Overview of the new Hospital@home service – South

This webinar will start shortly.

Overview of the new Hospital@home service – South

Zoom webinar – Thursday 9 November 2023 – 6:30pm to 8:00pm

Acknowledgement of traditional owners

We acknowledge the Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we are meeting today. We pay our respects to Elders past and present.

We would also like to acknowledge Aboriginal people who are joining us today.

Learning outcomes

After this session, I will be able to:

- Develop a sound understanding of the new Hospital@home service
- Understand the admission criteria and process for referring to the Hospital@home service
- Understanding the benefits of the Hospital@home service for patients

Some housekeeping

- Tonight’s webinar is being recorded
- Please use the Zoom Q&A feature to ask questions
- At the end of the webinar your browser will automatically open an evaluation survey. We appreciate you taking the time to complete this to help us improve our events programme
- Please don’t forget to register for your next webinar at: https://www.primaryhealthtas.com.au/for-health-professionals/events/

Presenter(s)

- **Rebecca Wilford** - Project Manager, Virtual Care Program
- **Miena Arnol** - Nurse Unit Manager, Hospital@home
- **Bianca Jones** - Pharmacy Manager, Covid@homeplus
- **Dr Tessa Cunliffe** - Geriatrician, Hospital@home
- **Dr Iestyn Lewis -** Head of Department, Hospital@home
- **Alison Graham** – Senior Occupational Therapist, Hospital@home

Panellist

- **Dr Emma Huckerby** - Clinical Director, Sub-Acute, Aged and Community Services
- **Trudi Steedman-** Acting Director, Virtual Care Program

Hospital@home - South

9th November 2023

Hospital@home

Department of **Health**

Tasmanian Government

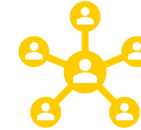
Virtual Care Tasmania: **Optimising care@home**

Need to leverage the achievements from the pandemic

Promote innovative care models

Driven by consumer & service need. System-wide pressure relief

Digitally enabled and flexible workforce



Integrated care delivery systems and processes

Equity of Access – State-wide

Capturing accurate and robust data to support service delivery, greater efficiency, productivity and improved outcomes

What is driving this change?

Our Healthcare Future Literature Review Report

Tas DoH Strategic Priorities (2021-23)

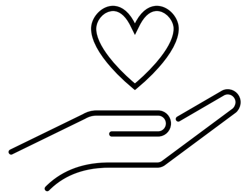
Tas DoH Digital Health Transformation (2021-31)

Tas DoH State-wide Access and Patient Flow Program

- The Long-Term Plan for Healthcare in Tasmania 2040 recognises the relevance of & need for providing hospital level care within people's place of residence & the community
- This shift is **driven by consumer preference** to receive care at home when clinically appropriate & the need to expand service delivery options to meet future demand for health care
- Hospital@home is the next step as we **optimise care at home** building upon successful programs & provide expanded consumer choice

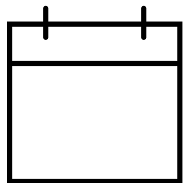
Introducing ….

Hospital@home - South



Hospital@home is the name of a new service integrating and expanding the services provided by:

- Hospital in the Home (HITH)
- Community Rapid Response Service (ComRRS)
- Allied Health Rapid Response Team (AHRRT)



