

Interim Care Guidelines for Health Services providing Interim Care



Scope

The guidelines provide information to assist and guide the providers of Interim Care and the people who use the service. They have been developed in response to the evaluation of the Interim Care program and have drawn on the experiences of the Health Services that have operated this program.

What is Interim Care?

In essence, the Interim Care program provides temporary support and active management of older people while longer-term care arrangements are being finalised. Generally, the Interim Care program offers a number of services to eligible people. The basic components of the program are

- an appropriate level of nursing and medical care
- allied health input to maintain physical functioning,
- personal care,
- social workers who actively involve the person and the family in securing appropriate accommodation and
- a level of case management for Home-based Interim Care clients.

Who is eligible for Interim Care?

People are eligible for Interim Care when they

- have completed their acute or sub-acute episode of care and are medically stable
- have been recently assessed by an Aged Care Assessment Service (ACAS) and recommended for high or low level aged residential care and
- could be transferred to a residential care facility immediately if a place were available.

What are the aims of Interim Care?

Interim Care

- provides high quality short-term care that is appropriate to the needs of older people in the target group
- actively assists the older person and their family to obtain suitable long-term care outside the hospital setting and
- optimises the functional capacity of the older person through the collective efforts of the Interim Care staff.

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How much Interim Care is needed?

Victoria's population is both growing and ageing. The primary driver for Interim Care demand is the variable availability of Commonwealth-funded residential aged care facilities and community care across the State. When external circumstances precipitate the need, Interim Care is a viable solution to the transition phase between hospital and the community for older, medically stable patients, who need supported care. Therefore it seems likely that Interim Care will be needed in the medium term, with higher levels of Interim Care required when there is insufficient residential care and community care to respond to the demands of this group of older hospital patients.

Interim Care has been conceived as a targeted program to assist Health Services with improving patient flow. There will be patients waiting for supported care (whether this be residential care or community care) in an acute or sub-acute setting, who are likely to secure these services within a reasonable timeframe. In these circumstances, it would be preferable to avoid moving the older person, as frequent moves can be associated with deterioration. However for those patients where the process of finding a suitable care setting is likely to take longer, Interim Care can be considered as an option. Thus not all older patients waiting for placement will need to access Interim Care. In the same vein, Interim Care funding is not an essential component for the continuum of care in every Health Service.

The provision of operational residential aged care beds, Extended Aged Care at Home (EACH) packages, Community Aged Care Packages (CACPs) and Linkages packages will be monitored across the State to assess the need for Interim Care as will the performance of the Health Services in managing Interim Care and related programs. The criteria for assessing the need for Interim Care and allocating resources are on the Department of Human Services Continuing Care web-site. Levels of Interim Care will be monitored, reviewed and possibly modified over time.

Recommended Models of Interim Care

It is essential that Interim Care be informed by the patient's needs as the centre of the planning process. The three models of Interim Care are ward-based, contracted residential care and home-based services. The preferred features of Interim Care setting include a less institutional, more home-like environment and the capacity for privacy as afforded by single rooms. Flexibility in the provision of care is also important. These characteristics are more readily found in the contracted residential care model and the home-based model.

Where Interim Care operates, it is recommended that both the Residential Care model and the home-based options be available. This maximises the Health Service's capacity to respond to individual circumstances and increase choices available to patients. Typically the Residential Care model utilises beds available in Supported Residential Services (SRSs) or spare capacity in Commonwealth-funded residential aged care facilities where there are additional unlicensed beds. Interim Care in a contracted residential service must be located in reasonable proximity to the main population centre or centres which constitute the Health Service's main catchment area. Home-

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based services can be contracted with existing, accredited case management agencies. New Ward-based Interim Care services in public hospitals, which require additional funds will not be a priority.

Current analysis of the 2001/02 and 2002/03 data collectively indicates an Average Length of Stay (ALOS) for patients in Interim Care programs of approximately 30 days, with the majority of patients having a length of stay less than this. In the home-based model, the ALOS has been shown to be approximately 2 months. The home-based Interim Care option should not be seen as a substitution for ongoing community care.

