



Department of Health
Government of Western Australia

Transitions Action Plan

for Western Australia 2004-2007

WA AGED CARE ADVISORY COUNCIL

2004-2007

Message from the Chairperson

On behalf of the WA Aged Care Advisory Council, I am delighted to present the *Transitions Action Plan for Western Australia 2004-2007*. This action plan relates directly to the second goal in the *State Aged Care Plan for Western Australia 2003-2008* which centres on providing services in ways that support the older person as their health and aged care needs change.

The State Aged Care Plan provides high-level, strategic direction. The ongoing task of the Council is to translate these aspirations into actions plans which are practical and will make a real difference in the journey towards 'getting it right' for older Western Australians.

Empowering individuals and their carers and considering their diverse individual needs is at the heart of the Transitions Action Plan. The plan focuses on the development and provision of information and services for older people at the transition points across their journey of care. To simplify the journey and support and enhance independence and quality of life for the older person, the plan looks at ways to better integrate and share information to meet individual needs through a coordinated service approach. The plan acknowledges and builds upon the many services currently in operation which provide valuable information and assistance to older people and their carers.

The Transitions Action Plan reflects work currently underway at a national level to develop a framework for the care of older Australians especially as they move from hospital to home, across the acute and aged care continuum. The framework strongly proposes providing services and treatment in a positive, inclusive and respectful way. Cooperative effort by many people is the key to ensuring a smooth response of services to a person's needs.

My thanks go to the WA Aged Care Advisory Council and to the Transitions Working Party. I commend the Transitions Action Plan to you, and look forward to welcoming achievements of great benefit.

Dr Penny Flett
Chairperson, WA Aged Care Advisory Council

About Transitions

Transitions for older people can be defined as the journey they experience when, as a result of changes in their health or care needs, the older person needs a different level of help and support to age in the place they choose. A person may be involved in more than one transition at one time depending on their care needs. The more complex the older person's care needs are the more complex the transition is likely to be.

Transitions can occur between different care locations or between different levels of care within the same location. Being admitted to a hospital or a health service for care and treatment is a significant transition for many older people. Being discharged home from hospital or moving to a residential aged care facility is a further transition. These are transitions across different care locations. As well as experiencing transition across care locations, an older person can experience transition within a care location, for example moving into different hospital specialty wards, as their complex care needs are met. These moves are all transition points in the care continuum.

The core of all transitions is the older person. As older people vary in their needs, transition care should be provided in a flexible way and be shaped around the diverse needs of the individual.

Transition care is often short-term and therapeutic in nature and aims to improve or maintain the older person's level of independence, whilst assisting them and their carer and family to make longer-term care arrangements. Transition care can help to prevent older people from unnecessary admission to or extended stays in hospital or premature admission to residential aged care.

The need for a Transitions Action Plan

Extensive consultation with health professionals and consumers undertaken as part of the development of the State Aged Care Plan highlighted transition care as a key area of concern for Western Australians.

Research into unnecessary and avoidable hospital admissions for older people highlights gains in delivering interface services which focus on primary intervention, reduce the need to extend long hospital stays, and provide extended rehabilitation-focused services in facilities other than in a hospital environment and also within the person's own home.

The Transitions Action Plan fits within the strategic framework of the *State Aged Care Plan for Western Australia 2003-2008* and aligns with its Vision, Values and Goals:

Vision



Values

- Aged care is about the person, both the individual and their family (of origin, or choice) and carers and is built on participation and respect
- Aged care is positive and enabling with service delivery based on flexibility and choice
- Equity and inclusion are fundamental
- Quality systems are fundamental

Developing the Transitions Action Plan

In December 2003, a Transitions Working Party was set up under the auspices of the WA Aged Care Advisory Council to develop a Transitions Action Plan for Western Australia. Gail Milner, A/Director of the Clinical and Aged Care Directorate in the Department of Health was appointed Convenor of the Working Party and Kathy Stack, Senior Portfolio Manager in the Clinical and Aged Care Directorate, was appointed to provide executive and project support.

The members of the Transition Working Party included: Professor Leon Flicker, Chair of Geriatric Medicine, University of Western Australia; Helen Attrill, Executive Director, Aged and Community Services, Western Australia; Stephen French, Manager Aged and Community Care, Commonwealth Department of Health and Ageing; Michele Kosky, Executive Director, Health Consumers' Council; Susan Abbotts, Nursing Director, Division of Cancer and Neurosciences, Royal Perth Hospital; Dr David Oldham, General Practitioner; and Dr Shiong Tan, Clinical Advisor Health Care, Department of Health.