Hospital@home - South will launch on 20th November 2023

Hospital@home

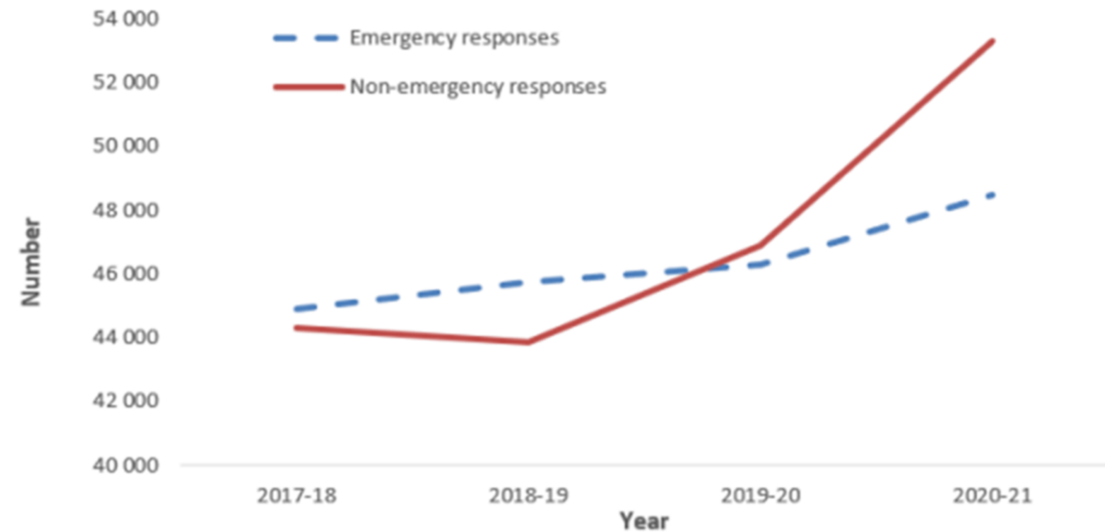
Why change?

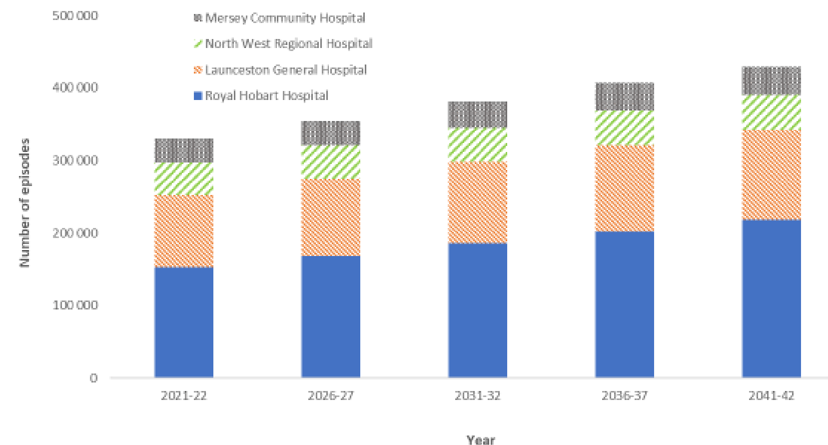
Increasing demand for our hospitals, ambulance & other health services

Extensive evidence demonstrates the value of providing hospital level care in the community

Approach supported locally by the success of well-established programs:

