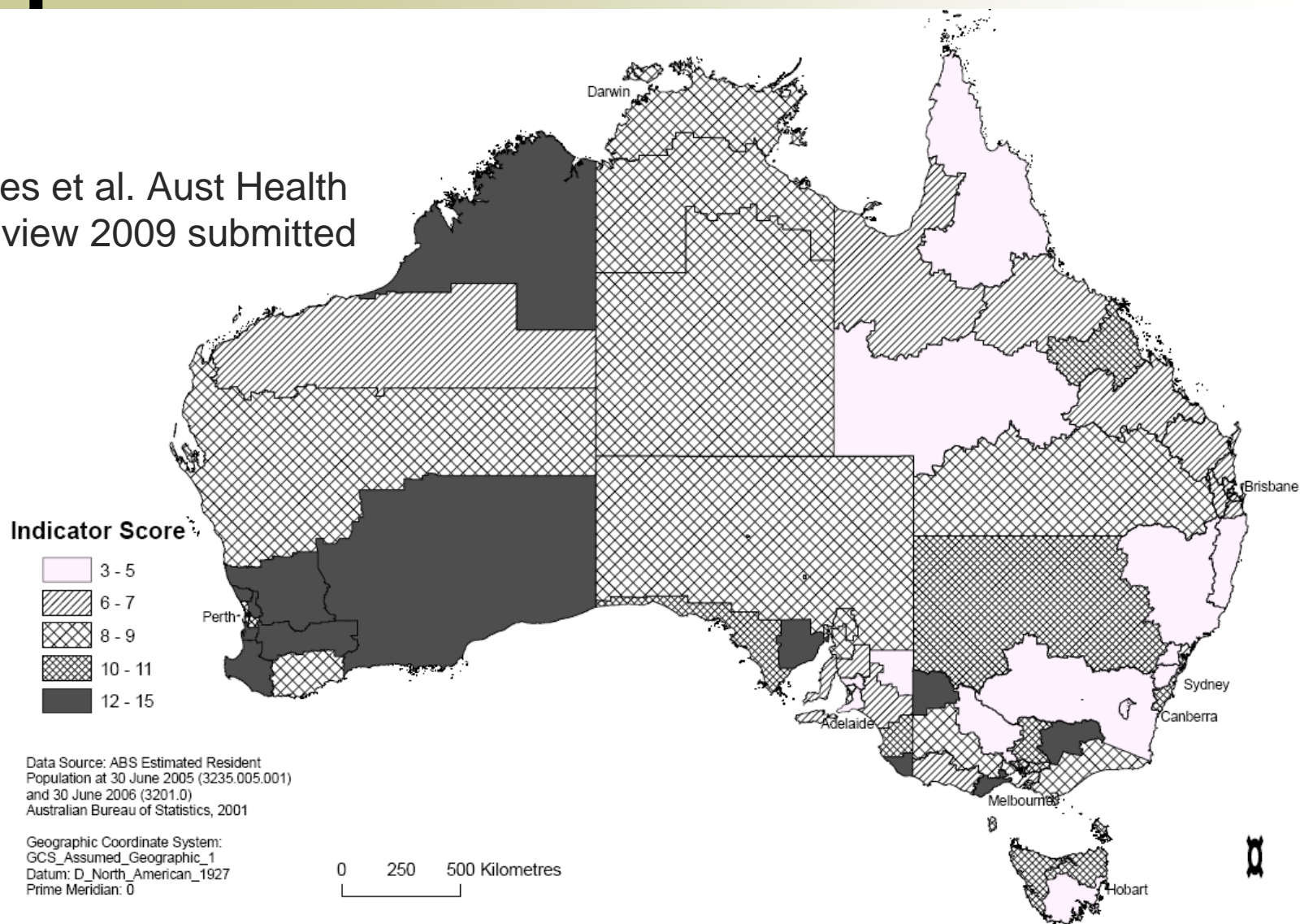
- TC is not low cost
- Achieved at a comparatively high cost
- for every day a recipient of Transition Care survives without institutional care cost is \$344 (over 6 months)

National Transition Care Evaluation – 2008

- Transition Care provided in a residential-based setting alone did not appear to prevent transfer to residential aged care
- Note health context where older people across Australia have widely variable access to rehabilitation and geriatric hospital beds
- Transition Care provided in a residential-based setting requires more evaluation
 - to clarify which groups will benefit
 - to explore whether this care should be delivered to a minimum number of co-located recipients
 - to identify minimum staffing levels and quality measures
 - note provision of residential TC is significantly more costly

