



## Transitional Aged Care

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# Table of Contents

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Acknowledgments and Advisors	4
Executive Summary	5
<b>Section One: The Need for Change</b>	<b>6</b>
<b>Sita's Story Prior to Transitional Aged Care</b>	<b>6</b>
What's Wrong with this Story?	7
Background to the Model	8
The Need for Transitional Aged Care	9
<b>Section Two: Transitional Aged Care</b>	<b>10</b>
<b>Sita's Story Under Transitional Aged Care</b>	<b>10</b>
What is Transitional Aged Care?	12
How Does Transitional Aged Care Work?	14
Various Models of Transitional Aged Care	16
Benefits	17
Ideal Patient Journeys	18
Implementing Transitional Aged Care	20
Staffing	22
<b>Section Three: Resources</b>	<b>23</b>
Resources	23

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# Executive Summary

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Advancing age is associated with increasing rates of chronic disease and complex medical and care issues. When hospitalised for an acute illness, older people often lose some of their independence and functioning. This deterioration in function can be seen in a range of activities of daily living such as mobility, transferring, toileting, feeding and grooming.

At this time, many older people, their carers and family are required to make decisions about the older person's long term care requirements. Many make a premature decision to enter an aged care facility based on their level of functioning while in hospital.

Elderly patients recover medically before they recover functionally. Those given the time and opportunity to recondition often regain their pre-illness levels of independence. An acute hospital is not an appropriate environment in which to allow patients the time to recover once they are medically stable.

Transitional Aged Care is a program to address the needs of older people who, in the absence of the program, would require residential aged care. It is a time-limited (12 weeks) period of support and low intensity therapy in a residential or community setting. It provides older people who have been assessed by an Aged Care

Assessment Team (ACAT) as eligible for admission to residential aged care with an opportunity to optimise their functional capacity and determine their appropriate long-term care requirements.

Key to the model is the provision of a goal-oriented therapy program which aims to help patients achieve their goals in their own home environment or a home-like environment. Support is provided for activities in which the patient is not fully independent. Services are tailored according to each individual patient's requirements and are adjusted as the patient's function improves.

The model requires the provision of case management, community care services and multidisciplinary therapy services. The exact configuration of services in each area will depend on the local infrastructure and needs of the community.

Studies indicate that models of care such as Transitional Aged Care that provide the opportunity for older people to optimise their function in an appropriate environment. They offer patients, their carers and families the chance to make a more informed choice about their long-term care needs and can prevent premature admission to residential aged care facilities.

# The Need for Change

## Sita's Story

### Sita's story prior to Transitional Aged Care

Sita is 86 years old and lives alone in a house. Her husband died eight years ago. Her six children are in daily contact.

Sita has had 23 hospital admissions in five years, is in quite poor health and is unable to look after herself adequately at home.

Sita has frequent respite care in a hostel and has had numerous admissions to private hospitals over the last two years.

This is her story of care prior to Transitional Aged Care.

*This is based on a true story, only names have been changed.*

I am 86 years old and I live in my own home. My five children visit regularly - not all at the same time though. My second daughter lives around the corner from me and pops in to check up on me every day. My son comes every other day. I like to see them although they get a bit bossy sometimes. My health has been a bit erratic lately. No worse than anyone else's though and I am still going strong. I enjoy a drink now and then - not when my children are around though - they get cross when I have a drink.

I have had a few falls and my arthritis is quite bad, so I eventually had to have my hips replaced. The big C visited me a few years ago and I had to have a gastrectomy and my heart has a bit of a hiccup now and then. Other than that I manage alright at home because someone comes in to clean the house and help with things most days and my daughter pops in and makes a cup of tea for me and stays to chat.

All these little health problems have meant that I have to visit the hospital quite often. Most times I have to go to hospital because I have had a little fall. They fix me up and I go home again but it gets lonely at home. I call my son and my other daughters and they get mad because I have had a nice drink. They got so cross they called the hotel down the road and told them not to serve me but I don't think they understand how lonely it is at home.

A few times my family have arranged for me to go to a private hospital and recover from my falls. If I get an infection it usually means I have to stay longer in the hospital. Often when I go home again I feel quite stiff and weak and it can be hard to get around sometimes. I keep losing my glasses so I sometimes can't see the edge of the rug that well. I really should get my glasses looked at again.

## Sita's Journey



Sita lives at home alone. She has experienced a number of falls.



Sita has a history of health issues including cancer, heart problems and hip replacements.



Sita's falls result in frequent visits to hospital and then hostel.

## What is wrong with this story?

Sita's journey could have been much better.

- Sita is having numerous hospital admissions and is losing her functionality and mobility.
- Sita's daughter supports her mother at home with the help of some Community Aged Care Package services but this is not adequate to reduce the falls and frequent admissions.
- There is no family agreement on Sita's living arrangements. Some of her children support Sita's desire to live at home but her daughter and son who live locally want her to have a permanent hostel placement.

