

**Keywords:****Transitional Care, Primary Care, Family Medicine, Care Integration.****SFP2015; 41(1): 5-10****INTRODUCTION****The Origins of Transitional Care**

Over the past few decades, the focus of health care has shifted from the community to the hospitals. There are many drivers for this phenomenon. Advances in medicine developed many effective treatments for diseases when there were none available in the past. Such treatments require specialised knowledge and procedures which are delivered by specialists and facilities through tertiary hospitals where such resources are aggregated for greater efficiency. This trend shifted the focus of health care into hospitals, and heralded the ascendancy of academic medical centres over other health care providers.

In the same time period life expectancy increased, thanks to improvements in living conditions and better access to health care. However, with greater affluence, many countries experienced an associated decline in birth rates. The rising life expectancy and falling fertility rates resulted in the rapid ageing of populations. This has been most pronounced in developed countries where fertility rates have decreased dramatically. Ageing is associated with declining organ function and rising prevalence of chronic diseases. As a result, ageing populations have a higher proportion of people with multiple co-morbidities and disabilities caused by the complications of chronic diseases. This in turn drives an almost insatiable demand for more hospital and social services. At the same time, ageing populations are associated with decreasing old-age support ratios. This is the ratio of the working-age population (age 20 to 64) to the elderly population (age 65 and above). In Singapore, this had declined from 13.4 in 1970 to 6.0 in 2014.<sup>1</sup> As our population continues to age rapidly, this ratio is expected to decline precipitously in the years ahead. By 2030, the old-age support ratio in Singapore is predicted to be 2.1. This means that while demand for health and social care is expected to rise inexorably, the number of economically active individuals generating resources to supply services will decline sharply in the years ahead. Everything spells unsustainable in this equation. This trend is global and most pronounced in developed countries. Even the richest country in the world cannot support this rising demand for health care with the present model of care delivery and financing.<sup>2</sup>

This perfect storm has raised alarms around the world. There is

emerging consensus that a hospital-centric system is not cost-effective and will not be sustainable in the long term. Prolonged stay in hospitals is also associated with hospital-acquired infections of multi-drug-resistant organisms and functional decline of patients, making a bad situation even worse. Therefore there has been renewed effort to shift the focus of health care back into the community. At the same time, the adverse effects of care fragmentation caused by the over-reliance on specialisation is now recognised as a leading cause of diminishing cost-effectiveness and the poor quality of overall care of patients. This has resulted in a belated effort in promoting generalist disciplines, including family medicine, as a counter-weight to excessive specialisation<sup>3</sup>. With health and social services coming under strain, various adaptive responses have emerged.

The hospitalist movement was first described in the mid-1990s. It advocated for physicians who focus on providing more comprehensive general medical care to hospitalised patients. These generalist physicians were referred to as hospitalists. Hospitalists are physicians who specialise in providing comprehensive general medical care to hospitalised patients. They were usually generalist physicians who were trained in general internal medicine, general paediatrics or family medicine.<sup>4</sup> The hospitalist movement can be seen as a response to the excessive specialisation of care in the hospital systems and the shortage of generalist physicians who were capable and prepared to take on overall responsibility of patients when they were admitted to acute hospitals. This movement started in North America and expanded to various parts of the world as health systems struggled to manage care fragmentation in hospitals.<sup>5</sup> In 2007, the first adaptation of the hospitalist model was implemented in Singapore with encouraging results in reducing the average length of stay in the hospital. This programme was delivered by family physicians taking on the role as the primary physicians of the patients. Unlike the traditional hospitalist model which limits itself to hospital care, the adapted programme expanded the scope of care to include an emphasis on the transition of care back to the community upon discharge.<sup>6</sup>

On the other end of the care spectrum, there are calls to organise primary care in a more effective manner to meet the challenges ahead. After decades of relative neglect, much of primary care had atrophied and lost its ability to provide care for patients with complex care needs. In the late 1980s, managed care came upon the scene and further hampered primary care with cost controls which made it difficult to manage complex patients in the community. Gatekeeping became a euphemism for triaging patients on behalf of tertiary hospitals.<sup>7</sup> There were repeated attempts to re-invigorate primary care in response to the decades of decline. The patient-centred medical home (PCMH) had been advocated as

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a new way to deliver primary care.<sup>8</sup> It was conceptually a call to return to the fundamentals of family medicine, with an emphasis on comprehensive care, patient centredness, care co-ordination, accessibility, quality, and safety. This call for quality resonated well with the primary care community but the call for a broad range of improvements in almost every aspect of primary care was difficult to translate into actual practice. Demonstration projects were initiated with an array of best practices in the various components of the PCMH model which practices could choose to implement. Not unexpectedly, assessment of outcome was challenging and the results were not convincing. Advocacy for broad-based improvements based on best practices without a clear strategy was not as effective as hoped for. It became apparent that general improvements in primary care without fundamental changes in the other parts of the health care system would not be effective.<sup>9</sup> It just was not enough for primary care to do more or even better of the same. The PCMH was a bridge too “near” to make a difference. Primary care needed to get itself ready to accept large numbers of patients with complex needs from the hospitals and keep them well in the community. This should have been the new model of primary care.