- HITH
- ComRRS
- AHRRT





Hospital@home

Hospital@home

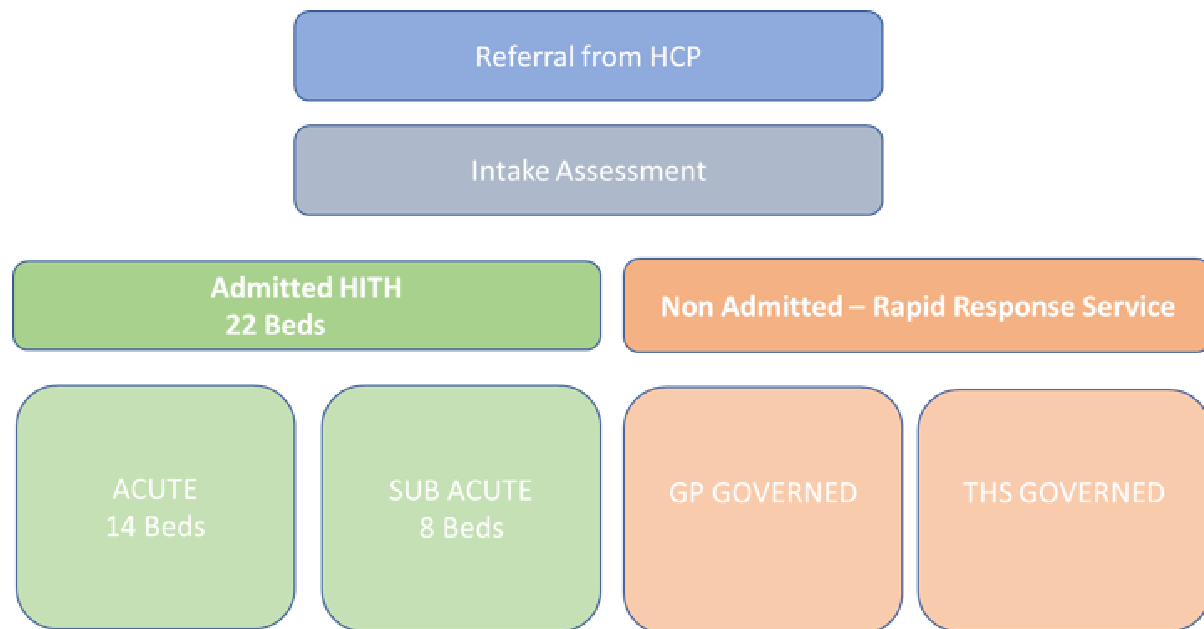
Tasmanian Government

Why Hospital in the Home?

- Equivalent clinical outcomes
- Increased patient & carer satisfaction
- Improved sleep, mood & nutrition
- Increased ability to see how the patient functions in their own environment

- Reduced
  - risk of hospital acquired infections & VTE
  - delirium, falls, pressure injuries & deconditioning
  - transfer to RACF
  - readmission rates
  - cost

Hospital@home - South



Hospital Avoidance: reducing unplanned presentations & admissions to acute care facilities

Hospital Substitution: deliver care and services in the home that would otherwise be provided in hospital

Enhanced healthcare delivery for Older People

Hospital@home is…

- For public & private patients
- Acute & subacute care to adults in the community
- Integrates ComRRS, AHRRT & HITH into one team
- Promotes interdisciplinary care in the community
- The model of care promotes compassion, respect & patient/family centred care

Hospital@home provides:

- Rapid Response service to provide single or short interventions for acute or acute on chronic health issues
- Community based hospital-level care for patient who need an acute admission
- Community based subacute care for elderly & vulnerable patients

- Provided by an Interdisciplinary team, led by a Staff Specialist
- 7 days a week, 07:30 - 22:30
- 24/7 clinical phone support

Hospital@home will..

Primary goals:

- Hospital-level care within the community setting
- Specialist led care allowing for hospital avoidance or complete substitution
- Subacute Geriatric evaluation & management (GEM) under the supervision of a geriatrician, with IDT support
- Rapid response interventions for acute health issues & chronic condition exacerbations, preventing hospital presentations & admissions
- A single point of referral & contact

What is Changing?

The existing teams will come together as one service (HITH, ComRRS & AHRRT).

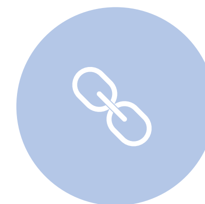
The new service will include a new **Geriatric Evaluation Management** model to support care of the older person in their home.

The new service, **Hospital@home will be managed from a new Centralised Hub**.

The Centralised Hub will coordinate referrals, systems and processes.

Cambridge Park will be the location of the Centralised Hub.

Glenorchy & Clarence Integrated Care Centers will operate as clinical hubs.



Single point of referral

AHRRT and ComRRS will integrate to strengthen the Rapid Response arm of the service.

A new THS clinically governed arm will provide enhanced flexibility and responsiveness for patients in the community

Referral points to the service will increase with Residential Aged Care Facility Nurses, Ambulance Tasmania, Community Nurses, Allied Health and Private Specialist being able to refer in addition to GPs & Hospital Clinical Staff .

The capacity of the service will increase with the number of beds available increasing from 12 to 22 (8 Sub-Acute GEM beds).

Service area is increasing to provide increased community based service to Southern Tasmania

Staffing levels and mix will increase.

Existing team members* will transition to the new service.

Recruitment process is underway for the additional roles. Leadership will work with individuals to ensure a smooth transition.

