

# Acute Transition Alliance: rehabilitation at the acute/aged care interface

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## Abstract

The acute/aged care interface has presented many challenges to funders, providers and planners in the health and aged care sectors. Concerns have long been expressed in the aged care sector about the changing needs of clients admitted permanently into residential aged care from hospitals where the decision for placement would often have been made in a crisis situation, without the opportunity to explore appropriate options.

This article describes the process and outcomes to date of a collaborative effort between the acute care and aged care sectors in South Australia to develop a more integrated approach to discharge opportunities for older people. The program involves both residential and community care elements and seeks to provide rehabilitation, to restore function and to avoid inappropriate permanent residential care for older Australians following acute admissions to a public hospital. Interim outcomes are promising and show only 17% of those admitted to the program are discharged to long-term residential care.

**Aust Health Rev 2004; 28(3): 266–274**

PATIENTS AGED 65 AND OVER account for an increasing proportion of hospital admissions in Australia (Nichol, Lonergan & Mould 2002). The reasons for this are complex. They include

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## What is known about the topic?

Transition of some older patients from acute to other forms of care is a problematic process for patients, families and health care providers. Decisions with long-term implications are made under pressure, and delays in implementing those decisions are common.

## What does this paper add?

An innovative placement strategy for older acute patients who had been approved for residential placement, but who might benefit from rehabilitation and support, enabled 60% of clients ( $n = 480$ ) to return to their homes. Less than 17% were discharged to residential aged care.

## What are the implications?

Aged care providers could provide rehabilitation for older people following acute admission, and thereby maximise the potential for them to return home. Training, relationship-building among providers and new models of service delivery and funding are needed.

an ageing population, a decline in the last decade in the number of residential aged care beds (especially nursing home beds) per 1000 of the population aged 70 and over, the introduction of ageing-in-place (which resulted in delayed movement from hostels to nursing homes), and a concurrent decline in the number of acute hospital beds per 1000 population (Howe 2002). These changes resulted from a policy response to client preferences and involved the substitution of community for residential care through Home and Community Care (HACC), Extended Aged Care at Home Packages and Community Aged Care Package (CACP) programs. However, there is now more concern about older Australians who have been identified as needing residential aged care remaining in acute hospital beds while they wait for suitable aged care options (a situation often described as 'bed-blocking' or 'access-block').

Despite a call for earlier recognition of the need for residential care, and accelerated referral and assessment processes in the acute setting (Whitehead, Wundke & Finucane 2001), there is evidence that transferring aged people prematurely to residential beds results in blocking access to both aged care and acute hospital beds (Lowe & Kasap 2002). Care needs to be taken, therefore, to avoid transferring those patients who, with appropriate rehabilitation and supports, could return to the community. Decisions made at the interface between the acute and aged care sectors thus not only affect the lives of older Australians and their families but can potentially impact on the current and future capacity of both sectors.

These challenges have led to the development of some innovative transitional care programs that may provide a sustained change in the way we deliver health and aged care in our community. In particular they seek to improve options and outcomes for older Australians following hospitalisation. Howe and her colleagues mapped a number of these programs on behalf of the Australian Health Minister's Advisory Council Working Group on Care of Older Australians (Howe, Rosewarne & Opie 2002). In doing, so they developed a framework of five levels of intervention in acute-aged care interfaces:

- Early intervention before presentation at hospital, to prevent hospital admission;
- Intervention in hospital to divert admission and reduce length of stay (LOS) of admitted patients;
- Hospital organised post acute therapy/nursing care after discharge, to reduce LOS and restore function;
- Hospital organised interim support package after discharge, to reduce LOS and restore function (this includes two sub-types — community care for a limited time or residential care for a limited time);
- Sub-acute rehabilitation services for clients at risk of admission to acute hospital care, to maintain the individual in the community.

They concluded that a combination of all of these intervention types did result in a reduction in the problem of access block (Howe, Rosewarne & Opie 2002).

