PAP Program Evaluation

HACC Post Acute Packages (PAP) Program - Quantitative and Qualitative Evaluation

Final Report – 20 February 2015

Acknowledgements

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Disclaimer

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With you, for you: Care Assess - *PAP Program Evaluation, Final Report - 20 February 2015*

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Care Assess specialises in coordination of services that enable more people to live well at home across Tasmania.

Care Assess welcomes your feedback on this report. To provide comment please email Care Assess at feedback@careassess.com.au.

Joe Towns | Managing Director

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1. Executive Summary

Care Assess' HACC Post Acute Packages (PAP) program aims to provide short term packages of support and care in the home for clients who have suffered an acute episode. These packages are time limited and more intensive than basic home support provided by mainstream HACC services. They help support elderly clients transition from a period of hospitalisation to living back in the community, enabling them to recover to their pre-acute level of independent functioning. This is achieved through the coordination of additional home support services such as personal care and domestic assistance, and through monitoring and review of client progress and service delivery. This enablement program is designed to:

- **Objective 1:** Support achievement of pre-hospital admission independence,
- **Objective 2:** Reduce unnecessary time in hospital,
- **Objective 3:** Reduce readmissions to hospital,
- **Objective 4:** Reduce longer term dependency on increased levels of home support, and
- **Objective 5:** Delay admissions to residential care.

This report assessed the PAP program's effectiveness at achieving its stated objectives through an analysis of program activity data throughout 2013-14 as well as stakeholder feedback provided by clients and hospital discharge planners during May and June 2014.

The summary findings of this evaluation are as follows:

- **Objective 1:** Support achievement of pre-hospital admission independence

  Client satisfaction was extremely high with 98% of clients being satisfied with the support they received and 64% achieving their program goals; i.e. achieving the same level of independence they had prior to hospitalisation as assessed by Care Assess Service Coordinators.

- **Objective 2:** Reduce unnecessary time in hospital

  The majority of Discharge Planners (77%), 'Agreed' or 'Strongly Agreed' that the PAP program successfully reduced unnecessary patient time in hospital.

- **Objective 3:** Reduce readmissions to hospital

  Additional analysis is required to determine the effectiveness of the PAP program at reducing unnecessary readmissions to hospital. Linkage with hospital separation data is required to establish an appropriate control group to enable measurement of program effectiveness.

- **Objective 4:** Reduce longer term dependency on increased levels of home support

  Only 5% of clients were referred for ongoing services at the completion of the program due to client goals not being attained, demonstrating the effectiveness of Service Coordinator's care management in adjusting support throughout the intervention period in line with the client's improved function.

  - The majority of clients (68%) completed the program within 6 weeks and 97% of clients completed the program within 10 weeks.

- Average support hours per week declined from 2.7 hours in Week 1 to 2.0 hours by week 6 and only 0.9 hours by week 10.

- **Objective 5:** Delay admissions to residential care

  Evaluation of the PAP program's effectiveness at delaying admissions to residential care was outside the scope of this evaluation.

Overall, hospital discharge planners were complimentary of the program with 95% of respondents rating the program as 'Good' or 'Excellent' and indicating they 'Agreed' or 'Strongly Agreed' with the following statements:

- "PAP increases patient safety when transferring clients home from hospital"; and,
- "Care Assess responds to PAP referrals in a timely manner."

The evaluation also identified areas for future improvement including:

- Broadening the eligibility criteria to meet the needs of clients that would benefit from this service but who do not meet the HACC eligibility requirements;
- Consideration of weekend admissions to reduce hospital length of stay;
- Increasing the availability of this service in the South; and,
- Increased use of electronic recording (including initial and final functional assessments) to support further evaluation activities.

2. Program Objectives and Description

2.1 Program Background

Care Assess' HACC Post Acute Packages[1] (PAP) program is a state-wide HACC service in Tasmania providing support with activities of daily living for a period of approximately six weeks[2] for hospital patients who are clinically safe to be discharged but are expected to experience difficulty in regaining independence if and when they return home.

The PAP program has operated since 2004, delivering a range of integrated services that:

- Support timely discharge from hospital,
- Promote faster recovery from acute illness, and
- Reduce the chance of:
  - Unnecessary acute hospital re-admission,
  - Referral for increased levels of ongoing / longer-term mainstream HACC service usage, or
  - Premature admission to long-term residential care.

Since the separation of the Commonwealth HACC Program from the Tasmanian HACC Program on 1 July 2012, the PAP program has continued to operate and be available to both younger people in the Tasmanian HACC Program target population and to older people in the Commonwealth HACC Program target population.

The PAP program is designed to support HACC clients in the vulnerable post-acute phase by providing suitably qualified oversight from clinical health professionals (Senior Registered Nurses or equivalent), who work as Service Coordinators and provide independent assessment and client care coordination of brokered services.[3]

The PAP program is an *enablement* service focused on avoiding unnecessary time in hospital through the provision of basic services; enablement services are one type of service on a continuum of intermediate care program types (See Table 1). It is important to note that Care Assess' PAP program is a non-clinical program of home support – it does *not* provide clinical care such as specialist post-acute care or rehabilitation services focused on direct treatment of acute illness to resolve health issues.

Table 1: Comparison of Intermediate Care Program Types

	Enablement	*Rehabilitation*	*Reablement*
Aim	Recovery of independent functioning; minimise or reduce functional decline	Resolving health care issues or acute illness; increasing independent functioning	Restoring independent functioning; increase independent functioning

[1] "Package" in this context means a short term plan of HACC support and care, limited by a Support Plan End Date, that integrates a range of service types that are tailored to an individual client's needs; does not refer to the Home Care Packages Program under the *Aged Care Act 1997.*

[2] The program provides services to support clients in the 6-week post-acute phase, but program length may be more or less than 6 weeks as necessary, commensurate with the client's assessed needs.

[3] Other than providing service specific assessment and client care coordination (including care planning, monitoring and review), Service Coordinators within the PAP program resource the Support Plans by brokering care from organisations subcontracted to Care Assess across Tasmania, and by referring clients to other available services.

	Enablement	*Rehabilitation*	*Reablement*
Purpose	Services to help *avoid* unnecessary length of hospital stay, unplanned admissions to hospital, referral for increased levels of longer term home support, or premature admission to residential care.	Services to *directly treat* client conditions, to help them to *get better.*	Services to help clients *accommodate their illness or condition by learning or re-learning the skills necessary for daily living*
Can Include	Short-term supported discharge programs, rapid response hospital avoidance services	Specialist post-acute care, clinical treatment.	Short-term restorative care service interventions
Examples	**Care Assess PAP program**	Clinical services such as physiotherapy	Care Assess HACC Home Independence Packages (HHIP) program

2.2 Program Objectives

The objectives of the PAP program are to:

- **Objective 1:** Support achievement of pre-hospital admission independence;
- **Objective 2:** Reduce unnecessary time in hospital;
- **Objective 3:** Reduce readmissions to hospital;
- **Objective 4:** Reduce longer term dependency on increased levels of home support; and
- **Objective 5:** Delay admissions to residential care.

2.3 Program Eligibility and Suitability

The PAP program targets HACC clients who, prior to discharge from hospital, are with assistance able to recover to a level where they can live independently in the community and their needs can be met by mainstream services provided prior to their hospitalisation.

