McMaster University | Health Forum

Rapid Evidence Profile

Examining approaches to improve care transitions to long-term care facilities

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Context

- Once it has been determined that individuals can no longer live safely at home, the transition to long-term care can be a vulnerable experience for the individual and their family and caregivers.
- Effectively managing the transition to long-term care influences the resident's quality of care and quality of life.
- This rapid evidence profile examines what we know about approaches that can help to ensure quality transitions from home or hospital settings into long-term care facilities.

Questions

- What are the features and impacts of approaches to improve transitions from home to long-term care in general and for Veterans?
- What recent innovations to improve transitions to long-term care are being pursued in general in Canadian provinces and territories and for Veterans in each of the 'Five Eyes' countries?

Box 1: Evidence and other types of information

+ Global evidence drawn upon

Evidence syntheses selected based on relevance, quality, and recency of search

+ Forms of domestic evidence used (🍁= Canadian)

Evaluation

Qualitative insights

*** Additional notable features**

Prepared in the equivalent of three-business days using an 'all hands on deck' approach

High-level summary of key findings

- We found 29 evidence documents, of which we determined 19 (nine evidence syntheses and 10 single studies) to be highly relevant to the question.
- Most of the identified evidence noted that the following changes to delivery arrangements improved residents', families', and caregivers' care transition experiences:
  - improving communication and collaboration between health professionals, residents, and their families/caregivers
  - improving or adding assessments during transitions to long-term care
  - providing medication reconciliation during transitions to long-term care
  - supporting connections and relationships with other residents and staff
  - providing support for family and caregivers
  - personalizing the care environment.
- Some of the identified evidence described challenges with implementing these approaches, namely supporting shared decision-making for transitional care and providing financial incentives for care coordination for health.

- From the jurisdictional scan, we identified several different approaches being used across Canadian provinces and territories to support successful transitions, as well as quality guidelines produced in Saskatchewan and Ontario that include tools for ensuring high-quality care.
- We identified relatively few programs or resources for Veterans in any of the 'Five Eyes' countries that explicitly support transitions from home or hospital into long-term care facilities.
- Given this gap, rapid evaluations of any transition-support efforts targeting Veterans should be publicly reported and used to improve care.

Framework to organize what we looked for

- Sectors involved in the transition
  - Home and community care
  - Primary care
  - Specialty care
  - Rehabilitation
  - Long-term care
- Providers involved in supporting the transition
  - Physicians
    - Generalists
    - Specialists
  - Nurses
  - Pharmacists
  - Allied health professionals
    - Physiotherapists
    - Occupational therapists
  - Caregivers and family members
- Changes to delivery arrangements to improve the transition to long-term care
  - Ensuring timely transitions (e.g., priority access for Veterans)
  - Supporting communication and collaboration between health professionals, residents, and their families/caregivers
  - Improving or adding assessments during transitions to long-term care
  - Providing medication reconciliation upon transition
  - Improving navigation supports for the resident and their families/caregivers during the transition
  - Providing culturally appropriate and trauma-informed care
  - Supporting connections and relationships with other residents and staff within the long-term care facility

Box 2: Approach and supporting materials

At the beginning of each rapid evidence profile and throughout its development, we engage a subject matter expert, who helps us to scope the question and ensure relevant context is taken into account in the summary of the evidence.

We identified evidence addressing the question by searching Health Systems Evidence and PubMed. All searches were conducted on 25 July 2024. The search strategies used are included in Appendix 1. In contrast to synthesis methods that provide an in-depth understanding of the evidence, this profile focuses on providing an overview and key insights from relevant documents.

We searched for full evidence syntheses (or synthesis-derived products such as overviews of evidence syntheses) and protocols for evidence syntheses.

We appraised the methodological quality of evidence syntheses that were deemed to be highly relevant using the first version of the AMSTAR tool. AMSTAR rates overall quality on a scale of 0 to 11, where 11/11 represents a review of the highest quality, medium-quality evidence syntheses are those with scores between four and seven, and low-quality evidence syntheses are those with scores less than four. The AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to evidence syntheses pertaining to delivery, financial, or governance arrangements within health systems or implementation strategies.

A separate appendix document includes:

- methodological details (Appendix 1)
- key findings from highly relevant syntheses and single studies (Appendix 2)
- details about each identified synthesis (Appendix 3)
- details about each identified single study (Appendix 4)
- details from the jurisdictional scan (Appendix 5)
- documents that were excluded in the final stages of review (Appendix 6).

This rapid evidence profile was prepared in the equivalent of three days of a 'full-court press' by all involved staff.

    - Providing support for families and caregivers
- Changes to financial arrangements to improve the transition to long-term care
    - Targeting payments or penalties for providers
    - Targeting payments for families or caregivers to support the transition
- Changes to governance arrangements to improve the transition to long-term care
    - Increasing the coordination between provincial and territorial supports and federal supports (e.g., those funded by Veterans Affairs Canada)
    - Increased accountability and quality monitoring
        - Public reporting
    - Involving consumers in the transition
    - Improving complaints management processes (for when problems do arise)
- Populations
    - People with dementia
    - People with frailty
    - Veterans
    - Indigenous peoples
    - People who are ethnically and linguistically diverse
- Outcomes
    - Health outcomes
        - Hospital admissions
    - Care experience (including for the caregiver)
    - Provider experience
    - Cost

What we found

We identified 29 evidence documents relevant to the question, of which we deemed 19 to be highly relevant. The highly relevant documents include:

- nine evidence syntheses
- 10 single studies.

