SHARED TRANSFER OF CARE

Guidelines for Shared Transfer of Care

primary health TASMANIA

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An Australian Government Initiative

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www.primaryhealthtas.com.au

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Endorsement

Primary Health Tasmania has invited health and education organisations, professional associations and community services to advocate and support this initiative to improve health outcomes for all Tasmanians. The following executive leaders and peak bodies have endorsed the *Guidelines for Shared Transfer of Care*.

To express your support for this initiative, please register as an endorsing organisation. Information on how to register is available on the Shared Transfer of Care web page at **www.primaryhealthtas.com.au**.

Department of Health and Human Services
Michael Pervan, Secretary

Aged & Community Services Tasmania
Darren Mathewson, Chief Executive Officer

Alzheimer's Australia Tasmania
Tony Reidy, Acting Chief Executive Officer

Australian Nursing & Midwifery Federation, Tasmania
Neroli Ellis, State Secretary

Calvary Health Care Tasmania, St John's Campus
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Tasmanian Council of Social Service Inc.
Kym Goodes, Chief Executive Officer

University of Tasmania, Faculty of Health
Denise Fassett, Dean

SHARED TRANSFER OF CARE

FOREWORD

Welcome to Primary Health Tasmania's *Guidelines for Shared Transfer of Care*.

We know that transfers of care within and between health and community services are linked with adverse events and disruptions in the continuity of care.

The *Guidelines for Shared Transfer of Care* will provide people working in health and community service with practical, evidence-informed strategies that will contribute to service system strengthening and improve health outcomes.

The *Guidelines* are conceived for the benefit of users of health and community services. They are not a blueprint which can be applied without taking into account the context; rather, they are recommendations that providers and organisations should consider in developing their own shared transfer practices.

We can all contribute to their successful implementation through advocacy and policy dialogue, and ensuring that we as individuals participate in care that is shared.

We thank the many providers, services and organisations—public, private and non-government—who have participated in the development of these *Guidelines*. Your collaborative efforts have ensured their relevance and applicability to support the building of a coordinated, integrated, effective primary care system.

Phil Edmondson, CEO
Primary Health Tasmania

Effective transfers of care are professional, integrated and supportive. They allow us to move safely through the different levels and types of services in our health system.

Transfer of care between services is complex. This interface presents a point of preventable safety risk to people and their carers.

These *Guidelines for Shared Transfer of Care* provide useful strategies to streamline the existing practices and processes within our system.

For health consumers, they promote a way of working that involves people in shared decision-making, and a more active partnership role in managing their health needs.

For health providers, the *Guidelines* foster a culture of collaboration and provide practical methods to improve integration between services.

The Tasmanian community as a whole will benefit from the recommendations contained in the *Guidelines for Shared Transfer of Care*.

All Tasmanian health and community service providers are urged to rigorously adopt and adapt the *Guidelines for Shared Transfer of Care* to ensure better health and better health outcomes for all Tasmanians.

Michael Pervan, Secretary
Department of Health and Human Services
Tasmanian Government

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"Elsie has a hard time remembering things, but every time that Elsie sees a clinician, she's expected to retell all the details of her medical history. Her family find it difficult to get information."

ELSIE'S STORY

Elsie, eighty-seven, was living independently in a unit complex attached to an aged-care facility.

Apart from some domestic assistance every two weeks, she was completely self-sufficient. She was socially connected to her local community and still driving her own car, but suffered from heart disease, short-term memory loss and severe osteoporosis. Because of the osteoporosis, she needed a total hip replacement.

After the operation, her cognitive impairment became more apparent, and she struggled with any instructions or new information. While still in the hospital—and with no family present—she was assessed for on-going home care. When her daughter visited, Elsie asked her to interpret the information left behind by the service provider. To Elsie, the three brochures the service provider had left were "meaningless" and "double Dutch". Elsie described her hospital stay as like "being in another world".

In the hospital, Elsie was taken off the heart medication (the white pill—as she described it) that she'd been taking for the last thirty years. She was told to see her GP about this. Her family arranged for Elsie to see her GP one week after discharge, but the practice had not received any information about her hospital stay, the medication changes or the care plan.

Unfortunately, this lack of communication continued. Over the next eight months, Elsie had twelve more interactions with health sector organisations, each one requiring a new assessment, with Elsie or her family having to repeat the same story over and over. When the family were not present, Elsie's declining cognitive function meant that the details she provided were often fragmented, with important snippets of information forgotten.

It was only toward the end of this period that health providers began to actively review previous assessments and consult with each other.

Elsie's family included medical professionals who were ready to support and advocate for her. But even though they had an understanding of the health system and the services available, they were not able to prevent Elsie's repeated assessments, being told that these were procedural requirements of the organisations.

All of the clinicians involved in Elsie's care had good intentions and supported her where they could, but all were bound within their organisational processes. In one incident, for example, Elsie had a fall while out in the community. The paramedics who attended were very supportive in picking her up and assessing her condition. They patched up some broken skin and drove her home when she said she did not want to go to hospital.

