APPENDIX B

EVALUATION OF REGIONAL INTERIM CARE MODELS

INTRODUCTION

Appendix B describes the various Interim Care Program models that are being used at the five metropolitan health services in Melbourne. The data sources are documentation from the Interim Care Programs and consultations with Interim Care Program Managers, staff, patients and carers.

The Interim Care Program descriptions are structured by health service and summmarise the main features of the Interim Care Programs implemented by the Health Services in the financial year 2001-2002.

EASTERN HEALTH

HEALTH SERVICE PROFILE

Eastern Health delivers:

- Acute Health;
- Aged Care, Rehabilitation and Community Health; and
- Mental Health Services,

to their catchment area, who reside in the central east, outer east, and Yarra Ranges areas of greater metropolitan Melbourne.

The health services are delivered from five main campuses at:

- Angliss Hospital;
- Box Hill Hospital;
- Maroondah Hospital;
- Peter James Centre; and
- Healesville and District Hospital.

In 2000, the population of the catchment areas was estimated to be 736,000 people.

HOSPITAL DEMAND MANAGEMENT STRATEGY

Hospital Demand Management strategies at Eastern Health include:

- Short Stay Units in acute hospitals;
- Enhanced Allied Health in Emergency Departments;
- Appointment of multi-disciplinary co-ordination staff in Emergency Departments;
- Appointment of Senior Clinical Physicians in Emergency Departments;
- Development of Pathways;
- Development of Interim Care Strategies;
- Expansion of Falls and Balance Clinics; and
- Prevention Strategies.

GENESIS OF THE PROGRAM

In 2000/2001, the Box Hill and Maroondah Hospitals commenced Interim Care initiatives as part of the then DHS Winter Beds Strategy prior to the currently funded program. The initiatives included a 15 bed commissioned 'ward' within Maroondah Hospital. The ward was utilised by both Box Hill and Maroondah patients awaiting high or low level care placement.

In addition to the ward, the health service sub-contracted occasional beds in the central east at various aged care facilities, such as nursing homes and hostels in an adhoc/as required manner. In the Outer East, Eastern Health had significant difficulty finding occasional beds to sub-contract, which contrasted with the Central East, where ad hoc beds were more readily available.

FINDINGS

Eastern Health originally intended to staff the Maroondah ward similar to a residential aged care high level staffing ratio. However, the nursing staff indicated their dissatisfaction with high level type staffing ratios being applied, partly due to the more complex mix of patients than would be found in a community nursing home, and significant industrial issues resulted.

The care provided to the patients was limited by the physical constraints of the building. There were minimal day activities and there was also difficulty in case managing patients when managed by off-site case managers. In addition, because patients were still being cared for in an acute setting, medical, investigative and clinical interventions were more complex than residential aged care high levels.

One hundred and thirty nine patients were admitted to the ward, which was about one-third of all residential aged care high level patients that were waiting in Eastern Health in the financial year. There was an average length of stay of 37.7 days for these patients.

The primary benefit derived from the ward was that all patients were in a core setting which although not custom designed for Interim Care, was reasonably central for the case managers located at Box Hill, and provided valuable experience for future developments.

INTERIM CARE MODEL

The three models in the current Interim Care Model at Eastern Health are:

- Sub-contracting of core beds in aged care facilities or Supported Residential Services (SRS);
- Ad hoc sub-contracting of a nursing home or other supported residential care beds, including hostels; and
- Provision of Nursing Care at Home support services (Home-Based model).

CORE BEDS - EH-SRS1

EH-SRS1 is a residential aged care facility with Commonwealth funded residential care beds and SRS units in the Outer East. The EH-SRS1 is seen as a major Interim Care initiative within Eastern Health. This program is predominantly orientated towards patients who reside in the Outer East Local Government Areas (Knox, Maroondah and Yarra Ranges) and who are inpatients at Maroondah Hospital and Angliss Health Service. In late 2001/2, the initiative was extended to Box Hill Hospital.

EH-SRS1 is a new purpose built aged care facility. It comprises a 65 bed Commonwealth accredited low level care hostel and operates the remainder of its beds as a Supported Residential Service providing high level of care commensurate with Commonwealth Standards.. EH-SRS1 has a total of 239 beds, with three 12-bed non-commissioned cottages, and currently they have two of these cottages available for Interim Care. TAC currently lease the other cottage for their brain injured clients.

The 12-bed cottages have single bed rooms with ample space for aids and appliances in the doorways and halls. The cottages are modern and designed for the nursing home type patients.

STAFFING

Angliss and Maroondah provide:

- Medical consultation immediately prior to transfer;
- Weekly geriatrician visit;
- Continuous case management;
- Pharmacy supplies and auditing;
- Routine ward supplies;
- Continence supplies, continuous oxygen, aids and equipment;

- Allied health services, with regular weekly physiotherapy sessions and other services required by the individual patients; and
- Local GPs (accredited by Angliss) visit within 24 hours of admission and weekly thereafter, and when clinically required.

Pharmaceutical supplies were originally supplied by a private pharmacy, and paid for by Eastern Health. Currently, at EH-SRS1 pharmaceutical supplies are provided by Maroondah Hospital pharmacy at no cost to the patient. Other core bed day services use the original arrangement of being supplied by a private pharmacy, and paid for by Eastern Health.

The local GPs, who are accredited by Angliss, are paid by Eastern Health and do not use the Medical Benefits Scheme for payment for services to the Interim Care patients.

The after hours medical service is through the Emergency Department at either Angliss or Maroondah. The current after-hours protocol is for the Nurse Unit Manager at EH-SRS1 contacts the Emergency Department Consultant to discuss the patient's condition. The course of action may include a visit by the hospital after hours nurse, or transfer by ambulance to the Emergency Department.

Nursing Staffing levels are such that a Registered Nurse is always present for the 24 Interim Care patients. Division 2 nurses, or Personal Care Attendants are present in the following staff:patient ratios:

- AM: 1:6;
- PM 1:7; and
- Night 1:10.

EH-SRS1did not use agency staff for the first seven months of the year 2002.

FUNDING

Eastern Health is charged $135 per bed day by EH-SRS1. Eastern Health receives $240 per bed day from the DHS for Interim Care patients. In addition, Eastern Health charges patients the equivalent of the standard nursing type resident charge.

OCCUPANCY

At the end of March 2002, 198 patients have been cared for, with an average LOS 18.7 days.

CORE BEDS – EH-RACF2

EH-RACF2 Residential Care Facility was a short term (six month) Interim Care strategy. EH-RACF2 is a very high quality 120 bed facility, but has Commonwealth licences for only 30 beds. The main source of Interim Care patients to this facility is the Peter James Centre. The facility is expecting more licences to be available at the end of the 2001-2002 financial year. The facility was available for the Interim Care Program from August 2001 and was wound down for the end of the 2001-2002 financial year.

Eastern Health contracted 9 beds from the EH-RACF2 facility. Eastern Health was charged $200 per bed day by EH-RACF2, with the equivalent of standard resident day rate being recovered by Eastern Health from the patient. This is considerably higher than the amount Eastern Health was being charged at EH-SRS1. The reason for the variance was the number and type of available services, including all medical and surgical supplies, continuous oxygen supplies, medical coverage and pharmacy available at EH-RACF2, along with the presence of allied health staff onsite. Peter James Centre provides case management and oversighting by a hospital geriatrician. Nursing staffing ratios were maintained at the same ratios as the EH-SRS1 model. Nursing Staffing levels are such that a Registered Nurse is always present for 30 patients in the facility. Division 2 nurses, or Personal Care Attendants are present in the following staff:patient ratios:

- AM: 1:6;
- PM 1:7; and

- Night 1:10.

Similar to EH-SRS1, the relevant hospital medical record was transferred to EH-RACF2 with the patient and was used by the staff for patient's continuance of care.

AD HOC PURCHASING

This strategy is orientated towards patients who are admitted to Box Hill Hospital and subsequently require Interim Care, and who would generally reside in the Local Government Areas of Manningham and Whitehorse.

The project was driven by a lack of suitable permanent or semi-permanent residential care facilities in the geographic area surrounding Box Hill Hospital. The models were ad hoc and were reactive depending on the availability of beds in the area at the time of placement. The types of models that were used include:

- Using a fixed number of Commonwealth funded beds in an extra services high care residential facility. The nursing home is EH-RACF3 Nursing Home. Eastern Health pays the nursing home $170/day. There is no patient contribution for the bed. The Residential Care Score is completed on the patient's admission to the nursing home. EH-RACF3 home receives the Commonwealth subsidy and the Eastern Health payments. The EH-RACF3 is responsible for placing the patient. The Eastern Health program manager responsible for negotiating this arrangement believes that as the RCS had been completed, then it is easier to place the patients, as other facilities were more willing to accept classified patients. This strategy has been used for 49 patients between May 2001 and June 2002;
- Arrangements were made to contract Commonwealth funded bed days in an ad hoc fashion as required. The bed days that were used were respite or permanent beds that were vacant. The facilities were often not confined to the Eastern Health catchment, but were geographically diverse, including rural areas, depending on the needs of the patient. The Resident Classification Scale (RCS) was not completed at the facility. As well as the Commonwealth funds, the facility caring for the patient received a negotiated rate varying between $28 and $85 per day. There was no financial patient contribution for the care delivered. This has been utilised between May 2000 and June 2002, to purchase bed days for 54 patients;
- Transferring patients into GEM beds at Peter James Centre to await placement. This was used for a short time only as there were vacant beds at the Peter James Centre at that time. This was used in April 2000 for only 7 patients;
- Returning patients to their own low care hostels with top up money to cater for increased care needs. The top up rates were negotiated, depending on the care packages that were agreed between the facility and Eastern Health. The patients, prior to their acute hospital admission had been low level type patients. The rates of payments to the hostels varied, and were generally approximately $140 per day, but could be up to $200 per day. No patient contributions were sought for their care. A total of 13 patients between May 2000 and April 2002 were involved in this plan.[1].
- Returning patients to their (or other) SRS facilities with top up money to cater for increased care needs. The rates that Eastern Health paid to the SRS facilities were negotiated depending on the level of care that was agreed between Eastern Health and the facility. Fifty-three patients received this type of care between May 2000 and June 2002;
- Using Interim Care beds at Maroondah Hospital. This model was described in Section 2.2 (58 patients between May 2000 and February 2001);
- Discharging patients home with a care package to cater for increased needs. The care packages were provided by Community Options providers. The patient needed to have a fit and able carer at home as Eastern Health could not afford to provide a 24/7 service. Eastern Health budgeted for the service to cost $170 per day. Patients were asked for a contribution for their care, but there was no compulsion for

[1] The Commonwealth has an "Ageing in Place" program that pays for extra care needs in low care facilities that may make a useful contribution for this category of patients.

patients to pay. The manager at Eastern Health explained that the payment contribution to their care was explained to the patients as similar to a donation, and the payment was entirely voluntary. (9 patients between May 2000 and April 2002); and

- Bed substitution for overnight and same day surgical patients. This model is not applicable for Interim Care patients. It is designed for patients who are travelling to or from rural areas to an Eastern Health campus for a surgical or diagnostic procedure. They are, on the whole, non-nursing type patients. The night before admission to the Eastern Health campus, they may stay at a SRS facility where minor pre-operative procedures, such as bowel preparation can be undertaken. (38 patients between December 2001 and April 2002.)

The data on the number of patients in the various schemes does not include those who were still in Interim Care as at April 30th 2002.

NURSING CARE @ HOME

The Nursing Care @ Home Service is a Home-Based Interim Care model that just commenced at Eastern Health at the start of the 2002/2003 financial year. Case management is contracted to Care Connect (Angliss and Maroondah) and to Uniting Care (Box Hill). Additional services such as nursing, allied health, and PCAs are contracted through the case management agencies or with relevant agencies in the person's local community.

Pharmaceutical supplies will be by a private pharmacy, and paid for by Eastern Health. The local GPs, who are accredited by an Eastern Health hospital, are paid by Eastern Health and do not use the Medical Benefits Scheme for payment for services to the Interim Care patients.

CONTRACTS

There is a written agreement between Eastern Health and providers of 'core' bed days. For providers of one off placements of patients, Eastern Health send a letter when the patient is being placed, outlining the arrangement.

QUALITY ASSURANCE

Eastern Health apply the levels of Commonwealth high level care standards and the associated quality guidelines to the providers of Interim Care core Bed Days and adhoc Bed Days Purchasing. All services that provide core Interim Care services are required to be compliant with the these standards and it is part of the agreement between Eastern Health and the provider that these standards are maintained for the Interim Care patients.

Agencies that are used for Nursing Care at Home are accredited through their own relevant agency.

In addition, some Key Performance Indicators have been developed by Eastern Health specifically for the Interim Care Program:

- Barthel Index Score monitoring;
- Notification of Complaints and incidents in accordance with both Commonwealth and Hospital processes;
- Monitoring of ambulance transfers; and
- Auditing of pharmacy / drug supply.

COMPLAINTS

The providers of core bed days in place abide by Commonwealth guidelines for accreditation and also the Eastern Health process for complaints monitoring. In relation to Eastern Health, complaints are managed in accordance with routine hospital procedure and form part of their monitoring system.

There have been three complaints from patients at EH-SRS1. One was a complaint about food which was investigated by a hospital dietician and recommendations (an extra piece of fruit placed in the common dining room) made. Another highlighted co-ordination issues between the hospital and the facility and the other was regarding payment issues.

All complaints were investigated according to the routine Eastern Health process and changes made were found to be necessary.

INFORMATION PROVIDED TO PATIENTS

Families, carers and patients have meetings with the Eastern Health Social Worker where the process of discharge to the Interim Care Ward is outlined. A letter or flyer is also available for families, carers, and patients. Through meetings and information the purpose of the program, time-limits, hospital care and support commitments and patient/family responsibilities, right to complaint and procedure etc. are covered.

BARRIERS TO INTERIM CARE PROGRAM INCLUSION

The current Interim Care arrangements at Eastern Health do not cater for or have limited ability to care for:

- Patients with dementia demonstrating disruptive / aggressive behaviour;
- Wanderers at the higher end of severity;
- Complex care; and
- Complex / disruptive family arrangements.

