Collaborative Health Care Initiative

Supporting our Regional Communities

CHC Initiative

Agreed Pilot Programs

June 2025

Background:

This document provides a high-level summary of each Pilot Project agreed upon by participants of the Collaborative Health Care Initiative workshops held in April and June 2025. This document should be read in conjunction with the CHC Interim Report which outlines next steps. Each project will be further developed, by designated steering committees and working groups in consultation with local community and health and aged care representatives, consumers and advocacy groups.

Pilot Program 1:
Shared Wellbeing & Lifestyle Strategy

Purpose

To provide older hospital inpatients with opportunities to engage in meaningful activities with residents at the local Care Home, to keep their minds and bodies active, thereby reducing the deterioration often associated with hospitalisation. The program will leverage an integrated approach where state and commonwealth funded services collaborate for better community outcomes.

Key Components

1. Activity Planning and Implementation — long-term hospital patients participating in wellbeing and leisure programs at the residential care home, including:

- ***Physical Activities:*** Eg. seated group exercise programs and walking groups to maintain physical health and mobility.
- ***Cognitive Activities:*** Puzzles, reading groups, and memory games to stimulate cognitive function.
- ***Social Activities:*** Group discussions, arts and crafts, and musical activities to enhance social interaction and emotional wellbeing.
- ***Cultural and Recreational Activities:*** Eg. culturally relevant activities and recreational outings to local sites.

2. Integrated Service Delivery

- ***Collaboration:*** Development of partnerships between hospital staff and residential care home personnel, to ensure a seamless delivery of activities.
- ***Coordination:*** Eg. use of a multidisciplinary approach involving healthcare professionals, and wellbeing & lifestyle coordinators to plan and execute activities.
- ***Communication:*** Establishment of clear communication channels between all stakeholders to coordinate schedules and share patient progress.

3. Evaluation and Feedback

- ***Monitoring:*** Regular assessment of the effectiveness of activities through patient feedback and health and wellbeing outcomes. Regular reviews by staff from both services to finetune processes and continuously improve the service.
- ***Reporting:*** Documentation and reporting of outcomes to relevant stakeholders to ensure transparency and accountability.

Organisation and Communication

1. Communication Strategies

- ***Regular Meetings:*** Regular meetings between hospital and residential care home staff to discuss patient and resident needs, activity schedules, and program updates.
- ***Designated Coordinators:*** Appointment of designated coordinators from both the hospital and residential care home to oversee the program and facilitate communication.
- ***Shared Documentation:*** Design and implementation of shared documentation resource or if this is not possible, development of agreed communication platforms to ensure all relevant information is accessible to both parties.

2. Facilitation of the Program

- ***Transition Planning:*** Develop detailed transition plans for patients moving between the hospital and residential care home, including activity preferences, health and manual handling requirements.
- ***Activity Calendars:*** Create and distribute monthly activity calendars to patients, families, and staff to keep everyone informed about upcoming activities.
- ***Feedback Mechanisms:*** Implement feedback mechanisms such as surveys and suggestion boxes to gather input from patients, residents and staff on the program's effectiveness.

3. Training and Support

- ***Joint Training Sessions:*** Conduct joint training sessions for hospital and residential care home staff to ensure consistency in activity delivery and patient care.
- ***Support Networks:*** Establish support networks for staff to share best practices, challenges, and solutions related to the program.

4. Community Engagement

- ***Volunteer Programs:*** Engage local community groups and volunteers to support and enrich the activity offerings.
- ***Partnerships:*** Develop partnerships with local organisations and service providers to enhance the program's reach and impact.

Benefits

1. Residents

- Socialisation with broader community, keeping residents connected to their community.
- Sense of purpose, helping others.

2. Patients

- Mental & physical stimulation reducing the impact of extended hospitalisation on overall health and wellbeing.
- Opportunity to demystify residential care homes and reduce the fear of entering one.