At the systems level, governments and policy makers began to advocate for better integration between services for patients. The term “integrated care” started as a buzz word that eventually became a global trend in health care reform. There are many definitions and the one described in a WHO publication refers to it as a concept for “bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency”.<sup>10</sup> At around the same time, the concept of transitional care emerged with the realisation that the lack of integration of services was most problematic when patients transitioned between care providers. Presently health care is organised along specialised silos and the patient is moved from one setting to the next, often with lapses in communication and co-ordination. Such discontinuity of care is associated with wasteful increase in length of stay, unplanned re-admissions to hospitals, and poor clinical outcome. The greatest risks are suffered by patients with multiple co-morbidities that require complex health and social care. Various care intervention programmes were developed to improve care co-ordination and continuity for such patients. Transition care is used as a term to describe interventions that are developed to improve care as the patients move from one care setting to the next, usually between the hospital and the community.

### Definition and Characteristics of Transitional Care

Unlike terms such as patient-centred medical home and integrated care, transitional care is a concept that is defined by practice. Definition is difficult as transition care is evolving rapidly, shaped by many variations of practices and emerging evidence that demonstrate effectiveness only in some, but not all, characteristics that had been ascribed to transitional care.

One of the earliest and most popular definitions of transitional care was proposed by Coleman and his co-workers, who were among the pioneers in this area of work. Transitional care was defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.<sup>11</sup> It is therefore by nature a collection of interventions aimed at improving care continuity. Within such interventions there are elements of primary care, care co-ordination, discharge planning, disease management, and case management. Transitional care therefore cannot be defined by exclusive features. There are dominant characteristics in transitional care. Transitional care focuses on ensuring care continuity and achieving specific outcomes, usually targeting reduction in the utilisation of hospital resources. As transitional care services are intensive, they tend to take a risk stratification approach focusing effort on patients at highest risk of discontinuity of care. While other forms of care are often limited to a specific setting, transitional care seeks to bridge care settings to bring about continuity. Finally transitional care interventions are usually, but not always, time limited. An emerging concept is for transitional care to follow patients up until an appropriate care provider can be secured for the patient to ensure continuity of care.

All things considered, it may be better to have a working definition of transitional care depending on the needs of the community. For practical purposes, transitional care may be defined as a combination of care interventions aimed at ensuring safe and timely transfer of vulnerable patients as they transit from one setting of care to the next more appropriate setting of care, in response to the patient’s changing needs.

### Elements of Transitional Care

Transitional care programmes comprise elements that are in common. However, most programmes differ from one another and usually do not contain all the elements. There is evidence that intensive programmes with multimodal interventions are more likely to be effective.<sup>12</sup> There is also consensus that programmes that are aimed at reducing wasteful hospital admissions should focus on preventable factors.<sup>13</sup> Risk stratification and identification of patients with preventable factors will become an essential element of transitional care programmes.

The different elements occur at different phases of patient care and are targeted at addressing discontinuity and lack of co-ordination through different mechanisms. These are summarised in Table 1.

### Competency Required for Transitional Care

Multidisciplinary care and interdisciplinary learning are critical success factors in transitional care programmes. Programmes that are silo or mono-disciplinary (e.g., only involving either doctors or nurses alone) have lower levels of effectiveness. Early programmes had relied on using case managers to link up other stakeholders. The outcomes were variable, often depending on the interpersonal skill and resourcefulness of individual case

**Table 1. Elements of Transitional Care**

Element	Objective	Rationale
Risk stratification	Identify patients at high risk of care discontinuity.	High-intensity transition care programmes are resource and labour intensive. Cost effectiveness is achieved by targeting patients who are at increased risk.
Comprehensive assessment	Identify medical and social care issues.	Transitional care is largely anticipatory and preventive in nature. Preventive interventions require effective identification of care issues that may potentially delay transfer to the next appropriate setting of care or result in discontinuity during transfers.
Care planning	Develop interventions for rapid optimisation of patients' condition and prevent discontinuity of care.	<p>Care planning occurs in 3 phases.</p> <p>Pre-discharge care plans aim for rapid stabilisation and getting patient ready for timely transfer to the next appropriate setting of care.</p> <p>Discharge planning involves taking measures to prevent lapses in care during handovers.</p> <p>Reception planning is done by the receiving party to ensure safe and timely admission to the next phase of care.</p>
Care plan communication	Ensure all parties in the transition process have a shared understanding of the care plan.	There are multiple parties involved in the transfer of patients with complex care needs. The communication is often multidisciplinary and multi-institutional in nature. Use of multidisciplinary meetings, family conferences, and information technology is critical. Stakeholders involved in the communication include patients, caregivers, clinicians,