The Transitions Working Party met regularly during the first six months of 2004. The Working Party undertook a statewide environmental scan of all services that could be considered 'transitional care services' to determine the current profile of transitional care in Western Australia. They also reviewed and discussed relevant literature and examined examples of recent research into and evaluation of transition models of care. The Working Party gave close attention to convergence with current national initiatives that recognise the unique needs of older people as a primary focus for health services, particularly the *National Framework for the Care of Older Australians* developed by the Australian Health Ministers' Advisory Council's Care of Older Australians Working Group.

The final draft Transitions Action Plan was presented to the WA Aged Care Advisory Council in August 2004 for endorsement.

Principle discussion documents

- Australian Government 2004, *Divisions of General Practice: Future Directions: Government Response to the Report of the review of the role of Divisions of General Practice*.
- Australian Health Ministers Conference, *Conference Papers April 2004*.
- Care of Older Australians Working Group, (unpublished papers).
- Department of Health WA 2003, *WA Assessment Strategy* (unpublished).
- Haggerty JL Reid J Freeman GK et al. *Continuity of care: a multidisciplinary review*, BMJ 2003;327:1219-1221.
- Institute for Healthcare Improvement 2004, *The courage to act on what if...2004 progress report*.
- NSW Health Department 2002, *My Health Record*.
- NSW Health Department 2002, *Partners in Health: Sharing information and making decisions together*.
- Reid, M. 2004, *A Healthy Future for Western Australians: Report of the Health Reform Committee*, Department of Health, Perth.
- Siggins Miller 2003, *Unnecessary and avoidable hospital admission for older people: A report to the Department of Health and Ageing*.
- Victorian Government Department of Human Services 2003, *Improving patient transition from hospital to the community: a good practice guide for hospitals*.
- Victorian Government Department of Human Services 2003, *Transitioning care: a review of the Effective Discharge Strategy*.

Consumer information

Aim To provide consumers with consistent and easily understood information

Actions

- Promote and further develop existing information access points where information resources are provided to help people understand transitions and the services available
- Provide relevant, accurate and up-to-date information about transition services for distribution at identified information access points
- Provide timely information in a simple format (preferably written) in an environment that fosters a positive and supportive approach to older people
- Involve older people, including people from diverse backgrounds and people with disabilities, in designing, developing and evaluating information resources

Outcomes

- The community and individuals are better informed about where and how to obtain information about transition services
- The information available to older people, their families and carers is the most suitable for their current and future needs
- Timely and easily understood information is provided in a way that is respectful of older people, their families and carers
- Older people benefit from suitable and easily accessible information resources and are well-informed about transition services available in their local area and know how to access the services

Streamlining assessments

Aim To implement streamlined assessment processes

Actions

- Promote and further develop existing assessment access points
- Identify common assessment processes especially those that address the needs of older people from diverse backgrounds, people with disabilities, and people from rural and remote areas
- Implement common assessment processes at transition points between the community and health sectors
- Provide older people, their families and carers with information about the purpose and outcome of assessments

Outcomes

- The community and individuals are better informed about where and how to access assessment services
- Assessment processes are responsive to the specific and individual needs of older people
- Processes to gather information about a person's changing care needs minimise repetition of personal health information
- Individuals are informed of the outcome of their assessments and are aware of the most suitable care options to meet their needs

Sharing information

Aim To improve the sharing of health information within and across care services to support transition

Actions

- Develop protocols and policies that guide and support the sharing of information between community and hospital-based settings, and the primary care and aged care sectors, while protecting the older person's right to privacy and confidentiality
- Facilitate the sharing of relevant health information by using information technology
- Provide opportunities for community members and health professionals to build working relationships
- Achieve continuity of care for older people across the range of care settings through promoting cooperation among care workers
- Develop a health record that is kept by the older person and can be presented whenever the older person accesses services
- Collect regular feedback from older people, their families and carers to improve planning and service delivery

Outcomes

- The individual's right to privacy and confidentiality is respected across the range of care settings
- Individuals are informed about and understand what information is being shared about them and with whom
- Linkages between health and community care providers are strengthened
- Health care staff are able to access the most current information about an individual's complex health care needs
- Individuals have their own hand-held medical record which reduces the need to repeat the same information to each new health professional or provider of services
- Individuals have the opportunity to help shape the types of services provided and how they are delivered

Effective coordination

Aim To improve the coordination of services within and across care settings

Actions

- Strengthen the commitment and involvement of community and health care services to provide services in a way that supports older people across the continuum of care
- Encourage the involvement and commitment of general practitioners in supporting transitions
- Identify and promote tools and processes that can be used to facilitate care coordination
- Develop protocols and policies that support transition between levels of care and across levels of care and are reflective of the needs of older people and care providers
- Develop and promote a range of care options that can be provided wherever an older person lives

