

The Community Transition Program

Transition and Rehabilitation for the Older Adult

**2nd Healthcare Without Walls: delivering the best care in the best place
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Outline

- **What is CTP?**
- **Eligibility**
- **Key principles**
- **Case Studies**
- **Statistics**
- **Evaluation**
- **Future**

What is CTP all about?

- **The Community Transition Program (CTP) is an innovative approach to transition and rehabilitation for older people living in the northern & eastern metro regions of Adelaide**
- **CTP provides an opportunity for older people to maximise their independence and achieve sustainable health outcomes (physical/emotional & social)**
- **Based on HHAC's broad "holistic" definition of rehabilitation**
- **CTP has two tiers of service -**
 - **Lower level (HACC)– allows 3 months of intervention with approx. 3hrs per week intervention**
 - **Higher level (CACP) – allows 6 months of service with up to 10hrs per week initially**

Aimed at older people who have experienced

- **An acute episode**
- **A gradual decline in health or quality of life**
- **A substantial change in their circumstances (e.g. death of a partner)**
- **A reduction in their capacity, functioning or quality of life for any other reason**

CTP aims to

- **Prevent inappropriate admission to residential care or long term services**
- **Maximise the capacity of older people to self manage**
- **Improve health outcomes and quality of life for older people**
- **Reduce use of and dependence on the service system**

Eligibility For CTP

- **60 years +**
- **Satisfy usual eligibility criteria for a CACP or HACCC program**
- **Identified as having the potential to benefit from goal oriented intervention**
- **Have self determination to maximise independence**
- **Live in the Eastern and Northern Council areas**

Key Principles

- **Structured** short and long term goal setting with clients from a **holistic** view of rehabilitation
- **Goals** focused on restoring or improving wellbeing
- **Time limited** – older people may require more time to improve and graduate to appropriate services
- **Purposeful** interventions which focus on achieving a high level of well being

Key Principles

- **It requires significant levels of motivation by the older person and significant others**
- **Creative and flexible service delivery which is client focused**
- **Aims to allow clients to exit at their best level of wellbeing and independence**
- **Coordinator at FOCAL POINT of ongoing communication, inclusive of reviews.**

Service Examples

- **Allied Health**
- **Counselling Support**
- **Personal care assistance**
- **Domestic assistance**
- **Meal preparation**
- **Regaining skills of independence**
- **Evaluation and /or supply of short term loan equipment**

Case Studies

- **Case Study 1)** **client with dementia**
- **Case Study 2)** **client with multiple chronic diseases**
- **Case Study 3)** **client with chronic mental health issues**

Case Study 1

- **Mrs F is an 88 year old woman recently diagnosed with early dementia, who had a fall at home (UTI) resulting in a R) wrist fracture.**
- **Goals 1) to return to independence with showering and dressing
2) to return to the ability of preparing breakfast and lunch.**
- **CTP provided Mrs F with personal care assistance and light meal prep Monday – Friday until her plaster removed and then commenced weekly Physiotherapy and a Podiatry visit.**
- **Discharged from the program independent with activities of daily living. Transferred over to a Helping Hand Community therapy client to receive ongoing physiotherapy (maintenance) and Podiatry services.**

Case Study 2

- Mrs P is a 70 year old woman with multiple chronic diseases including type two diabetes, bronchiectasis, dilated cardiomyopathy, minor coronary artery disease and obesity.
- CTP provided Mrs P with equipment, personal care assistance three times per week, weekly cleaning/laundry assistance, Physiotherapy and Occupational Therapy.
- Goals
 - 1) To routinely shower independently
 - 2) To return to routine activities of daily living
- Discharged to lower level ongoing HACCC funded program for her personal care and fortnightly cleaning.
 - Community walking and Exercise group to maintain levels of balance and endurance which had been attained through home Physiotherapy.

Case Study 3

- **Mrs H is a 79 year old woman who has bi polar disorder and receives ongoing treatment and case management through a public Mental Health Program.**
- **Mrs H had a fall resulting in a fractured L) hand and nose.**
- **Goals**
 - 1) **return to independence with personal care**
 - 2) **To return to independence with bed making**
 - 3) **To return to independence with sandwich preparation.**
- **Mrs H had reached her goals and was discharged from CTP after 5 weeks. Once her plaster and splint were removed she was able to return to own personal care, bedmaking and sandwich preparation.**
- **Through liaison with local council ongoing HACCC funded cleaning and shopping assistance were arranged along with a volunteer arrangement for a weekly social outing.**

Statistics

Client transitions out of the program with possible outcomes of

- **Fully independent at home**
- **Manages with help from Carer**
- **Other community Support**
- **Long term CACP**
- **Low level Care**
- **High Level Care**

Statistics cont.

Client snapshot of financial year 2006/2007

Outcome	CACP	HACC
Fully Independent at home	8 (16%)	71 (46%)
Manages with help from Carer	2 (4%)	4 (3%)
Other community Support	20 (41%)	73 (47%)
Long term CACP	7 (14%)	6 (4%)
Low level residential Care	10 (20%)	0
High level residential Care	2 (1%)	0
Total	49 (100%)	154 (100%)

Evaluation

Considered from the following perspectives

- Individual client measures using
 - 1) Goal attainment scale
 - 2) Geriatric depression scale
 - 3) Timed get up and go
- Client exit questionnaire
- HACCC funded independent evaluation during 2003 which provided a critical analysis of the CTP model and the way it has been implemented

Key Evaluation Outcomes

- **The CTP model provides effective transition and rehabilitation for older adults in the community**
- **Outcomes indicate significant restorative benefits for clients from CTP**
- **Tailors services to meet individual client needs including client goal setting – not menu driven**
- **Clients with early dementia can benefit from CTP with the correct support**
- **CTP fills a gap in the system for unique early intervention, rehabilitation-specific services**
- **Prevention of unnecessary entry to residential care is achieved in most instances**

The Future

- **Vision for expansion of the CTP model metro wide**
- **Further develop partnership approach to support the model**
- **Recent restructure at Helping Hand Aged Care with a merger of the Allied Health Dept and CTP to work under the banner of 'Rehabilitation'. This development has resulted from our organisation's major strategic direction for the future looking at embedding the rehabilitation philosophy in all service provision to clients.**
- **Further planning and development of innovative services in which rehabilitation can be supported through various funding options.**

Community Transition Program

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