It's what matters… not what *is* the matter
Redesign of the Transitional Aged Care Program

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The Transitional Aged Care Program (TACP) is 12 weeks of post-hospital restorative care for eligible over 65-year-olds with a view to reducing readmission to hospital and delaying moves to residential aged care

Case for Change

People
37% don't remain at home after TACP

7% improvement in ability to return to social activities and meaningful life roles

Staff
"Program measures aren't useful, what we do isn't captured"

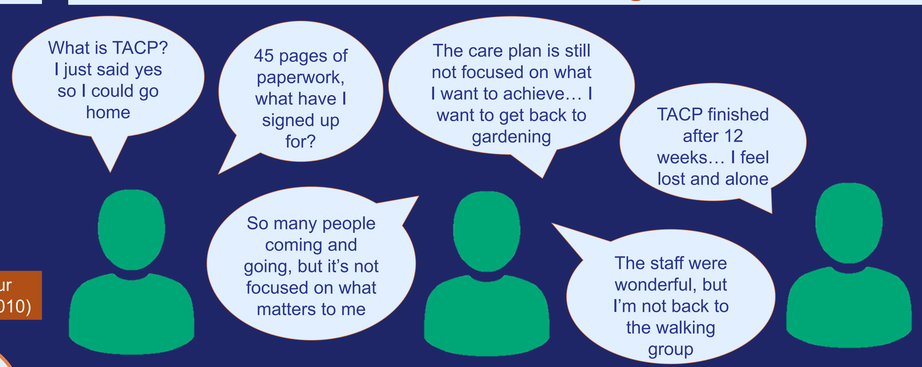
"Current documents and processes don't inform the services I deliver"

SNSWLHD
23% of people are readmitted to hospital either during or on completion of the program

12% stay longer than 12 weeks

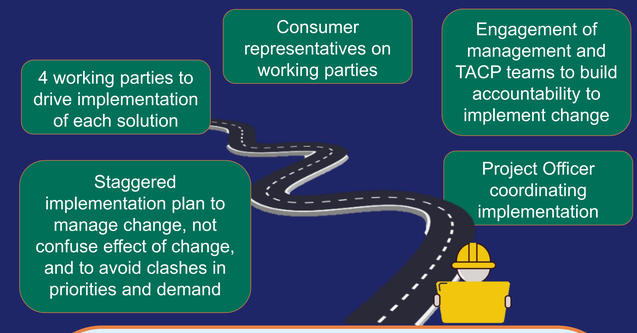
"Loneliness, living alone and poor social connections are as bad for your health as smoking 15 cigarettes a day." (Holt-Lunstad Smith and Layton 2010)

Diagnostics



- 53% of people received no care plan
- 64% of people did not have goals linked to roles and meaningful activities
- 4 different care plans were used
- Significant underspend of Program despite occupancy of 118%
- Significant variation in length of stay between sites
- PRMs are not used to inform service delivery

Implementation



Goal

To enhance the Transitional Aged Care Program to more effectively improve the health of participants and keep them in their own homes longer.

Objectives

1. Increase the number of people who report their ability to participate in social roles and activities within normal limits at the end of the program from 11% to 60% by December 2022.
2. Reduce people's readmission rate during and on discharge from the Program from 23% to 19% by December 2022.
3. Improve the communication and coordination of the Transitional Aged Care Program team. This will be measured prior to implementation, again in December 2022, using the Assessment of Inter-Professional Collaboration Scale II.

Solutions

1. Guiding Framework

This will outline the restorative philosophy of TACP, provide standard operating procedures, develop a support plan, terms of reference for the multidisciplinary team meeting, duty statements for each team member and evaluate the patient-reported measures.

Outcomes include:
- # completed PRMs at Week 6 and Week 12
- Inter-professional meeting discussion driven by participant's goals facilitated by the case manager

2. Case Manager

Improve and standardise quality case management processes within the existing roles and responsibilities. In order to create a sense of safety and truly understand what matters to the person, a single point of contact will be established for all persons enrolled in TACP. This single point of contact will be a nominated clinician from within the TACP team.

Outcomes include:
- 60% of support plans will have goals linked to meaningful roles and activities

3. Community Linker

Trial a community linker within TACP.
Their task will be to foster people's connections to meaningful community activity. The trial will add community linkers to the teams in three different ways:
- an additional staff member
- a brokered position
- giving additional time to an existing team member.

Outcomes include:
- Reduction in length of stay on Program and hospital readmission rates

4. Information Exchange Toolkit

To develop a communication and documentation bundle that can be tailored and delivered to the participant's / carer's preferences and circumstances as necessary, including exploration of multimedia options.

Outcomes include:
- Improvement in participation in roles that are meaningful to them and connect with social activities

Sustaining change

- Reinforcement of the change is tied to existing LHD-endorsed processes, such as inclusion in monthly-accountability meetings of line managers.
- Using current key performance indicators, such as PRMs and support plans, to measure and reinforce change.
- Using existing communities of practice to reinforce the changes, rather than creating new accountability channels.
- Engaging the media and communications team to highlight participant's success stories, and acknowledge effort by TACP to change the way service is delivered.

Method

- 32 consumer and carer interviews
- Focus groups with 33 staff
- Interviews with 18 staff
- Process mapping with 9 staff members
- Tagalongs during multidisciplinary team meetings
- Patient-reported measure (PRM) surveys – 195 experience measures and 369 outcome measures
- Problem and solution prioritisation surveys
- Two surveys with brokered providers
- Analysis of 10 different program and data reporting sources, including 45 file audits
- Cause and effect and 5-whys analysis
- Solution design workshop with managers, consumers and TACP team members

Lessons learnt…

- All stakeholders, including the participants and carers, must be involved throughout the whole process.
- A detailed communication plan and its execution is crucial to ensure all key stakeholders remain actively involved in the proposed changes.
- Those affected by the change should understand the new state so that implementation is not adversely impacted and the new state is sustainable.

Outcomes of this clinical redesign project will be transferrable to other multidisciplinary environments in SNSWLHD. Learnings will inform improved person-centred care across a range of different programs and services including emergency departments, inpatient, community health services.

Our sincere thanks to:

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Holt-Lunstad J, Smith TB and Layton JB. Social relationships and mortality risk: a meta-analytic review. *PLoS medicine*. 2010;7(7):p.e1000316.