However, there were no established systems in place for them to alert other services or family members, and not having a full history, they were unaware of Elsie's declining cognitive functioning. Elsie's family only found out about the incident when they later discovered her unconscious on the floor, and took her to the hospital emergency department. Elsie was eventually admitted to an aged-care facility, where she resides today.

This story is not about apportioning blame, but is an example of how our health system is failing many older Tasmanians.

Imagine how Elsie's experience and outcomes would have been improved if:

- there had been adequate information provided after the hospital visit
- clinicians contacted each other to discover the story
- Elsie required only a single assessment which she could share with all providers so that everyone was aware of who was involved in her care
- organisations worked collaboratively to ensure Elsie had a better coordination of care
- the family was included at every assessment.

Most of us know a story of a family member or loved one's incident in the health and community services system—or have had personal experiences. Some of us have family to support and advocate for us along our journey. However, many Tasmanians are not so privileged and have to navigate a complicated system on their own.

This is where the principles of Shared Transfer of Care will improve outcomes both for the people receiving care, and for people providing the care.

Can we do better?

What systems can we set up so that:

Adequate information is provided to consumers after time in hospital?

Clinicians can easily contact each other to share information?

Shared assessment templates are made available to all care providers?

Collaboration and coordination of care are improved?

Family are informed about assessments?

STRATEGIES, TOOLS AND RESOURCES

The *Guidelines for Shared Transfer of Care* contain a strategy for action that describes the processes to successfully implement Shared Transfer of Care with systems, teams and consumers.

The strategies are supported by tools and resources to provide users with the practical means to put Shared Transfer of Care into practice.

Material to support implementation of the *Guidelines for Shared Transfer of Care* can be found on the Shared Transfer of Care web page at **www.primaryhealthtas.com.au**.

The following icons appear throughout the text, and highlight links to topic-specific resources.

RESOURCE / ADDITIONAL READING

TOOLS

WEB LINK

STORY OR CASE STUDY

INTRODUCTION

The *Guidelines for Shared Transfer of Care (Guidelines)* are evidence-based guidelines developed to assist health and community providers achieve best practice in a person's transfer of care.

'Transfer of care' occurs when the responsibility for a person's care shifts between service providers and locations. Transfers occur regularly as a person's conditions and care needs change. These occasions of transfer are where the incidence of adverse events increase significantly, with a substantial negative impact on people and added stress to our service system.

The burden of sub-standard transfers includes:

- increased mortality and morbidity
- increase in adverse events
- delays to appropriate treatment and support
- additional primary healthcare or emergency department visits
- additional or duplicated tests
- preventable readmissions to hospital
- emotional and physical pain and suffering for consumers, carers and families
- dissatisfaction with coordination of care at the primary care—hospital interface[1]

Why are these guidelines important?

This document provides organisations with guidelines, strategies and resources to ensure the safe, effective transfer of people's care between providers in the health and community services. They outline the case for establishing a more connected, integrated system with agreed standards and shared protocols that will contribute to continuous quality improvement.

"...the right information being given and understood by the right people at the right time is key to ensure patient safety during the handover process."

Australian Commission on Safety and Quality in Health Care

Alignment with National Standards

The *Guidelines* align with national standards for service provision across a range of health and community professions and services. Implementing Shared Transfer of Care will assist organisations with accreditation processes to meet the quality and safety standards of the following organisations and bodies:

- Australian Aged Care Quality Agency
- Australian Commission for Safety and Quality in Health Care
- Australian Medical Association
- Australian Standards for General Practice
- Australian Residential and Home Care Standards
- Community Care
- Mental Health Services
- Pharmaceutical Society of Australia
- Royal Australian College of General Practitioners

A summary of the National Standards, which describes how each standard is addressed through implementing Shared Transfer of Care, is available at **Resources** on the Shared Transfer of Care web page.

Transfer of care—a shared responsibility

Improving transfer of care for individuals accessing health and community services is everyone's responsibility. If we collaborate across all sectors we can overcome the causes and consequences that poor transfers have on individuals and our service system.

Audience

The *Guidelines* have been developed for any organisation providing health and community services in Tasmania, and can be applied to transfers of care between all services. There are two main audiences:

- Governing bodies, CEOs, directors, and quality managers—those personnel responsible for the developing, approving and implementing strategies, plans and policies for their respective organisations.
- Health and community service professionals with a role in providing quality transfers of care, including
  - hospital and general practitioners/primary healthcare providers
  - hospital and residential aged services
  - primary healthcare and community service providers.

Development of the Guidelines for Shared Transfer of Care

The first version of the *Guidelines for Shared Transfer of Care* was called *Talking Points.* A solid evidence base ensured the *Guidelines* were a practical resource for system and service operators. This was developed through review and analysis of literature, policy documents, guidelines and protocols, followed by consultations with health and community sector stakeholders.

The first output from this research was *Listening to Both Sides—a discussion paper* that outlined the evidence and need for improved shared transfer of care.[2] *Listening to Both Sides* presents the research methods used, the summary of findings, and the extensive list of literature referenced in the development of *Talking Points.*

Listening to Both Sides is available for download at **Resources** on the Shared Transfer of Care web page.

