

## **Appendices**

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### Appendix 1: Pro-Forma from 1999 Inventory

<b>Project Identification State</b>	Number assigned
<b>Program</b>	Whether part of a formal government program and if so, name of program
<b>Project title</b>	Title used by project to identify itself
<b>Location</b>	Geographic location and area served
<b>Organisation/s or persons responsible</b>	Legal entity responsible for operation of project
<b>Budget/Funding</b>	Source of funding and annual amount in current and previous years (if applicable/available)
<b>Developmental Pathway/History</b>	Short narrative account
<b>Project type</b>	Function of project in relation to boundary
<b>Aims/Goals</b>	Formal statement
<b>Timeframe</b>	Time operating, including whether trial/pilot or continuing etc.
<b>Target group</b>	Intended client group
<b>Client numbers and characteristics</b>	Clients actually served
<b>Eligibility criteria</b>	Basis of selection of project clients, e.g. assessment by ACAT required
<b>Description</b>	Short account of key features of project operation, including mechanisms for transfer
<b>Scale</b>	Number of sites/outlets at which project operates
<b>Fees/Charges/Costs</b>	Financial data as available, including subsidy arrangements, co-payments etc.
<b>Scope</b>	Boundary /ies and care settings that are spanned by the project
<b>Services</b>	Types of services provided
<b>Outcomes</b>	General description of achievements at project level and specific data on client outcomes if available
<b>Problems identified</b>	
<b>Source of information</b>	Source from which inventory entry was compiled
<b>Evaluation</b>	Whether project has been subject to formal evaluation and if so, details of the evaluation (published accounts etc)
<b>Developmental capacity</b>	Assessment of capacity for future development, as reported by project and as assessed by the research team.
<b>Linkages to other programs</b>	Formal programs with which project was linked
<b>Potential/Recommendations</b>	As made by the project for its future
<b>Quality Assurance</b>	Details of QA activities

**Appendix 2**

**AHMAC Workplan on Acute/Aged Care Interface Issues**  
**Phase 1: Mapping Exercise**  
**Scan of State Post-acute and Sub-acute Care Projects and Programs**

Your assistance in completing this form as a matter of urgency would be greatly appreciated.

Please return this form by email to [anna.howe@bigpond.com](mailto:anna.howe@bigpond.com) or fax back to Anna Howe on 03 9383 4130.

Complete the form by deleting options that are not applicable.

Please send any other relevant material by email if possible, or by fax to Anna Howe on 03 9383 4130, or mail to Anna Howe, c/- Applied Aged Care Solutions, 14 Nathan Rd., Eltham, VIC. 3095

Please contact Anna Howe as per above if you have any queries about responses to this form.

**Identification**

State:            NSW            VIC            QLD            SA            WA            TAS            NT            ACT

Name of person completing form:

Your phone no. for follow-up contact:

**Part A: Organised Post Acute/Sub Acute Program**

1. Some states are now operating organised Programs for post and/or sub acute care. An organised Program is characterised by having formal program guidelines, a definition of eligible clients and funding arrangements, etc., that apply to all the hospitals and other agencies that participate in the program. Does your State health/aged care department operate such an organised post acute/sub acute program:

YES                      NO

If answer is NO, go to Part 2 on p.4

2. Year program commenced

3. Terminology in the post acute/sub acute areas is not standard. Please give the definitions of post acute care services and/or sub acute care services that are used in your State in the context of this program. If you do not differentiate between these terms, please complete the definition for the term that is used in your organised program.

Post acute

Sub-acute

4. Post acute and sub-acute programs can include a range of service components that serve different groups of patients and that operate across different boundaries in the acute and long term care systems. We have so far identified five main components and a number of sub-components, as outlined over. Please read these outlines carefully as there are some specific distinctions between them, and indicate whether or not your State's program includes each of these components by inserting YES or NO in the YES/NO column and complete other details as relevant. If there are further components operating in your state, please detail under Q. 5 over and forward further details by email, fax or mail.

