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Formative evaluation of the Transitions of Care Pilot

FINAL PROJECT REPORT

October 2018

HUMANCAPITAL
Alliance
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Document preparation

This Summary Report was prepared by Human Capital Alliance (International) Pty Ltd (HCA) as an internal report for the Capital Health Network (CHN) (ACT PHN) for the Formative Evaluation of the Transition of Care Pilot (the Pilot).

Acknowledgements

HCA would also like to acknowledge and thank all the stakeholders who participated in interviews for the evaluation. We are also grateful to the diligent efforts of the Transition of Care team in assisting with obtaining data for the evaluation process. This included providing documentation, setting and facilitating key meetings, and creating a database of service use. This later effort was required as a laborious retrospective development from patient notes.

Suggested citation

Cowles, C., Ridoutt, L. and Stanford, D. (2018) *Formative evaluation of the Transitions of Care Pilot Project: Final Report*. Prepared for Capital Health Network, ACT PHN, October 2018.

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Executive summary

Transitions of Care Pilot

Transitioning from hospital to home can be a significant area of risk for people with emerging or existing chronic health conditions. Risks emerge in relation to a break in support and continuity of care and poor coordination of services within the community, particular following a hospital admission. These issues are the focus of the Transition of Care pilot (the Pilot) commissioned by Capital Health Network (CHN).

The primary objective of the Pilot was to '*improve patient focused* ***transitions of care*** *between hospital and primary health care and community settings*' for Tier 2, or 'rising risk', patients, that is, people with emerging chronic health conditions. In collaboration with The Canberra Hospital (TCH) the program was delivered by Transition Coordinators (TCs) whose roles are complementary to other existing roles within TCH (e.g. discharge nurse, social worker).

The evaluation

A formative evaluation of the Pilot was undertaken between August 2017 and July 2018 to investigate how the program was implemented, what activities and changes were undertaken comparative to the service delivery model and what systems issues may help or hinder ToC services. The evaluation was undertaken by consultancy firm Human Capital Alliance.

Method

A management audit approach was adopted for the evaluation collecting data through a review of program documentation, interviews with over 20 key stakeholders, analysis of routinely collected data (patient information) and a descriptive analysis of a pre and post patient experience surveys specifically designed for the Pilot.

Findings

Implementation

The Pilot was originally delivered in collaboration with The Canberra Hospital's (TCH) Wards 6A and 7B of the Division of Medicine, but due to low referrals and changes within the TCH TCs commenced identifying patients admitted to the ED or Emergency Medical Unit (EMU). In addition six general practices partnered with the Pilot to identify eligible patients. Overall the Pilot was delivered according to the service delivery model however some modifications were made in relation to patient eligibility and patient identification processes.

Patient experience

The Pilot supported a total of 182 patients between April 2017 (commencement of the Pilot) and July 2018. Upon leaving hospital patients indicated feeling 'joy' but apprehension is also felt by some patients because of concerns about managing their health. The Pilot therefore was highly valued by patients and there is some indication from the patient experience surveys that there was an increase if patient knowledge for which services to contact and a moderate increase in confidence to self-manage a health condition.

Value of the Pilot and ToC services

One of the most valuable features of the Pilot is the ability to truly provide patient-centred care; TCs, through home visits and phone calls, provide one-to-one bespoke support that is tailored to the needs and self-identified goals of the patient. Over the past year the Pilot supported many patients who might otherwise have missed out on important services and encouragement to manage their emerging health conditions.

The Pilot is an important conduit between the hospital and community setting but also between the patient and services and programs within the community. TCs have the opportunity to assist patients with a smooth transition into new services by developing trust and rapport with patients and also with partnering services. Importantly, through the work of the TCs, considerable knowledge of available services and programs has been amassed and shared with patients and networks.

There are opportunities for the Pilot and ToC services to increase engagement with and seek collaboration from GPs and primary care to ensure patients receive well coordinated services. Engagement with the Practice Nurse within general practices was identified as a key strategy to connect directly with GPs both from the hospital-setting and for the purposes of delivering ToC services.

Lessons from initial implementation

The Pilot was implemented at a time of significant upheaval and change within the TCH which significantly impacted on the engagement of hospital staff with the program. The introduction of new initiatives or practice can be a challenge in the busy hospital environment where there is always a natural resistance to change, particularly when the benefits are not immediately evident. Compounded by a high turnover in hospital staff, and perhaps because the Pilot was not seen as part of the hospital, it was difficult for the Pilot to gain traction and engagement from within the hospital.

It was initially anticipated that hospital staff would play a bigger role in identifying eligible patients however referrals by hospital staff remained relatively low throughout the Pilot. In addition to the unstable environment with TCH, it was identified that the language and terminology utilised for the Pilot also potentially contributed to a poor understanding of the program and the 'right' type of patient; the focus was on 'Tier 2' or 'rising risk' patients, however, as an emerging focus in health, neither of these terms were known or used within the hospital setting.

While not in scope of the service delivery model, the implementation of the Pilot has brought to light issues in relation to patient discharge from hospital. Discharge planning was generally observed to be 'hit and miss' in terms of the quality of the information prepared but also the delivery and communication of the discharge summary plan (DSP) impacting impact on patient outcomes.

Conclusion

ToC services are required within the system to support patients with emerging or 'rising risk' chronic conditions as currently no other program exists in the ACT to support such patients. Ongoing delivery of the program would benefit from a clarification of patient eligibility criteria, and it may be useful to focus on identification of patients that have no established GP relationship and have a low understanding of medication use. Increased engagement with TCH and primary care is also critical and can be achieved by undertaking a formal assessment and engagement with key stakeholders.

Acronyms and abbreviations

CHN	Capital Health Network
DSP	Discharge summary plan
ED	Emergency Department
EMU	Emergency Medical Unit
HCA	Human Capital Alliance
HCCA	Health Care Consumers’ Association
KPI	Key Performance Indicators
MAC	My Aged Care
MDS	Minimum Data Set
PDSA	Plan-Do-Study-Act
PHC	Primary health care
PSG	Project Steering Group
SDM	Service Delivery Model
TC	Transition Coordinators
TCH	The Canberra Hospital
ToC	Transitions of Care

Contents

Introduction

Nature of the problem

Transfer of care issues have historically dogged health systems worldwide for decades (ACI, 2014) and have been a significant source of consumer grievances, poor health outcomes and many research studies. Transition problems can and do occur when health consumers move between youth and adult services, between ambulatory and acute, between emergency and inpatient, between acute and primary health care, and between primary and specialist health care. The problems can be most felt by vulnerable populations such as the aged (e.g. Ridoutt, et al., 2005; Halasyamani, et al., 2006), the mentally ill (e.g. Subotic, et al., 2007; Martin and Page, 2009) and culturally diverse populations (e.g. BHI, 2016).

In Australia the focus of most concern in regard to transition of care has been from hospital (inpatient care) to primary health care and/or community health care. As Halasyamani, et al. (2006) note:

> *"Discharge from the hospital is a critical transition point in a patient's care. Incomplete handoffs at discharge can lead to adverse events for patients and result in avoidable rehospitalization. Care transitions are especially important for … high-risk patients who have multiple comorbidities."*

Poor transition of care from acute care to primary health care can be the result of many different factors including incomplete discharge planning, limited understanding of patients and carers of underlying health problems, incomplete communication of patient information to primary health care providers and lack of awareness (more generally among clinicians in both acute and primary care settings) about support services available in the community. Poor transition often results in (CHN, 2016):

- delays in accessing appropriate treatment and community supports
- visits to Emergency Department (ED) or hospital admissions which should have been preventable
- high levels of consumer and provider dissatisfaction with the coordination of care across primary care/hospital interface.

Apart from the risk of achieving sub-optimal outcomes, poor communication wastes both patients' and clinicians' time and ultimately health system resources.

Best practice evidence

While there has been significant focus on chronic disease management within the health system, preventative interventions have the potential to reduce health costs and increase health outcomes (Cantor, Haller, Greenberg, 2018). 'Rising risk' patients, that is, patients with emerging or one or more chronic health conditions can significantly benefit from early intervention support to reduce the likelihood of becoming a 'high-risk' patient (Lobelo, et al., 2016). Identifying 'rising risk' patients before chronic conditions escalate involve anticipating or predicting the factors that may lead to a decline in health such as an emergency hospital admission (Cantor, Haller, Greenberg, 2018). In such instances, discharge from hospital acute care and transition to primary care is a potential flashpoint for 'rising risk' patients to fall into the high risk category.

Russell, et al. (2013) noted a review of the use of Medicare EPC Item numbers in Victoria in terms of the insight to discharge practice. The review identified seven building blocks to enhance post discharge involvement of the GP as follows:

1. Processes that encourage patients to nominate a GP
2. GP name to be on the patient file
3. Access to up to date GP contact details
4. Designated discharge coordinator at unit level
5. Process for routine notification of admission and/or discharge to GP
6. All staff see their job includes safe referral home
7. Senior and junior medical staff respect the GP role.

Burke, et al. (2014) in an extensive review of the literature identified three main factors positively associated with reducing readmissions:

- monitoring and managing symptoms after discharge
- enlisting the help of social and community supports (including designated carers)
- educating patients to promote self-management.

In the USA, Naylor, et al. (2004) evaluated an initiative, the Transitional Care Model, implemented by Kaiser Permanente and Aetna in a number of teaching hospitals. The model targets particular patients for more intensive discharge planning and follow-up, and involves the provision of comprehensive in-hospital planning and home visits. A trained Transitional Care Nurse visits the selected patient in hospital prior to discharge, facilitates the transition process, conducts weekly home visits, and is always available by phone. The program runs for 1-3 months, depending on patient needs. In the study hospitals readmissions were reduced by 36% and costs by 39% per patient during the 12 months following hospitalisation.

Transitions of Care Pilot – A possible solution

Objectives and expected outcomes

Consideration of best practice informed the development of the *Service Delivery Model for the Transitions of Care Pilot* (CHN, 2017).

The primary objective of the Pilot was 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]

Enrolled patients in the Transitions of Care (ToC) Pilot (the Pilot) are supported to optimise health outcomes by:

- successfully transitioning from the 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.

The Pilot, at the commencement of the program, was delivered by three Transition Coordinators (TCs)[2]. The aim of their role was to promote continuity and comprehensiveness of care for enrolled patients by facilitating a safe and seamless transition from the hospital setting to home, ensuring ongoing medical and pharmaceutical regimens and self-management capabilities are optimised and, social and community based services and supports are mobilised.

In the Service Delivery Model (SDM) it is explicitly stated that the TC role is complementary to other existing roles (e.g. discharge nurse, social worker) and is designed not to duplicate.

Core components

The Pilot was originally delivered in collaboration with The Canberra Hospital's (TCH) Wards 6A and 7B of the Division of Medicine. The core components of the Pilot include:

Table 1: Core components of the Pilot SDM[3]

Case-finding	Risk stratification (determining complexity of patient needs) and early identification (timely engagement by the TCs)
Eligibility/exclusion criteria	Eligibility based on patient demographics (50-80 years of age, ACT resident and socially isolated), high risk of Potentially Preventable Hospitalisation (patients with a score >10 in the Early Screen for Discharge Planning Algorithm), and poor primary care engagement

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[1] American Geriatrics Society

[2] A number of staff changes occurred during the over the course of the Pilot and the evaluation; a total of six people have been employed for the TC role and currently there are two full time TCs employed to deliver the program.

[3] Summarised from the SDM (CHN, 2017).

