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Exploring how transitional aged care supports older people leaving hospital

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Older Australians are more likely to be admitted to hospital than younger Australians. In 2022–23, 17% of Australians were aged 65 and over, yet they accounted for 44% of hospitalisations (ABS 2024, AIHW 2024a).

Older people admitted to hospital are at greater risk of experiencing functional decline; a reduction in their ability to perform day-to-day tasks, as well as cognitive decline (Chen et al 2022). This is not only the result of the illness or injury that led to being admitted to hospital, but also the hospital environment itself (SA Health 2024).

As a result, leaving hospital is a particularly vulnerable time for older people. An older person may need more support after leaving hospital if they have difficulty doing day-to-day tasks safely and on their own. If they receive assistance during this time, it can help them regain their functional independence and avoid the need for longer term care and support services.

The national Transition Care Programme (transition care) provides funding for short-term specialised support to help older people to regain their functional independence after a hospital stay. An earlier report found that transition care enabled older people to leave hospital earlier and could also help delay or prevent entry into residential aged care (KPMG 2019).

This report provides a snapshot of the people using transition care within a 1-year period. It uses linked aged care data to explore who uses transition care, how they use it, and how this use fits into the broader aged care system. As this report includes only people who used transition care, we cannot see what would happen without this support in place. Even so, the results suggest positive outcomes for people using transition care.

Around 3 in 5 people returned to the community (with or without other aged care support) after starting transition care in 2020–21.

Almost 9 in 10 people who returned to the community, improved their functional independence after receiving transition care.

People who did not return to the community at the end of transition care had lower functional independence at entry.

AIHW

The analysis shows that 3 in 5 people who used transition care returned to the community, and almost all of these people (86%) experienced an increase in their functional independence on leaving the program. Fewer than 1 in 7 people who returned to the community, went on to enter permanent residential aged care by the end of the following year.

This highlights the importance of targeted interventions that help older people regain their independence after leaving hospital. Aside from the benefits to the individual and their families, there is also a community benefit if such intervention delays or prevents a person's entry into residential aged care or readmission to hospital.

What data did we use?

This report focuses on people who started transition care services in 2020–21 and also follows their aged care service use from before and after they started transition care until the end of 2021–22. It describes people who have used transition care and episodes of transition care. A transition care episode refers to a single period of time that a person receives transition care services, based on one entry date and one exit date. A person can have multiple transition care episodes, and there is no limit to how many times a person can receive transition care within a year.

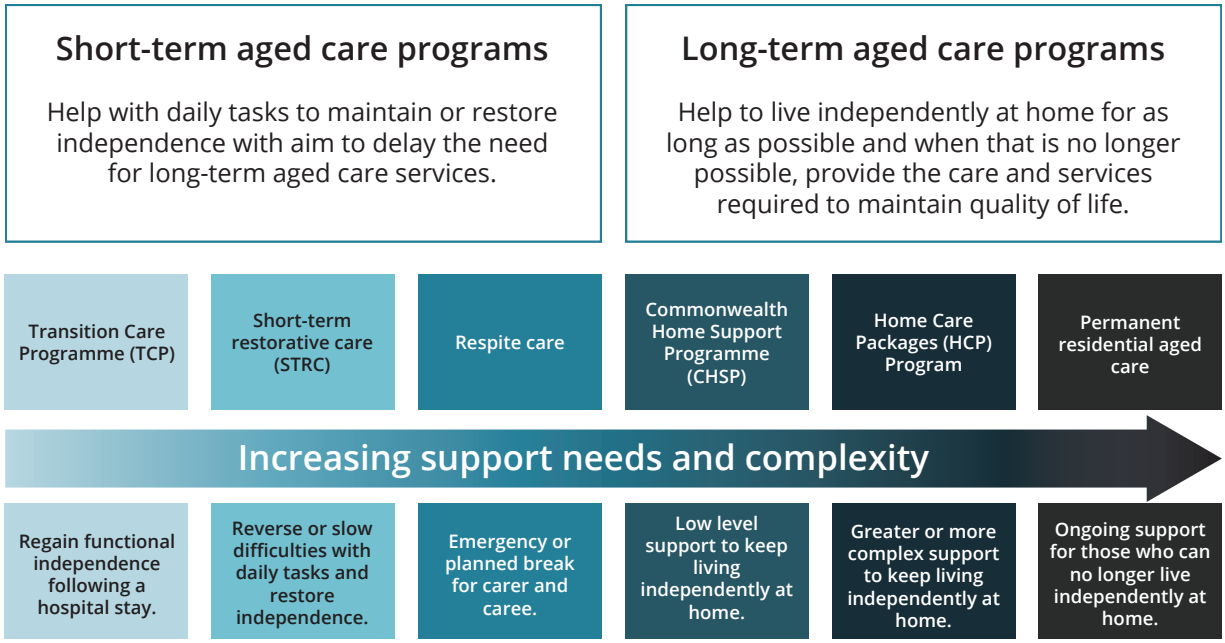
This report uses the Pathways in Aged Care (PIAC) link map. PIAC is a data asset derived by linking aged care activity data from the National Aged Care Data Clearinghouse (NACDC) and death records from the National Death Index (NDI). It includes activity data for aged care assessments, home support, home care, transition care and residential aged care. This information can be used to monitor, improve, and plan services.

Only people enrolled in Medicare are included in the PIAC data linkage. This means that some people using aged care may not be included, and data presented here may differ from other publications and sources.

The Transition Care Programme (transition care) is a unique program in the Australian Aged Care system

There are several Australian Government-funded aged care services available to older Australians. These fall under 2 categories: short-term aged care and long-term aged care. The different types of care have different aims, can be in different settings, and are designed to meet different needs (Figure 1). For more information, see the Department of Health and Aged Care's Types of aged care services and GEN People using aged care.

Figure 1: Australian Government-funded aged care services



Excludes flexible aged care programs available such as Multi-Purpose Services (MPS) and National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) Program.

Source: AIHW

For more information, see the Department of Health and Aged Care's Types of aged care services and GEN People's care needs in aged care.

Transition care is jointly funded by federal and state and territory governments. It is short-term, with distinct and discrete objectives compared to long-term aged care services. Short-term aged care services like transition care aim to maintain or restore independence and as such, capture information relating to this aim. The effectiveness of transition care in assisting people to regain their independence can be informed by transition care users' functional independence data that is captured at entry and exit to transition care (See *How is functional independence measured?*).

How is functional independence measured?

A person's functional independence is determined using the modified Barthel Index (mBI). Functional independence is a person's ability to complete activities of daily living, safely and autonomously.

Functional independence scores:

- provide an estimate of independence
- are out of 100
- assess how much help a person needs with 10 kinds of activities of daily living: feeding, bathing, dressing, personal hygiene, using the toilet, bladder control, bowel control, climbing stairs, walking or the ability to move about (for those not in a wheelchair), wheelchair use for those trained in using one; and moving between a chair and a bed.

Lower scores mean a person has less independence and more support is needed to complete self-care tasks. Higher scores mean a person has more independence, and less support is needed.

A person's functional independence is determined when they enter and leave transition care to see if it improved. In some cases, functional independence is not captured if the person leaves transition care unexpectedly, for example if they are readmitted to hospital or die (See *Three in 5 people returned to living in the community straight after using transition care*).