This evidence profile focuses on changes to delivery, financial, and governance arrangements that can improve the transition of older adults, including Veterans, to long-term care facilities. A complementary evidence profile looks at how changes to system arrangements can support the delivery of innovative models of home care.

For this rapid evidence profile on transitions to long-term care, evidence documents were determined to be of medium or low relevance when they addressed either rates of morbidity or mortality following the transition to long-term care facilities (rather than approaches to address them), or when they focused exclusively on changes to long-term care facilities without mention of residents' transitions.

Coverage by and gaps in existing evidence syntheses and domestic evidence

Most of the highly relevant evidence addresses changes to delivery arrangements to improve transitions to long-term care, while two evidence syntheses address changes to financial arrangements.(1; 2) We did not identify any evidence syntheses or single studies that address changes to governance arrangements.

Most of the highly relevant evidence provided findings about on patient, family, and caregiver experience outcomes. However, some evidence documents do include findings on health outcomes. We did not identify any evidence documents reporting on provider experience or costs.

Highly relevant evidence documents address transitions from home or hospital into long-term care but also include findings relevant to the involvement of other sectors including primary care and rehabilitation. Findings from highly relevant evidence documents addressed all providers noted in the framework above, including many related to the involvement of caregivers, family members, and patients.

For specific populations, we did not identify any evidence documents pertaining to Veterans or Indigenous peoples. However, we identified evidence relevant to people with dementia, people with frailty, and older adults who are ethnically and linguistically diverse.

Key findings from included evidence documents

Findings related to changes in delivery arrangements

Findings from evidence syntheses and single studies about changes in delivery arrangements focused on five approaches from the framework as well as one additional approach, including:

- improving communication and collaboration between health professionals, residents, and their families/caregivers
- improving or adding assessments during transitions to long-term care
- providing medication reconciliation during transitions to long-term care
- supporting connections and relationships with other residents and staff
- providing support for family and caregivers
- personalizing the care environment.

One recent low-quality evidence synthesis and one recent single study found that improving communication between health professionals during the transition experience and supporting the exchange of resident information were critical to a positive patient experience.(1; 3) One older medium-quality evidence synthesis noted that maintaining regular social contact with friends and family during and following long-term care transitions was a key principle for ensuring a positive experience for those with dementia.(4) The synthesis noted that this could be facilitated by encouraging family members to visit face to face and also by ensuring residents' access to technologies to support ongoing connections.(4)

Two recent medium-quality evidence syntheses and one single study found involvement in care planning and shared decision-making with those transitioning to long-term care improved the patient's quality of life and patient experience.(4; 5) Another recent medium-quality evidence synthesis examined how shared decision-making for transitions to long-term care has been operationalized in Canada. It found that despite the many positive effects of involving patients, it can be challenging to implement in practice.(6) In particular, the synthesis notes the difficulty of engaging individuals in decision-making in the context of declining cognitive capability and challenges around timing for these discussions. Finally, the synthesis notes that much of the evidence related to transitional decision-making support stems from one-off experiences rather than approaches that have been systematized, which may affect the results.(6)

Two single studies found patients benefited from additional assessments, including a rehabilitation readiness assessment and a patient checklist focused on social, physical, and cultural needs during transitions from hospital to long-term care.(7; 8) Both assessments were part of multi-component interventions, including elements such as providing residents and caregivers with information and education about what to expect following the transition, supporting them in making decisions regarding their care, and communication between health professionals.(7; 8)

One recent medium-quality evidence synthesis found that pharmacists' involvement in the transition to long-term care to provide medication reconciliation reduced medication errors.(9)

Two older medium-quality evidence syntheses and one recent single study found caregivers' experience of transitions for family members was supported when caregivers were familiar with residential care staff and had ongoing access to

their family members' information.(10-12) Three recent and one older single study found the use of the Residential Care Transition Module (a 12-week virtual intervention for caregivers of individuals who recently transitioned into residential care) reduced stress and guilt among caregivers; however, one recent single study reported no significant change to caregivers' experiences as a result of participating in the module.(13-17)

One older medium-quality evidence synthesis found that people living with dementia should receive support to integrate socially into their new setting.(4) The synthesis notes that this can be achieved through involvement in shared activities, measures to improve the communication ability of people with dementia, and training for residence staff on communicating with individuals with dementia or other cognitive impairments.(4) Similarly, a recent single study found that having one-on-one relationships with staff and participating in activities within the long-term care homes that reflect personal lifestyles improves loneliness and social isolation following transitions.(18)

