

Transitional care strategies at emergency department for elderly patients: A multicentre study in Singapore

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ABSTRACT

Introduction: Transitional care strategies (TCS) initiated for elderly patients prior to emergency department (ED) discharge are important for ensuring effective transition to other care settings. Such strategies have been shown to reduce avoidable acute admissions. This first nationwide study is targeted at public acute hospital EDs in Singapore, and aims to characterise TCS for ED-discharged elderly patients and understand the experiences of healthcare staff in the delivery of TCS.

Method: Seven key informants (KIs), one per ED, completed an online structured questionnaire and semi-structured video conference interview from 8 May to 31 August 2021. The KIs were ED specialists and an ED-trained senior staff nurse who were knowledgeable in geriatric emergency care and had contributed to at least one elder-related TCS. Field notes were compiled, transcribed, anonymised and analysed using thematic analysis.

Results: All 7 EDs have TCS as “usual care” available during office hours, at no extra cost to patients. Common components of TCS include screening, evaluation with comprehensive geriatric assessment, health education and follow-up telecare. TCS implementation was facilitated by organisational support in terms of established protocols and communication platforms, training and collaboration of a multidisciplinary team, and caregiver involvement. Obstacles faced include fragmented communication between personnel, limited resources, and poor buy-in from stakeholders.

Conclusion: Understanding the heterogeneous characteristics of ED-TCS at various hospitals will aid the development of service typology and identify service opportunities. Provider experiences grouped into themes help to inform future strategies for TCS implementation. More research is needed to evaluate patient outcomes and cost-effectiveness of TCS.

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INTRODUCTION

In Singapore, greater efforts are being directed towards developing an integrated health and social ecosystem under the new Healthier SG strategy announced by the Ministry of Health. This life-course approach aims to promote overall healthier living in collaboration with key community partners (e.g. intermediate and long-term care service providers) by utilising targeted measures of improvement in health outcomes, including the reduction of avoidable readmissions for specific vulnerable populations such as the elderly. This results in growing importance for the development of care

strategies at the emergency department (ED) to help reduce avoidable admissions especially for the elderly.

Transitional care strategies (TCS) refer to multi-disciplinary interventions designed to ensure the coordination and continuity of care as patients transfer between health care settings (e.g. between the ED and community health and support services).¹ Many studies have demonstrated that TCS are effective in reducing readmissions and providing better care for the elderly.²⁻⁶

In recent years, there has been a proliferation of elderly-related TCS initiated in various hospital settings islandwide,⁷ including the ED. The services usually

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CLINICAL IMPACT

What is New

- This is the first nationwide study in Singapore on transitional care strategies (TCS) for elderly patients discharged from public acute hospital emergency departments (EDs).
- ED-TCS are heterogeneous. Common characteristics include: screening/assessment at the ED, referral/transition workflows, and patient education.
- Organisational support, multidisciplinary care, caregiver involvement and addressing challenges such as lack of resources are important in ED-TCS implementation.

Clinical Implications

- Better understanding of ED-TCS will aid the development of service typology and identify service opportunities.
- ED-TCS may be broadened to address social determinants of health contributing to reattendance and avoidable admissions.

include an eligibility screening and geriatric assessment, which span domains on functional assessment, multi-morbidity status, psychosocial issues and polypharmacy matters—hence, enabling staff to right-site or prescribe appropriate care.^{8–11} Previously, Singapore studies have explored the transition from hospital to home, but to our knowledge, there have been no reviews of TCS at our EDs. This study aims to describe the characteristics of existing TCS for ED-discharged elderly patients from public acute hospitals in Singapore, and understand the experiences of ED healthcare staff in the delivery of TCS.

METHOD

Study design

We used an exploratory mixed-methods study design, comprising a self-developed questionnaire and semi-structured interview for a convenience sample of participants. Seven public hospital EDs were included in this study. Seven key informants (KIs; one per hospital ED) completed an online structured questionnaire and semi-structured video conference interview from 8 May to 31 August 2021. Six were ED physicians, while one was an ED-trained senior staff nurse involved in

geriatric emergency care. Ethics approval was sought from the Centralised Institutional Review Board (CIRB Ref: 2021/2273), and the study was deemed to not require further ethical deliberation.