Clients are *eligible* to be assessed and prioritised for this service if they:

- Are eligible for services under the Commonwealth HACC Program or the Tasmanian HACC Program;

Clients are *suitable* for referral if they:

- are likely to experience difficulty in regaining their independence in the community following an acute episode in hospital; or
- are the unpaid carer of an eligible HACC client who requires support following an acute episode to continue in their role of caring.

2.4 Program Detailed Description

The PAP program is available to clients following an acute admission to hospital, to enable safe and/or earlier discharge by ensuring coordinated services are arranged before clients return home. Referrals to the PAP program most often come from hospital staff and health

professionals across Tasmania whose patients require short term assistance at home following hospitalisation.

The PAP program is a basic package of short term care for approximately 6 weeks, which can include:

- Service specific assessment and client care coordination (including care planning, monitoring and review);
- Domestic help and assistance (for example, vacuuming, cleaning bathrooms, hanging out washing);
- Personal care assistance (for example, showering and assistance getting dressed);
- Safety-related home and garden maintenance assistance (for example, trimming bushes, cleaning out gutters, changing tap washers);
- Shopping assistance (unaccompanied);
- Social support (for example, accompanied shopping assistance);
- Respite care (to assist the role of the carer; coordinated but not paid for by HACC);
- Limited nursing visits to review aspects of client's care to maximise quality of client care (if required) (Not clinical treatments or high intensity requirements);
- Limited allied health assessment (for example, an Occupational Therapist or accredited Exercise Physiologist assessment) to ensure safe completion of the program (if required).

Each PAP program is managed by a senior clinician (a health professional, usually a Registered Nurse) from Care Assess in the role of Service Coordinator.

On receipt of a referral, the Service Coordinator firstly conducts a service specific assessment by arranging a visit during the patient's stay in hospital in order to:

- Assess the clients' health status and home support needs, including discussions with multi-disciplinary hospital staff and examination of client files to ensure appropriate level of knowledge of clients' health status is obtained on discharge;
- Discuss the program in-person with clients, family and carers prior to discharge, including any special needs, and obtain written agreement/consent prior to acceptance into the program.

Careful assessment ensures appropriate planning to support clients during the vulnerable six week period post hospital discharge and ensure they will be supported by mainstream health services at the completion of the program if they still require assistance. If a client's needs relate to longer term or more specialist services, Service Coordinators provide referrals to other appropriate programs.

Following assessment, the Service Coordinator undertakes client care coordination in order to:

- Complete and implement an individualised Support Plan for each client PAP program by brokering services (and generating referrals to other available services) from subcontracted service provider(s) identified at that time as able to best deliver value for money within each client program (optimising quality and appropriateness of care, access to responsive and timely services, and the efficiency and frequency of available services within the program budget);
- Plan for withdrawal or transition of clients' services at program completion;

- Maintain phone contact to independently monitor clients' progress and service delivery, and adapt/approve changes to clients' care as needed by reviewing Support Plans as appropriate; and,
- Finalise program completion and exit processes.

The PAP program is a holistic program which provides services in lieu of pre-existing HACC services for the duration of the program. While clients are on the PAP program, any existing HACC services are suspended until the completion of the program, at which time they can be resumed as required. The provision of a single, coordinated suite of services, coordinated exclusively by a single provider, helps ensure efficient delivery of services to meet client need.

3. Evaluation

3.1 Scope of Evaluation

The scope of this evaluation is to analyse PAP program activity during 2013-14 and feedback provided by clients and discharge planners who commenced services or provided referrals during May and June 2014.

3.2 Evaluation Objectives

The objectives of this evaluation were to:

- Analyse the activity trends of the PAP program; and,
- Assess the effectiveness of the PAP program at meeting its stated objectives through the use of quantitative activity data and qualitative feedback provided by clients and hospital discharge planners.

Only three of the five PAP program objectives could be assessed as part of this evaluation. Objective 3, '*Reduce readmissions to hospital*' could not be assessed as a linkage with hospital separation data would have been required to establish an appropriate control group to measure any reductions in avoidable readmissions attributable to the PAP program. This was beyond the scope of this evaluation.

Objective 5, '*Delay admissions to residential care*' was not assessed as linkage with residential care admission data and the establishment of an appropriate control group was beyond the scope of this evaluation.

3.3 Evaluation Independence

An independent (external) consultant was contracted to undertake evaluation design and all data collection, interrogation and analysis; in addition comment was sought from a range of stakeholders and subject matter experts and their feedback was incorporated into the final report where appropriate. Every effort has been made to maintain the objectivity of the study methodology, the analysis conducted and the findings published in this report.

However, a limited budget for this study required direct involvement by Care Assess in the design, development and publication of this report.

3.4 Evaluation Methodology

Demographic and activity data for all PAP program clients is electronically recorded as part of existing business processes. Activity and client demographic information for all clients referred to the PAP program throughout 2013-14 was extracted and analysed.

Clients and discharge planners who were referred or made referrals to the PAP program during May and June 2014 were asked to complete a customised survey (see Appendix A and Appendix B). Discharge planners were asked to complete their survey on referral while clients were asked to complete their survey at program completion.

Additional information not normally recorded as part of existing business processes was recorded by Service Coordinators. This information was then linked to data extracted from the Care Assess information system to provide a richer data set.

Upon completion of the data collection, there were:

- 1,616 in scope PAP program clients during 2013-14;
- 340 in scope PAP program clients during the survey period (May-June 2014);
- 163 (48%) clients with additional information recorded;
- 104 (31%) completed client surveys; and,
- 44 completed discharger surveys.

Statistical Reliability

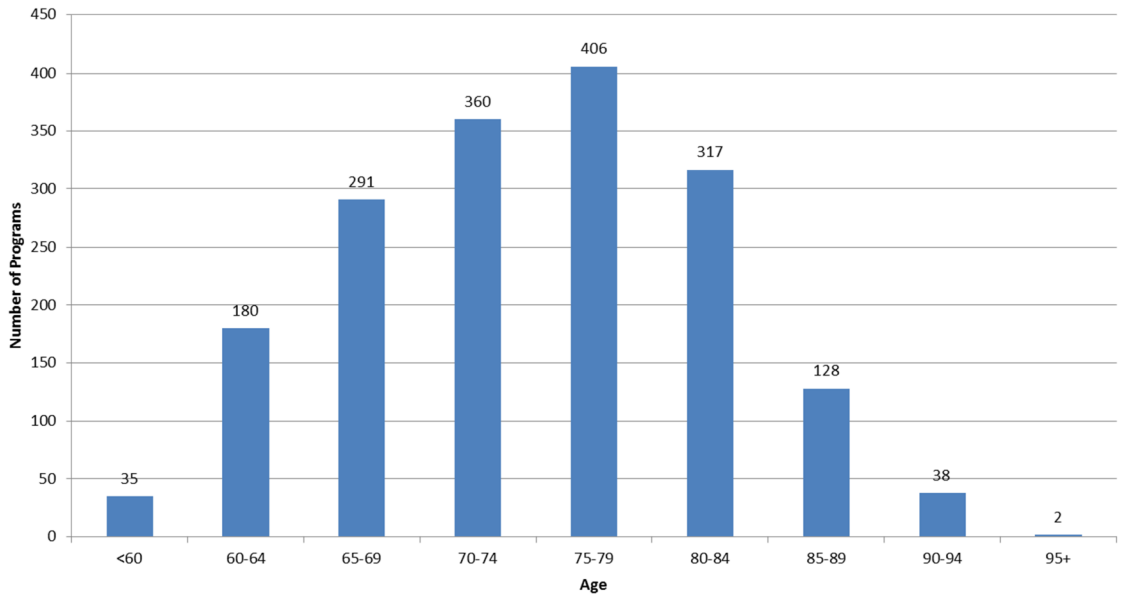
As only 31% of clients during the period May to June 2014 returned completed surveys, these results should be interpreted with care. A 95% confidence level has been used to calculate the range of values for which we are 95% confident contain the true population mean.

