

**Mapping of Services at the
Interfaces of Acute and Aged Care**

**Consultancy Report to the
Australian Health Ministers' Advisory Council
Working Group on Care of Older Australians**

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- The Task Group of the AHMAC Working Group on Care of Older Australians assigned to this part of the Work Program was ably chaired by Alice Creelman of the Commonwealth Department of Health and Ageing; Gloria Caruso (Victoria), Ann Pengelly (SA) and Kylie Mayo (WA) provided practical assistance to the Consultants in the field and their critical in comments on drafts were greatly appreciated. Our special appreciation goes to Christine Canning, also of the Commonwealth Department, for her unflagging enthusiasm, and her effective liaison with all the States and Territories.
- The AHMAC Working Group, comprising representatives of the Commonwealth and the States and Territories.
- The Clinical Reference Group of the AHMAC Working Group, comprising representatives of service providers and consumers.

Abbreviations

This list includes only generic abbreviations and acronyms. Acronyms for major state-wide programs operating in different States and Territories are included, but acronyms specific to individual programs and services are detailed in relevant sections of the report.

ACAT	Aged Care Assessment Team; also ACAS Aged Care Assessment Service
ADL	Activities of Daily Living – bathing, dressing etc.; also IADL Instrumental Activities of Daily Living – using phone, public transport, etc.
AHPMC	After Hours Primary Medical Care
ATA	Acute Transition Alliance (South Australia)
AQoL	Assessment of Quality of Life – health related quality of life index developed specifically for Australian conditions
CACP	Community Aged Care Package
CAP	Care Awaiting Placement (WA program)
CTT	Coordinated Care Trial
DGM	Department of Geriatric Medicine
DHS	Department of Human Services, Victoria
DRG	Diagnosis Related Group
EACH	Extended Care at Home
ED	Emergency Department
EPC	Enhanced Primary Care
GEM	Geriatric Evaluation and Management, used mainly in Victoria
HACC	Home and Community Care Program
HDWA	Health Department of Western Australia
HITH	Hospital in the Home
LOS	Length of stay

NDHP	National Demonstration Hospitals Program
NHTP	Nursing Home Type Patient
PAC	Post Acute Care (Victoria)
RASAH	Rehabilitation and Support at Home (South Australia)
RCS	Resident Classification Scale (basis for funding in residential aged care)
SF 36	Short Form of the General Health Survey – health related functional status index, covering physical and mental health dimensions from total of 8 dimensions, to provide health profile from patient’s point of view
SSOU	Short stay observation unit, attached to Emergency Department
WEDS	Winter Emergency Demand Strategy (Victoria), absorbed into Hospital Demand Management Strategy

Executive Summary

The task of mapping services at the interface of acute and aged care services was identified as the first part of an extensive Work Program on Care of Older Australians to be undertaken for the Australian Health Ministers' Advisory Council. This Executive Summary outlines the contents of each part of the Report and presents the main findings that inform the further development of transition services in an integrated framework. This integrated framework is seen to have considerable potential to enhance the care of older people whose care needs require timely and coordinated responses from both acute care and aged care services.

Part 1: Overview of the Mapping Exercise

Part 1 of this Report presents an overview of the Mapping Exercise. The **objectives** of the Mapping Exercise were concerned to give an up-to-date account of recent developments in both acute and aged care services that were addressing the transfer of older people into and out of acute care. As there are no standard definitions of the kinds of services to be included, and the field has been dynamic in recent years, considerable attention has been given to ensuring the **scope** of the exercise was inclusive rather than exclusive and that the full range of services would be canvassed. While the scope of the aged care "system" covered in the Mapping Exercise encompassed assessment, residential care and community care services, the investigation of services at the interfaces between the acute and aged care systems was exploratory. Coverage was shaped by conceptual considerations in the definition of these services and the lack of standard terminology, and practical considerations of the lack of central sources of information on the services of interest and the time frame of the project. This Report focuses on examples of the range of services that illustrate recent developments at the interfaces between acute and aged care services, and models have been developed as composites of these examples. The Mapping Exercise was *not* intended to provide a comprehensive account of all services providing post- and sub-acute care across the States and Territories, and this Report thus should *not* be taken as a comparative analysis of those services

To assist in the systematic identification, classification and analysis of the range of existing services, a framework of five levels of intervention, with a number of sub-levels, was developed, as set out in Chart 1 (Chart 1 appears as Table 1.3 in the Report). The levels of intervention were differentiated in terms of their purposes and the client flows to which they were directed.