Transition care provides support for older people leaving hospital

Transition care was introduced in 2005 to help older people recover after a hospital stay. It provides support to help people regain their functional independence and confidence sooner, with the aim of avoiding or delaying the need for longer term care and support services. Transition care can include services such as:

- low intensity therapy; for example, physiotherapy, podiatry, counselling
- nursing support; for example, pain management, wound care, dementia support
- personal assistance with everyday tasks; for example, bathing, showering, eating, dressing.

An eligibility assessment for transition care determines the services that would best meet a person's support needs. Care is then delivered in the most appropriate place. Transition care services can be provided in different settings (in the community or in a residential aged care facility) and can change as a person's support needs change. For example, a person with high support needs may require a short stay in residential aged care where 24/7 care and support is available. A person with low support needs may receive services at home and in the community. Some people may receive services in both settings as they recover and their needs change. While we know that outcomes of transition care vary markedly across delivery settings (see *More about transition care settings*), information about the location of transition care (in the community or residential aged care) was not available in the data used for this report. Future data supply, analysis and reporting will aim to fill this gap.

More about transition care settings

Previous research (Cations et al 2020) has reported that of the 120,000 people who used transition care for the first time between 2007 and 2015:

- 54% received transition care in the community
- 34% in a residential aged care facility
- 12% in both places.

Outcomes for people using transition care varied greatly depending on the setting in which transition care was accessed. Specifically:

- 2 in 3 of those who completed their transition care in the community or both settings returned to the community after transition care. In contrast, only 1 in 5 people who completed transition care in residential aged care returned to the community.
- People completing transition care in residential aged care had lower functional independence at the start and end of the program and half immediately entered permanent residential aged care.

To be eligible for transition care, a person must be admitted to hospital at the time of the initial assessment. Services can be provided for up to 12 weeks and possibly extended for 6 weeks after another assessment. There is no limit on how many times transition care services can be received, and they can be received at the same time as other aged care services, other than respite residential aged care and short-term restorative care.

The number of people using transition care has remained mostly the same since 2012–13

During 2020–21, around 5 million Australians aged 65 and over had a hospital stay (AIHW 2022). In the same year, 20,600 people started 22,900 episodes of transition care. Of these 20,600 people, just over 20,500 had data for the analyses included in this report (See *About aged care eligibility assessment data*). The rest of this report focuses on these 20,500 people and follows their aged care service use until the end of 2021–22. This number of people is different to that reported elsewhere as it only includes people linked in Pathways in Aged Care link map (see *What data did we use?*).

About aged care eligibility assessment data

Aged care assessments gather information about people's demographics, health conditions, support needs and other details that are used to determine aged care eligibility and appropriate aged care service recommendations.

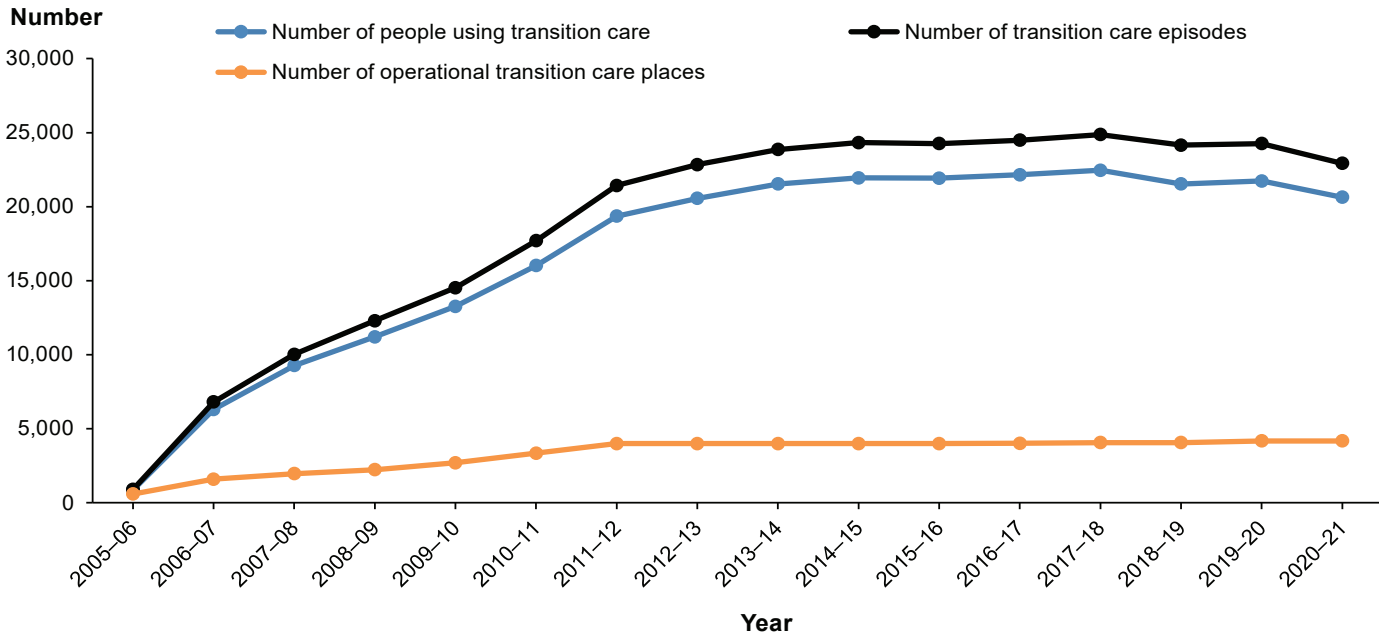
For this report, assessment data has been drawn from the aged care eligibility assessment, the National Screening and Assessment Form (NSAF). NSAF assessments were included if they occurred within 28 days of a person first using transition care services in 2020-21, consistent with the Transition Care Programme guidelines. Assessments dated to 1 day after entry to transition care were also included to allow for delays to administrative processes.

For more information on the NSAF, see My Aged Care – National Screening and Assessment Form fact sheet.

Overall, more than 270,000 Australians have received about 300,000 episodes of transition care from when the program started in 2005–06 to 2020–21. The number of people that can use transition care are limited by the number of operational places. Since 2012–13, the number of people using transition care each year has remained at around 21,000 to 22,000 (Figure 2). The number of operational places for transition care remained mostly unchanged from 2011–12 to 2020–21 (4,000 and 4,200 respectively).

Figure 2: The number of people using transition care has been stable over the decade to 2020–21, after an initial increase from when the program started in 2005–06

Number of people using transition care, number of transition care episodes and number of transition care operational places, 2005–06 to 2020–21



Source: AIHW analysis of PIAC 2022 (Table S1), Commonwealth of Australia 2006-2021.

Notes:

1. For more information on 'episodes', see *What data did we use?*
2. Year defined by the entry date of transition care episode. Operational transition care places are at 30 June.
3. People may have more than 1 transition care episode within a 1-year period, or across years. People are counted only once within the same year but can be counted multiple times across different years.
4. Includes only people who were able to be linked in the Pathways in Aged Care link map. Counts may vary slightly from other data sources (See *What data did we use?*).

It is important to note that from early 2020 aged care and health services in Australia were affected by the COVID-19 pandemic and associated social restrictions and lockdowns. Further information on this is in the Report on the Operation of the Aged Care Act. Further information on the effect of COVID-19 on hospital activity is on the MyHospitals website.

Transition care supports a diverse group of older Australians

Older Australians are a diverse group with different ages, socioeconomic backgrounds, life experiences and lifestyles. All these factors influence a person's health and wellbeing and how they choose to use aged care as they get older.