This last year I have had to stay at the hostel down the road a few times because my daughter hasn't been able to pop in to see me every day. I quite like staying at the hostel for a short time. The other people there are good company and I get lots of chances to play the piano and sing. I used to be a dancer so it is good to be able to perform in front of an audience again. I don't want to live at the hostel though. I mean your home is your home and you can't just up and leave your home.

I got back home the other day after a stay in the hostel because my daughter has got time to pop in to see me again. I had only been home a couple of days when I had a fall in the kitchen and I broke my leg so I had to go back to hospital.

My daughters and sons came to visit me and I told them that the nurse said I had a big file at the hospital because I had been in hospital 23 times in the last five years. My daughter got quite scratchy and said I should remember that I had only been home for 12 days in the last nine months. She said I was really living at the hostel and hospital not at my home. My other two daughters from Queensland came down to see me as well while I was in hospital. They said it was better if I stayed at home if I wanted and it wouldn't be long before my arm was better. After that I would be able to go home again. My general practitioner said I should consider moving to the hostel permanently because I find it difficult to manage at home but I don't need to do that because my daughter and son visit me every day.



# Background to the Model

Advancing age is associated with increasing rates of chronic disease and complex medical and care issues. Reduced mortality rates have resulted in a significant number of people living with chronic illnesses that have the potential to require repeated hospital admission for episodic care (Williams, 2004). Patients aged 65 years and older are accounting for an increasing proportion of hospital admissions. In 2000-01, 34.4% of NSW Hospital separations were for patients aged over 65 years. In 2004-05, this proportion had increased to 36.6% (Australian Institute of Health and Welfare, 2002; 2006). The increase is due to a number of factors, including the ageing of the population, the Australian Government policy aimed at allowing older people to age in place, the reduction in the number of residential aged care places per 1,000 people aged over 70 years, and a reduction in the number of acute hospital beds (Howe, 2002).

Patients aged 65 years and older are accounting for an increasing proportion of hospital admissions.

Older people often lose some of their independence while in hospital for an acute illness.

This deterioration is a result of both hospitalisation for the acute illness and associated bed rest.

Older people often lose some of their independence while in hospital for an acute illness. Loss of function may be seen in a range of activities of daily living such as: mobility, transferring, toileting, feeding and grooming (Hirsch et al., 1990). This deterioration is a result of both hospitalisation for the acute illness and associated bed rest (Creditor, 1993).



# The Need for Transitional Aged Care

Older people, their carers and families are often required to make decisions about long-term care at a time when the older person is in hospital experiencing an acute illness. Many older people, their carers and families make a premature decision to enter residential aged care based on their functional status at this time.

Elderly patients recover medically before they recover functionally (Hirsch et al, 1990) and with adequate time, many people who decide to go to Residential Aged Care during an acute medical episode will regain their function and be able to return to their existing home environment. Providing an appropriate environment in which older people can regain their function is a challenge. Once medically stable, an acute hospital is not appropriate. These patients no longer need the hospitals' services for which there is significant demand. They require a home-like environment where their potential for independence can be optimised. An aged care facility is not always appropriate either as these patients require specialised Transitional Aged Care programs, developed by therapists, to help them regain their independence.

One program that offered rehabilitation and support services to older people either in a facility or community setting showed that after an average of 54 days of low level therapy and support services, over 60% of people went home (either with their previous level of community support or a higher level) and only 17% were discharged to Residential Aged Care. In addition, 82% of those approved for low level Residential Aged Care and 70% of those approved for high level Residential Aged Care showed functional improvement, measured by the modified Barthel Index (Kroemer et al., 2004).

Models of care that provide the opportunity for older people to optimise their function in an appropriate environment offer patients, their carers and families the chance to make a more informed choice about their long-term care needs (Kroemer et al., 2004).

Older patients recover medically before they recover functionally.

Providing an appropriate environment in which older people can regain their function is a challenge.

Hospitals and (sometimes) aged care facilities are not appropriate environments.

One program that offered rehabilitation and support services to older people either in a facility or community setting showed that after an average of 54 days of low level therapy and support services, over 60% of people went home (either with their previous level of community support or a higher level) and only 17% were discharged to Residential Aged Care.

(Kroemer et al., 2004).

# Transitional Aged Care

## Sita's story under Transitional Aged Care

Sita is 86 years old and lives at home with daily support from two of her children and assistance with a Community Aged Care Package. Sita has been quite unwell for a number of years and had 23 hospital admissions over five years. Sita frequently accesses respite care at the aged care hostel and often complains to her daughter that she is lonely at home.

Sita lives alone in her home with daily visits from her daughter and support from a community aged care package five days a week.

Sita has had poor health over the last five years with 23 hospital admissions.

