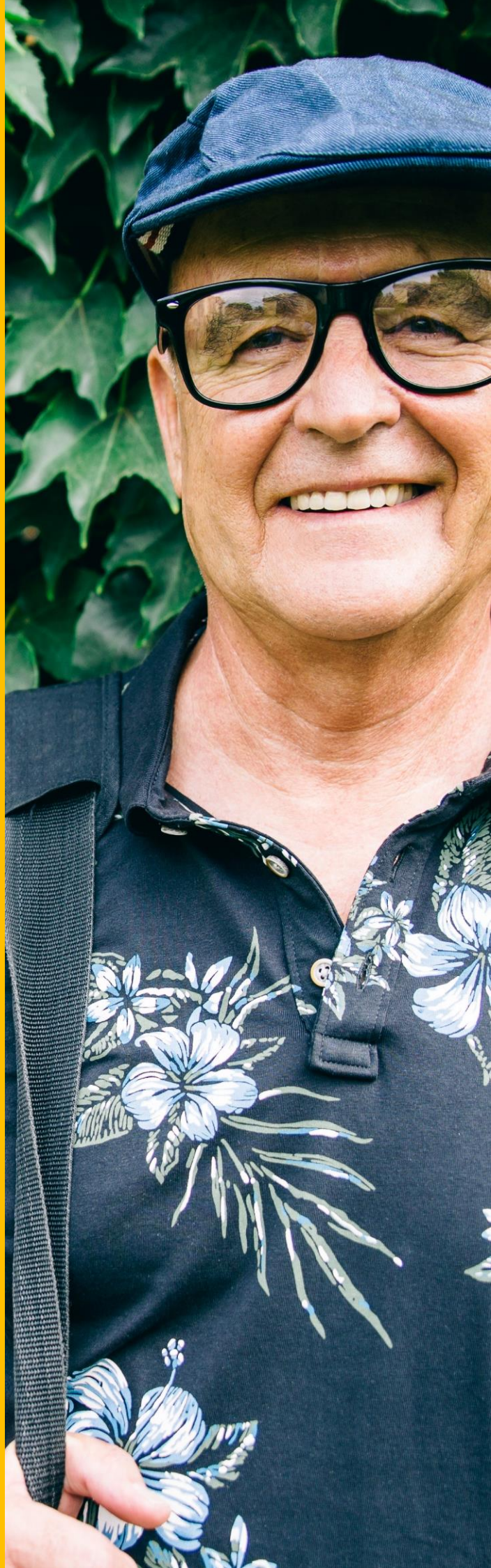
The Plug-in.

STAAR-SA

Work Package 2 – Qualitative review and client input on out-of-hospital outreach services

Key Insights Report



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State Action on Avoidable Rehospitalisations and Unplanned Admissions (STAAR): and Integrated Knowledge Translation project across SA, is funded through Medical Research Future Fund Rapid Applied Research Translation grants. The Plug-in is a research partner of the consortium delivering the STAAR-SA project which aims to understand and improve the pathway of older people being discharged from hospital and their integration back to living in community, with a view to reducing hospital readmissions. This report is part of Work Package 2 and outlines client feedback and insights from qualitative interviews conducted February to July 2021 with clients, and/or family members and carers, of out-of-hospital outreach services in metropolitan Adelaide.

1. Executive Summary

The State Action on Avoidable Rehospitalisations and Unplanned Admissions: an integrated Knowledge Translation project across SA (STAAR-SA) is working to reduce unnecessary hospitalisations in frail older people by unpacking client experiences within the complexities of South Australia's health and care system. Services and evaluation criteria differ across Local Health Networks (LHNs). Understanding the experiences of recipients of these services is key to understanding which types of services work best, and what standardised reporting would be useful for monitoring and facilitating successful integration back to community living and avoiding unplanned readmissions to hospital.

To investigate the consumer experience, The Plug-in conducted qualitative interviews with clients and/or family members and carers who received out-of-hospital outreach services within the previous 12 months, from selected services in the Northern, Southern and Central Local Health Networks (LHNs). Participants of this research were aged 65+, had been admitted to hospital within the previous 12 months and were at risk of readmission, and had accessed an out-of-hospital community outreach service via a referral. The Plug-in conducted a total of eleven (11) qualitative interviews with clients, and/or family members and carers, from February to July 2021.