Inclusion criteria

TCS is defined as an intervention or a group of interventions initiated prior to ED discharge for safe and effective transition of ED patients to other care settings.¹² In our study, we focused on TCS that catered to elderly patients aged 65 years and above. Their discharge may be from the (1) main ED; (2) clinical observation unit (such as the short stay unit), extended observation ward, or early diagnostic and observation unit; or (3) ED observation ward. We excluded TCS designed to address: (1) palliative care and terminally ill patients; (2) patients with psychosis, altered behaviour or neuropsychiatric symptoms not due to dementia; and (3) prisoners and persons-in-custody. To be eligible, KIs needed to be: aged 21 years or above; an emergency medicine specialist or emergency-trained geriatric staff nurse of senior rank and above; and contributed to one or more elderly-related TCS within the hospital.

Topic guide development

Expert inputs and a literature review of TCS were used to guide questionnaire development. The questionnaire covers domains such as type of TCS, components of the TCS, patient transition pathway, profile of recipients, key players, setting in which TCS is delivered, and any other information. The questionnaire comprised dichotomous questions (yes/no) and multiple selection questions. In-depth interview (IDI) was chosen as it provided access to depth of information and deeper insights into perspectives and experiences.¹³ Findings from the questionnaire and inputs from experts (e.g. ED physicians) were used to develop a semi-structured interview guide, comprising 16 main questions based on 4 main aspects: (1) development of the TCS; (2) overview of TCS components; (3) coordination and interaction among care provider; and (4) feedback, challenges and barriers. Probes were used when deemed appropriate.

Data collection

The questionnaire was completed first to guide the development of the interview. The interview guide was pre-piloted to ensure clarity and appropriateness. Data were collected by 2 medical students who obtained informed consent from all participants. Both students have no prior relationship with the participants and underwent study-specific training involving qualitative

interviewing. After obtaining informed consent, the KIs completed an online questionnaire (Qualtrics, Seattle, WA, US). Semi-structured IDIs were conducted on a separate day. The interviews were recorded and in-depth fieldnotes captured. The interviews ranged from 40–60 minutes. No member checking or follow-up interviews were conducted.

Data analysis

Descriptive statistics were used to summarise the TCS characteristics from the questionnaire. All analyses were performed in Microsoft Excel (Microsoft Corporation, Redmond, WA, US). Inductive thematic analysis based on Braun and Clarke's approach¹⁴ was used to examine the fieldnotes by the first and second authors of this study. The coding and organisation of themes were performed in Microsoft Word (Microsoft Corporation, Redmond, WA, US). Due to its time-bound nature and resource limitations, data or thematic saturation was not reached.

RESULTS

Overview of TCS at public hospital EDs

All EDs had elderly-related TCS available during office hours on weekdays, which were provided to eligible elderly patients as part of “usual care” at no additional cost. Characteristics of the 7 EDs are presented in Table 1, labelled as ED-A, ED-B, ED-C, etc. Components include identification of high-risk elderly patients with validated screening tools, recruitment and referral for on-site interventions, early engagement by various specialties, and patient education. In 6 of the 7 EDs, TCS were targeted at elderly patients or those with functional decline, employing observation medicine units to prepare the patients for their planned care trajectory. In ED-C (Table 1), although the TCS was not specifically designed or limited to the elderly, the patients served were mainly elderly patients.

All TCS adopted a multidisciplinary approach. In all EDs, patient identification and recruitment were done by ED personnel. In addition, 3 EDs had early in-person engagement of Geriatric Medicine physicians. Allied health professionals (AHPs) were also engaged in 6 EDs, reflecting multidisciplinary care. Most EDs (6 out of 7) also had direct ED-to-community-hospital admission pathways. There were telephone helplines for discharged patients requiring ad hoc assistance in 3 EDs. ED-E also utilised telemedicine for discharged patients; this consisted of videocall or telephone consultation performed by their community team of healthcare providers.