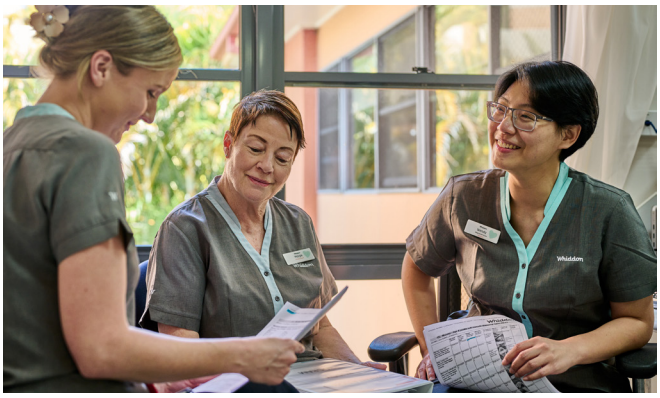
3. Hospital

- Improved outcomes for patients due to increased mental and physical stimulation.
- Potentially reduced bed days.
- Expanding symbiotic relationship with residential care home which may result in better community outcomes.

4. Residential Care Home

- Improved referrals from hospitals due to ongoing relationship development.
- Reduced fear from potential residents due to early exposure to the positive environments within residential care homes.
- Increased exposure/visibility across the community.

Pilot Program 2: Shared Workforce Model



Purpose

A **shared services employee model** between aged care providers and the State Health system aims to optimise workforce resources, improve continuity of care, and reduce duplication. It's increasingly relevant in settings where demand for skilled healthcare workers is high, especially in rural, remote and resource-limited areas.

Staffing Structure

1. Shared Roles:

- ***Registered Nurses (RNs):*** Rotate shifts between hospital and a residential aged care facility.
- ***Allied Health Professionals:*** E.g., physiotherapists, occupational therapists, social workers who provide services in both sectors.
- ***Care Coordinators:*** Bridge discharge planning and aged care intake to reduce readmissions.
- ***Support Workers / AINs:*** Flexibly rostered between services based on need.

2. Contracts:

Staff are either:

- Employed by one umbrella organisation (e.g. a health network) and deployed across settings, or
- Jointly funded and seconded through MoUs between hospital and aged care providers.

Operational Features

- ***Centralised Rostering:*** Employees are assigned to facilities based on patient acuity, demand, or skill mix required.
- ***Standardised Training:*** Orientation and clinical protocols aligned across both sectors.
- ***Mobile Workforce Pools:*** "Float teams" or "relief pools" deployed across multiple sites, improving flexibility and coverage.

Technology Integration

- ***Telehealth Support:*** Shared staff can provide remote consultations across sites when physical presence isn't needed.
- ***Consolidated Rostering*** – Tools that allow employees to access a roster that consolidates entities and provides a single view.

Governance and Funding

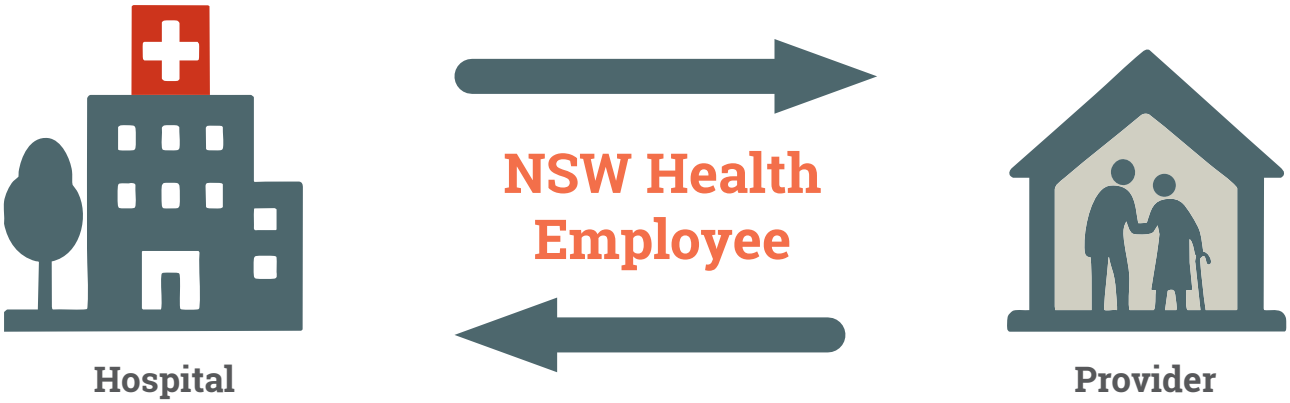
- ***Joint Governance Committee:*** Representatives from aged care and hospital services oversee model performance. Potentially a function of the Collaborative Health Care Governance Structure.
- ***Cost-Sharing Arrangements:*** Based on workload or hours provided to each facility.
- ***Incentives for Cross-Sector Work:*** Professional development opportunities, retention bonuses, or higher base rates.