Components of post acute /sub acute care	YES/NO	Name of component used in your state, as per Program Guidelines and common usage
<b>1. Before Hospital</b> - prevent next episode		
a. Prevent acute hospital admission or readmission, for those living in the community, including initiatives through Emergency Department or alternative delivery of acute care at home (hospital in the home).		
b. Prevent acute hospital emergency department presentation for those living in residential care, through development of guidelines and protocols		
<b>2. On presentation and admission to acute hospital via Emergency Department</b>		
a. Prevent acute hospital admission after treatment in emergency department, e.g. gerontic nurse consultant in ED		
b. After admission, <u>during stay in acute hospital</u> , to reduce LOS		
c. Acute hospital discharge planning <u>for action at end of hospital stay</u>		
<b>3. Post Hospital - Support from Hospital, post episode to achieve return home</b>		
a. focus on providing rehabilitation and therapy, in non-acute in-patient setting, to reduce re-admissions		
b. focus on providing intensive, short term home care, including personal care and/or nursing as needed, to re-establish individual at home and reduce re-admissions		
c. focus on higher level interim community care to support individual until CACP or other package available		
d. Check up phone call or home visit, by hospital nurse/social worker/discharge planner, within a few days of discharge		
<b>4. Post Hospital Interim residential care,</b> purchased by hospital as "stop gap" until residential care place available to assist discharge from acute care to permanent residential care		
<b>5. Sub Acute Services</b> - focus on people with continuing existing medical / dependency need seen as at risk of admission if sub-acute care not provided		
a. Sub acute: specialist geriatric clinic support, day hospital etc: prevents admissions and re-admission (eg. specialist falls program)		
b. Sub acute: community based rehabilitation services – targets general HACC users		
c. Sub acute: community based rehabilitation services – targets Aged Care Package users		

5. Are there any other **components of the organised post acute / sub acute program** in your State that are not covered in 1 to 5 above? Please give a short description of each such component.

Name of other service components in organised program	Brief description Please include an indication of which of levels 1 to 5 above each components fit into best

6. Please e-mail, fax or mail a list of specific hospitals and other agencies which are participating in your organised post/sub acute program and if possible, the name that each hospital/agency uses for its service and a contact person.
7. Please advise of web site for obtaining further details of your post/sub acute program/s, and attach any documents that describe your State's post/sub acute program, e.g. guidelines provided to hospitals and other agencies participating in the program, definitions of patient eligibility, etc. If not available by email, please forward to Anna Howe at the address above.

Web site:

Documents attached            YES            NO

Documents mailed            YES            NO

**Part B: Post and Sub-Acute Services that are not part of an organised program**

This part of the Scan is concerned with other post/sub acute projects that have been developed by State health/aged care agencies or by individual hospitals or groups of hospitals but which are **not** part of any organised post/sub acute Program.

Please insert the name and a brief general description of each such project that is known to you. Add further rows to the table as required.

Please attach an email list, or fax or send a hard copy list of the specific hospitals and other agencies that you know to be operating these projects. Please also forward by appropriate means any other documentation available on these projects.

Other service components - name	Brief description – please indicate which of levels 1 to 5 above each components fit into best

### Appendix 3

## POST ACUTE & SUB ACUTE SERVICES FOR OLDER PEOPLE PROFILE

Your **Hospital** or **Agency** has been identified as operating a service (or services) that has been **specifically organised** to manage care of older people in acute care and who need on-going care after their acute episode, or to reduce risk of admission or readmission to acute care of older people in the community, including those in residential care.

**Who should complete this form:** The identified person or the Service Manager or a senior staff member with access to appropriate documentation.

Could you please first confirm that you do operate a service/s of this kind:

Place a cross

YES

*Please complete this Profile. Feel free to write in any further details that will give a full picture of your service/s in areas not covered by this Profile*

NO

*Please complete the Contact Person & State details below and fax back this page to (03) 9431 5002*

If you have more than one Service, please complete a **separate response** for each Service and provide a **unique name** for each.

Throughout this Profile, the term Service means the service that you operate for post acute or sub-acute care.