Of the 20,500 people using transition care in 2020–21:

- 3 in 5 were women (60%, 12,300)
- around 1 in 50 (2.2%, 445) identified as Aboriginal and/or Torres Strait Islander people (First Nations people)
- just over 3 in 5 (61%, 12,500) were aged 80 and over
- 1 in 3 (34%, 6,900) were born in a country other than Australia.

The median age of people using transition care in 2020–21 was **82 for men** and **83 for women**.

People's current living arrangements are captured when they are assessed for eligibility for aged care services, including transition care (See *About aged care eligibility assessment data)*. Understanding where people live and whether they live alone or with others (for example with family, a partner, or other residents) is important when assessing their support needs when leaving hospital. It is common for older Australians to receive informal support from family and/or friends, and this support can be critical after a hospital stay. Looking at a person's living arrangements can also provide information about their level of community engagement and social isolation.

Half of people using transition care **live alone**.

Half (49%, 10,000) of all people using transition care in 2020–21 lived alone, 1 in 3 (32%, 6,500) lived with a partner and about 1 in 6 (18%, 3,700) lived with family, friends or others. Women were most likely to live alone (55%, 6,800), while men were most likely to live with a partner (44%, 3,600; Table S3). This may partially reflect that women tend to have a longer life expectancy than men (AIHW 2024b).

Most people lived in their house or apartment in the community (89%, 18,400) or independent living in a retirement village (7.6%, 1,600), with only 92 people (0.4%) reporting their usual accommodation before transition care was in residential aged care.

Most people had **4 or more health conditions** reported.

The reasons older people are admitted to hospital are reported in administrative hospital data and not aged care data. However, information about a person's health status is collected during completion of the National Screening and Assessment Form (See *About aged care eligibility assessment data*). This includes the reporting of physical and mental health conditions, disability, and signs/symptoms of a health condition. Health conditions may or may not be formally diagnosed, and not every health condition reported will affect a person's support needs or be related to their hospital visit.

Multiple health conditions were common – nearly 9 in 10 people (87%, 17,800) using transition care had 4 or more health conditions reported. Conditions of the circulatory system was the most reported health condition group, affecting more than 4 in 5 (85%, 17,500) people using transition care in 2020–21. These conditions include both chronic diseases such as high blood pressure and heart disease, and acute events such as heart attack and stroke. The next most common groups were:

- conditions of the musculoskeletal system (65%, 13,400) such as arthritis and osteoporosis
- injury, poison, external health conditions (55%, 11,300) such as dislocations and fractures
- conditions of the endocrine system (55%, 11,300) such as diabetes and high cholesterol.

While conditions of the circulatory system and endocrine system were reported similarly for men and women, conditions of the musculoskeletal system and injury, poison, external health conditions were much more commonly reported for women:

- 72% (8,900) of women had a musculoskeletal condition reported compared with 55% (4,500) of men
- 62% (7,600) of women had an injury, poison, external health condition reported compared with 46% (3,800) of men (Table S4).

The most reported individual health conditions were diseases often associated with older ages including high blood pressure (62%, 12,800), osteoarthritis (36%, 7,300) and high cholesterol (28%, 5,800). Stroke was reported for almost 1 in 5 people (19%, 3,800) and a type of dementia for around 1 in 10 people (11%, 2,300).

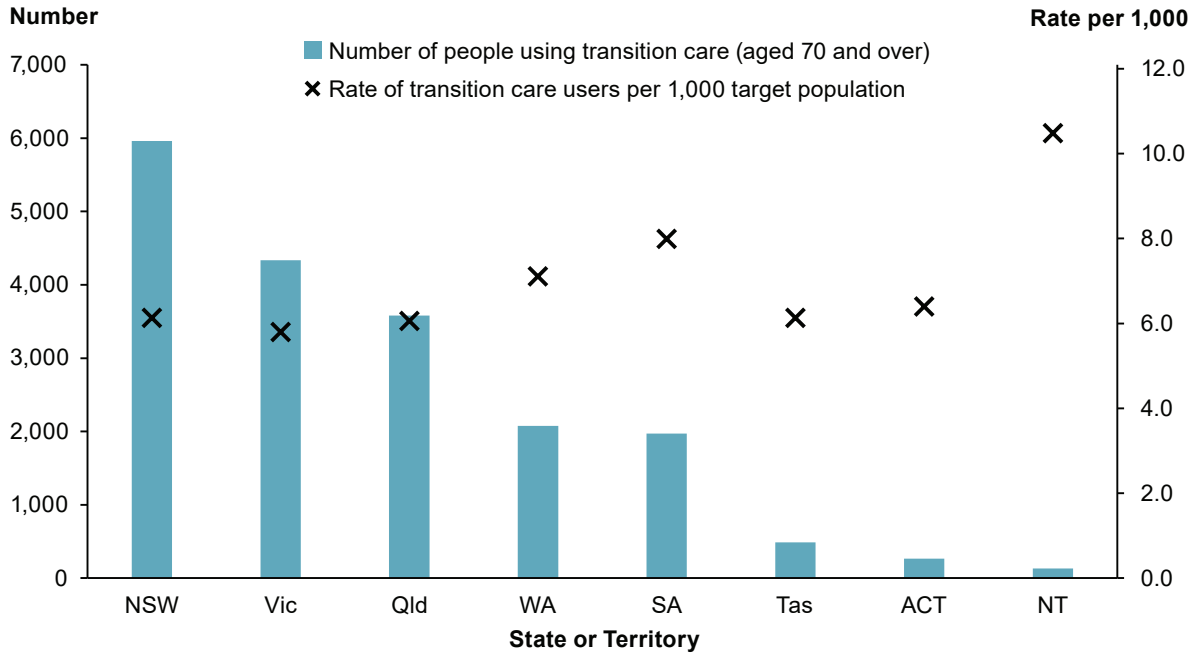
Older people in the Northern Territory have the highest rate of transition care service use

Across the states and territories, the number of people using transition care in 2020–21 was generally in line with population size. For example, New South Wales has the largest population and the highest number of people using transition care services (6,500). Conversely, the Northern Territory has the smallest population and the smallest number of transition care users (160).

However, when considering the rate of use by people aged 70 and over (the target population for Australian Government planning purposes), people in the Northern Territory were most likely to use transition care. The Northern Territory had almost twice the rate of transition care use in older people (10.5 per 1,000 target population) compared to Victoria, which had the lowest rate of use (5.8 per 1,000; Figure 3).

Figure 3: Older people in the Northern Territory were more likely to use transition care services than in other states and territories

Number and rate per 1,000 of the target population of people using transition care, by state and territory, 2020–21



Source: AIHW analysis of PIAC 2022 (Table S6)

Notes:

1. Number of people using transition care includes only people aged 70 and over at time of entry to transition care.
2. Target population includes all people aged 70 and over, aligning with Australian Government planning ratios.
3. Population based on ABS estimated resident population (ERP) at 31 December 2020 (ABS 2024).

The number of operational transition care places in 2020–21 was also generally in line with population size. However, when considering the target population, the Northern Territory had the highest number of operational transition care places per target population (3.1). This is double the rate of all other states and territories, and the Australian average (1.4). Access and availability to transition care vary state by state, given the program is jointly funded by the federal and state and territory governments.

