NATIONAL STAKEHOLDER WORKSHOP

RESTORATIVE CARE IN PRACTICE: ADVANCING THE TRANSITION CARE PROGRAMME

A white paper published by ARIIA and Flinders University Caring Futures Institute.

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About this White Paper

This publication is an ARIIA White Paper and Research Report.
The ARIIA White Paper and Research Report provides researchers and policy makers with evidence-based data and recommendations summarising national stakeholder workshop discussions with providers and professionals delivering transition care programmes across Australia.

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Acknowledgement of Country

Flinders University was established on the lands of the Kaurna nation, with the first University campus, Bedford Park, located on the ancestral body of Ngannu, near Warriparinga. Warriparinga is a significant site in the complex and multi-layered Dreaming of the Kaurna ancestor, Tjilbruke. For the Kaurna nation, Tjilbruke was a keeper of the fire and a peace maker/law maker.

Tjilbruke is part of the living culture and traditions of the Kaurna people. His spirit lives in the Land and Waters, in the Kaurna people and in the glossy ibis (known as Tjilbruke for the Kaurna). Through Tjilbruke, the Kaurna people continue their creative relationship with their Country, its spirituality, and its stories.

Flinders University and ARIIA acknowledges the Traditional Owners and Custodians, both past and present, of the various locations the University operates on, and recognises their continued relationship and responsibility to these Lands and waters.

About Aged Care Research and Innovation Australia

Aged Care Research & Industry Innovation Australia (ARIIA) is an independent, charitable organisation established to respond to the urgent challenges of our evolving aged care industry and is shaping the future of aged care in Australia through the translation of research and technology into practical evidence-based solutions that enhance the aged care workforce and improve service and care delivery.

About Flinders Caring Futures Institute

The Caring Futures Institute (CFI) at Flinders University is Australia's first fully dedicated research institute focused on advancing self-care and caring solutions across the lifespan. CFI is reimagining a future in which every person has access to the highest standard of health and care, and where evidence-driven innovations strengthen wellbeing, independence, and community inclusion.

Anchored in the Caring Life Course Theory, the Institute brings together researchers, clinicians, industry partners, and communities to generate transformative insights that shape policy, education, and practice. Its work spans critical domains including healthy beginnings, disability and community inclusion, cardiac care, cancer survivorship, palliative and end-of-life care, and fundamental care research.

About Flinders Ageing Alliance

Flinders Ageing Alliance is working diligently to achieve better ageing outcomes through collective wisdom by focusing on the areas that matter most to older Australians, from health and wellbeing to compassionate end-of life care. The ageing alliance approach is grounded in evidence and impact, driven by research, advocacy and capacity building.

The Flinders Ageing Alliance brings together over 100 researchers from more than 16 teams and individual contributors into a transdisciplinary research hub, united by a shared commitment to improving the lives of older Australians. Both CFI and ARIIA are partners in the Alliance.

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Acronyms

ARIIA - Aged Care Research and Industry Innovation Australia
CALD - Culturally and linguistically diverse
CFI - Caring Futures Institute (Flinders University)
EAG - Evidence Advisory Group
MDT - Multi-disciplinary team
OT - Occupational therapist
PCWs - Personal care workers
RAC - Residential aged care
SAH - Support at Home
TCP - Transition Care Programme

1. Executive Summary

This white paper summarises insights from a national stakeholder workshop exploring the implementation of restorative care within the Transition Care Programme (TCP) following the release of the updated 2026 guidelines. Stakeholders agreed the guidelines strengthen and formalise existing care, particularly person-centred goal setting, multidisciplinary input, and therapy-focused care, but noted a significant gap between these expectations and current system capacity.

Workforce shortages across allied health, nursing, pharmacy, and primary care were identified as the most critical barrier, affecting access, limiting multidisciplinary practice, and increasing reliance on brokered services. Goal setting remains central but is difficult to deliver consistently due to time pressures, variable staff capability, and limited outcome measures sensitive to restorative gains.

Equity and access issues, including financial hardship, unstable housing, low health literacy, limited interpreter access, and thin markets in rural and remote areas, were seen to undermine engagement and the sustainability of outcomes. Participants emphasised that TCP cannot function effectively as a standalone episode; delays in accessing ongoing supports often lead to loss of progress after discharge.