**Identification**

<b>State / Territory</b>		<b>Office Code</b>
<b>Contact Person:</b>	Name	
	Address	
	Phone:	Fax:
	Email	
<b>Name of Service:</b>		
<b>Unique Name: For multiple services</b>		
<b>Address from which service operates</b>		

**In completing this Profile, please note:**

1. The Profile covers the following areas:

- SECTION A: Focus of Service in Health and Aged Care System**
- SECTION B: Developmental Pathway**
- SECTION C: Client Selection and Management**
- SECTION D: Monitoring and Evaluation**

2. If you have any queries about this Profile, please phone:  
**Janet Opie on (03) 5979 1885 or Richard Rosewarne on (03) 9439 5373.**
3. When you have completed the Profile, please return via one of these methods:  
Email: [Janet.Opie@AgedCareSolutions.com](mailto:Janet.Opie@AgedCareSolutions.com) or [Richard.Rosewarne@AgedCareSolutions.com](mailto:Richard.Rosewarne@AgedCareSolutions.com)  
Fax: (03) 9431 5002  
Post: **Aged and Acute Care Boundary Mapping Exercise**  
Applied Aged Care Solutions,  
14 Nathan Rd. Eltham, VIC. 3095.

## SECTION A: Focus of Service in Acute & Aged Care System

This section concerns the focus of your Service in the management of the various flows that occur between acute hospital care and other health and aged care services.

Please insert a cross in the box to select your option, multiple options only if indicated e.g.

x
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### Goals and operation of service

1. Primary Goal of Service  (maximum of two options)	Prevent admission/readmission of a person living at home	
	Prevent admission/readmission from residential care	
	Reduce length of stay by improving treatment	
	Reduce length of stay by facilitating transfer to another setting	
	Reduce admission to residential care	
	Improve functioning / independence by providing rehabilitation	
	Other – please detail	
2. Secondary Goals of Service  (maximum of two options)	Prevent admission/readmission of a person living at home	
	Prevent admission/readmission from residential care	
	Reduce length of stay by improving treatment	
	Reduce length of stay by facilitating transfer to another setting	
	Reduce admission to residential care	
	Improve functioning / independence by providing rehabilitation	
	Other – please detail	
3. Which boundaries does the Service address?  (multiple options allowed)	Home to acute	
	Residential care to acute	
	Acute to home	
	Acute to residential care	
	Acute to an intermediate facility – please detail	
4. Mechanism used for making transfers across the boundary  (multiple options allowed)	Delivery of hospital services in the home (hospital in the home)	
	Purchase of places in residential care using funds designated for this purpose	
	Purchase of community care services using funds designated for this purpose	
	Other – please detail	
5. Does your Service operate under written Guidelines?	No	
	Yes - Guidelines developed by and specific to your service	
	Yes - Guidelines issued by State or Commonwealth	
6. Is your Service part of a wider program?	No	
	Yes – Commonwealth Coordinated Care Trial	
	Yes - State Coordinated Care Trial	
	Yes - Organised area/regional or state-wide post acute or sub-acute program	
	Yes- Other – please detail	

**This section aims to identify the focus of your Service at the boundaries between Acute Hospital Care, Community & Long Term Care.**

<b>Overview of the System Focus 5 categories of intervention</b>				
Intervention to prevent admission	In hospital -at ED - admitted	Post Hospital Nursing / Therapy	Post hospital interim care – package support at home or residential care	Sub acute service, incl. Specialist Geriatric Medical Centres/Clinics

**7. Which is the best description of the focus of your Service? Please read all options carefully and place a cross in the boxes that your Service primarily targets in options below from 7a to 7n.**