The **methods** adopted to identify relevant services varied across the States and Territories. Primary data collected involved completion of a Scan either at state-wide or regional level, and more detailed Service Profiles were provided by a selection of individual services. State and Territory authorities also provided a variety of secondary data by way of reports on service provision and policy reviews. Only a limited literature review was carried out, and although formal evaluation is limited, there is now an

adequate range of experience on which further service development can build. The web site of the Australian Resource Centre for Hospital Innovations (www.archi.net.au) developed in conjunction with the National Demonstration Hospitals Program proved a most valuable resource in locating reports of recent initiatives that had not been reported in the published literature. Given the interest of the Mapping Exercise in the evidence of effectiveness of different interventions, the types of evidence available from expert opinion, formal evaluations and randomized controlled trials was reviewed and an assessment made of the capacity for generalization from the available evidence. The evidence available from secondary sources was supplemented by the primary data collected in the Mapping Exercise which contributed to the evidence base for assessing the models.

Chart 1: Framework of five levels of intervention in acute-aged care interfaces

1. Early intervention before presentation at hospital, to prevent hospital admission
1a. Early intervention to prevent emergency department presentation of those living in the community
1b. Early intervention to prevent emergency department presentation of those living in residential care
2. Intervention in hospital to divert admission and reduce LOS of admitted patients
2a. Prevent acute hospital admission after treatment in emergency department
2b. Reduce length of stay of admitted patients (excluding discharge planning)
2c. Discharge planning (including treatment and therapy) to reduce length of stay, improve post discharge functioning and decrease the risk of readmission
3: Hospital organised post acute therapy/nursing care after discharge, to reduce LOS and restore function
3a. Check up phone call or home visit, by hospital staff, within a few days of discharge
3b. Therapy rehabilitation program provided in the community
3c. Nursing program provided in the community
4. Hospital organised INTERIM support package after discharge, to reduce LOS and restore function
4a. Provision of interim community care for limited time, until HACC, CACP or EACH package available
4b. Provision of interim residential care for limited time, until permanent residential care available (excludes respite admission to residential care)
5. Sub-acute rehabilitation services for clients at risk of admission to acute hospital care, to maintain individual in the community
5a. Geriatric Medical Centres providing rehabilitation and therapy (in-patient settings)
5b. Specialist out-patient Geriatric Medical Clinics / Day Hospitals providing management to prevent admissions and re-admission (eg. Specialist falls and balance clinic)
5c. Rehabilitation services targeted to HACC users
5d. Rehabilitation services targeted to aged care package users (CACP, EACH)

Part 1 concludes with an **overview of services in each State and Territory**, and the State and Territory reports are presented in full in Part 3. This overview shows that there has been substantial development of the interfaces of acute and aged care in all jurisdictions in the last few years, and that many innovative approaches have been

advanced. Level 1 interventions had especially developed through the Commonwealth initiatives for Enhanced Primary Care (EPC) and After Hours Primary Medical Care (AHPMC), and through State programs for Chronic Disease Management. Other interventions that served to reduce admissions to acute care or substitute for part of an acute stay were pre-admission clinics for elective admissions and Hospital in the Home. Outreach services to residential care facilities from ACATs were also aiming to limit transfers of residents to acute care. Together these programs provided a wide base for the expansion of services aiming to prevent admissions to acute care and no further development of models for service delivery was considered necessary at this level of intervention.