Benefits

- Reduced hospital readmissions from aged care.
- Improved care transitions and discharge planning.
- Increased staff utilisation and satisfaction.
- Smoother recruitment and workforce planning.

Example:

A small regional hospital may share an RN with the adjacent residential aged care home. The RN works in the hospital three days a week and in aged care two days, maintaining continuity for high-risk residents and supporting early discharge from hospital.



Pilot Program 3: Shared Transport Services

Purpose

To provide a seamless and supportive transport service for older hospital inpatients, and residents of residential care Homes to attend their medical appointments. The project will involve home care staff employed by an aged care provider, and potentially other transport service providers, providing transport to hospital patients and residents of aged care who are otherwise unable to access or afford transport.

Service Design

- ***Personalised Experience:*** Ensure that the transport service is delivered in a personalised, genuine, and warm manner, by appropriately trained staff.
- ***Partnership Approach:*** Foster a partnership with the hospital and residential care home to enhance the experience of the people in their care.

Operational Guidelines

- ***Staff Training:*** Home care staff should receive training on providing transport services, including handling medical emergencies, patient comfort, and communication skills.
- ***Scheduling and Capacity Management:*** Implement a robust scheduling system to manage transport requests efficiently. Ensure clear communication with patients about the availability and timing of transport services.
- ***Safety Protocols:*** Establish safety protocols for transporting patients, including vehicle maintenance, emergency procedures, and patient handling techniques.

Communication and Coordination

- ***Clear Communication:*** Ensure that all communication with patients, residents and staff is clear and consistent. Use a standardised script for booking and confirming transport services.
- ***Coordination with Hospitals***: Work closely with hospital and residential care staff to coordinate transport schedules and ensure that patients/residents are ready for their appointments on time.

Quality Assurance

- ***Feedback Mechanism:*** Implement a feedback mechanism to gather consumer and staff feedback on the transport service. Use this feedback to continuously improve the service.
- ***Performance Metrics:*** Establish key performance indicators (KPIs) to measure the success of the transport service, such as response time, consumer and staff satisfaction, and number of successful transports.