Technology and telehealth offer important opportunities to extend access to multidisciplinary care, but uptake is constrained by digital literacy, connectivity, clinician confidence, and restrictive IT systems.

The recommendations in this paper outline practical actions to strengthen workforce capacity, enhance multidisciplinary care, improve goal-setting processes, support planned transitions, promote equity, and expand the effective use of technology to ensure TCP can deliver on its restorative intent.

2. Introduction

The 2026 Transition Care Programme Guidelines (Australian Government Department of Health and Aged Care, Updated January 2026) have been significantly shaped by the Restorative Care Pathway Clinical Guidelines (Australian Government Department of Health and Aged Care, May 2025), reflecting a shared commitment to goal-oriented, multidisciplinary, and person-centred care.

These guidelines operationalise restorative care principles, including optimising independence and wellbeing through tailored goal setting, multidisciplinary, therapy-focused care involving nurses and allied health professionals, and seamless transitions across care settings to prevent hospital readmissions.

This alignment with the Aged Care Act 2024's rights-based framework underscores the need to understand how restorative care is being implemented in practice, especially as Transition Care Programmes (TCP) remain distinct from the Support at Home (SAH) program. Despite policy alignment, evidence on the practical integration of restorative care into aged care remains fragmented. Our scoping review (Gough *et al*. 2025) found there is limited definitional clarity across restorative, reablement, and rehabilitation approaches, inconsistent delivery models and outcome measures, and- a lack of robust evidence comparing effectiveness across settings.

This fragmentation makes it difficult to assess whether restorative care principles are effectively implemented in TCP services and whether the Transition Care Programme Guidelines (2026) can be integrated effectively into care delivery.

Aims of the workshop

The aims of this National Stakeholder Workshop were to: Understand the approaches of integrating the updated guidelines and restorative care recommendations into the implementation of the Transition Care Programme to Identify implementation challenges experienced by service providers, healthcare professionals, and aged care workers delivering care, and Identify differences to previous approaches, barriers and facilitators to promote restorative transition care to guide national practice.

Ethics approval

Approval was obtained from Flinders University Human Ethics Low Risk Panel (Project no: 9303)

3. Methods

The National Stakeholder Workshop was conducted online and used a qualitative discussion format. Service providers and healthcare professionals delivering transition care services across Australia were invited to participate.

Participants were identified by the authors based on their professional networks and knowledge of the health and aged care sectors. Individuals with recognised expertise in transition care and restorative care delivery were approached via email.

Prior to the workshop, participants received basic background information and a briefing paper summarising the Transition Care Programme Guidelines (January 2026) and the restorative care recommendations.

Key definitions noted that:

*'**Transition care** is a specialist aged care program… It provides short-term care to optimise the functioning and independence of older people after a hospital stay. Transition care is goal-oriented, time-limited and therapy focused.' **Transition Care Programme Guidelines (January 2026)***

*'The purpose of **restorative care** is to support individuals to regain function and enable them to live independently in their own homes for as long as possible.' **(Restorative Care Pathway Clinical Guidelines, 2024)***

The online workshop was held on 4 February 2026. The session was video- and audio-recorded, and minutes were taken to support the development of a report on the workshop findings.

All data were stored on a secure, password-protected Flinders University server accessible only to the chief investigator and named researchers. Only de-identified participant data were retained in the project folder.

Data analysis

Data was recorded and transcribed verbatim. The transcript was coded using NVivo software (version 12) by a single Senior Research Fellow who was present at the workshop. The researcher first read the full transcript and then applied line by line open coding, grouping similar words and sections of text and adding new codes as concepts emerged. The initial coding was reviewed and confirmed by the other authors who attended the workshop to ensure accuracy and consistency. Participants were provided with a draft report to verify that their views were represented fairly and that any identifying information had been removed.

4. Results

Sixteen key stakeholders attended the online national workshop discussions; participants held a range of roles across the Australian aged care sector in both community (in-home) and residential transition care as well as rural settings (Table 1). Five participants did not provide comment during the session, one left early due to a personal issue.