STAFF RECRUITMENT AND TRAINING

Staff for the Interim Care Program are recruited from both internal sources through Eastern Health & external sources. In cases where occasional sessional work is required this was usually recruited from Eastern Health internal part time employees who appreciated extra work, more substantial positions were recruited externally. At the Sub-contracted Bed Based Services models such as EH-SRS1 all nursing care is sub contracted to the facility, and the facility is responsible for staff recruitment. The GPs and pharmacist were from external resources until this year where one of the models – EH-SRS1 has brought the service in house.

Eastern Health formed an agreement with the private provider of care, such as EH-SRS1, regarding the resource level and classification of staff in 'core' settings where there is substantial bed allocation. At the core beds sites, the staff classification and levels are based on Commonwealth guidelines/standards for high level residential aged care.

INDUCTION

For new staff employed by Eastern Health hospitals all staff were placed through the hospital's orientation program. Meetings with relevant staff across campuses, including allied health, pharmacists, Health Information Managers etc and within each hospital such as Nurse Managers, Ward Clerks, Supply and reception staff have taken place to explain the Interim Care project and discuss implications in all areas.

For staff sub-contacted via the private facilities, the facilities undertook their orientation as the employer and information was specifically provided about the Interim Care Program.

SPECIFIC TRAINING

Specific training has occurred at EH-SRS1for staff on the following:

- Continence aids;
- Barthel Index Score measurement and scoring;
- Lifting patients with specific conditions;
- Social Work placement;
- Physiotherapy training for nursing staff for ongoing therapy ;

- In addition nursing staff at EH-SRS1have been included in the Maroondah Hospital nursing in-service program.

Training was specific for high level of care patients and often involved specific trained staff in these areas eg Continence.

Other service providers have had similar training sessions, or are currently planning them.

DISCHARGE PLANNING

Prior to the transfer to the Interim Care facility, every family, carer and patient has a meeting (usually a number of them) with the Eastern Health Social worker where the process is outlined. A written pamphlet is also available for the patients. Through meetings and written information the purpose of the program, time-limits, hospital care, support commitments, patient/family responsibilities, right to complaint and procedure etc. are covered.

When a patient is being discharged from an Eastern Health acute or subacute facility to the Interim Care Program, the following process is followed.

There is notification that a bed is available at an Interim Care core facility.

The Social Worker:

- Advises the patient's ward of the transfer;
- Advises the patient/family/carer;
- Liaises with Interim Care facility – patient information, timing transfer;
- Ensures all information is completed and any special care supplies, aids and/or equipment is transferred with the family;
- Informs the family when patient transferred.

The patient's ward arranges:

- medical discharge summary;
- nursing care plan;
- monthly drug chart;
- via Pharmacy a supply of medications;
- ambulance transfer;
- medical records to code file (so patients file can go to 'core' facility);
- informs Health Information Manager re patient transfer; and
- File transfer.

When a patient is discharged from an Interim Care 'core' facility, the following process occurs:

The Interim Care Nurse Unit Manager advises:

- Patient's family;
- Liaises with receiving nursing home and provides care plan, medical discharge, and drug transfer;
- hospital Social worker;
- Ambulance;
- GP with a summary forwarded;
- Eastern Health Patient File returned to Eastern Health hospital (applicable for 'core' services).

OTHER ISSUES

CULTURAL ISSUES

Eastern Health have had only a few requests for culturally specific care needs, which reflects the demography of the region having a low proportion of culturally and linguistically diverse people. On the occasions when there were specific requirements requested, the requests have been adhered to.

SUCCESS FACTORS

Continuous and dedicated case management has been critical in assuring patient flow. The flexibility and cooperation with the Interim Care facilities has also been a critical factor. The program managers believe that the staff's willingness to change practices and take on new projects has been exceptional.

INFECTION RATE

No program data on infection rate were available, however the Eastern Health Interim Care program manager reported that there have been no re-admissions or adverse events resulting from infections.

CHANGES SINCE THE INTERIM CARE PROGRAM COMMENCED

The changes that the program managers have made to the Interim Care Program since its inception include:

- at 'core bed' facilities high care patients have access to physiotherapy three times a week as required, and a range of other therapy services not always obtainable in the busy acute wards;
- patients in Interim care are reviewed weekly by a Geriatrician. This does not necessarily occur on the acute/sub acute wards;
- additional activities co-ordinator services are provided routinely in Interim Care but not in acute wards for patients waiting residential care placement;
- improved linkages between campus pharmacies improving communication on drug sensitivities;
- improved protocols for medical record transfer between sites resulting in improved clinical co-ordination;
- improved bed management and co-operation across all sites;
- improved purchasing arrangements and protocols;
- co-ordinated Geriatrician coverage and patient management;
- increased range of care options for families to choose for patient waiting permanent nursing home placement; and
- Development of consistent practice/protocols across campuses in Health information Management.

FUTURE PLANS

The ad hoc purchasing arrangements are being wound down to essentially be minimised at the end of the 2001/2002 financial year. The major emphasis at Eastern Health will be on negotiating arrangements for core beds.

In the 2002/2003 financial year, the plan is to have:

- 24 beds at EH-SRS1;
- 10 beds at EH-SRS4;
- 5 beds at EH-RACF3 Nursing Home; and
- 16 planned places for Nursing Care @ Home.

SUMMARY OF FINDINGS OF PATIENT/CARER CONSULTATIONS

There were 6 attendees representing four former and current patients at the EH-SRS1 facility. The method of consultation was via a group face-to-face consultation.

INFORMATION

Patients and carers commented that they did not receive any written information about the EH-SRS1 facility, and the purpose of the Interim Care facility. Two patients also stated that they received little verbal information about the facility and the Interim Care project, prior to their arrival at EH-SRS1.

One patient stated that he had ½ hour notice of moving from the acute ward to EH-SRS1, which he found quite stressful.

There was also a little uncertainty amongst the participants regarding the payment schedule for Interim Care at EH-SRS1.

CARE

All participants were very pleased with the type and level of care that they had received. They recognised that the level of care is different to the care provided on the acute wards, but it is more appropriate to their level of need.

STAFF

The participants commented that there was little turnover of nursing which facilitated continuity of care, and was a factor in ensuring that the patients were comfortable in the environment at EH-SRS1.

Most of the participants were all satisfied with the level of medical and allied health cover that they received at EH-SRS1. The medical Geriatrician and Social Worker ward round that is held on Thursdays is also reassuring for the patients and carers. One patient would like to see the social worker from Eastern Health more often.

A patient without significant carer support stated that adequate assistance was being provided by the social worker to obtain a placement in a residential aged care facility.

FACILITY

All the patients and carers commented that the facilities at EH-SRS1 were excellent, and wished that all residential facilities were of similar standard.

MELBOURNE HEALTH

HEALTH SERVICE PROFILE

Melbourne Health Service is a leading health care provider serving metropolitan and country Victorians through the provision of acute, sub-acute and community based programs.

Melbourne Health is Victoria's second largest health service, with an annual budget of $500 million, 6000 equivalent full time staff and managing 1200 beds across inpatient, community and residential services. The Service cares for 800,000 residents living in the northwestern communities of Melbourne.

Melbourne Health has one acute health service, the Royal Melbourne Hospital, with 350 beds. Melbourne Health's subacute facility is the Melbourne Extended Care and Rehabilitation Centre (MECRS). MECRS has 137 subacute beds, in addition to 80-83 low care beds and 21-bed high care beds at its main site in Parkville. There are two other sites that are geographically separate from Royal Melbourne and MECRS facilities with high level care beds, with 30 and 45 beds.

HOSPITAL DEMAND MANAGEMENT STRATEGY

Other Hospital Demand Management strategies that have been developed at Melbourne Health are:

- Discharge Co-ordinator in Royal Melbourne Hospital Emergency Department. Their role is the early identification of patients who may require residential care. The aim is to reduce the time between notification of residential care status and medical stability being achieved;
- Co-ordinated aged care and rehabilitation referrals integrated with the main acute referral sources – general medicine, stroke and orthopaedic.
- Prompt placement policy from RMH to MECRS when an acute episode has stabilised;
- Analysis of Risk Identification Factors that are the barriers to a patient being placed in residential care. These are continually monitored, reported, and steps taken to minimise or reduce them;
- Triage functions are undertaken at RMH Emergency Department with possible admission directly to MECRS GEM; and
- Priority at MECRS to admit RMH patients, over community patients, when previously community patients were given priority.

GENESIS OF THE PROGRAM

Melbourne Health's two campuses are located in Parkville, in the inner northern suburbs of Melbourne. According to the program managers at MECRS, the growth of the younger demographic in this area, together with the substantial increase in real estate prices, and the need for older facilities to upgrade and increase their size has resulted in the number of high level care beds in the inner northern suburbs reduced. The high level beds have tended to be relocated in the outer northern suburbs, resulting in considerable placement problems for MECRS high level care patients who live in the inner / middle suburbs of Melbourne.

MECRS are having increasing difficulty accessing GPs to medically service their patients.

A significant motivating factor for Melbourne Health to implement the Interim Care strategy was the large ambulance bypass rates experienced at Royal Melbourne Hospital. MECRS was not admitting non-rehabilitation patients (ie patients with Interim Care criteria) which was creating a bed blockage in RMH medical wards, and subsequently in the RMH Emergency Department.

INTERIM CARE MODEL

Melbourne Health is using a ward model for their Interim Care program at the MECRS campus. A closed ward was recommissioned into a 30 bed Interim Care ward which also manages GEM patients. The ward was recommissioned using funds from the Department of Human Services in the order of $250,000, as well as Melbourne Health infrastructure funds.

Melbourne Health initially planned to open more beds in summer and autumn as per the originally planned 54 bed ward, but the demand was not present. Melbourne Health partially attribute their changes in clinical processes (see previous section Hospital Demand Management Strategy) for the reduced demand for beds at RMH.

The building where the Interim Care ward is housed is over 100 years old. Consequently, the old facility incurs considerable maintenance costs for Melbourne Health. The ward has mostly 4-bed bays, which are reasonably small, although a large common area is available for use by the patients and their families.

MECRS has four subacute wards, which consists of two general wards, one secure ward for clients who are confused or who wander, and one Interim Care ward. Melbourne Health describe their model as a patient focussed model, as opposed to a bed focussed model. The two general wards and the Interim Care ward have capabilities to house GEM patients, and patients designated as Interim Care may be accommodated in the general wards. Therefore, Interim Care patients may be accommodated in a general ward, or the Interim Care ward, depending on availability of beds when they transfer from the Royal Melbourne Hospital. Similarly, a GEM or rehabilitation patient may be accommodated in the Interim Care or general wards at MECRS.

The rationale, according to the program managers at MECRS, for this method of patient allocation is two-fold:

- Medical supervision is more acute and constant on a GEM ward. If an Interim Care patient deteriorates or becomes more acutely ill, this episode can be intervened medically in a more timely manner in these types of wards; and
- A ward with solely Interim Care patients tends to be resource intensive from a nursing perspective, with manual handling a key issue. Distributing the patients throughout the three wards tends to reduce the occupational lifting requirements of the nursing staff.

The managers at MECRS claim that having an integrated model, with GEM and Interim Care co-located in all wards enables the health service to manage RMH beds more effectively. The next patient on the list, whether they are GEM, Rehabilitation or Interim Care is discharged from RMH and admitted to MECRS, rather than selecting patients in a certain category according to who was discharged from MECRS. Using flexible bed numbers ensures that Melbourne Health do not have a backlog of Interim Care patients at RMH waiting for MECRS admission if demand increases. In this situation, they temporarily use more of their bed pool at MECRS for this purpose.

However, at times, it is felt that families of Interim Care patients may hold have unrealistic expectations that the patient maybe improve and therefore will not have to access a residential care facility. This expectation may be reinforced by the presence of rehabilitation patients in the ward. A strength of a completely separate Interim Care ward would be that there is a clear message to the families that they need to pursue the residential care option. However the staff felt that this challenge did not outweigh the benefits of their integrated model.

INTERIM CARE AT HOME

Melbourne Health has also commenced a small community based service for Interim Care patients. In August 2002, approximately 10% of the patients, who access Interim Care at Melbourne Health, have a trial at home via this program.

Brokered services are used to provide care plans to the patients on the service. The services are brokered through the providers that are used for Post Acute Care and CACPS services.

A major barrier to these types of services being provided is the lack of community services available to patients, especially those who have been assessed as high level care, after the Interim Care Program has ceased to cater for their needs.

STAFFING

As the two general wards and the Interim Care ward all have GEM capability, they are staffed according to a subacute formula of 5:1 nurses:patients.

Medically the Interim Care patients have the same access to medical staff as the GEM patients. Therefore the patients are reviewed by a consultant, a registrar on a 54:1 patient ratio, and a House Medical Officer on a 30:1 patient ratio.

FUNDING

Patients are charged the standard nursing home type residential co-payment for their time spent in an Interim Care bed. Thus the funding that Melbourne Health receive for an Interim Care bed consists of the $240 per bed day rate from DHS, plus the standard residential co-payment from the patient.

CONTRACTS

There are formal agreements with the brokered services for the Interim Care packages at home.

STAFF RECRUITMENT AND INDUCTION

As the service is ward based, staff are employed within Melbourne Health, both internally and externally, using the standard recruitment process.

There was not a specific induction process as Interim Care is integrated across the MECRS wards, and the staff service a combination of Interim Care and GEM beds. The Interim Care beds at home are integrated into a larger program that also manages MECRS CACPS packages. Again, they needed little induction as team members were already competent case managers to patients who live in the community.

BANK / AGENCY STAFF

The amount of agency usage for the Interim Care ward is reasonably consistent with the usage in other sub-acute wards at MECRS. On reviewing the acute agency usage, the agency usage in the Interim Care ward is also consistent with the acute setting.

QUALITY ASSURANCE

- KPIs for waitlisting within 2 weeks;
- Monitoring of number of patients and time to be admitted into the Interim Care Ward once decision is made to transfer to the Interim Care Ward;
- Monitoring that patients awaiting residential care are in Interim Care beds, instead of GEM or Rehabilitation beds, where feasible;
- Other Key Performance Indicators:
    - 80 % of referrals from the acute sector are admitted to Interim Care within 3 days of referral; and
    - 90% of clients do not exceed a length of stay of 90 days.

COMPLAINTS

The complaints mechanism is not specific for Interim Care patients, but is covered by the Melbourne Health guidelines.

