A case study on easing an institutional bottleneck in aged care

Anne Bergin, Sandra G Leggat, David Webb and Koh Ai Lane

Abstract

This is a case study about a cross-sector Interim Health Care Strategy (IHCS) developed by a Victorian metropolitan health service in partnership with a private residential facility and a community agency to provide a range of transitional or interim care initiatives for public hospital patients awaiting permanent residential care after completing acute or subacute treatment. The aims were to improve access to emergency and acute inpatient services, while meeting the needs of residential care clients in the metropolitan suburbs. The components included care within a residential care facility, community-based interim care and a subsequent Extended Rehabilitation Program. This IHCS has shown how a cross-sector initiative can improve care and outcomes of patients awaiting residential care placement. The case study shows how a multifaceted strategy that built upon existing relationships with strong planning, organisational commitment and a facilitating structure was successful in improving care integration.

Aust Health Rev 2005: 29(3): 327–331

What is known about the topic?

Bottlenecks between acute care and rehabilitation or residential care experienced by older patients are the result of discontinuities in funding, regulation, management and eligibility criteria, as well as problems of supply and effective working relationships among providers. Attempts to find solutions to this problem "on the ground" are showing some success.

What does this paper add?

This case study documents a multifaceted strategy that provided, among three agencies, alternative step-down care and rehabilitation, as well as home care and support for carers. The program built upon existing relationships with strong planning, sustained organisational commitment, clear protocols and successful engagement of staff.

What are the implications?

Innovations which attempt to ease the bottlenecks affecting older patients after an acute episode require careful attention to the engagement of staff, and evidence of long-term commitment by agencies, as well as the necessary clinical and technical elements.

THE INTERIM HEALTH CARE STRATEGY (IHCS) was developed to address access issues related to the emergency department and inpatient services, while better meeting the needs of patients requiring residential care.

The delivery of health services for older adults in the catchment area was a critical factor for the acute system, as the system experienced increasing demand on emergency departments and difficulty in providing access to acute inpatient services. There was a need to ensure adequate provision of geriatric assessment and treatment services and appropriate rehabilitation services both in inpatient and home settings.

This scenario is common in Victoria and across Australia as public health care providers grapple with the challenge of meeting the health and care demands of an ageing population. Over the last 20 years the number of people over 65 years of

Anne Bergin, RN, BA, BSW, Director of Operations, Aged Care and Rehabilitation

Eastern Health Service, Forrest Hill, VIC.

Sandra G Leggat, MHSc, MBA, PhD, Senior Lecturer
Koh Ai Lane, BNursing, Postgraduate student

School of Public Health, La Trobe University, Bundoora, VIC.

David Webb, BEc, State Manager

Australian College of Health Service Executives, Sydney, NSW.

Correspondence: Dr Sandra G Leggat, School of Public Health, La Trobe University, Bundoora, VIC 3086.
SPH@latrobe.edu.au

age has increased by 164%, compared with total population growth of 29% over the same period.[1] It is predicted that by 2016, 16% of the Australian population will be over 65 years, increasing to 25% by 2051.[2]

In addition, there are more people with debilitating illnesses and conditions who are generally living longer. In 1998, 54% of Australians aged 65 years and older reported a disability.[3] Illustrating the link between disability and need for care, nearly all older people in cared accommodation (97%) had a disability, and most of these (82%) had profound activity restriction. Older people's need for assistance with everyday activities has been shown to increase with age, regardless of whether or not they had a disability.[3] The number of people aged 65 years and older who require assistance with personal care, mobility or communication increases by more than 2% each year. The ageing population, the increasing proportion of the population with disability and the increasing proportion of the older population requiring assistance have all been shown to increase the demand for public health services.[4]

Setting

The IHCS was designed with a number of components developed separately, but linked through consistent management to respond to the needs of the identified patient group. Successful implementation was conditional upon the partnering organisations working together to improve care integration for these patients. In all instances the initiative followed the requirements of the *Aged Care Act 1997* (Cwlth) and the Victorian Department of Human Services Interim Care guidelines.[5] Each of the components is described below.

The residential facility interim care component is a bed-based service subcontracted to an existing residential care facility. The residential care service provides the facility (with its purpose-built environment), nursing and general resident care. The health service ensures geriatrician monitoring, allied health therapy and medical practitioner support, and additional aids and appliances where required. This component started with 12 beds in one community hospital designated for interim care and grew to 56 community residential care beds offering interim care services to patients waiting to be discharged from the Metropolitan Health Service's (MHS) acute and subacute hospitals. To date the MHS and residential care partners have provided high quality care for over 500 patients waiting for nursing home accommodation.