Allied Health staffing will increase, with all disciplines represented to provide appropriate community/home based care

Hospital@home

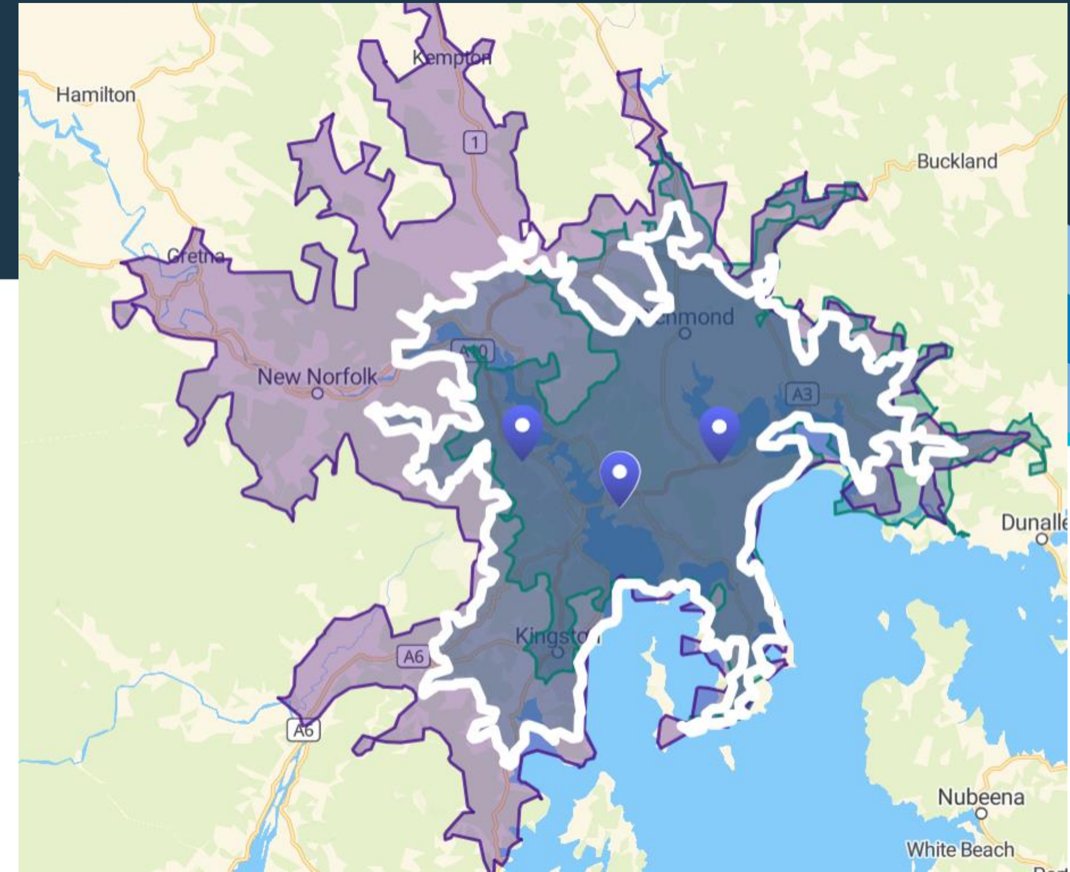
Service Areas

Hospital@home – South

Expanded geographical reach

The Hospital@home team works from:

- Glenorchy Health Centre
- Clarence Health Centre
- Cambridge Park Virtual Hub
- Royal Hobart Hospital
- THS Community Health Centre Clinics



Patients out of catchment area considered in certain circumstances on a case-by-case basis.

Eligibility criteria

Eligibility

- Care that can be delivered safely in the community setting
- Consents to the referral
- Lives within catchment area (ish)
- 24-hour access to a working telephone and can use it
- 18 years or over (mostly)

Ineligibility

- Medically unstable
- Needs exceed the capability of Hospital@home
- Does not consent to referral to the service
- Acute mental health condition is the primary reason for referral
- Care needs can be managed by Primary Care or Community Nursing Services
- Care needs are better suited to hospital-based inpatient care

Referrals

- Direct from **any health care provider**
- Refer by phone call: centralised Hospital@home referral line: **1800 329 042** (live on 20 November 2023)
- In-take nurse provides advice regarding patient suitability for the service (with the Staff Specialist if required)
- Once accepted, in-take nurse will allocate a timeframe and resources (4 hours or 24 hours depending on acuity) for initial assessment

- **Referral should include**:
  - Reason for the referral and the presenting problem
  - Service(s) requested
  - Current patient management plan and medication list

- Discharge correspondence sent to the patient's GP

Mrs. LK

- 86-year-old woman referred to Hospital@home by her General Practitioner with decompensated HFpEF
- LK's daughter had taken her to GP for review due to two weeks of increased orthopnoea, dyspnoea & peripheral oedema
- Referral triaged by the Hospital@home in-take nurse & LK reviewed by a Hospital@home clinician in her home within 4 hours of referral