She was not coping at home. Three days after leaving respite care and returning home Sita falls at home and breaks her leg. She is admitted to hospital once again.

This is her story under the Transitional Aged Care Model of Care.

*This is based on a true story, only names have been changed.*

Between the hospital admissions and respite care, Sita has only spent 12 days at her home in the last nine months. Sita's daughter and general practitioner are keen for Sita to move permanently into a hostel but Sita wants to stay at home because as she says 'your home is your home'.

Three months ago Sita had another fall and fractured her tibia. Sita was admitted to hospital and as she became medically stable she was referred to the transitional aged care unit. By this time Sita's functionality had reduced further and she needed assistance with many of her daily living activities. The NUM of the transitional aged care unit visited Sita in hospital, spoke to her family about the transitional aged care program and arranged for Sita's personal effects - outdoor clothing, glasses and hearing aids to be brought with her.

On admission to the transitional aged care unit a family conference was held with Sita and her children. It was agreed that the goals for Sita while in the transitional aged care program were to improve her mobility and functionality and establish the best discharge option. Sita's family who lived locally and supported her at home thought the best option was a hostel placement while the other family members supported Sita's wish for discharge home.

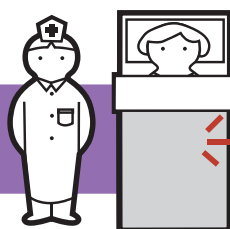
The day after her admission to the transitional aged care unit a multidisciplinary team assessment was carried out to identify what was needed to assist Sita to improve her mobility and to keep her safe at home. Sita's general practitioner, the transitional aged care nursing staff, physiotherapist, occupational therapist and the case manager developed an individual program for Sita.



Sita lives at home alone. She's 86.



Sita has a history of health issues including cancer, heart problems and hip replacements.



Sita has experienced a number of falls which result in frequent visits to hospital. In the most recent fall, Sita fractured her tibia.



Sita becomes medically stable but her functionality has reduced further.

### Transitional Aged Care Program



After assessment of Sita's functionality and consultation with the family Sita is admitted to the Transitional Care Program.

Over the next four weeks, Sita's mobility improved dramatically and she was encouraged to attempt normal activities that would help her to be at home with a community aged care package. Despite the intensive therapy Sita had difficulties with everyday activities, such as making tea or coffee and always requested that the staff attend to her needs. Sita didn't really seem to be interested in going home and never mentioned it unless home was being discussed in usual conversations.

The case manager also met with the community aged care package provider who had indicated they had concerns about Sita's safety at home and their ability to support her adequately if she returned home. In discussions with Sita's family and her general practitioner it was agreed that a neurological assessment be carried out.

After four weeks another family conference was arranged and the results of the neurological assessment were discussed. This assessment showed that Sita had impaired problem solving skills and reasoning ability and limited awareness of how to deal with minor or major household emergencies. Sita thought that 23 hospital admissions over five years could happen to anyone.

Sita reluctantly agreed to a hostel placement and all her family supported Sita in this decision. The Case Manager took Sita to view some hostels in the local area and eventually Sita agreed to the hostel where she had spent the most time over the last two years. Sita knew most of the people there and liked the staff.

Six months later Sita is living happily at the hostel. She can now walk unaided and is able to carry out her daily living tasks. Best of all Sita has not had a hospital admission since she moved to the hostel. Sita spends a lot of time performing in their concerts and playing the piano on special occasions for the other residents.

### What's good about this story

- Sita receives a therapy plan to support the achievement of her goals.
- Sita receives coordinated care that is responsive to her changing needs.
- Sita's neurological impairment is recognised and her family is able to support the discharge option to a hostel placement.
- Sita regains her mobility and has been able to avoid a hospital admission for over six months.
- Sita is happy at the hostel and enjoys the company of her peers at the hostel.



With therapy, Sita's functionality dramatically improves but has some impairment in the skills required to carry out everyday tasks.

Another consultation with Sita and her family results in the decision to move Sita to hostel accommodation.