This component was strengthened by using a purpose-built facility with staff experienced in the needs of residential care clients. Unlike acute care hospitals, the facilities included lighting and call systems that specifically met the needs of the aged care residents and provided private rooms with well-designed bathrooms and access to safe outside areas. In addition, the average bed-day cost (which was around $270) was substantially less than the comparable bed-day cost for an acute (about $720) or subacute bed (about $400) in a hospital, where these patients would have previously waited.

The bed-day cost of $270 for the program comprised a fee to the residential care facility of around $165 per day for all daily general care and nursing costs; $40 for geriatrician, podiatry and other allied health therapy sessions; $25 for the hiring of equipment and purchasing of continence aids, wound management, additional nutrition requirements, pharmaceuticals, and oxygen; and $40 per day for the cost of and management and general support to the program, including part-time manager and freight charges.

The community-based interim care component is a home-based model where patient care is contracted to community service providers managed by a case management agency. This component includes coordinated support for clients who are assessed as requiring high level residential care and who, with the support of their carer/s, have decided to return home. (Home may be a low level residential facility where the client had been living prior to hospital admission.) The services may include personal care, meals on wheels,

home help, Royal District Nursing Service, and home maintenance.

This care in the community component was more difficult to implement. Acceptance of care at home was a barrier for both families and clinical staff. Many families, who were already exhausted from caring for their family member, found it hard to accept the concept of a return home. A community interim care support system was established, with out-of-hours hotlines for carers to contact professional staff when faced with difficult issues at home for which they needed support.

Hospital staff were also wary of the ability of families to care for a "patient" 24 hours a day, seven days a week, and expressed concerns related to their duty of care for the patient. It was only with experience and successful cases that clinical staff began to have confidence in the ability of families to cope, with the timely support of the community agencies.

The contracting of home-based care and support to a familiar case management agency was a definite advantage for this component. Clinical staff were aware of the level of services provided, and confident in the service delivery. Although the change to accept community-based care was not easy, linking the new service with an existing, known case management service provider assisted this transition.

The extended rehabilitation program (ERP) is a separately funded joint Commonwealth – State Innovative Care Rehabilitation Service (ICRS) initiative. The ERP initiative is a structured program of slow-stream rehabilitation with a target length of stay of 12 weeks provided in residential care and in patients' homes. Clients eligible for this program have a current high- or low-level of residential care assessment (HLRC or LLRC). The ERP has been operating as a pilot project for about 11 months. Building on the relationships developed between the MHS, the residential care provider and the case management agency, this initiative is an effective partnership among the three organisations. Twelve residential beds and 3 home-based care management places are provided. This component required the agreement of the Commonwealth Government for funding. During implementation, minor facility refurbishment was undertaken to accommodate residential therapy requirements consistent with the functional and care requirements of slow stream rehabilitation patients.

IHCS outcomes

Through the multifaceted strategy, the IHCS was able to accommodate the needs of the patients at substantially lower cost and better quality of care than could be provided if the patients had remained in the acute or subacute facilities. In particular, the community interim care support system has been identified as a great source of comfort to carers. Case management has increased liaison with community and residential services such as hostels or supported residential services (SRS) to aid patients to return home. This has contributed to the reduced length of patient stay throughout the MHS for patients waiting for HLRC.

At the time of this report, there were 74 client admissions to the ERP with 61 clients discharged. On admission, 68 patients (92%) were assessed as requiring HLRC and 6 (8%) as requiring LLRC. Of the HLRC admissions, 17 (25%) were reassessed as requiring LLRC on discharge. Of all of the clients, on discharge:

- 12 (20%) were discharged home;
- 5 (8%) improved such that referral to inpatient intensive rehabilitation was appropriate;
- 10 (16%) went to hostels;
- 3 (5%) were discharged to a supported residential service; and
- the remaining 49% were admitted to the expected HLRC.

Overall, the level of functioning for the IHCS patients had markedly improved. For many of these patients this did not result in discharge to a lower level of residential care or back to their home, but resulted in improved quality of life. For example, a patient who was unable to move from the bed can now use a motorised wheel chair, while another patient's physical abilities

improved to the point where she could be seated in a family car, thereby enabling her to visit family and attend other functions.

The ERP program, operating in a purpose-built residential setting, with appropriately trained nursing staff and with hospital-trained therapists, has achieved outcomes for these clients that would not have been possible in the acute, subacute or residential sectors alone. Acute hospitals have difficulty providing targeted therapy at the slow stream rehabilitative level, and diversional activities are not usually part of hospital treatment. Also, public hospitals do not have the appropriate purpose-built environment that this program requires to assist with the patients' ongoing improvement.

Together the sectors were able to establish an effective program. Overall, the IHCS has contributed to improved patient care and functional outcomes. In addition, the MHS found that after implementation of the IHCS there was substantial improvement in access to acute and subacute beds by patients admitted via the emergency departments, and the provision of regular nurse education and training in the residential care facility has resulted in staff retention and improved competencies.