Sub-acute rehabilitation services, Level 5 interventions, were found to have a long history in most States and Territories, and diverse modes of delivery were identified, ranging from generalist day hospitals and community rehabilitation centres to specialist clinics for geriatric and chronic conditions. Inpatient geriatric rehabilitation units provided for admission directly from the community as well as for post acute transfers, and in-home rehabilitation extended the scope of service delivery in the community. Although the level of service provision was not always adequate to meet demand, the main need for service development was integration of the many separate programs that had come into being in recent years; one issue was clarification of the contribution of Commonwealth funded Day Therapy Centres to post acute care. There was not seen to be a need for development of further models for service delivery, and accordingly no models were developed for Level 5 interventions.

Services at Levels 2, 3 and 4 were in contrast characterised by great diversity and were unevenly developed within and between the States and Territories. These services combined four functions: specialist clinical input to assessment and management; coordination and liaison, brokerage for purchase of direct care services, and provision of direct care services. The balance between these functions varied for different interventions, as did the functions performed by hospitals vis-a-vis other agencies. The scope for refinement and consolidation of services at these three levels of intervention made them the focus for development of further service models.

Part 2: Service Models for Transition Services

No particular services, nor one kind of service, stood out as having the capacity to make a major impact on the flows between acute and aged care services. Rather, there was seen to be a need to strengthen a range of services that together would enhance management of transfers across various interfaces. Notwithstanding the diversity of existing services at Levels 2, 3 and 4, most shared three common features that identified them as transition services and distinguished them from both Level 1 and Level 5 services, namely:

1. They manage the transfer of clients between acute care and another setting;
2. Their prime functions are assessment and care coordination ahead of delivery of direct care services; and

3. Their timelines are characterized by quick response, and provision of support was for limited time periods until “usual” support services could be instigated.

The selection of services that warranted further development took account of patterns of existing service provision in the States and Territories, available evidence as to the effectiveness of existing services, the potential impact of further service development on the various flows between acute and aged care, and capacity for wider implementation to achieve more appropriate outcomes for clients and to facilitate transitions between acute and aged care services. The selection was also informed by advice from the Clinical Reference Group. The relationship between the five level framework of interventions and the services selected for development of models is set out in Chart 2. (Chart 2 appears as Table 2.2 in the Report).

Chart 2: Relationships between five level of intervention framework and services selected for development of models

Level of intervention	Client flow	Purpose	Current initiatives	Further development options
Level 1. Early intervention before presentation at hospital, to prevent hospital admission				
Older people living in community, at risk of hospital admission	Large and undifferentiated flow of older people likely to use to acute care	Prevent admission	1. Enhanced Primary Care: Health Assess. & Case Conf. 2. Chronic Disease Management 3. After Hours Primary Medical Care	Further development through existing programs.
Individuals living in residential care, at risk of hospital admission	Small flow		4. Enhanced Primary Care: Case Conferencing 5. Outreach from ACATS, including GP home link services	Increase take up of EPC
		Substitute for Admission	6. Hospital in the Home 7. Preadmission Clinics	Extend HITH to residential care
Level 2. Intervention in hospital to divert admission and reduce LOS of admitted patients				
Emergency Department presentation	Large and Undifferentiated flow of older people presenting at Emergency Dept.	Divert Admission	1. Geriatric service in ED, including liaison nurse and geriatrician, possibly ACAT 2. Short stay observation units	Increase geriatric medical presence in ED; sound evidence of effectiveness. Evidence does not provide strong support for priority development
MODEL 1	Small flow from residential care		3. Quick response provision of services, for 1 week only	Increase availability of community services for quick response service Address issues around return to hostel care
Admission to inpatient care in general medical or surgical wards	Selected on basis of likely delay in discharge due to <ul style="list-style-type: none"> • advanced age (80+), • co-morbidities, • already using support services 	Reduce LOS Maximise function on discharge Allow time for decision	1. Fast track management of specific conditions e.g. fractured NOF 2. Prompt discharge to slow stream rehabilitation 3. Discharge planning 4. Step down unit providing intermediate care	Increase and refine roles of geriatric medicine in acute hospitals, especially in expansion of intermediate care step down units in conjunction with other hospital wards. Establish funding levels, including review of NHTP classification, SNAP etc.
MODEL 2				

