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POLICY BRIEF

Enhancing Care Transitions for Older Adults

WHAT IS THE PROBLEM?

Many older adults face transitions between care settings, such as when discharged from hospitals, moving into care homes, or seeking emergency care. These transitions can lead to negative health and care quality outcomes and should be prevented or optimized when possible. Care transitions should ideally be based on older adults' preferences and needs. They should involve person-centered communication, comprehensive planning, and collaboration among relevant parties to ensure seamless transitions and maximize well-being. Unfortunately, coordination across care settings is often lacking, causing fragmented care, service duplication, and high costs. This is intensified by a silo mentality among healthcare workers and a policy focus on specific settings rather than the quality of care during transitions. The EU faces three main challenges: increasing demand for long-term care, fewer informal caregivers, and rising pressure on care standards.

WHAT ARE POTENTIAL SOLUTIONS TO ADDRESS THE PROBLEM?

Addressing challenges in care transitions for older adults involves a multifaceted approach, with tailored protocols, standardized tools, and empowerment strategies to improve the overall quality of care. These solutions encompass various aspects of care transitions, from triage services and decision-making harmonization to the implementation of innovative care models. Potential solutions emanating from the work of our ESRs are:

- Making Person-Centered Care the cornerstone of care transition reform.
- Empowering older adults and their informal caregivers, a critical condition for success.
- Integrating care models, to significantly improve care coordination.
- Successfully implementing transitional care innovations through tailored strategies that involve organizations, stakeholders, and interdisciplinary collaboration.
- Establishing standardized quality-monitoring systems to bridge the gap between different care settings.

WHAT ARE SOME IMPLEMENTATION FACTORS THAT WE NEED TO CONSIDER?

When implementing solutions to improve care transitions, it is essential to consider factors such as collaboration, legislation, resource allocation, and contextual adaptation. These implementation considerations ensure that the proposed solutions are not only effective but also feasible and sustainable within the diverse healthcare landscape, fostering transparency, accountability, and quality care for older adults. Some implementation considerations that emerged from this work are:

- Adapting implementation strategies to the local context and healthcare setting.
- Collaborating with a range of stakeholders, including healthcare professionals, policymakers, and patients.
- Enacting appropriate legislation provides the legal framework necessary to support the standardization of care transition tools and guidelines.
- Allocating sufficient financial and human resources to research, training, and the implementation of care transition models.
- Providing comprehensive training and ongoing support to healthcare professionals
- Establishing mechanisms for continuous monitoring and evaluation.
- Promoting effective communication and collaboration among stakeholders.

PROBLEM AND BACKGROUND

Many older adults face transitions between care settings (e.g. at discharge from hospitals or other inpatient care organisations, when moving into a care home, or when seeking emergency care). Care transitions come with a risk of negative health and quality of care consequences, and should be avoided or optimised when possible. This requires capacity building on the interface of science, policy and care innovation. The need to improve care for an increasing number of care-dependent older adults by avoiding unnecessary transitions and optimising care transitions that are actually needed represents a major challenge facing European long-term care systems. Society ages and ghere is an increasing need for long-term care. **Three main challenges for the EU are expected**:

- not all newly won life years are spent in good health and the need for long-term care (LTC) will increase.
- though more needed than ever, the availability of informal caregivers decreases.
- growing demands for professional care will stress care standards.

Given these challenges, investing in evidence-based long-term care is crucial. Long-term care covers a continuum of services in different settings including support for self-management, home care, household assistance, respite care, sheltered living, and residential care. It implies care over longer periods, typically for a care-dependent older population.

Due to illness or increased dependency, older adults may have to receive care in different care settings over time. A care transition occurs when a person moves from one care setting to another. Ideally, the need for a care transition is critically considered in relation to older adults' preferences, needs, context, and any potential risks and benefits. When transitions cannot be avoided, person-centred communication, adequate planning, and involving all relevant parties, should enable seamless care transitions and maximal health and well-being benefits. Unfortunately, care across settings is often not well coordinated. As a result, older adults are at risk of receiving fragmented care and poorly executed care transitions, resulting in duplication of services, gaps in information delivery, inappropriate or conflicting care recommendations, harm (e.g. through medication errors, or increased confusion and distress), and high costs due to unnecessary hospitalisations, ED visits and other unnecessary use of services. Too often, health and social care workers apply a 'silo mentality' and operate without knowledge of the personal preferences expressed, problems addressed, services provided, or treatments prescribed in other settings. Also, policies and financing often focus on care in specific settings only, and neglect quality of care during transitions between these settings.