	Exclusion of Aboriginal and Torres Strait Islander people who are eligible for and choose to utilise other programs and overdose/toxicology patients classified as 'intentional overdose and self-harm'
Patient enrolment and consent	Informed consent to participate includes giving access to patient records and sharing of personal information with key stakeholders across the care continuum to enable transition coordination (maximum eight weeks)
Discharge planning	TCs are party to discharge planning processes (insofar as they are meant to facilitate participation of consumers/carers and primary care clinicians in planning efforts) and have access to records, summaries and discharge plans
Flexible funds	Availability of small pool of 'flexible funds' to undertake purchasing of ad hoc services and support on a gap-filling basis
Self-management capacity	Health coaching by TCs to promote patient activation and development of self-management and carer responsibilities
Patient tracking	Tracking to assess whether post discharge health and care requirements in discharge summaries/plans are realised in a timely manner
Effective communication and information exchange	TCs promote and facilitate effective communication and information exchange across health professionals and community based services and settings

The role of the TCs specifically involved:

- early identification and enrolment
- engaging with the discharge planning team, primary care and service providers
- effective transition of care from hospital to primary care and community setting
- supporting patient care planning and service navigation
- self-management and support.

A full description of the Pilot and the role of the TCs can be found in the SDM (CHN, 2017).

The evaluation

Evaluation purpose

The purpose of almost any evaluation, formative or summative, can be simply summarised in terms of one or more of four possibilities, which Suchman (1967) categorises by way of measurement of intention, effort, effect and efficiency. The primary focus of this evaluation is on **effort.**

The measurement of effort answers the questions "*What did you do*?" and "*How well did you do it*?" This is the essence of a formative evaluation, and while it is not always the case that a well implemented intervention will deliver its intended objectives or outcomes, the reverse is generally a rule – that is that a poorly implemented intervention will rarely deliver intended outcomes.

The specific requirements for measurement of effort are to:

- assess actual versus planned interventions and report on progress and results
- document activities, changes over time and learnings
- identify the status and influence of participant and contextual factors including, for example, strengths and weakness, key enablers and change levers, limitations, and, modifiable barriers to effective implementation
- identification of system wide issues that help or hinder the delivery of ToC services, continuity of care and service outcomes.

The underlying principle of the formative evaluation was to make the outcomes of the evaluation **immediately benefit the active Pilot program** by feeding them into quality improvement discussions.

Method overview

A management audit approach was adopted for the evaluation and it was initially planned that data would be collected in three discrete time periods, occurring at roughly three-monthly intervals. At the end of each interval the data was to be fed into Plan-Do-Study-Act (PDSA) discussions with stakeholders of the Pilot (Pilot personnel, CHN staff and members of the Project Steering Group). The process is illustrated below.

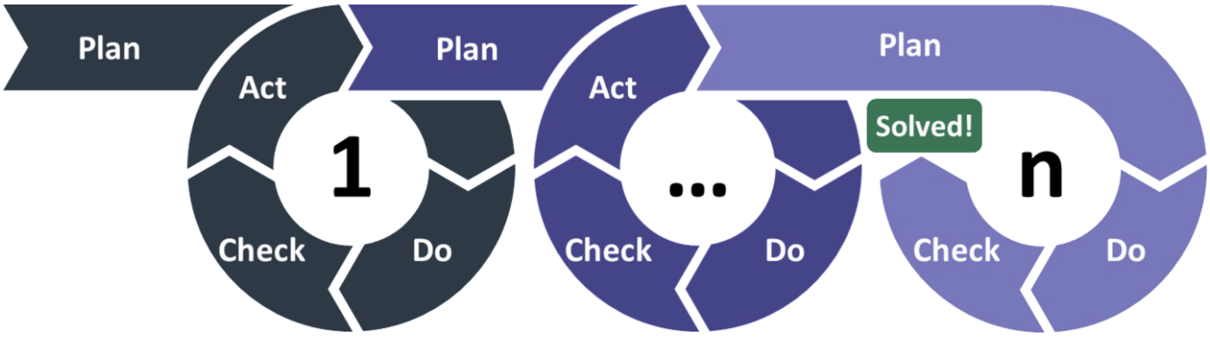

Figure 1: Illustration of the iterative nature of PDSA / PDCA approach

While the management audit data was collected in a way that was suitable to input into a PDSA discussion – although not in the regular quarterly cycles initially planned – the PDSA discussions never quite happened in the way originally envisaged. For each cycle, feedback was provided initially to CHN and Pilot staff and management, and then a report provided to the Project Steering Group (PSG) and a short presentation of findings at PSG meetings by the HCA team. This meeting is where the 'findings' of the check phase of the PDSA were considered and solutions to be acted upon determined.

Each PDSA cycle focussed on specific issues most pertinent at the time of data collection to the way implementation was tracking and the particular challenges being faced while also examining all parts of the Pilot program.

The focus of each PDSA cycles is as shown in Table 1.

Table 2: PDSA cycles

Oct/Nov 2017	Cycle 1: Initial management audit of what had been implemented in the Pilot so far. Focus of the management audit data collection was on the early stages of implementation, particularly the manner of case-finding and processes for patient selection and enrolment. Mapping of the workflow processes for patient identification and enrolment was also conducted.
Jan/Feb 2018	Cycle 2: A review of the results from the patient experience survey. This cycle focussed on post-hospital health services and support elements including: ▪ handover to primary health care (PHC) and engagement with social care services ▪ service navigation and support ▪ medication management support ▪ patient education ▪ information transfer.

Aug/Sept 2018	Cycle 3: A broader review of the program overall, patient tracking and follow up and results from the patient experience survey and key learnings from the implementation of the program.

Data collection activities

The table below outlines the specific data collection activities employed for the evaluation overall.

Table 3: Data collection activities for the evaluation

Data collection activity	Description
Document review	Review of program documentation: ▪ the SDM documentation ▪ ToC tools and patient proformas (e.g. Action Plan template, Patient Information Sheet, Assessment form) ▪ business case for funding ▪ correspondence with the funding agent (CHN Board) ▪ governance arrangement documents ▪ minutes of PSG meetings These items were reviewed to: ▪ clarify elements of the Pilot ▪ understand implementation ▪ inform interviews ▪ development of workflow mapping.
Interviews with Pilot personnel and key stakeholders	26 interviews were undertaken during the evaluation overall with 23 individuals[4] from the following stakeholder groups: ▪ CHN (including Pilot staff) ▪ PSG members ▪ TCH staff ▪ ACT Health ▪ Community services 30-60 minute interviews were undertaken by the HCA team either in person or by phone.
Interrogation of quantitative data	A Minimum Data Set (MDS) was collected for the Pilot *post hoc* according to specifications negotiated between the consultants and workers. The MDS items for each

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[4] CHN staff were interviewed for each PDSA cycle.

Data collection activity	Description
	patient record were completed from the administrative records of each service episode and / or derived through extraction from the comprehensive clinical notes taken by the TCs. In some cases, for some items, the clinical notes had not captured the *post hoc* data measure and in this case, the record was left blank or marked 'unknown'. Ideally the MDS would have been established at the commencement of the Pilot and patient data collected progressively rather than retrospectively, however advice from the evaluation team regarding the MDS was not provided until late in the evaluation. Compounding the problems of no initial MDS, no baseline data was made available from TCH. Requests from the consultant and program staff to TCH for DRG / URG data on patient casemix was not forthcoming, the health information service claiming that such data was not collected (URG) or not easily made available (coded diagnosis and DRG data). It was noted that clinical records at TCH are still largely paper based. Notwithstanding a departure from the ideal, it is possible that as the Pilot progressed the data collection content and processes evolved and were adjusted to capture the most relevant patient information. The current evolved data set now represents a solid basis for analysis going forward. This data was analysed through simple descriptive statistical analysis (frequency distributions and cross-tabulations) to examine the types of patients entering the program and the types of interventions they received through the Pilot. A correlation analysis was undertaken to establish the degree of relationships between variables; for this analysis data was complete for all necessary variables only for a sample of patients (50 of the 181). A smaller sample resulted from: (1) the time and resources required to retrospectively clean and complete patient information within the evaluation period was limited;[5] (2) not all records had data for all variables, resulting in many

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[5] The data extraction process had to be undertaken by TCs on top of their normal program duties.

Data collection activity	Description
	records for the correlation analysis needing to be discarded.
Descriptive analysis of the Pre and Exit Patient Experience Surveys	Data collected through the Pre and Exit Patient Experience Surveys. Both surveys were developed by the HCA team for the Pilot in collaboration with the CHN; both were administered by the CHN. Given the unique nature of the project, the survey development required constant reflection, collaboration and refocussing to ensure patient experience was well documented. This resulted in the survey not being finalised until 12 months into the project. The Pre survey was provided to new patients entering the program. A total of 24 Pre surveys were completed by patients between 5 April and 17 August 2018 (See Appendix 1 for the survey). The Exit survey was posted or emailed by the CHN to previous patients of the program. A total of 26 surveys were completed and returned to the CHN between 19 March and 17 July 2018. The data was analysed to understand the knowledge and ability to self-manage of patients at the commencement of receiving ToC services, and to understand the knowledge and ability of patients after receiving ToC services as well as their experience of the program. The patient data was not linked between the Pre and Exit survey; only one patient completed both surveys. This is primarily due to the shortfall in time and resources from survey development to final evaluation date The results are presented in relevant sections in this report; additional graphs can be found in Appendices 2 (Pre survey) and 3 (Exit survey).

Findings

Review of program activities

The following table provides an overview of how the Pilot was implemented, and any changes made to the model, according to the Core Components of the model.

Table 4: Core components of the ToC Pilot compared to actual implementation

Component	Description	Actual implementation
Case-finding	Risk stratification (determining complexity of patient needs) and early identification (timely engagement by the TCs)	▪ the preferred risk stratification tool was not used regularly by TCH staff in targeted service areas and it was also found that scoring was not useful to identify eligible Tier 2 patients and so was abandoned[6]; ▪ patients were primarily identified and enrolled into the Pilot by the TCs; the task of case-finding by TCs was much more involved than originally anticipated ▪ case-finding was undertaken by TCs by attending multidisciplinary team meetings on Wards 6A or 7B (medical wards), however, few Tier 2 patients were identified through this method ▪ due to low numbers of referrals TCs commenced identifying patients admitted to the ED or Emergency Medical Unit (EMU) ▪ six GP practices commenced partnering with the Pilot in November 2017 as an additional source of referrals
Eligibility / exclusion criteria	Eligibility based on patient demographics (50-80 years of age, ACT resident), recent hospital discharge, chronic illness condition, high risk of	▪ From April 2017 the age range of patients was expanded from to 35-80 to capture more patients ▪ TCs focussed on ‘rising risk’ patients, and from early 2018 attempted to focus on a

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[6] This issue is discussed later in the findings. In short, the variables measured in the risk assessment tool are not highly correlated with ToC service usage.