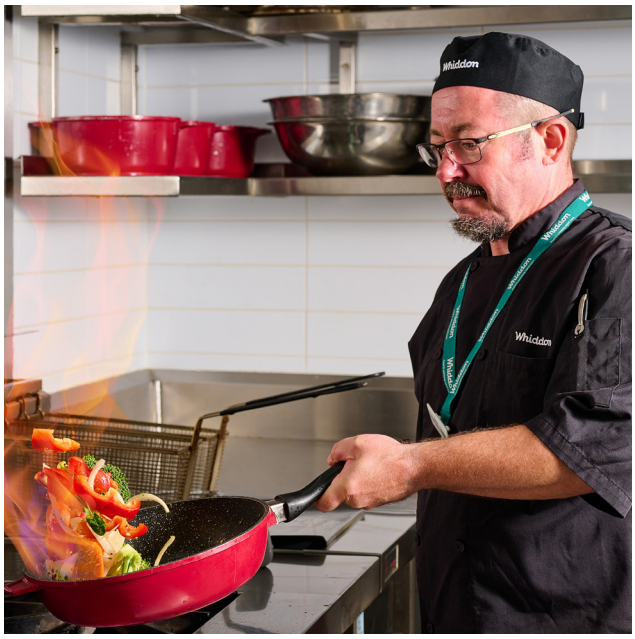
Risk Management

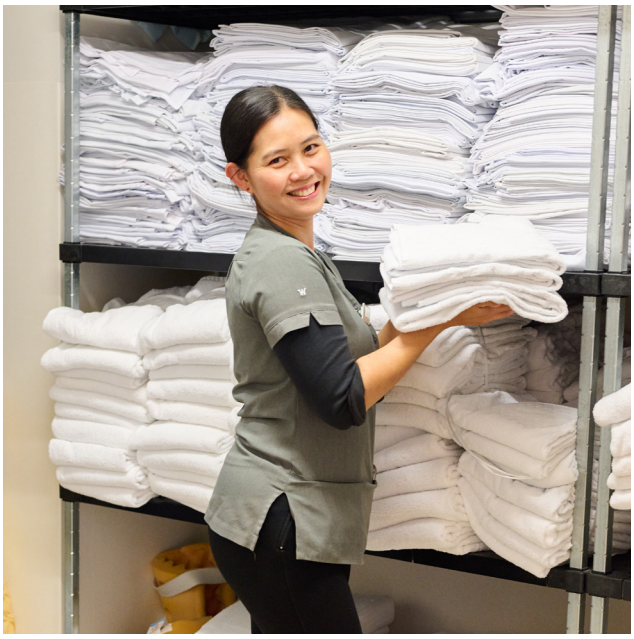
- ***Incident Reporting:*** Develop a system for reporting and managing incidents that occur during transport, including medical emergencies and vehicle breakdowns.
- ***Insurance and Liability:*** Ensure that all vehicles and staff are adequately insured and that liability issues are clearly defined and managed.

Community Engagement

- ***Awareness Campaigns:*** Conduct awareness campaigns in local communities to inform older Australians about the availability of the transport service.
- ***Partnerships with Local Organisations:*** Partner with local organisations and community groups to promote the transport service and reach a wider audience.

Pilot Program 4: Shared Catering Operations/ Laundry/ Maintenance (non-clinical services)





Purpose

To deliver high level outcomes for aged care residents and hospital patients, through shared non-clinical services, eg. Food, laundry and maintenance, while realising operational efficiencies for all stakeholders, and combating staff shortages.

Benefits of a Collaborative Healthcare Model

Benefit		Description
Co-location		In many instances, the rural residential care home and the local hospital are either co-located or within a short distance from each other. Centralising non-clinical operations could provide economic benefits to both the hospital and care home and reduce duplication of expenses and staffing shortages.
FOOD	Qualified chef recruitment pool	The recruitment pool for qualified chefs is small and reducing. In rural and remote areas, qualified chefs are difficult to source. By combining operations, this will ensure that recruitment for the same pool of people will be less competitive with a better outcome for both operations.
	Foodies Group Menu Approach	Residential care home menus, created in consultation with residents help to ensure that food preferences and intolerances are accommodated. This approach emphasises a local community food focus, catering to residents who have spent most of their lives in the region. Long-term hospital patients could be invited to join meetings, to ensure that their requests and preferences are also addressed.