## **The South Australian context**

In South Australia, older people have faced difficulties accessing appropriate, timely and responsive aged care services when they no longer required acute care but were unable to return to their previous environment. While acknowledging that, if given extra time for rehabilitation, some of these people might have been able to return home, hospitals have been under increasing pressure to move them on so that other patients can be admitted. The availability of beds for aged care rehabilitation declined nationally between 1992 and 2001 from 1.2 beds to 0.7 beds per 1000 population aged 70 years and over. In South Australia the decline was from 0.54 beds to 0.35 beds (Gray et al. 2002). Consequently, it is often easier for hospitals to seek to place these people in residential aged care rather than look for scarce rehabilitation or support services.

This situation was exacerbated in 2000–2001 due to the temporary closure of a number of residential aged care beds. In some cases aged care bed licences were sold or relocated, resulting in shortages until new facilities came on stream; in other cases temporary closures occurred while building improvements were made to meet the new standards required. This resulted in a doubling of the numbers of older people waiting in South Australian metropolitan public hospitals for appropriate residential beds. These older people, as well as those in hospital requiring longer to recover and rehabilitate back to their previous functional level, were targeted in the press and hospitals flagged them as 'bed blockers'. The hospitals, aged care providers and the Commonwealth all sought to avoid blame for this situation and shift the responsibility elsewhere (Williams 2001).

### **First pilot January–December 2001**

The Acute Transition Alliance (ATA) was an initiative of the Department of Human Services (SA) in collaboration with an alliance of nine aged care providers to pilot a placement strategy for hospital patients who no longer required acute care and had been targeted for residential placement, but who might benefit from further support and rehabilitation.

The pilot brought together the collective expertise of aged care providers, metropolitan public hospitals and the state in a partnership to improve the care options for aged people targeted for residential care. The project identified the capacity of the aged care sector to provide flexible care, and challenged existing practices in both the acute and aged care sectors in relation to timely access to appropriate rehabilitation and support. Only 36% of those admitted to the pilot program went to permanent residential care. The majority returned to their previous homes, some with no further supports and others with low level community supports.

These results challenged the validity of the identification and approval of many elderly people in hospital as requiring permanent residential aged care when in fact they may have benefited from rehabilitation, restoration and the opportunity to resume normal life in the community.

In 2001 the Australian Health Ministers Advisory Committee established a Working Group on Care of Older Australians with the aim of improving the interface between acute hospital care, community care and residential aged care. It established the Innovative Care Rehabilitation Services (ICRS) project to explore innovative approaches to the provision of care to older Australians outside the current framework of residential and community aged care. In 2001–2002, a pool of 500 places was created to support the development of innovative care models. Due to the success of the ATA project in South Australia, the first program to be funded was the Acute Transition Alliance–

Home Rehabilitation & Support Service (HRSS) which commenced operations in January 2002.

### **The Current Project: ATA-Home Rehabilitation Support Services (ATA-HRSS)**

The current ATA project has 21 hospitals referring to 18 collaborating aged care providers who provide rehabilitation and support services either in a residential or community setting. This project extends beyond the metropolitan area to include some regional and rural areas in South Australia.

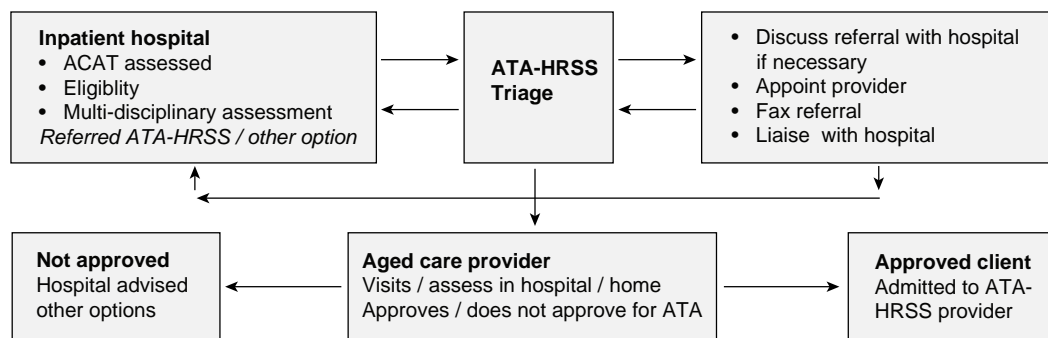
The ATA-HRSS is managed through an Advisory and Steering Committee structure. Each of the participating aged care providers and hospitals are represented on an Advisory Group, and a smaller more operational Steering Committee was established to provide more frequent oversight. In this project, joint contribution through the Advisory Committee has been essential to ensure transparency between sectors and organisations, and to develop and maintain agreement regarding the processes, development and review of the project.