Themes in the delivery of TCS

The thematic analysis revealed 4 important themes in terms of the implementation of elderly-related TCS within Singapore's EDs (Fig. 1). Selected quotes from participants are listed below.

Theme 1: Organisational support and established processes for TCS

Sub-theme 1: Established protocols integrated into organisation's mainstream processes

KIs identified established protocols within their organisation as a key facilitator for the delivery of TCS. This was seen in the use of simple screening tools and integration of TCS into the mainstream ED workflow. Comments from the IDIs are presented in quotes.

“Since it has been integrated into mainstream ED care, no one refuses the service.” – IDI6

“Patient referred for PT (physiotherapy) assessment but MediSave/MediShield cannot be used; patient has to pay SGD80 in cash, hence a lot may decline in view of other ED charges, e.g. CT (computed tomography) scan.” – IDI7

KIs reported that observational medicine units were used for patients undergoing treatment and evaluation. These relatively slower-paced units are more conducive for transitioning to the next phase of care. Admission to such units may also allow patients to utilise the national health savings scheme (MediSave) in Singapore and private health insurance. However, limited subsidies for ancillary TCS services, such as physiotherapy assessment, discouraged some patients from proceeding further with TCS.

Sub-theme 2: Opportunities for education and training

In Singapore, ED nurses involved in TCS implementation are often experienced staff who undergo additional formal training programme and assessment to ensure competence. Some KIs highlighted training opportunities provided by their organisation to improve awareness of TCS, such as inter-organisation knowledge sharing locally and internationally.

“Nurses have to undergo a standardised training course and pass a competency test to be part of the programme.” – IDI3

“[Organisation name omitted] previously came for a visit and the [TCS intervention name omitted] intervention was shared.” – IDI4

Table 1. Key characteristics of transitional care strategies for emergency department-discharged elderly in 7 acute public hospitals in Singapore.

Emergency department	A	B	C	D	E	F	G
Overview of transitional care strategies							
Target age	Elderly	Elderly	Not specific	Elderly	Elderly	Elderly or patients with functional decline	Elderly
Operating hours	Weekdays, office hours	Daily, 7am to 3pm	Ad hoc referral	Sunday evening to Thursday evening	Daily, office hours	Weekdays, office hours	Weekdays, office hours
Components of transitional care strategies							
Screening tool	None	ER ²	None	CFS	CFS	Hospital-developed algorithm	TRST
Assessment tool	CGA	CGA	Clinical judgement	CGA	CGA	CGA	CGA
Patient education	Face-to-face	Face-to-face, individualised written action plan	Phone call, face-to-face	Patient education brochures, face-to-face	Patient education booklet, face-to-face	Face-to-face	Patient education brochures, face-to-face
Utilisation of ED observation unit	Yes	Yes	Not applicable	Yes	Yes	Yes	Yes
Early in-person ED engagement by geriatric physicians	Yes	No	No	Yes	Yes	No	No
Early in-person ED engagement by allied health professionals	Yes	Yes	No	Yes	Yes	Yes	Yes
	PT, MSW, pharmacist	PT, OT, MSW		PT, OT, CC	MDT including PT, OT, pharmacist	PT, OT, MSW, ST	PT
Transition to ILTC services	Yes	Yes	No	Yes	Yes	Yes	Yes
Post-discharge helpline availability for patients	No	No	No	Yes	Yes	Yes	No

CC: care coordinator; CFS: clinical frailty scale; CGA: comprehensive geriatric assessment; ED: emergency department; ER²: emergency room evaluation and recommendation; ILTC: intermediate and long-term care; MDT: multidisciplinary team; MSW: medical social worker; OT: occupational therapist; PT: physiotherapist; ST: speech-language therapist; TRST: triage risk screening tool