Component	Description	Actual implementation
	Potentially Preventable Hospitalisation (patients with a score >10 in the Early Screen for Discharge Planning Algorithm), and poor primary care engagement. Exclusion of Aboriginal and Torres Strait Islander people who are eligible for and choose to utilise other programs and overdose/toxicology patients classified as 'intentional overdose and self-harm'.	younger cohort (<65 years), prioritising the enrolment of these patients over those aged over 85years.
Patient enrolment and consent	Informed consent to participate includes giving access to patient records and sharing of personal information with key stakeholders across the care continuum to enable transition coordination (maximum eight weeks)	▪ TCs speak directly with patients in hospital (or by phone if referred from the community) and provide them with an information sheet ▪ patients are enrolled into the Pilot once the patient has signed the consent form
Discharge planning	TCs are party to discharge planning processes (insofar as they are meant to facilitate participation of consumers/carers and primary care clinicians in planning efforts) and have access to records, summaries and discharge plans	▪ While the SDM states clearly that TCs were to be involved in discharge planning processes, at the commencement of the Pilot this was reviewed and subsequently articulated as TCH responsibility and not the scope of the Pilot ▪ TCs had access to Discharge Summary Plans (DSPs) once they commenced supporting patients.
Flexible funds	Availability of small pool of 'flexible funds' to	▪ Flexible funds were not spent during the Pilot as TCs were able to identify and

Component	Description	Actual implementation
	undertake purchasing of ad hoc services and support on a gap-filling basis	coordinate adequate community services to accommodate patient needs[7]
Self-management capacity	Health coaching by TCs to promote patient activation and development of self-management and carer responsibilities	▪ TCs participated in training with Health Coaching Australia to develop skills in promoting self-management ▪ TCs try to assess and understand readiness to self-manage and knowledge and ability of patient to navigate services ▪ where relevant TCs refer to disease specific groups/associations and Living a Healthy Life, a 6 week Stanford University self-management program ▪ one-to-one unstructured health coaching which may include using YouTube video to demonstrate correct use of medications, and/or gentle encouragement to build confidence to undertake tasks such as making calls to services
Patient tracking	Tracking to assess whether post discharge health and care requirements in discharge summaries/plans are realised in a timely manner	▪ during the first home visit (TCs aimed to see patients within 48 hours of discharge from hospital) TCs ensure the patient has received/read the discharge summary and understands the follow-up care required ▪ patient is reminded to book appointment with regular GP, ideally within 7 days of discharge or sooner if required, identify any barriers to access and follow up with patient whether the GP visit has occurred ▪ an Action Plan is developed with the patient, as part of the health coaching

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[7] The CHN reported that it was funding short term/gap filling services could also be detrimental as a patient may be assessed as not requiring a service and therefore not prioritised for longer term services.

Component	Description	Actual implementation
		process, to identify health goals they would like to support to achieve through the Pilot
Effective communication and information exchange	TCs promote and facilitate effective communication and information exchange across health professionals and community based services and settings	▪ an email is sent to the patient's GP informing them of patient enrolment in the ToC services and advising on patient needs/actions undertaken ▪ other services are initiated and advocated for by the TC as required, such as making contact with community services, identifying any barriers to access and following up with patient for whether services have been provided ▪ TCs also regularly attended community network meetings such as: o ACT Community Assistance & Support Program (CASP) o Feros Care o ACT Council of Social Services (ACTCOSS) o TCH chronic disease and COPD network meetings. ▪ The Pilot was presented at various forums including CHN specific events attended by GPs, Allied Health and Practice Nurses. ▪ Promotion of the Pilot was undertaken through the CHN website, TCH GP Liaison Unity Newsletter, and in the Health Advocate Magazine (commencement of Pilot).

ToC Pilot patient population

A total of 215 patients were recruited during the course of the Pilot from commencement in April, 2017 until July 2018. Just over 15% (33) of the patients approached declined the service meaning there were 182 recorded cases of service.

The age of patients ranged from 38 to 95 years old (see Table 5); a majority of patients (61%) were aged 65 years or older with the most prominent age group being 75-84 years old. The cohort of patients that declined the service were proportionally slightly older than those who accepted the service.

The TCs observed that those patients that they identified as being Tier 2 seemed to have a high withdrawal rate as they stated they did not feel they required assistance. Paradoxically then, those patients deemed to be 'rising risk', because they are not yet feeling the impact of their risk profile, are therefore not inclined to engage with ToC support.

Table 5: Distribution of patient population by age (n=181, one missing value)

Age (years)	Count	%
35 – 44	16	8.8
45 - 54	25	13.8
55 - 64	30	16.6
65 - 74	38	21.0
75 - 84	52	28.7
85 +	20	11.0
	181	99.9

In subsequent sections more about the patient population will be detailed.

Perceived value of the Pilot by patients

Pre and Post service survey data was collected from a small sample of patients (23 pre and 26 post, or approximately 10-12%) to gain insight on their service experience. This survey data strongly suggests the ToC Pilot is seen as a valuable program by patients. Interview data also suggests that clinicians and practitioners working in the primary care, community services and hospital setting consider the program, if not currently well understood then ripe with potential.

Most patients in the survey when exiting the program rated it as being 'fairly useful' to 'extremely useful' (see Fig. 2), with more than 50% rating the service a score between 8 to 10 out of a possible 10. The question of usefulness of the program was only asked in the Exit-Survey (26 respondents).

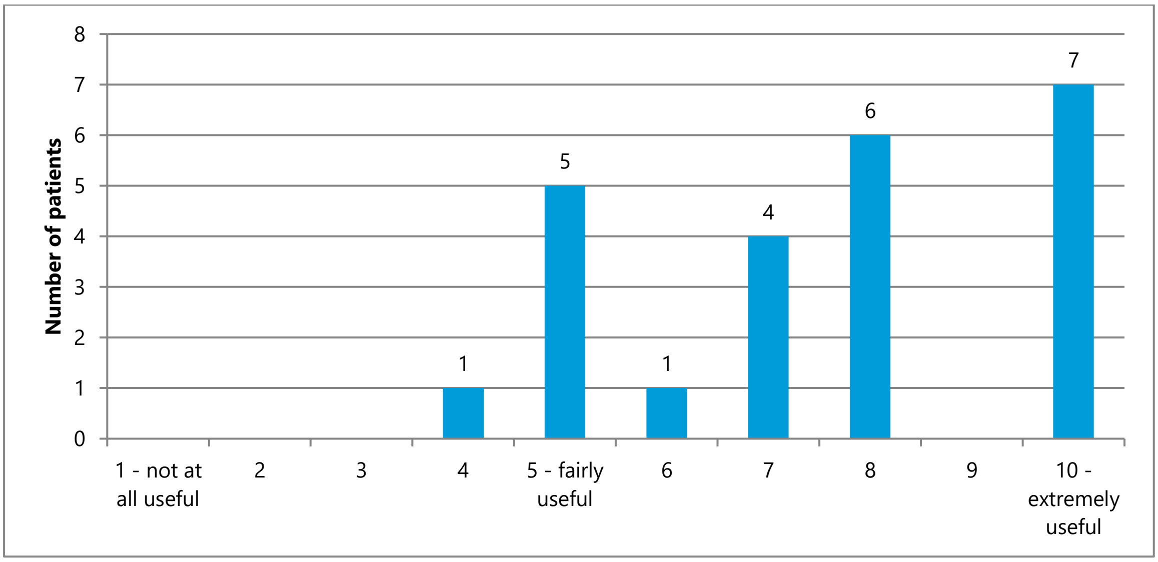

Figure 2: How useful was the ToC? (n=24)[8]

Figure 3: Word frequency analysis of how patients felt when they left hospital (n=23)

Figure 4: Word frequency analysis of patient feedback about the Pilot (n=11)

Respondents to the question *"How did you feel when the hospital staff informed you that you were going home"* in the Pre survey, most commonly indicated, from a selection of 12 options, that they felt 'joy', followed by 'apprehension' and 'trust' (Fig. 3). Joy (n=9 respondents) was generally related to wanting to go home and not liking the hospital environment; apprehension (n=6) was related to worry about how to manage their health at home; trust (n=6) was related to feeling cared for in hospital. Patients also expressed feeling 'fear' and 'confusion'.

This finding indicates that patients were generally negative about leaving hospital emphasising the point that being confronted with a health problem can be a vulnerable time in any person's life. ToC services, therefore, can be useful to alleviate such feelings by creating a sense of assurance and being supported. This latter point is somewhat supported by the results from the Exit survey. Patients were asked to provide further comments about the ToC services they received and indicated that they found the program to be helpful and useful and that they obtained advice and support (Fig. 4).

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[8] The Exit survey was completed by a total of 26 patients however, two patients did not respond to this question.

Impact of the Pilot on patient knowledge and self-management

The data from the Pre survey indicates that patients are not necessarily starting from a low base in terms of their knowledge and ability to manage their health and the results from the Exit survey indicate only a subtle improvement for patients after receiving ToC services. All but one patient indicated that they had a regular GP; 75% (n=18) patients indicated they had a regular pharmacist in the Pre survey and this increased to 92% (n=24) in the Exit survey.

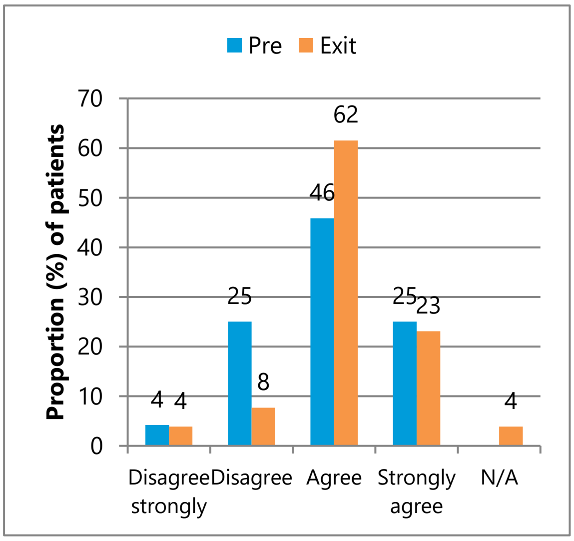

Figure 5: Comparison of patient confidence to put in place strategies before and after receiving ToC services (pre n=24, exit n=26)

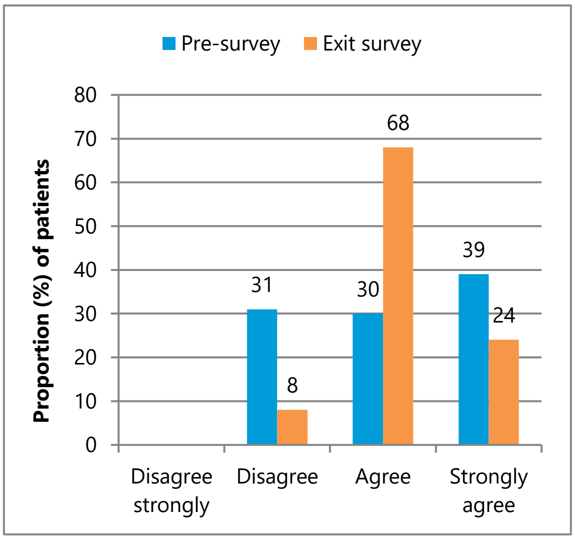

Figure 6: Comparison of patient knowledge of services to contact before and after ToC services (pre n=23, exit n=26)

One area where a moderate change was evident was patient knowledge of which services to contact to manage their health condition or personal circumstances. Figure 5[9] illustrates that the proportion (%) of patients agreeing or strongly agreeing that they have better knowledge of services to contact increased from 79% pre-service to 92% post receiving the service.

Similarly, a slight increase in confidence to put in place strategies to stop or reduce issues with a health condition was noted; 71% of patients agreed or strongly agreed prior to ToC services increasing to 85% after services (Fig. 6).

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[9] One patient did not respond to this question in the pre-survey.

