Transition care: will it deliver?

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ABSTRACT

- Transition care is a new program to Australia that is designed to facilitate transitions of frail older people between the hospital and aged care systems.
- This program is designed to deliver potentially important improvements to the Australian health care system — but will it deliver?
- The current evidence base regarding the efficacy of this type of program is mixed, and there is little evidence to indicate improved patient outcomes.
- An average transition care episode is expensive (about $11 000). Therefore, careful consideration of the relative cost-effectiveness compared with other interface programs such as inpatient subacute services is essential.
- Transition care services should be established within the context of overall regional plans for aged care, incorporating hospital acute and subacute inpatient services, and long-term community and residential care programs.

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The Transition Care Program was announced by the Australian Government in 2004,[1] and at 30 June 2007, 2000 places had been allocated across Australia, with 1594 of those operational.[2] (A "place" is the community equivalent of a hospital "bed".) When all places are fully operational and occupied (anticipated to be in 2008), the projected annual operating budget will be about $150 million. Transition care is a priority area of the National Action Plan 2004–2008 for improving the care of older people across the acute–aged care continuum, and is informed by earlier initiatives within the Aged Care Innovative Pool scheme.[3]

Given the significant investment in the program and the undeniable importance of the program's objectives, it is imperative that future decisions regarding the program and the overall allocation of health dollars are determined on the basis of sound evidence. In particular, investment in the program should not come at the expense of other programs that support older Australians, such as rehabilitation and inpatient geriatric units, residential care places or conventional community care programs.

What is transition care?

Transition care is provided at the conclusion of an inpatient hospital episode and involves short-term (up to 12 weeks) support and active management for older people who require additional time and assistance to complete the restorative process, optimise functional capacity and finalise longer term care arrangements.[4]

Assessment and approval from an Aged Care Assessment Team is required for entry. Services are designed to improve patients' physical, cognitive and psychosocial functioning, thereby improving capacity for independent living, and may include medical and nursing support, rehabilitative services, personal care and case management (including identification of longer term care options). The program is offered predominantly in the community, but also in selected residential aged care facilities.

Transition care is jointly funded and developed by the Australian Government in partnership with the state and territory governments and, as such, represents a unique example of the two levels of government working collaboratively to improve coordination and integration at the acute–aged care interface. The state governments' financial contribution generally equals that of the Commonwealth, although there is some variation. Additional funding is derived from means-tested user co-contributions.

The stated key goals of the program include both patient-oriented and health system objectives:

- to optimise patients' functional capacity,
- to ease transitions at the nexus between the hospital and aged care sector through improved service integration, and
- to minimise inappropriate extended hospital stays and avoid premature admission to residential care.[4]

Transition care commenced in some regions in 2005. When all 2000 places are fully operational, it is estimated that the program will admit up to 13 000 older Australians annually.[5]

What is the evidence that transition care works?

Although transition care is generally considered to be a concept new to Australia, a wide range of services designed to bridge the gap between the hospital and home have previously been trialled (described variously as transition care, intermediate care, subacute care, early supported discharge and rehabilitation programs). The evidence regarding the efficacy of such approaches is mixed, and it remains unclear whether such approaches positively influence clinical or other outcomes.[6,7] The marked variation in the format of services, the considerable variation in intervention goals, objectives and place and mode of service delivery, together with heterogeneous outcome measures, have precluded a definitive answer.

A systematic review of the international literature determined that most of the evidence for "intermediate care" relates to interventions to support or facilitate discharge from inpatient hospital care.[6] (Intermediate care is a United Kingdom program that incorporates a range of services surrounding hospital care, including admission prevention and postacute care.) It was concluded that the effectiveness of such schemes largely depends on the broader service context and that the availability of community services (eg, residential care beds) can markedly influence the capacity of acute units to discharge older patients. The evidence indicates that such services have a variable effect on length of inpatient stay and are not generally associated with improved health status. Large cost savings have not been demonstrated for intermediate care, and few studies adequately addressed the issues of patients' quality of life, or costs to providers, patients and their families.