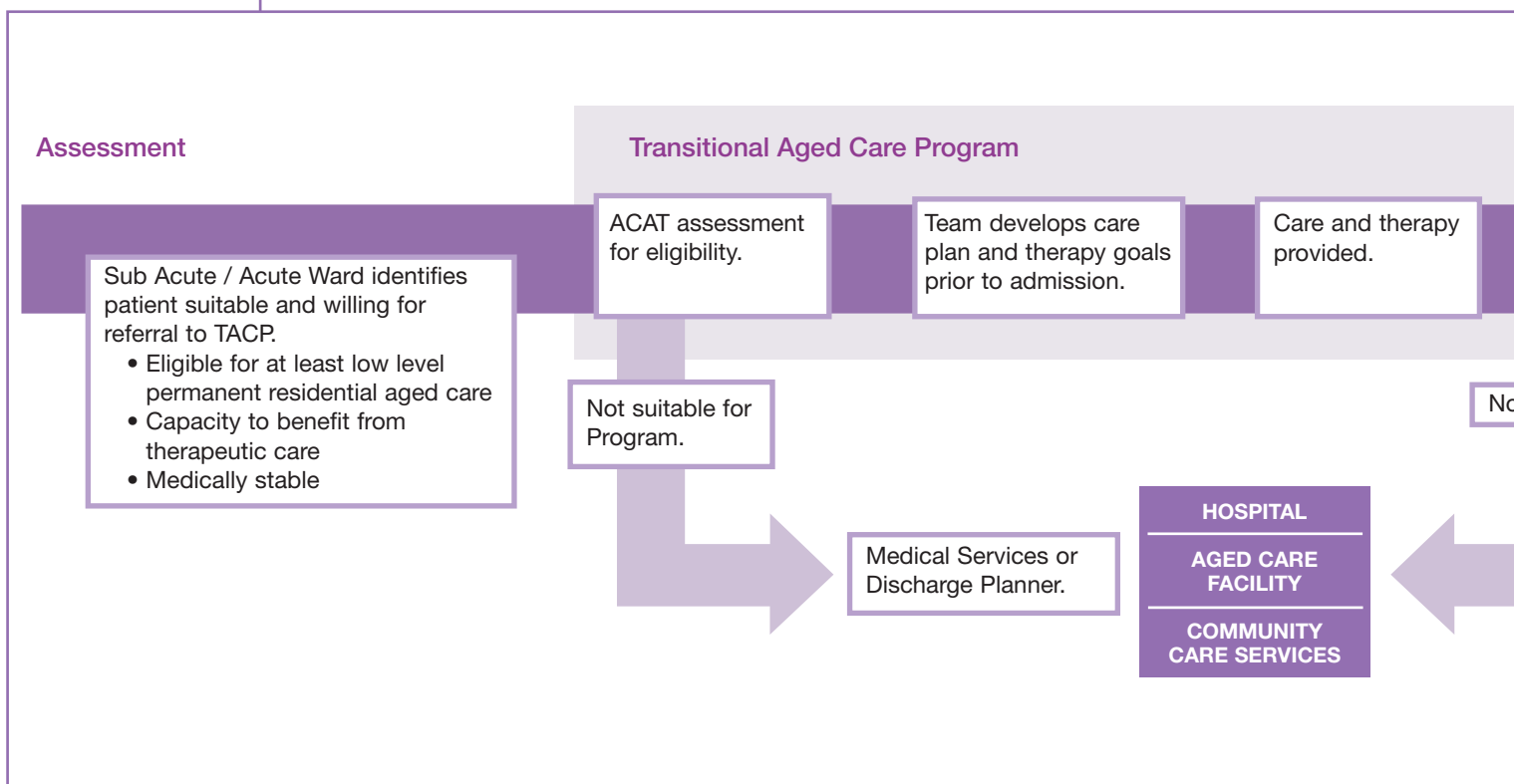
Six months later Sita is living happily at the hostel. She can now walk unaided and is able to carry out her daily living tasks. Sita has not had a hospital admission since she moved to the hostel.

# What is Transitional Aged Care?

*Transitional Aged Care is a program to address the needs of older people who, in the absence of this program, may require residential aged care. It is a time-limited period of support and low intensity period of therapy in a facility or community setting. It provides older people who have been assessed by an Aged Care Assessment Team (ACAT) as eligible for admission to residential aged care with an opportunity to optimise their functional capacity and determine their appropriate long-term care requirements*