Benefit		Description
FOOD	Bulk Food Delivery	Food created in bulk, ready for plating by the relevant service will ensure residents and patients are able to access high quality food at short notice.
	Expert Oversight	Qualified Head Chef or Kitchen Team Leader ensures quality and safety with a range of overarching support services support.
LAUNDRY	Third Party Laundry Provider vs local provider	Rather than relying on businesses from major cities for outsourced laundry services, utilising local services ensures increased job availability for residents and a quicker response time in emergencies. Keeping laundry operations local not only has economic benefits but also fosters stronger ties between the community and the business.
	Laundry Space Optimisation	With a local supplier completing laundry operations, this may reduce the need to hold additional linen onsite with more frequent deliveries.
	Ad-hoc Requests of Personal Laundry	Patient or resident laundry on an ad-hoc basis can be laundered.
BOTH	Community & Local Economy Support	Strengthens community ties and supports local employment.
	Scalability	With a fluctuating number of residents or patients, the flex in rosters will help to reduce cost with a per person cost rather than a fixed fee.
SCOPE:		This project may roll in Pilot 3 (shared transport) and shared maintenance or other con-clinical services.

Pilot Program 5: Collaborative and Agile Transitional Care Model for Residential Aged Care

Purpose

A reimagined transitional aged care model that is collaborative, flexible, and agile in funding. It enables hospitals to discharge patients directly into residential aged care homes at a fixed daily rate—without the administrative burden of grant applications or rigid eligibility criteria. This model is designed to reduce hospital bed blockages, improve continuity of care, and enhance outcomes for older Australians, particularly in regional and rural settings.

The Royal Commission into Aged Care Quality and Safety and subsequent sector reviews have called for more flexible, place-based, and person-centred models of care. The proposed model builds on the Transitional Aged Care Program (TACP) but removes bureaucratic barriers and introduces a streamlined, outcome-focused funding mechanism.

Model Overview

Key Features:

- **MOU or HOA Based:** Providers and NSW Health Hospitals enter an agreement that provides access to vacant RAC beds for suitable hospital residents **as needed**.
- **Fixed Daily Rate Discharge Pathways:** Hospitals can discharge eligible older patients to either:
    - Residential aged care homes with available beds.
    - Potentially also, accredited home care providers for community-based support (Phase 2 if RAC successful).
- **No Grant Applications:** Providers are pre-approved through a quality and compliance framework, eliminating the need for case-by-case funding applications.
- **Integrated Workforce Models:** Shared staffing arrangements between hospitals and aged care providers (e.g., rotating RNs, allied health professionals) ensure continuity of care.
- **Shared Governance:** A joint governance structure oversees performance, funding, and quality assurance across sectors.
- **Technology Integration:** Ideally, shared electronic health records and telehealth support ensure seamless transitions and ongoing care coordination. Alternatively, agreed shared documentation or information sharing will form an important part of the pilot.

Benefits

For Older People

- **Faster Transitions:** Reduces hospital stay duration and supports timely return to familiar or home-like environments.
- **Continuity of Care:** Integrated teams and shared records reduce the risk of medical errors and care gaps.
- **Improved Outcomes:** Access to reablement services and wrap-around supports enhances recovery and independence.

For Hospitals

- **Reduced Bed Block:** Frees up acute care beds by enabling timely discharge of patients awaiting aged care placement.
- **Lower Costs:** Reduces the cost burden of long-stay patients in high-cost hospital settings.
- **Improved Flow:** Enhances emergency department throughput and elective surgery scheduling.

For Aged Care Providers

- **Predictable Revenue:** Fixed daily rates provide financial certainty and reduce administrative overhead.
- **Workforce Optimization**: Shared staffing models improve recruitment, retention, and utilisation.
- **Strategic Positioning:** Providers become integral to the broader health system, enhancing influence and sustainability.

Implementation Considerations

- **Pilot Programs:** Launch in regions with high hospital discharge delays and aged care bed availability.
- **Policy Alignment:** Engage both state and federal stakeholders to harmonize funding and regulatory frameworks.
- **Evaluation Metrics:** Track hospital readmission rates, patient satisfaction, and cost-effectiveness.

