AGMR
Annals of Geriatric Medicine and Research

Letter to the Editor
pISSN 2508-4798 eISSN 2508-4909
Ann Geriatr Med Res 2021;25(1):60-62
https://doi.org/10.4235/agmr.21.0019

We Need Better Solutions for Care Transitions after Hospitalizations in Korea

Chan Mi Park[1], Hee-Won Jung[2]

[1]Department of Family Medicine, Korea University Anam Hospital, Korea University College of Medicine, Seoul, Korea
[2]Division of Geriatrics, Department of Internal Medicine, Asan Medical Center, University of Ulsan College of Medicine, Seoul, Korea

Mr. Kim, a 79-year-old man, was diagnosed with community-acquired pneumonia (CAP) and admitted to the hospital for intravenous antibiotic treatment. As one of the most common acute infectious illnesses, most people do not consider CAP a life-changing medical event. During his 1-week stay in the hospital, Mr. Kim recovered from pneumonia; however, he also became weaker and could not walk for several minutes or perform daily activities without assistance. This deconditioning, called "hospitalization-associated disability," is defined as a newly acquired disability among activities of daily living (ADL) during hospitalization.[1,2] In a recent study, almost one in two older adults hospitalized with pneumonia developed hospitalization-associated disability.[3]

After a rapid economic and social transformation, older adults in Korea are in crucial need of long-term care system due to the shift in family duties away from caring for one's parents.[4] In response to these needs, the Long-Term Care Insurance (LTCI) was launched in 2008.[5] LTCI has played a major role in the transition from home care to long-term care facilities and increased social responsibilities for older adults.[6] While LTCI has built the foundation for care benefits in communities focusing on ADL, the system has provided little attention to caregiving issues associated with post-acute care. Older adults are vulnerable to the adverse effects of hospitalization,[1] are prone to experiencing functional decline, and in many cases, never return to their baseline status.[7] Patients with stronger familial support and hence the ability to perform self-rehabilitation showed better resilience to functional decline after hospitalization, underscoring the role of social support in care transition.[3,8]

Older patients with both multimorbidity and functional impairment who are in the transition phase of acute hospitalization require attention from multiple domains of medical, nursing, and social care in both communities and hospitals. However, in the current medical delivery system of Korea, at the patient level, there are few options after discharge from hospitalization, with gaps in serving discharged patients with newly developed hospitalization-associated disabilities. To receive LTCI services, patients sometimes have to wait up to 6 months during the screening period before receiving benefits;[9] moreover, the service does not cover care expenses for convalescent hospitals. Consequently, caregiving issues in the transition period fall largely to family members.

Care transition is a broad idea, comprising all transitions within the hospital setting or across healthcare settings.[10] Moreover, care transition does not refer only to physical changes in healthcare settings. Issues from care transitions might be addressed by a form of multidisciplinary intervention consisting of assessment, identification, communication, home visits, and involvement by primary care physicians for follow-up.[10,11] In 2018, the Ministry of Health and Welfare announced the launch of community care projects in local communities to promote community care as an extension of LTCI. As of February 2020, two distinct pilot programs have been established: a nationwide transitional care team and the Pilot Project of Rehabilitation Medical Institutions.[12] These models are structured under responsible medical institutions to supply essential medical councils with regional government-designated centers and local healthcare institutions. Therefore, the model requires well-linked cooperation between institutions and communities; however, this remains insufficient due to a lack of communication and awareness within the medical institutions and local healthcare centers. The barriers to cooperation with public health centers include a high rejection rate and unfamiliarity with the service.[13]

The aim of the transition of care for older adults should include patients' functional recovery from hospitalization by minimizing the fragmentation of healthcare services. To meet this goal, discussions on medical and functional care plans should be started at the initial admission.[14] Moreover, we need to identify factors to help select the target population for optimal care settings; in this con-

text, some studies have suggested measuring frailty as a guide for resource allocation.[15,16]

To date, there is little evidence regarding the effectiveness of the transitional care systems in Korea and further research is needed. Resolving the existing drawbacks of current systems with care transition services requires strategies to identify the target population who would benefit from the service, when they should receive the service, and in which state of care. In addition, streamlined strategies should be developed to interlink medical services paid by the National Health Insurance System and welfare services by the LTCI. Both qualitative and quantitative studies on potential barriers and solutions targeting patients and healthcare personnel to foster effective care transition strategies in older adults are warranted. Intervention studies with varying scales, adopting the hypotheses from qualitative and observational studies, may provide effective and scalable service models. By successfully filling current gaps in care transition from acute hospitalization to different levels of care, a significant population with functional issues that currently end up in care facilities may instead be able to stay at home and regain functional independence.