## Aims

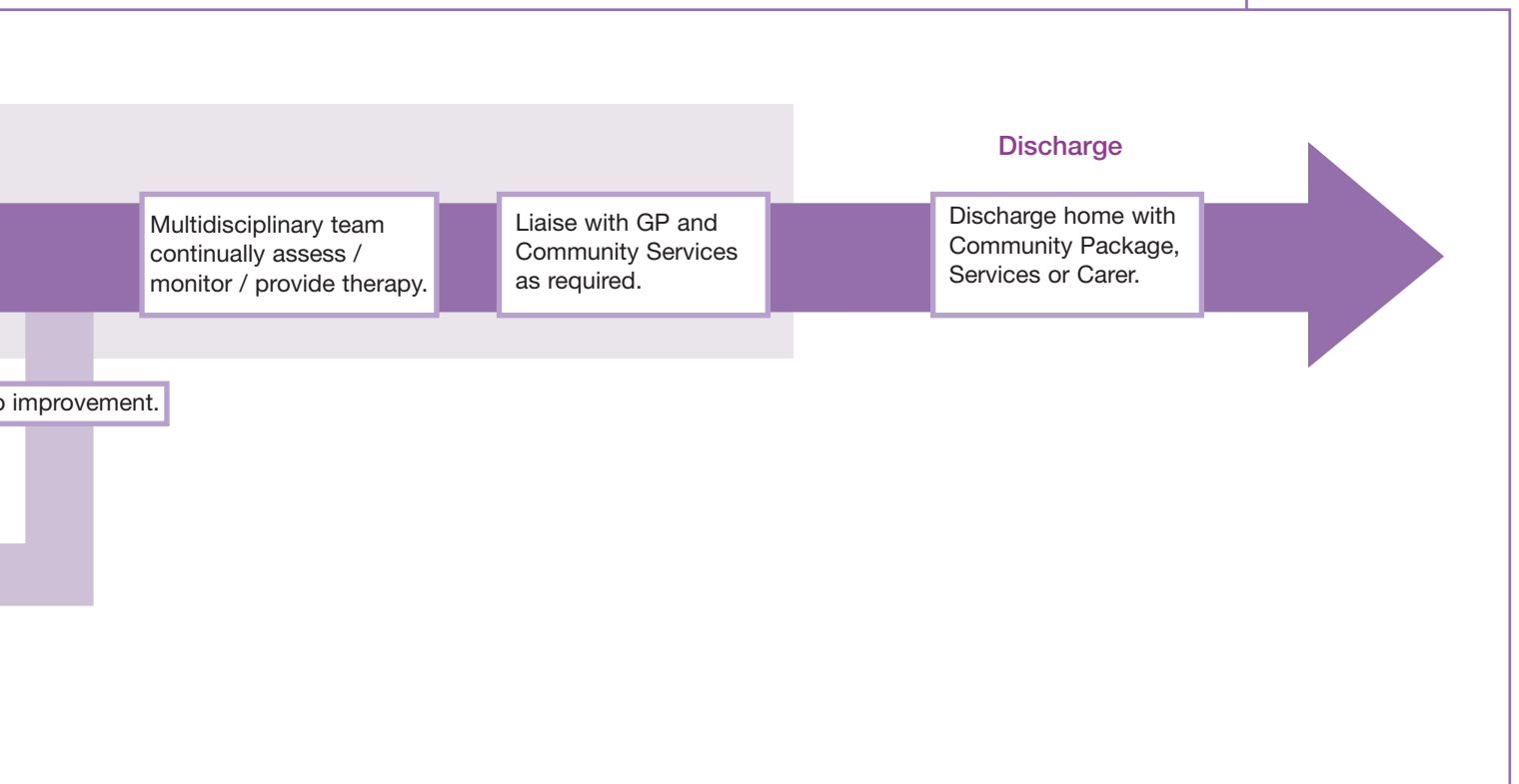
- To allow time for older people to complete their recovery and optimise their functional capacity in a non-hospital environment.
- To allow the older person, their carer(s) and families to make the most appropriate choice about their long-term care needs.
- To reduce inappropriate extended hospital lengths of stay and minimise premature admission to residential aged care.



## Entry criteria

Older people who:

- Are in the process of making a decision about their long-term care options after a stay in hospital (older people who have already decided to enter residential aged care are not eligible).
- At the completion of their acute/subacute hospital episode, have the capacity to benefit from a period of low-intensity therapy and who have been assessed by the ACAT team as eligible for at least low-level residential aged care.



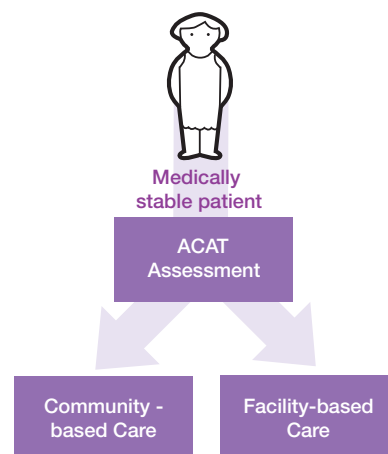
# How Does Transitional Aged Care Work?

## Key Elements of Transitional Aged Care

- ACAT assessment
- Goal-specific therapy plan
- Multidisciplinary team care

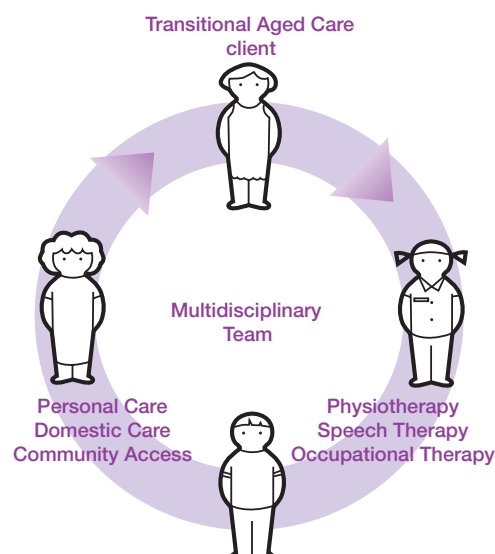
### ACAT assessment

Medically stable patients who are willing to participate in Transitional Aged Care and who have not regained previous functional status are assessed by the ACAT team to see if they are eligible for at least low level residential care. The appropriate site (community or facility-based) for this care is identified according to the needs of the patient and the types of care available.