Table 1- Workshop participant details

Participants	Location
Clinical and Quality Assurance Manager	WA
Service Manager- Community Aged Care	QLD
Principal Advisor Healthy Ageing and Reablement	WA
Team Leader Community Transition Care Program, MNHS, Qld.	QLD
Senior Community Wellness Manager	SA
Service Design and Innovation Manager	NSW
Physiotherapist - GM Reablement at Whiddon	NSW
General Manager Wellbeing and Allied Programs	SA
Clinical Nurse	QLD
Occupational Therapist - Transition Care Program	QLD
Consultant pharmacist	VIC
Occupational Therapist- Team Leader	SA
Senior Research Fellow, Bolton Clarke Research Institute	VIC
Team Leader TCP	QLD
TCP Senior Clinical Coordinator	SA
Facilitators- Dr Claire Gough (CFI), Liana Donleavy (ARIIA) and Joanna-Lee Tan (ARIIA)	

Findings (overview)

Workshop discussions indicated broad agreement that the updated Transition Care Programme (TCP) Guidelines do not represent a fundamental shift in care delivery. Instead, stakeholders viewed the update as formalising and strengthening practices already embedded in restorative care, particularly person-centred goal setting, multidisciplinary and therapy-focused care, and time-limited approaches aimed at optimising independence. For many services already using a restorative approach, the guidelines provided welcome clarity and a useful training resource.

Participants emphasised, however, that implementation challenges stem less from clinical philosophy and more from structural and system constraints. Workforce shortages, thin markets in rural and remote areas, and the complexity of coordinating care with contracted providers continue to limit the extent to which the *'ideals'* of the TCP guidelines can be realised. The timing of the guideline release, coinciding with the end-of-year period and occurring alongside multiple concurrent reforms, including Support at Home, further slowed operationalisation, with many providers only beginning implementation at the time of the workshop (February 2026). Stakeholders also noted that while the guidelines are clear and well written, additional staff training is required to address ageist assumptions and strengthen capability to *"do with"* rather than *"do for."* Translating the guidelines into practice remains challenging in the context of significant system pressure, limited workforce capacity, and a lack of detailed implementation guidance.

Key themes

The workshop provided rich discussion from the key stakeholders over a two-hour period. Key themes affecting the implementation of updated guidelines included: Workforce capacity, multidisciplinary care, goal setting, planned transitions beyond TCP, increasing client complexity, appropriate referrals, equity, vulnerability and access barriers, and technology and innovation.

Workforce capacity

A consistent theme during stakeholder discussions was the widening gap between the expectations of the updated TCP guidelines and the reality of what the current workforce were equipped to deliver.

Service providers, particularly those in rural and remote regions, described persistent challenges in accessing a skilled workforce with sufficient capacity. As one stakeholder commented, *'This is compounded even more in those remote communities where GPs don't even exist, let alone allied health and community services.'* Although pronounced for rural and remote areas, providers in metropolitan areas also reported increasing difficulty accessing timely specialist input. Shortages of allied health professionals, pharmacists, GPs and nurse practitioners were common across all settings, leading many providers to rely heavily on brokered services.

> *'Brokered providers are a third-party entity such as a nursing agency or private allied health business or service provider that is contracted to deliver services to a care recipient on their behalf.'*

For other providers, eligible individuals were turned away from services as there were no providers with capacity available to provide the services required:

> *'We had an exceptional number of patients in an ageing population that would be suitable and eligible for a TCP programme, but absolutely no providers who were able to provide that service.'*

This was particularly true for providers who didn't have dedicated TCP or restorative care teams to deliver care. These providers were therefore unable to take on clients, *'we just can't do it.'* This was reportedly due to conflicting priorities for those delivering care as they did not have capacity to provide care across multiple programs.

During discussions, stakeholders consistently emphasised that workforce constraints are not limited to rural and remote communities, but are being felt state-wide, reflecting a systemic rather than a geographically isolated issue.

Recommendations to strengthen workforce capacity

- **Expand and diversify the allied health workforce**- Increasing training places, offering targeted scholarships and supporting supervised practice pathways to help grow the workforce needed to deliver restorative care.
- Incentives for rural placements and long-term retention would be especially useful.

Reduce reliance on brokered services- through targeted and ongoing workforce investment and incentives.