Level of intervention	Client flow	Purpose	Current initiatives	Further development options
Level 3: Hospital organised post acute therapy/nursing care after discharge, to reduce LOS and restore function				
Post acute program organised by Hospital Rehabilitation focus MODEL 3	Small and selected flow of patients assessed as requiring rehabilitation support to return home and has potential to benefit	Reduce LOS Restore function Through therapy	Post Acute Community Care, with focus on rehabilitation Various initiatives with common features: <ul style="list-style-type: none"> Delivered in community Range of services include therapies Time limited Brokerage models Most services purchased from HACC providers 	Concentrate client flow with ACATs taking lead role Increase direct service delivery through Innovative Care Pool, with wider range of approved providers, Expand access to community rehabilitation, including in-home rehabilitation Clarify role of C'w funded Day Therapy Centres
Level 4: Hospital organised INTERIM support package after discharge, to reduce LOS and restore function				
A. Interim community care General support focus MODEL 4	Moderate flow of patients assessed as requiring general support to return home	Reduce LOS Re-establish at Home	Post Acute Community Care, as for Model 3, but with focus on general support rather than rehabilitation. Various initiatives with common features: <ul style="list-style-type: none"> Delivered in community Range of services Time limited Brokerage models Most services purchased from HACC providers 	Address impact of additional demand on HACC services Streamline brokerage arrangements
B. Interim residential care MODEL 5	Highly selected group of clients, characterised by delays & difficulties in discharge	Provide care while awaiting placement	Purchase of interim residential care beds, cost above RCS <ul style="list-style-type: none"> WA Care Awaiting Placement, residential care component Small number of services in Victoria, bed numbers range from 5-10 to 20+ 	Monitor evaluations Reduce need for interim residential care through all other strategies Take account of further provision of residential care, especially in areas of under supply.
Level 5: Sub-acute rehabilitation services for clients at risk of admission to acute hospital care, to maintain individual in community				
Outpatient Geriatric medical Services	Referral on discharge, by ACAT Admission from community, via GP	Maintain in Community	Day Hospitals Special Geriatric Medical Clinics	Add Transition Care Component to existing sub-acute care programs, for patients referred by ACAT

Chart 2 chart shows that rather than developing one model at each of the five levels of intervention in the framework, the models were developed at Levels 2, 3 and 4 as:

- Level 2: Model 1: Interventions in the Emergency Department
- Model 2: Step down care following the acute phase of inpatient care
- Level 3: Model 3: Post acute care organised by the hospital, with rehabilitation focus
- Level 4: Model 4: Interim community care
- Model 5: Interim residential care

Each model is developed as a composite of existing services, drawing on the information collected in the Scans and Service Profiles and from secondary sources. While the models aim to incorporate current good practice, they are not ideal types but rather prototypes with potential for further refinement. Development of the models gave particular attention to identifying factors that contributed to effectiveness, by way of demonstrated impacts on service systems and client outcomes, and/or through evaluation.

The remainder of Part 2 is taken up with systematic accounts of the five models. The summaries that follow here highlight the factors contributing to effectiveness to which further service development should conform to achieve similar outcomes. The limited evidence base from formal evaluations was supplemented with the primary information collected on services covered in the Mapping Exercise and enabled an assessment of services on the basis of operational considerations and outcomes reported directly in the Scans, Service Profiles and other sources. The criteria set out in the Project Brief for assessing the models and the assessments made are noted in Chart 4 following the summaries.

Model 1: Intervention in Emergency Department, aiming to divert admission***Basis of model***

- Addresses major flow: half of all acute admissions of older people are via the ED.
- Evaluations demonstrate potential for significant impact on diverting admissions to return home with support.
- Existing services widespread but unevenly developed and practices not standardized.
- Key features are:
 - services instigated within 24 hours;
 - presence of specialist geriatric medical and nursing staff in ED;
 - close liaison with GPs;
 - capacity to act promptly to arrange provision of critical support services.

Focus in acute and aged care systems

- Goal is to prevent admission after treatment in ED, divert to other services and reduce likelihood of readmission.
- Focus is on ED to home interface.
- Assessment, coordination and brokerage usually provided by hospital, but some notable exceptions in SA; direct care services by community services and GP.

