Service Delivery Model – Transitions of Care Pilot

Objective

The primary objective of this Pilot initiative is to *'improve patient focused **transitions of care** between hospital and primary health care and community settings'*.

Transitions of care is defined as *'the movement of patients between health care locations, providers or different levels of care within the same location as their conditions and care needs change'*.[1]

Transitions of care are a subpart of the broader concept of care coordination and should be based upon a comprehensive care plan and the availability of well-trained practitioners and carer providers who have current information about the patient's treatment goals, preferences and health or clinical status.

The only constant in any transition of care is the patient and their carer - it is critical that any model is patient focused and centred on addressing their needs.

Effective Transitions of Care

There is a significant body of evidence showing that a multifaceted approach is required to keep those people with chronic disease well and out of hospital, and, reduce hospitalisations, ED presentations and readmissions of patients with complex needs. Key interventions encompassing: [2]

- Identification through risk stratification of a targeted in-patient population – patient segmentation and case finding i.e. identifying those at risk of poor health outcomes who would benefit most from primary care led care, typically Tier 2 (Rising Risk) level patients – people with complex chronic disease who have been in hospital once or twice and have an increased risk of ED presentations and/or re-hospitalisation if they are not properly supported.
- Effective patient-centred discharge planning - supporting the continuity of health care, based on the individual needs of the patient. It is the critical link between treatment received in hospital by the patient, and post-discharge care provided in the community and emphasises the importance of comprehensively identifying patient needs and implementing interventions prior to discharge.
- *Immediate post hospital follow-up* - appropriately skilled staff to monitor and manage symptoms after discharge and ensure access to planned clinical and support services.
- *Self-management support* - enhancing health literacy, shared goal setting and care planning, decision making and self-management capability, based on evidence based self-management planning models (e.g. Flinders/Stanford models).
- Care coordination – the ability to plan comprehensive care, deliver point in time health care and leverage/co-ordinate timely and sustained access to health care through local health pathways and community based services linked directly to health care homes.

[1] American Geriatrics Society

[2] Burke RE et al Identifying keys to success in reducing readmissions using the ideal transitions in care framework, *BMC Health Services Research* 2014, 14:423

- Multi-disciplinary team support – timely access to multi-disciplinary team care arrangements either through public or private sector – including follow-up specialist care in ambulatory settings.
- *Accessible community and social care support* – involvement of and enhanced access to health and social care services in the home as required to support optimal recovery.
- Effective communication and information exchange – application of electronic health records to aid patient information exchange between clinicians.

The Transition of Care Pilot will support the accomplishment of the above interventions as appropriate on a case by case basis with an emphasis on the *italicised* interventions which have been shown to be the most effective in reducing hospital readmissions.

Outcomes

Enrolled patients are supported to optimise health outcomes by:

- Successfully transitioning from a recent hospital setting to the primary care and community setting and actively engaging with services and supports;
- Optimising patient activation and self-management capability;
- Reducing the number of adverse events, crisis/acute situations and resultant potentially preventable ED presentations and inpatient readmissions;
- Enhancing patient satisfaction and experience of continuity of care.

Core Components

The Pilot will be delivered in collaboration with the Division of Medicine and the Emergency Department, the Canberra Hospital (TCH) and General Medical Practices across the ACT to encompass the following core components:

Case finding

Risk stratification – Complexity of patient needs will be determined by the Transitions of Care team. Those Tier 2 or rising risk patients who meet the eligibility criteria will be identified as potential candidates for enrolment into the Pilot.

Early identification – It is imperative that potentially eligible patients are identified early in the post discharge period to ensure timely engagement of the Transition Coordinator.

In line with standard operational processes, patients will be assessed by the ToC team for eligibility following identification and/or referral from hospital or General Practice Potential need for transition coordination should be identified as part of the patients post discharge planning process.

Eligibility/exclusion criteria

Eligibility criteria for transition coordination support include:[3]

- Patient demographic:

  - Age range: above or equal to 35 years and over;
  - Residence: ACT residents only;
  - Social: Limited network of supports or social isolation or where carer stress/capacity/ capability may be an issue;
  - Discharged from a hospital over the last 4 weeks.