Multi-disciplinary care *endorsed but hard to sustain*

Stakeholders strongly endorsed a multidisciplinary approach to delivering TCPs, noting that delivery by multi-disciplinary teams (MDTs) aligns well with restorative care principles. However, they emphasised that sustaining genuine multidisciplinary practice remains difficult, particularly in rural and remote communities where access to key professionals is limited. Even when providers are committed to an MDT model, the practical reality is that many regions simply cannot secure the mix of allied health and nursing expertise required.

While use of third-party services often enabled continuity of care, it also introduced complexity into multidisciplinary coordination, as brokered practitioners are typically not funded to attend multidisciplinary meetings, limiting their participation in treatment planning and goal-directed restorative care delivery. Whilst the use of brokered providers enabled clients to receive care they required, this was often linked to significantly higher costs for the provider, and higher out of pocket costs for the consumer.

These constraints create ongoing tension around workforce efficiency and skill mix. Providers described the need for a more flexible workforce, one in which staff can work across dual roles or take on broader responsibilities spanning nursing, allied health, and system-level tasks. Without this flexibility, teams struggle to maintain continuity of care, and service capacity becomes highly variable.

Stakeholders also highlighted an implicit selection process that occurs when workforce gaps limit the types of care that can be delivered. Eligibility alone does not guarantee acceptance into TCP. Individuals may be declined because the provider cannot access the specific professionals required to meet their needs, for example, speech pathologists. As one stakeholder noted, *'No provider is going to be able to have access to all of that everywhere*,' meaning some clients will inevitably miss out on services as providers prioritise those whose needs they can realistically meet.

Pharmacy-related issues were also raised as a significant barrier. Pharmacists and other allied health practitioners were often unaware of the updated guidelines, and communication gaps between hospital and community settings contributed to medication errors. Stakeholders described clients returning home and resuming pre-admission medications rather than following their updated hospital prescriptions, creating risks that can undermine participation in restorative care. Stakeholders also noted that TCP clients are excluded from key funding models when they enter residential aged care and that some general practitioners are unwilling to take them on temporarily, leaving limited oversight. These gaps highlight the need for accurate, up to date, digital health records to prevent medication errors during transition.

Stakeholders were optimistic that greater pharmacist involvement in MDT meetings could strengthen transitions of care and reduce these errors but noted that system-level changes would be required to support this.

Recommendations to strengthen multidisciplinary care

- **Strengthen MDT capacity** through targeted workforce investment
- **Support flexible workforce models** to maintain service continuity
- **Improve pharmacy integration and medication safety across transitions**
    - Embed pharmacists in multidisciplinary team processes
- **Build system supports that make MDT practice sustainable**

Goal setting *remains central but is time and skill intensive*

Goal setting remained central to restorative care delivery, as per the updated guidelines, yet stakeholders emphasised that goal-setting is both time and skill-intensive, particularly within a low-intensity, time-limited TCP programme.

Stakeholders described the need to break long-term goals into achievable short-term goals, while remaining realistic about what can be accomplished within the duration of the service. Although person-centred goal setting is fundamental to restorative care, stakeholders noted that it requires a high level of skill to ensure goals are genuinely meaningful to the individual, rather than shaped by assumptions about age, prognosis, or functional potential. Stakeholders stressed the importance of

removing ageist assumptions from the process and ensuring that goals reflect the person's own priorities rather than what others believe is "realistic" for them.

The quality of goal setting was seen as highly dependent on the skill base of staff. Providers reported that identifying personalised goals can be challenging at intake, particularly when medical handovers are framed through an acute-care lens or focus primarily on discharge readiness rather than longer-term functional outcomes. This can make it difficult for providers to establish appropriate goals early in the program, especially when clients are still overwhelmed by their recent hospital experience and have limited understanding of what TCP involves. Stakeholders noted that many individuals initially express only a desire to *'get home,'* and require time, support, and follow-up conversations to articulate more specific or longer-term goals.

The role of an advocate, whether a case manager, liaison worker, or another trusted person, was highlighted as critical in supporting unbiased, person-centred goal setting. Family conflict or differing expectations was noted to complicate the process, and advocates were seen as essential in ensuring that the client's own preferences remain central to care.

Stakeholders reported a shift, where in-depth goal-setting conversations were moving into liaison roles rather than case management. While this can improve continuity, it also raises questions about when and where these conversations should take place, and how to ensure clients have adequate time to define clearer goals. Staff emphasised that clients often need space to process information before meaningful goal setting can occur.

