



**Finding older people in need when they are not asking for help!**

**The challenge for the Treatment Response Assessment Aged Care (TRAAC) team.**

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*Continuing the Mission of  
the Sisters of Charity*

# TRAAC Aims

- Decrease acute healthcare utilisation
  - ↓ emergency department presentations
  - ↓ inpatient admissions
- Effective care coordination of client and carer needs across acute, subacute and primary care sectors
- Improved client and carer quality of life and health status

**LEVEL 1: Frequent Hospital users /  
chronic & complex needs**

- Tertiary prevention, rapid response, outreach services
- Intensive / Case management
- Specialist & GP management

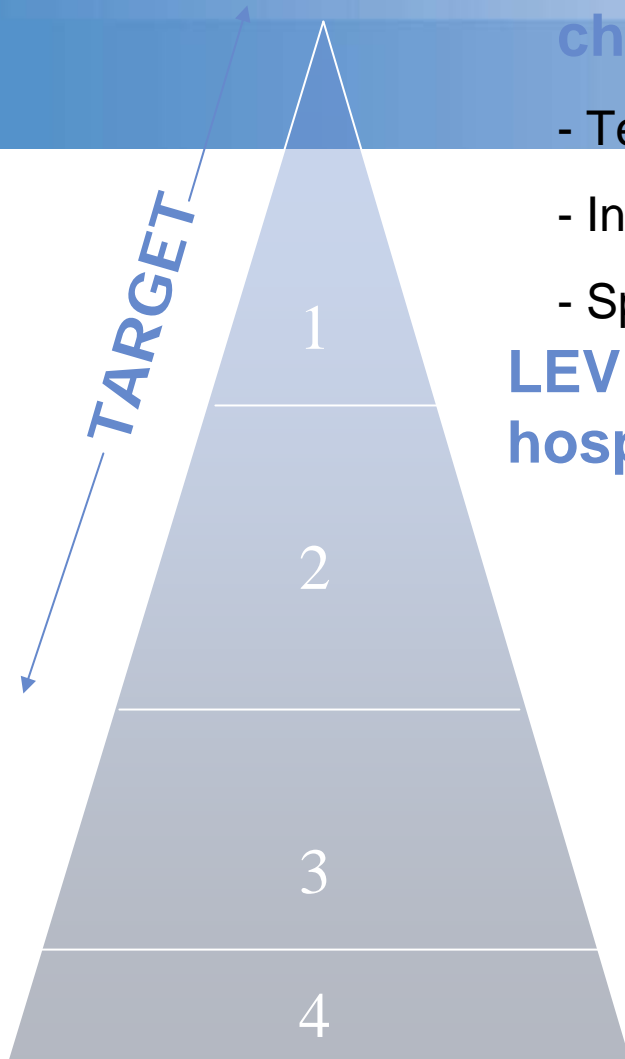
**LEVEL 2: Current user / at risk of  
hospitalisation**

- Community based care coordination
- Secondary & tertiary prevention
- Care Coordination / planning

**LEVEL 3: Chronic condition for usual care**

- GP care
- Self-management programs
- Mainstream community services

**LEVEL 4: Whole population, primary  
prevention**



# Our Clients

- Older people 65+
- Complex health conditions
- Recent change or decline impacting on health conditions
- Low likelihood of having established links with mainstream services
- They are unlikely to:
  - Seek assistance
  - Engage with a regular GP or health service
  - Be compliant with health related interventions
  - Be aware they are at risk
  - Be ringing anybody!!!!

## Where are our staff?

- TRAAC is comprised of a virtual team
- Partnership relationship with key community organisations developed to strengthen the bridge between hospital and community
- Optimising the health outcomes of complex clients through this collaborative arrangement

# Community linkage

- TRAAC Case managers
  - Work patiently to engage
  - Prioritise planned interventions on a risk / needs basis
  - Rapid access to
    - Medical and Allied Health services
    - flexible care arrangements using brokerage
  - Implement a stable care plan for mainstream service to take on
  - Being based in Community organisations allows direct liaising with the carers who may provide the long term care plan and enable communication of strategies and new issues