This policy brief addresses the urgent need to enhance care transitions for older adults across Europe. It consolidates findings and recommendations from a diverse group of Early Stage Researchers (ESRs) who have conducted extensive research on various aspects of care transitions, aiming to improve the quality of life and healthcare experiences for older adults and their caregivers. This brief offers a comprehensive approach to reforming care transitions, emphasizing the importance of person-centered care, integrated models, empowerment, and effective implementation strategies.

The ESRs were part of a TRANS-SENIOR project, funded by the European Union's Horizon 2020 research and innovation programme under the Marie Skłodowska-Curie grant agreement No 812656, to advance our understanding of healthcare transitions for older adults. Through rigorous research, the ESRs have examined various facets of care transitions, spanning telephone triage services, harmonizing decision-making, reablement, empowerment, transitional care innovations, the care triad experience, integrated care models, citizen panels, and performance assessments. Details regarding each project, related recommendations and associated references, in Appendix.

OVERARCHING POLICY RECOMMENDATIONS AND ACTIONS

Person-Centered Care as a Foundation (ESRs 1, 3, 8): Person-centered care, which tailors healthcare services to individual needs, preferences, and contexts, should be the cornerstone of care transition reform. Policymakers must prioritize person-centered approaches to ensure the well-being and satisfaction of older adults.

- **Action**: Develop and implement standardized protocols and tools for person-centered transition planning. Ensure that care transitions are necessary, and if they are, then they are tailored to individual needs and preferences.

Empowerment and Involvement (ESRs 4, 10, 11): Empowering older adults and their informal caregivers is critical. Policies should encourage shared decision-making, advanced care planning, and the inclusion of older adults and caregivers in policy development through citizen panels. This empowers them to have a voice in their care.

- **Action**: Establish policies that promote shared decision-making, advanced care planning, and the active involvement of older adults and caregivers in care transition decisions. Create mechanisms for ongoing feedback and input.

Integrated Care Models (ESRs 5, 9): Implementing integrated care models, such as reablement and the Transitional Care Model, can significantly improve care coordination. Policymakers should allocate resources, encourage collaboration among healthcare professionals, and adapt models to local contexts.

- **Action**: Encourage the adoption of integrated care models, such as reablement and the Transitional Care Model, by providing financial incentives, training healthcare professionals, and adapting models to local contexts.

Effective Implementation Strategies (ESRs 7, 13): Successful implementation of transitional care innovations requires tailored strategies that involve organizations, stakeholders, and interdisciplinary collaboration. Policymakers should support research and development efforts and monitor outcomes to ensure effectiveness.

- **Action**: Allocate resources for the effective implementation of transitional care innovations. Support interdisciplinary collaboration, data sharing, and ongoing evaluation to refine strategies.

Quality Monitoring (ESRs 7, 8, 12): Establish standardized quality-monitoring systems to bridge the gap between different care settings. This promotes accountability, enhances collaboration among care providers, and ensures older adults receive high-quality care.

- **Action**: Implement standardized quality-monitoring systems that span different care settings. Monitor and assess care transitions to ensure they meet established standards of quality and effectiveness.

IMPLEMENTATION CONSIDERATIONS

When implementing solutions to improve care transitions, it's essential to consider factors such as collaboration, legislation, resource allocation, and contextual adaptation. These implementation considerations ensure that the proposed solutions are not only effective but also feasible and sustainable within the diverse healthcare landscape, fostering transparency, accountability, and quality care for older adults and their caregivers.

It is important to note that most of the studies were conducted in one context, either a certain type of transition, or in a certain country/region, therefore implementation strategies and models need to be adapted to the local context and setting where they will be delivered. The unique needs and preferences of older adults and caregivers in different healthcare environments and countries must be taken into consideration.