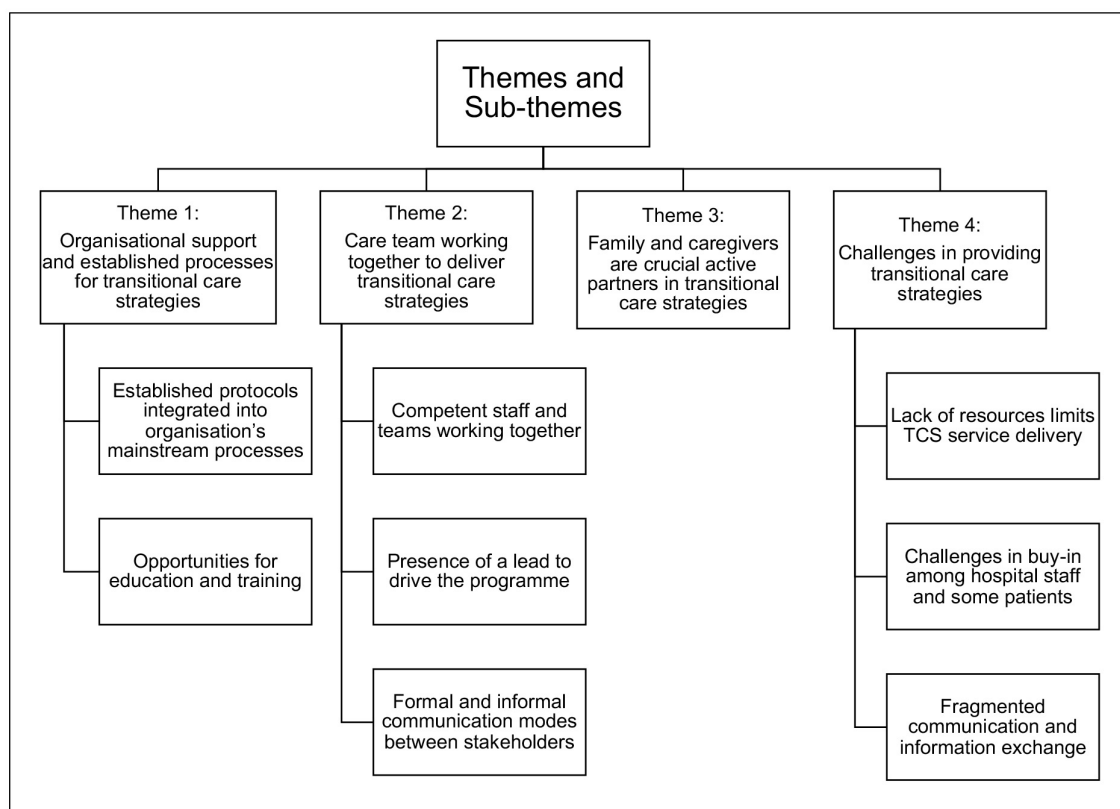


Fig.1 Themes and sub-themes identified.
TCS: transitional care strategies

Theme 2: Care team working together to deliver TCS

Sub-theme 1: Competent staff and teams working together

Most KIs mentioned the specialised expertise of each team as crucial components of TCS. Patients are reviewed by a multidisciplinary team in the ED, including AHPs and geriatric physicians. Some also highlighted that having dedicated teams for care coordination facilitated implementation. Interdisciplinary collaboration between independent and knowledgeable medical professionals enabled the smooth delivery of TCS.

“The TCS team works closely with the [organisation team name omitted].... TCS can activate the [organisation name omitted] team for patients suitable for subacute care, complex social issues, and/or require closer follow up... The [organisation name omitted] team will then review the patient and suggest the appropriate disposition and management of the patient.” – IDI1

Most KIs highlighted the Agency for Integrated Care (AIC) as an important case management partner.

Sub-theme 2: Presence of a lead to drive the programme

The presence of a lead, usually a nurse or clinician, was identified as the key to initial set-up of the TCS, and its sustainability in the long run.

“Lead nurse has been very important to the discussion and implementation of [TCS intervention name omitted].” – IDI2

Sub-theme 3: Formal and informal communication modes between stakeholders

Multidisciplinary coordination was facilitated by formal and informal modes of communication. KIs reported regular meetings between stakeholders. Digital tools such as electronic clinical documentation systems and emails are used to transmit patient information, while instant messaging applications (e.g. WhatsApp, TigerText [a form of organisational text messaging for medical professionals]) facilitate immediate feedback, especially with community partners. Technology also allowed for data linkages and case clerking between clinical systems during the screening and referral process.