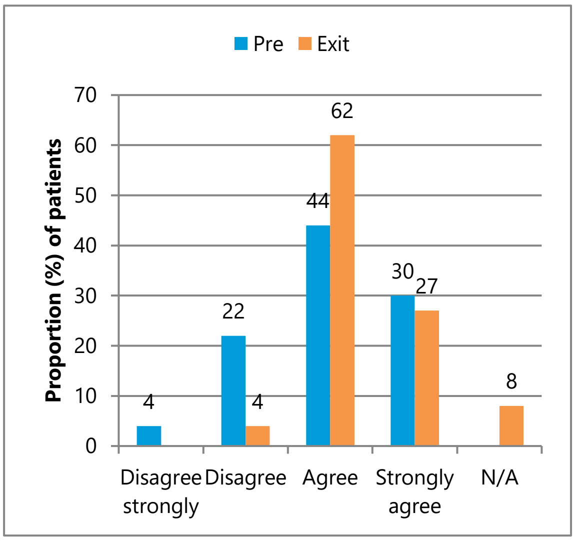

Figure 7: Comparison of how confident patients feel to manage their health condition, before and after ToC services (pre n=24; exit n=26)

An increase in confidence to self-manage a health condition was also found (Fig. 7), 74% agreeing or strongly agreeing with the statement, *"I feel confident to contact services if there is a problem or change with my health condition or personal circumstances"*, pre-service and 89 % after.

Patient-centred care

One of the most valuable features of the program identified by stakeholders is the ability to provide one-on-one support to develop 'bespoke' action plans that meet the needs and goals of the patient. Through this approach patients are encouraged to ask questions and are at the centre of the decision-making process to ensure they find the service and support that fits them best. As stated by one of the stakeholders interviewed:

> *"It can be a very positive and rewarding experience to work with people one-on-one with more time and space to help them plan and manage a condition that would otherwise have a very negative life changing impact."*

The Pilot has supported people who might otherwise have missed out on services. This includes people who have had minimal engagement with services but also includes people who do not understand how to engage with a service or what a service might have to offer. For example, referrals to MAC are not always successful because a patient has not been properly informed of what it can offer and the service is then declined. In such cases, TCs have been able to properly inform patients, advocate for them and link them with a service.

Conduit to services and health care

Navigating the health system and having knowledge of available services and programs is a challenge for many people, even those working within the health system. Over the course of the Pilot, TCs have played a role in gathering information about the health, community and social services and programs available as well as gain an understanding of how the services interact with each other within the broader health system. For example, the Pilot has been helpful to navigate and understand eligibility and access to the ACT Community Assistance & Support Program (CASP)[10], or even MAC[11].

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[10] ACT Community Assistance & Support Program – http://www.health.act.gov.au/our-services/community-based-services/act-community-assistance-support-program

[11] MyAgedCare – https://www.myagedcare.gov.au/

The extent to which TCs act as a conduit between the patient and the services they need is able to be observed through analysis of the quantitative service usage data. As noted previously, this database consisted of patient records being re-constructed through a combination of collecting minimum administrative details at the time of service and then subsequent extraction from patient notes maintained by the TCs.

Just over 87% of the 'eligible' patient population (those who did not decline the service) received at least one service organised through the Pilot[12] (see Fig. 8) including 154 who received at least one home visit. A small number (13%) received more than one visit. Exactly half of those receiving services received only one or two services, while the others who received a service obtained up to eight.

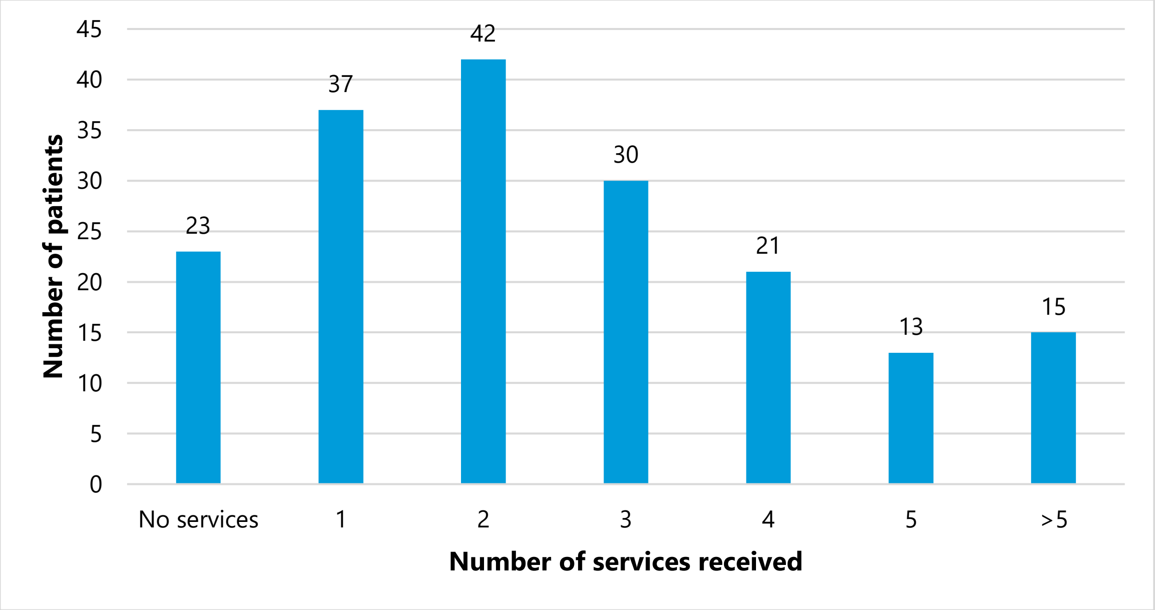

Figure 8: Distribution of patients by number of services received (n=181,[13]

The types of support were (in order of most to least common) (n = 181):

- the provision of information (69, 38%) that is information about chronic diseases (might be a brochure or a referral to a trusted information source), information on service providers and MAC
- assistance to access a GP (61, 34%)

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[12] The average number of services received was 3.2.

[13] One value missing. Missing values generally occur when data is not available for a record (patient) for this variable.

- support in the use of medications (58, 32%), which could also be information but might also be referral to a GP or pharmacist or recommendation for a Webster Pack
- referral to aged care services through MAC or some other pathway (57, 31%)
- transport assistance (43, 24%).
- referral to allied health in the community (31, 17%)
- referral to community support services (27, 15%)
- information on mental health providers & services i.e. Next Step (19, 16%)
- provision or arrangement of domestic help (18, 10%)
- referral to living support services (14, 8%)

Interviewees noted that for many people it can be very confronting to let someone in to their home if they need domestic services or to even receive support from a new service. The time spent by TCs to develop a relationship and trust and rapport with the patient enables them to introduce a patient to a service and vice versa, to ensure effective transfer of information and a smooth transition for the patient. This outcome was observed by some stakeholders interviewed.

In some instances, according to one community service interviewee, TCs indirectly continue to provide support through ongoing communication with services even once the patient has been 'handed over' as illustrated in the following statement:

> *"…being able to go back to the ToC to chat about the patient and troubleshoot issues to ensure the patient gets holistic care; they are a good sounding-board."*

In this way, services have been able to receive detailed information about a patient to ensure the patient receives personalised quality care and support.

Further opportunities for the Pilot

Several opportunities were identified for the Pilot and the ToC services on offer. Engagement with GPs and primary care was considered a key area of development for the continuation of ToC services. Various strategies were implemented over the course of the Pilot to increase engagement with GPs, however, this did not eventuate in the referrals that were anticipated.

From some of the interviews with hospital, community service and primary care personnel, it was noted that there is an opportunity for TCs to coordinate directly with GPs to streamline services for patients and ensure the right services and referrals are in place. Contact with the Practice Nurse was seen as the best pathway to connect with GPs; the Practice Nurse can then organise and prioritise patients' information and results to make the most of the GPs time.

The point was made that patients managing chronic diseases are often being over-serviced with little coordination or communication between services and specialists. At the commencement of the Pilot there was an assumption that services were not available for patients, however, TCs learned that adequate services were available but were not being fully utilised due to poor coordination or lack of awareness of hospital staff (e.g. Discharge Liaison Nurses). Assisting patients to identify the services they actually need, together with GPs, is a useful focus for the program.

Who could benefit from ToC services?

To begin to answer this question it is best to look again at the people currently using the service. As noted earlier the age composition of the patient population ranges from 36 to 90, but is more characterised by people over 65. As well as age, some other patient characteristics that could be associated with need of ToC services, living arrangements and mobility, were analysed.

Almost half of the patients live alone (47%) while most others live with a partner, relative or have a live-in carer (41% in total). Just over one in 10 is a carer themselves. Figure 9 illustrates the distribution.

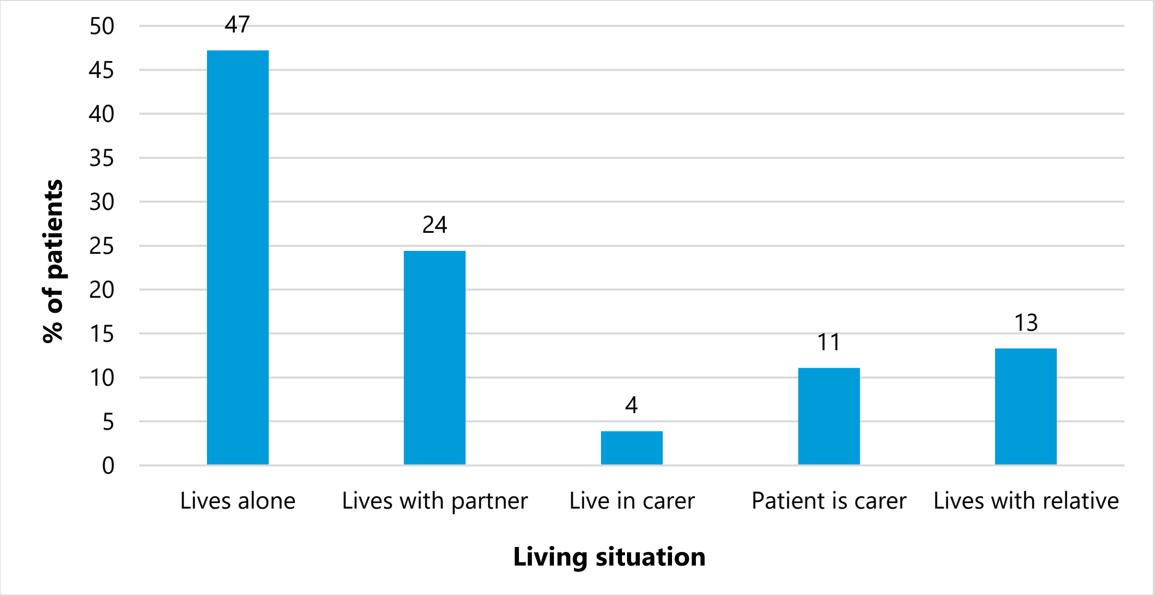

Figure 9: Distribution of patient population by living circumstances (n=180)

Most of the patient population has good mobility and can move around independently (66%, see Table 6).

Table 6: Distribution of patient population by mobility status (n=179)

Mobility status	Details	Count	% of total
Independent	Independent	90	50.2
	Independent with history of recent falls	28	15.6
	Sub-total	*0*	*65.8*
Compromised	Affected by chronic disease	9	5.1
	Utilises aids/affected by recent or a history of falls	31	17.3
	Affected by pain	21	11.7
	Sub-total	*0*	*34.1*
Total		179	99.9

The potentially most vulnerable part of the population (i.e. those that live alone or are a carer and have compromised mobility) accounts for just over 21% of patients.

Lessons from initial implementation

The final interviews conducted for the evaluation highlighted a number of important lessons or learnings from the implementation of the Pilot that were noted throughout the evaluation.

Planning, implementation and communication of the Pilot

Initial planning and implementation

The design of the Pilot was highly dependent on the involvement of hospital staff to assist with identifying and referring patients, yet, there was minimal commitment and engagement from the beginning of the Pilot by hospital staff which had a significant impact on the number of patients being referred for ToC services.