For those providing care, training in goal setting practices was described as *'super critical,'* yet many providers reported that it has become inconsistent due to competing operational pressures and high workforce turnover. As client complexity increases, staff require more advanced skills to uncover underlying goals and support progress within a short timeframe, an ongoing challenge for time-limited restorative care programmes.

It is also worth noting that stakeholders reported the Modified Bartel Index (MBI), used to measure goal attainment is not appropriate to capture goal attainment, specifically *'not sensitive enough to capture the changes we actually can achieve.'* Suitable outcome measures to demonstrate

progress may therefore be useful to support measuring progress and effectiveness of restorative care in TCP.

Recommendations to support goal setting

- **Strengthen staff capability** in person-centred goal setting
- **Build time and process supports for iterative goal setting**
- **Improve the quality of handover** to support early goal setting
- **Support staff to manage complex goals** within time-limited programmes
- **Review appropriate outcome measures** that capture goal attainment

Planned transitions beyond TCP *from episode to pathway*

A recurring theme across stakeholder discussions was the need to shift from viewing TCP as a discrete episode of care to understanding it as one component of a broader, and often fragmented, care pathway.

While the aim of TCP is to support safe discharge and reduce avoidable hospital readmissions, stakeholders emphasised that the programme cannot achieve this in isolation. Gaps in the wider system, particularly delays in accessing ongoing home support, allied health services, or longer-term aged care packages, were seen to place clients at risk of deterioration once TCP ends. As one participant observed, if appropriate follow-on services are not available, *'they risk going back into hospital whether they have had TCP or not.'*

Stakeholders agreed that the intention and capability of TCP are strong, but the programme alone *"is not going to be the solution for everyone."* Many described a sharp drop-off in support once TCP funding ceases, with clients facing long waits for home support packages, financial barriers to interim fee-for-service care, or the sudden loss of allied health input. These gaps were viewed as undermining the restorative gains achieved during TCP and contributing to frustration and moral distress among staff who felt they were discharging people into avoidable instability.

Participants emphasised the need for planned transitions from the outset of care, rather than treating TCP as a standalone episode with a defined start and end point. Effective exit planning and maintenance strategies were seen as essential to sustaining progress, particularly for clients with complex needs or limited informal support. Stakeholders argued that TCP should be

embedded within a clearer, more predictable pathway that ensures continuity of care beyond the programme, reducing the risk of functional decline and preventable hospital readmission.

Recommendations for planned transitions beyond TCP

- **Introduce early, proactive transition planning from day one**
- **Strengthen system linkages to reduce post-TCP service gaps**
- **Adress access delays** for ongoing home support and aged-care packages
- **Reduce financial barriers to interim care**

Increasing client complexity *reshaping TCP restorative practice*

In workshop discussions, stakeholders reported that clients receiving TCP are more medically complex and frail than they have been in previous years, possibly due to being discharged from hospital earlier to ease ramping and free up bed space. One stakeholder commented on how some individuals were referred to TCP primarily to relieve acute bed pressure rather than the individual being well suited to the restorative care pathway:

'I think it's just worth recognising that there's probably a parallel increase in complexity of clients, which means including with hospital pressures, you know, we have the same sort of bed pressures in our region that I've heard that we are taking on clients that, you know, previously we might not have.'

As a result, services are seeing high (and often inappropriate) referrals, including cases where clients return to hospital and pass away shortly after TCP admission.

'We're struggling to keep them out of hospital whilst they're on the programme. So, we have a very high readmission rate.'

Stakeholders agreed that the updated Transition Care Guidelines alone will not be effective to reduce readmission rates without improvements in the appropriateness of referrals and broader system capacity.

Increased complexity and dependency

One stakeholder provided examples of specific goals they worked on with clients at the beginning of their career in 2010 and more recent goals, which demonstrated a significant shift in the baseline function of individuals accessing TCPs:

'So, I started as an OT back then and I was taking people on the golf course and our restorative goal was to get back to golfing/ continuing to visit the coffee shop to engage socially.'
'Now I'm working on significant equipment scripting, large pieces of equipment to support people to be able to stay at home.'