ACKNOWLEDGMENTS

CONFLICT OF INTEREST

The authors claim no conflicts of interest.

AUTHOR CONTRIBUTION

Conceptualization, CMP; Supervision, HWJ; Writing-original draft, CMP, HWJ; Writing-review & editing, CMP, HWJ.

REFERENCES

1. Covinsky KE, Pierluissi E, Johnston CB. Hospitalization-associated disability: "She was probably able to ambulate, but I'm not sure". JAMA 2011;306:1782-93.
2. Chodos AH, Kushel MB, Greysen SR, Guzman D, Kessell ER, Sarkar U, et al. Hospitalization-associated disability in adults admitted to a safety-net hospital. J Gen Intern Med 2015;30:1765-72.
3. Park CM, Kim W, Rhim HC, Lee ES, Kim JH, Cho KH, et al. Frailty and hospitalization-associated disability after pneumonia: a prospective cohort study. BMC Geriatr 2021;21:111.
4. Kwon S. Future of long-term care financing for the elderly in Korea. J Aging Soc Policy 2008;20:119-36.
5. Ga H. Ten years of long-term care insurance in Korea: light and shade from a geriatric point of view. Ann Geriatr Med Res 2017;21:147-8.
6. Ga H. Long-Term Care System in Korea. Ann Geriatr Med Res 2020;24:181-6.
7. Yoo HW, Kim MG, Oh DN, Hwang JH, Lee KS. Factors associated with functional decline in older adults after discharge from an acute-care hospital. Asian Nurs Res (Korean Soc Nurs Sci) 2019;13:192-9.
8. Cournane S, Conway R, Byrne D, O'Riordan D, Silke B. Persons with disability, social deprivation and an emergency medical admission. Ir J Med Sci 2018;187:593-600.
9. Korea Ministry of Health and Welfare. Notice on the standard for providing long-term care benefits (2018-130) [Internet]. Sejong, Korea: Ministry of Health and Welfare; 2018 [cited 2021 Mar 15]. Available from: http://www.mohw.go.kr/react/jb/sjb0406vw.jsp?PAR_MENU_ID=03&MENU_ID=030406&page=1&CONT_SEQ=345247.
10. Mansukhani RP, Bridgeman MB, Candelario D, Eckert LJ. Exploring transitional care: evidence-based strategies for improving provider communication and reducing readmissions. P T 2015;40:690-4.
11. Schaap LA, Pluijm SM, Deeg DJ, Visser M. Inflammatory markers and loss of muscle mass (sarcopenia) and strength. Am J Med 2006;119:526.e9-17.
12. Korean Ministry of Health and Welfare. Designation of a responsible medical institution for cooperation in essential medical care in the community [Internet]. Sejong, Korea: Ministry of Health and Welfare; 2020 [cited 2021 Mar 15]. Available from: http://www.mohw.go.kr/react/al/sal0301vw.jsp?PAR_MENU_ID=04&MENU_ID=0403&BOARD_ID=140&BOARD_FLAG=00&CONT_SEQ=352960.
13. Shin J, Han SH, Choi J, Kim YS, Lee J. The experience of providing older adult patients with transitional care from an acute care hospital to home in cooperation with a public health center. J Korean Med Sci 2020;35:e348.
14. Mai Ba H, Son YJ, Lee K, Kim BH. Transitional care interventions for patients with heart failure: an integrative review. Int J Environ Res Public Health 2020;17:2925.
15. Cations M, Lang C, Crotty M, Wesselingh S, Whitehead C, Inacio MC. Factors associated with success in transition care services among older people in Australia. BMC Geriatr 2020;20:496.
16. Larsen RT, Turcotte LA, Westendorp R, Langberg H, Hirdes JP. Frailty index status of Canadian home care clients improves with exercise therapy and declines in the presence of polypharmacy. J Am Med Dir Assoc 2020;21:766-771.e1.

Corresponding Author: Hee-Won Jung, MD, PhD
Division of Geriatrics, Department of Internal Medicine, Asan Medical Center, University of Ulsan College of Medicine, 88, Olympic-ro 43-gil, Songpa-gu, Seoul 05505, Korea
E-mail: hwjung@amc.seoul.kr
ORCID: https://orcid.org/0000-0002-2583-3354

Received: February 10, 2021; Revised: March 4, 2021; Accepted: March 8, 2021