The results of Australian trials have similarly failed to allow definitive conclusions to be made regarding the efficacy of transitional programs, as some (but not all) programs have demon-

strated positive results, including improvements in patients' quality of life and cost savings.[8,9] Likely reasons for this include variability in patient characteristics, the outcome measures used and the type of intervention trialled. There is some evidence that such heterogeneity also exists within the current transition care program, limiting the ability to interpret the outcomes.[10]

A forerunner to the Transition Care Program — the Innovative Care Rehabilitation Services Pilot Program — was implemented across Australia in 2001–2002. Evaluators reported that overall the initiative resulted in positive outcomes for participants, with most realising substantial improvements in physical functioning and most achieving a successful outcome, defined either as returning to live in their community or to a lower level of residential care.[7] In addition, cost savings attributable to the program were estimated to be around $4.7 million dollars. Although these results appear impressive, the methods used were not robust. In particular, there was no comparison group. Further, the estimated cost saving was not based on actual expenditure, but on the rather bold assumption that people admitted to the program would otherwise have been admitted to residential care.

Gaps in the existing knowledge base

Thus, considerable uncertainty exists as to whether transitional care programs improve clinical or other important outcomes. Clearly, there is a need for well designed research to formally evaluate the effect of the program on patients, their carers and the broader health care system to make more fully informed decisions regarding the future provision of such services. Although carefully constructed randomised trials are required to rigorously test the outcomes, the transition care program has already been widely implemented and thus the opportunity to conduct a rigorous controlled evaluation may be forgone. The current national evaluation is observational in design and will permit only limited conclusions regarding the program's efficacy.

In our view, there are two key research areas that should be addressed as a matter of priority. The first concerns patient outcomes: does transition care promote accelerated recovery from newly acquired disability compared with traditional approaches (including inpatient subacute and day-hospital programs), and is such recovery sustained over the medium or longer term? And if there are no measurable clinical improvements, does the program influence the patients' quality of life through the provision of additional support services during the transition period?

The second issue concerns the potential of the program to enhance service efficiency and its effect on other sectors within the health and welfare systems. A stated program aim is to reduce "inappropriate extended hospital admissions", although there is only limited evidence to suggest that such an outcome might be achieved within the Australian context.[8,9] Although desirable from the hospitals' short-term perspective, length-of-stay reductions may be associated with adverse outcomes such as increased patient and carer morbidity and dissatisfaction, increased consumption of community services, greater admission rates to nursing home care, and higher hospital readmission rates. A "whole-of-system" perspective is required when assessing the efficacy of the transition care program.

Total system costs also require consideration. Investment in transition care represents an opportunity cost, deflecting funds from alternative programs. Our crude estimates show the estimated annual cost of transition care at $150 million to be equivalent to:

- around 400 acute hospital beds at $1000 per day, or
- 850 subacute beds at $500 per day, or
- 2100 permanent residential care places at $200 per day.

If one episode of transition care in the community setting costs around $11 200 (56 days at $200 per day), a reduction in the acute care length of stay of around 28 days per patient is required (assuming the average cost of the final days of hospital care to be $400) to break even. Although these cost illustrations are crude, they highlight the importance of carefully evaluating the cost of the program in relation to outcomes.

A particular concern is that transition care may deflect attention from other key programs, including subacute hospital geriatric assessment and rehabilitation services.[11] The sound evidence base for their efficacy in improving patients' functional status and reducing hospital discharge rates to residential care, coupled with the uncertainty that out-of-hospital programs are an effective alternative, suggests that redressing the inadequate provision of these services in some regions should take priority over transition care programs. Also of concern is the method of allocation of transition care places, which in some regions has been on a population basis without apparent consideration of the existing supply of aged care services, which would have been a more judicious approach.

In conclusion, although the transition care program has the potential to improve the care of frail older people at the acute–aged care interface, implementation should be evidence-based and the provision of existing aged care resources should be considered before the allocation of transition care places.

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Competing interests

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