Hospitalisation rates in the Northern Territory, and more generally in remote and very remote areas, tend to be higher than in other areas of Australia (AIHW 2024a). This means that, on average, people in the Northern Territory are more likely to use hospital, and a higher proportion of transition care places exist for older people to access supportive services when leaving hospital.

Three in 5 people return to living in the community straight after using transition care

The following and subsequent sections of this report (unless otherwise specified), describe people's first transition care episode in 2020–21. An **episode** refers to a single period of time that a person receives transition care services (See *What data did we use?*).

The main aim of transition care is to help older people recover after a hospital stay and restore their functional independence so that they can return to living in the community. People may exit transition care to return to the community, with or without other aged care support in place, consistent with this aim. However, sometimes a person may leave transition care unexpectedly, for example if they are readmitted to hospital or die, or due to entry into residential aged care.

Nearly 3 in 5 (57%, 11,600) people who started a transition care episode in 2020–21 (across all settings) returned to living in the community on exit from transition care:

- with no formal aged care support (16%, 3,200)
- with formal aged care support of a Home Care Package (HCP) (12%, 2,400)
- with formal aged care support of the Commonwealth Home Support Programme (CHSP) (29%, 6,000).

People who returned to the community with no formal aged care support were more likely to report at assessment that they lived with a partner, family, friends or others (58%,1,900), compared with people returning to the community with formal aged care support in place (HCP: 45%, 1,100; CHSP: 48%, 2,900). As mentioned earlier, informal care plays a crucial role in the Australian aged care system and information about informal care people may receive after leaving hospital and/or transition care are not captured here.

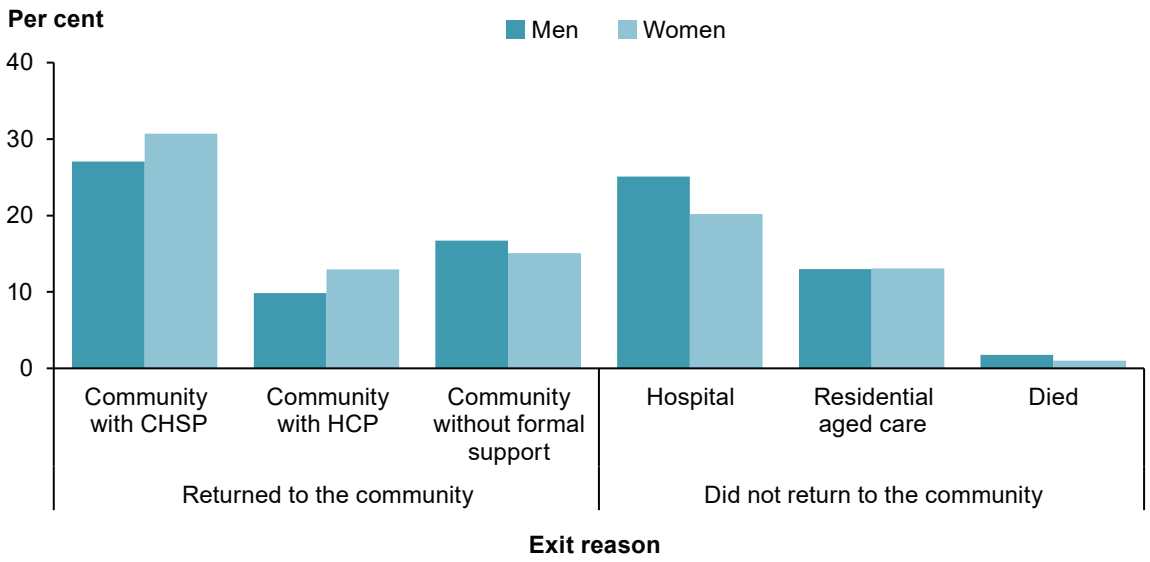
Women were more likely than men:

- to return to living in the community (59%, 7,200 and 54%, 4,400 respectively)
- to return to living in the community with the support of HCP (13%, 1,600 and 10%, 810 respectively)
- to return to living in the community with the support of CHSP (31%, 3,800 and 27%, 2,200 respectively).

Returning to hospital (22%, 4,600) or entering residential aged care facilities (13%, 2,700) were also common after exiting transition care. Around 25% (2,100) of men returned to hospital, compared with 20% (2,500) of women (Figure 4).

Figure 4: Women are more likely to return to living in the community after exiting transition care than men

People starting a transition care episode during 2020–21, by sex and exit reason



Source: AIHW analysis of PIAC 2022 (Table S7)

Note: Proportions in the graph do not include people with an unknown exit category (1,200) or exit reason of 'transferred to another transition care service' (210).

CHSP: Commonwealth Home Support Programme. HCP: Home Care Package.

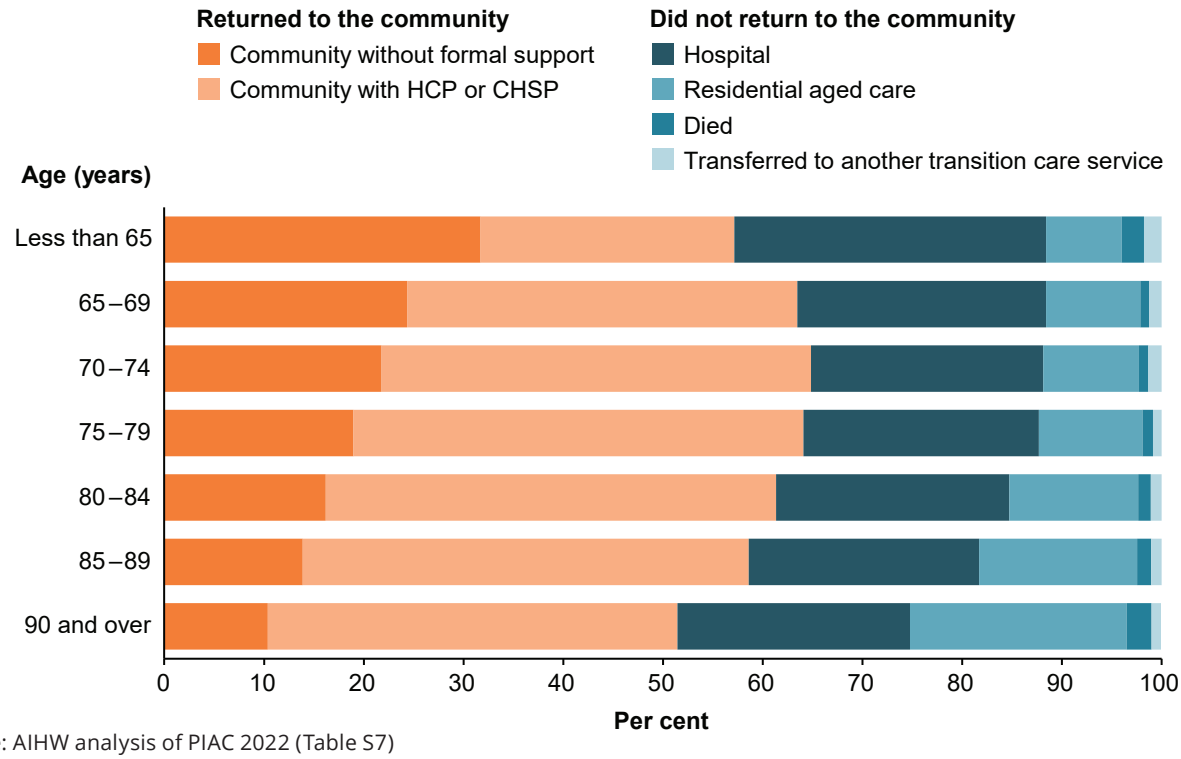
The youngest and oldest age groups had different exit patterns to other age groups (Figure 5):

- More than 1 in 5 (22%, 690) people aged 90 and over exited transition care to enter residential aged care, the highest of all age groups.
- People aged less than 65 were the least likely (25%, 57) to leave with formal aged care support in place and most likely (31%, 70) to return to hospital.