The Pilot commenced by working in partnership with two medical wards but changes with hospital staffing and structures diminished the engagement with the program. The TCs also found that the relevant Tier 2 rising risk patients were not in the medical wards – most of the admitted patients were people with complex health conditions i.e. Tier 1 and already linked in with support services or other programs. Arrangements were then made to work with the ED and EMU where the program has continued but where staff engagement has been low.

Communication and promotion

A number of interviewees noted that a communication strategy would have assisted implementation by identifying potential 'champions' of the program, the most appropriate methods and frequency of communication and to also establish common language and terminology used by hospital staff.

Language and terminology utilised for the Pilot was also a potential pitfall for communication. For example, the Pilot was designed and communicated as catering for 'Tier 2' patients or a 'rising risk'; yet it was found that neither of these terms were known or used within the hospital setting contributing to a lack of understanding and confusion by hospital staff about the purpose of the program and patient eligibility.

Similarly, using the term 'Pilot', may have given the impression of a temporary program, which negatively impacted on the commitment of hospital staff to refer patients. In a fast-paced and ever-changing environment, hospital staff are unlikely to utilise a program that is perceived to have a short lifespan and will instead 'stick to what they know'.

Within the hospital setting, it was highlighted that communication and promotion really needs to be driven and led by nursing staff. In the early stages of the Pilot, there were some key nursing staff advocating and promoting the Pilot, however, with staff changes this quickly dropped and was not properly picked up again by the TCH.

Several positions were identified by the CHN as being potentially influential and included the Assistant Directors of Nursing, Chief Nurse, Director General TCH and Allied Health. The Pilot was regularly promoted with the ACT Minister for Health, Director General level, at the joint ACT Health, Calvary Health Care, Health Care Consumers Association and CHN Coordinating Committee, TCH in-service sessions and multidisciplinary meetings at the operational level. However, in reality, maintaining the interest for the Pilot was difficult as the environment within the TCH became increasingly changeable and unstable with high turnover of hospital staff.

Patient eligibility criteria

The eligibility criteria for patients have been a challenging issue throughout life of the Pilot for both the staff implementing the program but also for external stakeholders and partners of the program. Originally the criteria consisted of an age range (50-80 years), presence of a chronic illness condition and a certain Early Discharge Screening (EDS) tool risk score (indicating risk of readmission but not the highest level of complexity). After the EDS tool was discarded (because it was not found to be helpful), a broader set of criterion were employed *to inform* risk assessment and patient eligibility referring to the above criteria as well as consideration of the patient's network of supports or social isolation or where carer stress/capacity/ capability may be an issue.

While there was a rationale for the original eligibility criteria, overwhelmingly it was found from interviews that the initial criteria were too narrow – patients could not be too young or too old – and needed to be much broader to capture more patients and to encourage referrals from hospital staff. Several interviewees, throughout the evaluation noted that there did not seem to be clear articulation of the criteria and so hospital staff did not know which 'type' of patient to refer to the program.

As described by one interviewee, the lack of clarity and agreement in relation to eligibility may have significantly impacted on hospital staff enthusiasm:

> *"Initially staff were trying to refer to the program, they saw the program as another resource to help with patients, but kept being told that patients were too complex, they rejected patients too many times and so staff put them in the "you're getting in may way" category".*

To properly capture patients and provide ToC services, it was strongly felt by several interviewees that the eligibility needed to be broad enough to accept anyone with a chronic health condition at any age. Importantly the program needs to be open to supporting people with multiple comorbidities, including psychosocial issues as these tend to go hand-in-hand with physical health issues.

An analysis of the correlation between the level of support to patients in the ToC (estimated through the number of services provided) and a range of patient characteristics was undertaken for a sample of the patients where a complete data set could be obtained. The level of support variable was explored for its relationship with:

- living situation (those living alone assessed as being at higher risk)

- mobility (those with limited independence assessed as being at higher risk)
- the level of support required to access and gain a relationship with a GP
- the level of compliance with outpatient 'prescription'
- the number of home visits
- the level of concern with medication compliance

A strong relationship ($r > 0.4$) was found between a high level of support needed to find a stable GP relationship, the number of home visits and medication concerns.

System issues affecting implementation and delivery

The Pilot has been successful in supporting 181 patients with transition from hospital to the community setting, but there were, and continue to be, several systems and structural issues that have affected the implementation and delivery of the program. Some of these issues could have been identified and built into the planning phase such as a common language or terminology between the Pilot and the hospital system, but others it was not known or anticipated.

Hospital systems and culture

From the beginning of implementation the Pilot has had to contend with a busy and changing hospital environment which at times made it challenging for the TCs and the program to gain traction and engagement. The CHN noted that the Pilot had initial engagement from the health system but that this dissipated as the system underwent significant change and other priorities took over.

Across ACT Health there are 250 separate systems and within the TCH, it was noted that there are over 100 programs on offer for patients as well as different systems within each hospital ward. Introducing a new program under such circumstances and gaining the attention of hospital staff was always going to be a challenge. In addition, in the last year the TCH underwent a significant amount of change and restructuring including a change in senior level staff. It was felt that because of these changes, coupled with the normal work environment, hospital staff were in 'change-fatigue' impacting on the ability and desire of hospital staff to engage with the Pilot. This is succinctly captured in the following statement:

> *"Clinicians know what they want to know so you need to keep the program on the agenda at ward meetings, in-service, changing of shifts".*

Aside from the numerous programs and services and the changes that took place within the TCH, it was noted that there exists a territorial culture within hospitals more generally which can make it difficult to introduce new programs or practices. That the Pilot was not seen as part of the TCH or a TCH program was cited as being significant issue for the low level of engagement by hospital staff. It was suggested that new programs or practices not only need to be regularly promoted from executive to operational levels of the TCH but they also need to be attached to hospital Key Performance Indicators (KPIs) to ensure measurable results;

without such visibility and link to outcomes there is simply no perceived benefit for the hospital.

Patient discharge from hospital

While discharge planning was not in scope for the Pilot, it is an issue that cannot be ignored as it was consistently raised and discussed throughout the evaluation. Discharge planning and coordination does have some impact on the ability to effectively provide ToC services, but ultimately it can affect outcomes for patients. The findings in relation to discharge are discussed in terms: planning, communication with primary care, improvements.

Discharge planning

Discharge coordination from hospital was described by several interviewees as 'hit and miss'; this was in relation to the quality of the information prepared but also the delivery and receipt of the DSP.

Most patients (86%) definitely receive a discharge plan (it could be higher), but only just under half (47%) of the patients claim to have read their plan (See Figure 10) and are aware of the plan's instructions. The TCs were able to verify that in 63% of patient cases the GP also receives the discharge plan, but in another 32% of cases they could not be sure.

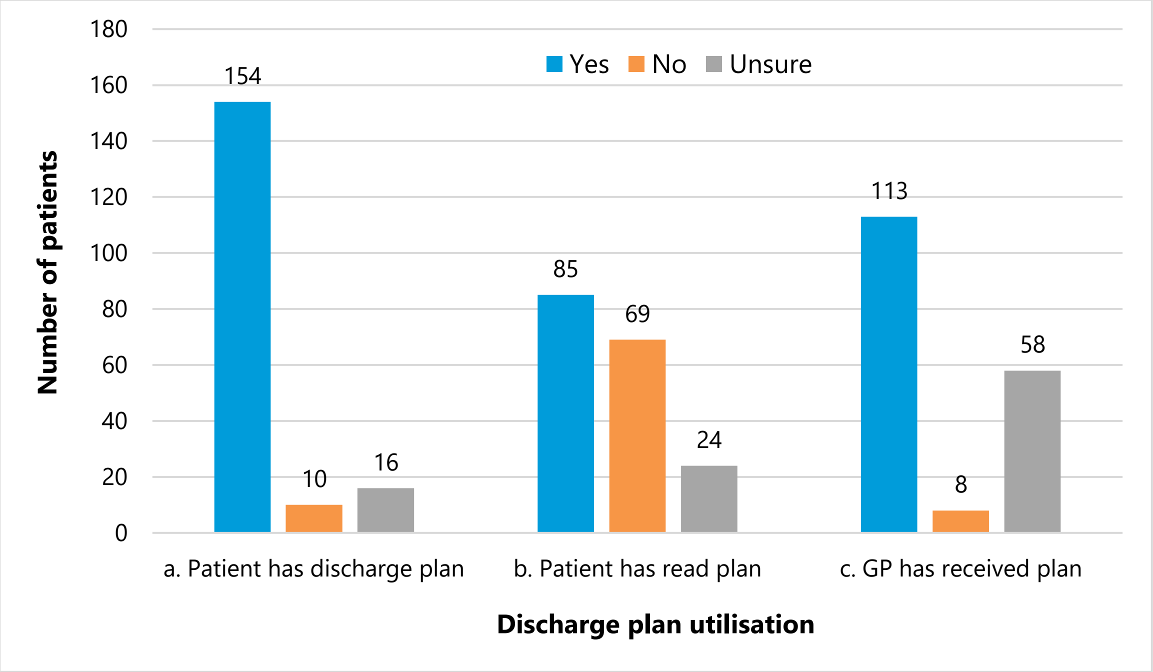

Figure 10: Receipt and use of the discharge plan from inpatient care (n=180)[14]

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[14] At the time of analysis, data was incomplete for two records for graphs 'a' and 'b'; three records were incomplete for graph 'c'.

Results from the Pre survey completed by patients indicated that just over 25% (n=6) of those clients that did read their discharge plan rated their understanding of their DSP from 2 to 5 (understanding some information) out of a possible 10 (Fig.11).

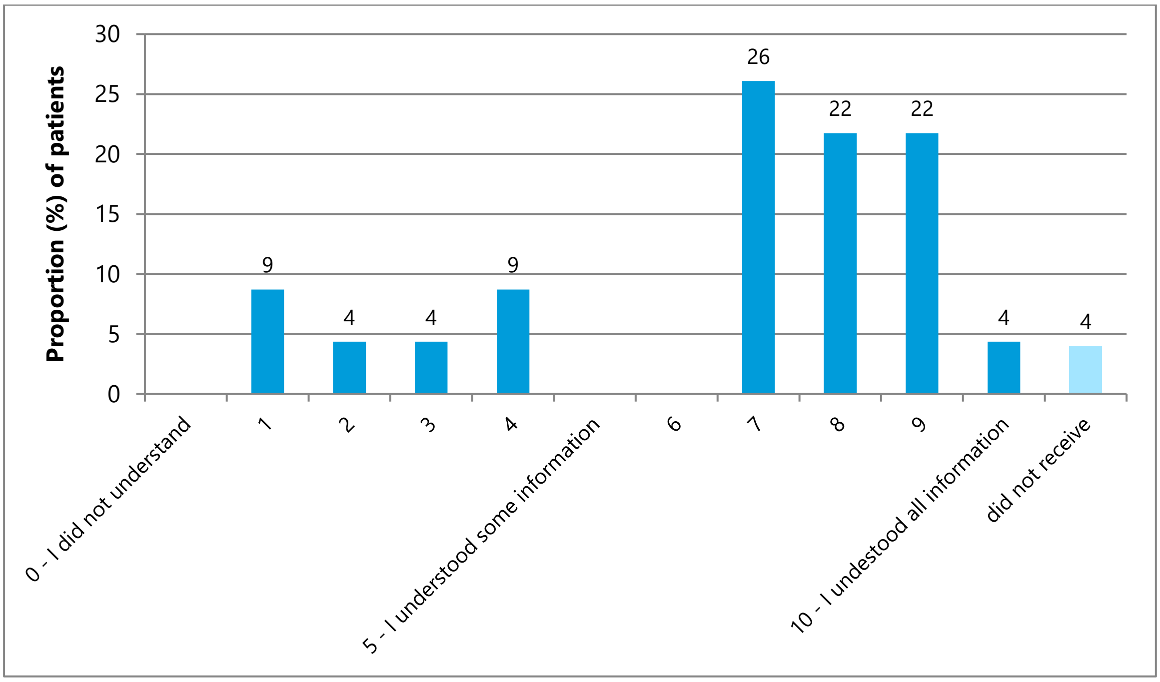

Figure 11: Proportion of patient understanding of DSPs (n=23)[15]

TCs indicated that key information is often missing or patients are not asked the right questions about their health or living circumstances resulting in insufficient support for patients. Some patients receive support or services organised through DSPs, but this is largely ad hoc because hospital staff generally have little awareness of the services available in the community and may also have a lack of knowledge of 'on-the-ground' reality for how activation of services occur. For example, there is a significant time lag between patients being referred to services and then receiving services; plans may be prepared for patients but they may not be activated for several weeks which can have significant impacts for many patients.