Figure 1: Composite indicator of acute, sub acute and aged care places per 1,000 older people

Giles et al. Aust Health Review 2009 submitted



National Transition Care Evaluation – 2008

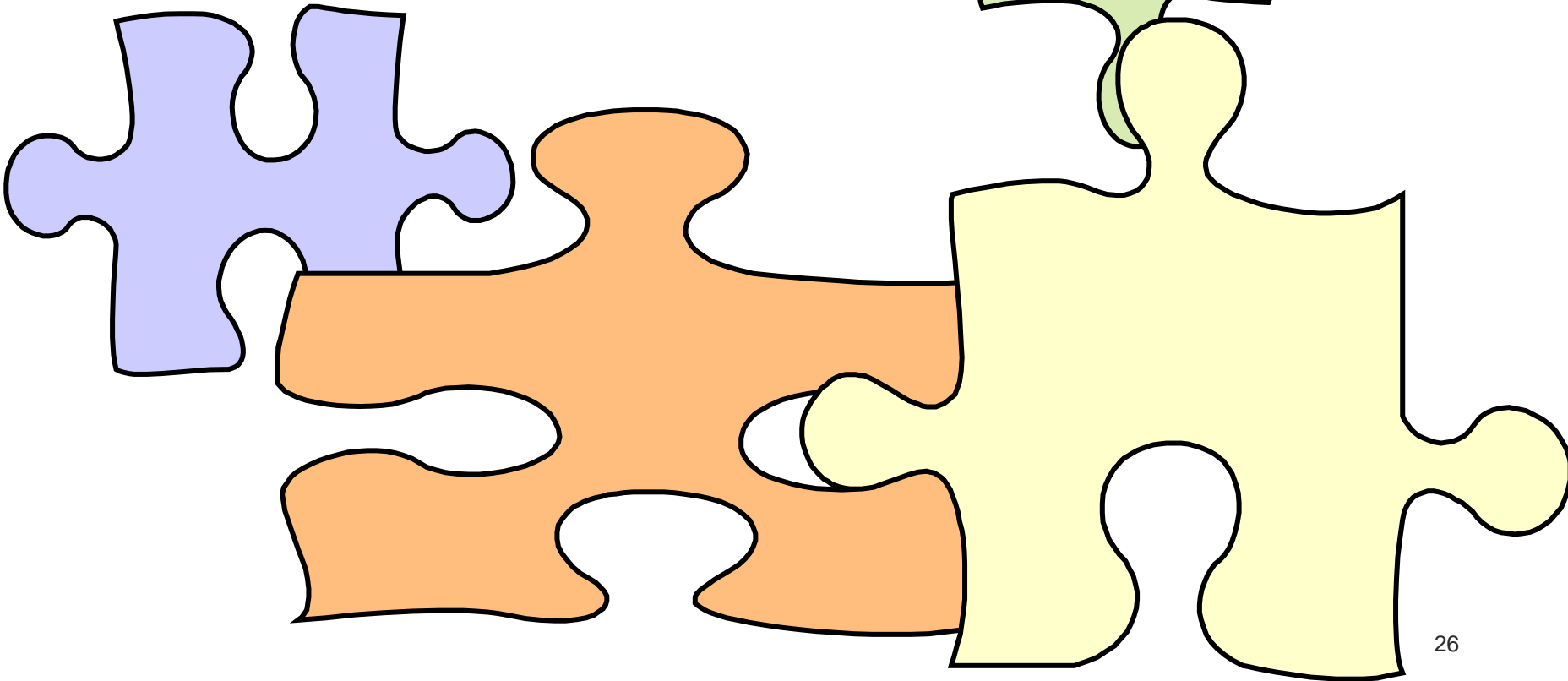
- TC struggled with the interface with acute care (communication and support)
- Priority should be given to areas of service need including rural areas
- Broader range of interventions and models of TC should be considered
 - Dementia
 - End of life care (20% deceased by 6 months)

Intermediate Care – United Kingdom

- “twin objectives of avoiding inappropriate hospital admissions and inappropriate bed occupancy”
- enormous diversity both in how intermediate care was conceived and implemented locally.
- evaluation has underlined the importance of intermediate care being seen as a set of bridges at key points of **transition** in the person’s journey from hospital to home (and vice versa) and from illness/injury to ‘recovery’.