<b>Prevention / Early Intervention Projects before Presentation at Hospital</b>		
7a. Prevent acute hospital emergency department presentation for those living in the community		
7b. Prevent acute hospital emergency department presentation for those living in residential care		
<b>Intervention in Hospital</b>		
7c. Prevent acute hospital admission after treatment in emergency department		
7d. Reduce the length of stay of patients (excluding discharge planning)		
7e. Discharge planning (including treatment and therapy) to reduce length of stay, improve post discharge functioning and decrease the risk of readmission		
<b>Hospital organised Post Acute Therapy / Nursing Care after discharge</b>		
7f. Check up phone call or home visit, by hospital staff, within a few days of discharge		
7g. Therapy rehabilitation program provided in the community		
7h. Nursing program provided in the community		
<b>Hospital organised INTERIM support package after discharge</b>		
7i. Provision of interim residential care for limited time, until permanent residential care available (do not include respite admission to residential care)		
7j. Provision of interim community care for limited time, until HACC, CACP or EACH package available		
<b>Sub Acute Rehabilitation Services for clients who are at risk of admission to acute hospital care</b>		
7k. Geriatric Medical Centres providing rehabilitation and therapy (in-patient settings)		
7l. Specialist out-patient Geriatric Medical Clinics / Day Hospitals providing management to prevent admissions and re-admission (eg. specialist falls program)		
7m. Rehabilitation services targeted to HACC users		
7n. Rehabilitation services targeted to aged care package users (CACP, EACH)		

**SECTION B: Developmental Pathway**

These questions concern how your Service developed and how it is likely to develop in the future

**Origin of Service** (if you require more space, please attach extra page)

8. What was the main reason for developing / adopting this project?

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**Past Development**

9. Commencement Date	More than 2 years (operating before June 1999)	
	1- 2 years (commenced since June 1999)	
	Less than 1 year	
	Will be operational in future (next 6 months)	
	At planning / developmental phase	

10. Nature of initiative	Original initiative within this hospital/agency	
	A direct replication of a service/program operating in another hospital/ agency	
	A modified replication	
	Commenced under program guidelines established for other services	

**Current Status**

11. Is your project currently operating as:-	Local one-off project – no plans to develop in other hospitals/agencies	
	Local pilot but plan to extend to other hospitals/agencies	
	Pilot being conducted with an area/regional health framework	
	Part of a multi-hospital/agency trial within the state	
	Part of a national trial	

**Funding**

12. Source of funding for 2001-02	Funded only from Hospital/agency operating budget	
	Separate funding from Commonwealth Government	
	Separate funding from State Government	
	Foundation (e.g. Rotary)	
	Pharmaceutical Company	
	Other	

13. Budget for 2000-01	\$	
14. Budget for 2001-02	\$	

15. Current Funding Source	No change from original source	
	Changed from:	

16. Is the current level of funding	adequate for your Service?	
	insufficient to the point of imposing severe limits on capacity to cater for all clients in need of the Service?	

**Future development**

17. Is the budget expected to grow in the future?	No	
	A little	
	Substantially	

18. Is your Service now, or has it in the past, been represented on any kind of area/ regional planning committee that provides a vehicle for promoting development of this kind of service in other hospitals/agencies?	No - neither in past or now	
	In past but not now	
	Yes – in past and currently	

19. What is the potential number of patients that you consider this type of service could cover if it was implemented in all major hospitals/agencies in your state?	Relevant to a large number of actual/potential admissions in aged population as a whole (not specific to a particular clinical condition)	
	Relevant to moderate number of actual/potential admissions (focused on a clinical condition or groups of conditions that commonly precipitate hospital admission in the elderly population.	
	Relevant to only a small number of actual/potential admissions because highly targeted to specific clinical condition with small numbers presenting to hospital	

20. Rate on the scale of 1 to 5 how readily you think your Service could be developed in other hospitals / agencies. Please insert a cross in the box above to select your option

1. Very easily	2.	3. Possible	4.	5. Very Difficult

(if you require more space, please attach extra page)

21. Please comment on factors that you consider will <b>facilitate</b> the future development of the Service in your hospital/agency and in other hospitals/agencies (e.g. staffing availability, skills required, high level of interest)	
22. Please comment on factors that you consider <b>pose barriers</b> to the future development of the Service in your hospital/agency and in other hospitals/agencies	

**SECTION C: Client selection and management**

**Please attach a copy of any protocol that sets out client selection criteria and processes**

23. Clients numbers - Target number planned /expected in 12 m. (if no target N/A)	
24. Actual number of clients admitted in 12m or ..... months	