Developmental pathway

- Services developed to address pressures in ED and stimulated through Coordinated Care Trials and National Demonstration Hospitals Program, but tended to still operate under own guidelines.
- Funding often opportunistic, drawing on many sources, and hence unstable in some services.

Target population

- Large flow of clients, selected after initial ED triage.
- Screening tools required modification to achieve stricter selection
- Patients characterized by *multiple* risk factors: 75+, ADL and IADL limitations, impaired mental status, prior use of support services, high risk of readmission.
- No waiting lists and time limits on services.

Monitoring and evaluation

- Considerable evaluation as required by programs under which established (CCT, NDHP).

Assessment

- Highly likely to achieve intended outcomes due to specificity of service and selectivity of client group, substantial scale and cost effectiveness.
- High cost effectiveness.
- Added impact from positive flow on effects.

Model 2: Inpatient step-down care to reduce LOS***Basis of model***

- Expansion of diagnostic focused services, e.g. management of orthopaedic conditions, to more general intakes;
- Evidence of effectiveness of diagnostically focused services, and scope for transfer of experience;
- Uneven development and instability of some services needed to be addressed.
- Step-down care is usefully described as *intermediate* in intensity, setting, type of care, duration and combination of individual and group management.
- Goals of discharge home and other features distinguish step down care from interim residential care as detailed in Model 5.

Focus in acute and aged care systems

- Addresses interfaces within hospitals, between acute and non-acute care, between streams of care within Departments of Geriatric Medicine and between inpatient and post acute community care.
- Extensive range of action within hospital and across community care services, with ACATs involved in assessment at several points.
- Concentration of patients promotes focus on restorative care and discharge.

Developmental pathway

- Diverse origins, mostly from within hospitals, and diverse operating practices.
- Funding approaches were through part of casemix funding or per diem flat rate.

Target population

- Careful selection from potentially large flow, based on clinical assessment of potential for further improvement and uncertainty of outcome.

Monitoring and evaluation

- Individual services that monitored activities served as demonstration models.

Assessment

- Potential to achieve intended outcomes increased with greater specificity of service, clinical selection and concentration of patients.
- Cost effectiveness relatively high.

Model 3 Post acute rehabilitation and/or nursing, organised by hospital and delivered in community

Basis of model

- Instigation of a variety of services to facilitate discharge and relieve pressure on inpatient rehabilitation services.
- Evidence of effectiveness in formal evaluations.
- Key features are prompt instigation of services with rehabilitation focus, not readily available through HACC.

Focus in acute and aged care systems

- Goals were to reduce LOS and reduce admissions to residential care.
- Addressed inpatient to home boundary, with wide range of action to secure community services.
- Specific focus on allied health services.

Developmental pathway

- Range of services established in early 1990s under Medicare Incentive Packages to more recent initiatives, including State Post Acute Programs.
- Key roles of Departments of Geriatric Medicine and rehabilitation departments

Target population

- Potentially large client flow, with selection on basis of clinical assessment of potential to benefit.
- ACATs involved in assessment.
- Time limits on services enables small services to manage considerable numbers of clients.

Monitoring and evaluation

- Further rigorous evaluation required, especially of more costly one-to-one in-home rehabilitation.

Assessment

- Moderate potential to achieve intended outcomes; major determinant is strictness of assessment and selection of clients with potential to benefit.

Model 4: Interim post acute community care***Basis of model***

- Recent proliferation of diversity of services.
- Evaluations reported some positive and some neutral outcomes.
- Common split between assessment and coordination function in hospital, with brokerage for purchase of community care services, but widely varying arrangements.
- Distinct from:
 - HACC and CACPs in rapid response and intensity and range of services provided, although most care services purchased from HACC providers;
 - More general client groups and more integration with general community care services than rehabilitation services (as per Model 2, or Level 5 services).

Focus in acute and aged care systems

- Primary goals are to reduce LOS through provision of services to re-establish client at home.
- Addresses interfaces between acute care and home, and across wide range of community services.