Understanding or assessing the personal circumstances of a patient prior to discharge from hospital is also not addressed or included in DSPs, for example where the patient will be returning to and who might be accompanying them. Without such information there is a risk that the DSP may be sent to the wrong location, resulting in further delays for services, but also if a patient still needs additional support, there will be delays in determining who or how the support will be provided.

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[15] One person did not complete this question.

Communication with primary care for discharge planning

Engagement and communication with primary care was also cited as being poorly executed by the hospital highlighting the need for better follow up and direct contact with GPs in the community. Issues arise around the transfer of information where the DSP is emailed directly to a GP yet it may not be read by the GP for several days due to internal systems utilised by general practice. This is particularly problematic for patients if they are sent home on a Friday afternoon.

Additionally, it is important to ascertain that the receiving GP is the current GP; in hospital patients are vulnerable and unwell and not always able to properly recall information, therefore it is incumbent on hospital staff to confirm that the DSP will be emailed to the correct GP.

Potential improvements for discharge planning

Again, while it is not the scope of the Pilot or this evaluation to address discharge planning from the TCH, a number of notable improvements were suggested by one interviewee for discharge planning. These included:

- implementing a *"Triage criteria"* for direct handover to a GP practice by connecting with the Practice Nurse to identify and support 'at risk' patients, e.g.:
    - patients with major medication changes, such as commencing anti-embolic therapy, reducing/increasing steroid therapy
    - patients with new clinical diagnoses which require major medication or life changes
- Ensuring DSPs meet the National Guidelines as outlined by the Australian Commission on Safety and Quality in Health Care (2017).

Also as previously mentioned, confirming the patient's current GP prior to sending the DSP and confirming where the patient will be returning to (it may not be the normal home) and with whom.

Conclusion

As identified through previous PDSA review cycles the ongoing delivery of the ToC program can benefit people in the ACT with a chronic illness requiring support to access a regular GP, find their way to other required support services (aged care, allied health) and manage their medications.

Some improvements to the ToC program are required, first in order to increase the service utilisation (from a base of approximately 12 patient enrolments per month) and second to increase the impact of the service for those actually receiving services.

Addressing 'rising risk' patients is a relatively new and emerging field therefore it can be difficult to find an established definition of 'rising risk' (Cantor, Haller, Greenberg, 2018). It was evident from this evaluation that this area of health is still relatively unknown or poorly understood within TCH and perhaps more broadly across the ACT health system. The search for a tool that identifies appropriate 'rising risk' (Tier 2) patients and can be easily applied across the hospital needs to continue, and, based on the findings of the correlation analysis, it will most likely include early identification of patients that have no established GP relationship and are clearly struggling with their understanding of medication use. Information on both issues is currently captured in the hospital information systems, one in the patient administration system, and the other likely in nurses' clinical notes.

Improved engagement with and acceptance from the TCH is also required for improved utilisation and the delivery of the program. The program would benefit from undertaking a more formal implementation plan that includes assessing the key stakeholders and identifying the most appropriate central location or contact point within TCH. 'Clinician expertise and intuition' is an important strategy at the individual level for identifying rising risk patients as part of a spectrum of identification processes (Cantor, Haller, Greenberg, 2018), therefore endorsement and engagement by clinicians with TCH is critical for successful delivery of the program.

Several programs currently exist in the ACT to support people with existing chronic health conditions in the community such as the Chronic Care Program[16] and Transitional Therapy and Care Program[17]. However, other than the ToC program, no programs currently exist in the ACT that aims to support people with emerging or developing chronic health conditions. While there is some overlap between the aforementioned programs and the ToC program, there is still 'room' for the program particularly in regard to supporting patient navigation and transition from hospital to home. A similar program, the Patient Care Navigator program, is currently being investigated by the Health Care Consumers' Association (HCCA) funded by

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[16] Chronic Care Program, ACT Health website http://www.health.act.gov.au/our-services/chronic-disease-management/chronic-disease-services accessed online on 24 September 2018.

[17] Transitional Therapy and Care Program, ACT Health website http://health.act.gov.au/our-services/rehabilitation-aged-and-community-care/transitional-therapy-and-care-program accessed online on 24 September 2018.

ACT Health[18], underscoring the value of a service like the ToC and presenting an opportunity for collaboration and coordination of resources to improve patient transition and, ultimately, patient outcomes.

Within such a collaborative approach though the ToC program still needs to properly define what it uniquely brings to the table and how it adds value. Given the location of the program (within a Primary Health Network) seemingly its greatest selling point is the relationship with GPs and by extension the relationship between GPs and hospital clinical services.

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[18] HCCA (2018). *Consumer Bites: The newsletter of the Health Care Consumers' Association Inc.* Vol. 5, Issue 5 accessed online at file:///C:/Users/longcow/Downloads/Consumer%20Bites%20-%20Issue%205%202018%20(2).pdf on 23 August, 2018.

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Appendix 1: Patient feedback survey

The Pre survey version of the patient experience survey has been provided to demonstrate the format of both the pre and exit survey. The Exit survey does not include the 'Transition from hospital to home' questions, but does include three additional questions relating to the experience with the Pilot. The surveys were designed by the HCA team in consultation with the CHN.

Pre survey : Patient experience at the commencement of the Transitions of Care program

This survey should be used at the first home visit by the Transition Coordinator in conversation with the patient.

The purpose of the tool is to understand the patients experience, knowledge and ability in relation to managing their health conditions.

The information collected using this tool can then be used to develop an **Action Plan** with the patient.

The **Exit Survey** should be completed at the final visit with the patient to assess changes when they exit the Transitions of Care program and to identify further actions for managing their health conditions.

Date:	Patient identifier:	
Attending Transition Coordinator:		

Transition from hospital to home

1. How did you feel when the hospital staff informed you that you were going home? Circle all that apply or add your own words.

optimism sadness apprehension fear confusion Interest joy annoyance anger acceptance trust disapproval

Write extra words here:

1. Why did you feel this?

2. What could be changed to make you feel differently?

3. How did you feel when you arrived home? Circle all that apply or add your own words.

optimism sadness apprehension fear confusion Interest joy annoyance anger acceptance trust disapproval

Write extra words here:

4. Why did you feel like this?

5. What could be changed to make you feel differently?

6. On a scale of 0 to 10, how much of the information do you understand in the Discharge Summary Plan?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I did not receive it	I haven't read it yet	0	1	2	3	4	5	6	7	8	9	10
		I did not understand any of the				I understood some					I understood all of	

information		of the information		the information	
Follow up and service navigation					
Please indicate how much you agree or disagree with each of the following statements.					
1. I understand the medical tests I have had and/or will be having	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
2. I feel confident talking to health and community service professionals (such as a GP or support worker) if I am worried about my health conditions or personal circumstances even if they don’t ask	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
3. I know which services to contact to help me manage my health conditions or personal circumstances	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
4. I feel confident to contact services if there is a problem or change with my health condition or personal circumstances	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
5. What goals or issues are you currently receiving support for? Can you list the support you might be receiving for these goals or issues? (e.g. do you have an NDIS package, MyAgedCare, physiotherapy sessions, etc.)		6. Are there any other goals or issues for which you think you might need some support?			
7. Do you have any concerns or questions about your goals or issues and the support you are currently receiving or will receive?					

Medication management					
1. Do you have a regular GP?	Yes	No	Unsure		
2. Do you have a regular pharmacist?	Yes	No	Unsure		
Please indicate how much you agree or disagree with each of the following statements.					
3. I understand what my prescribed medication/s are for	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
4. I feel confident I can take my medication/s as prescribed	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
5. I feel confident talking to my GP about my medication/s	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
6. I feel confident talking to my pharmacist about my medication/s	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
7. Is there anything you don’t understand about your medication/s?					
Self-management					
Please indicate how much you agree or disagree with each of the following statements.					
8. I understand the type of health condition/s I have, how it is caused and how it affects me	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable

9. It is important to me that I take charge of managing my health conditions or personal circumstances	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
10. I feel confident that I know when I can manage a health issue by myself and when I need to contact health services	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
11. I feel confident I can put in place strategies that will stop or reduce issues with my health condition	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
12. I feel confident that I can manage the medical treatment/s I need to do for my health condition at home	Disagree strongly	Disagree	Agree	Strongly agree	Not applicable
1. Is there anything you don't understand about your health conditions?					

End of survey

Appendix 2: Additional graphs of Pre survey data

Follow up and service navigation

Up to 22 patients (the lowest being 16) stated they ‘Agree’ or ‘Strongly agree’ that:

a. they understand the medical tests they have had or will have

b. they feel confident talking to health professional about health concerns even if they don’t ask

c. they know which services to contact to manage their health or personal circumstances

d. they feel confident to contact services if there is a problem.