People aged less than 65 who access the aged care system tend to have different health conditions and characteristics to older people (see Exploring pathways for younger people living in residential aged care).

Figure 5. People aged 90 and over and under 65, were less likely to return to the community on exit from transition care

Reason for transition care exit, by age group, 2020–21



Source: AIHW analysis of PIAC 2022 (Table S7)

Note: Proportions in the graph do not include people with an unknown exit category (1,200).

CHSP: Commonwealth Home Support Programme. HCP: Home Care Package.

People tend to use transition care once, for varying durations up to 12 weeks

Transition care services are designed to be provided flexibly and based on individual support needs. People can be eligible to receive transition care as many times as needed, even within the same year, and the program guidelines recommend duration is based on meeting the person's support needs rather than the maximum length of 12 weeks (or 18 with an approved extension) (Department of Health and Aged Care 2022). Whilst there is no limit to how many times a person can access transition care, most people included in this report (84%, 17,300) only used transition care once. This includes transition care use in previous years from 2005–06, to the end of 2021–22.

Before starting transition care in 2020–21, around half (45%, 9,300) of people stayed in hospital for 4 weeks or longer (median length: 27 days). Only 1 in 25 people (4.3%, 890) stayed in hospital for less than 1 week. Men and women stayed in hospital for similar lengths, as did people across all age groups (median length: 25 to 28 days).

Following their hospital stays:

- 2 in 3 (65%, 13,400) people had a transition care episode for less than 11 weeks
- 1 in 4 (25%, 5,100) had an episode for 11 to less than 12 weeks
- 1 in 10 (10%, 2,000) had an episode for 12 weeks or more.

There was little difference in transition care episode length between men and women, however there were differences across age groups. People aged 90 and over had the shortest transition care episodes (median length: 51 days), and people aged 65 to 69 had the longest (median length: 64 days).

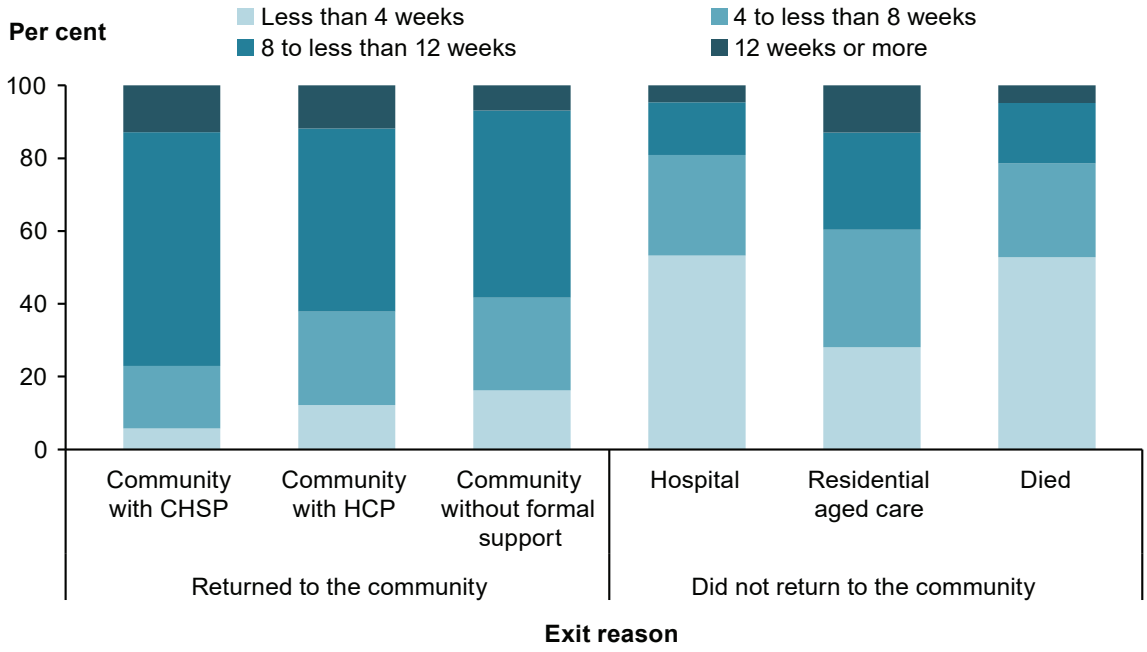
The different lengths of stay for people aged 90 and over are closely related to their reasons for exiting the program (see *Three in 5 people return to living in the community straight after using transition care*). This age group are much more likely to exit the program for those reasons that typically have shorter lengths across all age groups, namely hospitalisation, entering residential aged care, or death. Whilst 23% (4,800) of all transition care episodes ended after less than 4 weeks:

- 53% (2,400) of all episodes ending in hospitalisation lasted less than 4 weeks.
- 28% (750) of all episodes ending to enter residential aged care lasted less than 4 weeks.
- 53% (145) of episodes that ended due to death lasted less than 4 weeks.

In contrast, only 10% (1,200) of transition care episodes ending with the person returning to the community lasted less than 4 weeks (Figure 6).

Figure 6. People were in transition care for less time if they left due to rehospitalisation, residential aged care, or death

Length of transition care episode, by transition care exit reason, 2020–21



Source: AIHW analysis of PIAC 2022 (Table S11)

Note: Proportions in the graph do not include people with an unknown exit category (1,200) or exit reason of 'transferred to another transition care service' (210).

CHSP: Commonwealth Home Support Programme. HCP: Home Care Package.

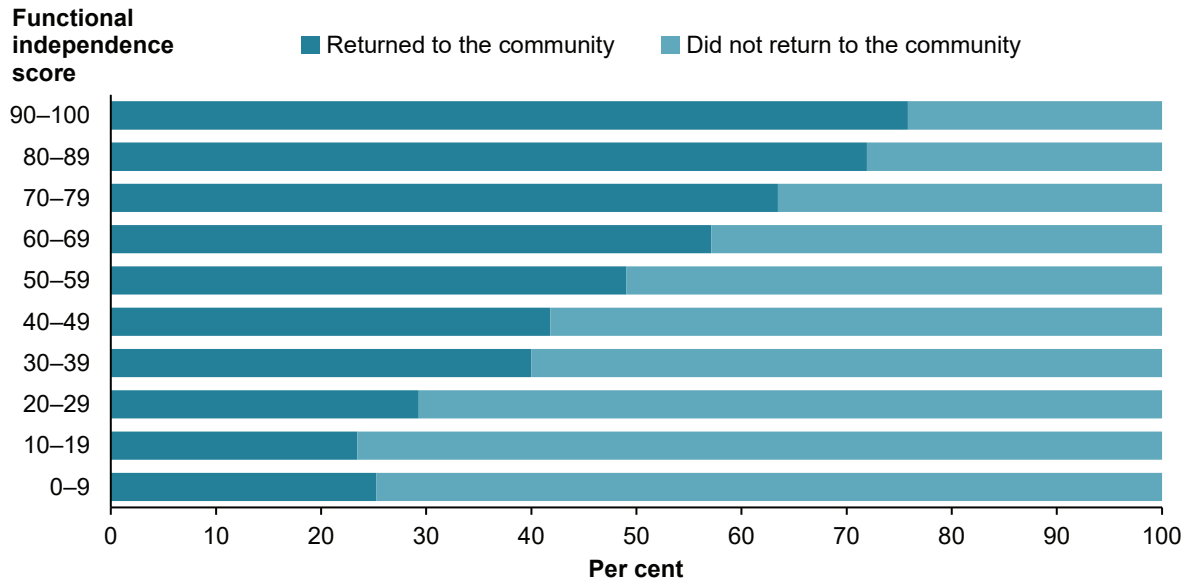
People who start transition care with lower functional independence are less likely to return to living in the community