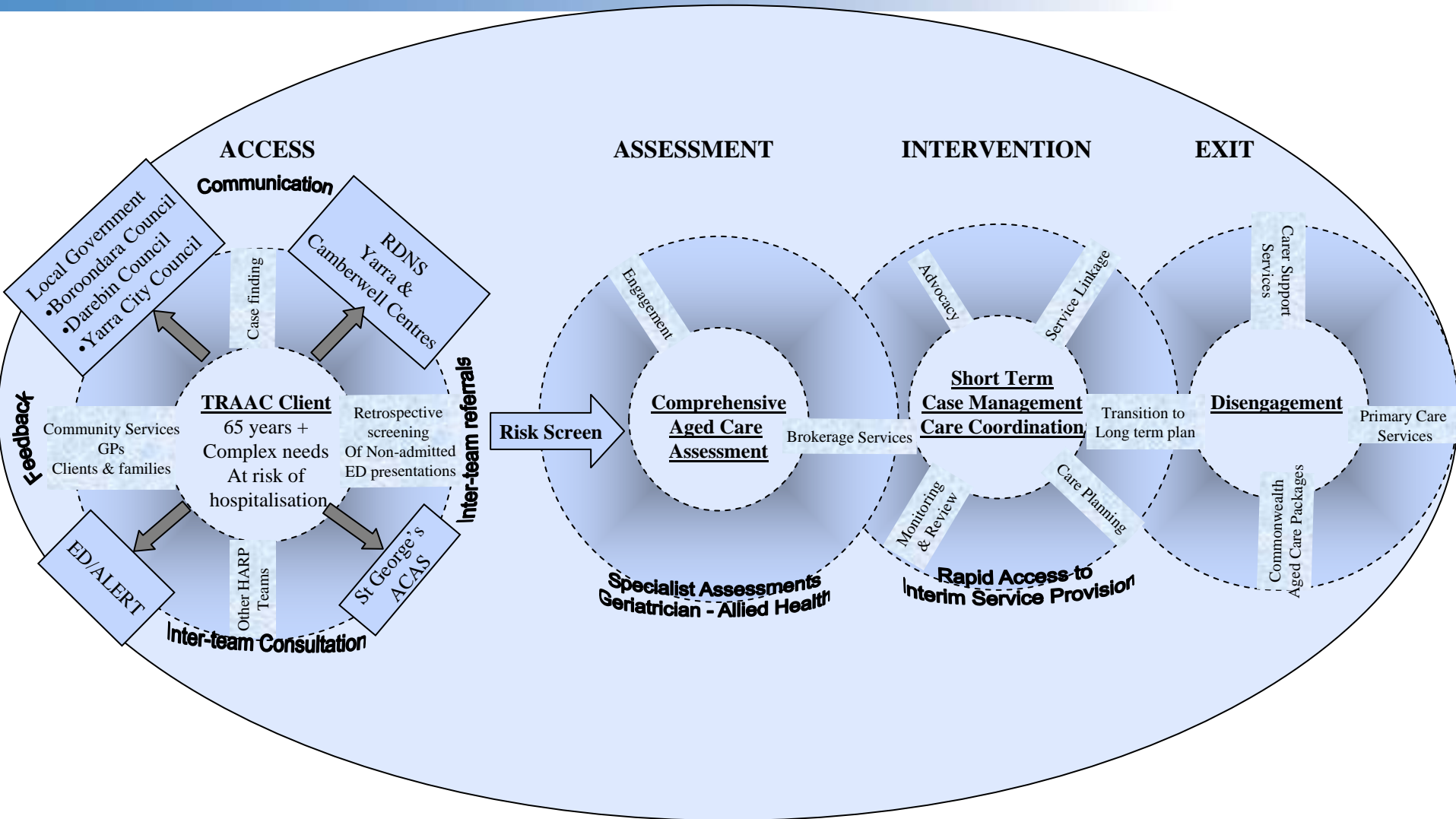
# TRAAC

- Recruitment
  - Direct referral & case finding via partner organisations
  - Emergency diversion
  - Retrospective screening post ED presentation
- Assessment
  - Comprehensive aged care
  - Specialist assessment