The findings confirm the importance of out-of-hospital services in improving the integration of frail older South Australians back to community following hospital admissions. While health and care for older South Australians can be fragmented, and the options for ongoing care services overwhelming, the community outreach services provide support and guidance for individuals who are often vulnerable and at high risk of readmission to hospital.

Overwhelmingly, each service was highly valued by clients and/or family members and carers. Key themes emerged around a skilled workforce that can be trusted, is personable and caring, knowledgeable about processes and services, and balances client and family goals with health outcomes. Participants highlighted the importance of a single-point-of-contact in the continuity of accurate information and follow up. From the perspective of participants, there

was a disconnect between acute care in hospital, and the holistic support offered by each of the out-of-hospital services.

Participants had different complexities, however most described similar vulnerabilities when being discharged from hospital back to home and expressed immense relief to be linked to an out-of-hospital service in the weeks/months following discharge. Commonly, participants explained feeling overwhelmed by different services available to assist in rehabilitation, support to continue living at home, or assessment to determine whether returning home was possible.

The insights from participants highlights the importance of community-based outreach services for older South Australians to successfully rehabilitate and transition back to living at home with the right supports in place to avoid readmission to hospital. The information gained through this research has high relevance for clinicians, program managers, general practitioners, clients and their families, about the quality and performance of these services. It will inform quality of care and quality improvement processes and facilitate a broader understanding of the effectiveness of the selected out-of-hospital care services from the perspective of older South Australians who use these services. It supports and adds value to the economic evaluation component of STAAR-SA and will feed back into the overall STAAR-SA workplan.

Strengths of service

- Highly skilled workforce
- Single-point-of-contact
- Advocacy for older people

Qualities of Staff

- Personal, caring and empathetic
- Honesty and trust
- Enabled to go above and beyond expectations

Possible improvements

- Sense of control
- Clarity of service delivery
- Transparency of processes
- Consistent messaging
- Identifying areas of concern and follow up

2. Background

The State Action on Avoidable Rehospitalisations and Unplanned Admissions (STAAR): an integrated Knowledge Translation project across SA (STAAR-SA) aims to improve the pathway of older people being discharged from hospital. There is evidence about strategies to improve older clients' experiences of hospital discharge and reduce readmissions, however this is not implemented systematically across South Australia (SA). Data linkage and the Register of Older South Australians (ROSA) is being used to untangle the matrix of South Australia's out-of-hospital services and assess the strengths of different services for different groups of patients.

STAAR-SA is led by Professor Maria Crotty from Flinders University and a consortium of research partners, including COTA SA, and funded through a Medical Research Future Fund Rapid Applied Research Translation grant administered by Health Translation SA. It leverages ROSA's wide collaborative network of aged care providers, clinicians, researchers and clients.

STAAR-SA includes 3 major metropolitan hospitals, 3 Local Health Networks, regional Local Health Networks, clients, and has the commitment of leading international and local researchers. It is split into three (3) work packages and focuses on older people who are particularly vulnerable to admission/readmission.

As part of Work Package 2 of STAAR-SA, The Plug-in conducted qualitative research with clients to understand recent experiences within three (3) outreach services that had been identified across Northern, Southern and Central Local Health Networks. Participants were 65+ years, hospitalised within the previous 12 months, and were recruited by key contacts within each service. In situations where a client had limited ability to participate, interviews were conducted with family members and/or carers. The Plug-in managed all ongoing communications, interviews, and research. Eleven (11) interviews were conducted between February and July 2021.

This report highlights key insights from clients, family members and/or carers of community outreach services, and complements work being undertaken to evaluate the cost-effectiveness of the selected out-of-hospital outreach services. This will help to provide a more rounded picture of SA's current out-of-hospital services.