### **Objectives**

The primary aim is to assist older people to move out of hospital, recover, and to have the best possible opportunity to live their preferred lifestyle. It is recognised that this requires changes across both sectors.

The secondary aim is to improve the capacity of the acute and aged care sectors to support older people to recover and manage with the lowest level of care that allows them to retain as much independence as possible. Many aged care programs assume that most aged people will enter them and remain (ATA 2002). This project is interested in changing ageist attitudes of hospital staff, providers and society so that the potential of older people for improvement and recovery is recognised and they don't become unnecessarily and prematurely

## I Referral and assessment flow chart



ACAT = aged care assessment team

ATA-HRSS = Acute Transition Alliance-Home Rehabilitation & Support Service

dependent on services that reduce their competence and autonomy.

It follows that the intention is also to change practice in both residential and community services that would enable people to receive services only for the period of time that they needed them, making access and provision more flexible.

## Referral and assessment process

The referral and assessment process is set out in Box 1.

Patients being targeted for Residential Care are identified while in hospital. They require an Aged Care Assessment Team (ACAT) approval that they require residential care and have potential for benefiting from rehabilitation and support to get to a lower level of care. Patients must be medically and psychiatrically stable and not require secure dementia care. Each hospital has an identified referral point (mostly either social work or allied health departments).

A multi-disciplinary assessment is made, considering the needs for residential placement and the potential for rehabilitation. Patients who meet the eligibility criteria and agree to

pay a client contribution are then referred to the ATA. (Fee waiver is by negotiation.)

Demographic information, approval for ACAT status, the Modified Barthels score measuring functional status, continence and cognitive indicators are included in the referral information.

## Triage and assessment

The triage function or coordination is managed by one of the providers (Aged Care and Housing Group) on behalf of the ATA and provides the referral, project management, fund holder and data management service for the pilot. This model seeks to ensure a single access point to the service, to manage the pilot environment and provide an opportunity to develop a consistent approach for the hospitals and providers to the developing service model.

On receipt of the referral, the triage coordinator allocates a service provider depending on the client/family's region of choice, services required, need for a residential or community option and the appropriateness of the provider to individual needs. Clients are then assessed by the provider, firstly as to their likelihood to benefit and to get to a lower level of care, and secondarily as to their suitability for that facil-

## 2 Discharge outcomes from ATA-HRSS – Jan 2002 to end Dec 2003

### Discharge outcomes (n=449)

ATA-HRSS place	Total nos. admitted ATA-HRSS	HLC	LLC	CACP/CO	Existing comm	Family/None	Readmiss	Deceased	Still on project
Residential	222	34	25	24/15	39	18/11	34	2	21
Community	266	7	9	60/30	44	22/9	65	2	18
Total	488	41	34	129	83	60	99	4	39
%		9.1%	7.5%	28.7%	18.4%	13.3%	22%	0.9%	

ATA-HRSS = Acute Transition Alliance-Home Rehabilitation & Support Service

HLC=High Level Care (nursing home)

LLC=Low Level Care (hostel)

CACP/CO=Community Aged Care Package / Community Options Package

Existing comm=Existing or Home and Community Care level services – ie Domestic Care/ District Nursing / Private

Family/None=returning to family supports or no external supports

Readmiss=readmitted to hospital (most of these are for new medical conditions)

Deceased=died on project

Still on project=not yet discharged from HRSS

ity or service, and either accepted or referred on immediately.