At the same time that the *Guidelines* were being produced, the Australian Primary Health Care Research Institute (APHCRI) was federally commissioned to report on sub-acute care in Tasmania. The resulting APHCRI report[3] added powerful validation to the principles contained in the *Talking Points*, and the need for a set of guidelines on shared transfer of care. The APHCRI work was used in refining the second version of the *Guidelines*, published in September 2014.

This updated version of the *Guidelines* was used in familiarisation sessions throughout the sector in 2014-15. During the familiarisation process, service providers also identified the need for resources to help put the *Guidelines* into practice. In response, Primary Health Tasmania developed the following resources:

- Framework for Action
- A Shared Transfer of Care eLearning Course (in collaboration with the University of Tasmania)
- Templates, tools, and list of additional resources to support Shared Transfer of Care
- A Facilitator's Guide for Shared Transfer of Care, so that others may teach the Shared Transfer of Care method.

The Framework for Action and supporting resources have now been trialled with a range of providers in aged care, community health, general practice, and the acute/community interface. The learnings from this trial, and the evidence from an external evaluation, were used to further refine the *Guidelines* and framework documents. These two documents are now combined into the *Guidelines for Shared Transfer of Care* (this document).

The Guidelines, Tools, Resources, Facilitator's Guide and eLearning resource can be **accessed** from the Shared Transfer of Care web page.

Implementing the Guidelines

The *Guidelines* describe the principles associated with quality shared transfer of care. They are supported by strategies, tools and resources to enable implementation of Shared Transfer of Care at all levels—system, service and individual. Ultimately, the aim is for all Tasmanian health and community services to apply the Guideline's policies and protocols, thus ensuring safe, shared transfer of care across all sectors.

Many organisations have existing transfer-of-care policies and procedures; these are sometimes referred to as 'discharge policies'. Rather than 'reinventing the wheel' these organisations are encouraged to use the *Guidelines* and tools to review the effectiveness of their current policies and arrangements to continually improve Shared Transfer of Care practices.

Changes to culture and practice are challenging due to the complex nature of systems and organisations. Successful implementation of Shared Transfer of Care will require effort and collaboration within and between organisations, with all services are working towards a safer journey for people within the health and community services system.

Terminology

The term 'transfer of care' refers to the movement of a person's care between locations and providers. This term replaces 'discharge' and reflects that a person's care continues after transfer, whether to another service, facility, or to care in the community.

'Clinical handover' specifically refers to the transfer of professional responsibility and accountability for some or all aspects of care for a person, to another person or service on a temporary or permanent basis. The term 'transfer of care' is broader than 'clinical handover' as it encompasses not only the clinical aspects of care transfer, but also the views, experiences and needs of the person.

The terms 'patient', 'person' and 'consumer' are used interchangeably in the document and may also refer to a resident of an aged services facility. It is important to note that patients and residents are people first with unique needs and expectations in relation to their care.

A list of the common terms used in these guidelines is included in the glossary.

GUIDELINES FOR SHARED TRANSFER OF CARE

To achieve quality shared transfer of care, service organisations must operate in an integrated and collaborative fashion. Research in Australia and overseas confirms that improving systems and processes for shared transfer of care is challenging. Change initiatives are needed beyond simply developing another policy or mandating a new process—they must embody a cultural change.

Principles

The following core **principles** underpin the *Guidelines*, and are essential for shifting from a service-driven model to a person-centred model of transfer of care.

Person- and family-centred care. A person and their family and/or carers collaborate with service providers to receive services that place the person at the centre of their health and wellbeing.

Evidence-based, quality services. Professionals and people work together using the best available evidence and their individual expertise to make shared decisions.

Equity in access to care. Access to services and support that meet the needs of a person.

A strengths-based approach. The focus is to engage with the person to identify their capabilities and so achieve their goals.

Strong linkages and coordination across sectors. Providers work together using a coordinated and integrated approach to service delivery, with respectful communication as the key.

Interdisciplinary approach. A person receives support that involves the different services they need for holistic care.

Elements

The key **elements** are presented as five 'Sharing Points'. These Sharing Points provide the framework for quality Shared Transfer of Care and further support care that is person-centred.

Each element is followed by suggestions and recommendations to achieve best-practice.

Sharing with People

A person and their family and carers are involved in the transfer plan, which is based on the person's needs—physical, social, spiritual and cultural.

A person is supported to manage their wellbeing in their daily life.

A person is aware of transfer timeframes, key contacts and actions to take as required.

A person receives information and documentation related to their care in a format they can understand, depending on their health literacy. Providers check with the person for understanding of information received.

Sharing Accountability

2

Shared accountability between service providers and including the person, to enable a person-centred approach to care.

A person is supported to understand their condition and share responsibility for their wellbeing.

The provider initiating a transfer is available to answers questions from the receiving provider(s), the person and their family.

Roles are clearly defined, ensuring all providers and the person receiving care understand their responsibilities.

Sharing Communication

Communication (both routine and non-routine) between providers is timely and appropriate, and involves the person.

3

Agreed protocols, standardised assessment and referral templates to promote consistency and shared language and reduce multiple assessments.

Communication between providers is planned, succinct and complete, occurs prior to a person's transfer and includes processes to close communication feedback loops.