Finally, one recent medium-quality evidence synthesis found that personalizing the care environment (e.g., through decorating using personal possessions) alongside other person-centred care principles improves residents' quality of life following their transition to long-term care,(5) while an older medium-quality evidence synthesis identified including personal possessions and maintaining elements of choice as facilitators of positive transitions.(19)

Findings related to changes in financial arrangements

Two recent evidence syntheses – one medium-quality and one low-quality – found that financial incentives may improve patient experience during transitions to long-term care, with one of the evidence syntheses suggesting incentives for primary-care coordination helped to ensure patient follow-up from primary-care providers during the transition.(1; 2) Both evidence syntheses acknowledge that additional evidence is needed as some included studies noted mixed effects and some harms as a result of some of the forms of incentives, including the unnecessary incurrence of costs and in one included study an increased likelihood of medical mistakes.(1; 2)

Findings related to changes in governance arrangements

We did not identify any evidence documents addressing changes to governance arrangements and its effect on improving transitions to long-term care.

Key findings from the jurisdictional scan

For the jurisdictional scan, we looked at the Canadian provincial and territorial level to identify approaches being used to support transitions to long-term care. We also looked at the federal level in each of the 'Five Eyes' countries – Australia, Canada, New Zealand, U.K., and U.S. – to identify supports for transitions to long-term care specific to Veterans.

Many policy documents and websites that were reviewed found information related to broader changes to the long-term care sector rather than the specifics of transitions. We identified some supportive approaches to transitions being used in provinces and territories and have listed them below. Three of the most helpful identified documents include the quality guidelines for long-term care transitions produced by the Saskatchewan Health Quality Council, Health Quality Ontario, and Registered Nurses' Association of Ontario, all of which provide guidance and tools for ensuring a high-quality transition to long-term care.

We identified the following approaches being used in Canadian provinces and territories to support successful transitions:

- providing additional eligibility assessments that help to ensure long-term care is the most appropriate level of care (BC; AB; ON; NL)
- using a case manager/care coordinator who is responsible for supporting a resident's transition to long-term care (AB; MB; ON; NS; PEI)

- developing personalized care plans in cooperation with other health professionals, patients, and their families (QC)
- developing decision support for patients and families moving into long-term care (AB; ON; NB; NS)
- developing resident guides to help set expectations for those moving into long-term care facilities (BC)
- supporting patient/family preference for the long-term care residence they are placed in (BC; MB; NS)
- supporting connections and relationships with other residents and staff (YK)
- providing culturally appropriate care (PEI)
- developing resources to help family members and caregivers as they prepare for the transitions to long-term care (BC; NS)
- maintaining quality guidelines focused on transitions to long-term care (SK; ON)
- maintaining a patient complaint and helpline specific to long-term care (ON)

As part of the Veterans' residential aged care program, the Australia Office of Veterans' Affairs has prepared a Veteran's guide to moving into an aged-care home, which includes details about what Veterans are eligible for, how to access services, as well as the range of supports that are available within and beyond aged-care homes. The Coordinated Veterans' Care Program also provides proactive care coordination for Veteran Gold Card holders (e.g. have qualifying service or disability), which can include developing a personalized care plan including supporting transitions to aged-care, if necessary.

In Canada, as part of a short-term preferred admissions initiative, Veteran Affairs Canada arranged an agreement with provincial partners for broader eligibility and expedited access to long-term care beds for Veterans. Select long-term care homes in provinces that maintain Veteran-preferred beds that can help to ensure a timely transition to long-term care also often include additional Veteran-specific supports. Examples include:

- Veterans Memorial Lodge in British Columbia
- Parkwood Institute in Ontario
- Sunnybrook Health Sciences Centre in Ontario
- Perley Health in Ontario
- Caribou Memorial Veterans Pavilion in Newfoundland.

While we identified some financial supports for Veterans in New Zealand related to coverage of long-term care home expenses, we did not identify any Veteran-specific supports for aiding with transitions.

In the U.K., we identified one-off programs to help Veterans with transitions, including the Aged Veterans Fund in the Greater Manchester Armed Forces Families Integrated Health and Wellbeing, which sought to create an integrated care model that involved improvements in transitions to different levels of care. More broadly, Age UK's Personalised Integrated Care Program brings together voluntary health and social organizations, where an older adult co-creates a care plan with a coordinator, engages with Age UK volunteers to help achieve goals, and meets with multidisciplinary teams in primary care settings. This program can extend to supporting older adults as they transition into aged care homes.

For the U.S., while we did not identify any specific programs that support Veterans to transition to long-term care, we did identify a decision aid to help Veterans consider their needs and preferences for long-term care, as well as a self-assessment for caregivers to help determine whether additional supports may be beneficial.

Next steps based on the identified evidence

- The identified evidence notes that care transitions are improved through shared communication and information between providers working across sectors (e.g., primary care, rehabilitation, long-term care), personalization in care, maintaining patient choice where possible, and continued contact with family members and caregivers following admission to long-term care facilities.

- We identified relatively little about how these approaches may be used specifically to advance the needs of Veterans and whether they may benefit from different approaches or adjustments.
- To help fill this gap in the evidence base, rapid evaluations of any efforts for this specific population should be publicly reported and used to improve care.

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