- Questions / Comments



[Case Study – Mrs Trent]

- 76 yo married
- Lived with husband
- Had chronic illness requiring complex surgery and prolonged recovery
- No use of community services
- Had elective surgery in major hospital
- Transferred to rehabilitation ward
- Mobilised gradually and improved self care

[Case Study – Mrs Trent (cont)]

- Transferred to TC residential service due to delayed follow-up from surgery
- Client and husband unhappy with care – “staff were so thin on the ground ... it was hard to get anyone to see to her needs”
- Slipped and fell when transferring to the commode
- Ankle fracture
- Surgical fixation of fracture
- Pneumonia
- Died

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- Died

- Inquiry due to death as a result of hospitalisation
- Ministerial complaint

TC did not work well

- ? Inability to provide the level of care required
- ? Equipment / facility inadequate
- ? Selection / liaison issues

Case Study – Mr Smith

- 89 yo widower
- Previously living independently with support from daughter
- Some cognitive problems
- Fall, fractured arm
- Persistent delirium in hospital
- TC to allow
 - time for resolution of delirium
 - improve function
 - assess potential for return home
- Persistent agitation in secure area of residential TC - recurrently trying to leave
- Trial leave to open low care facility in rural setting, close to family
- Wandered off on the first night.
- Now placed in secure dementia unit
- Family not happy initially
 - "too good" compared to other residents

TC provided time to work things out – raises issue of dementia in TC

Issues for development – from National Evaluation

- Uncertainty around the effectiveness and resource implications of model configurations and delivery approaches
 - no information on the impact on costs of different governance and brokerage arrangements
 - detailed economic analysis of differing models of delivery (e.g. voucher system versus conventional TC)

Issues for development – from National Evaluation

- Modelling to explore the functional status shifts per week
- Exploration of ideal lengths of stay – can the episode be shorter without losing the effect?
- Very little information available on the differences in the approach to implementation which occurred in each state

Transition Care: Innovation and Evidence Research Program

- **Projects in progress:**
- Frailty as an indicator of “transition”
 - Randomised trial of a ‘treatment’ for frailty
 - Carer study – frailty and carer strain
 - Participation study – community
- Decision making for residential and community care
 - Randomised trial of 2 forms of information provision and participant / carer liaison
 - Analysis of preferred components of TC
- TC quality indicator development



Other relevant developments
influencing TC

A HEALTHIER FUTURE FOR ALL AUSTRALIANS

INTERIM REPORT OF THE NATIONAL HEALTH
AND HOSPITALS REFORM COMMISSION

SUMMARY

-
- Complete the “missing link” of sub-acute services
- Expand choices for care and accommodation in aged care
-

Connecting care

Comprehensive care for people over their lifetime

Strengthen and integrate primary health care through:

Commonwealth responsible for all primary health care

New Comprehensive Primary Health Care Centres

Voluntary enrolment for young families and complex and chronic patients with primary health care services (including general practice)

Personal electronic health record

Invest in a healthy start to life from before conception through the early years

Reshape hospital roles for emergency and planned care and fund accordingly

Complete the 'missing link' of sub-acute services

Hospitals – National Access Guarantees and Targets

Expand choices for care and accommodation in aged care

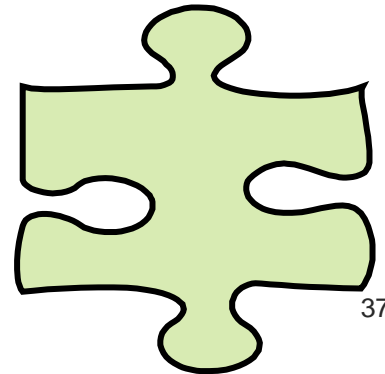
Improved palliative care and advanced care planning



■ COAG (Council of Australian Government)

-
- older Australians receive high-quality, affordable health and aged care services that are appropriate to their needs and enable choice and seamless, timely transitions within and across sectors;
-

- COAG (Council of Australian Government)
 - Additional Commonwealth funding of \$500 million in 2008-09 will provide the equivalent of an extra 1,600 sub-acute care beds (an increase in capacity of five per cent per year over four years) This will enable many older people to leave hospital and help free up hospital beds.
 - Plus other “additional [hospital] throughput” measures



Principles for provision of aged care services

- What would we want?
 - Ageing in place
 - User pays
 - Robust safety net
 - Flexible accessible TC
 -
 - One level of government administering health
 -

Future evaluation and research agenda for TC

- Efficacy / effectiveness study of TC in Australia
 - Currently can't be done
 - It should be done
 - Key questions are:
 - Effectiveness compared to the alternatives eg subacute or community care
 - Cost effectiveness

Future evaluation and research agenda for TC

- Quality indicators
- Variability of TC across Australia
- Waiting times / occupancy
- Barthel changes / readmissions / deaths
- Costs

- Fewer older people waiting in hospital?
- Reduction in demand for RACF?