Sharing Documentation

4

High-quality documentation is shared between providers and the person, regardless of the setting.

The person being transferred has a clearly documented care plan.

Shared assessment and referral templates are clear, person-centred and free of jargon.

Information between providers is confidential and secure, but accessible to the person and includes a medication list where relevant.

Sharing Coordination

Care is coordinated, evidence-based and person-centred across sectors.

Best-practice guidelines and protocols are used across all sectors.

Where transfers of care are inter- or multi-disciplinary, there is a collaborative approach across sectors, with a focus on respectful communication.

Evaluation of coordination processes, including consumer feedback, is built into quality improvement processes.

5

STRATEGY FOR ACTION

A review of national and international initiatives found that strategies which focus on processes to improve communication and develop relationships are more likely to be successful in resolving problems associated with poor transfers of care.[4]

Three key strategies are recommended to help organisations implement Shared Transfer of Care:

1. Introduce systems and processes to support Shared Transfer of Care at a system and service level.
2. Engage with the person, their families and carers in shared transfers of care.
3. Build on communication, integration, coordination and teamwork both within the organisation and across health and community services.

Health and community services are encouraged to review their own policies, procedures and staff education programs to ensure they align with the principles of the *Guidelines for Shared Transfer of Care*.

STRATEGY 1
Introduce ways to support Shared Transfers of Care at a system and service level

Initiatives for Shared Transfer of Care should be introduced in a systematic manner which considers the complex environment in which services are delivered. The nature of working across different sectors—all going through significant reform in their own environments—means that a flexible approach should be taken.

The literature review undertaken in developing this Strategy identified that the following organisational processes most often needed improvement:

- **shared practice guidelines and protocols**
- **referral processes**
- **admission processes**
- **discharge processes.**

It is essential that these processes are reviewed at the organisational level to ensure they contribute to safe and effective transfers of care. Improvements in these areas will likely involve a number of stakeholders in a change process that is both complex and challenging. A formal change process is strongly recommended.

A 'barriers and enablers' analysis using a range of techniques to engage with clinical and non-clinical staff may assist organisations to focus their efforts. Interventions can then be tailored to address specific barriers, and capitalise on specific enablers.

Further information to manage change can be downloaded at **Resources** on the Shared Transfer of Care web page.

Organisations and individuals can influence the success of initiatives for improvement of Shared Transfer of Care through the following actions:

- establish a positive organisational environment
- lead and resource the initiatives
- create individual staff awareness and positive behaviours
- engage staff in improving transfers of care
- establish productive partnerships
- determine the outcomes
- develop effective policies, guidelines, tools and resources.

"Health systems have always been complex, messy, hard to comprehend and even harder to change."[5]

1.1 Establish a positive organisational environment

Developing Shared Transfer of Care requires specific strategies to identify and address potential barriers to implementing new processes.

The organisational environment can support or inhibit the uptake of effective practices for Shared Transfer of Care.[6,7] Leaders should assess the potential positive or negative impacts of the organisation's culture on these initiatives and foster a positive culture committed to action. Change is more likely to be supported where the reasons for change are clearly articulated, made an organisational priority and embedded in existing structures and processes.

Process and system redesign works best when the change program moves through clearly defined phases. A flexible, phased example is called the Theory of Constraints (Figure 1).

The phases include:

- defining the scope of work
- diagnosing the issues
- developing appropriate interventions
- evaluating the outcomes
- sustaining the improvement.[8]

Further information on applying the Theory of Constraints in a health care setting can be **accessed** from the Shared Transfer of Care web page.

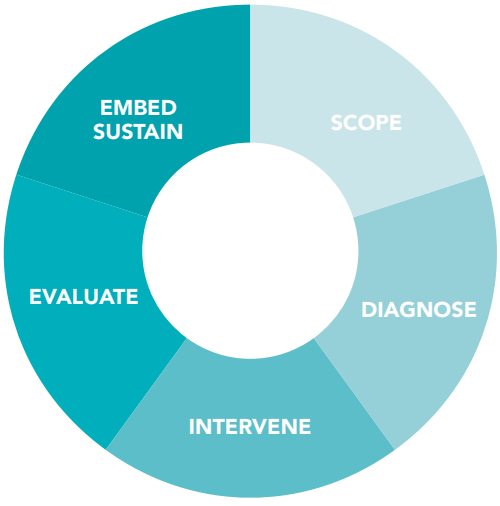

Figure 1. Theory of Constraints

1.2 Lead and resource transfer-of-care initiatives

Effective change is driven by influential people, including clinical and non-clinical leaders, key stakeholders and front-line staff. While the board and senior staff have an important role to play, mid-level managers through their leadership of groups within the organisation can either enhance or undermine an organisation's ability to implement change.[9]

The External Evaluation of the National Clinical Handover Initiative Pilot Program found that "supportive leaders also invested in dedicated project resources, such as project managers, and this was cited by a number of health service-based projects as vital for driving the project day to day."[10] Leaders of successful projects also supported the spread of initiatives through clever marketing of tools for change and success stories, and including initiatives on key safety and quality committees.