### Service model

The project offers choice, rehabilitation and support in a goals-focussed model of care that provides opportunity for clients to get to their best possible level of function before long-term care decisions are made.

The care plan is developed focussing on the client's strengths, the roles they wish to retain/regain and specific services that will enhance potential for rehabilitation/restoration of function, and includes a discharge plan. Clients and families are strongly encouraged to contribute to the care-planning process, and communication strategies ensure that the review process is open and addresses the needs of the clients.

Most clients receive personal care, domestic and allied health services (such as physiotherapy, occupational therapy and speech therapy) as required. The providers deliver rehabilitation and support through their existing residential or community services; or broker

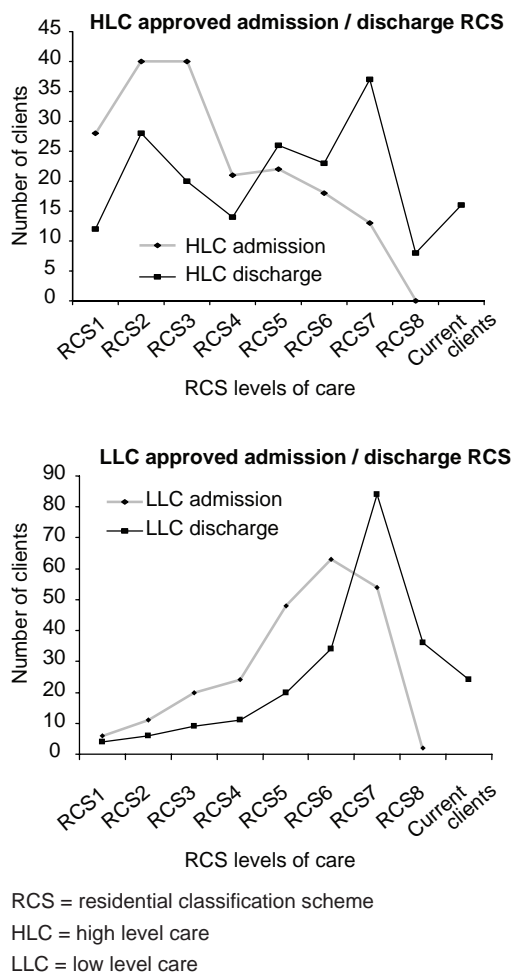
services (including additional allied health services) as needed. Providers supply significant service information for the National Evaluation.

Time on the project depends on individual needs and progress and review processes for discharge planning are included in the care plans.

### Funding

The ATA-HRSS is funded equally by the Commonwealth Department of Health and Ageing and South Australian Department of Human Services (currently \$525 000 per annum from each). These contributions are pooled to provide flexible funding for rehabilitation and support components. Providers are then funded under the Commonwealth Residential Classification Scale (RCS) as the base for services and care, and also receive the client contribution. The RCS is utilised both in residential and community settings and the client contribution is consistent with aged care standard

### 3 Changes in Barthels Scores from admission to discharge



fees for each setting. These have been indexed over the time of the project.

Providers invoice the ATA for days of service at particular levels of RCS on a monthly basis. Providers are required to do an RCS at commencement of the service, on discharge and whenever there is significant change in services or client status.

Extra funding can be provided for specific services and intensity of services above what would normally be provided in a residential or

community service. Providers are not reimbursed for hospital assessments or case management specifically. However, most clients require 1–5 hours of case management per week, and the National Evaluation will further tease out what this costs. Bolus feeds and oxygen are two of the unusual extra services funded outside of the RCS. Some transport and equipment may also require increased funds.

There is capacity to waive client fees where it can be demonstrated there is significant hardship. This is at the discretion of the provider and/or the project, and the extent of use of waivers is being monitored.