3. Service Overview

Three (3) out-of-hospital community outreach services were selected for evaluation:

+ **Multidisciplinary Community Geriatric Service** (MCGS) from the Central Adelaide Local Health Network (CALHN)
+ **Community Geriatric Evaluation and Management** (GEM) Service from the Northern Adelaide Local Health Network (NALHN)
+ **Residential Care Outreach Team** (RCOT) from the Southern Adelaide Local Health Network (SALHN)

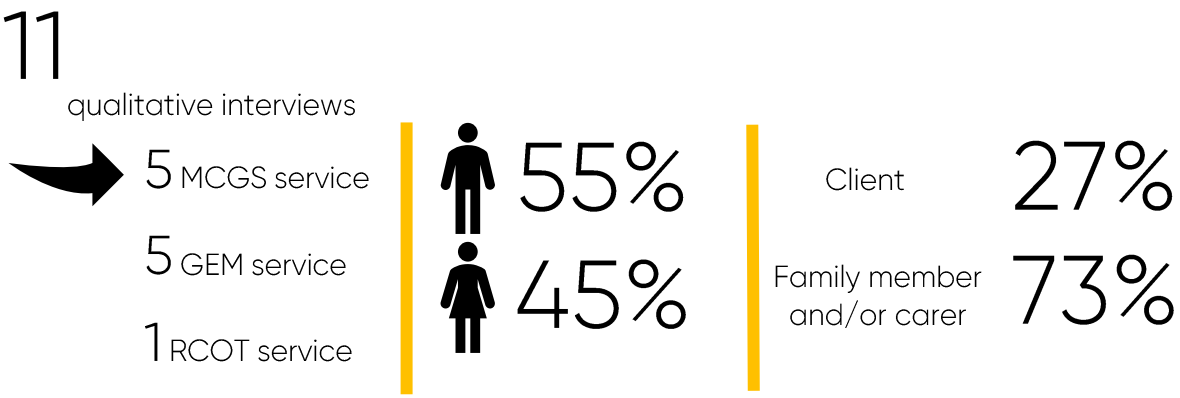
Two (2) of the three (3) out-of-hospital community outreach services – MCGS and GEM – have a similar offering, providing short term comprehensive multidisciplinary assessment, intervention and care planning for complex frail older people. A single-point-of-contact (SPOC) liaises with the client, family member and/or carer. These services are initiated through referrals and target individuals who live within the community, have limited supports, and are at high risk of readmission to hospital. Services include but are not limited to the provision of current information, connections to community services, geriatric assessment, occupational therapists, physiotherapy, and social workers.

RCOT is a Geriatrician-led medical team and works to help avoid the admission of residents of aged care facilities to hospital where possible. A Nurse Consultant based within the Flinders Medical Centre Emergency Department provides a single-point-of-contact (SPOC) for residential aged care facilities who require support to determine if a resident should be transported to hospital, and advice on what alternative care options may be available.

4. Research Design

To gain an in-depth understanding of each of the outreach services, 5-7 interviews of clients and/or family members and carers were planned to be conducted per service. Interviews were semi-structured and allowed for free-flowing conversation to understand each participant's circumstance and experience within the service; what worked well, and what could be improved. All interviews followed the same discussion guide, designed to allow participants the freedom to discuss their individual circumstances and interactions with the service. Participant Information, Consent Forms, and Interview Guides were prepared and received ethics approval.

In total, eleven (11) interviews were conducted by phone, each audio-recorded and transcribed. Of those interviews, only one (1) was conducted for the RCOT service in Southern LHN due to pressures within the health and care system which restricted the recruitment of participants by SALHN staff.



5. What we discovered

The three (3) outreach services reviewed across metropolitan Adelaide are run independently of each other, however, the research findings identified key themes across the services.

For the two (2) community-based outreach services, there is a clear relationship between the expert skillset and personal characteristics of staff that leads to a very high satisfaction with the out-of-hospital experience for clients and their family member(s) and/or carer. At a time where a critical health event has led to the admission of an older person to hospital, discharge back to community commonly increases apprehension about how the individual will manage. Some participants described a desire to return home, while others did not feel ready. Regardless, most participants expressed relief to be linked to advice and health services while transitioning back to community living or awaiting assessment and transition to temporary or permanent care.

While the target client group is residents of aged care facilities, the RCOT service insights were consistent with the community-based outreach services. Having a key contact to help guide the care of clients and minimise the need for admission to hospital, reduced confusion and anxiety over the management of client health. Being able to bring alternate care options into the residential facility (such as palliative care) instead of transportation to hospital, provided security, comfort and continuity of care for the individual and family. From the family and/or carer perspective, this approach limits the physical and mental decline experienced by individuals once admitted to hospital.