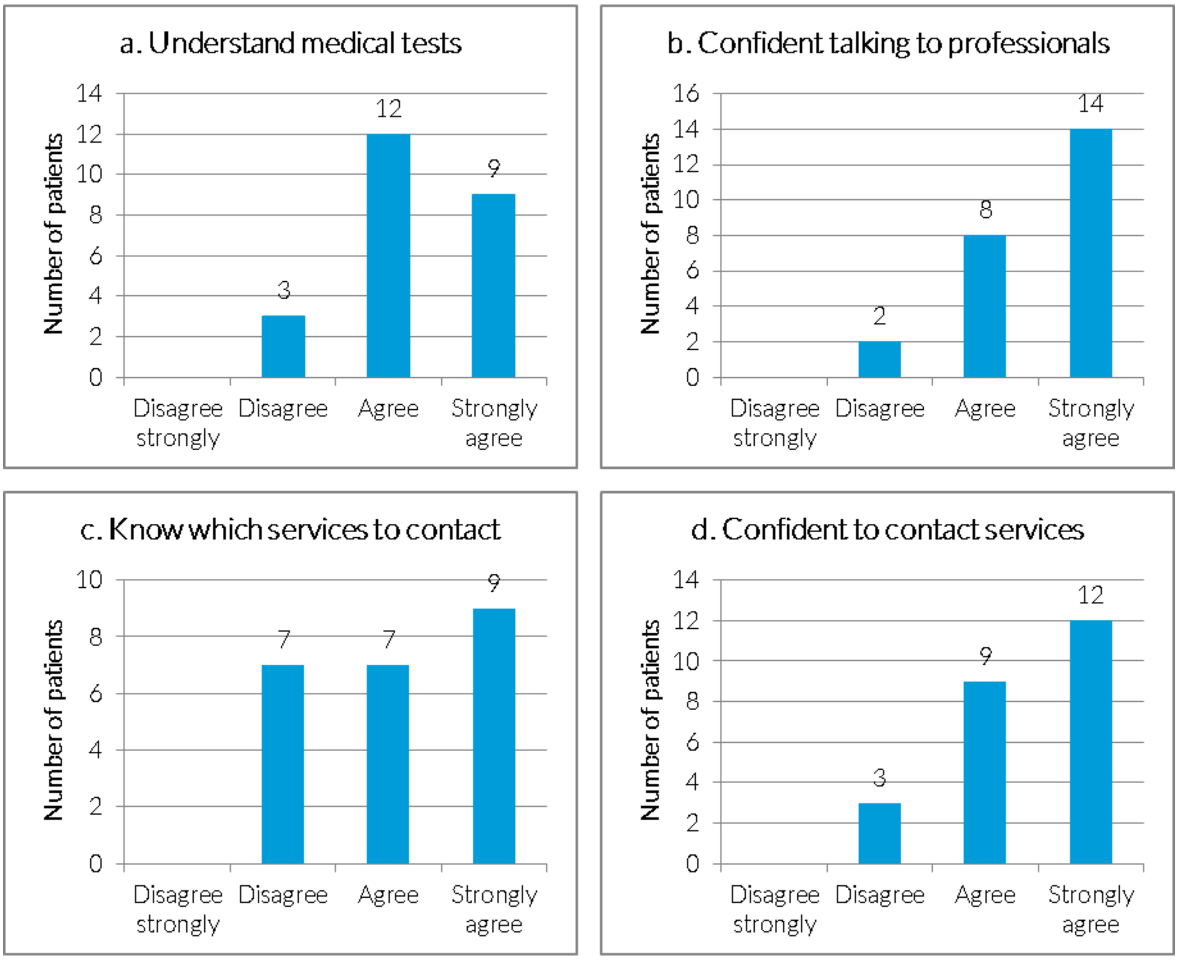

Figure 12: Patient understanding of follow up and service navigation at pre survey (n=24)[19]

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[19] One person did not respond to the question represented in graph C.

Medication management

Up to 22 patients (the lowest being 21) stated they ‘Agree’ or ‘Strongly agree’ that they:

a. understand what their medication/s are for
b. feel confident to take their medication/s as prescribed
c. feel confident talking to their GP about their medication/s
d. feel confident talking to their pharmacist about their medication/s

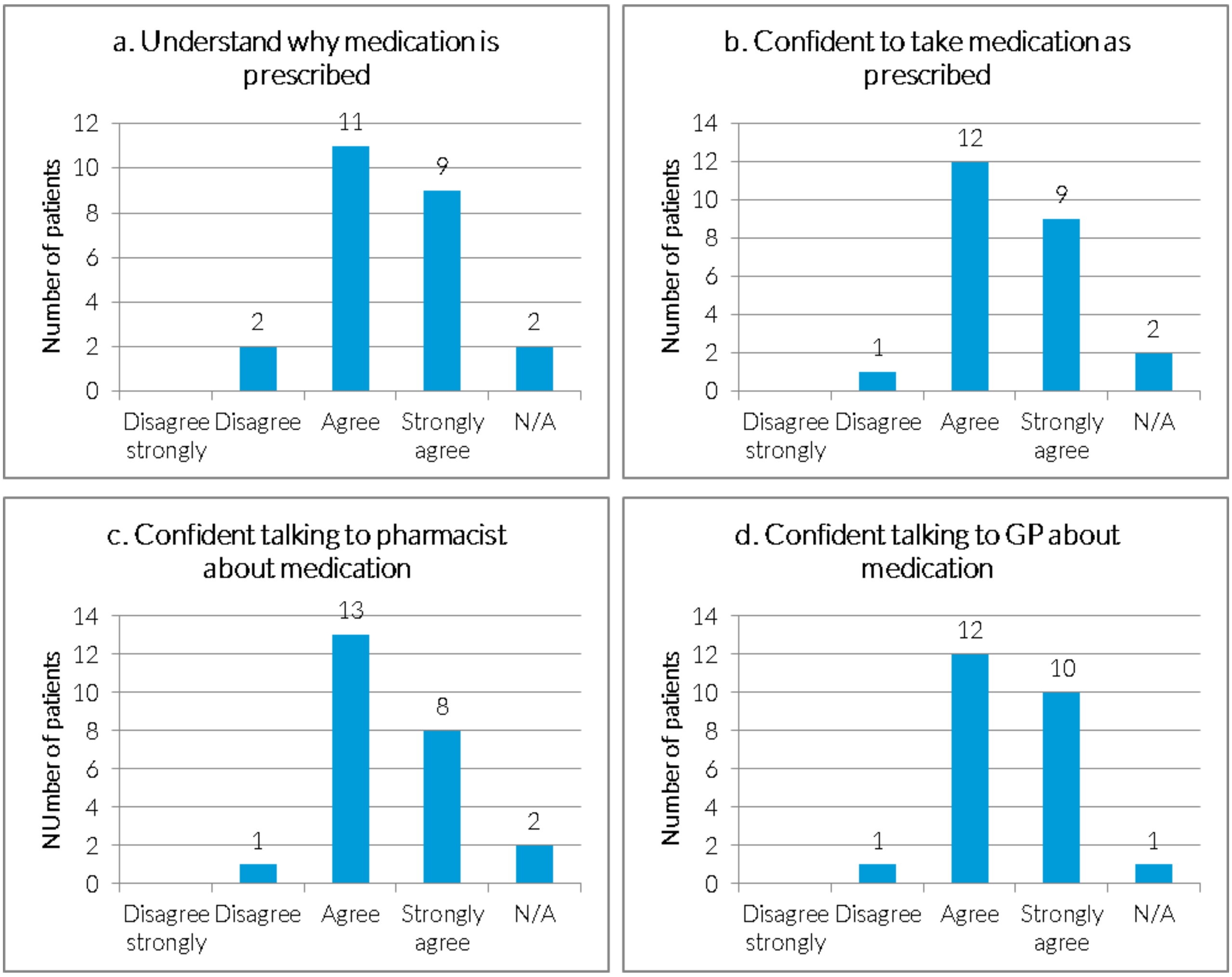

Figure 13: Patient medication management at pre survey (n=24)

Self-management

Up to 23 patients (the lowest being 17) stated that they 'Agree' or 'Strongly disagree' that they:

a. understand the type of health condition/s they, its cause and affect
b. feel it is important to take charge of managing their health conditions or personal circumstances
c. feel confident that they know when they can manage a health issue and when they need to contact health services
d. feel confident to put in place strategies that will stop or reduce issues with their health condition
e. feel confident that they can manage the medical treatment/s they need to do.

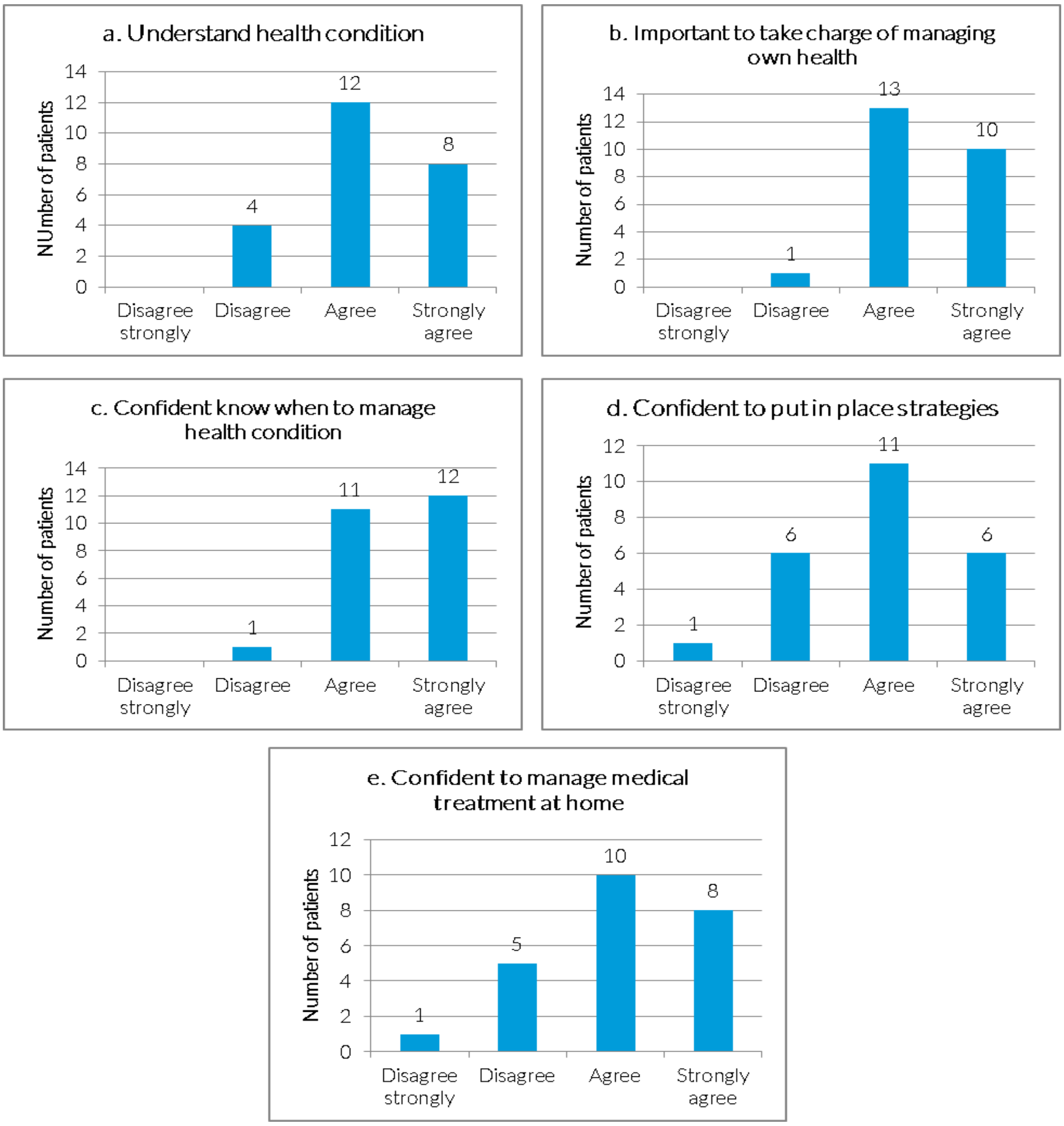

Figure 14: Level of self-management at pre survey (n=24)

Appendix 3: Additional graphs for Exit survey

Follow up and service navigation

Up to 25 patients (the lowest being 23) stated they ‘Agree’ or ‘Strongly agree’ that:

a. they <u>understand</u> the medical tests they have had or will have

b. they feel <u>confident</u> talking to health professional about health concerns even if they don’t ask

c. they <u>know</u> which services to contact to manage their health or personal circumstances

d. they feel confident to contact services if there is a problem.