Whilst most people return to living in the community on exiting transition care, the short-term and less intense support provided by transition care may not be enough for people who begin transition care with lower functional independence. People who did not return to living in the community on exiting transition care had considerably lower functional independence scores at entry to transition care than people who did (median functional independence scores of 66 and 80 respectively), as measured by the mBI (see *How is functional independence measured?*).

Further, the lower functional independence score at entry to transition care, the less likely someone was to return to living in the community on exit from transition care (Figure 7). For people with a known exit category, only 1 in 4 (25%, 95) people starting transition care with a functional independence score of less than 10 returned to living in the community. This increased to more than 3 in 4 (76%, 2,400) for people starting transition care with a functional independence score of 90 or higher.

Figure 7. People with lower functional independence at entry to transition care are less likely to return to living in the community on exit from transition care

People starting transition care episode of care during 2020–21, by functional independence score at entry to transition care and exit category



Source: AIHW analysis of PIAC 2022 (Table S12)

Note: Proportions in the graph do not include people with an unknown exit category (1,200).

More than 1 in 7 (15%, 55) people with functional independence scores of less than 10 at entry, exited due to dying. This was far larger than all other functional independence scores, with the proportion of people dying decreasing with increasing functional independence scores (ranging from 4.2% for scores of 10–19 to 0.4% for scores 90–100).

Most people who return to living in the community have improved functional independence when leaving transition care

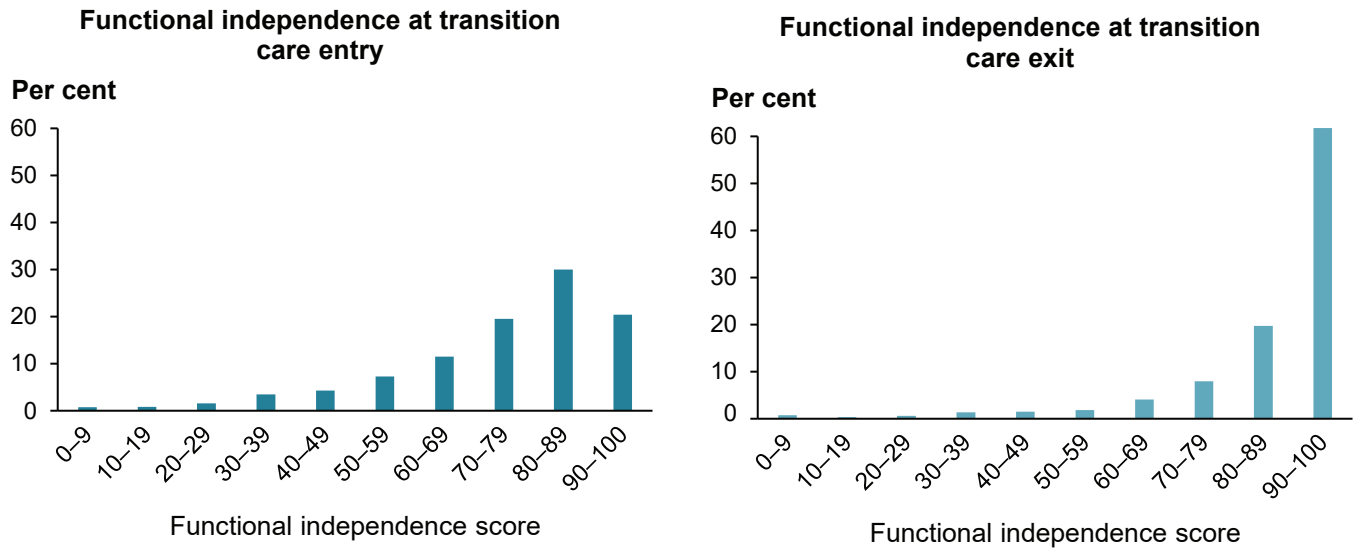
A key aim of transition care is to support older people to improve their level of functional independence following a hospital stay, in order to regain independence and remain living in their home. Looking at functional independence scores at entry and exit to transition care allows exploration of whether a person's functional independence has increased after receiving transition care services. However, functional independence is only one component of a person's recovery, and many other components contribute to a person's recovery and ability to return to living in the community. Analysis of functional independence change in this report is limited to where people return to living in the community on exit from transition care. This is because not everyone who exits for other reasons, such as due to hospitalisation or death, has a second measurement of functional independence on exiting transition care.

On exit from transition care into the community, most people (86%, 10,000) had an improvement in their functional independence score compared to when they started transition care.

- The median change in functional independence score was 12.
- The median functional independence score on exit was 92 (up from 80 at entry).
- Most people had a functional independence score on exit of 80 or higher (81%, 9,500), compared with 50% (5,900) on entry (Figure 8).
- Women were slightly more likely to show improvement on exit (88% compared with 84% for men).
- Apart from people aged less than 65 years, in which 82% of people saw an improvement in functional independence, little variation between age groups was found (all other age groups: 85% to 87% people experienced an improvement).

Figure 8. Most people had a functional independence score on exit of 80 or higher

People who returned to living in the community on exit from transition care that started during 2020–21, by functional independence scores at entry and exit



Source: AIHW analysis of PIAC 2022 (Table S13)

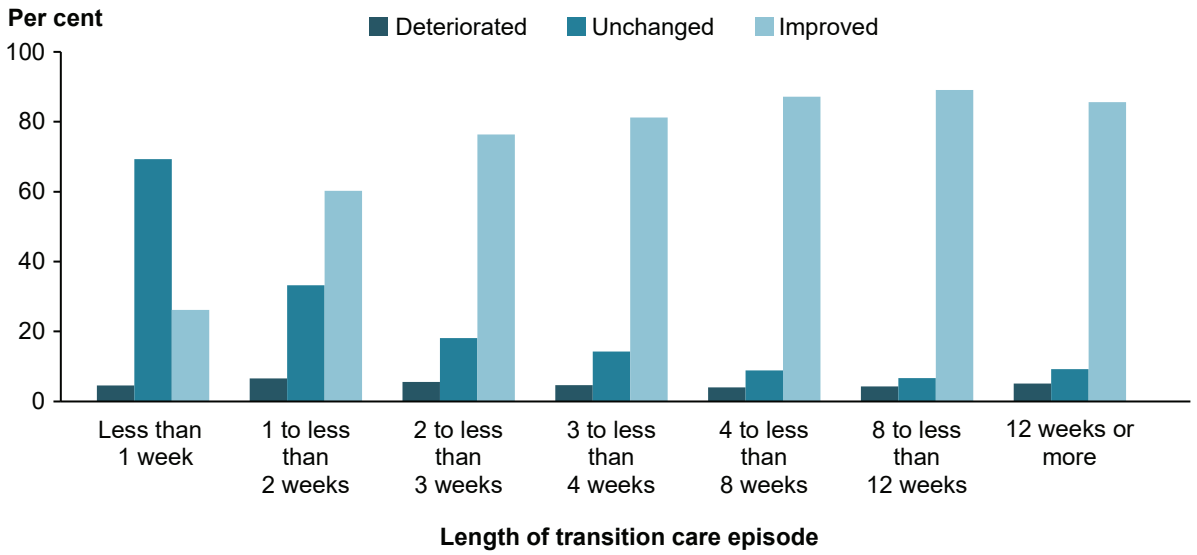
These strong results reflect well on transition care for those who are able to return to the community. It is important to note that some improvement in functional independence is likely due to people recovering from their hospital stay. Improvement due to transition care cannot be distinguished from improvement that would occur without this support. Additionally, recovery rates would be expected to differ based on different reasons for hospital stays. Reason for hospital stay is not captured in the aged care data.