The following section details the findings from the qualitative interviews, detailing participants experience of the out-of-hospital services. Project participants have been de-identified and pseudonyms used for the purposes of this report.

5.1 Strengths of the service

When discussing their experiences, most participants expressed a sense of relief to be in regular contact with one person who knew about their particular situation, and who had invaluable knowledge of My Aged Care, rehabilitation and outreach services, to be able to support them at home. For a couple of participants, the situation was highly complex and involved the South Australian Civil and Administrative Tribunal (SACAT) or issues with elder abuse. Having someone available who was an expert to help navigate services and outcomes, helped clients and/or family members and carers to cope with significant life events.

+ Highly skilled workforce

The MCGS and GEM community-based outreach services are each staffed by a multidisciplinary team where a client is admitted under the care of a specialist geriatrician. Several participants compared hospital care to the community outreach service, believing the latter to be informative and helpful. The outreach service teams are staffed by highly skilled medical professionals, however participants felt their approach differed from acute care, and was not limited by process and procedures in the same way. On the experience within hospital, Pauline said:

> *"The delirium was quite constant and it was presenting itself in wandering behaviours …. They said to me, 'She's not compliant. She doesn't want to do what others are saying,' and I said, 'Well, actually, that should be a strength.' I would say, 'Yes, my auntie is very strong-willed. So perhaps instead of thinking she's non-compliant, is it because she's feeling her privacy's invaded? Because she went from being at home to having a one-to-one nursing care in the hospital'."*
>
> ***Pauline, legal guardian***

Within acute care, information could be hard to obtain and it sometimes appeared that the best interest of the client was not be aligned to hospital targets, leading to early discharge or discharge with little information. Family members and/or carers, found it difficult to obtain consistent information within the hospital setting. In contrast, the out-of-hospital outreach service provided both medical support and social support, was easy to contact, and therefore critical to clients and family members and/or carers to successfully integrate back to living independently at home where possible.

Being connected to experts who 'know their business' helped participants feel supported. Knowledge was as important as the approachability and caring attitudes of staff on the team.

> *"…in my situation with everything that's going on with my dad, I mean that's an enormous relief to have someone who has inside knowledge of aged care and …. of his conditions and things like that."*
>
> *Erin, family member*

Several participants were overwhelmed on discharge from hospital or rehabilitation and expressed immense relief to be connected to a team of people passionate about enabling the client to remain as independent as possible at home. From the family member and/or carer perspective, transition to home could feel overwhelming when trying to balance emotional and physical support to the patient and investigate what types of services were needed. To be connected to a service designed to support return to home with the right services in place provided relief and assurance.

+ Single-point-of-contact role

The Single-point-of-contact (SPOC) held a revered position within the teams. This type of role and the personal attributes of that individual is a major contributing factor to satisfaction with service. Most explained that knowing how to contact the SPOC, and their knowledge of individual circumstances was greatly appreciated and a standout of the service experience. In a couple of instances, participants explained there was a break in continuity of the SPOC which didn't necessarily hinder services, but advice may slightly differ; this speaks to the success of the role in contributing to satisfaction with the service.

When facing decisions about care provision, having a knowledgeable touch point to discuss circumstances and provide current information about services provided reassurance and support to people making decisions about care options.

> *"For me, in this whirlwind that was super useful that I had a 'one stop shop' if you like, who really knew their business, you know? Really knew aged care and knew dementia, and knew what new carers might be going through. And just having spoken with lots of non-government services, or trying to find different things, trying to piece it all together, up until that point it had been really piecemeal for me."*
>
> *Pauline, legal guardian*

+ Advocacy for older people

Many participants highlighted their lack of knowledge of outreach services to assist with transition to living independently at home and could not praise the service highly enough. Although entry to the service is through risk assessment during a hospital admission or GP referral, several participants expressed a view that while the health care system can be subject to public scrutiny, programs like these provide reassurance that the ongoing health and care of older people is a priority and should be more widely publicised and celebrated.