Developmental pathway

- Services have evolved from earlier Transition Care Pilot Projects and other initiatives.
- Formal programs providing post acute community care now established in Western Australia and Victoria.
- Most recent initiatives through Commonwealth Innovative Care Pool.

Target population

- Varying approaches to assessment, including but not solely via ACATs.
- Time limits and transfer to HACC or CACP if ongoing care required avoided development of waiting lists.
- ACATs involved if transfer to CACP required.

Monitoring and evaluation

- Differences between services have major impact on reported outcomes.
- Small client numbers and modest power of interventions on outcomes pose problems in measurement of outcomes and attribution of effects.

Assessment

- Spread of services has been based on expert clinical judgment of effectiveness of post acute care, but tensions in degree of targeting on selected or broader target group.
- Although a response to local conditions, the diversity of service organization, variations in range and level of care services provided and client groups served limit assessment of effectiveness.

Model 5: Interim residential care***Basis of model***

- Marked variations in extent of and approaches to establishment of services between States and territories.
- Need for clarification of nature of interim residential care vis-à-vis step down care and slow stream rehabilitation.
- Relationship of State initiatives to the Commonwealth residential care program.
- Little evaluation as most services only recently established.

Focus in acute and aged care systems

- Addresses boundary between acute care and residential care.
- Services equivalent to residential care, particularly high level care, but may also include additional therapy.
- Social work support for finding permanent placement.

Developmental pathway

- Initiated by State health authorities and hospitals, outside of Commonwealth residential care program.
- Diverse funding arrangements, including State payments with or without Commonwealth residential care benefits, and user charges.

Target population

- Highly selected client group, assessed by ACAT as requiring residential care and with completed Assessment and Approval Form (Form 2624), but little specification of placement difficulties or time waited before admission to interim service.
- Some references to Nursing Home Type Patients (NHTPs).

Monitoring and evaluation

- No evaluations reported and only just being implemented in new services.

Assessment

- Relatively small margin for potential impact.
- Need for interim residential care dependent on level of provision of residential care, effectiveness of other transition strategies and normal arrangements for discharge to residential care, which affect size of client group that experience delays and difficulty in discharge to residential care.
- Need for clearer differentiation of services providing only care equivalent to high level residential care and those providing additional therapy to achieve other outcomes.

Chart 4: Summary Assessment of Models for Service Development

How specific is the model?	How selective is the client group?	What is the balance between functions provided by hospital based service vis-à-vis others?	What proportion of funding is for the assessment and care coordination functions and for direct services	Appraisal of Potential Impact, considering scale, likely success in achieving outcome (LSAO), and cost effectiveness (CE)
Model 1: Intervention in the ED aiming to divert admission				
Highly specific – key distinguishing aspect is: Presence in the ED required for first contact	Quite selective - Selected through second round assessment following initial ED triage	Hospital provides assessment and liaison functions Care coordination can be external (eg SA HomeLink) Direct care services are mostly external but may require hospital input for allied health and HITH	Even balance between assessment and care coordination functions and brokerage of direct services as services are short term only, about 1 week on average.	Scale: high LSAO: high CE: high
Model 2: Inpatient step-down care to reduce LOS				
Moderately high specificity – key distinguishing aspect is: Provision within acute hospital and linked to Geriatric Medical Department to concentrate focus on this group of patients, to minimise patient transfers, and for continuity of care (Note that some step down care is provided in dispersed beds outside hospital e.g SA ATA)	Highly selective on clinical grounds for completion of inpatient episode and assessment of support needs Assessment for residential care NOT confirmed on admission ACAT involved in assessment of eventual outcome	All services provided in hospital, referral to ACAT and care coordination unit for arranging on-going care	Most costs are for continuing in-patient care Additional allied health	Scale: moderate LSAO: high CE: moderate