“WhatsApp chat group facilitates instant feedback sharing, and if needed, can be escalated to the monthly meeting sessions.” – IDI5

Theme 3: Family and caregivers are crucial active partners in TCS

Involvement of family and caregivers in providing information and decision-making was crucial for patient care. They also play a role in reinforcement of health education transmitted as part of TCS. Patient education in TCS involved different modes of delivery (e.g. verbal and/or visual aids). Education was individualised according to comprehensive geriatric assessment findings, which helped to identify areas with potential knowledge gaps. In some instances, caregivers were engaged, including medically untrained foreign domestic workers who are the main care providers at home. Their involvement was viewed by all KIs as crucial to the success of TCS as the domestic workers help to monitor patient recovery and reinforce medical advice.

“Elderly care in the ED will almost always involve family members, especially if they have cognitive issues, to reinforce the management (pharmacological, non-pharmacological).” – IDI6

However, no formal “check-back” was performed to ensure understanding, and the onus lies with patients to raise their queries or dial post-discharge helplines. KIs mentioned that any concerns or caregiver stress raised were also attended to by TCS staff.

Theme 4: Challenges in providing TCS

KIs described challenges and barriers in their efforts to provide TCS, such as fragmented communication loops, lack of interest and limited resources.

Sub-theme 1: Lack of resources limit TCS delivery

Currently, TCS is only available during office hours on weekdays within most organisations. KIs consistently mentioned manpower constraints and limited funding as key barriers to increasing TCS availability. Improving accessibility of these services, such as on weekends, will help more patients and may further prevent admissions.

“Ideally would like to make the service available beyond office hours, on weekends and 24/7, but limited by manpower... this is my dream” – IDI7

Sub-theme 2: Challenges in buy-in among hospital staff and some patients

Most KIs mentioned good uptake rates among patients. However, a deviant case was identified where a KI noted that:

“Some patients—they come to the ED, they just want to get the problem fixed and go home.” – IDI1

Some participants raised challenges getting support from medical staff due to competing priorities such as other clinical duties, and the TCS might be considered as extra work:

“I think a lot of doctors just want to do their jobs very fast. Because whatever the risks identified, then require the medical doctor to address, then they think that this is actually extra work for them. So, I do have a bit of hard time to convince them for this strategy [TCS].” – IDI1

“Of course, nursing manpower is always something that is needed, so trying to convince the nursing officers that this was a need and we needed to take one nurse, or two nurses even, off the daily roster to do this [TCS] screening, that was a challenge and is still a challenge currently.” – IDI5

Junior doctors on rotational postings who have limited knowledge of TCS form a significant portion of the physician workforce. Thus, local success would depend on ED nurses and permanent doctors to identify suitable candidates. Studies have found that educating medical students on transitional care shows promising results,^{15,16} making this an area worth exploring in the future.

“Senior supervising doctors do not place adequate emphasis on importance of TCS; junior doctors are not aware of or do not make referrals to TCS; junior doctors are not aware or do not make referrals to [name of TCS intervention omitted].” – IDI5

Sub-theme 3: Fragmented communication and information exchange

Inadequate communication or fragmented information exchange was reported to affect the delivery of TCS. KIs reported the lack of access to integrated health information systems among some TCS partners. Coupled with limitations of formal communication channels, providers are drawn to informal communication methods to ensure timely information exchange.

“Community providers can call the [TCS intervention name omitted] operator line to inform any issues faced, but rarely is feedback escalated to the ED team.” – IDI3

“But records from private community services like AIC cannot be seen.” – IDI7

DISCUSSION

To our knowledge, this study is the first mixed-methods study on elderly-related ED-TCS within Singapore. Our findings show that ED-TCS are complex multi-disciplinary interventions⁶ delivered by different

providers at varied settings, in a coordinated manner during the full length of stay at the ED. Even though TCS across institutions are heterogeneous, we identified some common characteristics that will help to develop the typology for elderly-related ED-TCS in future: (1) screening and assessment of elderly at the ED; (2) workflows for referral and transition; and (3) patient education.