> *"… It just seems a shame the general community don't know about them. You know? I tell everybody, and I think now I'm familiar with the term Community GEM, and I'd never heard of them before, you know… it's a shame that we don't know how much good is out there to benefit people, you know? It's very easy to criticise the medical, the situation, the hospitals, and can easily gripe, but my goodness there are so many dedicated people and so many of these services that benefit so much…. And yes, it's good that you don't know about them because you haven't needed them which is good in one way, but it's a shame that the community in general doesn't know about them and get credit… credit be given to whoever sets them up."*
>
> *Georgina, family member*

Chris reflected on a previous hospital discharge when discussing his recent experience and connection to the community outreach service. He was surprised the service existed and was very happy to be connected to the service to help him adjust to living back at home.

> *"Well, as I said, I've never – when I had my stroke 22 years ago, all of these things didn't exist. You were simply put in a taxi and sent home and there was no follow-up to it. And I've never had a single day follow-up to that stroke in 22 years. So the fact that these things existed when I went in to hospital four months ago was a total shock to me because I'd gone 22 years not knowing that they exist. As I've said, they didn't exist 22 years ago. So, I didn't know what to expect from them and what I did get took me by surprise simply because I wasn't expecting it, didn't know what to expect, and quite happy that it happened anyway."*
>
> *Chris, client*

For a client and family member of the RCOT service, respect, and ability to stay within the residential aged care facility that the client was familiar with instead of a clinical environment reinforced a sentiment of best practice and genuine care at a difficult time.

> *"And I know towards the end, they – she needed almost one-on-one care for a week or two. I know the RCOT helped cover that cost as well as [residential aged care facility]. Everything that happened was – seemed to be well-constructed and thought-out and everybody just did their jobs as it was meant to be. I don't know enough about the system to say if you can improve it or not because what I saw I thought was good."*
>
> *Jude, family member*

"I felt they had Auntie Tammie in their mind when they were talking with me. So I felt not only did they have me in mind and supporting me but I believe that they were thinking the best for what they could do for her, and I think that is pivotal but what I found, sadly is that it's rare."

Pauline, legal guardian

5.2 Qualities of staff

Participants were quick to provide their feedback and praise for the staff of the outreach services. All the described qualities of the staff follow a person-centred care approach, something the participants highly valued. Qualities were focused on being personable, caring, empathetic and honest. Additionally, participants observed staff operating autonomously to find the best outcomes for their specific circumstances, rather than being restricted to only working within a set of guidelines.

+ Personable, caring and empathetic

  Participants all observed that the staff appeared to really care about their work and their clients and took time to thoroughly explain processes. Several participants were emotional recalling their experiences, with some explaining connections with the service being like a counselling session. The caring attitude of staff seemed to directly correlate to a sense they would go the extra mile to get the best possible outcomes for clients.

  > *"Well, look, without her, I would've gone mad. …. She treats you on the same level. …. She knows how to communicate with people. She's a lovely person."*
  >
  > *Deborah, client*

+ Honesty and trust

  Honesty about processes and information led to trust in the service. People within the team, particularly the SPOC, were upfront about their knowledge and if they didn't have the answer, were honest about needing to conduct further research.

  There was a shared perspective among most participants that people working in the team consistently went above and beyond to build rapport and achieve the best outcome possible for clients. One family member described the efforts of a team member in developing a trusted relationship for her aunt as being critical and pivotal to getting much needed medical attention in a highly complex situation.

  > *"…[Lucy] came into her house with no judgement. …. She kneeled down on the floor and looked after Kirsty's legs in the dark because there's no lights, they had to go and get torches and stuff. …Lucy didn't come in and tell her that her house was disgusting or, you know, she didn't show any kind of reaction to the living conditions.*

She was so respectful and made Kirsty just feel so comfortable and not so embarrassed, 'cause she's actually mortified. I mean, she really was mortified of that house she was living in. I realise that now. It wasn't stubbornness, it was shame, but that Lucy was able to crack through and make her feel comfortable and not judged was a huge thing. Huge."