It should be noted that SRSs and Commonwealth-funded residential care facilities are governed by regulations and standards, which are essential to uphold for their continued operation and the satisfactory care of their usual client group. SRSs are covered by the State government's *Health Services Act 1988*, while residential aged care facilities (nursing homes and hostels) are covered through the Commonwealth government's *Aged Care Act 1997*. The integration of an Interim Care program into these settings should take account of the needs of the Interim Care clients, the existing residents in the facility and the obligations of the proprietors to the regulatory bodies. For SRSs the regulatory body is the Department of Human Services and for Commonwealth-funded facilities it is the Aged Care Standards & Accreditation Agency.

What should Interim Care clients expect?

For the patients, Interim Care is more than a temporary accommodation option at the conclusion of hospital treatment. It includes an active process that encourages the patient and their family to secure long-term care in a timely way. Interim Care is characterised by an appropriate level and configuration of maintenance care, preferably in a non-hospital setting. The following points each contribute to a patient-focussed approach to Interim Care:

Information

- Where an ACAS assessment indicates that a residential aged care option is likely with Interim Care as the transition phase, this possibility should be discussed with the patient at the earliest opportunity in the patient's continuum of care.
- Information about the Interim Care program should be provided in a timely and accurate way to the person, the carer and family to enable all parties to consider their options in an informed manner. This includes an explanation of
 - the nature of the program
 - which agency has responsibility for the program
 - which agency/ies have responsibility for patient care while on the program
 - the roles of the various Interim Care staff
 - a statement of patient rights and responsibilities while on the program
 - patient complaints and appeal process systems that operate in Health Services and within the State of Victoria as well as
 - an agreement form for patients and /or their carers to sign when they confirm their intention to participate in the program.

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Information about Interim Care and its role in the continuum of care should be consistent throughout the entire episode of care.

- Where Interim Care has been sub-contracted to another service provider, patient complaints are a shared responsibility between the contracted service provider and the Health Service. Both need to be informed in the event of a complaint, though their differing areas of responsibility should be made clear to the patient and their family.
- The patient's medical information, preferably the medical record should be part of the hand-over between acute or sub-acute and the Interim Care staff. Arrangements should be established for the transmission of the key aspects from the patient's medical information to any sub-contracted Interim Care providers and in the context of the Privacy regulations.

Assessment

The assessment principles in Interim Care are

- When home-based care is being considered as an option, the patient be given a multi-disciplinary assessment, including a risk assessment, to determine their suitability to return home with support while waiting for a placement.
- The patient be provided with an opportunity for reassessment of their long-term care needs and options if their circumstances change after entering an Interim Care program; the ACAS will need to be reinvolved at this point.

Based on experience, a small but significant minority of patients are able to remain at home after leaving the Interim Care program, being supported by other existing programs such as EACH, CACPs, Linkages or core HACC services. Patients for whom a low care residential facility is indicated by the ACAS, should be assessed for the home-based Interim Care option. Those people assessed as requiring high care could be given the opportunity for a home-based option if there are positive indicators such as a strong preference to return home and/or carer ability and willingness to assist, among other factors.

There should be the flexibility for Interim Care patients to move from a contracted Residential Care model to the home-based model (or vice versa) if the needs of the patient require this. Home-based Interim Care clients should be returned to the bed-based option if they are not coping at home.

Service

The essential elements and processes for patients in Interim Care are

- The provision of an appropriate balance between nursing and personal attendant care in response to individual patient needs.
- For ward and contracted bed Interim Care services, a regular clinical review by an Aged Care consultant, for example the Health Service Geriatrician, and for home-based Interim Care services, the patient's General Practitioner.
- The provision of allied health and/or diversional activities to maintain the patients' level of physical and cognitive functioning.