At the time of compilation of the evaluation, the complaints data base at MECRS was inaccessible so the number of complaints received specifically related to interim beds could not be determined. The complaints process at MECRS is very thorough, with an information brochure on how to lodge a complaint or compliment distributed throughout the site.

CULTURAL ISSUES

Dieticians ensure that all patients have culturally appropriate food.

DISCHARGE PLANNING

FROM THE ACUTE/SUB-ACUTE SETTING:

The initial step is patients are referred to Royal Melbourne Hospital ACAS. Once a patient is assessed as suitable for Interim Care they are either transferred to MECRS as an inpatient, or they go home on an Interim Care package. The patient is usually transferred to MECRS within 24 hours or discharged home within 3 days. The MECRS Interim Care model is an integrated model - ie. Interim Care patients are not all housed in one ward, they are accommodated throughout the GEM wards. This gives the greatest flexibility as the bed configuration can alter with the change in demand for either GEM or Interim Care.

This also allows Melbourne Health to place the patient in the most suitable ward for example a patient who is wandering can be placed in a secure environment,.

FROM INTERIM CARE PROGRAM:

- Patients are reviewed weekly;
- Waitlisting as per protocol;
- If the patient improves and is showing potential, then they can be reclassified as GEM and the amount of rehabilitation they are receiving can increase.

BARRIERS TO INTERIM CARE INCLUSION

- According to the staff, the integrated model used at MECRS reduces the barriers. As stated above, patients are still within a ward that can monitor their improvement and therefore reclassify them if necessary;
- It has also reduced the waiting time for a patient in the acute sector as they are eligible for the next bed at MECRS, not the next Interim Care bed;
- The integrated model allows the patient to be in the most suitable ward eg. if a patient needs a secure GEM environment they are able to get this;
- There is no provision for young patients requiring residential care; and
- Special needs clients who require Interim Care still cannot get it - eg tracheostomy care.

CHANGES TO THE INTERIM CARE PROGRAM

The procedure by which a patient makes the transition to a residential care facility is now uniform across Melbourne Health. A Residential Care team has been established within the Social Work Department. This minimises the amount of change for the patient and family as they make the transition to residential care. It also makes the whole process quicker. For the majority of the time the residential care Social Worker stays with the patient from the acute setting all the way through to their placement in the residential care facility

The integrated model has facilitated an earlier identification of the patient as residential care by the MECRS wards. The ward team members are more comfortable in classifying a patient as residential care if the patient stays at the ward and can be reclassified if they show some improvement, and can be reassessed.

FUTURE PLANS

Melbourne Health are continuing to provide their Ward Based model at MECRS and the Interim Care at Home option of Interim Care in the financial year 2002-2003. They aim to increase the number of patients supported at home on the Interim Care Program in the year 2002-2003 compared to the previous year.

SUMMARY OF FINDINGS OF PATIENT / CARER CONSULTATIONS

There were 3 patients represented at MECRS, with 4 people in total attending the focus group. As one of the patients was accommodated in a separate ward to the other two patients, and because of the patient's elderly status, this patient was interviewed individually.

INFORMATION

There was a view amongst the three participants that the information about the Interim Care Program and the facility was inadequate, and was a cause of distress during their acute stay. In addition, one patient was moved very quickly from the acute wards, which they also found stressful.

CARE

The level and type of medical and nursing care was seen by the patients and carers as appropriate for their needs. All patients and carers were aware that their care requirements did not require the level of intensity as on an acute ward.

Two of the participants believed that their communication channels with the doctors were poor, especially regarding prospects for the future.

Two patients were having physiotherapy for a short period when admitted into Interim Care, but was discontinued. They believed that the physiotherapy was benefiting them from a maintenance perspective, and would like it continued. The other patient was referred to physiotherapy but did not want to be treated by the physiotherapists as he felt he was too old and did not have the energy.

STAFF

The nursing staff was viewed as caring and bright. One patient believed that although the numbers of staff were adequate, there did not seem to be many qualified staff.

There were differing views amongst the patients/carers regarding the assistance of social workers into the process of placement. One patient felt they were not of use, even though he had carer support, and spoke to the social workers on the ward round every week. The other three participants felt that the social workers provided good advise and assistance if requested.

All patients and carers stated that there was a lack of diversional activities, and they would appreciate more structured activity to be organised.

FACILITY

The physical environment was seen as inadequate by three of the four patients/carers. The beds were too close together, and there were too many in each room. The physical set up limited privacy, and discretion was lost.

Another problem was the lack of a bathroom with a shower trolley as the patient could not fit in a shower chair.

One patient stated that the food was not very good, although it did not differ from food in other institutions.

OTHER

Two of the patients believed that they were paying the standard daily rate but had not received an account to date.

NORTHERN HEALTH

HEALTH SERVICE PROFILE

The external environment of Northern Health is characterised by:

- Relatively new buildings in the acute and subacute services that currently have no further capacity for physical beds. There is a plan for Stage 2 expansion of the hospital ;
- Poor provision of residential care beds, with a ratio of 70.4 beds available per 1,000 of the population (70+ compared to a benchmark of 90); and
- Long waiting lists for community based long term care options, such as CACPs and Linkages.

Northern Health has one acute facility at The Northern Hospital. The Northern Hospital is a 225 bed general hospital, with 65 medical beds included in this facility.

Additionally Northern Health have two subacute facilities:

- Broadmeadows Health Service 48 beds; and
- Bundoora Extended Care Centre 70 beds.

GENESIS OF THE PROGRAM

The Evaluation of the Winter Demand Emergency Strategy (WEDS) which was designed for the winter months in 2000, identified the need for further service development to manage people who were waiting for residential care in acute and subacute beds

INTERIM CARE MODEL

Northern Health has trialled three models of Interim Care over the past year:

- In house bed substitution model. This was trialled under the Winter Emergency Demand Strategy in the year 2000/2001 and was continued in 2001/02.
- Residential-Based model; and
- Home based Service.

The models were dependent upon increasing the assessment capacity across Northern Health, and this is a critical element underpinning the latter two models trialled.

IN-HOUSE BED SUBSTITUTION MODEL

These beds are funded under the normal subacute funding stream, not the Interim Care Model. However, they are a critical element in Northern Health's approach.

The in-house substitution model is undertaken at Broadmeadows Health Service (BHS) campus. Currently, there are six beds that are used for patients fulfilling the criteria of the Interim Care model. In the financial year 2000/01, four of these beds were funded through the WEDS Strategy. In 2002/03 the funding was converted to the subacute bed day rate and capacity increased to six beds.

BHS has a total of 78 beds. As well as the interim care, the types of beds at BHS are:

- Palliative (20 beds);
- GEM (24 beds); and
- Rehabilitation (28 beds).

The program managers stated that although the program uses the Interim Care Program criteria, the patients, who are receiving care within this model, are not reported as Interim Care patients on the VAED.

The BHS Interim Care beds are reserved for The Northern Hospital patients only. BHS do not have any choice in receiving Interim Care patients from The Northern Hospital, in contrast to the Transitional Care Program, and NH-RACF1 Nursing Home.

As a consequence, the Interim Care patients admitted to BHS may be more complex, than those admitted to the Transitional Care Program or NH-RACF1. The program managers at BHS believe they admit a high proportion of patients who have dementia, and provide a security risk.

STAFFING

The interim beds are staffed according to subacute nursing ratios, as the beds are funded as GEM beds. The Interim Care Ward at BHS must have the capacity to cope with high care, complex Interim Care patients necessitating a sub-acute staffing ratio.

Allied Health is provided as necessary to Interim Care patients.

FUNDING

The funding for the beds is supplied as part of the normal subacute funding pool of resources. There is no charge to the patient, as the beds are funded under the subacute ratio.

RESIDENTIAL-BASED MODELS

NH-RACF1 NURSING HOME

NH-RACF1 is a private nursing home, from which Northern Health are using nine subcontracted beds. All nine beds are high level beds. The beds are located in a 24-bed wing within the facility that have been deemed extra service beds. NH-RACF1 currently has a total of 50 high level beds, including the Interim Care beds. These extra services beds were not being fully utilised by NH-RACF1. The NH-RACF1 model has been in operation since June 2001. NH-RACF1 was accredited in 2000, until August 2003.

The nine beds that Northern Health contracts from NH-RACF1 Nursing Home, includes nursing care, allied health, and diversional activities. Pharmacy supplies are via the Pharmaceutical Benefits Scheme.

As Interim Care patients are residents of NH-RACF1, they are statistically discharged from the Northern Hospital to Interim Care (as a contracted out service). They are maintained on the VAED as an Interim Care patient (contracted out service) until they are discharged from NH-RACF1 Nursing Home.

As a consequence, the Residential Classification Scale (RCS) is completed on arrival at NH-RACF1, so that the Commonwealth subsidy can be claimed by NH-RACF1.

Discussions between Northern Health and NH-RACF1 staff acknowledged that initially there were a couple of admissions that were unstable and probably inappropriate to the NH-RACF1 environment in the early stage of the Program. NH-RACF1 and The Northern Hospital negotiate on a patient by patient basis to ensure that a patient is suitable for the environment at NH-RACF1. The program managers state that they will admit most patients from the Interim Care team at Northern Health, however they do have choice. For example, NH-RACF1 can refuse Interim Care patients with PEGS if they already have a high number of patients who require PEG feeding.

Because of this, the Interim Care patients at NH-RACF1 are generally not as acute when the program initially commenced.

Staffing

For the NH-RACF1 facility as a whole, the facility is always staffed by at least two Division 1 nurses during the day (until 5 pm). At night, there is always one Division 1 nurse staffing the facility. During the day, there is two Division 2 nurses, whilst at night there is one Division 2 nurse.

The Clinical Nurse Manager, who is one of the Division 1 nurses during the day, has had their role restructured in early 2002. The restructure essentially involves a reduction in administrative duties to enable a clinical focus to be maintained.

In addition to the nursing staff, NH-RACF1 employ a "Team Leader" who may be a Division 1 or 2 nurse, or a Personal Care Attendant. The role of the Team Leader is to provide organisational capacity to the clinical staff. The team leader should also assist the clinical staff in any task that is requested. The team leader's assistance does not include medication rounds.

Medical cover is via the general practitioner. Northern Health funds a weekly geriatrician ward round. The ward round was introduced some months after the commencement of the program.

Northern Health provides case management via their social worker. The social worker from Northern Health and the NH-RACF1 nursing staff are present during a geriatrician ward round to facilitate quality care and communication.

Medical Records

As the patient is a resident of NH-RACF1, the NH-RACF1 medical record is utilised to record their care. However since the geriatrician has commenced ward round, The Northern Hospital's and NH-RACF1's medical records have been used for the ward round. The use of The Northern Hospital medical record necessitates the transferral of the medical record from the Health Information Management Department to NH-RACF1 for the duration of the ward round only.

Funding

Northern Health pays for the equivalent of the extra services rate that would normally be charged to a resident in one of the extra services beds. ie Northern Health pays NH-RACF1 $66.54 per bed day. NH-RACF1 Nursing home claims the Commonwealth subsidy and charges the resident the standard nursing home type per bed day rate.

Occupancy / Activity

The average occupancy rates for the nine Interim Care beds at NH-RACF1 since August 2001 are around 90%, with the lowest rate being 77% in December 2001. There have been 55 patients discharged from the program since its commencement, comprising 31 females and 24 males.

NH-RACF2

NH-RACF2 is a 57 bed low level (hostel). The model is co-ordinated from Bundoora Extended Care Centre.

Northern Health subcontract three beds from NH-RACF2 for the Interim Care Program. The NH-RACF2 facility is available for low care patients only. Under the Winter Emergency Demand Strategy, Bundoora Extended Care Centre (BECC) and The Northern Hospital have priority of access to the NH-RACF2 beds. BECC provides most of the patients to this facility. The purchasing arrangement with NH-RACF2 originally commenced under the Winter Emergency Demand Strategy, and is thus reported as GEM beds.

Staffing

There are two Registered Nurses working at NH-RACF2:

- 1 RN x Mon - Fri 9am - 12pm; and
- 1 Clinical Care Coordinator (RN) Mon - Fri 9am - 5pm (and on call 24 hours).

An Activities Manager works 24 hours/week, and an Activities Staff Member is allocated 27.5 hours/week at NH-RACF2. A Physiotherapy Aide is present for 30 hours.

Employing Registered nurses on staff is unusual for a hostel facility.

Funding

The three beds in NH-RACF2 that are sub-contracted by Northern Health are currently unlicensed beds. The other beds in NH-RACF2 are Commonwealth licensed beds. Northern Health sub-contract the beds at a rate

equivalent of the Commonwealth subsidy ie $71.95 per bed day, and the patient is charged the basic resident fee by Bundoora Extended Care Centre. Northern Health use subacute funding as their source for these funds. It costs Northern Health approximately the equivalent of 1.5 average subacute bed days to fund the 3 beds.

Prior to the development of the Interim Care program, the case management was provided by the BECC Social Work Department. Since the implementation of the BECC Interim Care Program, responsibility for managing Interim Care patients has been transferred to the Interim Care Program.

Medical cover is provided by the general practitioners, with geriatrician backup if necessary. These patients are low care patients and tend to be more medically stable than the NH-RACF1 patients, as they have had a longer period to recuperate due to their residency in BECC. Pharmaceuticals are provided under the Pharmaceuticals Benefits Scheme.

NH-RACF3

The NH-RACF3 model is a similar model to NH-RACF2, although NH-RACF3 is a high level facility. Northern Health sub-contracted five high level beds that are unlicensed beds at NH-RACF3. The main source of patients is BECC.

Northern Health are charged the equivalent of the Commonwealth Subsidy. This fee is calculated on the basis of the RCS level of care for residents in the 5 beds ie two 2 RCS patients and three 3 RCS patients. This formula resulted in an average rate of $140 per day. The resident is charged the basic resident fee by BECC.

A significant difference between the NH-RACF3 and NH-RACF2 models on one hand, and the NH-RACF1 model on the other is that there is no routine geriatrician round at NH-RACF3. The primary reason for this difference is the patients at NH-RACF3 tend to have longer stays at BECC than the acute patients from The Northern Hospital, and the patients medical management routines are well established. A geriatrician from Northern Health will consult an Interim Care patient if requested by the nursing staff at NH-RACF3.