The total number of dischargers referring clients to the PAP program was not known; therefore confidence intervals for results drawn from these surveys are not provided.

4. Demographic Analysis

The age range of PAP program clients during 2013-14 follows a normal distribution with a mean age of 74 years old. The minimum age was 45 and the maximum age was 97.

Figure 1: Programs x Age (2013-14)



Gender Distribution

During 2013-14, 72% of PAP program clients were female and 28% were male. This compares with 53% of the Tasmanian population aged 60 and over being female and 47% male.

Aboriginal Distribution

During 2013-14, 0.8% of PAP program clients were recorded as Aboriginal, 92.7% non-Aboriginal and 6.5% as not stated, not recorded, missing or unknown. This compares to 1.3% of Tasmanian's aged 60 years and over identifying as Aboriginal, 94.0% as non-Aboriginal and 4.7% as unknown.

Regional Distribution

During 2013-14, 42.7% of PAP program clients were from the South, 34.9% from the North and 22.4% from the North West. This compares with 48.3% of Tasmanians 60 years and older living in the South, 28.6% living in the North and 23.1% living in the North West.

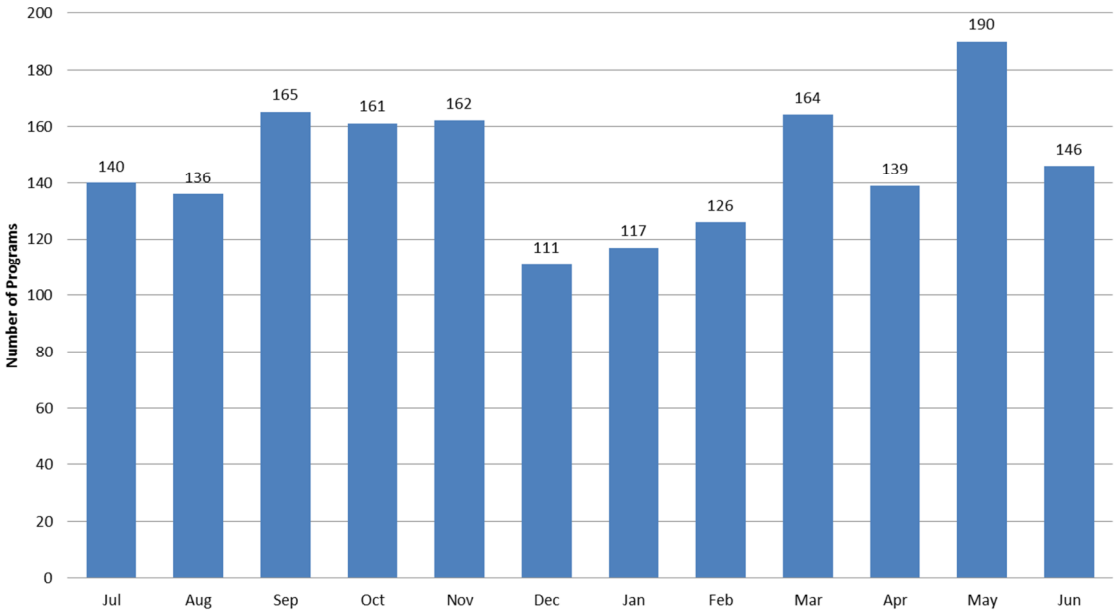
FINDING

The rate of clients receiving PAP program services in the North is greater on a per capita basis than the South.

Seasonal Distribution

There appears to be a seasonal effect upon the number of programs commenced throughout the year. The period December through to February has a markedly lower number of programs commencing compared to other periods throughout the year.

Figure 2: PAP Programs Commencing x Month (2013-14)



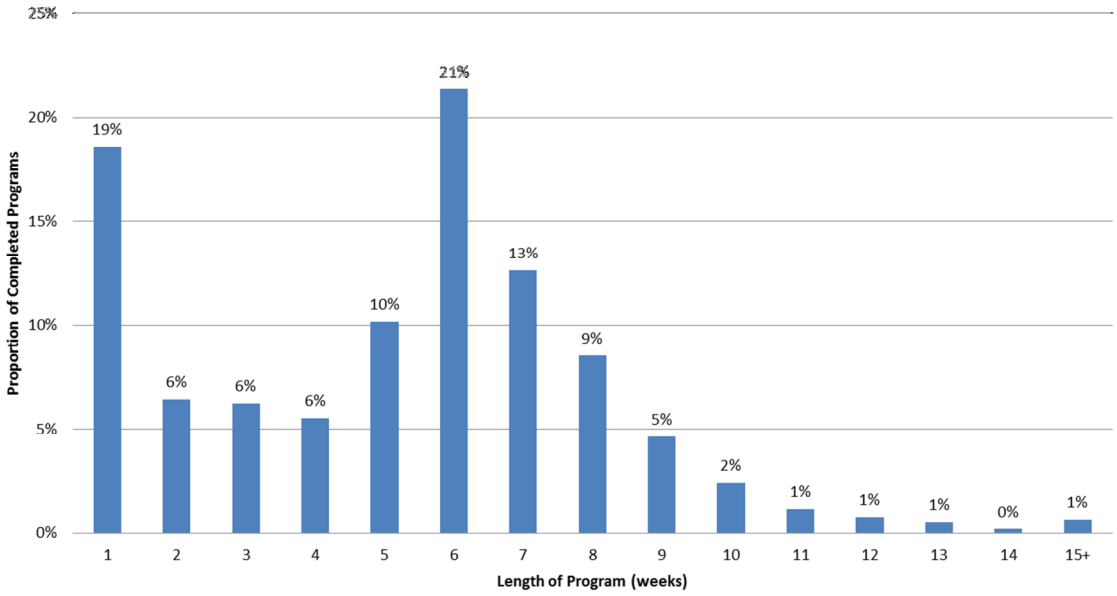
5. Program Activity Analysis (2013-14)

Program Duration

The average PAP program received 11.8 hours of services and lasted for 5.2 weeks.

More than two thirds of programs (68%) were completed within 6 weeks and 97% were completed within 10 weeks.

Figure 3: Distribution of PAP Program Duration (2013-14)



Service Intensity Over Time

The average number of service delivery hours each client received gradually decreased each week the program was delivered, particularly for clients receiving services more than six weeks after commencing the program.

The South had the lowest average number of service hours per client, except for the first week when it was higher than the North. Feedback from Care Assess' service manager indicated that practice differences across regional teams regarding the levels of services allocated is likely to be a primary driver explaining the difference in average package duration between regions. Consideration should be given as to whether the difference is attributable to the varying needs of the client cohorts between regions, referral practices or reflective of a need to ensure consistency of service practice.