How specific is the model?	How selective is the client group?	What is the balance between functions provided by hospital based service vis-à-vis others?	What proportion of funding is for the assessment and care coordination functions and for direct services	Appraisal of Potential Impact, considering scale, likely success in achieving outcome (LSAO), and cost effectiveness (CE)
Model 3: Post acute rehabilitation and/or nursing, organised by hospital and delivered in community, to complete treatment, reduce LOS and restore function				
Moderately high specificity – key distinguishing aspects are Organised by hospital for patient requiring in-home rehabilitation/ nursing to complete inpatient care and to re-establish patient at home	Clients selected on basis of clinical assessment of potential to benefit from rehabilitation. Clients are within wider flow of clients assessed by ACAT.	Allied health services provided from hospital as not generally available from outside hospital services.	Skilled allied health and nursing inputs are main cost, including aids and equipment. Cost limited by careful assessment and short term service provision	Scale: moderate LSAO: moderate /high CE: moderate
Model 4: Interim community care, to reduce LOS and re-establish the client at home				
Low specificity – key distinguishing aspects are Discharge planning in hospital Prompt instigation of services Limited time duration Otherwise overlap with HACC/CACPs in range of services provided.	Clients are similar to those in general ACAT flow and consistency of assessment enhanced when ACAT involved.	Hospital functions of assessment and care coordination; may be carried out by another agency through referral arrangements – eg. ATA model. Most direct care brokered from general HACC and community health services, and may incl. short term use of resi. care beds.	Most cost for assessment and care coordination functions. Level of brokerage funds related to availability of HACC /CACP services	Scale: moderate LSAO: moderate CE: high
Model 5: Interim residential care				
Equivalent to residential care, mostly high level. Some provision of additional nursing and allied health	Clients are within the total flow to residential care, assessed via standard ACAT process as requiring residential care, with Form 2624 completed Factors associated with delay in discharge require clarification to distinguish client /care related factors, bed access factors, and seasonal factors	Variations in provision of beds in State hospitals and sub-acute facilities, or purchased from non-government providers, usually special services facilities	Mixed funding arrangements involving different mixes of Commonwealth residential care subsidies User fees State government top up NHTP criteria used in some cases	Scale: low LSAO: low CE: moderate compared to acute care, low compared to residential care.

Rather than one service model standing out as the key to facilitating interaction between acute and aged care, the findings of the Mapping Exercise indicate that the effectiveness of each service is enhanced when it operates in conjunction with other services. The report accordingly concludes with some proposals for integration of the transition services for which models have been developed, together with services at Level 1 and Level 5, to capture these synergistic effects. A diagrammatic representation of the integration of all transitions services across the five levels of intervention is set out in Chart 5 (appears as Figure 2.2 in Report). This framework shows how the various transition services act together as a series of filters that maximize transitions that result in return to the community and minimize flow-ons to further acute care and residential care.