Outcomes

- Services are provided in a way that respects older people, their families and carers and helps them to improve their health and independence
- There are stronger links between general practice, community services and health services
- Individuals are aware of who is responsible for coordinating care services in their local area
- Service providers promote cooperation and continuity of care within and across services and regions
- Individuals receive a range of transition care services which can be provided within their own homes and are planned and tailored to best meet their individual needs

Actions for Implementation

Actions		Opportunities	Phased Implementation		
			2004/05	2005/06	2006/07
Consumer Information	Promote and further develop existing information resource access points to help people understand transitions and the services available	Department of Health to work with government, non-government and consumer organisations to identify key access points for the distribution of transition information and how best to promote them			
	Provide relevant, accurate and up-to-date information about transition services to information access points	Department of Health to facilitate regular updated transition information within the public sector to assigned information access points			
	Provide timely information in a simple format (preferably written) in an environment that fosters a positive and supportive approach to older people	1. Target training opportunities for health providers through health services, HACC, aged care providers and community groups to raise awareness of the needs of older people at transition points 2. Department of Health to support the implementation of the <i>National Framework for the Care of Older Australians</i>			
	Involve older people, including people from diverse backgrounds and people with disabilities, in designing, developing and evaluating information resources	Commission appropriate consumer organisations to work with the Department of Health to produce a range of transition information resources			
Sharing Information	Develop protocols and policies for sharing of information between community, hospital, primary and aged care, while protecting the older person's right to privacy and confidentiality	1. The Department of Health jointly with sector representatives to develop a framework for robust protocols and agreements to support sharing of information between the sectors.			
		2. Work with Department of Health Information Policy branch to make available protocols and policies via the website, and promote the "Sharing of Health Information for the Continuity of Care" policy to all health professionals.			
		3. Electronically generated hospital patient discharge summaries to be routinely provided to GPs			
		4. Trial secure electronic transmission of health information between health services providers			
	Facilitate the sharing of relevant health information by using information technology	1. The Department of Health to work with the Australian government and Health Information Council in reforming health information and technology			
		2. HACC to develop software that links across community-based providers and with ACATs			
		3. Utilise Health Call Centre technology and infrastructure to support interface between GPs, community and hospital based services			
		Target joint learning opportunities made available through health services, HACC, aged care providers and community groups			
Provide opportunities for community members and health professionals to build working relationships	Department of Health to initiate a working party to develop clinical pathways which highlight strategic partnerships between general practice, community services, acute care and aged care and enable cooperation to support transition				
Achieve continuity of care for older people across care settings through promoting cooperation among care workers	Work with Department of Health Information Policy branch to pilot a Personal Health record towards the implementation of a system-wide clinical information system				
Develop a health record to be kept by the older person and presented whenever services are accessed	Involve consumer organisations in obtaining regular feedback from consumers				
Collect regular feedback from older people, their families, carers and staff to improve planning and service delivery					
Streamlining Assessment	Promote and further develop existing assessment access points	Department of Health to work with Australian government and Divisions of General Practice to identify key transition assessment access points and how best to promote them.			
	Identify common assessment processes especially those that consider the needs of older people from diverse backgrounds, people with disabilities, and people from rural and remote areas	Participate in COAWG's commissioned development of "Best Practice Assessment Guide for the Care of Older People in Health Service Settings"			
	Implement common assessment processes at transition points between community and health care sectors	Implementation of WA HACC Assessment Strategy; standardised HACC Needs Identification and links with ACATs.			
	Provide older people, their families and carers with information about the purpose and outcome of assessments	Promote evidence-based initiatives and quality improvement standards in this area			
Effective Coordination	Strengthen the commitment and involvement of all community and health care services to provide services in a way which supports older people across the continuum of care	Department of Health to work collaboratively with the Australian government and all service and care providers.			
	Encourage the involvement and commitment of general practitioners in supporting transitions	1. Involve GPs in transition care planning 2. Work with Division of General Practice and Australian government to promote the use of Medicare Plus items			
	Identify and promote tools and processes that can be used to facilitate care coordination	1. Explore options with the Health Call Centre 2. Metropolitan implementation of the Residential Call Line			
	Develop protocols and policies that support transition between and across levels of care that reflect the needs of older people and care providers	Jointly with sector representatives, the Department of Health is to utilise COAWG framework for the development of robust protocols and agreements to support transfers between the sectors			
	Develop and promote a range of care options that can be provided wherever an older person lives	1. Work with the Australian government to further develop and implement Innovative Pool initiatives including intermittent and transitional care services 2. Progress Care Awaiting Placement as a transitional care option			

WA Aged Care Advisory Council

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