Figure 4: Average Hours x Region x Week (2013-14)

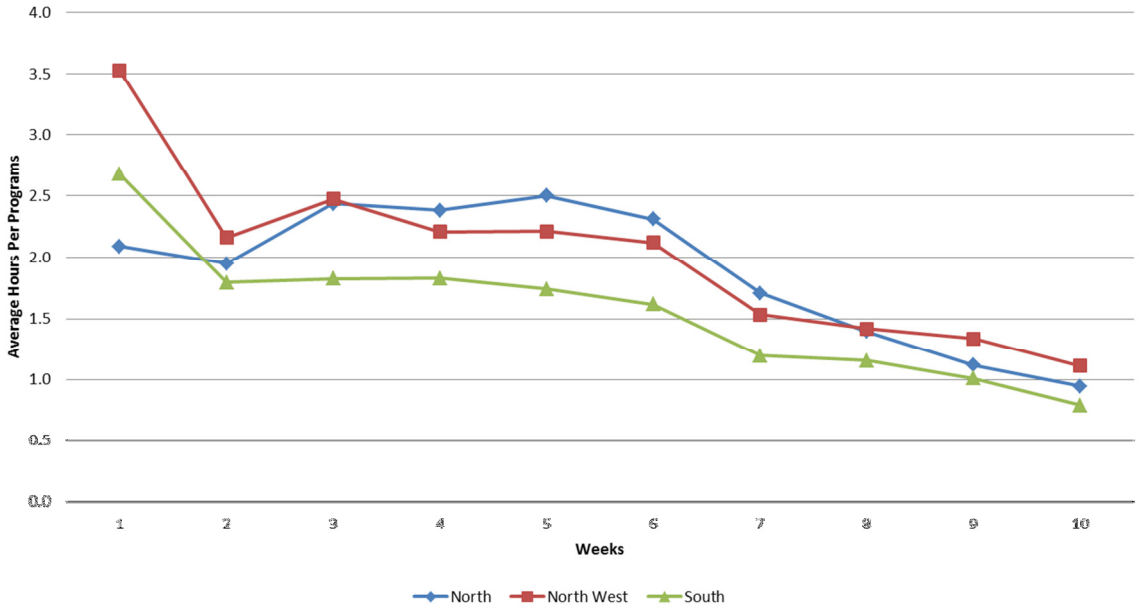


Table 2: Average Service Hours per Client x Region x Week*

Weeks	North	North West	South	State-wide
1	2.1	3.5	2.7	2.7
2	2.0	2.2	1.8	1.9
3	2.4	2.5	1.8	2.2
4	2.4	2.2	1.8	2.1
5	2.5	2.2	1.7	2.1
6	2.3	2.1	1.6	2.0
7	1.7	1.5	1.2	1.5
8	1.4	1.4	1.2	1.3
9	1.1	1.3	1.0	1.2
10	0.9	1.1	0.8	0.9
Average Hours Per Program	**11.9**	**14.9**	**10.1**	**11.8**

*Note: Average weekly service hours do not equal the total average service hours per program as not all clients receive services each week, for example, the majority of clients only receive services for 6 weeks.

FINDING

The South delivers less hours per program than either the North or the North West.

Service Delivery Mix

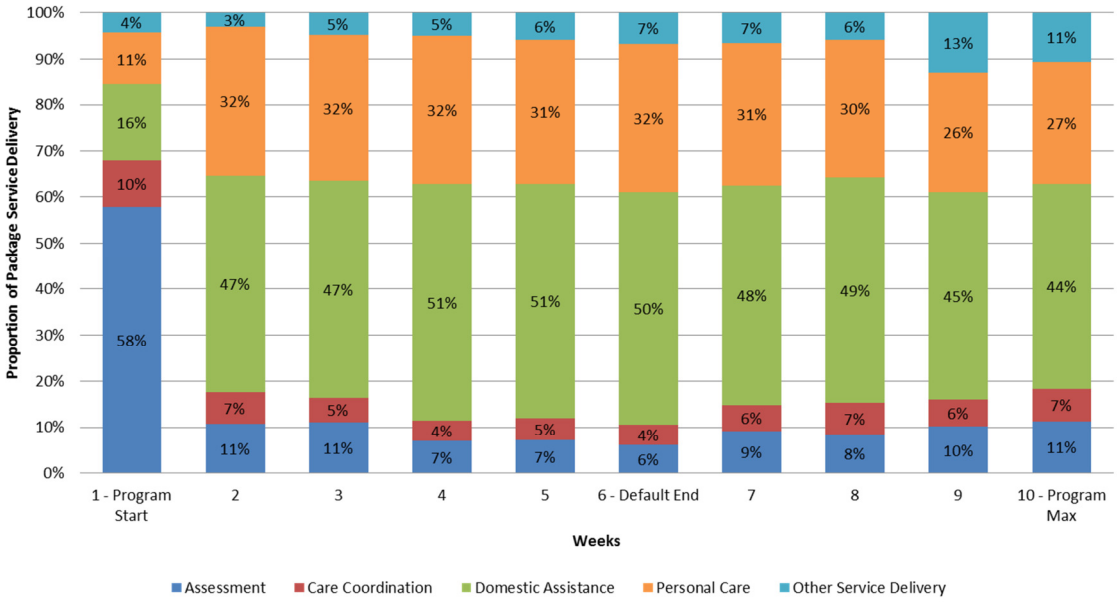
As clients receive PAP services, their service mix changes. As expected, initial services are largely comprised of assessment activities; i.e. 58% of service delivery hours during the first week of packages are for Assessment.

Over the course of the package, Assessment activities comprise of an average of 20% of all service hours and Client Care Coordination comprises of 6% of all service hours. Personal Care comprises over one quarter (27%), and Domestic Assistance comprises of almost half (44%) of all service hours. The remaining 5% of service hours are comprised of a range of other services such as Nursing in the Home and Allied Health Care.

Table 3: Proportional Distribution of Service Hours x Service Type x Week

	Assess-ment	**Care Coordinatn.**	**Personal Care**	**Domestic Assistance**	**Other Service Delivery**	**Grand Total**
1 - Start	58%	10%	11%	16%	4%	100%
2	11%	7%	32%	47%	3%	100%
3	11%	5%	32%	47%	5%	100%
4	7%	4%	32%	51%	5%	100%
5	7%	5%	31%	51%	6%	100%
6 - End	6%	4%	32%	50%	7%	100%
7	9%	6%	31%	48%	7%	100%
8	8%	7%	30%	49%	6%	100%
9	10%	6%	26%	45%	13%	100%
10 - Max	11%	7%	27%	44%	11%	100%
Grand Total	**20%**	**6%**	**27%**	**41%**	**5%**	**100%**