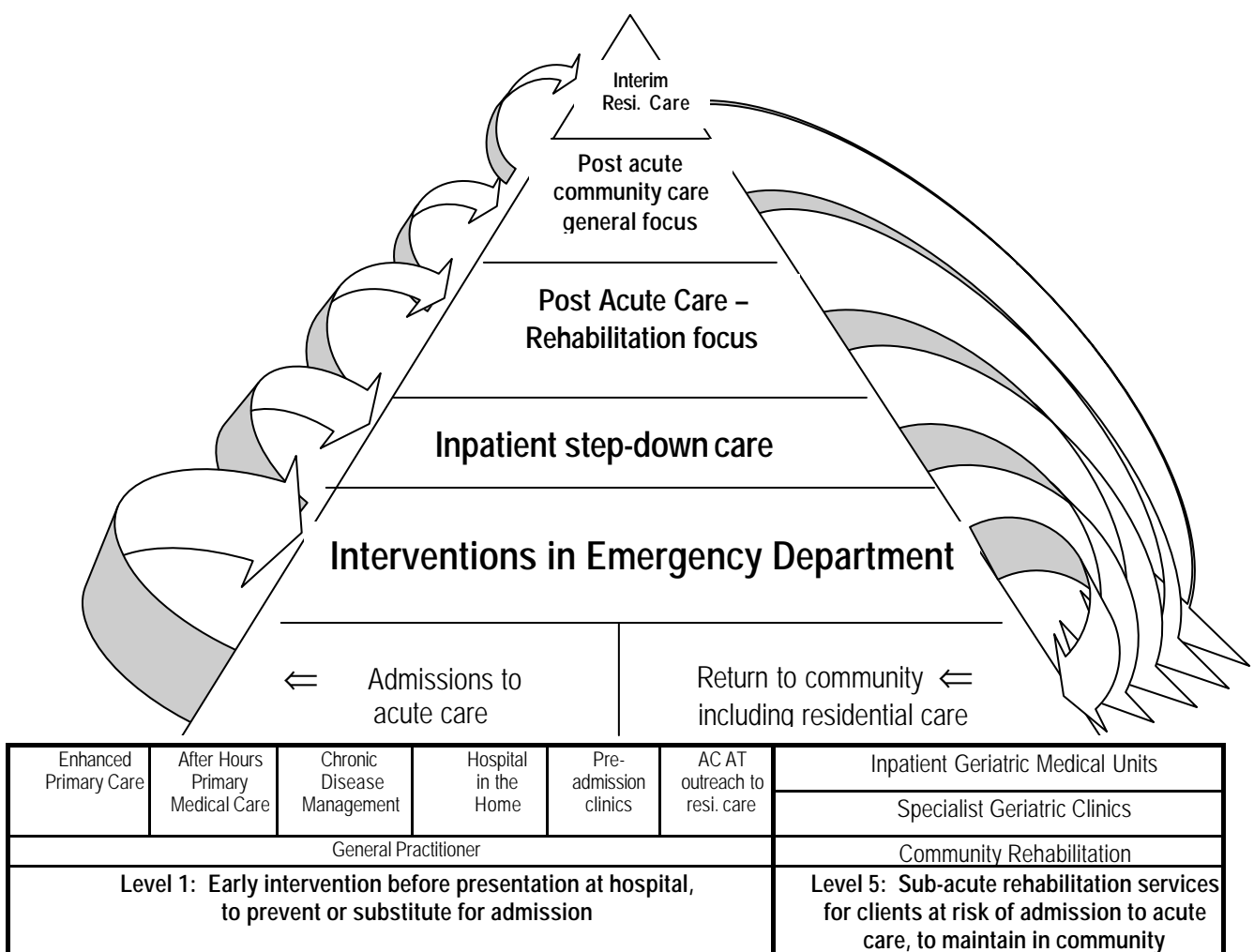


Chart 5: Diagrammatic representation of integration of transition services

To promote such integration of transition services, the Mapping Exercise identified a set of principles to guide further service development. These proposed principles are that

1. Client flows are the starting point;
2. Multiple interventions are required;
3. Interventions need to be brought together under an umbrella of Transition Services;
4. Transition services need to be managed through a single lead agency;
5. Interventions require concentration of effort to maintain focus and achieve critical mass;
6. Existing and new transition services need to be consolidated;
7. Assessment and funding must be consistent with existing arrangements;
8. Resource considerations have to be addressed;
9. Flexibility can be realised within a coherent framework; and
10. Monitoring and evaluation is required to strengthen the evidence base

Part 3: Services reported at the Interfaces of Acute and Aged Care in States and Territories

The state by state accounts of services reported at the interfaces of acute and aged care presented in this Part follow a common format, in four sections:

1. Information Sources
2. Background
3. Reported levels of post-acute and sub-acute services, using the five level framework.
4. Factors affecting further development

This standard format facilitates the identification of common elements of services that are then drawn on in developing the composite models presented in Part 2, but at the same time, it is sufficiently flexible to allow attention to be given to factors that make for differences between the states. These reports aim to canvass the range of services that were operating as of late 2001 and are not intended to give a comprehensive account of all post and sub-acute services. It also has to be recognized that past development of existing services has been shaped by the markedly different structure of acute care systems in each state, and relationships with aged care services vary accordingly. In looking to the future, three sets of factors commonly identified by key informants as likely to shape development were moves to further the integration of post- and sub-acute services with acute and aged care services, the role of ACATs and Geriatric Medical Services, and outcomes of recent and current State policy and program reviews.