KEY MESSAGES

ANALYSING SUB-ACUTE AND PRIMARY HEALTH CARE INTERFACES: Research in the Elderly (The ASPIRE Study)

July 2015

Strivens E, Harvey D, Foster M, Quigley R, Wilson M.

Policy context

For older patients and their carers, the health care system is often confusing and difficult to navigate with services poorly coordinated between and across different levels and locations of care. There is also an increased risk of functional deterioration, frequent presentations to hospital and emergency services and readmissions. The Geriatric Evaluation and Management (GEM) model of care promotes a multidisciplinary, coordinated solution in a sub-acute setting and is designed to enhance system interfaces to facilitate improved care transitions and outcomes. A longitudinal case study design incorporating multiple methods was used to examine care transitions of older patients who transfer to hospital from the community into sub-acute care and return home. The aim was to examine the experiences and impacts of the GEM service and factors influencing care transitions.

Key messages

Potential tipping points for subsequent care transitions and underutilised early intervention opportunities occur across the system, though these are complicated by unpredictable health trajectories of older people and a dispersal of responsibility across multiple providers, services and sectors. The Emergency Department is a tipping point for subsequent care transitions and an opportunity for enhanced in-reach and out-reach strategies to improve care transitions.

Inpatient sub-acute care is a critical touch point for coordinated, timely transition to community based on patient needs, not system pressures. Yet, patients' and carers' sub-acute care experiences and discharge preparedness impact how transitions and system interactions evolve after discharge.

Patients trusted their GPs but perceived them to have a peripheral role in care transitions. For providers, GPs had a central coordination and monitoring role which was inhibited by a complex and changeable system, no referral reference point and poor information linkages. Patients' help-seeking, carer involvement and confidence were complicating factors in care transitions.

Periodic comprehensive assessment is warranted across the system for early detection of treatable causes of disability and to facilitate timely access to GEMS.

Systemised in-reach and out-reach at sub-acute/primary care interfaces is required to enhance coordinated discharge and successful care transitions.

Resourcing Primary Health Networks to administer a program of case management of identified cases in primary care is another key consideration.

Evaluation of established navigator roles to support patients and carers to proactively manage care transitions and identify referral and access points will enhance care transitions.

The research reported in this paper is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Australian Government Department of Health under the Primary Health Care Research, Evaluation and Development Strategy. The information and opinions contained in it do not necessarily reflect the views or policies of the Australian Government Department of Health.