Figure 5: PAP Service Delivery Hours x Week (2013-14)*

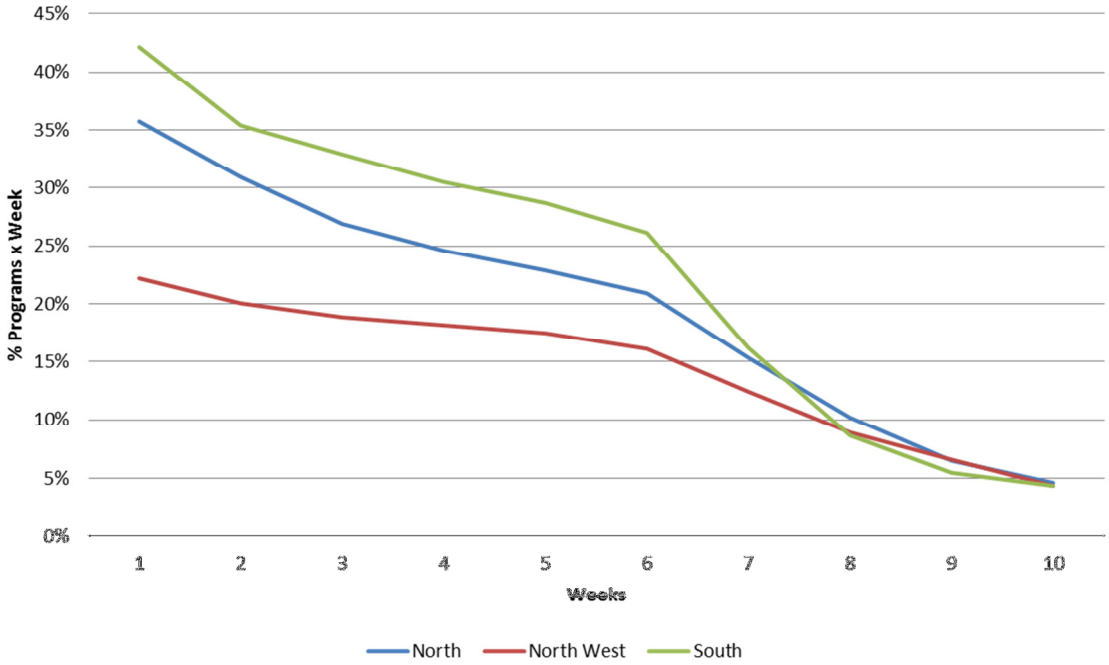


* Note: Totals may not sum to 100% due to rounding.

During 2013-14, the average composition of a client PAP program consisted of:

- 41% service delivery hours for Domestic Assessment;
- 27% service delivery hours for Personal Care;
- 20% service delivery hours for Assessment;
- 6% for Client Care Coordination; and
- 5% for other service delivery types.

Figure 6: Proportion of PAP Programs x Week x Region (2013-14)



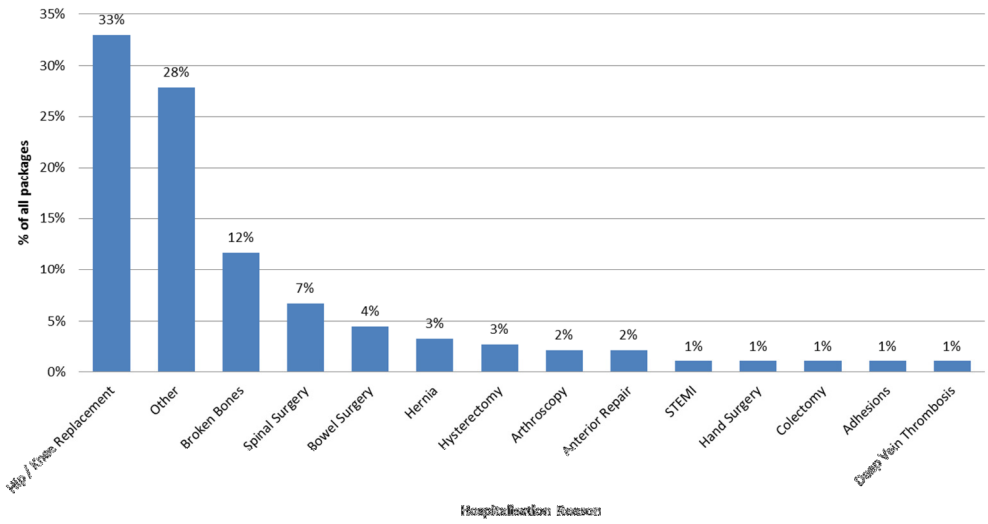
FINDING

The PAP program successfully reduced client dependence upon services through the provision of time limited services, which reduced in intensity as clients recovered from their hospital admission.

Hospitalisation Reasons

The most common hospitalisation reasons for PAP program clients were hip and knee replacements (33%) and broken bones (12%). The 'Other' category included a range of hospitalisation reasons including laparotomy, tendon repairs and facial surgery.

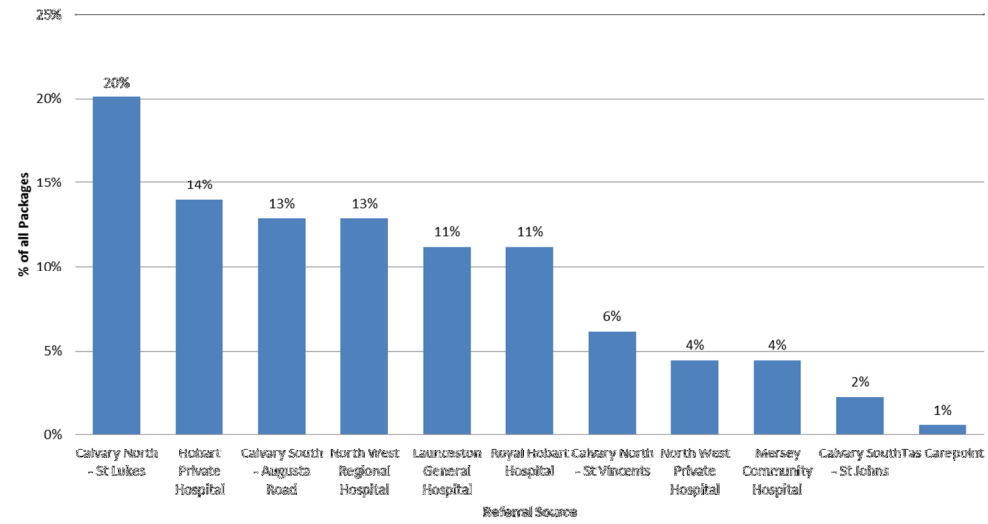
Figure 7: Clients x Hospitalisation Reason (May - June 2014)



Referral Sources

Clients were referred to the PAP program from a total of 10 Hospitals and TasCarepoint between May and June 2014. Over half (59%) of all referrals between May and June 2014 came from private hospitals.

Figure 8: Clients x Referral Source (May - June 2014)



6. Program Outcomes Analysis

6.1 Economic Outcomes

The PAP program aims to provide safe and early discharge for clients following an acute episode of care, thereby reducing unnecessary costs for acute health services. Hospital discharge planners were asked to identify if the PAP program successfully reduced unnecessary time in hospital for patients. If they answered 'Strongly Agree' or 'Agree', they were asked how many days in hospital were avoided on average.

Four out of five respondents (77%) 'Strongly Agreed' or 'Agreed' that the PAP program successfully reduced unnecessary time in hospital. The remainder (23%) were neutral or did not respond.

When asked to assess the number of hospital days saved due to the availability of the PAP program, the majority of respondents (52%) did not answer this question. A number of comments were provided stating it was difficult to assess how many hospital days were saved and results would vary depending upon patient needs.