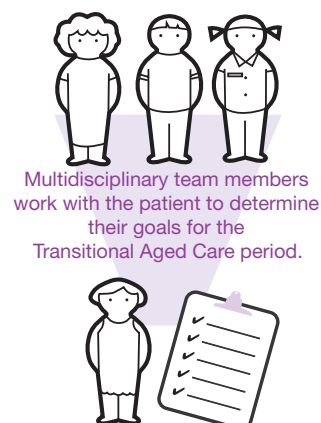
### Multidisciplinary team care

Transitional Aged Care clients receive assistance from a multidisciplinary team. This assistance may comprise low intensity therapy (e.g. physiotherapy, occupational therapy, speech therapy and social work) as well as assistance with activities of daily living (e.g. personal and domestic care, and community access).



### Goal-specific therapy plan

Multidisciplinary team members work with the patient to determine their goals for the Transitional Aged Care period. These goals relate directly to the functional outcomes that the older person desires. A therapy plan is then designed to assist in achieving the goals.



## Key Elements of Transitional Aged Care

- Case management.
- Care in a home-like environment.
- Time limited interventions.
- Therapy and assistance with daily living.

### Case management

Each client has a case manager who coordinates and monitors their care. The case manager is responsible for:

- ensuring there is a comprehensive care plan at the time of discharge from hospital
- ensuring that all aspects of the care plan are implemented
- identifying any changes to the patient's care needs
- liaising with and organising care requirements provided by external service providers
- arranging for appropriate care following Transitional Aged Care or managing the return of the recipient to the community or their normal care arrangements.

(Department of Health and Ageing, 2005)

### Care in a home-like environment

Care is provided either in the patient's own home or in a facility with a home-like environment. This allows context-specific rehabilitation to occur which is known to result in better functional outcomes (Carr and Shepherd, 1987).

A home-like environment for facilities providing Transitional Aged Care includes features such as: a communal living space, dining room, facilities to prepare snacks for self and visitors, and outdoor areas in which to move around.

### Time limited interventions

Transitional Aged Care is only provided for a limited period. Care is usually provided for a period of 8 weeks, with a maximum of 12 weeks. If a patient has further Transitional Aged Care needs care may be extended for a maximum of 6 weeks. At the end of this time patients are discharged to the most appropriate long-term environment, either home or to an aged care facility.

### Therapy and assistance with daily living

Patients are provided with low-intensity therapy as well as assistance with activities of daily living. All therapy provided is based on a comprehensive multidisciplinary initial assessment and a set of goals developed by the patient and the therapists. The aim of therapy is to regain the patient's pre-hospital level of independence and where this is not possible, to maximise their independence.

# Various Models Of Transitional Aged Care

## Key Elements of Transitional Aged Care

The exact Transitional Aged Care model will depend upon the needs of the community and the existing resources and infrastructure available. Consider:

- the capacity of the area health service and other non government organisations - are there other already established organisations able to provide such services?
- staffing levels and the ability to recruit.

Below are some examples of the different ways in which Transitional Aged Care can be delivered.

### PARTNERSHIP MODEL

#### Where?

Northern Sydney Transitional Aged Care Program (Northern Sydney Central Coast Area Health Service)

#### Environment:

Strong existing infrastructure for both domiciliary and therapy services. The Area Health Service did not have the infrastructure to ensure consistent delivery of a therapy service and lacked expertise and experience in providing community care services.

#### How it works:

Non-government organisations (NGOs) provide the community care component, and affiliated organisations provide the multidisciplinary therapy services. NGOs are paid a per diem rate per client per episode and therapy providers are paid on a fee for service basis.

### HYBRID MODEL

#### Where?

Central Coast Community and Residential Transitional Aged Care Program (Northern Sydney Central Coast Area Health Service)

#### Environment:

No established infrastructure for therapy services outside the Area Health Service. The Area does have strong partnerships with community care providers.

#### How it works:

The area health service provides both the therapy services and community care. This works well because the transitional aged care residential facility is located within a subacute hospital setting. When the care is delivered in the community setting rather than the residential setting of the sub acute hospital the area health service staff continue to provide the therapy services with the community care component brokered to a NGO.

### 'IN-HOUSE' MODEL

#### Where?

Westmead Community Transitional Aged Care (Sydney West Area Health Service)

#### Environment:

The existing staff base complements the area health service's aged care service.