The managers at NH-RACF3 had some choice into which residents are admitted to the facility, as this is their first venture into high level care. The NH-RACF3 model has a limited lifespan from 11/2/02 – 30/6/02. NH-RACF3 are finishing service to the Interim Care Program as licenses for their beds are becoming available.

Staffing

The staffing ratios for NH-RACF3 are:

- AM - Ratio 1:5 including 4x RN Division 1 2 & 2 x Division2 or PCA;
- PM 1:7 including 2 x Division 1 and 2 or 3 Division 2 or PCA;
- Night: 1: 15 including 1 x RN and 3 Division 2 or PCA.

A Diversional Therapist is present on site.

HOME BASED SERVICE

The Northern Health Home-Based Interim Care Program is known as Transitional Care (home). It commenced in September 2001.

The patients for transitional care are sourced from the three campuses within Northern Health, The Northern Hospital, Broadmeadows Health Service, and BECC.

The target population is patients discharged from a Northern Hospital or who present at TNH Emergency Department who are:

- Assessed by ACAS as requiring residential care (high or low care);
- At risk or residential care in the short term;
- Prepared to have a 'trial' at home prior to a final decision being made regarding residential care;
- People with high care needs who are motivated to stay in the community in the long term.

Specific criteria for the acceptance onto the program include:

- The client is medically stable;
- Carer or family commitment to the trial;
- The process for looking for a residential care place has commenced; and
- An agreement has been reached regarding the length of time the 'trial at home' will be and options for continuing care clearly explained.

Usually the maximum time frame for supporting a person in this way is three months, however extensions to this timeframe can be negotiated on a case by case basis.

The care is delivered by service agencies who have a service agreement with Bundoora Extended Care Centre. The case manager purchases the required services from the service agency who can best meet the clients needs. Case managers are either employed by Northern Health or are contracted providers. The contracted case managers are supervised by the Transition Care Clinical Coordinator and need to liaise extensively with the Interim Care social workers/case managers.

A major difference between the Home-based Program and the other Interim Care models is that it is not a bed substitution service, it is a community service, and the patients have been discharged from the hospital.

FUNDING

Because the Home-Based service was a new model of care, the funding formula was based on experience with other programs such as Post Acute Care and Linkages. Consequently, the budget was built on an estimate of the cost of purchased services and the cost of case management

The philosophy of Northern Health is that the care plan on discharge from hospital is designed according to client need. After the client has settled at home, the care plan is reviewed. The service level is reduced as the client settles at home and their care needs change. The cost of purchased services was originally estimated to be $3,000 per patient, with a large variance in cost per patient depending on their level of care and time on the program.

The cost of case management per client was originally underestimated. Early analysis indicated that the cost of case management per client was $1,500, but further analysis is required as the program develops.

The philosophy of the Home-based Interim Care Program is to reflect 'normal life" for the Interim Care clients. Northern Health's preference is to designate these clients as 'discharged' clients and not 'inpatient substitution clients'.

The program managers at Northern Health believe that reflecting normal life sets the parameters for what can be achieved when the person is discharged. This creates an attitudinal focus that facilitates the return to the community. It prevents a dependency on the hospital being created by the hospital taking over issues that would usually be part of normal life.

- Therefore clients access their GP in the normal fashion and this is funded through the MBS; and
- The client accesses PBS in the normal fashion.

The program does fund additional medical backup via a specialist geriatrician and any consumables eg dressings, kylies etc.

CONTINGENCIES

The Interim Care program managers have organised an arrangement with BECC, Broadmeadows Health Service and The Northern Hospital that if the Home-based Program is not appropriate for the patient then the first bed at their facility that is free will be made available to this patient.

OCCUPANCY / ACTIVITY

There were 76 referrals for the Home-Based Program from September 2001 and February 2002. Of these 76, 15 clients, after family meetings, decided not to pursue a community option.

In February 2002, there had been 28 discharges from the program, with an average LOS at 39.8 days for discharged clients. Of these 28 patients, 36% were discharged to hospital, 32% to residential care, and 28% to a community option.

KEY SUCCESS FACTORS

The key success factors for the Home-based Program are considered as:

- Close links with ACAS to streamline assessment processes and be able to review level of function in the community regularly;
- Improved links with the Northern Health inpatient team, especially in participating in team meetings, family meetings and identifying appropriate clients earlier during their admission; and
- Recognition that these patients may take time to discharge from the Home-based Program, however the longer LOS on the Program may prevent a re-admission.

A home based program may allow patients and families extra time and a realistic trial of community supports to decide whether residential care is the best long term outcome or whether remaining in their home environment is a feasible outcome.

Many clients who have been on the Program have had significant improvements in their general health and functioning on return to the home environment which can probably be directly related to the environment itself. Once at home clients are often more motivated to be independent and to return to premorbid activities.

A significant issue for the program has been facilitating timely discharge from the program for clients who are wanting to remain in the community long term because of long waits for Linkages, EACH and CACP supports. In most cases the client group that are managed on Transition Care need continuing Case Management and maximum community supports and cannot be discharged from our program until these are in place.

CONTINUING ASSESSMENT

The Home-based Program reintegrates many clients into the community and diverts them away from residential care. In this way, the Home-based Program may be making a small contribution in managing the demand on the residential care sector. However, the Program does increase pressure on the community sector.

PARTNERSHIPS WITH RESIDENTIAL CARE PROVIDERS

Clients with complex care needs often have an extended waiting period as they are difficult for a residential care facility to support. Flexible funds are used to assist the residential care facility in purchasing the additional care requirements for a limited period, until the patient's care needs have stabilised.

INCREASED ASSESSMENT CAPACITY

The need to increase the assessment capacity at The Northern Hospital and in the community was identified as an important component in establishing the model.

At The Northern Hospital, increasing the availability of Aged Care Assessment to 5 days a week in order to assess people was considered a vital component in developing a responsive service.

Increasing the capacity in the Aged Care and Assessment Teams (ACAT) at BECC to follow-up people in Interim Care to ensure that their level of care was re-assessed as their care needs change was also considered to be a vital component of the service.

The increased assessment capacity at Northern Health is demonstrated through the following appointments:

- Geriatrician (0.3 EFT) & Registrar (0.3 EFT) at The Northern Hospital. The role of this geriatrician is to follow up ACAS assessments. The rationale of the appointment is that assessments are often undertaken

early during the acute stay of the (usually elderly) patient, when the patient tends to be very ill. As the patient's acute condition improves, the registrar may re-assess the patient, and provide input to the ACAS team, usually to communicate to the ACAS team that the patient may not require the level of care that the ACAS initially assessed;

- ACAS Community Worker. This position, which is currently filled by a physiotherapist, has a similar rationale to the Registrar noted above. However, the main assessment target client group is the Home-based Program patients who are residing in the community. When patients are released to home from the acute environment, they tend to improve their level of functionality and have reduced care needs compared to when they were in the acute environment.
- Saturday Duty Care Worker. The rationale behind this position is to liaise with carers/relatives at home, who cannot be accessed during the week primarily for work reasons. Making contact with these people can enhance the planning process for their relatives, who may have a placement issue.
- Geriatrician (0.4 EFT) & Registrar 0.7 EFT at BECC. The geriatrician's and registrar's role is to provide a follow up role for the Interim Care patients, who are residing in NH-RACF2 or NH-RACF3 or those at home being supported by Transition Care. The role will include telephone liaison with the facility staff, or on-site consultations at NH-RACF2 and NH-RACF3, liaison with General Practitioners, and clinical support to the case mangers including home visits for assessment if required,

ORGANISATIONAL / CLINICAL PRACTICE CHANGES

There have been a number of changes that have occurred in the clinical practice especially pertaining to managing discharges of very complex clients:

- Increased number of family meetings to discuss the options of ongoing care outside the hospital setting ie residential care vs a trial at home;
- Improved tolerance of the risks associated with a complex discharge and more tolerance in allowing time to ensure a plan is in place to manage all those risks;
- Establishment of a process to facilitate re-admission to the discharging hospital ie acceptance of the situation if the trial at home is not successful and the person needs to be re-admitted to await residential care in a bed based service OR if their condition deteriorates; and
- Re-established the involvement of ACAS in case conferencing (via the Transition Care staff) for more effective discharge planning in inpatient units.

CONTRACTS

For the bed based services there are formal service agreements / contracts in place between The Northern Hospital and NH-RACF1 Nursing Home, and Bundoora Extended Care Centre and Aged Care Service Group who manage both NH-RACF2 and NH-RACF3. Northern Health also has a contract with NH-RACF4.

For the community based service, BECC has a Service Agreement with all service providers from whom the Program purchases services on the clients behalf.

QUALITY ASSURANCE

NH-RACF1

Northern Health apply the levels of Commonwealth applicable high or low level care standards and the associated quality guidelines to the providers of Interim Care Bed Days such as NH-RACF1. All services that provide core Interim Care services are required to be compliant with the these standards and it is part of the agreement between Northern Health and the provider that these standards are maintained for the Interim Care patients.

All the residential care facilities utilised by Northern Health are accredited by the Aged Care Standards Agency.

HOME-BASED PROGRAM

The Quality Plan was completed and monitored by BECC CQI reporting procedures. The main activities in the Quality Plan for 2001/02 were to:

- set up the policies, procedures and reporting mechanisms to underpin the new program;
- re-formulate all the contracts with service providers and set up a more formal mechanism for reviewing contracts; and
- develop client friendly information about the service.

COMPLAINTS

NH-RACF1

Complaints can be made to either NH-RACF1 or The Northern Hospital. The nature of the complaint will determine which institution will manage it. If the complaint is primarily concerned with the day to day care of a patient then NH-RACF1 would manage this through their complaints process. If the complaint was specifically regarding a Northern Hospital staff member, or regarding the process of transfer from TNH to NH-RACF1 then the complaint would be managed by TNH complaint program. A complaint handled by TNH would follow TNH policy and procedure which commences by being presented to the General Manager and then subsequently being presented to the Clinical Risk Management Committee.

When a patient is to be transferred to NH-RACF1 a family meeting is convened at The Northern Hospital. At the meeting, the family is requested to sign a "Statement of understanding" which outlines that the family can contact the Placement Coordinator at TNH should there be any concerns regarding the Interim Care Program.

There have been complaints which have varied in nature and managed on a case by case basis. One family had concerns about the feeding of their relative and there was some conflict about what the family believed was normal feeding practices and what the nurses at NH-RACF1 felt was force feeding. In this circumstance a Geriatrician from TNH spoke with the GP who held a family meeting to discuss feeding options. When family was still not agreeable the patient was transferred back to TNH for further management.

HOME-BASED PROGRAM

No complaints were received from clients regarding the Home-based Interim Care Program. BECC has a formal process for managing complaints that would be followed if a complaint was received.

INFORMATION/ASSESSMENT PROCESSES

Initially, the information regarding the program has been delivered verbally by the social workers. Some information is provided in written form in the client's Home Folder eg client's rights & responsibilities, client agreement, client care plan.

For clients entering the Home-based Program, an agreement was signed that incorporated their acceptance of the services provided, the time limited nature of the service, and permission to pass information onto the service providers involved in their care.

For the clients at NH-RACF3 a formal agreement was signed that outlined the conditions of the arrangement and gave permission to pass information onto those involved in their care.

Information brochures have now been developed. The information is in different formats for each stage of the process eg a general outline to take away after initial discussions,; a more detailed agreement if the person decides to pursue the option; and a care plan etc when they then go home.

BARRIERS TO INTERIM CARE PROGRAM INCLUSION

Northern Health's structure of three models of Interim Care allows for a diverse clientele to be catered for. The Broadmeadows Health Service is able to cater for the very high level care patients, as well as those patients who present a considerable security risk to themselves.

HOME-BASED PROGRAM

The patient's care needs to be manageable at home and in some cases not all risks can be managed eg person living alone that is severely cognitively impaired. Some families cannot manage at home despite an intensive Care Plan. Often the need for unscheduled overnight assistance is difficult to provide through a purchased service and is something that families find difficult to sustain.

BECC, through the Home-based Program, has been able to cater for patients who have refused to sign a 2624 and will only consider a community based option. These clients tend to be very high level care, but also have very committed carers at home prepared to provide very high levels of care themselves.

The Home-based Interim Care Program have also accepted referrals for clients who have been assessed at low level care who need support at home whilst waiting a hostel bed or a community package such as a CACP. These clients normally would often not even be considered for discharge because they have complex issues to resolve to ensure a safe discharge and there are not adequate community supports available whilst they are waiting the appropriate care.

STAFF RECRUITMENT AND TRAINING

NH-RACF1

When the Interim Care Program commenced at NH-RACF1 Nursing Home, an additional Social Worker was funded for 4 days a week to assist with transfers from TNH to NH-RACF1 and then from NH-RACF1 to a permanent residential care placement and general case management of patients requiring placement. All other staff were employed by NH-RACF1 Nursing Home itself.

As the program has developed a Geriatrician and a nurse has been seconded by TNH to complete a consultation round at NH-RACF1 on a weekly basis.

In May 2002, an additional Grade 1 Social Worker was employed by TNH to assist with the case management of patients needing residential care placement.

TNH does not have any input into the recruitment of staff at NH-RACF1, however has become aware of nursing ratios and allied health input at NH-RACF1.

Training was provided to hospital staff in regards to the process of transferring a patient to the Interim Care program.

HOME-BASED PROGRAM

RECRUITMENT

Initially staff were seconded from other areas to work on the Home-based Program equating to 1.8EFT. At that time, it was not known whether the community based model would be viable from a patient care perspective and so recruitment was reflected the 'on trial' nature of the service. Additional case management time was contracted from an external agency.

When it became clear that the program would continue into the next financial year (2002-2003), seconded staff became "permanent' on the service and an additional position was advertised (0.8 EFT Admin staff and 1.0 Care Coordinator).

BECC staff were involved in the interview process for the contracted care co-ordination staff.

INDUCTION

For the three initial seconded staff, there was no official induction as the program was new and in the developmental phase. The three staff members liaised extensively with each other to develop the care model and operational aspects of the program. All staff members were already very experienced in the areas of ACAS and Post Acute Care work and had been employed at BECC for several years.

For the contracted staff, there was an orientation program to BECC & ACAS. Then the Transition Care Clinical Coordinator trained staff on the job.