Natalie, family member

+ Enabled to go above and beyond expectations

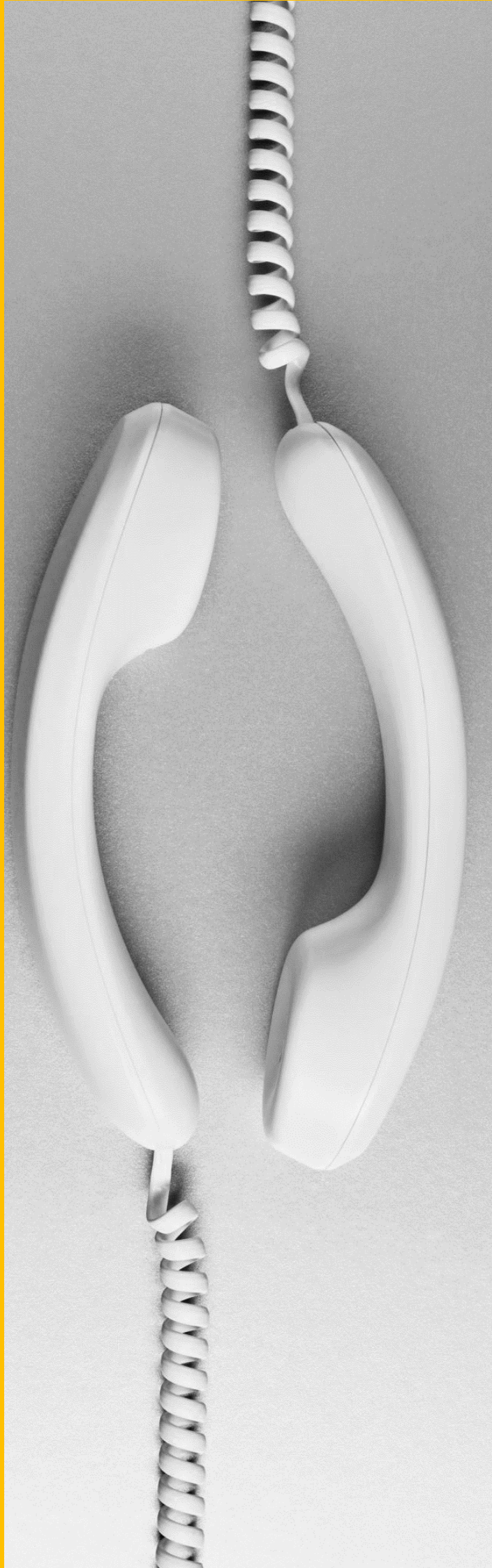
There was a strong sense among participants that staff on each team are genuine and care deeply about the best outcome for clients. This is not 'just a job' where people operate within a set procedure, but rather a team that operates autonomously with an ingrained desire to help their clients in any way they can. One participant mused that the leadership had to enable the team to be flexible to work outside of set procedures, and explained:

"They got together and got [the Geriatrician] on board and they wrote a four-page letter in support of my Mum getting her Visa case reviewed earlier. That's in no manuals. The manual provides the quality of service. It guarantees that the minimum set of things are going to be delivered in a specific way so that the bare minimum is delivered. And as I said this is where I said other services stop because they are allowed to be complacent… 'I've done my part', whereas this service, these guys, they have a completely different attitude. They know 'our job is not to tick the boxes. Our job is to care. A checkbox is just a framework to make sure we don't omit something… that we don't skip something unintentionally. It is not a feeling, it is a flaw. And our job is to care, so let us care.' And care… is in the heart, and it is in the attitude, and it is in the culture."

Amos, family member

"Other services stop where the manual stops… These guys do have a manual, but this is their starting point… First of all, I received two phone calls from two of the four people after she was discharged, and they questioned 'How is your mum?' And do you know what? When I hear 'How is your mum?'… somebody verbally saying 'How is your mum?', then they non-verbally say, 'I care about what I do. And when I care, I deliver'."

Amos, family member



5.3 What might work better

Overall, there was high satisfaction with the services reviewed. Most participants could not think of ways to improve the service. A couple were able to share aspects of their experience that weren't as satisfactory. The following examples may or may not be able to be improved but are important to note as part of the client and or family member/carer experience.

+ Establishing a sense of control

  One participant found some of the services frustrating, almost an invasion of privacy as she felt she didn't need that kind of help, for example, having someone come out daily to ensure medication was being taken. This may not have been avoidable in the particular circumstance, but perhaps the way that service was delivered may have helped it feel less like 'big brother' and would have helped her feel more in control of the situation.