Recommendations for managing increasing client complexity in TCP

- **Strengthen referral appropriateness and triage processes**
- **Enhance clinical governance to reduce readmission risk**
- **Review restorative expectations and goal-setting processes for complex clients**

Appropriate referrals and patient readiness

Stakeholders noted that associated brokered providers do not get to see care plans for their clients. The referrals received are often short and transactional, which can make providing care and setting goals difficult. This lack of data capture and poor communication can affect the level and appropriateness of care an individual receives. One-off meetings with associated providers would be useful to support handover, as would translations of nursing summaries. Stakeholders noted that this communication is currently one directional, '*one way at the moment'* and there is a need to get associated providers involved in client goal setting.

Stakeholders also noted that referrals do not currently include consideration for patient readiness, which is an important tool that can help to determine who gets a package and who is appropriate for more intensive restorative care. This could be especially important light of limited resources:

'What I'm not really hearing across all programs is getting a sense check around the client, the client or the patient's readiness to make a change. We don't seem to include that as part of our decision making. I think it will help us triage where we can actually divert our resources to and work with clients who are ready to take a step forward.'

Without this sense check, resources are potentially being wasted despite the detail included in referrals:

'We put them back into hospital and they are dying in hospital because they weren't the right client for our programme, but yet they come with a support plan that has their restorative goals and it's all written beautifully.'

Recommendations appropriate referrals and identifying patient readiness

- **Standardise referral content and minimum data requirements**
- **Ensure associated providers receive full care plans and summaries**
- **Embed patient readiness assessment into eligibility considerations for referrals**

Equity, vulnerability and access barriers

Socioeconomic and health-system vulnerability

Stakeholders questioned how well the guidelines account for participants experiencing vulnerabilities including financial hardship, low health literacy, unstable housing, or weak links to primary care. These factors were seen to influence engagement during TCP and the ability to sustain gains after discharge. Providers noted that ongoing supports often require co-payments, which can limit access and shape decisions about what is included during the TCP episode:

'There is a temptation to put in everyday personal care workers… knowing full well the client may not be able to afford them later.'

Early exit planning was therefore viewed as essential.

Service availability and geographic inequity

In many regions, particularly rural and remote areas, there are few services to refer clients to after TCP to progress their goals. Resulting in a potentially missed opportunity to build on the functional gains made during the program that would potentially delay the need for more intense services or admission to residential aged care. Long wait times for Support at Home packages, limited CHSP availability, and workforce shortages mean that even when clients are willing to pay, services may not exist or be available at the time needed: *'In order to say "I can't afford that" means you have to*

have been offered something to start with." Residential TCP providers also reported gaps in access to allied health, with ongoing care often falling to lifestyle staff who are not trained to deliver restorative interventions.

Home modifications and environmental barriers

Home modifications were frequently recommended to support independence, but the short duration of TCP means many modifications cannot be completed within the episode. Delays arise from approval processes, contractor shortages, and supply issues, particularly for renters and people in public housing. As one provider noted, *'Modifications can't be done in the TCP program… if there's no one to carry it on, it just doesn't get done.'*

Limited visibility of primary care and medical governance

Some participants lacked a regular GP or stable connection to primary care, leaving TCP teams without clear medical governance. This was described as a significant barrier for people experiencing homelessness or unstable housing: *'The program not necessarily always having medical governance can be a real barrier.'*

Cultural and linguistic barriers

While the guidelines reference person-centred and culturally safe care, stakeholders felt they provided limited practical direction for working with culturally and linguistically diverse participants. Access to interpreters and culturally appropriate services was inconsistent, leading to reliance on family members, which can influence engagement in goal setting and self-management. Language, health literacy, and unfamiliarity with service systems were seen to compound existing inequities.

Recommendations for promoting equity and service access in TCP

- **Embed systematic screening for vulnerability at intake**
- **Initiate exit planning from the start of the episode**
- **Strengthen pathways to ongoing community and primary care**
- **Improve access to allied health in residential TCP settings**
- **Create mechanisms to progress home modifications beyond TCP**
- **Enhance cultural safety and interpreter access**

Technology and innovation

Stakeholders consistently described telehealth and digital tools as essential components of care delivery, yet uptake across the sector remains uneven. Providers reported that while technology offers clear opportunities to address longstanding access barriers, particularly in rural and remote areas, implementation is constrained by a combination of client, workforce and system-level factors.