- COAG 1,600 subacute bed effects

Transition Care Form 2009

Tuesday 24 November,
Canberra

Immediately prior to
Australian Association of
Gerontology Annual
Meeting

Professor Stuart Parker -
Professor of Health Care
United Kingdom

ABSTRACTS INVITED

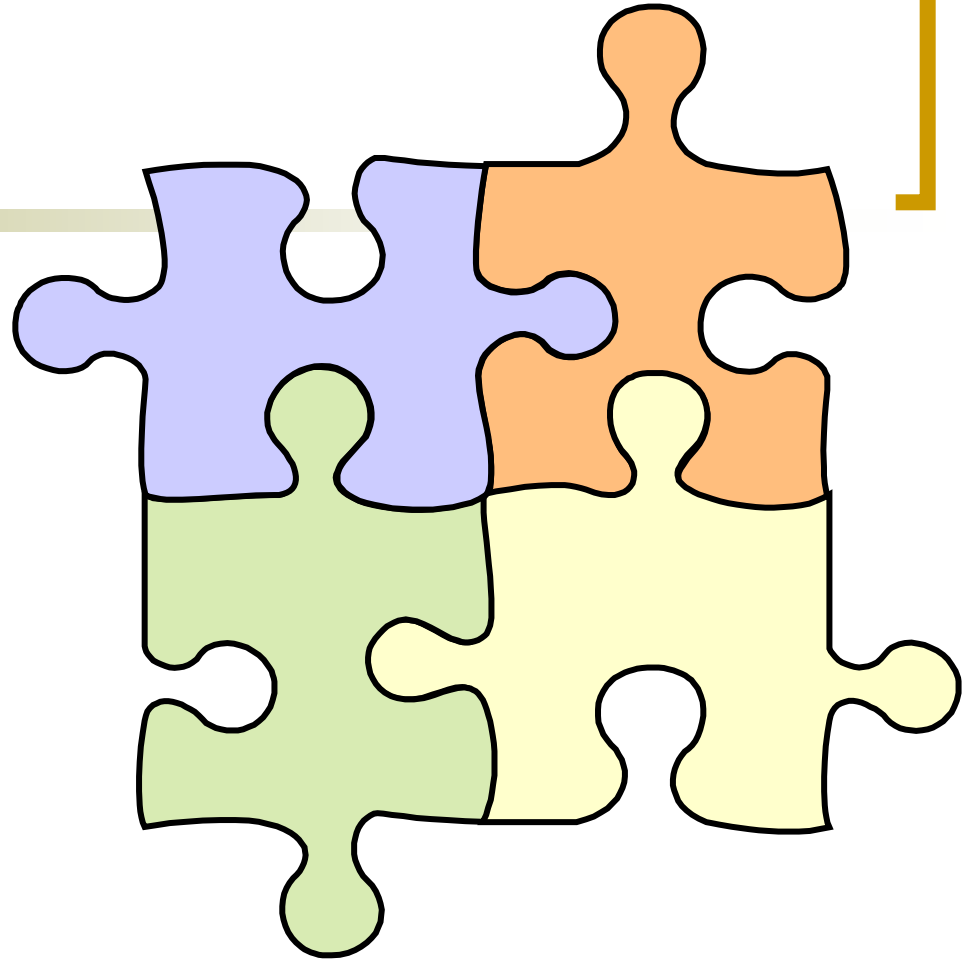
- Transition Care Australia 2009/2010
- Aged Care Providers Perspectives
- Australian Government Policy Development
- Consumer Perspectives on Transition Care
- State Reports on Transition Care
- National Report on Transition Care
- Health Economic Issues
- Models of Transition Care – Comparative Effectiveness
- Intermediate Care – Implications for Australia

[Questions]

Transition Care Form 2009

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- Ian Cameron, ianc@mail.usyd.edu.au
- <http://www.rehab.med.usyd.edu.au/tie/>