		and administrators. Institutions involved include payers, government agencies, health and social care providers.
Inter-setting patient care	Bridging care between settings to support care continuity.	Typically involves case managers and/or clinical staff visiting the community or the patients' homes. May also involve care teams providing care in different settings for the same patient.
Self-management support	Invoking self-care to enhance care continuity.	Interventions under this element include health education, disease-based action plans, caregiver training, home monitoring (with or without telehealth) and call centre support.

**Table 2. Relationship Between Family Medicine Competencies and Transitional Care**

Domain of Family Medicine Competency	Application Transitional Care
Primary	Taking on the role of the most responsible physician that is overseeing care transition processes.
Personal	Contextualising care in accordance to the care needs of the patient based on the biopsychosocial model.
Preventive	Reducing the risks of repeated and prolonged hospitalisation by maintaining the health of the patient in the community. Prevent suboptimal outcome due to care fragmentation.
Comprehensive	Manage the full range of medical conditions of the patient in consultation with specialists. Reduce unnecessary specialist consults.
Continuing	Bridging the divide between the hospital and the community to ensure that smooth and seamless care transition is not disrupted as the patient moves from one setting of care to the next.
Community	Return the care of hospitalised patients back to the home and community. Linking up medical and social care to ensure that patients remain well in the community.



managers. A better strategy which produces sustainable and better outcomes is to develop a structured framework that supports multidisciplinary collaboration and action. Such a structured framework entails work processes that enhance interdisciplinary communication and co-ordination. Use of information technology and multidisciplinary meetings are the norm. The framework usually involves securing commitment to a common pool of patients, integrated work processes and common performance indicators.

On an individual level, doctors involved in transitional care work will require competency in specific areas. These include:

- Communication and working within a multidisciplinary environment.
- Coaching patients in self care.
- Knowledge of community and social services which are appropriate for patients with different needs.
- Effectiveness in applying clinical knowledge and skills in the context of different care settings.
- Ability to develop effective care plans that are appropriate to the setting of care.
- Awareness of the capabilities and limitations of other stakeholders.

#### **The Role of the Family Physician in Transitional Care**

Physicians that are involved in transitional care are usually generalist physicians who include family physicians, geriatricians, rehabilitation physicians, and internists. Their commonality lies in their competency in providing general medical care to patients. Each discipline brings with it its unique strengths. All disciplines need to review and enhance their competencies that have been stated in the previous section. Among all the disciplines, family physicians have an advantage due to the congruence of their care philosophy with transitional care which emphasises comprehensive and continuing care. The family physicians' added competency in caring for patients in their home environment and within the greater eco system of the community confers additional advantages.

Transitional care is an important area of work for family physicians as elderly patients with complex medical and social care needs will return to primary care eventually. It is the missing link that will enable the patient-centred medical home to reach its full potential. The process of leaving the hospital and re-integrating back to the community and primary care is hazardous unless a well-trained generalist enhanced with the competencies of family medicine is on hand to oversee the transition. The six key areas of competency in family medicine translate very well into the competencies needed in transitional care. This is illustrated in Table 2.

## **CONCLUSION**

The challenge posed by a rapidly ageing population to the health care system is formidable and is potentially unsustainable. We need a whole of system response through improved integration of all the services that are needed by our patients. As we integrate we need to ensure that care transitions are optimally carried out so that we minimise risk to the patients and reduce waste for the system. The effectiveness of family medicine and primary care are critical success factors in overcoming the excesses of the present hospital centric health care system. Primary care providers must develop and adopt new models of care that will meet the needs of the new environment. Family medicine must retool our training programmes and give appropriate emphasis to our core competencies. This will ensure that family physicians will be ready to take on the vital role as the generalist who specialises in providing comprehensive and continuing care for the patient across the continuum of care.

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## LEARNING POINTS

- The demands on existing hospital services are unsustainable as the population ages and complex chronic diseases become more prevalent.
  - Transitional care is a new concept in health care delivery that seeks to improve system efficiency by improving care continuity and co-ordination.
  - Transitional care may be defined as a combination of care interventions aimed at ensuring safe and timely transfer of vulnerable patients as they transit from one setting of care to the next, in response to the patient's changing needs.
  - Transitional care is an important area of work for family physicians as elderly patients with complex medical and social care needs will return to primary care when they are discharged from hospitals.
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