Some **implementation considerations** that emerged from this work are:

Collaboration & stakeholder involvement

- Engage relevant stakeholders, including service providers, healthcare professionals, policymakers, and older adults and caregivers.
- Foster collaboration between organizations and governmental bodies to ensure effective implementation.

Legislation

- Develop appropriate legislation to support the implementation of standardized tools and guidelines, both locally and nationally.

Resource allocation

- Ensure financial grounds for the adoption and sustainability of uniform practice tools.
- Allocate sufficient financial resources to support research, training, and the implementation of care transition strategies.
- Ensure that funding is available for the development and refinement of transitional care innovations.

Training & Support

- Provide training and resources to healthcare professionals to build necessary competencies and skills for implementing care transition models.
- Offer guidance and support to organizations and care teams to facilitate the implementation of integrated care and person-centered care.
- Provide training and skill development to informal caregivers to support them in supporting the older adults in the care transition process

Monitoring & evaluation

- Establish mechanisms for monitoring and evaluating the impact of implemented strategies and innovations.
- Regularly assess the performance of long-term care systems using appropriate assessment tools.

Communication & collaboration

- Promote effective communication among older adults, informal caregivers, and healthcare professionals.
- Encourage collaboration between different providers and care settings to ensure a smooth transition process.

CONCLUSION

Enhancing care transitions for older adults is a multifaceted endeavor that demands a holistic and collaborative approach. By prioritizing person-centered care, empowerment, integrated care models, effective implementation, and quality monitoring, policymakers can create a more comprehensive and effective care transition framework. The integration of these recommendations will lead to improved healthcare experiences and a better quality of life for older adults across Europe, ultimately realizing the goal of seamless and high-quality care transitions.

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TRANS-SENIOR

Transitional Care Innovation in Senior Citizens

Funded by the European Union

SUMMARY OF EACH ESR'S PROJECT AND OVERARCHING RECOMMENDATIONS

PROJECT TITLE	BRIEF DESCRIPTION	POLICY RECOMMENDATIONS	ESR PAGE AND PUBLICATIONS
ESR 1: Harmonisation of decision-making on avoidability of care transitions	This project addresses the avoidability of care transitions and the need for a uniform practice tool. It discusses decision-making processes that influence care transitions	• Prioritize the creation of standardized tools and guidelines for determining the necessity of care transitions, promoting equity and transparency. • Develop appropriate legislation and work with relevant bodies to adopt and sustain a uniform practice tool for assessing the avoidability of care transitions.	https://www.trans-senior.eu/trans-senior-esrs/rustem-makhmutov
ESR 3: Reablement as usual care in the Netherlands	This project discusses reablement as a person-centered approach to support aging in place, which can have implications throughout the care transition process, from pre-transition to post-transition.	• Advocate for funding to research client-, family-, and organization-level outcomes of reablement and the working mechanisms of the I-MANAGE model of care. • Prioritize funding for research and implementation of reablement as part of their efforts to address the growing pressure on financial and workforce resources in long-term care.	https://www.trans-senior.eu/trans-senior-esrs/ines-mouchaers
ESR 4: Improving the accuracy of telephone triage services for older adults seeking non-urgent, out-of-hours unplanned care	This project focuses on improving the accuracy of telephone triage services for older adults seeking non-urgent, out-of-hours unplanned care. It addresses the initial point of contact and assessment before a care transition may occur.	• Healthcare authorities should collaborate with service providers to ensure that triage protocols are tailored to the specific needs of older adults, improving the accuracy of out-of-hours telephone triage services.	https://www.trans-senior.eu/trans-senior-esrs/farah-islam
ESR 5: Implementing a community-based integrated care model for home-dwelling older adults: lessons learned from the INSPIRE Project	The INSPIRE Project investigates implementing a community-based integrated care model for home-dwelling older adults. It relates to ongoing care and support provided after a transition.	• Support implementation science initiatives that are adapted to the context and setting for the development of a shared care planning and coordinating care for frail home-dwelling older adults in real-world settings.	https://www.trans-senior.eu/trans-senior-esrs/maria-jose-mendieta
ESR 7: Policy and practice: the experiences of the care triad during the transition from home to a nursing home	This project explores the experiences of the care triad of older person with dementia, informal caregivers, and healthcare professionals during the transition from home to a nursing home. It focuses on the experiences and challenges faced during the transition.	• Policymakers should work on policy measures to bridge the gap between different care settings, promote collaboration, reducing the gap between home care and residential care to create a continuous transition process and ensure a smooth transition experience.	https://www.trans-senior.eu/trans-senior-esrs/lindsay-groenvynck
ESR 8: Tri-national ethnographic multi-case study of person-centred practices on resident quality of life in long-term residential care (TRIANGLE)	The TRIANGLE project investigates person-centered care in long-term residential care settings. It covers various stages of the care transition process, with a focus on improving quality of life during and after the transition.	• Consider the context of care facilities and provide support for training and resources to ensure the effective implementation of person-centered care models.	https://www.trans-senior.eu/trans-senior-esrs/megan-davies