Client Selection Criteria	NO	Yes - provide details
25. Age		
26. Diagnosis (focus on specific conditions)		
27. ADL dependency (e.g. score on Barthel index)		
28. IADL dependency		
29. Financial		
30. Other- please detail		

31. Referral Sources please specify up to 4 main sources of referral of clients to your Service	

32. Who does the assessment for entry to your Service?	ACAS/ ACAT	
	Emergency Dept staff - medical	
	Emergency Dept staff - nursing	
	Inpatient Hospital staff - medical	
	Inpatient Hospital staff - nursing	
	Inpatient Hospital staff - allied health	
	Inpatient Hospital staff - other	
	Outpatient Department	
	HACC providers - general	
	HACC provider – specifically Nursing Agency	
Other – please specify		

33. Main source of admissions, i.e. location of most patients immediately prior to admission to Service (one option only)	Emergency Department	
	Own hospital wards	
	Other hospitals	
	Community sources	
	Other	

34. Secondary source of admissions i.e. main location of other patients immediately prior to admission to Service (one option only)	Emergency Department	
	Own hospital wards	
	Other hospitals	
	Community sources	
	Other	

**Private hospitals**

35. Does your Service <b>admit</b> patients from private hospitals?	No	
	Yes	

36. Does your Service <b>discharge</b> patients to private hospitals?	No	
	Yes	

## Time limits

37. Is there a limit on how long the patient can stay on your Service and how readily can this limit be achieved?	No limit	
	Yes, easy to achieve – no clients reach the limit	
	Yes, achievable in most cases, few reach or exceed time limit	
	Yes but difficult to achieve – half or more clients reach or exceed time limit	

38. Is there a waiting list for admission to your Service?	No	
	Yes	

**39. Please tick to indicate whether your Service provides each function directly, through brokerage with other agencies, or not applicable**

Function	Provided Directly	Brokered	Not applicable
a. Coordination of care services in community			
b. On-going case management			
c. Medical management of a diagnosis e.g. #NOF, COAD.			
d. Inpatient rehabilitation			
e. Rehabilitation in community setting			
f. Rehabilitation at home			
g. Brokerage – use of service funds to purchase care services from other agencies			
h. Aids and equipment for use at home			
i. Other: specify			
j. Other: specify			

40. Director of Service - Is the Director of your service located in:-	Emergency Department	
	ACAS/ACAT	
	Geriatric Medicine Department	
	Other Hospital Department – please detail	
	Outside hospital – please detail	

41. Are other staff of your Service attached to:-	Emergency Department	
	ACAS/ACAT	
	Geriatric Medicine Department	
	Other Hospital Department – please detail	
	Outside hospital – please detail	

**SECTION D: Monitoring and Evaluation**

42. Does your Service collect a standard Minimum Data Set for monitoring?  Please attach a copy	No	
	Yes – MDS specific to Service	
	Yes – as part of another MDS, e.g. Hospital Inpatient data collection	

43. Has your Service been subject to a formal evaluation?	No	
	Yes – Randomised Control Trial	
	Yes – before / after comparison or other quasi experimental design	
	Yes - descriptive account of service development and outcomes	
	Yes – other – please detail	

44. Was the protocol submitted to a formal Ethics or Research Committee?	No	
	Yes	
45. Who carried out the evaluation?	Service staff only	
	External advice on design and analysis	
	Evaluation conducted in collaboration with a third party e.g. consultant, university	

46. Outcomes reported – please tick the outcome variables used in the evaluation	
Reduced Length of Stay in acute hospital	
Reduced rate of readmissions	
Reduced presentation at Emergency	
Change in use of community services	
Cost of hospital use	
Cost of community service use	
Client satisfaction/Quality of Life	
Carer burden/satisfaction/Quality of Life	
Other – please detail	
Other – please detail	

47. Has a report of the evaluation been published? If yes, please send a copy	No	
	Yes – published own report	
	Yes – included in report published by another body	
	Yes – published in a refereed journal	