Of the 48% of responses that did provide an estimate, there was significant variation with the estimates ranging from a minimum of one day to a maximum of two weeks.

The average number of days saved due to the PAP program was 4.2 days. However, due to the low number of responses (n=21) and concerns expressed about variations in client need, caution should be used when interpreting this result.

FINDING

The PAP program appears to successfully reduce unnecessary time in hospital for patients. However, the magnitude of this reduction cannot be accurately reported at this time.

6.2 Health and Wellbeing Outcomes

Clients were positive about the services received as part of the PAP program. Detailed comments can be found in Appendix C – Client Feedback Comments.

Selection of Client Feedback Comments

"Very satisfied with the ladies. Made me feel at ease after my operation. Thank you."

"The service was excellent. Cannot be faulted."

"Excellent care. Could not have coped without it."

The following word picture represents client comments. The larger the words, the more frequently they appeared in the feedback provided.

Figure 9: PAP Client Feedback (Wordle)

FINDING

Clients where overwhelmingly positive about the service, care and support provide by Care Assess and contracted service providers.

Client Survey Responses

The client survey responses reveal that almost all clients (98%) believed the program was appropriate to their needs and four out of five clients (82%) felt safe to continue independent activities of daily living. Of the 17 clients who did not feel safe, 10 (58%) were referred to another service when the program had finished.

One quarter of clients (25%) were referred to another service[4], however only 5% of clients were referred to services which were more intensive than pre-admission levels of service due to program goals not being obtained.

Almost all clients (98%) would recommend the program to others, and a total of 94% of clients were happy with the communication with Service Coordinators.

[4] Client referred to another service at the end of the program includes a wide range of services, the majority of which were low level service which were similar or less intensive than services the client received before admission to hospital.

Table 4: PAP Client Survey Responses

Question	Yes	Yes %	No	No %	Total
Was the program appropriate to your needs?	102	98% (±2.3)	2	2% (±2.3)	104
Were you satisfied with the care you received?	102	98% (±2.3)	1	1% (±1.6)	104
At the end of this program do you feel safe to continue independent activities of daily living?	85	82% (±6.2)	17	16% (±5.9)	104
Were you referred on to another service when the program finished	26	25% (±6.9)	71	68% (±7.5)	104
Would you recommend the program to others?	102	98% (±2.3)	1	1% (±1.6)	104
Were you happy with the communication between the program co-ordinators and yourself?	98	94% (±3.8)	3	3% (±2.7)	104

Package Closure Reasons

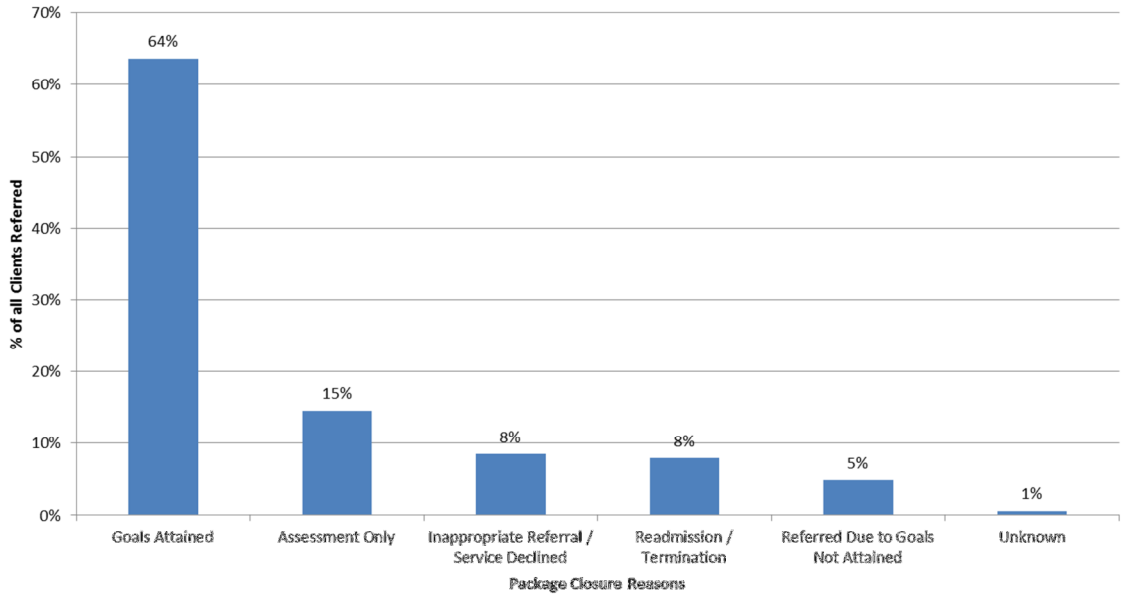
An objective of the PAP program is to provide short term community support services commensurate with client need until pre-admission independence is regained. Care Assess Service Coordinators stated that 64% (±5.4)[5] of clients referred to PAP attained their program goals. A total of 15% (±4.0%) received an assessment only and 8% (±3) were readmitted or terminated the service. Only 5% (±2.4) were referred for further, more intensive services. The remaining clients were either inappropriate referrals or declined services 9% (±3.2).

The fact that only 5% of clients were referred for ongoing higher levels of service at the completion of the program due to program goals not being met, demonstrates the effectiveness of PAP at minimising longer term dependency on increased levels of home support. The program appears to minimise unnecessary levels of ongoing higher level services while still ensuring clients that genuinely require these services are referred appropriately.

The figure below identifies the closure reasons for each of the packages referred to the PAP program during the survey period (May to June 2013-14).

[5] Figures in brackets are 95% confidence intervals.

Figure 10: Package Closure Reasons for all Clients Referred to PAP (May - June 2014)



FINDING

The majority of clients (64%) achieved their program goals as assessed by Care Assess Service Coordinators upon completion of their PAP program. Considering client goals are set for clients to achieve their pre-admission level of independence, this can be interpreted as 64% of referrals resulting in clients achieving their pre-admission levels of independence.

Hospital Readmission

Additional analysis is required to determine how effective the PAP program is at reducing unnecessary readmissions to hospital. Linkage with hospital separation data would be necessary to establish an appropriate control group to measure program effectiveness. A single measure of hospital readmission without an appropriate control is not particularly meaningful as a number of hospital readmissions are unavoidable, even when high levels of clinical support and community care are provided.

6.3 Service System Outcomes

The PAP program provides early intervention and enablement services which help support long term outcomes. The Program aims to reduce longer term dependency on home support services through the provision of time limited services, thus ensuring the efficient provision of services at a system level, and reducing unnecessary ongoing demand for the system as a whole over the longer term. Further longitudinal analysis is required to determine the effect of PAP upon ongoing HACC services.

The PAP program aims to reduce the need for increased HACC services by providing a mechanism to prevent unnecessary instances of new or existing HACC clients being referred for higher levels of 'mainstream' home support services. The provision of short term services (average of 5.8 weeks per client) and low referral rates a program completion to more intensive services (5%) indicate positive service system outcomes.

Feedback from hospital discharge planners indicates Care Assess communicates well with hospital staff and works collaboratively to ensure positive outcomes for clients.