PROJECT TITLE	BRIEF DESCRIPTION	POLICY RECOMMENDATIONS	ESR PAGE AND PUBLICATIONS
ESR 9: Integrated Healthcare Delivery: implementing Transitional Care Model to improve outcomes for older patients with multimorbidity	This project focuses on integrated healthcare delivery, particularly transitional care models, to improve outcomes for older patients with multimorbidity emphasizing continuity of care post-transition.	• Address key challenges, including technological infrastructure, coordination, financial support, and political backing, to enable sustainable implementation of transitional care models. • Allocate resources and establish supportive policies to overcome barriers to the implementation of transitional care models for older patients with multimorbidity.	https://www.trans-senior.eu/trans-senior-esrs/merel-leithaus
ESR 10: Institutionalizing Citizen Panels For Older Adults and Informal Caregivers' Involvement In Health Policy Development	This project discusses the institutionalization of citizen panels for older adults and informal caregivers' involvement in health policy development. It has implications for policymaking throughout the care transition process, ensuring that older adults' voices are heard in decision-making.	• Actively engage older adults and informal caregivers in health policy development by creating an enabling environment for citizen panels. • Develop a regulatory framework, provide training for panel facilitators, allocate sufficient financial resources, and establish mechanisms for monitoring the impact of citizen panels.	https://www.trans-senior.eu/trans-senior-esrs/opeyemi-kolade
ESR 11: Policy and practice: empowering older people and informal caregivers in the transitional care decision-making process	This project emphasizes empowering older people and informal caregivers in the transitional care decision-making process. It relates to the decision-making and planning during the transition stage.	• Create frameworks that facilitate the active involvement of older adults and their caregivers in care transition decision-making and ensure that their voices are heard and respected. • Promote shared decision-making in care transitions.	https://www.trans-senior.eu/trans-senior-esrs/lotan-kraun
ESR 12: Assessing the performance of long-term care system in relation to care transition	This project emphasizes the importance of assessing the performance of long-term care systems in relation to care transitions. It can inform decision-making and policy adjustments at various stages of the care transition process.	• Policymakers should mandate the regular use of performance assessment tools to improve decision-making and the overall performance of long-term care systems concerning care transitions. • Implement the Transitional Care Assessment Tool in Long-Term Care (TCAT-LTC) at least once a year to assess the performance of long-term care systems in relation to care transitions.	https://www.trans-senior.eu/trans-senior-esrs/estera-wieczorek
ESR 13: Utilizing Implementation Strategies is Crucial to Promote Successful Transitional Care Innovations (TCIs)	This project discusses the importance of utilizing implementation strategies to promote successful transitional care innovations. It specifically addresses the process of implementing innovations during the transitions.	•Encourage long-term care organizations to continuously refine implementation strategies for transitional care innovations based on feedback and outcomes. •Policymakers should support ongoing improvement efforts in transitional care by providing resources and incentives for organizations to adapt and enhance their strategies.	https://www.trans-senior.eu/trans-senior-esrs/amal-fakha

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