Digital literacy and connectivity were the most frequently cited barriers. Providers noted that many clients lack the skills or confidence to use technology independently, limiting the feasibility of fully remote models of care. As one participant reflected, *'I feel very strongly that this is absolutely critical. But- I think we're working with a client group that is still not independently able to use technology.'* Connectivity issues further compound these challenges, with rural providers emphasising that, *'just getting the technology to work in someone's home is still a barrier.'*

Despite these limitations, stakeholders highlighted the significant potential of telehealth to improve access, efficiency and multidisciplinary collaboration. Providers in rural areas described telehealth as enabling more agile and interprofessional practice, *'I absolutely think that it helps have a much more interprofessional approach as well as address access issues for us, you know, access and efficiency issues for us in rural areas.'* Telehealth was also seen as a practical response to workforce shortages, reducing travel time and enabling clinicians to support multiple clients simultaneously. Group telehealth programs, such as physiotherapy home-exercise groups were viewed as particularly effective.

Promising hybrid models were also identified, including arrangements where a clinician delivers care remotely while a trained support worker provides in-home assistance. These models were seen as especially valuable in regional settings where access to specialised professionals is limited.

However, uptake of telehealth is also shaped by client expectations and funding arrangements. Providers observed that clients who contribute co-payments often prefer face-to-face services, with one noting a *'reluctance of people to accept telehealth when they are co-paying for a community-based service.'*

Internal workforce factors further influence adoption. Some clinicians remain resistant to telehealth, preferring traditional in-person practice, *'there is a workforce issue after all of these years, we still have clinicians who are resistant to using it and want to be face to face sitting in a room."*

Restrictive organisational IT systems were also described as limiting flexibility and innovation. Overall, stakeholders viewed technology as a necessary but insufficient solution. While telehealth and digital tools can help bridge access and workforce gaps, their effectiveness depends on addressing digital literacy, connectivity, clinician capability, and system-level constraints.

Recommendations for integrating technology and innovation into TCP

- **Strengthen digital access and literacy supports for clients**
- **Invest in connectivity solutions for regional and rural areas**
- **Build clinician capability and confidence in telehealth delivery**
- **Address organisational and IT system barriers**

Limitations to guideline uptake

While stakeholders welcomed many aspects of the 2026 Transition Care Programme Guideline update, several limitations were identified, particularly the requirement for a dementia assessment for all clients. Clinicians expressed strong reservations about the universal application of cognitive assessments, noting that it can be unnecessarily burdensome and clinically inappropriate for some individuals. As one stakeholder explained, *'it's a lot to put a person through when you know it might not necessarily be needed for that person.'* Staff described the process as confronting for clients and questioned the value of repeating assessments *"just to tick a few boxes,"* especially when a diagnosis is already known.

Concerns also extended to the practical implications of the guideline changes for the broader workforce. Personal care workers (PCWs), while not responsible for setting goals, play a central role in delivering restorative care and supporting clients to work toward their goals. Stakeholders highlighted a current gap in training for PCWs, emphasising the need to ensure they are equipped with the skills and language of restorative practice. Embedding a consistent 'doing with, not doing for' approach across all levels of the service was seen as essential to maintaining fidelity to restorative care principles.

Overall, stakeholders felt that while the updated guidelines provide important direction, some requirements risk adding unnecessary burden without clear benefit, and greater attention is needed to workforce capability- particularly for those delivering day-to-day restorative support.

5. Discussion

The national stakeholder workshop highlighted strong sector endorsement of the restorative intent underpinning the updated Transition Care Programme Guidelines. Participants agreed that the guidelines largely formalise existing good practice rather than introduce a new model, reinforcing long-standing principles of person-centred goal setting, multidisciplinary input, and time-limited, therapy-focused care. However, the workshop also revealed a significant gap between the aspirations of the guidelines and the realities of service delivery across Australia.

Workforce shortages, particularly in allied health, nursing, and primary care, remain the most substantial barrier to implementing restorative care as intended. These shortages are not confined to rural and remote areas; they are now a system-wide constraint that limits access, narrows the scope of multidisciplinary practice, and contributes to reliance on brokered services. This reliance, while necessary, complicates communication, increases costs, and reduces opportunities for coordinated goal-directed care. These findings reinforce the need for strengthened multidisciplinary capacity and flexible workforce models that can sustain restorative practice.