TRAINING

The Training on the job consisted of:

- Reinforcing the philosophy of the program;
- Managing family meetings;
- Administrative processes re purchasing services etc; and
- Team based education within a case conference environment: A specific focus was on improving the knowledge of services available in the community for clients wishing to remain home in the long term and the knowledge of the local residential care sector to assist in facilitating timely transfer to appropriate residential care facility for waitlisted clients.

DISCHARGE PLANNING

HOME-BASED PROGRAM

TO INTERIM CARE

A Transition Care staff member attends team meetings across Northern Health to triage referrals to the service. Referrals are also taken over the phone or via email/fax.

Within the Team Meeting environment the Inpatient Team identifies the patient's needs and discusses appropriateness of a trial at home with the Transition Care Program. Discussion includes risk identification and risk management and focuses on both short and long term discharge planning.

Following the team meeting a family meeting is held with client/family, treating team and Transition Care staff member to discuss the hospital team's recommendations and to gain more understanding of the client's preferences re their long term care.

If the patient and family request a trial at home with the support of the Transition Care Program, a Care Coordinator from the Program is allocated and this staff member liaises with the client and team to establish a Care Plan. The Care Plan addresses both the client and their carer/families needs and attempts to address any safety issues and to maximise client independence where possible.

A final family meeting is held prior to discharge to confirm the Care Plan.

FROM INTERIM CARE

The initial discharge plan is developed in the inpatient environment ie it is made clear to the patient and their family and carers what the goals of the intervention are (either community outcome or definitely residential care). Formal reviews are held monthly with client and family to review progress and to confirm the discharge plan from Transition Care

There is ongoing liaison with either residential care providers or community providers (eg CACP/Linkages) re the discharge plan and entry to their services.

OTHER ISSUES

CULTURAL ISSUES

Northern Health select a culturally specific agency to deliver the service eg Migrant Resource Centre, Ultima etc. and provide a carer who speaks the appropriate language. Interpreters are used during the assessment and care planning process and for formal reviews.

INFECTION CONTROL

There is no specific infection control statistics kept by The Northern Hospital for Interim Care patients. However, the infection control nurse is available for consultation with NH-RACF1 should the need ever arise.

PAYMENT DETAILS

All patients on the Residential Based Services Interim Care Program at Northern Health pay the aged care compulsory contribution of $24.63. After 28 days of being at NH-RACF1, as if in any residential care facility, all patients are income tested by Centrelink, which may result in a higher charge. The Northern hospital pays the "extra services component" of patients on the program, and the patient also attracts funding from the Commonwealth government depending on their level of care needs (RCS)

No fees are charged to Home-based Program clients. They are responsible for living expenses that they would normally be responsible for. Payment of additional services is sometimes negotiated as part of the discharge plan if there is a gap between what the community service can provide and the service level that is required to sustain the person in the community in the long term.

CHANGES IN THE INTERIM CARE PROGRAM

The major change is the commencement of the Home-based Program, which increases the options for Interim Care patients. This has allowed more open discussion about care options and outcomes because the Northern Health team is able to offer more choices, including a supported trial at home.

FUTURE PLANS

There are high care beds available at another residential aged care facility, NH-RACF4, for Northern Health clients, which commenced on the 13th May 2002. BECC will have first options for these beds, but other Northern Health Hospitals will have access to the beds should BECC be unable to relocate a suitable resident.

BECC has a preference for the beds to be two single rooms to ensure maximum flexibility, but will work within the constraints of available beds at this facility.

The initially negotiated rate to payment to NH-RACF4 from Northern Health is $160 per bed day. BECC will charge the resident the basic resident fee.

Northern Health is also negotiating with another residential aged care facility in the area for Residential-Based services.

All facilities are reviewed at the 6 month mark, as the facilities are often applying for Commonwealth licences.

SUMMARY OF FINDINGS OF PATIENT / CARER CONSULTATIONS

NH-RACF1

There were 5 residents represented, with 8 participants in the group. A Greek interpreter was present at the focus group also.

INFORMATION

The patients and carers had mixed views whether there was a satisfactory amount of information that they received regarding both the Interim Care Program and the NH-RACF1 facility. Some of the carers stated that they received plenty of information, and visited the NH-RACF1 site prior to the patient's transfer there to reassure themselves.

One gentleman appreciated having the Interim Care Program explained to him in his native language (Greek) when he was an acute inpatient.

CARE

The patients and carers viewed the level of care at NH-RACF1 as generally appropriate to their needs. They were mindful that they may not require the same level of care that is required in an acute ward. However, they believed the environment that is provided at NH-RACF1 was more appropriate than in the acute wards, and all preferred to be at NH-RACF1 than "in hospital".

Interestingly, although medical coverage is provided by the Northern Health geriatricians via a weekly ward round, one patient was accessing his own GP and viewed his GP as the main treating doctor.

STAFF

Two patients stated that although the number of nursing staff was adequate during the day, there appeared to be a less than optimal number of nursing staff at night. One patient stated that there was a long wait for assistance to the toilet at night.

Generally the consensus was that the staff were friendly, and staff turnover was low.

A patient without carer support was satisfied with the level of support received from the social workers to assist him being placed in a residential aged setting.

FACILITY

Patients and carers were unanimous that the physical environment was pleasant, clean and appropriate. The food was viewed as good.

OTHER ISSUES

The facility was viewed as adequately catering for culturally and linguistically diverse people.

All patients in the focus group have listed NH-RACF1 as one of their preferred six options.

HOME-BASED PROGRAM

Telephone interviews were conducted with seventeen current and former patients/carers of the Home-based Program over a period of three days.

INFORMATION

The patients and carers had mostly positive views on whether there was a satisfactory amount of information received regarding both the Home-based Program, with the exception of two respondents. One respondent prefaced their comments that although they were not as well informed as they would have preferred, the time had been very stressful and information was difficult to absorb.

There was one patient, who because of an organisational mix up did not receive any information about the Program.

Bar the one exception, all patients/carers stated that they were involved adequately with the decisions about the type and extent of services and assistance needed to assist the patient at home.

CASE MANAGEMENT

The respondents had overwhelmingly positive comments about the type of support that they received from the case managers. The patients/carers stated that the case managers were accessible, and responded to the concerns of the patients/carers.

CARE

The patients and carers viewed the level and type of care received as generally appropriate to their needs. The patients/carers recognised that quality of care could change when there was a change in carer, which often occurred. Patients/carers preferred to receive their care from the same carers for continuity and familiarity reasons. However most respondents realised that this was not possible at all times. One relative stated that the carers changed too often which reduced the sense of continuity of care for the patient.

Only a small proportion of the patients felt they needed physiotherapy services, and they stated that they continued receiving these services, as a satisfactory level, for a period of weeks when they were discharged home from hospital.

One relative believed that there was not enough access to services such as pain clinic and psychiatric services, and mental health group sessions.

MEDICAL COVERAGE

Most of the respondents felt that they were serviced adequately by their GPs. Most GPs were willing to perform home visits regularly. There were two patients who changed their GP to allow better access. Approximately half of the patients surveyed were able to visit the GP at the surgery, and were not reliant on home visits.

OTHER ISSUES

The most positive aspect of the Program from the patients/carers perspective was having the patient living in their own environment. There were a number of carers with relatives who were placed in residential aged care facilities after a period of months in the Program. These carers all still viewed the Program as very positive as it allowed them to have relatives home for a few months more than may have possible with other options.

Another positive issue from the Program was the time it allowed patients and their families to consider the other options available to them, whilst being in their home environment. Often these decisions need to be confronted in the stressful and time limited environment of the hospital.

SOUTHERN HEALTH

HEALTH SERVICE PROFILE

Southern Health is Victoria's largest Metropolitan Health Service and provides primary, secondary and tertiary health services to approximately 750,000 Victorians.

There are three major acute hospitals:

- Monash Medical Centre Clayton (MMC Clayton);
- Moorabbin Hospital; and
- Dandenong Hospital.

The Moorabbin Hospital provides mainly elective surgery and oncology services, and has no Emergency Department.

MMC Clayton has the busiest Emergency Department in Victoria, with 48,879 attendances in 2000/2001. Dandenong Hospital Emergency Department treated 38,513 attendances during the same period.

Subacute facilities in Southern Health include:

- Kingston Centre, the major campus which has 118 subacute beds. Kingston also has 112 nursing home, beds, 110 hostel beds, 20 Acute Aged Mental Health beds and 35 Psychogeriatric Nursing Home beds.
- Hampton Hospital, which has 26 acute rehabilitation beds. (Services due to be relocated by end of 2002.)
- Dandenong Hospital, which has 30 GEM beds and 15 acute rehabilitation beds.

Additionally Aged and Mental Health Services include two psycho-geriatric assessment and treatment teams, a 30 bed psycho-geriatric nursing home in Noble Park, and ten Acute Aged Mental Health beds in Dandenong and a 29 psycho-geriatric hostel in East Bentleigh.

GENESIS OF THE PROGRAM

The program was commenced by a prompt from the Department of Human Services. The hospital bed-based model that was chosen was due to the availability of the vacant ward onsite at Kingston.

In mid 2002, the area served by Southern Health has a significant shortage of Commonwealth funded residential aged care high and low care facilities . On the Mornington Peninsula, all residential aged care high care facilities except one have closed lists, with the exceptional facility having 150 patients waiting.

Another significant factor impeding residential care placement are patients who are culturally and linguistically diverse and/or who have religious preferences and are only prepared to accept placement in ethnic or religion specific services. The shortage in high care facilities becomes less acute closer to Melbourne within Southern Health.

Following the commencement of Interim Care, ambulance bypass rates initially showed a significant reduction. However, there has been a change lately, with Monash not meeting its targets. This change in rate coincides with the reduction in agency nurses being used at the hospital, which has been a directive of the Department of Human Services.

The number of agency nurses has not increased ie 170 Equivalent Full-Time, but due to the short supply, the price of labour of nurses has increased. In March 2002, new guidelines came into effect across the public hospital system. They are summarised as:

- Agency staff can only be used for unplanned absences;
- A price cap must be imposed on their labour; and
- A public hospital's own staff who are also working as agency staff are not to be engaged within their 'Parent Hospital'.

The effect of these changes, effective in April 2002 led to 15 Emergency Department beds being closed, and 10 Emergency Department were beds closed in May 2002. This is the primary contributory factor to Monash Medical Centre's bypass targets being exceeded in June-July 2002.

Prior to the implementation of the Interim Care Program, Southern Health used bed brokers to assist the health service to place their patients in nursing homes. Anecdotally, the managers at Southern Health felt that the bed broker's performance in finding beds was similar to their own staff performing the role.

INTERIM CARE MODEL

There are two main models currently in use by Southern Health:

- 24-bed Interim Care ward; and
- Ad hoc private sector purchasing beds.

INTERIM CARE WARD

The North 3 Ward is the dedicated 24 bed Interim Care ward. North 3 Ward had been vacated for about two years, and was re-commissioned for use for the Interim Care strategy. Capital works to upgrade utilised the Interim Care funds, as the capital grant in the prior year (2000/2001) was not enough to complete the required upgrade.

Southern Health has also used residual Hospital Demand Management funding for ad hoc private purchasing of private hospital beds for acutely ill non Interim Care patients, and to accommodate Interim Care patients within exempt residential beds and supported residential services.

The Interim Care ward commenced operations on 12 November 2001. The sources of Interim Care patients are the Monash, Dandenong, and Kingston campuses.

The Interim Care ward has mostly 6-bed bays. This limits the patient mix regarding gender balance and dementia. Currently, there is work being done to split one 6-bed bay into two 3-bed bays to reduce the patient mix issues.

ELIGIBILITY

The initial criteria for Interim Care was:

- The patient has concluded their acute and/or sub acute episode of care;
- The patient has been assessed by the relevant Aged Care Assessment Service and holds a valid 2624 (eligibility for Commonwealth Residential Care Subsidy); and
- Had listed for placement at six residential care facilities.

Due to the time taken for people to list at six services, particularly given the number of facilities in the area with closed waiting lists, this was reduced to a minimum of three residential care services.

Initially there was pressure within Southern Health for allocation of a proportion of available beds to each acute hospital with an Emergency Department. However the Interim Care team has resisted this pressure and no prescriptive formulae was organised to detail hospital admitting priorities to the Interim Care ward. Priority has been given to the hospital within Southern Health that was most at risk of exceeding their ambulance bypass target. Some pressure has also been experienced from non-Southern Health (private) Hospitals keen to access to these beds. Southern Health has not extended access to outside agencies.

STAFFING

The Interim Care ward is staffed with Division 2 nurses mostly, with one Division 1 nurse as shift manager. The nurse unit manager is supernumerary. Asides from initial setup there have been no staffing issues with the ANF. The nursing staff: patient ratios are:

- Day 5:24 + Division 1 Shift Manager;

- Afternoon 3:24 + Division 1 Shift Manager; and
- Night 1:24 + Division 1 Shift Manager.

On the Interim Care Program, 83%of the staffing is provided by permanent nursing staff members, and 17% by bank or agency staff. This is a similar ratio to other Southern Health services, such as the acute setting.

Medical cover is via a full time Registrar with a Geriatrician performing a ward round once per week. .Allied health cover consists of:

- Physio 20 hour per week;
- Activities person 20 hour per week;
- Dietician, as needed;
- Speech Therapy 8 hours per week;
- Psychologist 4 hours per week; and
- Social worker 20 hours per week. In addition, the services of a full time Social Worker responsible for placement of patients from Kingston Centre to residential services makes a significant contribution to the throughput of the ward.

Other services available are those that are common to all the wards at Kingston and include quality control, engineering, and complaints.

FUNDING

The program managers are very strong advocates for the co-payments as an incentive for throughput. The co-payment is means-tested depending on whether the client is on the full pension, and is equivalent to the standard resident co-payment that would be paid in a Commonwealth nursing home. Thus the funding that Southern Health receive for a Interim Care bed is the standard resident co-payment, and $240 per bed day from the DHS.

All medical and pharmacy services are provided and paid for, by the Interim Care Program. No related costs are passed on to the patients. Pathology and radiology costs related to Interim Care patients are also absorbed by the program and not passed on to the patients themselves.