- High risk of Potentially Preventable Hospitalisation:

  - Tier 2 / Rising Risk category patients:
  - Chronic disease condition, comorbidities, complex health and/or community care needs (i.e: increased likelihood of potentially preventable hospitalisation if not supported in primary care or community settings),
    AND;
    - Unintentional overdose or idiopathic events: e.g. patients admitted due to medicine mismanagement;
    - Evidence of low engagement of medical services;
    - Limited knowledge of the impact of disease management;
    - Identified barriers to accessing GP services /medical services.

- Primary Care:

  - Patients with a nominated regular GP/practice or those who are willing to nominate a regular GP/practice or
  - Patients who don't have a regular GP/practice and require assistance in obtaining ongoing GP services.

[3] These have been developed following desk top review of risk stratification methodology, national and international transition support and/or care coordination programs, feedback from key stakeholders and an assessment of potentially preventable hospitalisation data.

Specific exclusions are:

- Aboriginal and Torres Strait Islander peoples - who are eligible for and choose to utilise local Integrated Team Care Activity supports under the Commonwealth funded Indigenous Australians' Health Program provided by Winnunga Nimmityjah Aboriginal Health Service or Grand Pacific Health.

- Overdose/Toxicology patients - who have been classified 'intentional overdose and self-harm' who would be best managed by suicide ideation and mental health services (e.g.: The Road Back, Woden Community Services).

Patient consent and enrolment

Informed consent will be required for patient participation in the Transition of Care Pilot.

This will encompass consent to participate, access to relevant medical patient records and the sharing of personal information with key stakeholders across the care continuum.

Where appropriate translation, advocacy and supported decision making services/supports will be utilised to aid effective communications and decision-making.

When patient consent is received the individual will be enrolled onto the Transition of Care Pilot and supported by the team of Transition Coordinators.

It is anticipated that transition coordination support will routinely be provided for an average four weeks (and up to eight weeks maximum unless in exceptional circumstances).
Support will be withdrawn when:

- Health and care needs have been consolidated in the planned delivery of ongoing primary care and post hospital community based health services and/or relationships established with identified care coordinators/case managers (as appropriate);
- Social services and community based supports have been activated and/or a relationship established with the in-service case manager or wait-list manager if relevant;
- Referrals have been made to appropriate self-management programs (as appropriate), and;
- The patient has a confirmed network of support services and named key contacts.

There may be provision to follow-up a sample of patients three months (12 weeks) post disengagement to consider outcomes and patient experience, assess the influence of complicating factors and develop remedies.

Discharge Planning

Transition Coordinators will be party to patient-focused multidisciplinary discharge planning processes and will have access to relevant patient records including discharge summaries/plans to gain:

- A broad understanding of patient needs, goals and anticipated discharge plans (i.e. Clinical/Pharmacological, Allied Health, social services and community supports) and anticipated service requirements and key stakeholders.
- An appreciation of potential barriers to access and/or delays in the provision of post hospital specialist, outpatient, rehabilitation and/or community based services including NDIS and the interface with the aged care system and My Aged Care, and potential mitigation strategies.

A copy of the discharge summary encompassing Clinical/Pharmacological, Allied Health and Social Work components will be provided by hospital staff to the patient, the patient's GP, ToC staff and Pharmacist (when changes to the medicine regimens have been made).

Flexible Funds

A small pool of 'flexible funds' will be available to undertake the spot purchasing of ad-hoc services and supports on a gap filling basis when patient needs are identified but not immediately able to be met through normal channels. Such funds will only be utilised on an exceptional basis and in line with specified criteria as set out in the Standard Operational Processes and the Transitions of Care Flexible Funds guidelines.

Flexible funds are intended to build system capacity rather than divert responsibility from existing service providers who remain ultimately responsible for providing services in a timely manner as set out in the discharge summary/plan and/or the patients' GP Management Plan (GPMP). Wherever possible patients' needs should be addressed through current services and supports.

Transition Coordinators will be responsible for ensuring that associated policy and procedures are adhered to at all times

Self-management Capability

Evidence shows that increasing patient activation levels and carer knowledge and skills can better equip people to manage their own health conditions and improve health outcomes, enhance the experience of care, reduce carer fatigue and reliance of health services, and help with cost reductions.