The workshop also underscored the complexity of delivering high-quality goal setting within a short-term programme. Staff require advanced skills to support meaningful, iterative goal development, yet turnover and operational pressures have eroded training consistency. The limitations of current outcome measures, such as the Modified Barthel Index, further constrain the ability to demonstrate progress. These insights highlight the importance of building capability in person-centred goal setting and reviewing measurement tools to better capture restorative gains. Participants emphasised that TCP cannot be viewed as a standalone episode. System fragmentation, long waits for Support at Home packages, and limited community services mean that many clients experience a sharp drop-off in support after discharge, undermining the gains achieved during TCP. Early and realistic exit planning, stronger primary-care pathways, and clearer post-TCP referral processes are essential to sustaining outcomes.

Equity concerns were prominent throughout discussions. Financial hardship, unstable housing, low health literacy, limited access to interpreters, and geographic isolation all influence engagement and outcomes. Stakeholders questioned whether the guidelines sufficiently address the needs of

people experiencing socioeconomic disadvantage, cultural and linguistic barriers, or limited access to ongoing care. These findings point to the need for systematic vulnerability screening, culturally safe practice supports, and mechanisms to progress home modifications and other environmental interventions beyond the TCP episode.

Finally, while technology and telehealth were widely recognised as enablers of access and efficiency, uptake remains inconsistent. Digital literacy, connectivity, clinician confidence, and restrictive IT systems continue to limit implementation. Hybrid models and group telehealth were viewed as promising, but require investment in workforce capability and infrastructure.
Overall, the workshop findings demonstrate that while the updated guidelines provide a strong conceptual foundation, their successful implementation depends on addressing structural, workforce, and equity barriers that influence the implementation of the guidelines into practice.

6. Conclusion

The updated Transition Care Programme Guidelines offer a clear framework for restorative, goal-oriented care. Stakeholders acknowledged the value of this direction and expressed strong commitment to delivering high-quality, person-centred restorative care. However, the workshop highlighted that realising the full intent of the guidelines requires system-level action. Workforce shortages, fragmented care pathways, inequitable access to services, and variable digital capability all constrain the ability of providers to deliver restorative care consistently and sustainably.

The recommendations arising from this white paper outline practical steps to strengthen workforce capacity, enhance multidisciplinary practice, improve goal-setting processes, support planned transitions, promote equity, and expand the effective use of technology. Implementing these recommendations will help ensure that restorative care can be embedded into TCP services, optimising independence, safe transitions, and outcomes for older people recovering from hospitalisation.

7. References

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8. Appendices

Appendix 1- Semi structured interview guide

Discussion questions

We have a range of questions we will ask to lead discussion and would like you to share your personal experiences of delivering restorative care as part of Transition Care Programme's and how this may have influenced outcomes.

1. How have you interpreted the restorative care recommendations in your service context? (Have you used/seen them?)
    a. What aspects of the recommendations have been easiest or hardest to implement so far?
2. What impact has the multidisciplinary focus had on your team?

- Are you impacted by workforce availability, training and/or understanding of restorative care?
- What supports or resources would make collaboration easier?
- How have the recommendations impacted goal setting?
    a. How have the recommendations influenced the way goals are set with clients?
- Have you noticed a shift toward more person-centred or goal-oriented planning?
    b. What strategies have worked well for engaging clients in goal setting?

3. Are there specific challenges working with culturally and linguistically diverse (CALD) individuals and/or individuals from socio-economically vulnerable backgrounds or living in unstable or unsuitable housing locations that should be considered?
4. What might be the impact of restorative care recommendations on integrated care pathways and safe discharge planning to prevent readmissions?
    a. How might this change care delivery?
    b. Do these guidelines/restorative care approach keep people in their homes/out of hospital/
5. What tools, training, or resources would help you implement restorative care effectively?

- What role could technology or digital solutions play in supporting a restorative care approach in Transition Care Programmes?
- What would success look like for your organisation in adopting these recommendations?
    a. Clinical outcomes
        i. Quality of life/client preference
    b. Financial?
    c. Rates of readmission?
- Clients become ongoing customer of TCP provider?

OPTIONAL

6. If you could change one thing in the guidelines to make implementation easier, what would it be?