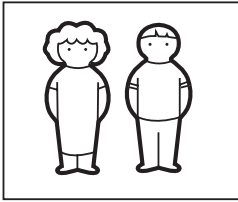
#### How it works:

All services, including both the community care and therapy components, are provided by Area Health Service staff.

Where current staffing levels do not allow for the use of Area Health Service staff and where recruitment to positions is likely to be difficult, the brokerage model works well. In addition, many community organisations have an established track record in the provision of support services and as such, are better placed than the Area Health Service to provide these

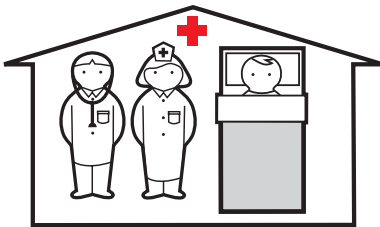
# Benefits of Transitional Aged Care

## Patients and their Carers



- Increases functioning for de-conditioned older people.
- Assists people who wish to remain at home, rather than going into residential aged care. This is very beneficial for couples who wish to stay together.
- Patients receive context specific therapy in their own home environment. (Therapy in a ward environment does not always translate easily to the home environment.)

## Hospital/Area Health Service



- More appropriate use of acute hospital beds.
- Reduction in readmissions because of adverse events due to a decline in functioning/inability to live independently at home.
- Potential reduction in length of stay.
- Stronger partnerships with other health service providers.

## Residential Aged Care Facilities



- Allows those people who really do require aged care beds to access them in a timely manner.
- Reduces the number of residents who do not wish to be in an aged care facility but are there as a risk management strategy.

## Other Service Providers



- Allows community service providers to grow their base and consolidate their expertise as responsive, expert providers of community services.
- Allows community service providers to increase the quantity and quality of their staff.
- Gives the service the capacity to provide improved continuity of care (especially if patients receive services from the organisation post-discharge from Transitional Aged Care).
- Stronger partnerships with hospitals/area health services.

# Ideal patient journeys

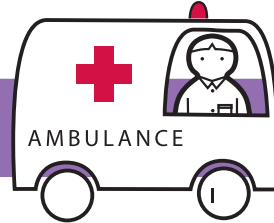
## Transitional Aged Care to Hostel: John's story



John is 95 years old and lives in a hostel. He is very active and is able to carry out daily living tasks.

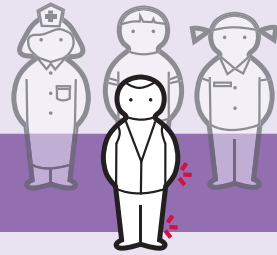


John is admitted to hospital after a fall, fracturing his wrist and femur. John's function deteriorates and his longer term requirements are likely to be high level. Hospital assessment indicated that John should now be admitted to a high care nursing home as he could not roll in bed, and had difficulty communicating and eating.



As John was previously active and motivated, he was transported by ambulance to the transitional aged care unit. Family conference held. John's goal is to return to the hostel. John's family replaced his old hearing aids with new ones, and found another set of glasses as he had lost his in all the confusion at the hospital.

## Transitional Aged Care Program



Assessed by a multidisciplinary team. Individualised program of active daily living improvement and mobility. Encouraged to attempt the activities he would need to perform at the hostel. John is very motivated despite his incapacity arising from his fall and fractures.

## Transitional Aged Care allows patient to live at home: Mimi's story



Mimi is an 80 year old woman who is independent at home and still drives her own car. Her daughter lives with her but is rarely at home.



Mimi falls at home and fractures elbow and pubic rami. Medically ready for discharge after four weeks in hospital. Mimi received physiotherapy and occupational therapy in hospital but hasn't regained her pre-admission function. Mimi has to keep her arm in a sling.



Mimi is medically stable but is not ready to look after herself at home.

## Transitional Aged Care allows couple to stay together: Betty's story



Betty is a 79 year old lady who has suffered a sub-dural haemorrhage. Betty was living at home and was independent in all ADL. Betty is the main carer for her husband who has a mild cognitive impairment.



Betty shows little improvement on the ward. Inpatient rehabilitation is ruled out - nature and extent of her injury. Both Betty and her husband want her to return home. If Betty does not return home, her husband will most likely require Residential Aged Care too and they could be separated.



Multidisciplinary team agrees Betty is motivated and will probably continue to improve if given time. Betty and the team decide a Transitional Aged Care package is the best option for her future care. Betty is assessed by ACAT as eligible.

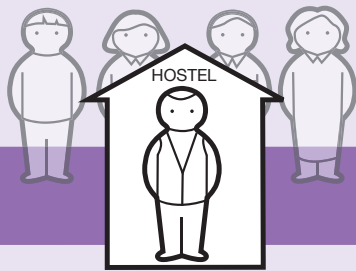
## Transitional Aged Care Program



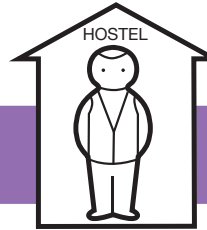
Betty is visited by a Transitional Aged Care case manager and is discharged home the following day.