Figure 11: Hospital Discharge Planner Feedback (Wordle)

FINDING

Hospital discharge planners were positive about the helpful, professional and outcomes-focused approach demonstrated by Care Assess staff.

Detailed comments can be found in Appendix D – Hospital Discharge Planner Comments. However, a selection of hospital discharge planner comments are provided below:

Selection of Hospital Discharge Planner Comments

"Gives patients confidence that they have a 'fall back' at home and care will be maintained. Less stress for patients on discharge."

"Such great support for those of us involved in discharge planning. Gives us peace of mind where life situations are less than optimal for clients."

Almost all hospital discharge planners (95%) 'Agreed' or 'Strongly Agreed' that the PAP program 'increases patient safety when transferring clients home' and that 'Care Assess responds in a timely manner'. The majority also 'Agreed' or 'Strongly Agreed' that Care Assess worked collaboratively (88%), reduced the likelihood of avoidable readmissions (86%), and patients had better wellbeing outcomes due to receiving the PAP program (81%). Three quarters (77%) 'Agreed' or 'Strongly Agreed' that the PAP program successfully reduces unnecessary time in hospital.

Table 5: Hospital Discharge Planner Survey Responses

Indicator	Agree or Strongly Agree	Minimum Rating	Maximum Rating
Successfully reduces unnecessary time in hospital	77%	Neutral	Strongly Agree
Increases patient safety when transferring clients home	95%	Neutral	Strongly Agree
Reduces the likelihood of avoidable readmissions	86%	Disagree	Strongly Agree
Care Assess responds in a timely manner	95%	Neutral	Strongly Agree
Care Assess works collaboratively	88%	Neutral	Strongly Agree
Patients have better wellbeing outcomes due to receiving the PAP program	81%	Neutral	Strongly Agree
Patients have better health outcomes	83%	Disagree	Strongly Agree

Indicator	Good or Excellent	Minimum Rating	Maximum Rating
Overall assessment of the PAP program	95%	Neutral	Excellent

FINDING

Hospital discharge planners were very positive about the PAP program, particularly its ability to increase patient safety when transferring clients home and ability to respond in a timely manner.

FINDING

Areas for possible improvement include:

- Continuing to find ways to reduce unnecessary time for clients in hospital; and
- Identifying qualitative measures to demonstrate improved client outcomes due to the provision of the PAP program.

6.4 Quality of Care

Almost all clients (98%) indicated that they were satisfied with the services provided by the PAP program and would recommend the program to others.

Quality Business Processes

The majority of clients (94%) were happy with the communication between the Service Coordinators and themselves. Similarly, 95% of hospital dischargers agreed or strongly agreed that Care Assess responded to PAP program referrals in a timely manner.

A total of 88% of hospital discharge planners agreed or strongly agreed that Care Assess works collaboratively to ensure the best possible outcomes for patients.

FINDING

Clients and hospital discharge planners were very satisfied with the communication, responsiveness and collaborative approach demonstrated by Care Assess staff.

6.5 Service System Improvements

Some suggestions provided by clients for additional services which could be included or brokered by the PAP program include:

- Shopping support by way of grocery delivery
- Transport

Considering the PAP program coordinates respite care (not paid for by HACC), similar processes could be adopted for meals/food delivery and transport.

7. Recommendations

Recommendation 1:

Investigate the potential need to increase access to the PAP program for greater numbers of clients in the South (to ensure state-wide equity).

Recommendation 2:

Investigate the potential need to increase the service hours allocated for clients in the South during the first 6 weeks (to ensure state-wide equity) by identifying reasons for existing differences.

Recommendation 3:

Investigate whether the reason for decreased levels of services over the December – February period is attributable to a decrease in referrals during the period or a delay in program commencement. If this is due to a delay in program commencement, identify how this might be addressed.

Recommendation 4:

Investigate options for coordinating provision of additional services such as assistance with transport due to the high number of clients with knee and hip replacements.

Recommendation 5:

Investigate additional funding sources in order to broaden eligibility criteria and/or suitability of the program for clients requiring the PAP program's services.

Recommendation 6:

Investigate options to streamline the referral process (from a discharge perspective).

Recommendation 7:

Investigate how patients can be referred to the PAP program and be discharged over weekends to receive after business-hours service commencement.

Recommendation 8:

Undertake further research into the efficiency and effectiveness of the PAP program through:

- Economic analysis of the impact of the PAP program;
- Improved electronic recording of pre and post functional assessments to enable improved evaluation of PAP program client outcomes;
- Longitudinal measurement of client dependency on home support services, and admissions to residential care; and
- Linkage with hospital separation data to establish a control group to enable improved analysis.

8. Further Acknowledgements

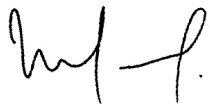
Care Assess wishes to thank all of our referrers and clients who have used or received the services of the HACC Post Acute Package (PAP) program over the last 10 years; thank you for the privilege of working **with you, for you.**

Care Assess wishes to particularly thank our dedicated staff; each of the many Service Coordinators and other support staff who have made the PAP program happen since 2004.

Care Assess also thanks all of our service providers across Tasmania who have worked with us in delivering home support for our clients in this program. Care Assess' business model is distinctive in completely separating the assessment/coordination function provided by our staff from direct support service delivery, such as personal care and domestic assistance, provided by the staff of other organisations subcontracted to Care Assess. Thank you to the many organisations and support workers who provided services on our behalf to HACC clients in this program across Tasmania.

Care Assess wishes to acknowledge Silver Chain Group whose Personal Enablement Program (PEP) demonstrated the strategic benefit of short term enablement support programs within the context of the HACC program in Australia. Additionally, Care Assess thanks Silver Chain Group for the input they provided in preparing this evaluation report.

Finally, Care Assess owes a debt of gratitude to Tasmania's Department of Health and Human Services who prior to 2004 first developed and operated their "HACC Packages" program to serve our local hospital and home support system. Thank you for the funding and other support received by the Department since that time, when Care Assess first developed and began managing the PAP program, which has now for a decade provided the benefits demonstrated in this Report both to our local health system and Tasmania's home support system.



Joe Towns | Managing Director

20/02/2015

Appendix A – Client Feedback Survey Form

PAP Client Feedback Survey

As you have completed your program we would appreciate your feedback in order for us to evaluate and improve our services. Could you please complete this evaluation form, and return it in the envelope provided.

Age ..... Gender..... Postcode.....

1. How did you hear about the service? Please circle all appropriate.

GP Hospital Friends or neighbours Other

2. Was the program appropriate to your needs? YES / NO
3. Were you satisfied with the care you received? YES / NO
4. At the end of this program do you feel safe to continue independent activities of daily living? YES / NO
5. Were you referred on to another service when program finished? YES / NO

   If yes, comment: .....

6. Would you recommend the program to others? YES / NO
7. Were you happy with the communication between the program co-ordinators and yourself? YES / NO
8. Please list any services that you would have liked to receive that were not offered.....
   .....
9. Do you have any other comments you would like to make?

   .....
   .....
   .....

Thank you for your participation in our program and for taking the time to complete this questionnaire.