1.3 Create individual staff awareness and positive behaviours

Individual staff members must be aware of the impact of poor transfer-of-care practices. Motivation to change and behavioural routines are likely to influence the success of initiatives to improve transfers of care. Without staff acknowledgment that there is a problem with existing transfer-of-care arrangements, it will be very difficult to persuade them to invest time and energy in change.[11]

Stories are a useful strategy for strengthening the case for change amongst staff.

Consumer stories highlighting the impact of poor transfers of care can be found at **Stories & Case Studies** on the Shared Transfer of Care web page.

"Every provider needs to have a sense of personal satisfaction, every day."

1.4 Engage staff in improving transfers of care

Clinical and non-clinical staff engagement throughout the development, implementation and review of Shared Transfer of Care initiatives is critical in overcoming barriers to change. Engagement ensures staff involvement defining the broad goals of Shared Transfer of Care. This includes recognising the problems created by poor transfers of care, having opportunities to contribute to proposed initiatives, and having support to apply the initiatives to their respective work environments, including capacity-building though training and development.

Strategies that do not take into account the different culture and workforce practices of healthcare sectors are unlikely to be successful.

1.5 Establish productive partnerships

As the title **Shared Transfer of Care** indicates, quality improvement cannot be implemented in isolation of other providers, consumers and carers. The development of a quality transfer process requires a partnership approach.

Partnerships can be complex and involve people with differing expectations and motivations for being involved. However, successful partnerships can increase the efficiency of systems that have an impact on health by making the best use of different, but complementary, resources.[12]

The Partnership Quality Matrix can be accessed at **Resources** on the Shared Transfer of Care web page.

1.6 Determine the outcomes

Organisations should establish early the intended outcome of implementing Shared Transfer of Care. A focus on outcomes is essential to providing a person-centred, cost-effective system.

Outcomes are more than wanting to know about satisfaction or the process of service provision. At the centre of our care should be outcomes for the person; it is about people's *"functional improvement to live normal, productive lives."* Did we achieve the results that matter most to the individual? To measure these outcomes, we need to operate differently.[13]

Further reading on outcomes-based care can be accessed at **Resources** on the Shared Transfer of Care web page.

1.7 Develop effective policies, guidelines, tools and resources

Studies of successful change initiatives showed that staff members need to consider any new policy, guideline or tool to be feasible, credible and accessible. These projects were able to show that a new tool or process was tailored for the specific environment, was practical, and was an improvement on current practice.[14]

Tools contain sample policies, procedures and templates to support implementation of Shared Transfer of Care. The tools can be adapted to a number of different settings.

STRATEGY 2
Engage the person, their families and carers in transfers of care

There is growing evidence about the importance of partnerships between service organisations, professionals, families, carers and consumers."[15]

Organisations could undertake work in the following areas to promote the engagement of the person, their families and carers in Shared Transfer of Care:

- **Promoting a person-centred care approach**
- **Improving the health literacy environment**
- **Supporting people to self-manage**

A Partnership Quality Matrix is available for download at **Tools** on the Shared Transfer of Care web page.

"People want independence and a sense of ownership over their own health."

"We need to remember that every patient is a person."

2.1 Person-centred approach

Successful Shared Transfer of Care has the person, their family and carers at the centre of the transfer plan—assessment and planning is based on the principles of person-centred care. This care is respectful of, and responsive to, the preferences, needs and values of consumers.[16] It includes the respect, emotional support, physical comfort, information and communication, continuity of transfer, coordination of care, and involvement of family.

A person-centred approach embeds people, their families and carers at the service and system levels to inform organisational quality, service planning and design, and system-wide improvements.

Outcomes in person-centred care are the results people care about most when seeking treatment, including functional improvement and the ability to live normal, productive lives.[17]

Person-centred care outcomes include:

- appropriate medication treatment
- avoidance of over-treatment
- decreased likelihood of being hospitalised
- improved quality of life, being able to fit health needs into lifestyle.[18]

At a systems level, consumer participation in, and self-management of, chronic conditions will save significant public funds by reducing overall costs in care; reduce complaints and provide increased satisfaction. [19,20]

2.2 Health literacy

The definition for health literacy at an individual level is "the knowledge, motivation and competencies of a person to access, understand, appraise and apply health information to make effective decisions and take appropriate action for their health and health care."[21]

The health literacy environment includes "the infrastructure, policies, processes and relationships that exist within the health system. These factors can make it easier or more difficult for consumers to navigate, understand and use health information and services to make effective decisions and take appropriate action about health and health care."[22]

Organisations must develop a health literacy environment which has clear and useable health information. Staff should use effective interpersonal communication to support Shared Transfer of Care. Improving health literacy in organisations includes:

- organisational preparedness and awareness
- improving spoken communication
- improving written communication
- supporting self-management and empowerment of consumers
- strengthening systems.

Health literacy and health outcomes. Evidence indicates an association between individual health literacy, health behaviours and health outcomes. People with low levels of health literacy are estimated to be up to three times more likely to experience an adverse outcome.[23] Lower levels of health literacy are linked to a range of poor health outcomes, including increased rates of hospitalisation, greater use of emergency care, poorer ability to interpret labels and health messages, poorer knowledge of a person's own disease or condition and a higher risk of death among older people.[24]

A person's level of health literacy and the health literacy environment are significant factors which influence their capacity to actively participate in Shared Transfer of Care.