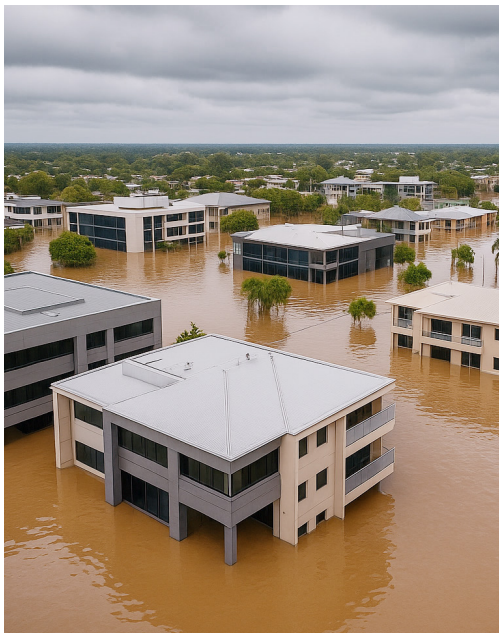
Conclusions

This agile, collaborative model offers a practical and scalable solution to some of the most pressing challenges in aged and health care. By removing red tape, funding bottlenecks and fostering true integration, it delivers better outcomes for older Australians while improving system efficiency.

Pilot Program 6: Collaborative Emergency & Disaster Response Framework

Purpose

To enhance emergency preparedness and response through a collaborative framework that ensures the continuity of care, safety of residents and patients, and effective use of local resources.



Overview

This outline proposes the development of a Memorandum of Understanding (MOU) between local hospitals and aged care providers to formalise a joint approach to emergency and disaster management. The suggested plan outlines how organisations can coordinate their efforts in response to events such as floods, fires, and power outages by sharing accommodation, staff, and critical resources.

Key Components

1. Creation of a Joint MOU

- Establish formal agreements covering shared responsibilities, communication protocols, and emergency support arrangements.
- Define activation criteria, decision-making pathways, and joint governance mechanisms.

2. Shared Accommodation Protocols

- Identify spaces in each facility suitable for temporary accommodation of residents, patients, or staff.
- Include transportation logistics and care continuity planning.

3. Collaborative Workforce Planning

- Develop a pooled staffing registry to enable mutual aid during workforce shortages or surge events.
- Address credentialing, supervision, and emergency rostering processes.

4. Resource and Equipment Sharing

- Maintain a shared inventory of critical supplies (e.g. PPE, medical equipment, generators).
- Define access protocols, transport methods, and usage priorities.

5. Training and Simulation Exercises

- Conduct regular joint drills covering realistic scenarios (e.g. flood evacuation, bushfire smoke inhalation shelter-in-place).
- Build cross-organisational understanding and trust.

6. Unified Communication and Command Structure

- Establish a shared incident command system with designated liaison officers.
- Implement consistent reporting and communication procedures.

Additional Initiatives to Strengthen the Plan

7. Continuity of Operations Planning (COOP)

- Develop shared strategies to maintain critical services during extended disruptions, including care delivery, food, pharmacy, and records management.

8. Shared Risk Assessment and Hazard Mapping

- Conduct joint site assessments to identify vulnerabilities and inform mitigation strategies for both facilities.

9. Public and Family Communication Plans

- Pre-prepare joint messaging templates for communicating with families and the community during emergencies.

10. Evacuation and Shelter-in-Place Planning

- Detail evacuation routes, transport options, and shelter-in-place procedures tailored to specific threats.

11. Redundant Communication Systems

- Incorporate backup communication tools (e.g. satellite phones, radios) in case of IT or power failure.

12. Surge Capacity Planning

- Establish protocols for managing increased demand or capacity shortfalls, including overflow accommodation and triage processes.

13. Documentation and Debrief Processes

- Include procedures for incident documentation and joint post-event reviews to improve future readiness.


Collaborative
Health
Care
Initiative
Supporting our Regional Communities