People who had shorter transition care episodes were less likely to see an improvement in their functional independence (Figure 9), even though they still left the program to return to live in the community. Unsurprisingly, given how long recovery after a hospital stay can take, most (69%, 105) people who exited transition care after 1 week had no change in functional independence. Whilst this group had the lowest proportion of people showing improvement in functional independence, they also had the lowest proportion of people exiting to the community with the additional support of formal aged care. Only 41% (62) of people who left transition care after 1 week returned to the community with formal aged care home support (Home Care Package or Community Home Support Programme), compared with 76% (6,100) of people who exited transition care after 8 weeks or more. It is unclear why people exited

transition care to the community without formal aged care support so soon after entering. It is possible they were able to access formal or informal support or services outside of aged care, which are not captured in the data.

Figure 9. People with shorter transition care episodes are less likely to see improvement in functioning

People who returned to living in the community on exit from transition care that started during 2020–21, by improvement category and length of transition care episode



Source: AIHW analysis of PIAC 2022 (Table S14)

Improvement in functional independence was relatively consistent, irrelevant of length of hospital stay. Between 84% and 88% of people recorded an improvement for hospital stays ranging from less than 1 week to 8 weeks or more.

Prior to transition care, most people have already used aged care services

Exploring people's use of aged care prior to entering transition care is important to provide more context about where this service fits in with the larger Australian aged care system (See Figure 1). Prior to using transition care services for the first time ever, nearly 3 in 4 (74%, 15,200) people had previously used aged care. Women were more likely to have previously used aged care than men (78% and 68% respectively).

Of those that used aged care services, the types of aged care services used were similar across men and women.

- Home support alone was by far the most common, used by nearly 4 in 5 men and women (79%, 4,400 and 78%, 7,500 respectively).
- A combination of home support and home care packages was the next most common and slightly less common for men than women (12%, 660 and 14%, 1,300 respectively).

3 in 4 people used other aged care, mostly home support, before using transition care for the first time.

Almost all people who had previously used aged care services before using transition care, had used home support as their first aged care service (98%,14,800). Typically, home support provides lower levels of support than other aged care services and is often the first aged care service used by people.

Most people use other aged care services after transition care

Exploring how people use aged care services after transition care, provides further information on where this service fits in the larger Australian aged care system (See Figure 1). Following aged care use from when the 20,500 people used transition care services for the first time ever, up until the end of 2021–22, the data show:

- Most people (86%, 17,600) had used another aged care service after transition care, including 5,300 who had died.
- The remaining 14% (2,900 people) hadn't used any other aged care services after transition care, including 1,000 who had died.

Consistent with the analysis on exit reasons presented earlier (See *Three in 5 people returned to living in the community straight after using transition care*), many people using transition care went on to use community-based aged care services such as home support and/or home care packages. Looking at each of the most common aged care services:

- Home support was the most used aged care service after transition care, used by nearly 7 in 10 people (69%, 14,100).
- The next most used aged care service was permanent residential aged care, with around 3 in 10 (29%, 6,000) people going on to live in permanent residential aged care.
- Home care packages were used by around 1 in 4 people (26%, 5,400) and respite residential aged care by around 1 in 5 people (21%, 4,300).

Almost all people (86%) used aged care services after transition care, most commonly home support.

Around 2 in 5 people (43%, 8,900) used a combination of multiple aged care services after exiting from transition care. The combination of home support and home care packages was the most common, used by 1 in 7 people (14%, 2,900).

After using transition care, a considerably larger proportion of men died than women. Almost 2 in 5 men (38%, 3,100) who started transition care in 2020–21 had died by 30 June 2022, compared with 1 in 4 women (26%, 3,100). The most common causes of death were consistent across sexes and with the general causes of death seen in older Australians (AIHW 2024b):

- coronary heart disease (10% (325) of men and 8.1% (255) of women)
- dementia and Alzheimer's disease (6.4% (200) of men; 7.1% (225) of women)
- cerebrovascular disease (6.3% (200) of men; 7.1% (225) of women).

Three in 10 people were living in permanent residential aged care by the end of 2021–22

A key aim of transition care is to prevent premature entry into permanent residential aged care. As mentioned earlier, around 1 in 7 (13%) people who started transition care in 2020–21 exited the program to enter residential aged care (See *Three in 5 people returned to living in the community straight after using transition care*). People can enter residential aged care facilities to access multiple aged care services including respite and permanent residential aged care. This section focuses on people who went on to live in permanent residential aged care after transition care. This may be either immediately after their 2020–21 transition care episode, or between exiting transition care in 2020–21 and the end of the 2021–22 follow up period.

The following analysis should be considered in the context of previous research showing that entering permanent residential aged care is more common among people receiving transition care in a residential aged care facility than in the community (Cations et al 2020). Due to the unavailability of data on setting in which transition care has been accessed, the following analysis is not split by setting.

By the end of 2021–22 around 3 in 10 people (29%, 5,900) using transition care in 2020–21 went on to live in permanent residential aged care. Around 2 in 5 of these (41%, 2,500) were people who exited transition care directly to residential aged care (See *Three in 5 people return to living in the community straight after using transition care*).

Around 3 in 10 (29%, 1,700) of the 5,900 people who went on to enter permanent residential aged care entered on the same day as exiting transition care, and a further 47% (2,800) had entered within 6 months of exiting transition care. Even delaying entry to permanent residential aged care has many benefits.