OCCUPANCY

In the Interim Care ward, two people have been in the ward since opening. From November 2001 to May 30 2002, there have been 71 discharges from the ward, with 64 people placed to high care facilities, and five placed to low care facilities. Although the criterion for admission to the Interim Care ward is requiring low or high level care, two patients have improved unexpectedly such they that could go home, or be transferred to a rehabilitation ward.

ADHOC PRIVATE PURCHASING

The purchasing models have been used with surplus funds available because the Interim Care ward did not open at the start of the financial year (July 2001), but in November 2001. When purchasing beds, rates were negotiated with each provider, and were approximately $135 per day.

There have been 12 patients, who have been transferred to 6 nursing home, or hostel facilities. This model of service is currently subject to the constraint of a lack of exempt beds in the area. The patients in this model use medical services from general practitioners, access medications via a community pharmacy, and use the allied health staff at the nursing home. Case management of the patient is undertaken by the case managers at Southern Health.

It is anticipated that next year a private nursing purchasing model will not be used for Interim Care, as the ward at Kingston will be open all financial year.

Interim Care funds have also been used to sub-contract beds in private hospitals. However these patients do not fit the criteria of Interim Care patients in that they are still acutely ill at the time of transfer to the private hospital.

This mechanism has however enabled the creation of acute hospital capacity to support the Hospital Demand Management objectives.

From the 11th June 2002, a 10-bed ward will be commissioned at Dandenong for 4 months. The establishment of this ward is being supported via the under-expenditure of Southern Health's Hospital Demand Project, again supporting the objectives of this program. The clinical focus of this ward will be behaviourally disturbed people, who have proved extremely difficult to manage in an environment of 6-bed bays as exist in the Kingston ward. The ward will accept patients from any site in Southern Health (primarily Dandenong and Monash), but will be open for a period of 4 months only. After this time the site will be demolished. These patients are not the current target group for Interim Care.

QUALITY ASSURANCE

The EQuIP model is used to guide Interim Care service delivery, which is in line with the rest of Southern Health. EQuIP is the cyclical continuous improvement process of the Australian Council of Health Care Standards (ACHS). The ACHS process involves self assessment and external audit, with Quality Accreditation being awarded where audit deems appropriate. Southern Health was last surveyed in November 2001 and received Accreditation for the maximum 5 year period.

COMPLAINTS

All complaints are acknowledged within 24 hours, Southern Health also provide a written response to complainant within 30 days. The Complaints Liaison officer, who is located on-site at Kingston Centre co-ordinates complaints including monitoring response times and keeping a data base on numbers, type etc.

In the year 2002, to date (August), Southern Health have received one complaint over a loss of a hearing aid, which was resolved. They have also received two complaints relating to issues of care. One of the complaints has been resolved, whilst the other is outstanding. The ward was awaiting advice from the Southern Health Complaints Co-ordinator and Corporate Counsel before the matter can be resolved.

BARRIERS TO INTERIM CARE PROGRAM INCLUSION

The main barriers to admission to the Interim Care ward are:

- Behavioural issues. The physical layout of the unit does not support the management of people with moderate to high levels of disturbed behaviour;
- Gender mix: At times the mix of gender is also a barrier, again related to multi-bed room layout of the environment;
- Patients requiring extensive and complex care. The staffing ratios precludes the ward admitting too many patients with complex care needs simultaneously;
- Patients requiring oxygen and lack of piped gas facilities.

STAFF RECRUITMENT AND TRAINING

Staff were recruited from within Southern Health (internal advertising and Nurse Bank) and externally via advertising in a daily newspaper.

INDUCTION

Staff employed on the Interim Care Program undergo the Southern Health orientation. As this was a new service, specific ward orientation also was included, such as models of care and admission processes.

SPECIFIC TRAINING

There was a specific training program focused on managing patient with challenging behaviours, and complaints management.

INFORMATION PROVIDED TO PATIENTS

Information pertaining to the Interim Care Program is supplied to patients by Social Workers in acute and sub-acute programs within Southern Health. In fact, information regarding the Interim Care Program is given to families by Social Workers throughout Southern Health and the Continuing Care Coordinator as part of their discussions about residential care placement. The Social Work Department also has a pamphlet on finding a nursing home, which includes a section on interim Care. The Continuing Care Coordinator also sends a letter to families when they are referred which includes information on interim care. At present there is no pamphlet specifically about the Interim Care Program.

DISCHARGE PLANNING

When a patient is being discharged from a Southern Health acute or subacute facility, the following process is followed.

There is notification that a bed is available at the Interim Care facility.

- Multidisciplinary team discussion re patient's progress recommends residential care.
- Social worker discusses recommendation with patient and family and explains ACAS assessment, looking for residential care, fees, need to list 6 places etc. Families can start process of looking but cannot formally list without a completed 2624.
- Social worker faxes a referral to ACAS.
- ACAS visits and undertakes assessment, usually leaving paperwork for social worker to give to family.
- Social worker sees family again and gives them 2624 and ACAS kit and reiterates information about residential care.
- Social worker refers the patient to the Continuing Care Coordinator
- Family visits residential care facilities, places patient's names on waiting list and informs social worker/Continuing Care Coordinator.
- Continuing Care Coordinator/Social Worker follows up family to check that they are continuing with process. The expectation of Southern Health is that family will list six facilities within two weeks. However this is often difficult to achieve as many facilities have inspections once a week or less and many facilities also have closed waiting lists.
- Continuing Care Coordinator contacts nominated residential aged care facilities to ensure patients are listed.
- Continuing Care Coordinator rings all nominated residential aged care facilities regularly to update list and advocate for patients on waiting list.
- Continuing Care Coordinator places patient's names on waiting list for Interim Care when they have 3 facilities listed
- If Southern Health are notified of a bed which is available in a facility that has not been nominated by any patient the continuing care coordinator will contact families for whom this bed may be suitable. The Continuing Care Coordinator will encourage families to visit and accept the bed if appropriate.
- Continuing Care Coordinator will ask families to visit and list extra facilities if patients have not been placed after 6 weeks.
- When bed becomes available for patient, nursing staff arranges transfer with relevant facility.

When a patient is discharged from an Interim Care 'core' facility, the following process occurs:

The process is similar for Interim Care except that patients are further through the system when they are admitted to the Interim Care Ward.

Continuing Care Coordinator and Social Worker on ward follow up families about listing.

Continuing Care Coordinator contacts facilities regularly etc.

OTHER ISSUES

CULTURAL ISSUES

Expressions of cultural preferences are welcomed and catered for through menu choices including kosher. This information is collected as part of patients' admission process, and documented on the Patient Care Plan. Southern Health has an Ethnic Liaison Officer and Committee to promote cultural sensitivity in service development and delivery.

PAYMENT DETAILS

Interim Care patients are deemed eligible to be charged a daily co-payment fee if they meet the NHT definition of 35 days continuous hospitalisation.

Interim care patients are then charged at the prevailing co-payment rate, currently $24.63 per day, if on a full pension and $30.76 per day, if not receiving a full pension.

In addition, two Interim Care patients, who were privately insured, attracted a daily bed day rate higher than those mentioned above.

Invoices are raised fortnightly and billed directly to the patient or care of their next of kin or representative.

SUMMARY OF FINDINGS OF PATIENT / CARER CONSULTATIONS

There were three written surveys received from patients/carers at Southern Health. There were also two telephone calls received from carers, and the consultants met with one patient and their carer.

INFORMATION

The information that was conveyed to patients pre admission to the Interim Care Program appeared adequate. The general view is that the Social Workers at the acute hospitals explained the purpose of the Program in a satisfactory manner. One of the patients was admitted directly from the Emergency Department at one of the acute campuses, so the information they received was not as extensive. However, they were grateful for the timely admission to the ward.

CARE

There was a mixed view from patients/carers regarding the level and type of care received on the Interim Care Program. Three of the patients/carers believed that the level and type of care was excellent. However the other three patients/carers were of the view that the level of care was inadequate. They stated that inappropriate practices were not being actively discouraged by the management of the ward, and such practices were allowed to continue.

One patient/carer believed that the level of allied health or medical care available to the patients was very inadequate, whilst one other carer stated that there was a doctor on duty all the time.

STAFF

The participants commented that there was low turnover of nursing staff and relatively few agency nurses, which facilitated continuity of care.

Three of the patients/carers were of the opinion that a minority of the staff were not treating the patients in a dignified manner. They alleged that certain patients were treated inappropriately because they were outspoken and seen as demanding by the staff members.

FACILITY

Three of the patients/carers described the facilities as grossly inadequate. They had specific complaints regarding the space between beds, the lack of privacy afforded to them, and the quality and quantity of the bathrooms and the toilet facilities.

OTHER ISSUES

Two of the patients/carers believed that the Social Workers were very helpful in assisting their placement. One of the patients/carers believed that pressure on the patient by the staff in the ward to be discharged to a residential aged care facility was inappropriately strong.

St Vincent's Health

Demographics

St Vincent's Health provides adult medical, surgical, sub-acute, mental health and aged residential services and a range of community and outreach services. The health service is a major teaching, research and tertiary referral centre, with major campuses on the fringe of Melbourne's central business district and in Kew.

Health Service Profile

St Vincent's Health, formerly known as Sisters of Charity, has three campuses in the inner suburbs of Melbourne:

- St Vincent's Hospital Fitzroy;
- St Georges Hospital Kew; and
- Caritas Christi Hospice, Kew.

St Vincent's has approximately 320 acute beds, 22 Rehabilitation beds and 24 GEM beds. Until the Interim Care ward was opened, St Georges was an 80 bed hospital, consisting of GEM and Rehabilitation beds. It now has a total of 84 beds, including 20 Interim Care beds in "Ellerslie" ward.

Caritas operates 24 palliative care beds at the Kew campus.

Hospital Demand Management Strategies

The Hospital Demand Management Strategies that have been utilised at St Vincent's Health include:

- The development of an emergency medical unit. The unit is essentially a short stay unit, for patients who are deemed to require an inpatient stay of less than 48 hours;
- More funds allocated to attract Emergency Medical Specialists;
- An ALERT program providing early assessment and case management;
- Rehabilitation in the Home program;
- More resources allocated to a Falls and Mobility clinic; and
- 'Designing Care' Project - a program that streamlines processes to enhance patient flows between acute and subacute areas.

Genesis of the Program

A major issue for St George's was the bed configuration of the hospital. This led to industrial problems in terms of nursing staffing. There was also a sense that St George's was over-bedded.

St Vincent's did not have the similar problems of inability to access Commonwealth funded nursing beds, with subsequent blocking of acute beds to the extent that other health services have commented. Anecdotally, 12 months ago there were approximately ten patients waiting in St Vincent's Hospital for residential care placements at any given time.

With respect to nursing home supply, the local government area of Boroondara anecdotally has less problems than other areas, especially the outer suburban areas. Nevertheless, patients from Ellerslie go to all areas of Victoria. A high proportion of patients, around 90%, go their selected nursing home. However there has been a recent trend in the area for Commonwealth beds to be converted to extra services beds. This may have the effect of not reducing the overall supply of residential facilities, but rather limiting the choices available for a significant proportion of the population who are cannot access extra service beds for financial reasons.

INTERIM CARE MODEL

A capital grant was received from the Department of Human Services to convert a former maternity ward to Interim Care. Thus an Interim Care ward called "Ellerslie" was created using previously existing beds in St Georges. With the restructure, an extra four GEM beds were created at St George's. The current bed configuration at St George's is:

- 34 GEM and Rehabilitation;
- 30 GEM and Rehabilitation; and
- 20 Interim Care.

The Ellerslie Interim Care ward was opened on 8/10/01. The ward is described as an "Awaiting Placement" ward, to portray the message clearly that the ward is not a permanent placement.

The facilities at Ellerslie are comfortable with most of the rooms being two 2 bedrooms and a small number of one bed rooms. The two bedrooms are a good size for the patients' families to visit, and to enable easy access by staff and mobility aids such as wheelchairs.

ELIGIBILITY

Patients eligible for residential aged care can be admitted to Ellerslie. They do not take patients from private hospitals, and the program managers are not keen to have patients transfer from other health services to Ellerslie as they believe that their residential care placement model is the key to the unit's success. St Vincent's could not be certain that other hospitals would adhere to their placement to optimise their results.

There have been two phases regarding eligibility at St Georges. During the first phase, patients needed to be fully waitlisted prior to admission to Ellerslie. Initially, during Phase 1, there were problems with average occupancy rates at Ellerslie being 65% in November 2001. This was due to the effectiveness of the residential care placement model used by the Social Work Department. Many patients were being placed before getting to Ellerslie.

The eligibility criteria changed in Phase 2 with patients being transferred immediately after being assessed, and waitlisting carried out at Ellerslie. Under Phase 2 guidelines, patients are generally transferred to Ellerslie within one day of being assessed for residential care. St. Vincent's Social Work staff are located at the St George's campus to carry out this work, but do not appear on the Ellerslie budget. The occupancy rate of Ellerslie is now averaging 95% over the past three months.

STAFFING

The ward is staffed by 2 medical officers from other wards at St George's. The Interim Care ward is divided into 2 groups of 10 patients, and each group of 10 patients has a Registrar and a Home Medical Officer available for their care.

If a patient requires more acute care, they can be transferred to another ward at St George's, or to St Vincent's.

The nursing staffing ratios are:

- Mornings 1:7 + incharge nurse;
- Afternoons 1:7 + incharge nurse;
- Nights 1:15 + incharge nurse.

The ward has been fully staffed all year, and there have been no issues with the ANF.

Allied Health staffing levels are as follows:

- Allied Health Assistant 0.6 EFT ie 3 days per week;
- Physiotherapy / Occupational Therapy as required; and
- Social Worker 1.5 EFT, but is funded via the St Vincent's Hospital budget (not including senior support and administration of the residential care database). 0.5 Social Work funded through the Ellerslie budget.

The managers at St Georges believe that the Ellerslie is considerably busier than the subacute wards at St Georges because the throughput at Ellerslie is greater. This impacts on the Division 1 nursing staff on Ellerslie as they are primarily responsible for the number of admissions and discharges.

MEDICAL RECORDS

Because the hospitals are separate legal entities, a new record must be created at St Georges when the patient is transferred from St Vincent's. This is probably the major problem with the Interim Care model at St Georges. The core summaries are faxed from St Vincent's to Ellerslie on patient transfer.

A system is being trialled whereby the medical record is borrowed from St Vincent's for the extent of the patient's stay at St George's.

