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JAMES COOK UNIVERSITY AUSTRALIA

POLICY OPTIONS

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

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

Policy context

In 2009 the National Health and Hospital Reform Commission recommended major changes to the way health services are delivered in Australia to ensure appropriate and timely care in the most appropriate setting for patients with complex needs. Of central interest are older people who present to the hospital Emergency Department (ED) with interrelated medical, functional and psychosocial issues and increased risk of functional deterioration, readmissions and unplanned institutional care. In 2010 the Australian Government invested substantially in more sub-acute beds and spread of Geriatric Evaluation and Management (GEM) models of care, with the goal of ensuring appropriate use of resources and optimising care transitions and health outcomes for this population. To deliver on this policy objective also requires locating and reconciling interface difficulties within and across acute, sub-acute and primary care transitions. This report contributes to this agenda with a study on care transitions of older people and options for localised practice and policy strategies to enhance system interfaces and to achieve quality coordinated care transitions for older people who present to a hospital ED.

Policy options

By examining care transitions of community dwelling older people across acute, sub-acute and primary care from patient, carer and service provider perspectives, this study exposes important patient and system interface issues that potentially facilitate and hinder quality care transitions. From the synthesis of findings a number of key messages are derived which incorporate options for consideration and integration into policy and practice. These relate to:

- Embed early intervention and prevention through improved screening, assessment, care coordination and formalised in-reach and out-reach linkages
    - Periodic comprehensive assessment and screening for treatable causes of disability in primary and acute care, including ED.
    - Resource Primary Health Networks to administer a program of case management of identified cases in primary care.
    - Comprehensive assessment and targeted interventions to prevent premature disability including greater access to GEMS in community and hospital.
    - Systemized in-reach and out-reach between sub-acute and primary care for coordinated discharge and care planning (increased coordination led by Primary Health Networks).

- Strengthen system interfaces by building on existing programs
    - Revise the Australian Health Minister's Advisory Council Guide to Assessing Older People in Hospitals 2004 to include comprehensive assessment linked to management and intervention plans and create capacity via workforce education in case identification and intervention pathways.
    - Broaden Medicare item numbers 721 and 723 for discharge planning meetings to include public patients including use of telehealth and remote technology.
    - Broaden the scope of the Transition Care Program beyond hospital based discharge planning to extend access in the community via GPs.

- Enhance care transition experiences and outcomes for patients and carers through stronger inclusive practices and educative and self-help initiatives
    - Targeted, transparent and meaningful involvement of carers and patients in discharge planning including Care Transition Coaching in sub-acute care.
    - Navigator roles in primary, acute and sub-acute settings to assist patients, carers and providers to proactively manage transitions in care and identify referral and access options. These could be new roles or incorporated into existing roles e.g. Nurse Navigators, General Practice Liaison Officers, Practice Nurses.

- Build research capacity in the area of care transitions
    - Longitudinal research to accurately identify health transition trigger points, system responsiveness and the factors that improve care transitions and health outcomes for patients and enhance appropriate use of resources across the system.

Key findings

In this study, a care transition is defined as movement to a different location or level of care, and includes both intra-organisational, such as hospital transitions from an acute unit to sub-acute care and inter-organisational transitions such as a transition from sub-acute care to home. Across the patient and carer case studies as a whole, three categories of care transition experience were identified: disrupted, manageable and emergent. The categories are not mutually exclusive or fixed. Older people can cycle through these experiences in their journey across acute, sub-acute and primary care due to variations in health status, system responses, local care arrangements and temporal factors. Each category comprises notions of care transitions (movements), needs (unmet or otherwise) and access and interactions with services. From a provider perspective, four main themes characterised care transitions: unpredictable, dislocating transitions; weakly connected agents of care; pivotal touch points and discretionary and emergent practices. Key findings based on a synthesis of all the findings include:

- There are potential discernible but undetected tipping points associated with patients' health transitions which impact care transitions. For example, patients spoke about reaching a threshold, which signalled something had to change. This was compounded by the lack of systemized linkages within and between locations and levels of care, which in turn meant underutilised opportunities for early intervention across the system.
- From the provider perspective, it was not uncommon to see a pattern of fluctuating needs and recovery, punctuated at times by a sudden escalation in care needs, which went undetected until a crisis, despite in some cases having routine interaction with services.

- ED is a discernable ‘tipping’ point and a critical interface to strengthen an aged care focus and early intervention with capacity to identify ‘red flags’ and instigate appropriate risk management, identify appropriate linkages and referral pathways.
- Patients, carers and providers differ in their views of the GP in care transitions. Most patients identify with a regular GP and report a trust relationship, but many also see the GP’s role primarily for episodic monitoring and other minor or non-urgent matters that occur during the week. According to patients GPs were peripheral to their acute and sub-acute care transitions.
- GPs are a significant but underutilised resource for coordinated care transitions according to providers. This is related to a multiplicity of factors including: inadequate, arduous and/or delayed information linkages across the system, a complex and unstable service landscape, the lack of a central reference point for referrals, and varying capacities, resources and pressures related to general practice.
- The Older Persons Evaluation and Rehabilitation Assessment (OPERA) service represents an optimal touch point for patients, carers and providers. For patients and carers there was a perceived alignment with their goal to return home, holistic care processes, and expectations of recovery. For providers, OPERA offers more holistic care and through the Transitional Care Program (TCP) provided a bridge between multiple providers across various locations and services.
- On the other hand, disruptive discharges from OPERA did occur mainly due to communication breakdown and system pressures and in some cases patients and carers were disillusioned upon returning home due to inflexible or changed service arrangements. Restrictions on TCP access and follow-up time were also highlighted as potential impediments to strengthening the acute, sub-acute and primary care interfaces.
- Collectively, these findings highlight a further issue: that of the fluctuating but potentially identifiable risk gradient across the system which warrants practice and policy attention. At the patient level clinical and social risk, including unpredictable health trajectories, fluctuating needs, and help seeking behaviours. For example, some patients prefer a ‘wait and see’ approach and to use ED when in crisis.
- At the system level, there are risks associated with ill-defined care and referral pathways for older people who present to ED from the community; fragmented information exchanges and weak provider connectivity across the system; access delays and gaps in follow-up; and the instability of the service system.
- Inevitably, managing the risk gradient to achieve quality coordinated care transitions involves multi-component policy and practice strategies to ensure the appropriate care, at the appropriate time and in the appropriate location.

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