### Outcomes

To December 2003:

760 referrals were received and 480 people were admitted to the project.

- The average age of clients admitted was 83 years, with 36% aged more than 84 years, and 5% aged less than 65 years.
- 12.7% of clients were from culturally and linguistically diverse backgrounds.
- 30% of clients were admitted within 4 days of the initial referral, while over 60% were admitted within 7 days of the initial referral.
- Clients admitted to the project had spent an average of 35 days in hospital before admission, with 8% having been in hospital for more than 65 days.
- Less than half of all clients received services in a residential care setting.
- Clients spent an average of 54 days on the ATA-HRSS project
- At discharge from the ATA, over 60% of people went home (24% with additional community services; 21% with their existing community support; and 15% with no additional support).
- Twenty per cent were readmitted to hospital (of whom two thirds returned to the project) and less than 17% of people were discharged to residential aged care (see Box 2).
- Eighty-two per cent of those with low level care approvals and 70% of those with high

level care approvals had a functional improvement as measured by Modified Barthels on discharge, and 56% of people were discharged at a lower RCS level (see Box 3).

## Lessons learned

Aged care providers are capable of providing rehabilitation for older people following a period of acute care. Cooperation between hospitals and the ATA in identifying patients who are appropriate for rehabilitation by aged care providers has been important to this project.

One of the key outcomes has been a better understanding of the capacity building required within the acute and aged care sectors to enable a more flexible, rehabilitative model of care. This has required providing different services, changing focus within care models, changing staff mix, and often a cultural shift within the service/facility from a more passive long-term support model to one of short-term rehabilitation. Training has been important to achieve the necessary shift to a rehabilitation focus. This has proven more difficult in residential facilities, where RCS payment arrangements constitute a disincentive to rehabilitate clients (as the facilities are not rewarded for getting people to a lower level of care). This has reinforced a practice of 'doing things for patients' rather than 'encouraging patients to do things for themselves'.

Aged care providers have access to funds for services for their existing clients that encourage restoration of function and in some cases rehabilitation within the RCS funding model (via the *Aged Care Act 1997* [Cwlth]). However most ATA providers have needed to make changes to their existing arrangements to ensure clients are able to receive the intensity of intervention required. Consequently, several models have developed over the period of the project that ensure individual providers are able to deliver appropriate services to their ATA clients. They are:

- Existing staff — either through Day Therapy services or contracted allied health. For some this has required upskilling or changes in existing roles within organisations.
- Brokerage — either privately or from other aged care providers on a fee-for-service basis. An example is the need for a Punjabi-speaking speech pathologist who was able to assist a client to return home by providing coordination as well as language assistance.
- Linking into existing regional services — such as Domiciliary Care Services, sometimes on a fee-for-service basis.

In some cases, outstanding social problems, which had either not been identified or had not been dealt with within the hospital setting, proved to be barriers to effective rehabilitation. Residential services, which normally only dealt with patients and families after decisions had been made about either returning home after respite or seeking permanent residential placement, found themselves having to work with patients and families still struggling with these issues. While issues of grief and loss, family conflict and other social issues are normal for an aged care setting, the resolution of many of these issues was required before the best outcomes for clients could be successfully pursued.

Community service providers, while finding an easier cultural fit with a rehabilitation focus, often struggled to use the RCS funding model to describe the activities that the project required of them. In particular, many social support and rehabilitation activities could not be easily fitted within the RCS framework. The funding model has required considerable defining over the period of the project, however the flexibility has provided an extremely fertile ground to explore options and services for clients.

## Case Studies

### Mr B

Mr B is an 81-year-old man who was admitted to hospital following a right CVA (stroke) with

a left-sided hemiparesis. Long recovery time meant he was not eligible for clinical mainstream rehabilitation programs. If he had remained in hospital it was possible that he would become even more deconditioned. He lacked insight into his current condition and options.

In hospital he was assessed as needing high level, permanent, residential care. On discharge to the ATA project he required a two-person assist with all transfers and all personal care, was incontinent, had periods of confusion and was assessed as an RCS 3.