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- A response to patients' cultural preferences in meals and other services.
- The planning, review and where necessary modification of each patient's care and maintenance activities, while placement is being arranged.
- An appropriate exit strategy for the patients from the Interim Care program.
- Interim Care staff are expected to collaborate with residential and community care providers in their catchment area. In the case of the Home-based Interim Care option, Interim Care staff will consult with the clients' primary health and care network.
- Opportunities to involve external residential care staff in training within the Health Service should be encouraged.

Hospital and Other Service Provider Issues

All decisions relating to Interim Care should be guided by protocols, which guide each of the decision-making steps. Where there is a choice of Interim Care setting, clear criteria are to be established to guide decision-making regarding patient placement.

Health Service and contracted service provider staff involved in the delivery of Interim Care services need to be fully informed about the program, including the guidelines, and their responsibilities.

Contracting

- Proper due diligence processes should be followed in setting up contracted Interim Care services to check the track record of the providers.
- When a Health Service contracts Interim Care to an SRS or a Residential Aged Care facility, they must ensure that the agency has minimum public liability cover of \$5m.
- Sufficient time should be allowed in setting up Interim Care to ensure a smooth transition for patients and providers.
- Health Services planning an Interim Care option using an SRS are strongly advised to include appropriate regional Department of Human Services staff in their negotiations with the SRS.
- Where a high care Interim Care patient is in an externally contracted service, they must have 24 hour on-site access to a Division 1 Registered Nurse. Other Interim Care patients should have access to appropriate nursing services depending upon their needs.
- Non-nursing staff involved in the personal care of Interim Care patients need to have or be working towards Certificate 3 standard of training.
- The contract should include flexibility to vary service according to the Interim Care patient's need.
- Patients in ward or contracted bed Interim Care services have inpatient status. All bed-based Interim Care is to be reported on the Victorian Admitted Episode Database.
- Home-based Interim Care clients are discharged and have access to their General Practitioner, the Pharmaceutical Benefits Scheme and the Medical Benefits Scheme. An agreement needs to be established with the relevant GP to visit the Interim Care patient. However the Health Service

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is still responsible for the effective overall operation of the Home-based program, even though particular health and personal care responsibilities are delegated.

- Health Services providing home-based Interim Care should use existing infrastructure where appropriate. There may be case management services already available through the Health Service or in the community.
- For home-based Interim Care, where Health Services contract with case management agencies that have a Funding & Service Agreement (FASA) with the department, the agency is covered for insurance. If the case management agency does not have a FASA with the department, the Health Service should be certain that the contracted agency has sufficient insurance cover.
- If the case management agency then sub-contracts services to other agencies, the contracting agency (the case management agency) is responsible for ensuring that the sub-contracted services have adequate levels of insurance.
- Interim Care service providers need to have a critical mass of these patients in order to have access to staff skilled in their care. Therefore ad hoc Interim Care arrangements with a number of providers, each with a few Interim Care patients, may not be the preferred option unless it is in the best interests of the patient.

Risk management

- For both the Health Service and the contractors, the due diligence process will take into account financial risk, indemnity and quality issues. For SRSs, appropriate standards should be met, and for Aged Care facilities there should be satisfactory compliance with Aged Care accreditation standards. No active sanctions against the facility should be present.
- Arrangements need to be in place for priority access of an Interim Care patient to return to the Health Service if needed.
- In the event of an Interim Care Residential Care facility losing accreditation or failing to meet the expected standards of care for Interim Care patients or non-Interim Care patients, the Health Service should have contingency plans to manage Interim Care patients until an alternative arrangement is put in place.
- The contracted agency/ies must comply with relevant State and Federal legislation.
- Quality processes that apply to existing Australian Council on Healthcare Standards (ACHS) should also apply to the Health Service's Interim Care program.

Monitoring and Fees

- Health Services receiving funding from the Department for Interim Care will be required to acquit for the sum at the conclusion of the financial year. Through-put targets will also be set for the Health Services operating Interim Care programs.
- Admitted Interim Care patients can only be charged fees after 35 days continuous hospitalisation under the same provision and at the same rate as NHT patients. Fee charging by the Health Service is discretionary.