Information and processes to support health literacy can be accessed at **Resources** on the Shared Transfer of Care web page.

2.3 Self-management

Self-management is the active participation of people in managing their own health and wellbeing. It puts the person in the 'driver's seat' and enables them to choose how they want to live with their condition/s. Self-management varies between a person being the lead manager of their own care to those who are able to be involved in managing their own care with the support of resources and other people.

Self-management support is the facilities that services provide to enable people to enhance management of their own health.[25] Self-management support differs from traditional approaches to chronic disease management. Rather than having a disease-specific emphasis, it focuses on individual family support by using collaborative goal-setting and a range of self-efficacy strategies including:

- effective problem-solving
- group support
- relapse prevention plans
- shared decision-making
- lifestyle education.[26]

The characteristics of a 'good' self-manager refer to an individual's capacity to:

- have knowledge of their condition
- follow a care plan agreed with professionals
- actively share in decision-making with professionals
- monitor and manage signs and symptoms of their condition
- manage the impact of the condition on their physical, emotional and social life
- adopt lifestyles that promote health
- have confidence, access and the ability to use support services.[27]

Self-management and health outcomes. People involved in their self-management report better communication with health providers, increased confidence in their ability to navigate the healthcare system, greater satisfaction with care, better physical functioning, and reduced anxiety.[28] Supporting self-management facilitates greater person-centred care, as individuals are better able to communicate, share in accountability and responsibility for their own health, and play a greater role in their transfers of care.

These outcomes have been reported to translate into:

- changes in individual's health-seeking behaviour
- reduced demand on health service use
- reduced health care costs.[29]

Links to further reading and strategy documents to support implementing self-management initiatives are available on the Shared Transfer of Care web page.

"People want to be able to ask questions… and get answers they can understand."

STRATEGY 3
Communication and teamwork—integration and coordination

It is recommended that organisations undertake work in the following areas to improve:

- **Promoting communication and teamwork**
- **Integrating care**
- **Coordinating care**

3.1 Communication and teamwork

Poor communication and teamwork are key contributing factors to adverse events, while effective communication and teamwork are cited as critical for achieving a culture of safety to support quality care.[30, 31]

While it is generally accepted that healthcare depends upon collaboration and cooperation, the organisation and management of services does not always reflect this insight.[32] Separate departments, budgets and performance targets can lead to a focus on internal issues and promote competition, rather than consideration of the system as a whole and the needs of person receiving care.

The complexity of healthcare and the dynamics among providers creates a myriad of challenges to establishing sound practices. Health and community sector environments possess a number of systemic characteristics which inhibit effective communication between professionals.[33] For example, service providers from a variety of disciplines are involved in providing care at various times throughout the day, from different locations, limiting opportunities for communication and teamwork. In addition, most organisations have hierarchical organisational structures and power inequities which frequently inhibit open, safe communication.[34]

Effective communication, productive relationships and teamwork within and between organisations are necessary conditions to support and sustain effective Shared Transfer of Care processes. It is highly likely that poor communication and teamwork within a workplace will limit the effectiveness of initiatives designed to improve transfers of care within and between healthcare facilities.

A questionnaire that staff can use to assess if they are a high-performing team is available at **Tools** on the Shared Transfer of Care web page.

While a focus on communication and teamwork is likely to yield organisational benefits beyond improving transfers of care, the challenge of achieving such cultural change in communication should not be underestimated.[35] Organisations will need to assess the requirement to improve communication and teamwork as part of introducing Shared Transfer of Care initiatives.

"Our purpose is to never break the continuous thread of an individual's care and trust."

3.2 Integrating care

Improvement of outcomes related to Shared Transfer of Care can be achieved through system and service relationships that are based on integration during the planning of services across disciplines and across acute and community service boundaries.[36]

Integration is a coherent and coordinated set of services which are planned, managed and delivered to individual service users across a range of organisations and by a range of cooperating professionals and informal carers.[37]

The World Health Organization (WHO) argues that by adopting person-centred, integrated health services, health systems will provide services that are of better quality, are financially sustainable and more responsive to individuals and communities.[38] The benefits of person-centred, integrated care to individuals, families, communities, providers and systems are outlined in the table on the following page.

3.3 Coordination of care

'Coordination of care' refers to the deliberate organisation of care activities between two or more participants involved in a person's care to facilitate the appropriate delivery of services. Organising care involves the marshalling of personnel and other resources needed to carry out all required person care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.[39] It often implies that there is a designated person involved in the person's care whose specific responsibility is to oversee and coordinate care delivery.

Concepts associated with coordination of care involve activities at the client, service delivery and the system level.[40]

Reports on integrating care in rural and aged communities in Tasmania are available at **Resources** on the Shared Transfer of Care web page.

At the level of the client, coordination of care is person-centred care targeted at people with complex needs. It is holistic, involving social and risk assessments, shared care planning, regular reassessment, and monitoring and review across service boundaries. It includes engagement with the person and their carers to support self-management.