His initial assessment by ATA provided evidence of his clear desire to rehabilitate to a level which would enable him to remain at home. He required a slow stream approach, which ATA-HRSS provided.

He was admitted to residential care for rehabilitation and received:

- physiotherapy
- speech therapy
- socialising/activity
- family conferences
- capacity building for daily living activities.

Two months later he was independent in daily living activities, was continent, but still lacked insight regarding some issues. He was discharged to home with community ATA services and assessed at that time as an RCS 7.

Six months later he is totally independent. He walks to the shops, plays bowls and has reconnected to aspects of his previous life that are important to him. He is maintaining his dignity, and a place in his community, and is receiving a small number of services he requires in his place of choice — his own home.

## **Mrs T**

Mrs T is a 92-year-old lady with a crush fracture in her lumbar region.

In hospital she was assessed and approved for permanent, high level care. She was assessed at RCS 3, had unmanaged pain, was doubly incontinent, and required standby

assistance for all mobilising and daily living activities. She had a considerable lack of confidence and was extremely distressed by this. She was not safe to return to her own home, but lacked confidence and support to make another choice. It was not appropriate for her to remain in an acute setting — high level care was viewed as the only option.

Her rehabilitation was conducted in a residential facility. Two months later, following considerable confidence and strengths building, she has been reassessed as requiring low level care and is at RCS level 6. She has a well supervised pain management regime; is on a continence management regime resulting in occasional incontinence only; requires set-up assistance only for daily living tasks; and is much more confident and able to cope. Because her family have not been able to support her choice to remain at home she elected to move to low level care. The project allowed her time for decision making and appropriate recovery. She is happy with the outcome.

In both of these cases the financial impact should they have remained in high level care would have been more costly to the Commonwealth than the cost of the ATA services.

## **The future**

Older people often need considerable time, rehabilitative interventions and support to maximise their functional status and morale following acute illnesses. Acute hospitals, with high demand for beds, often do not have the resources needed to assist older people in making the best recovery possible. A new approach is needed, combining aspects of aged care and support with rehabilitation services. The ATA-HRSS has demonstrated how hospitals and aged care providers can collaborate in providing rehabilitation options for older people.

Multidisciplinary teams in hospitals are becoming more familiar with and confident in the services that the ATA-HRSS can provide, and are becoming better able to identify patients who would benefit from this approach.



More work, however, needs to be done in fine-tuning this process. Formal feedback from the aged care providers about individual patient outcomes and the success of the project will assist this development.

This approach suggests radical rethinking about the role of the aged care sector, and raises questions about whether it should be seen primarily as a source of long-term or permanent care only, or a range of much more flexible short-term options that older people can access as and when required.

After June 2005 the National Evaluation will report to the Commonwealth on all the ICRS projects. Decisions will then be made about which models may be further funded and possibly mainstreamed.

## Acknowledgements

*Participating hospitals:* Barossa Valley Health Service (3), Clare, Flinders Medical Centre, Gawler, Hampstead, Lamerloo, Lyell McEwin, Modbury, Mt Barker, Mt Pleasant, Murray Bridge, Noarlunga Health Service, Royal Adelaide, Repatriation General, Southern Districts War Memorial, St Margarets, Strathalbyn, Tailem Bend, The Queen Elizabeth.

*Participating aged care providers:* Aged Care and Housing Group, Alwyndor Aged Care, Anglicare SA, Adelaide Hills Community Health Service, Barossa Village Inc, Country Home Advocacy Program, Elderly Citizens Homes, ElderCare, Gleneagles Aged Care, Helping Hand, Italian Benevolent Foundation, Fullarton Lutheran Homes, Masonic Homes, Murray Mallee Aged Care, Resthaven Inc., Southern Cross Care, Tregenza Ave Aged Care, Wesley Mission.

## Competing interests

None identified.

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(Received 6 Jul 2004, accepted 29 Oct 2004)