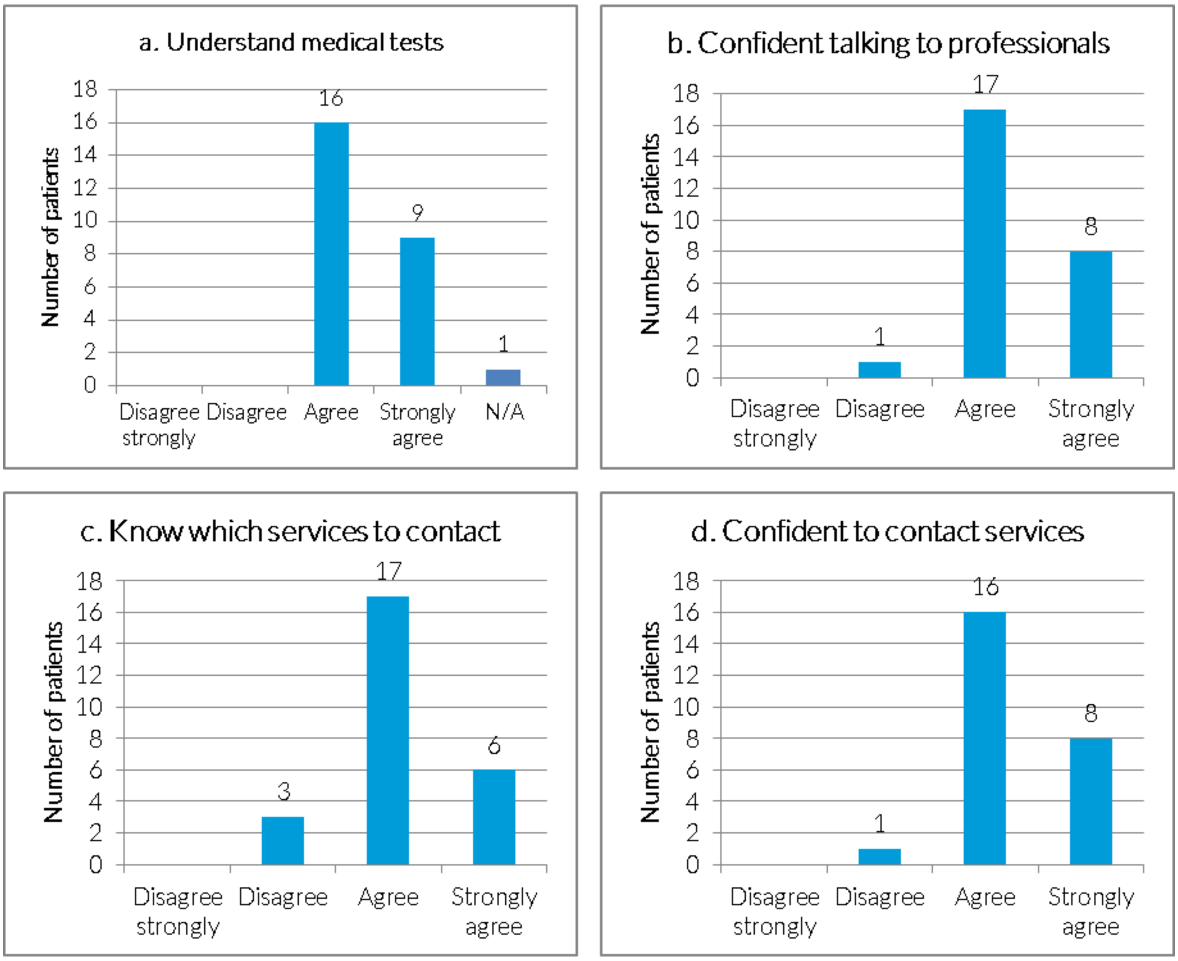

Figure 15: Patient understanding of follow up and service navigation at Exit-survey (n=26)[20]

Medication management

Up to 25 patients (the lowest being 24) stated they ‘Agree’ or ‘Strongly agree’ that they:

a. understand what their medication/s are for
b. feel confident to take their medication/s as prescribed
c. feel confident talking to their GP about their medication/s
d. feel confident talking to their pharmacist about their medication/s

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[20] One person did not respond to the question represented in graph D.

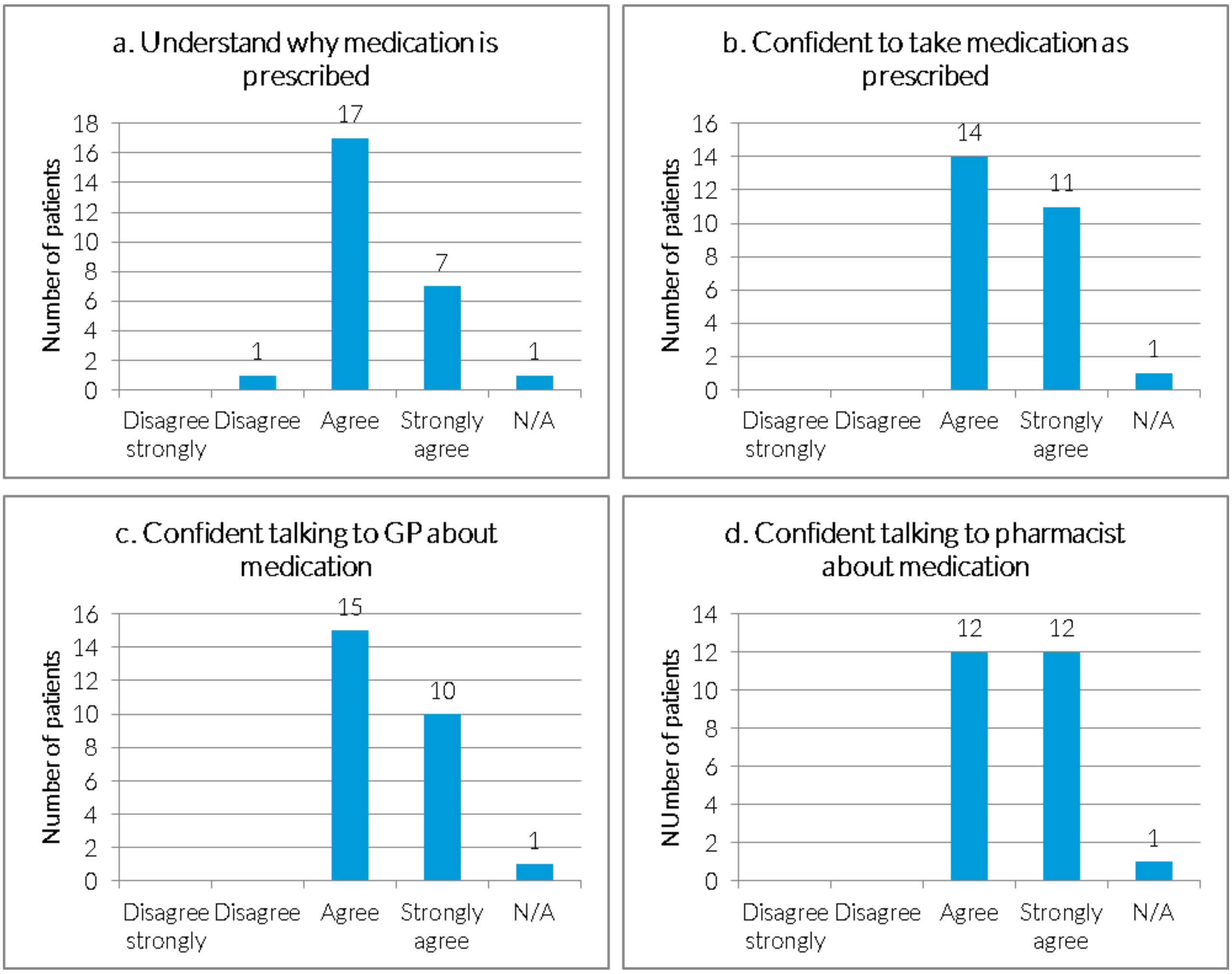

Figure 16: Patient medication management at Exit survey (n=26)

Self-management

Up to 23 patients (the lowest being 17) stated that they 'Agree' or 'Strongly disagree' that they:

a. understand the type of health condition/s they, its cause and affect

b. feel it is important to take charge of managing their health conditions or personal circumstances

c. feel confident that they know when they can manage a health issue and when they need to contact health services

d. feel confident to put in place strategies that will stop or reduce issues with their health condition

e. feel confident that they can manage the medical treatment/s they need to do.

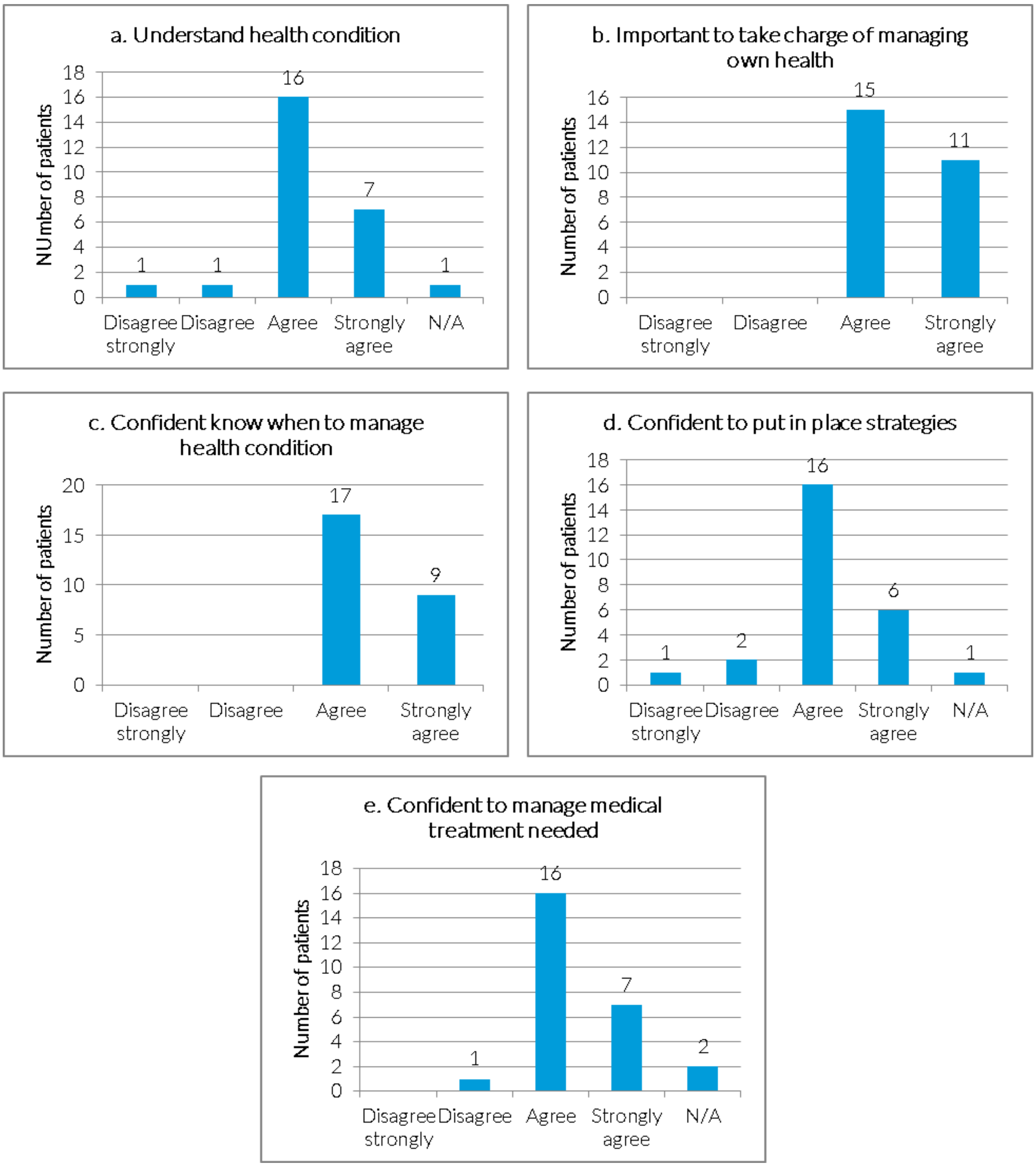

Figure 17: Level of self-management at Exit survey (n=26)

phn
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