At the level of service delivery, coordination of care involves a cooperative, multidisciplinary primary care team with a clearly identified coordinator, defined team roles, and communication processes that facilitate timely interactions among all care partners, including service providers, clients and families. The use of evidence-based policies, guidelines and protocols underpins flexible care provision.

At the level of the system, coordination of care necessitates effective resource coordination including fund pooling, the involvement of senior and middle management, mechanisms for efficient and effective transfer of information across settings and integrated networks of organisations. This includes linkages between all components of the system, and collaboration among elements of the system.[41]

A coordination of care publication can be accessed at **Resources** on the Shared Transfer of Care web page.

Coordination of care is a key component of shared transfer of care. As communication and relationships are strengthened, they wrap around the person and ensure their quality transfers across sectors. Effective coordination of care results in better consumer outcomes, reduced complications associated with care and an enhanced consumer and carer experience of care.[42,43]

The potential benefits of person-centred and integrated services

To individuals and their families	To health professionals and community workers
› increased satisfaction with care and better relationships with care providers › improved access and timeliness of care › improved health literacy and decision-making skills that promote independence › shared decision-making with professionals with increased involvement in care planning › increased ability to self-manage and control long-term health conditions › better coordination of care across different care settings.	› improved job satisfaction › improved workloads and reduced burnout › role enhancement that expands workforce skills so they can assume a wider range of responsibilities › education and training opportunities to learn new skills, such as working in team-based health care environments.
To communities	**To systems**
› improved access to care, particular for marginalized groups › improved health outcomes and healthier communities, including greater levels of health-seeking behaviour › better ability for communities to manage and control infectious disease and respond to crises › greater influence and better relationships with care providers that build community awareness and trust in care services › greater engagement and participatory representation in decision-making about the use of health resources › clarification on the rights and responsibilities of citizens to health care › care that is more responsive to community needs.	› enables a shift in the balance of care so that resources are allocated closer to needs › improved equity and enhanced access to care for all › improved patient safety through reduced medical errors and adverse events › increased uptake of screening and preventive programmes › improved diagnostic accuracy and appropriateness and timeliness of referrals › reduced hospitalisations and lengths of stay through stronger primary and community care services and the better management and coordination of care › reduced unnecessary use of health care facilities and waiting times for care › reduced duplication of health investments and services › reduced overall costs of care per capita › reduced mortality and morbidity from both infectious and non-communicable diseases.

Modifed from *WHO Global Strategy on people-centred and integrated health services—Interim report.* World Health Organization. Geneva, Switzerland. 2015. 48 p

This can be downloaded at **Resources** on the Shared Transfer of Care web page.

CONCLUSION

In the process of developing the *Guidelines*, providers and consumers agreed that the foundational issue related to Shared Transfer of Care is a lack of communication. In adopting the *Guidelines for Shared Transfer of Care*, it is envisioned that people will experience a consistent, organised, well-implemented care experience.

The person-centered, integrated health and community system will reflect care that is SHARED. It will be a system in which the continuous thread of a person's care and trust is never broken.

Change is happening

All of us are committed to improving the health of Tasmanians through better communication, integration and collaboration.

The *Guidelines* promote a different way of working; putting people at the centre of their care, involving them in a shared decision-making process, and encouraging health providers to collaborate; sharing communication, and accountability for the transfer of care.

People, their families and carers, and the professionals who serve them want a system that supports better health outcomes for all. Shared Transfer of Care is a goal we can all have ownership over. Through implementing the principles contained in the *Guidelines*, we can work together to achieve this goal.

The Shared Transfer of Care Planning Checklist is available for download at **Tools** on the Shared Transfer of Care web page.

GLOSSARY OF TERMS

Admission	The processes, tools and techniques by which an episode of care is formally commenced by a health professional or health provider organisation involving their acceptance of responsibility for a person and/or their treatment and care.[1]
Barriers	Obstacles that may potentially prevent a quality transfer of care can be a person, a system or a process
Best practice	Practices, behaviours, systems and processes that are based on research and evidence to provide quality shared transfer of care outcomes for the consumer
Boundaries of care	The interface between care services.
Care coordination	The facilitation of appropriate service delivery for a person following assessment, goal-setting and care planning. It involves linkages with other service providers, efficient use of resources and regular review.
Carer	*The Carers (Recognition) Act* 2008 identifies a carer as an individual who provides, in a non-contractual and unpaid capacity, ongoing care or assistance to another person who, because of disability, frailty, chronic illness or pain, requires assistance with everyday tasks.[2]
Clinical handover	The transfer of professional responsibility and accountability for some or all aspects of care for a person, or group of people, to another person or professional group on a temporary or permanent basis.
Collaborative approach to shared transfer of care	A collaborative approach to shared transfer of care includes effective communication, productive relationships and teamwork within and between organisations.
Community Service	The broad understanding of the nature of community services is that they include activities that support individual and family functioning.[3]
Community Service Provider	An individual who provides community services to a person or group of people.
Consumers	Any actual or potential recipient of health care, such as a patient in a hospital, a client in a community mental health center, or a member of a prepaid health maintenance organisation.[4]