**When you have completed the Profile, please**

Email: [Janet.Opie@AgedCareSolutions.com](mailto:Janet.Opie@AgedCareSolutions.com) or [Richard.Rosewarne@AgedCareSolutions.com](mailto:Richard.Rosewarne@AgedCareSolutions.com)

**or fax back to 03 9431 5002**

**and return hard copy and any supporting material to  
Applied Aged Care Solutions, 14 Nathan Rd. Eltham, 3095.**

**Please include supporting material such as:**

- Protocol for client selection and management
- Data collection schedule
- Copy of any monitoring / evaluation reports
- Any other relevant material describing your service

**Thank you for your assistance**

### Appendix 4: Services completing Service Profiles

Note: # indicates information equivalent to Service Profile compiled from secondary sources

	State	Service completing Service Profile	Level of intervention
1	ACT	Morling Lodge Innovative Care and Rehabilitation Program #	4A/B
2	NSW	DEED Prince of Wales #	2A
3	NSW	Prince of Wales Rehab in the Home #	3B
4	NT	Transitional Care Project, Darwin	4A
5	NT	Kintore Street Community Services, Katherine	4A
6	NT	Community Care, Tennant Creek	4A
7	QLD	Ipswich Hospital Interim Bed Program #	4B
8	QLD	Transitional Care - Post Acute Component of Elective Surgery Projects reported in Continuity of Care Report #	3B/ 4A
9	SA	Emergency to home outreach service (ETHOS) Flinders Medical Centre	2A
10	SA	Flinders Medical Centre Step Down Unit	2B
11	SA	Tregenza House	4A/B
12	SA	Acute Transition Alliance, coordinated by Aged Care and Housing Group	4A/B
13	TAS	Royal Hobart GP Liaison	2A
14	TAS	North West Regional Hospital	2A
15	TAS	Royal Hobart Inpatient Rehabilitation	2B
16	TAS	Aged Care Rehabilitation Unit/Hobart Day Centre	3B
17	TAS	Royal Hobart Hospital Transitional Care Unit (Interim Care)	4B
18	Vic	Northern Hospital, Chronic Disease Management	1A
19	Vic	Box Hill Designing Care - Case management for COPD and CCF	1A
20	Vic	Peninsula Health - PrimaryCare liaison	1B
21	Vic	Box Hill ED care coordination	2A
22	Vic	Northern Hospital ED Care Coordination	2A
23	Vic	Peninsula Health Care Coordination	2A
24	Vic	Royal Melbourne Hospital Care Coordination	2A
25	Vic	St Vincents ALERT Care Coordination	2A
26	Vic	Maroondah Hospital SSOU	2A
27	Vic	Angliss Hospital SSOU	2A
28	VIC	Northern Hospital Inpatient Care Coordination	2C
29	Vic	St Vincents Rehabilitation in the Home	3B
30	Vic	Northern Hospital Rehabilitation in the home	3B
31	Vic	Northern Hospital PAC	4A
32	Vic	Box Hill PAC	4A
33	Vic	Box Hill Interim Care	4B
34	Vic	Maroondah Hospital Interim Care	4B
35	Vic	St Vincents/St Georges Interim Care	4B
36	Vic	Southern Health Kingston Interim Care	4B
37	Vic	Northern Hospital Interim Care	4B
38	WA	Sir Charles Gairdner Hospital Home Link Elderly Post Acute Services (Rehabilitation)	3B
39	WA	Royal Perth HANDS (Rehabilitation)	3B
40	WA	BentleyHospital Elderly Post Acute Service	3B
41	WA	Sir Charles Gairdner Hospital Home Link Care Packages (general)	4A
42	WA	Bentley Hospital Home Care Packages (general)	4A
43	WA	Care Awaiting Placement Health Department of WA Guidelines	4B
44	WA	Armadale Health Service Care Awaiting Placement	4B
45	WA	Sir Charles Gairdner Hospital Home Link Care Awaiting Placement	4B
46	WA	Bentley Hospital Care Awaiting Placement	4B

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