FUNDING

The Interim Care ward is costed as a GEM bed ward by St Vincent's Health. However, Interim Care beds are funded at $240 per bed day by the DHS. The remainder of the funding, which is the difference between the GEM bed rate and the $240 per day is used to run innovative programs. The Interim Care patients are charged a standard co-payment by St Vincent's Health, which is equivalent to the standard resident nursing home charge.

OCCUPANCY

One hundred and eighty-three patients have been accommodated at the Interim Care ward, from a total of the 287 patients who were assessed across the Health Service as requiring high or low level residential care. Of these 187 patients, 139 required high level care, and 45 required low level care. Currently most patients, who are acute patients at St Vincent's Hospital or are sub-acute patients at Fitzroy or St George's and require nursing home care are admitted to Ellerslie prior to placement.

OTHER IDENTIFIED PATIENTS SUTIABLE FOR AN INTERIM CARE TYPE ENVIRONMENT

Another group of patients who has been identified as having the potential to need "Interim Care" is non-weight-bearing patients. They may have longer term care needs following assessment. This group of patients does not require an acute bed for their period of nonweight bearing which is usually around 6 weeks. These patients should not have to go to a nursing home for 6 weeks, as they are not necessarily nursing home type patients. To send them to GEM is a poor use of a GEM bed, although the bed is certainly considerably cheaper than an acute bed.

QUALITY ASSURANCE

The Social Work Department at St Vincent's Hospital has designed and produced an Access database to monitor the process of patients eligible for residential care, through the acute, subacute, and Interim Care areas in the domain of St Vincent's Health.

St Vincent's Social Work Department have also designed Key Performance Indicators to measure the key timelines of the residential care patients and staff. The aggregate statistics calculated by structured reports in the Residential Care Database are benchmarked against the KPIs that St Vincent's have developed.

STAFF RECRUITMENT AND TRAINING

Initially when Ellerslie opened, there was a very low rate of using agency or non-permanent nursing staff on the ward. The Nurse Unit Manager on Ellerslie estimated that the initial rates of bank and agency usage was approximately 20% of staff shifts.

However the rate is much higher now as the number of permanent nursing staff has reduced over the last ten months since the ward became operational. The nursing staff have found the work on Ellerslie quite physically heavy which contributes to the reduction in permanent staffing numbers.

A residential care facility will be paid according to the RCS levels of their patients, and will staff their facility according to the care needs of their residents. When residents leave the facility, and are replaced by other

residents, the residents' care levels may change. The staffing structure of the facility can change accordingly. Therefore the facility has the inherent ability to be flexible in response to patient needs.

Most of the patients on Ellerslie are assessed as high level care, with consequent high nursing demands. St Georges cannot employ Personal Care Attendants (PCAs) to assist the nursing staff on the wards because of its status as a hospital precludes this practice. The Nurse Unit Manager on Ellerslie believed that employing PCAs would assist the flexibility of the Interim Care ward.

DISCHARGE PLANNING

The following two diagrams illustrate the flow process that occurs as a patient is assessed as eligible for residential care, together with the KPIs that are triggered at the point in the care cycle.

The KPIs currently used by St Vincent's Health relating to the Residential Care Program incorporating the Interim Care Model are:

- Days from referral by the treating unit to the Geriatric Consult Service (GCS) to date seen by GCS (KPI=1 day)
- Time from decision by GCS (that patient is eligible for a 2624) to referral by the unit SW to the Residential Care Coordinator (RCC) to begin the residential care process (KPI= 1 day);
- Time from Geriatric Consultation Service assessment (eligible for 2624) to time patient waitlisted for Ellerslie (KPI= this should be same day. Patient should only be eligible for a 2624 if they are medically ready for residential care);
- Time between patient waitlisted and transferred to Ellerslie; (no set KPI at this point);
- Time between when the patient/family meets with the Residential Care Coordinator (RCC) to begin the residential care process to date family returns selected list for 6 residential care facilities, as per hospital policy (KPI= 7 days);
- RCC contacts all residential care facilities (KPI=1 day);
- RCC asks patient/family to consider other alternative nursing homes (KPI= 14 days post GCS assessment);
- Social Worker follows up with residential care facility one week post discharge;
- % of patients discharged to the facility of choice as per their selected list; and
- Maintenance of Barthels Score on patients.

Figure A1-1: St Vincent's Health Nursing Home Flowchart and Performance Measures Phase 1

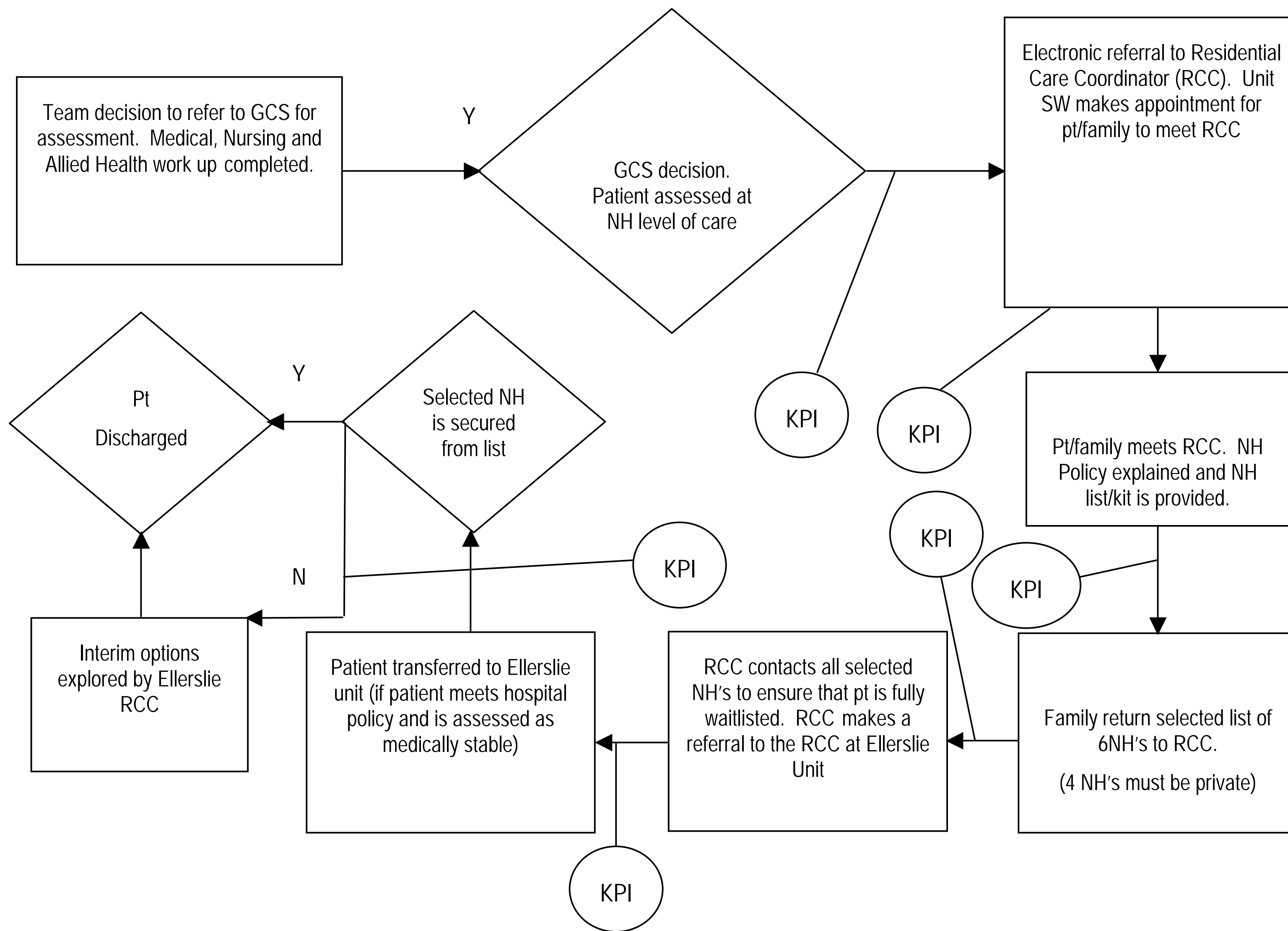
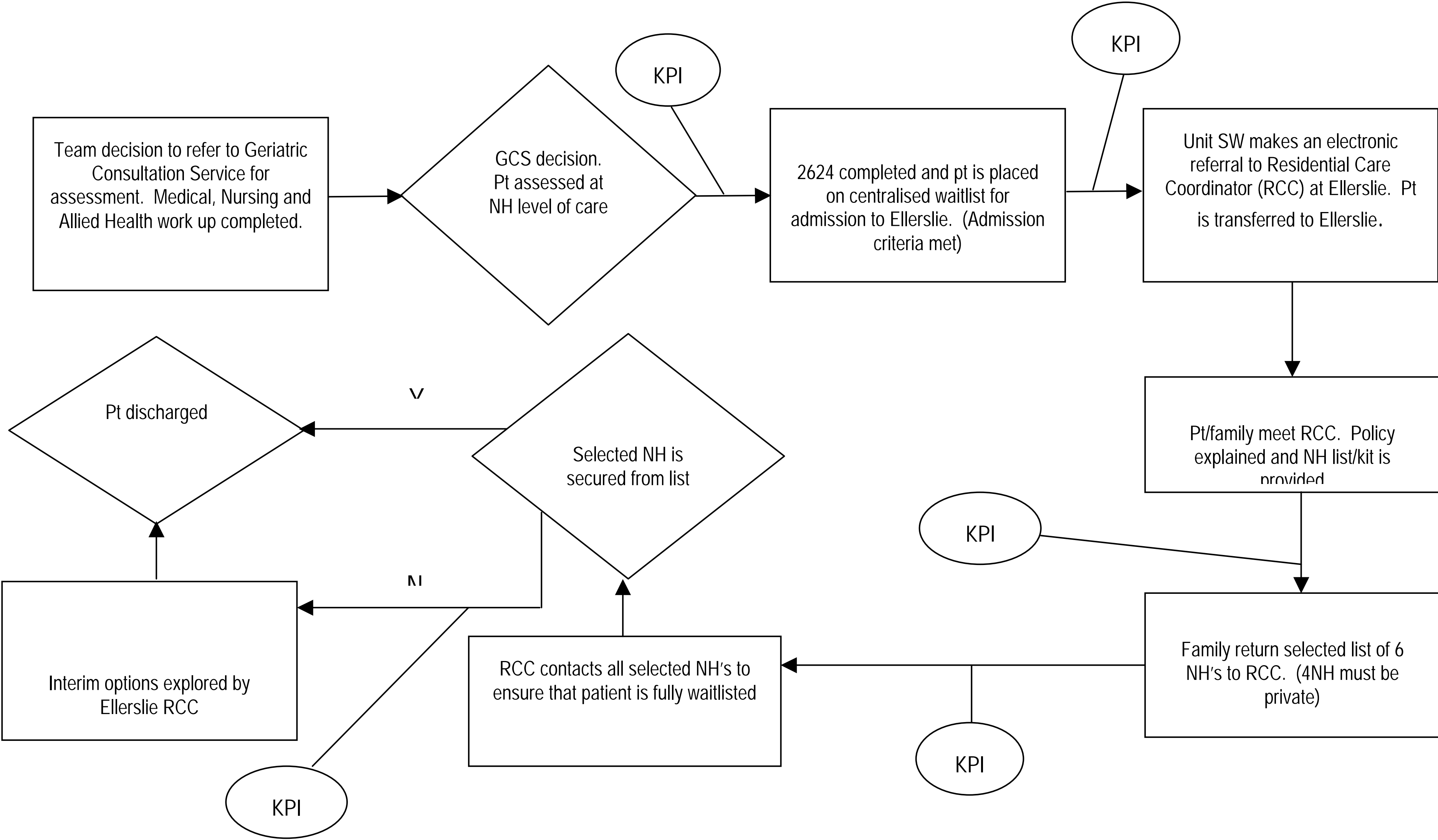


Figure A1-2: St Vincent's Nursing Home Flowchart and Performance Measures Phase 2



OTHER ISSUES

INFECTION RATES

Infection rates for Ellerslie were not available for analysis.

PAYMENT DETAILS

The patients are charged the equivalent of the resident standard daily rate from the time of admission to the Interim Care Ward.

FUTURE PLANS

At this stage St Vincent's intend to continue with their current model of bed substitution. The program managers have no intention of purchasing beds or commencing an Interim Care model at home.

SUMMARY OF FINDINGS OF PATIENT / CARER CONSULTATIONS

Two carers of a former and present Ellerslie residents returned written surveys to the consultants.

INFORMATION

The carers had mixed views whether there was a satisfactory amount of information given regarding both the Interim Care Program. One carer said there was a satisfactory amount of information supplied by the patients and carers, whilst the other carer believed that there was an unsatisfactory amount of information regarding the Interim Care Program and patient payment.

CARE

One carer was very pleased with the level and type of care delivered on Ellerslie. The carer viewed the level of care at Ellerslie as appropriate to the patient's needs. The carer was mindful that the patient may not require the same level of care that is required in an acute ward. The other carer compared the level received at Ellerslie unfavourably with the level of care received at St Vincent's Palliative Care. This carer was of the opinion that there was no physiotherapy treatment provided to the patient, and the patient suffered physically because of the lack of physiotherapy.

STAFF

One carer believed that the staff were "wonderful" and provided excellent support to both patients and carers. The other carer stated that there was an air of indifference in the attitude of the staff.

FACILITY

The two carers both agreed that the physical environment was pleasant and clean.

APPENDIX C

MEDICAL RECORDS EVALUATION

MEDICAL RECORDS EVALUATION

SUMMARY FINDINGS FROM INTERVIEWS WITH HEALTH INFORMATION MANAGERS ACROSS THE HEALTH SERVICES

VICTORIAN ADMITTED EPISODE DATA SET REPORTING REQUIREMENTS

Dissemination of VAED reporting requirements

In the early stages of the Interim Care program Health Services experienced some difficulties fulfilling the VAED reporting requirements because it was unclear what requirements were. As a result some admission transactions had to be double-handled (cancelled and resubmitted) to comply with the guidelines when they were subsequently published on 30 July 2001[2] and 7 September 2001[3]. Patient medical records also had to be retrieved and updated with revised admission transaction records.