The use of technology is also seen widely among EDs. Integrated health records systems and communication platforms enable information-sharing within a multidisciplinary care team.¹⁶ Going forward, further development and adoption of a common, integrated and secure communication platform for hospital- and community-based TCS providers is needed.

The wide prevalence of ED-TCS noted from our study indicates a major shift in the focus of our care models from disease-specific care to frailty-centred care in order to meet the multidimensional needs of elderly patients.¹⁷ A Singapore study found that early geriatric specialist intervention in the ED reduced potentially avoidable acute admissions without escalating the risk of reattendance and possibly attenuated frailty progression.⁸ Another study found that geriatric assessment in the ED observation unit resulted in objective reduction in both ED reattendance and hospitalisation rates.¹⁰ These highlight the importance of delivering holistic, needs-based geriatric emergency care right from the start of the patient's visit. With well-designed TCS for elderly ED patients fit for discharge, unnecessary hospital admissions may even be avoided.

Established protocols are also crucial in ensuring safe transitional care for elderly patients.¹⁶ Protocolised direct admission of elderly patients at a local ED to the subacute care unit of a partnering community hospital also appeared to reap benefits by removing the need for intervening stays of longer than 24 hours at the acute hospital. This helped to reduce the overall length of stay across both institutions, decrease acute hospital admissions, and cut down the number of patient hand-offs.⁹

Delivery of TCS within the ED often requires flexibility due to time and space constraints. Our study revealed that key roles in TCS for care coordination and liaison was often undertaken by nurses. This has also been reported in other countries.¹⁶ In Singapore, nurses take on flexible roles, often going beyond traditional duties to bridge gaps in patient care.¹⁸ They play an important role in building rapport with patients and care providers. This trust between TCS providers and patients is crucial in overcoming care gaps.¹⁹

We identified opportunities to incorporate telemedicine into ED-TCS in future. It may be used to enhance interprofessional collaboration remotely or deliver direct services to patients and their caregivers. A Singapore study has found a higher uptake of telehealth services by the elderly during the COVID-19 pandemic,²⁰ indicating that this is a high-impact, feasible solution worth exploring. Going forward, with a capitation model for healthcare funding, there is the opportunity to sustainably resource EDs to better accomplish TCS through such avenues.

Finally, it is important to note that singular interventions might not be as impactful without an overhauling transformation of the hospital and healthcare system.²¹ Aside from TCS and operational processes, EDs in Singapore should look into the “hardware” and infrastructural redesign needed to incorporate geriatric-friendly design principles. With greater attention to population health and community support structures for the elderly to not just “get well”, but “live well, age well”, the scope of ED-TCS may be broadened to better address other factors, such as social determinants of health among elders and foster closer partnership between EDs and community services.

Limitations

Our study has several limitations. It only looked at elderly-related ED-TCS currently implemented, thus not accounting for those in the planning phase, of which many have been delayed during the COVID-19 pandemic. Also, there was a lack of data saturation as only one KI per ED was recruited, which might impact the findings. However, this study was intended to be exploratory in nature to gather novel insights and experiences from ED staff. Future studies will enrol more participants to garner insights from multiple stakeholders. Furthermore, the findings were reviewed by the head of department of each hospital's ED, to ensure accuracy of what was reported. Lastly, medical student interviewers may have limited insight into clinical care strategies, which may limit exploration on the subject and the depth of the interviews. To mitigate this, interview questions were reviewed by 2 ED specialists (study investigators) to improve information capture.

CONCLUSION

This study sheds light on elderly-related ED-TCS available for elderly patients discharged from 7 public acute hospitals in Singapore. Common components

and characteristics of these TCS were identified. Understanding the heterogeneous characteristics of TCS at various hospitals will aid the development of service typology and identify service opportunities. Factors that facilitated implementation included established workflow protocols, effective usage of communication tools, active involvement of competent personnel, staff training, and caregiver participation. More research is needed to investigate the clinical effectiveness of elderly-related ED-TCS and foster closer partnership with community care providers.

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