John progresses well and can soon get out of bed unaided and dress himself each day. During his stay, John has a cardiac episode that was managed within the transitional aged care program. His family are very concerned about his ability to return to the hostel. The family want John to move into the high care nursing home.



In consultation with the family the case manager visits John's hostel where she discovers that his room is a long walk away from any assistance and the facilities. After discussion with John, his family and the hostel staff it is agreed that John can change rooms at the hostel when he returns so he is close to the facilities and the staff.



John returns to his new room at the hostel and once again is able to walk to the dining room, visit his friends and carry out his daily living tasks again with the hostel staff close by.

### Transitional Aged Care Program



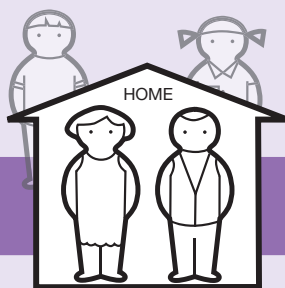
Mimi is assessed by ACAT and approved for low level Residential Aged Care and Transitional Aged Care. She is referred to the Transitional Aged Care program to reduce the need for residential care.



Mimi's case manager organises personal care services and home based therapy. Her level of support decreases as she becomes more independent. Care workers help Mimi perform tasks to live independently.



After nine weeks of transitional aged care, HACC services start to provide domestic assistance. There is no break in service. Mimi is independent in most activities and can manage comfortably at home with a small amount of assistance.



Case manager arranges daily personal care, domestic assistance and a therapy program. Betty's husband and personal carers help her to perform her exercises. Occupational therapist arranges home modifications.



After two weeks, Betty no longer requires personal care and assistance. She catches a taxi to see her GP.



After twelve weeks, Betty is independent in all ADLs and is discharged from the program. Case manager arranges local day centre for social activities and local HACC program for ongoing domestic assistance.



Betty and her husband remain living together at home.

# Implementing Transitional Aged Care

## Process Map

Visit the online version of this process map on the ARCHI website at [www.archi.net.au/elibrary/build/moc](http://www.archi.net.au/elibrary/build/moc)

Here you will be able to access more information on each of the steps in implementing the model. You will have access to tools and templates as well as hints and lessons learned by others who have implemented the model.

	<b>Planning</b> <b>Where are you now?</b>
<b>Governance</b>	Identify leaders. Develop a Process Map. Establish a Steering Committee.
<b>Patient Journey</b> How do patients flow through the model	Map Patient Journey
<b>Policies and Protocols</b>	Identify and review current policies and protocols affecting care of the elderly.
<b>People</b> Understand who the staff are, how they function and what role they play in the patient journey	Engage Geriatricians, GPs, ACAT and key allied health personnel Stakeholder Analysis Develop staff profile
<b>Resources</b>	Survey current resources Identify resources needed to establish and maintain Transitional Aged Care
<b>Communication</b>	Develop communication plan

	<b>Preparing Make it happen</b>	<b>Operationalise Make it stick</b>
	<p>Develop a Governance Plan.</p> <p>Develop service agreements with partners (if appropriate)</p> <p>Establish and Mobilise Team</p> <p>Develop Key Performance Indicators (KPIs)</p>	<p>Monitoring, Evaluation and KPIs</p> <p>Provide regular project reports and updates for senior management</p>
	<p>Identify changes that need to happen to improve the patient journey</p> <p>Document 'new' patient journeys that the Transitional Aged Care Model of Care can enhance</p> <p>Include the perspective of carers and/or family members</p>	<p>Regular monitoring of patient experiences via regular patient journey mapping.</p>
	<p>Develop patient selection criteria</p> <p>Develop policies and protocols</p>	<p>Implement and monitor compliance with new protocols.</p>
	<p>Develop position descriptions for staff allocated to Transitional Aged Care.</p> <p>Develop competencies and an educational program for staff</p>	<p>Develop a review process.</p>
	<p>Deliver required resources</p>	<p>Monitor resource use</p>
	<p>Execute communication plan</p> <p>Identify how results will flow back to Transitional Aged Care</p>	<p>Feedback and review process</p>

# Staffing

When determining staffing of a Transitional Aged Care Program consider whether:

1. the program offers community or facility-based treatment, or both
2. services are brokered through other agencies - brokerage makes it difficult to determine staffing as they are not always exclusively designated to the Transitional Aged Care Program.

Delivery of transitional aged care packages requires a multidisciplinary approach. Clients receiving a transitional aged care package may need care and services from community care workers, general practitioners, social workers, physiotherapists, occupational therapists, domestic care staff, speech pathologists, dieticians, nursing staff and other specialist staff. Clerical support and data management will also be needed to help track the program and manage the delivery of the services.



# Resources

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