The Transition of Care Pilot will provide health coaching to promote patient activation and the development of self-management and carer capabilities. Patients and carers will be provided with appropriate information and Transition Coordinators will establish direct referral pathways to self-management training programs and community based supports. Consideration will be given to Carer needs.

Patient Tracking

Processes will be established to track whether post discharge health and care requirements, as set out in patient discharge summaries/plans, are realised in a timely manner. Patient advocacy and support will be provided to facilitate access to services e.g.: supporting patients to obtain timely GP appointments post discharge.

Where services are not realised feedback will be provided to the referring party e.g.: Junior Medical Officer, Discharge Liaison Nurse, Social Worker with a request to confirm the referral has been made/received, has being acted on, the anticipated wait time and/or service start date.

Where the patients' clinical needs change both the service provider will be notified by ToC Team accordingly and patient advocacy provided to try and escalate/accelerate access to services.

Service Availability and Activity

The Pilot start date is 10 April 2017 with services offered through to the end of June 2018 (i.e. 15 months).

Services will be delivered on a Monday to Friday between 8am and 6pm (reflecting standard business hours for General Practice and community services intake/administration).

It is not anticipated that the Transition Coordinators will work on evenings and weekends given access to general practice, social supports and community services is limited. For patients identified in the hospital setting, Transition Coordinators will subsequently engage with patients and the discharge planning processes in the hospital setting (i.e following the patient journey from the Emergency Department to Medical Wards and/or home).

Where a patient has been admitted to and discharged from hospital in the absence of direct contact with a Transition Coordinator i.e. evenings and weekends, referral from General Practice, Transition Coordinators will follow up the individual in their home setting (i.e: telephone or face to face) to enrol them onto the program, establish a relationship and ensure discharge summaries/plans are mobilised.

The anticipated caseload of each Transition Coordinator is expected to be no more than 30 and the Manager-Transition Coordination 20 active clients at any given time[4]. Activity levels across the 15 month Pilot are estimated to be 885 clients (recognising scale up and wind down activities).

Effective communication and information exchange

Effective communication and information exchange is critical to the success of the Transition of Care Pilot, patient safety, clinical handover and the ongoing care and support of the individual. Whilst the role of the Transitions Coordinator is to promote and facilitate effective communication and information exchange across health professionals and community based services and settings, each party directly or indirectly engaged in the delivery of care is ultimately responsible for quality communications and effective information exchange.

[4] As benchmarked against ACT Health, Chronic Disease Management Unit, Chronic Care Program - Clinical Care Coordinators caseloads

Services provided by Transition Coordinators do not negate the need for effective multidisciplinary and whole of system communication and collaboration. Collectively primary care, acute hospital and community health and social care services have a responsibility for ensuring patient safety, effective transitional care, continuing and comprehensive person focused team based care.

Transition Co-ordinators – Role, Function and Capabilities

The role of the Transition Coordinator is to promote continuity and coordination of care for enrolled patients and their families by facilitating a safe and seamless transition from a recent hospital presentation or admission to home. The Transition Coordinator role is to ensure that ongoing medical and pharmaceutical regimens together with self-management capabilities are optimised, and, social and community based services and supports are mobilised as set out in the individual's discharge/ GP management plans. It is also the Transition Coordinator role to ensure patients and families are aware of how to communicate and navigate services for future contact.

It is intended that this role will complement, not negatively impact nor duplicate the roles and responsibilities of hospital staff and/or community based practitioners, services and supports (e.g. Discharge Liaison Nurses, Hospital and community Social Workers and/or Chronic Care Program Clinical Care Coordinators). Current service providers, regardless of setting, retain their current responsibilities and accountabilities for effective patient care and transition of care.
The role of the hospital and primary care is to continue to assess and address ongoing and comprehensive health and community based needs and secure access to services.

Role and Function

Three Transition Coordinators (encompassing one Manager – Transition Coordination) will:

Early identification and enrolment:

- Work with lead clinicians (hospital staff and GP practice staff to identify suitable and eligible patients through the use of a referral form to for Transition of Care support, and where appropriate and with patient consent, enrol them on the Pilot program.