Coordination of care	A concept that involves activities at the person level, service level and system level. It helps provide high-quality care services that minimise duplication and addresses service gaps.
Discharge	The processes, tools and techniques by which an episode of treatment and/or care to a patient is formally concluded by a health professional, health provider organisation or individual.
Discharge summary	The written account of a person's episode of care within a facility. Referred to as Transfer Summary in the corresponding documents.
Enabler	People, systems or processes that support quality shared transfer of care.
Equity in access to care	Access to services and support that meet the needs of a person.
Evidence-based, quality practice	Professionals and people work together using the best available evidence and their individual expertise to make shared decisions.[5]
Family carer	A person who is providing or who has provided unpaid support and care to a family member or friend who is living with a disability, mental illness, chronic condition or terminal illness or who is frail or aged.
Guidelines	Systematically developed statements to assist practitioners and people to make appropriate decisions about health care for specific circumstances.
Health literacy	Individual health literacy is the knowledge, motivation and competencies of a person to access, understand, appraise and apply health information to make effective decisions and take appropriate action for their health and health care.[6] The health literacy environment includes "the infrastructure, policies, processes and relationships that exist within the health system. These factors can make it easier or more difficult for consumers to navigate, understand and use health information and services to make effective decisions and take appropriate action about health and health care."[7] A person's level of health literacy and the health literacy environment are significant factors which influence their capacity to actively participate in shared transfer of care

Health service	An organisation that is responsible for the clinical governance, administration and financial management of a service providing health care.
Health service provider	An individual who provides health services to a person or group of people.
Integrated care	Integrated care is a coherent and coordinated set of services which are planned, managed and delivered to individual service users across a range of organisations and by a range of cooperating professionals and informal carers.[8]
Interdisciplinary approach	A person receives support that involves the different services they need for holistic care.
ISOBAR	Effective communication at the transfer of care is important for improving patient safety and reducing adverse outcomes. ISOBAR is a clinical communication tool used widely in the health and community sector, prompting minimum information requirements to improve a person's safety, and reduce adverse events at the point of transfer. The acronym ISOBAR (identify–situation–observations–background–assessment–recommendation) summarises the components of a checklist adapted to promote effective communication.
ISOBAR SHARED	The addition of SHARED (safe-heard-agreed plan-relationships-easy information-destination) provides a person-centred approach to the ISOBAR (see above) clinical communication framework.
Medical home	The medical home refers to a model of primary care that is person-centred, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.[9]
My Health Record	A secure online summary of a person's health information. The individual supported by the primary care team controls the information entered and accessed. This enables doctors, hospitals and other health care providers to view and contribute to the record, to facilitate easy access to the person's health care information.[10]
Person-centred	A person-centred approach to transfer of care is respectful of, and responsive to, the preferences, needs and values of consumers. It includes the respect, emotional support, physical comfort, information and communication, continuity of transfer, coordination of care, and involvement of family.

Person- and family-centred care	A person and their family and/or carers collaborate with service providers to receive services that place the person at the centre of their health and wellbeing.
Primary health care	The first level of contact that a person, families and communities have with the health care system. It involves health promotion and prevention. The underpinning interconnecting principles of equity, access, empowerment, and community self-determination and collaboration across sectors are implicit. It encompasses an understanding of the determinants of health.[11]
Principle	A fundamental truth or proposition that serves as the foundation for a system of belief or behaviour.
Protocol	An established set of rules used for the completion of tasks or a set of tasks.
Referral	The processes, tools and techniques by which a person (and the provision of all or part of their care) is transferred between health professionals and health provider organisations to facilitate access to services and/or advice that the referring source is unable or unwilling to provide.
Self-management	Self-management is the active participation of people in managing their own health and wellbeing. It puts the person in the 'driver's seat' and enables them to choose how they want to live with their condition/s. Self-management varies between a person being the lead manager of their own care to those who are able to be involved in managing their own care with the support of resources and other people.
Shared transfer of care	Shared transfer of care has the person, their family and carers at the centre of the transfer plan—assessment and planning is based on the principles of person-centred care.
Strengths-based	A strengths-based approach focuses on engaging with the person to identify their capabilities and so achieve their goals.
Strong linkages and coordination across sectors	Providers work together using a coordinated and integrated approach to service delivery, using respectful communication as the key.
Sub-acute care	Continuing care delivered after an acute care episode. This might be rehabilitation, palliative, psychogeriatric, geriatric, management or maintenance care and may be provided in facilities or in the community. In Tasmania this care may also be provided in hospital (prior to discharge) due to the absence of needed sub-acute care services.

GLOSSARY OF TERMS

Talking Points / Sharing Points	Key elements of the *Guidelines for Shared Transfer of Care* which designed to improve the quality of shared transfer of care for people living with chronic complex needs. 1. Sharing with People 2. Sharing Accountability 3. Sharing Communication 4. Sharing Documentation 5. Sharing Coordination
Tasmanian health care system	A complex system in which both public and private providers, through a variety of funding mechanisms, work to provide access for all community members to a range of health care services ranging from primary to acute health care, in hospital and community settings.
Transfer of care	Transfer of care refers to the movement of a person's care between locations and providers
Transition of care	The movement of patients between health care locations, providers or different levels of care within the same location as their conditions and care needs change.[12]

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