Factors for success

Evaluation of the IHCS resulted in the identification of the following factors that contributed to its successful implementation.

The importance of visible acceptance and participation

Participants felt that the success of the program was dependent on effective and visible participation of key stakeholders who demonstrated the commitment of the partnering organisations. This included the health care managers, nursing directors, medical staff, allied health professionals and health information managers. The participation of these individuals was also a key factor in the successful development and implementation of operating policies and procedures, and training and development programs.

Protocols for quality and continuity of care

Early articulation of protocols and processes provided the guidelines and boundaries for practice. Establishing protocols for patient care at the interface of the sectors (that is, the private residential facility, community and acute public hospitals) and ensuring staff compliance were important to the success of the initiative. The initial protocols addressed continuity of care and access to emergency services, quality and infection control standards and incident reporting, and transfer of health information with the patient. Protocols continue to evolve, with all sites raising new issues for improving continuity and quality of care.

A variety of process and outcome measures were used to ensure quality service delivery. These focused on pharmacy, medical records, monitoring demand and appropriate auditing, falls and incident reports, complaints and patient/carers satisfaction survey results, with specific indicators for length of stay, discharge destination and return to acute setting for medical treatment.

Permanent staff appointment

The participating staff also felt that employment of permanent staff within the services had an overall positive effect on the success of the program. Many suggested that this secured the IHCS future more than any other single factor. For example, the appointment of a competent nurse manager to the residential care unit facilitated the establishment of relationships with both the residential care staff and the hospital staff to form a working team in the care of the interim care patients.

Assisting participants to explore their views on community-based care

For the community interim care and ERP components, the first important task was the need to increase acceptance, at the hospital level and within the community, that HLRC patients could receive interim care at home while waiting for permanent HLRC placements. This was a

difficult step, and it was fundamental in ensuring that appropriate utilisation and referrals were obtained. It was achieved through close links with the case management agency and the development of appropriate pathways that addressed the needs of those clients who were successful in the program, but also had fallback approaches for those who were less successful. In addition, there was a need to increase acceptance at the hospital level and within the community that HLRC patients could benefit from slow stream rehabilitation to ensure appropriate utilisation and referral to the interim care services.

Access to medical care

General practitioner (GP) involvement was seen as critical to the success of the program, yet the community programs experienced difficulties in encouraging local GPs to participate. The issue was eventually resolved by the MHS employing its own medical staff to work within the residential care program and by the case management agency taking charge of patient care links and needs in the community. This suggested the need to consider the GP role early in the process and explore a range of options. The ability to use hospital clinical nurses for home assessment and ongoing monitoring was a vital resource in the absence of adequate medical practitioner input.

Conclusion

The Interim Health Care Strategy implemented in partnership has shown how a cross-sector initiative can improve care provision and outcomes of patients awaiting residential care placement. The case study shows how a multifaceted strategy that built upon existing relationships with strong planning, organisational commitment and a facilitating structure was successful in improving care integration. Well established protocols for quality and continuity of care were a strong outcome of the planning process and were a major factor in achieving the staff changes required to support the program. The organisational commitment was demonstrated through visible senior-level support within all partner organisations, identified staff committed to the success of the initiative and focused attention to the prevailing views that may have impacted the effectiveness of the services. The IHCS structure was designed to address clinical issues and facilitate integration among the participating organisations.

The IHCS has facilitated a closer working relationship and improved understanding between the acute/subacute, residential and community sectors. Staff retention and increased competencies have been positive outcomes of the initiative. The IHCS has provided immediate benefits for the participating patients, and it has also created the potential for future developments to reduce duplication and enhance benchmarking and performance improvement activities across the sectors.

Acknowledgements

The documentation of the IHCS was supported by a Myer Foundation Vision 2020 grant.

Competing interests

None identified.

References

1 Access Economics. Population ageing and the economy. ACT: Commonwealth Department of Health and Aged Care, 2001.

2 Australian Bureau of Statistics. *Age Matters* 2003; 2 (April).

3 Australian Bureau of Statistics. Disability, ageing and carers, Australia: summary of findings. ABS; 1998. (Catalogue no. 4430.0.)

4 Department of Human Services. Metropolitan Health Strategy. Directions for your health system. Available at: <http://www.health.vic.gov.au/metrohealthstrategy> (accessed Jun 2005).

5 Department of Human Services. Interim care guidelines for health services providing interim care. 2003. Available at <http://www.health.vic.gov.au/subacute/overview.htm> (accessed Jun 2005).

(Received 4 Oct 2004, accepted 5 Jun 2005) □