Name..... Phone Number.....
(optional)

Appendix B – Discharger Feedback Survey Form

PAP Discharger Survey

Please can you assist us in evaluating the outcomes for your patients who have received care through the Post Acute Program.
When answering the following questions, please provide your overall assessment of the program over the last 12 months:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The Post Acute Program:					
1. Successfully reduces unnecessary time in hospital for patients					
2. If you answered Strongly Agree or Agree – how many days on average					
3. Increases patient safety when transferring clients home from hospital					
4. Reduces the likelihood of avoidable readmissions					
5. Care Assess responds to PAP referrals in a timely manner					
6. Care Assess works collaboratively with discharge planners to ensure the best possible outcome for patients					
7. Patients have better wellbeing outcomes due to receiving PAP					
8. Patients have better health outcomes due to receiving PAP					

What is your overall assessment of the Post Acute Program?

1-Excellent 2-Good 3-Neutral 4-Poor 5-Very Poor

Comments .....
.....
.....

Thank you for your time and feedback
Care Assess Management Team

Appendix C – Client Feedback Comments

The following list is a full set of comments provided by clients as part of this survey. Identifiable names have been removed to protect privacy and replaced with generic references to carers.

- I was very satisfied with the services I received and thoroughly recommend the services to others - which I have done already.
- After reaching 'old age' I found it difficult to find out exactly what is available in Tasmania. The 'Domestics' don't appear to have been trained and are not hygienically minded. This did not apply to my helper.
- I was very happy with the service my carer gave me over the 9 weeks they visited.
- Excellent service and lovely people. It was most beneficial in my recovery.
- Excellent services.
- If possible I would like my carer to come once a week to put the cleaner round all rooms, my husband isn't well enough to help with the cleaner, I am coping a lot better. Another four weeks would be a good help.
- Very satisfied with the ladies. Made me feel at ease after my operation. Thank you.
- Excellent work and help
- Very satisfied with service
- Very disappointed. Ladies never came at the right time so I missed out on several occasions, while the neighbours took me shopping! Whenever I asked a question I received blunt answers: Look in the Yellow pages, or 'This has nothing to do with us, or ring meals on wheels if you are hungry.
- The service was excellent. Cannot be faulted.
- Very happy with service
- We are very pleased with the help we get from the district nurses [Editor: Likely reference to Care Assess]
- The service was fantastic and has allowed my recovery to go smoothly not having the stress of vacuuming etc. on my back. Many thanks. Fantastic service.
- Excellent care. Please pass on my appreciation to your helpers in particular to my carer who cleaned my house and gave me friendship.
- My two girls were lovely and Isis particularly is very good at what she does.
- Thank you for the care and help received - the girls were so kind and cheerful - they certainly helped to make my recovery time so much easier.
- I am very happy with the service. My carer was most thoughtful and kind.
- Excellent care. Could not have coped without it.
- Yes. Perhaps it would be beneficial if a booklet was published on all facilities that are available when one is incapacitated. I was well prepared on the home front as I had enough frozen meals for a month that I could heat and eat with a fork. But, there are still a number of things that I still have difficult carrying out. If you wish to discuss further, please do not hesitate to call me.
- Excellent people
- I was very satisfied with the help and the helpers
- I was very happy with the communication. I was always appreciative of their efforts.
- I am very appreciative of the help I received. Thank you.

- I was very happy with my carer. Care Assess co-ordinator's service very helpful compassionate & understanding person
- Excellent service from carer
- I appreciate the help that I received
- The women were exemplary in their professionalism and care. Evidence of their training and aptitude for the task.
- The assistance made a huge difference to recovery
- Programs like this help us to stay living in our home in the country
- Only to say thank you
- Not used to only 3 showers a week. I know funding is not enough for more. I have to cope now despite still not able to do normal things for at least six months. Writing this hurts a lot.
- Would like to continue 1/2 hours home help per week due to shortness of breath and back pain. Following large myocardial infarction.
- I really appreciated the care and kindness of the lady who came to me, I found her to be understanding and helpful.
- Was very happy with and will be sorry to lose her.
- Most pleasant and obliging people and fitted my needs.
- The cleaner who came was excellent - she was so bright and helpful - a real delight when you don't feel well. Thank you.
- The service was greatly appreciated as I really was unable to do necessary household chores. Thank you!
- I found the ladies very caring. I had my niece stay for the first week I was out of hospital, but I was very grateful for the help after that.
- Very pleased with advice given
- Personal care was excellent but domestic duties a little lacking.
- Very pleased with the care I received. A thank you to Libby my carer.
- Why isn't your service common knowledge? I could have used this service for 2 years at least prior to initial contact.
- A very good service, much appreciated.
- Very efficient and obliging
- Thank you for - a special and beautiful helper - just so right for the job of caring.
- My carer was most helpful and understanding.
- Thanks to carers and coordinators
- Very happy with all aspects and thank you
- A very beneficial program at such a reasonable cost.
- Thank you
- Service was top class
- I found it very good and the lady helpful
- Much appreciated, thank you!

Appendix D – Hospital Discharge Planner Feedback Comments

The following list is a full set of comments provided by hospital discharge planners as part of this survey. Identifiable names have been removed to protect privacy.

- A fantastic program - we are very lucky to have access to. Thank you
- Thankyou
- It would be helpful if the patient didn't always have to be seen in hospital pre-discharge as sometimes we only discover a referral is required on day of discharge and it is then too late to refer.
- Great program and responsive and helpful staff
- Don't have much to do with patients once discharged - unsure of outcomes for most patients.
- Gives patients confidence that they have a 'fall back' at home and care will be maintained. Less stress for patients on discharge.
- Personally haven't been involved and haven't discussed with referred patients.
- Such great support for those of us involved in discharge planning. Gives us peace of mind where life situations are less than optimal for clients.
- Care Assess are very easy to work with. Referrals are responded to quickly and efficiently. Great team to work with
- Great job! Easy to liaise with. Thanks!
- Feedback from clinic audits and assessments demonstrate that client's experience of the package is a positive one
- Rarely re-admit or see patients who have received PAP
- I am able to consult with them, help decide what would get the best outcome. They are flexible and prompt once they receive the referral.
- Good service - works well. Co-ordinators helpful - work well together with Hospital team.
- Staff have expressed issues with processes and eligibility criteria. Willingness to work collaboratively to achieve best outcomes in an imperfect world is not always present in current structure.
- I always find PAP team helpful and friendly to deal with. They always endeavour to find a good outcome for patients and their families.
- North West staff are extremely professional and caring and provide services promptly which aids in discharge planning being more efficient.
- Thank you for ongoing team work approach for continued patient outcomes
- Keep up the good work and good to receive confirmation faxes are received
- PAP is very helpful in providing service for clients requiring discharge from the Emergency Department. The service is always prompt and communication between HALT and PAP is good.
- Referral process quite time consuming and irrelevant questions regarding acute stay.
- Staff link well with hospital nursing staff which is much appreciated and are very quick to respond to referrals
- Pity funding does not allow for daily hygiene assist or help for patients younger than 60 years
- I have recently moved from North Queensland to Launceston where we had a similar program. I believe that this is a great system. Many years ago was working in District Nursing where we did contribute to post discharge care.

- We don't see patients after they've received post care services - unable to rate
- Do not hear feedback once a patient has discharged.
- Sometimes when discharge has not been discussed in a timely manner by us a patient cannot go home Fri->Mon due to having to be seen prior to discharge; a more detailed form could be filled in by us in this case to allow discharge and assessment by you at home.