# TRAAC

- Care planning –
  - Client/carer involvement in care planning
  - Established referral and care coordination links with mainstream aged care services & GPs
  - Short-term case management role
- Outcomes
  - Optimised client independence through sustainable support arrangements
  - Reduced hospital utilisation

# TRAAC Model of care



# Consolidation of the program



- Community recruitment process well developed in a preventative model
- Identification of fluctuating geographic workload and need to share clients across the team
- Recognition that optimising TRAAC's recruitment strategies at interface points such as Emergency Department and Outpatients is a logical development to focus on

# Enhancement to the model of care



- Reduced service responsiveness to new referrals when individual staff caseloads are high
- TRAAC ED staff was at capacity and potential referrals being managed within the hospital
  
- Targeting of frequent ED attendees as a priority
- Maximise the number of older people with complex needs recruited to TRAAC following a presentation to Emergency
- Increase flexibility of referral distribution across the team
- Improve communication of treatment plan from ED

# Emergency Department Recruitment



- 6 month pilot project
- establish retrospective screening of clients discharged from ED
- building on the strength of the existing recruitment mechanisms
- identify clients that have outstanding unmet complex health and psychosocial needs
- Recognition that presentation to ED an indicator of breakdown of their normal coping mechanisms and without follow-up risk of representation continues

# Screening process

- Reporting from the Patient Administration System (PAS) targeting relevant clients for contact was developed
- Risk factors are gathered from Emergency notes and the medical history with subsequent phone follow-up to explore their situation in more depth
- The TRAAC ED Screen and Data Form utilised to identify key risk indicators e.g. recent changes in medical and physical conditions, hospital presentation, psychosocial factors, and service usage/lack of supports

# Screening process

- For 'at risk' people it is important you don't scare the person off, as you only see many issues when you get in the door
- Emphasis is put on
  - “help to keep you out of hospital”,
  - “it's a free service the Hospital provides”
  - and “some advice to consider which may help keep you well as you get older”
- Matching client needs with staff availability

## Consent and referral

- Verbal consent obtained for home visit and for sharing Hospital information within the TRAAC team
- Relevant information regarding the presentation and follow-up is faxed to the TRAAC case manager who then prioritises and organises a time to visit

# ED Pilot results summary

- 324 clients screened during project.
- 143 clients were recruited to TRAAC post ED
- 67 clients were recruited through this new process
- Effectively doubling the capture of appropriate clients at the ED access point
- These results demonstrated the effectiveness of this role in increase recruitment to TRAAC

# ED Pilot results summary

## The positive outcomes identified by TRAAC staff

- Increased identification of 'Clients that don't want to be found'
- Recent medical review
- Easier to engage as contact seen as an extension of the hospital presentation
- Comprehensive handover of information enhancing continuity of care

# Result summary



- The risk factor tool used in the pilot was shown to include statistical predictors of whether a client is a suitable candidate for TRAAC

## Frequency and percentage of client risk factors

(\* indicates statistically significant)

|   | Frequency | Percent |
|---|-----------|---------|
| Chronic medical condition/s such as stroke, arthritis, diabetes, cardiac, respiratory & neurological conditions | 234       | 72.2    |
| New medical issues  | 167       | 51.5    |
| *Person lives alone   | 133       | 41.0    |
| Condition/s have become progressively worse over the last month   | 123       | 38.0    |
| *Problems with balance, transfers and falls within the last 3 months  | 123       | 38.0    |
| Experiencing pain   | 118       | 36.4    |
| *Client anxiety or stress   | 90        | 27.8    |
| *Carer difficulties   | 72        | 22.2    |
| Concerns with taking medications  | 55        | 17.0    |
| Confusion/memory or behavioural problems worse over past 3 months   | 44        | 13.6    |
| *Concerns with self-care over the past 3 months   | 43        | 13.3    |
| Has experienced mental health issues or depression in the last 12 months  | 24        | 7.4     |