Engage with the clinical team:

- Maintain an oversight of the patients' progress and hospital journey and support discharge planning, for example:
  - Promoting patient and carer/existing support peoples' engagement in discharge planning processes and decision-making. Facilitating effective GP involvement in the discharge planning processes;
  - Supporting effective communication and information exchange with the nominated GP/general practice/pharmacy /Hospital and follow up required post discharge / GPMP ensuring the nominated GP/general practice/pharmacy/care provider have received all relevant discharge plans (e.g. Clinical/Pharmacological, Allied Health and Social Worker) as appropriate.

Facilitate an effective transition of care from recent hospital discharge to primary care and community setting .This will include:

- Actively engaging with primary care, hospital and community based services;
- Following up patient within 48 hours of discharge / referral, preferably via a home visit or alternatively a telephone call;
- Ensuring patients and their carers are informed and aware of ongoing service requirements and provisions (e.g. forthcoming outpatient appointments, community services);
- Liaising with clinical (e.g.: GP, Practice Nurse, Pharmacist, Allied Health, Clinical Nurse Consultant, Discharge Liaison Nurses, Social Workers, Outpatient departments and/or Specialists, Practice Nurses) and non-clinical service providers (e.g. CHI, , appointed case managers and service providers) to ensure that the services required (as set out in the discharge plans) have been booked, planned and coordinated, realised and a planned date of commencement has been communicated with the patient and family;
- Assist in medication review/reconciliation, and understanding of medication safety.
- ensuring a lead case manager/care coordinator is identified (e.g. GP, practice nurse, community service provider) as appropriate;
- Documenting and reporting on delays in service provision and anticipated wait times and ensuring this is communicated to patient / family e.g. Following up on clinical appointments (GP, Allied Health, Specialist and/or Outpatient clinic);
- Identifying short term and ad hoc services on a gap filling and exceptional basis where required and / or appropriate;
- Assess whether clinical and medication regimens are stabilised/sustained and care services/supports do in fact address the patient needs;
- Ensuring understanding and encouraging compliance against discharge plans (encompassing clinical and pharmacological, allied health and social work);
- Handover to nominated case manager/care coordinated and normal ongoing services as required;

Care planning and service delivery

Work with patients, carers and/or advocates, GPs and the primary care team to assist where appropriate:

- Translation of the hospital discharge instructions into a GP led chronic disease management plan (i.e.: GPMP), team care arrangement (TCAs), age specific assessment and/or home medications review as appropriate
- Explore the use of private services and private funding mechanisms as appropriate (eg: personal funds and/or private health insurances) and/or promote the appropriate use of Medicare MBS items to ensure comprehensive and continuing care to optimise health outcomes
- Strengthen ongoing therapeutic relationships between patient, GP and extended primary care team including specialist and outpatient services by facilitating connections and continuity of care

Self-management education and support

Work with patients and carers to enhance health and system literacy and self-management capability via health coaching (e.g. ensuring safe medication management, establishing networks of support etc.), facilitating access to self-management and lifestyle modification programs in line with patient needs as set out in the care plan.

Capabilities

Core capabilities of Transition Coordinators include:

- System navigation;
- Excellent verbal and written communication skills;
- Effective relationship building, networking and information exchange;
- Patient advocacy and facilitation;
- Patient activation and health coaching;
- Ability to prioritise and multi-task;
- Administration, monitoring and audit skills;
- Self-direction and leadership;
- Results focused and action orientated.

Transition Coordinators will require an understanding of:

- Patient and carer rights and health service responsibilities;
- ACT health systems and patient pathways;
- The operations of health and care services and associated referral and triage mechanisms;
- Health system funding mechanisms and key enablers (including for example MBS chronic disease management item numbers);
- Barriers to effective case management/care coordination;
- Barriers to access to services and supports.

Implementation and Evaluation

The Transition of Care Pilot will be supported by a change and adoption strategy, encompassing educational, promotional and communication activities, tools and resources to accelerate understanding of the role and contribution of the Transition Coordinators and integration within and across the ACT Health and care service system.

The 15 month Pilot will adopt a PDSA approach to service development and continuous improvement.

A formative evaluation will be conducted by Human Capital Alliance from September 2017 to 30 June 2018 and will be responsible for developing the evaluation framework and conducting the evaluation itself. The evaluation framework will encompass qualitative and quantitative components (including patient and carer experience) and process measures.

Interim findings will communicated at key milestones across the Pilot and the final evaluation report at conclusion.