The Health Services acknowledged that strategies aimed at reducing pressure on acute hospital beds often need to be implemented quickly. Outlining the changes that may be needed to the VAED to capture data about new models of service delivery are likely to be a secondary consideration. In ordinary circumstances, the VAED and hospital-based information systems can be modified to include new data codes and data edits (to flag or reject incorrect data), that are specifically tailored to support the strategy. Such software modifications and the timely dissemination of clear reporting guidelines are necessary to underpin the collection of good quality data at the Health Service level. Where there is insufficient lead-time, data quality is likely to be compromised.

During the 2001/2002 year, Health Services experienced some administrative problems distinguishing between non-nursing home type (non-NHT) Interim Care patients and GEM patients because they both had the same VAED Care Type code. In addition, GEM patients could not be statistically separated and statistically admitted to Interim Care because they both had the same Care Type code, so a formal separation and formal admission had to be recorded. Nursing Home Type (NHT) interim care patients also had the same Care Type code as other NHT patients, so a formal separation and formal admission had to be recorded.

The quality of VAED data for 2001/02 Interim Care episodes is unlikely to be as good, as the data gathered during 2002/03.

From 1 July 2002, the VDHS has introduced new Care Type codes for Interim Care patients so they can be easily distinguished from GEM patients and other NHT patients. The Health Services report that the changes are an improvement on the 2001/02 reporting arrangements.

Unfortunately Health Services experienced some problems in the transition to the new Care Type codes. In May 2002, the VDHS advised health services that all Interim Care patients remaining in on 30/6/02 were to be statistically separated and statistically readmitted (using the new Care Types codes) on 1/7/02.[4] On 6 August, the VDHS amended that advice to require all Interim Care patients remaining in on 30/6/02 to be statistically separated at 2359 hours on 30/6/02 and statistically readmitted at 0001 hours on 1/7/02. The change was necessary to avoid VAED data rejection edits. As a consequence, health services had to cancel and resubmit the affected admission transactions. One Health Service reported that the change also had implications for patient billing. Patients had already been charged for 30/6/02, but now 30/6/02 was their separation date and patients cannot be charged for their last day of an admission. The Health Service also reported that the total separated bed days included on AIMS for 2001/02 do not include the Interim Care bed days to 30/6/02, because the patients were originally separated on 1/7/02. Thus, it may not be possible to reconcile their VAED and AIMS data for 2001/02.

From 1 July 2002, VDHS has included a range of data edits that will improve the quality of interim care data being reported to the VAED. The edits flag or reject codes or combinations of data elements that are inconsistent with other data being reported for the same episode.

---

[2] VDHS Health Data Standards and Systems Bulletin Issue 24, 30 July 2001

[3] VDHS Health Data Standards and Systems Bulletin Issue 27, 7 September 2001

[4] HDSS Health Data Standards and Systems Bulletin Issue 36, 22 May, 2002

BARTHELS SCORES

A review of the VAED data (1/7/02 – 31/3/02) for Interim Care patients found that Barthels Scores are routinely reported by Melbourne Health, Northern Health, St Vincent's Health and Southern Health. Eastern Health reported few actual scores, in most instances the score was reported as zero or one.

The VAED data extract supplied to Health Outcomes International does not include Barthels Scores for any Nursing Home Type (NHT) Interim Care patients. The VAED system does not enable Barthels Scores to be reported for NHT patients so Health Services had to submit them separately to the VDHS. From 1 July 2002, the VAED can accept Barthels Scores for NHT Interim Care episodes.

MORBIDITY CODING

A review of the VAED data (1/7/02 – 31/3/02) found that of the 827 Interim Care separations, 49 (5.9%) were not coded in accordance with VAED reporting requirements. That is, they did not have a principal diagnosis code of either:

- Z75.11 Person awaiting admission to residential aged care facility, or
- Z75.12 Person awaiting admission to psychiatric facility.

Some of the incorrectly coded separations occurred before the reporting requirements were published on 30 July 2001, but most occurred afterward.

Data edits introduced by VAED from 1 July 2002 will reject such coding errors and result in improved data quality.

Most Interim Care separations have a principal diagnosis code and associated diagnosis codes reported to the VAED. The Northern Hospital and Box Hill Hospital code only the principal diagnosis because they have insufficient information from which to code associated diagnoses. However, the associated diagnoses are coded, where relevant, for the acute admission from which the patient was separated to interim care.

There is no explicit requirement for hospitals to code associated diagnoses for Interim Care separations, so they are coded at the discretion of the hospital. Associated diagnosis codes have not bearing on AN-DRG assignment.

Where models of contracted care are in use for interim care services, it is the responsibility of the contracting hospital to ensure that its medical records include sufficient information to support the diagnosis and procedure codes reported to the VAED. This requirement is outlined in the VDHS Concept Definition for Contracted Care[5]:

Responsibility for exchange of information
The contracting (purchasing) hospital (Hospital A) is responsible for ensuring that the contracted (service provider) hospital (Hospital B) provides adequate information for inclusion in the patient's record at Hospital A to (i) enable ongoing patient care at Hospital A and (ii) support the diagnosis and procedure codes reported to the VAED by Hospital A.

MEDICAL RECORDS

Medical record maintenance

Interim care episodes are documented in the Interim Care facility's medical record. At sub-acute facilities such as Kingston Centre, MECRS, Peter James Centre or a nursing home, the Interim Care episode is documented by the health care team in the same way as other episodes of care.

The arrangements for maintaining medical records at EH-SRS1 (a supported residential care service) are less clear. Some members of the referring hospital's health care team continue to provide services to Interim Care patients at EH-SRS1. The health information managers at Eastern Health reported that some documentation is being made in the referring hospital medical record but it is not comprehensive, suggesting that EH-SRS1 may be maintaining a record as well. The health information managers are currently liaising with EH-SRS1 to establish clear documentation guidelines.

---

[5] VDHS PRS/2 Manual, Concept Definitions, 11th Edition, July 2001, p2-11

Medical record review

A small medical record review was undertaken at two Health Services. Approval was obtained from the Health Service's Human Research Ethics Committee to conduct a medical record review. The task was to consider the structure of care, rather than the course or details of treatment. The review involved inspection of ten (10) randomly selected medical records pertaining to patients who had completed an episode of Interim Care in the past six months.

The review found that the medical records included patient referral/transfer documents prepared by the referring hospital. The Interim Care episodes were documented using established medical record forms and practices consistent with the requirements of sub-acute care. The health care teams used integrated progress notes to facilitate communication and planning. There was evidence of liaison with the patient's family and residential care facilities documented in the progress notes or on other forms within the records. At separation, a separation summary was prepared. Other separation and transfer documents were completed by other members of the health care team to support the patient's transfer to residential care.

In addition, the referring hospitals have an established practice of transferring their medical record with the patient to the Interim Care facility, to ensure continuity of patient care.

USE OF TERMINOLOGY

When patients move to and from interim care an admission and separation is reported to the VAED. In 2001/02, the Care Type (e.g. GEM, Rehabilitation) that patient was separated from determined whether the subsequent admission to interim care was reported as a formal admission or a statistical admission. The VAED reporting conventions do not allow a patient to be statistically separated from one Care Type and statistically admitted to the same Care Type. In 2001/02, GEM patients had the same Care Type code (9) as non-Nursing Home Type interim care patients. Patients had to be formally separated from GEM and formally admitted to interim care, a statistical admission could not be used. NHT patients had the same Care Type code (1) as NHT interim care patients, so a statistical admission could not be recorded for NHT patients admitted to interim care.

Patients admitted to interim care from other Care Types could be recorded as a statistical admission.

Patients could also be formally admitted to interim care where they have been formally separated from another health care facility, e.g. formally separated from St Vincent's Hospital and formally admitted to St George's Hospital.

For ease of communication, the following discussion uses the terms *admitted* and s*eparated* as inclusive of both formal and statistical admissions and formal and statistical separations.

Where the terms *formal admission* and *formal separation* are used, it is to highlight that a patient has moved from health facility A to health facility B for interim care services and those services are not being provided under contract to facility A.

EASTERN HEALTH MEDICAL RECORDS EVALUATION

Information about medical record practice was gathered by interviewing the health information managers nominated by the Health Service.

Eastern Health uses a model of contracted care[6] for Interim Care services. Acute patients are statistically separated from the Angliss Hospital, Box Hill Hospital or Maroondah Hospital and statistically admitted to the facility or service that is contracted to provide Interim Care, as shown in the following table.

Table B-1: Medical Records Interface between acute services and Interim Care Eastern Health

Angliss Hospital, Box Hill Hospital, Maroondah Hospital		
Acute Services		**Interim Care**
Admission → Statistical Separation		Statistical Admission → Separation
Angliss Hospital	⇒	EH-SRS1
Angliss Hospital	⇒	Nursing Care @ Home
Box Hill Hospital	⇒	EH-SRS1
Box Hill Hospital	⇒	EH-RACF3
Box Hill Hospital	⇒	Maroondah Hospital [1]
Box Hill Hospital	⇒	Peter James Centre
Box Hill Hospital	⇒	EH-SRS4
Box Hill Hospital	⇒	Ad hoc arrangements with a range of nursing homes (pre 1/7/02)
Box Hill Hospital	⇒	Nursing Care @ Home
Maroondah Hospital	⇒	EH-SRS1
Maroondah Hospital	⇒	Nursing Care @ Home

[1] Interim care services were provided from May 2001 to Feb 2002

[6] As defined in VDHS PRS/2 Manual, Concept Definitions, 11th Edition, July 2001

Similarly, patients are statistically or formally separated from sub-acute services at Peter James Centre and statistically or formally admitted to the contracted facility, as shown in the following table.

Table B-2: Medical Records Interface between acute services and Interim Care Peter James Centre

Peter James Centre Interface between sub-acute services and Interim Care		
Sub-Acute Services Admission → Separation		**Interim Care** Admission → Separation
Peter James Centre	⇒	EH-RACF2 [1]
Peter James Centre	⇒	EH-SRS4

[1] Ceased providing Interim Care March/April 2002

MEDICAL RECORD PRACTICE

The Angliss Hospital, Maroondah Hospital and Box Hill Hospital medical records are used to record the patient's acute care from admission to statistical separation. The acute care is documented in the hospital medical record, from admission to statistical separation.

When the patient is transferred to EH-SRS1, their hospital medical record accompanies them and is returned at separation. This practice was only commenced by Box Hill Hospital from 1 July 2002. Previously there were so many facilities providing Interim Care to Box Hill Hospital patients that the health information manger was concerned the medical records would be lost if they went off-site or not available in a timely fashion for morbidity coding.

The hospital medical records are also held at EH-SRS1 for patients receiving Nursing @ Home because the health care team meetings are held there.

There is some uncertainty among the chief health information managers about the medical record documentation requirements for Interim Care provided at EH-SRS1. Currently EH-SRS1 is using the referring hospital's medical records to document the Interim Care episode but the documentation does not appear to be comprehensive, suggesting that EH-SRS1 may be maintaining its own patient record. The chief health information managers are currently investigating what documentation should be included in the hospital medical record.

The VDHS Concept Definition for Contracted Care[7] states:

> ***Responsibility for exchange of information***
>
> *The contracting (purchasing) hospital (Hospital A) is responsible for ensuring that the contracted (service provider) hospital (Hospital B) provides adequate information for inclusion in the patient's record at Hospital A to (i) enable ongoing patient care at Hospital A and (ii) support the diagnosis and procedure codes reported to the VAED by Hospital A. (p.2-11)*

This requirement does not impose an obligation on the contractor to use the purchaser's medical record to document the episode of care, nor does it preclude that option. The hospitals and EH-SRS1 need some documentary evidence of the episode of care to fulfil their own operational requirements. This may be achieved if EH-SRS1 maintained its own patient record and a separation summary pertaining to the Interim Care episode was included in the hospital medical record.

[7] As defined in VDHS PRS/2 Manual, Concept Definitions, 11th Edition, July 2001

Another consideration is that hospital staff continue to provide services to Interim Care patients at EH-SRS1. Clear guidelines are needed about which record should include details of the services they have provided.

The chief health information managers are currently exploring this matter with a view to establishing guidelines as to which facility's record should be maintained on a day-to-day basis for recording the Interim Care episode, and what documentation is required. The guidelines will also outline what information is to be transferred to the other facility to fulfil its operational requirements.

The issue of medical record maintenance does not arise for patients who are referred by the hospitals to Peter James Centre, EH-RACF3 or other nursing home. They document the Interim Care episode in their own medical record.

Patients transferred from Peter James Centre to EH-SRS4 have their Interim Care episode recorded in the EH-SRS4 patient record. A copy of the episode is added to the Peter James Centre medical record at separation.

REPORTING TO VAED

Patients receiving Interim Care services are recorded on the Admission, Transfer and Separation (ATS) systems of their referring hospital. This requires the hospital to maintain a process of being notified whenever a patient is separated from Interim Care so the ADT can be updated. Before VAED data is submitted to the VDHS an admission reconciliation process is undertaken to ensure that the status of Interim Care patients is accurate.

The Eastern Health hospitals use common codes on the ADT system to facilitate the tracking and reconciliation of Interim Care episodes within and between sites.

The acute hospitals do not routinely use Barthels Scores and have had experienced some difficulty fulfilling this VAED reporting requirement for Interim Care patients. Box Hill Hospital and Angliss Hospital have reported accurate scores for some but not all Interim Care patients. Dummy scores have been used for many episodes because the score was not available.

The Peter James Centre is familiar with reporting the Barthels Scores because it reports them for other sub-acute patients. However, they do experienced some difficulties trying to obtain Barthels Scores from contracted Interim Care facilities at separation.

MORBIDITY CODING

Angliss Hospital, Maroondah Hospital and Peter James Centre code the principal diagnosis and associated diagnoses, where relevant for Interim Care episodes. Box Hill Hospital codes only the principal diagnosis because it has insufficient information to enable coding of associated diagnoses. However, the associated diagnoses are coded for the acute admission from which the patient was statistically separated to Interim Care, so they are reflected in part of the overall episode of care.

APPENDIX D

BARTHEL INDEX SCORE

APPENDIX E

DATA SUMMARY

APPENDIX F

CLASSIFICATION AND REGRESSION TREES

APPENDIX G

Hospital Demand Management Strategies