  > *"Well, I kept saying it but eventually I said, 'Look, no that's it. I don't need that'… someone wasting their time coming in your house, watching you take medication."*
  >
  > *Deborah, client*

+ Clarity of service delivery

  A couple of participants who were direct clients of the service found it hard to identify where some of the services they had received at home linked together. This may be a result of being unwell or overwhelmed by different people coming into the home, or in some instances related to underlying health conditions.

+ Transparency of processes

  One participant, described a complex situation with their family member and had been working with the out-of-hospital outreach service and the Aged Care Assessment Team (ACAT) assessor with the goal in mind for the patient to return home. Late in the process, they discovered the assessor for the outreach service was the same assessor who worked for the hospital. This was upsetting and it felt like a significant conflict of interest as the acute medical perspective drive is different, and not in the interest of the outcome the family were working towards at that time. The ACAT assessor's recommendation was that the patient needed to go into full time care. In retrospect, it was the right call, but the way it came about did not feel right – they felt that this information should have been disclosed. On the ACAT assessor, the participant said:

"So I believe that she's in the same team as the person that I'd had such a great experience with, but I don't even know if those two have talked and if the two stories ever lined up, and what that would have meant in terms of service delivery, I'm not sure."

Pauline, legal guardian

+ Consistent messaging

Another participant explained that conflicting information was unsettling in a particularly difficult situation of a family member whose home was unsafe to return to. Over time, this participant was extremely satisfied with the outcome for her family member, but found the early stages of the process tumultuous.

"I did get a few different things like I get a response of 'Oh, no. We can't let her go back home. We need to do something to stop it,' and then the next day, I'd be told, 'Oh, there's nothing we can do to stop her if they're going to release her, that's – we have no legal power to stop them from doing that.'"

Natalie, family member

+ Identifying areas of concern for clients, and follow through

One client explained they had discharged themself from hospital over the need to sort out an ambulance bill that they felt pressured to pay. This discharge led to several falls and readmission to hospital, whereas if help had been provided to the client to resolve the problem while in hospital, he wouldn't have self-discharged and the subsequent falls may have been prevented.

"And then they got in touch with me when I was released. And then after that, I've taken several falls – all the result of me getting out-of-hospital when I shouldn't have done all that time back here, back home – had no choice at the time because... my ambulance fees were due the very week I was in, and if I'd stayed there another couple of days, and I couldn't have gone to the post office to pay my ambulance. And when I got out-of-hospital, I wouldn't have been covered for anything. And that was just one of the things that week that forced my hand into coming home when I really shouldn't have done. But even though somebody from GEM at the hospital said – oh, it may have been a doctor, I don't know – 'We can make arrangements for this.' Nobody ever came back to me over it. And I was getting desperate to get out to pay this ambulance fee... to cover myself.

Chris, client

6. Next Steps

These insights provide a client perspective and compliments the cost-effectiveness evaluation of the three out-of-hospital programs selected for this project. Such services are important in bridging gaps for individuals and helping the transition back to community living and avoiding hospital readmission.

Although these particular services are provided on a risk basis and not widely available for all older South Australians, for consumers, it is important to be aware that community services, such as the three evaluated in this report, exist. Awareness of programs and services to help transition out of hospital can proactively be sought and discussed with medical professionals such as General Practitioners.

The STAAR-SA program continues to evaluate data and services to reduce avoidable hospital admissions and build improved models of health care and transition from hospital to home for older South Australians

The information collected from this project will be fed back to each respective out-of-hospital service and included more broadly in the outcomes of the overall STAAR-SA program of work. The information will be considered in relation to the health economic component of Work Package 2 of STAAR-SA, so that a more complete picture is presented in the findings.

7. Acronym Reference

Patient	used in the context of a person in acute care
Client	used in the context of a recipient of a community-based outreach service
Participants	used in the context of referring collectively to patients, clients, family members, and or carers interviewed for this qualitative research
CALHN	Central Adelaide Local Health Network
NALHN	Northern Adelaide Local Health Network
SALHN	Southern Adelaide Local Health Network
STAAR	State Action on Avoidable Rehospitalisations and Unplanned Admissions project
ROSA	Register of Older South Australians
MCGS	Multidisciplinary Community Geriatric Service
GEM	Community Geriatric Evaluation Management Unit
RCOT	Residential Care Outreach Team
SPOC	Single-point-of-contact

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