# Carer study Jan '06

## *Examples of comments from clients that had carers:*

- ***Re: Feelings when TRAAC got involved...***
- *"Absolute relief – here was someone who knew the system and could guide you with the options. For me it was about learning of other services and someone who can give information about linking in. This specialist expertise also provided increased time management for me."*
- *"I was greatly relieved – straight away the case manager caught on to the situation between me and my Mum"*
- ***Re: Understanding of what the service was trying to do....***
- *"Yes – case manager explained it beautifully and also sent a package of comprehensive information to me about what we discussed in the mail."*
- *"I had no idea initially but once I spoke with the case manager it was clear what she was trying to do."*
- ***Re: Did you feel that you could ask questions at this early stage.....***
- *"Yes – case manager was very open to questions from my aunt and to myself."*
- *"Yes but I was a little overawed at first and didn't."*
- *"Yes – the case manager was very comforting and understanding of my situation. case manager made me feel quite comfortable so I could spill my guts".*

# Results – TRAAC

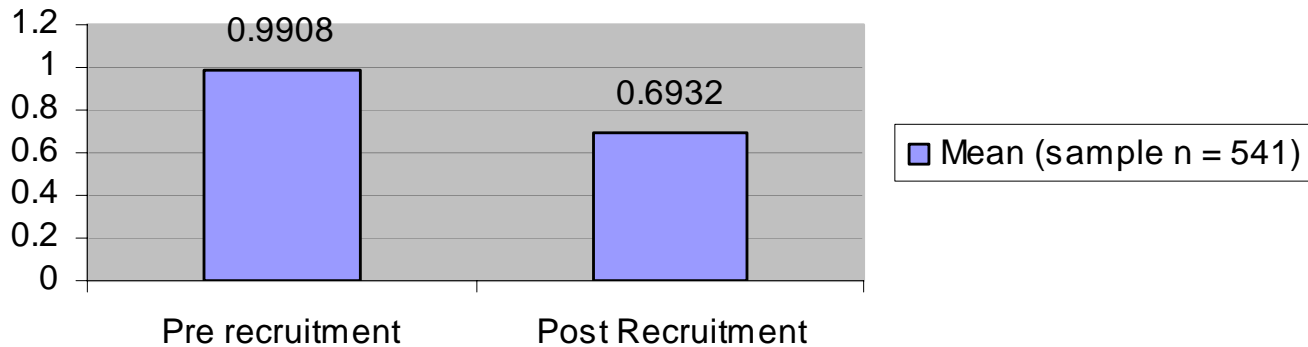


|        |                                  | Mean   | N   | Std. Deviation |
|--------|----------------------------------|--------|-----|----------------|
| Pair 1 | ED presentations pre program     | 0.9908 | 541 | 1.51960        |
|        | ED presentations post program    | 0.6932 | 541 | 1.41753        |
| Pair 2 | Hospital admissions pre program  | 0.7116 | 541 | 1.23154        |
|        | Hospital admissions post program | 0.4935 | 541 | 1.03747        |

# Results – TRAAC



## Emergency Presentations



## Hospital Admissions



# Results – TRAAC



|        |  | Paired Differences |       |                 |   | t      | df    | Sig. (2-tailed) |        |
|--------|--|--------------------|-------|-----------------|---|--------|-------|-----------------|--------|
|        |  | Difference in Mean | SD    | Std. Error Mean | 95% Confidence Interval of the Difference |        |       |                 |        |
|        |  |                    |       |                 | Upper                                     |        |       |                 | Lower  |
| Pair 1 | ED presentations pre program – ED presentations post program       | 0.298              | 1.622 | 0.0697          | 0.1606                                    | 0.4346 | 4.267 | 540             | >0.005 |
| Pair 2 | Hospital admissions pre program – Hospital admissions post program | 0.218              | 1.340 | 0.0576          | 0.1049                                    | 0.3313 | 3.785 | 540             | >0.005 |

# Summary

- Statistically significant reductions in hospital utilisation were in the post recruitment phase supporting the hypotheses that TRAAC interventions do successfully help to reduce ED presentations and hospital admissions.

# What's Next?

- Develop effective interface processes with nearby HARP-CDM services to ensure that clients receive the 'right care in the right place' and are not affected by catchment area issues
- Explore additional recruitment and access points for development i.e., Outpatients clinics and sub acute care access points
- Developing direct access to hospital information for our Community based case managers and communication of their information back to the hospital
- Reviewing past clients whose care plans are most likely needing a 'tune up'