The positive outcomes of people using transition care continued particularly for people who returned to living in the community on exit from transition care (Figure 10), with:

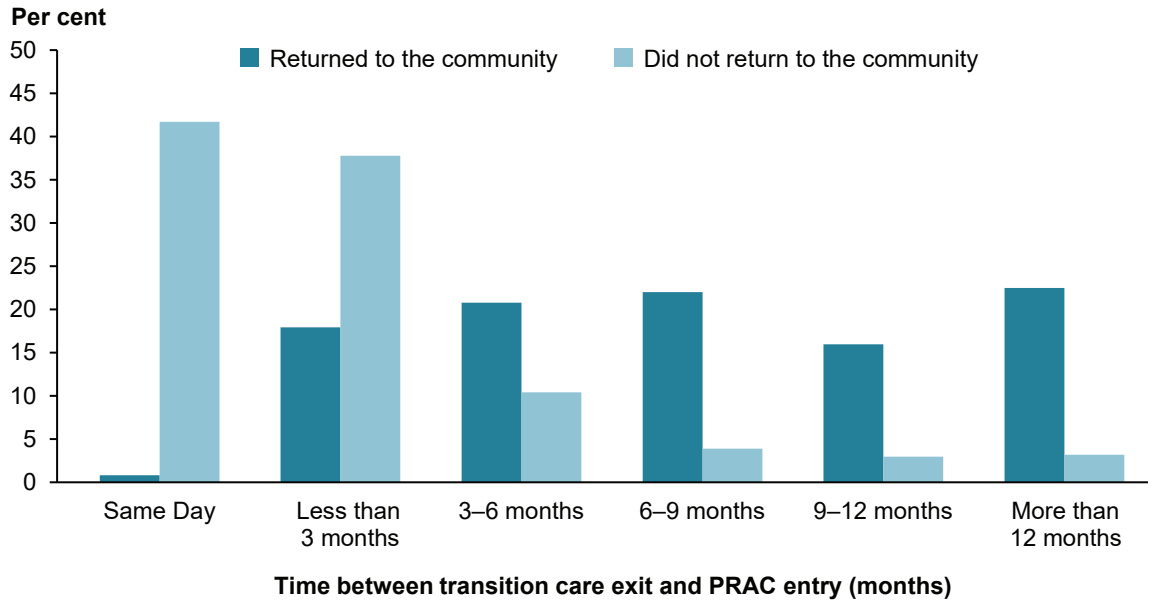
- Less than 1 in 7 (14%, 1,600) going on to enter permanent residential aged care
- Of those that did enter, most (60%, 950) entered 6 months or longer after leaving transition care, with 1 in 4 (22%, 355) entering around a year later.

Unsurprisingly, people who did not return to living in the community on exit from transition care were more likely to enter permanent residential aged care and soon after using transition care services:

- More than 1 in 2 (53%, 4,100) entered permanent residential aged care
- Most entered permanent residential aged care within 3 months of exiting transition care (80%, 3,200), and half of these entered on the same day as exiting transition care (1,700).

Figure 10. Most people who did not return to live in the community on exit from transition care and enter permanent residential aged care, do so within 3 months of leaving transition care

Transition care exit type in 2020–21 and time to entry to permanent residential aged care by the end of 2021–22



Source: AIHW analysis of PIAC 2022 (Table S16)
Note: Includes only people entering permanent residential aged care by 30 June 2022 (5,900 people).
PRAC: permanent residential aged care.

Regardless of whether people returned to live in the community on exit from transition care or not, people who went on to live in permanent residential aged care had lower functional independence scores at entry to transition care than those who did not go on to live in permanent residential aged care. Similar to above in relation to improving functional independence, the support provided through transition care may not be enough to delay entry to permanent residential aged care for people with complex support needs. One in 4 (25%, 1,500) people who went on to enter permanent residential aged care started with a functional independence score of 80 or above, in contrast to half (48%, 6,900) of people who did not enter permanent residential aged care.

It is important to note that some people with high functional independence scores in transition care still went on to live in permanent residential aged care. This may reflect that support needs and outcomes are impacted by more than functional independence.

Transition care is different to other forms of aged care and so is the data

Transition care is one of the few short-term aged care services available in Australia and is jointly funded by federal and state and territory governments. While much of aged care has a long-term approach focusing on accommodating the increasing support needs of ageing Australians, transition care expects to see a reduction in its users' support needs.

Transition care data is different to other data captured in other aged care services, as it includes information about function and support needs before and after the program. This allows some of the unique analyses presented in this report. In summary, transition care data shows:

- *The positive effects of the short-term transition care service intervention are visible through repeated measurement.* The collection of functional independence through the same validated assessment instrument at the person-level at entry and exit from the program, allows before and after comparisons to reflect effective intervention.
- *Program effectiveness can be based on improvement in functional independence (and reduced support needs).* The risk of functional decline in the hospital setting is high prior to the start of transition care. By capturing a recovery period, the short-term program allows a reduction in support needs to be observed. Functional independence maintenance and reablement are also relevant to long-term aged care services. It should be noted however, that over the longer term as people age, they tend to accumulate health conditions. Even with successful interventions in place, this can result in an increasing need for more support over time, not less.
- *Transition care outcomes are person-based.* Long-term programs are not currently able to assess effectiveness at an individual level in terms of functional independence maintenance or improvement in functioning. Instead, measures like Quality Indicators are used in residential aged care to look at the proportion of service residents who have experienced a decline in their ability to perform activities of daily living over a quarter. Similar measures are currently in development for community-based aged care.
- *Support needs and outcomes are impacted by more than functional independence.* Capturing additional domains at the start and end of transition care could be of benefit. A persons' support needs and outcomes are determined by other dimensions, for example, social, economic, cognitive, and psychological factors. Given social and psychological services can be included as part of transition care, and these domains are important to a person's physical health, including them could provide benefit to holistically assessing support needs and program success. It is important to note that a person may experience an improvement in one dimension at the same time as a deterioration in another. This may be indicated in our analysis where people with improved functional independence at the end of transition care, still went on to live in permanent residential aged care shortly after. The value of

capturing broader dimensions has previously been highlighted by service providers (KPMG 2019), and the Transition Care Programme Guidelines recommend capturing more domains than just functional independence (Department of Health and Aged Care 2022).

By using linked data to conduct person-centred analysis of people using transition care, this report expands on previous reporting of transition care. This allowed a unique perspective of transition care to be gained, with new insight into how the service fits in with other aged care services. In summary:

- Transition care is often used alongside home support services.
- Transition care is not usually the first aged care program people use.
- Most people go on to use home support services immediately after transition care.
- A small proportion go on to use permanent residential aged care within the year or so after transition care, about half of whom enter directly from transition care.

Future work could build on this analysis by looking at the broader group of older people leaving hospital and comparing their outcomes with older people who use transition care when leaving hospital. As mentioned earlier, improvement due to transition care cannot be distinguished from improvement that would occur without this support. Using the new National Aged Care Data Asset, future aged care use of older people exiting from hospital, and entry into residential aged care in particular, could be explored for people who did and did not use transition care when leaving hospital. Such analysis would contribute to further understanding about whether transition care is meeting the program's aims.

Lastly, this report highlights the value of collecting consistent information at regular intervals in a person's journey through the aged care system. In the context of transition care, consistent and repeated capture of functional independence provides an indication of support needs and how these needs change as a person interacts with aged care services.

If consistent measurement occurred across the aged care system, irrespective of aged care program, person-centred analysis could explore the characteristics and support needs of people using aged care services across various settings and over time. Until such time, analysis is limited to aged care program-specific data and measurement, limiting the value and impact of analysis on informing how well the aged care system in Australia is supporting its users. AIHW continues to contribute to data improvement activities in the aged care sector, with further information available on the GEN webpage.

More information

For more information about data improvements and standardising aged care data, see the AIHW's dedicated aged care data website GEN.

More information on pathways through aged care can be seen on the GEN website – Pathways in aged care.

Detailed information on First Nations peoples' use of aged care services is published in:

- Aged care for First Nations people
- Aboriginal and Torres Strait Islander Australians using aged care

Data tables (Tables S1–16) can be found under Data.

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