Further background history

- Her family have noticed her memory has declined & she is needing more assistance from her family for community and domestic activities of daily living
- She is having recurrent falls
- She still drives & has had several recent minor accidents

Frailty
Multi-morbidity
Multi-chronic organ failure
Polypharmacy
Adherence & administration

Past Medical History

- HFpEF
- Atrial fibrillation
- Moderate aortic stenosis & moderate mitral regurgitation
- Chronic obstructive pulmonary disease
- CKD stage III
- Bladder cancer with previous TURBT
- Hypertension
- Hyperlipidaemia
- Hearing impairment
- Recurrent falls

Medications

- Frusemide 40mg daily
- Apixaban 2.5mg BD
- Clopidogrel 75mg daily
- Perindopril 5mg daily
- Amlodipine 2.5mg daily
- Atorvastatin 20mg daily
- Tiotropium 1 puff daily
- Temazepam 10mg nocte PRN

- Medications administered from bottles & packets, concerns about adherence.
- Multiple expired & ceased medications in her home

Social History

- From home alone with her much-loved dog
- Supportive family, one daughter has travelled from interstate to stay with her in the short-term
- Current smoker
- Nil previous ACAT assessment & nil formal services
- Has previously appointed two of her daughters joint EPOA & Enduring Guardian
- Her daughter has had to take over management of finances
- Enjoys watching her grandsons play in the local footy team

Hospital@home Acute Medical Progress

- LK admitted to the Hospital@home
- On intake: flagged for initial Allied Health assessment & access to brokered support services
- Consultant, NP, RN & Physiotherapist reviews performed during her acute admission
- Min:1 visit per day, plus 24/7 telephone support
- Clinical improvement in fluid balance & symptoms, de-escalated back to oral frusemide
- Transferred to Hospital@home Subacute GEM service on **day 4**

Comprehensive Geriatric Assessment

Impression

1. Progressive advanced mixed Alzheimer's & vascular dementia with BPSD
   a. Associated with increased functional dependence on her family for activities of daily living to remain living in her own home, which is her wish & preference

2. Ongoing multi-factorial high falls risk in the setting of recurrent falls, impulsivity, frailty, non-adherence with gait aid, arrythmia/aortic stenosis & polypharmacy

3. Frailty & malnutrition

4. Polypharmacy

5. Safety concerns regarding driving

6. Requiring ongoing future planning given chronic life-limiting multi-morbidity, frailty & advanced dementia

Hospital@home

Tasmanian Government

Identification of patient goals, made in conjunction with her and her family, based on her values & wishes.

Goal	Progress	Outcome
Perform formal cognitive assessment	Diagnosed with mixed dementia with BPSD	Explanation & education provided. Family linked in with Dementia Support Australia
Assess functional cognition & home environment. Assess & reduce falls risk To remain supported in her own home for as long as possible	OT home assessment conducted with falls risks identified OT functional assessment for personal activity of daily living performed	Minor home modifications; grab rails inserted in the bathroom, handrail installed at front entrance Provision of falls alarm, shower stool & transit wheelchair Brokered support for personal care assistance
Assess & reduce falls risk To attend the local footy to watch her grandsons play & mobilise outdoors to have a cigarette	Physiotherapy falls/balance assessment performed. Car transfer & gait aid use assessed	Upgrade of home exercise program, education on how to utilise 4 wheel-frame safely Able to transfer in/out of car to attend the local footy
Optimise nutritional state	Comprehensive dietician assessment	Prescription & delivery of protein supplements drinks & family education

Hospital@home

Tasmanian Government

Identification of patient goals, made in conjunction with her and her family, based on her values & wishes.

Goal	Progress	Outcome
Support her and her family so she can remain in her own home for as long as possible Support future planning	Extensive social work input. Family meeting performed Referred for ACAT, Community Health & Service Package (CHSP) & Carer's Gateway	ACAT assessment performed during admission, approved for level 4 home care package, respite & permanent care Ongoing support via CHSP & Carer's Gateway in the interim
Perform financial capacity assessment	Financial capacity assessment performed by Geriatrician, determined to no longer have the capacity to make financial decisions	Enduring Power of Attorney formally enacted
Review fitness to drive	Discussion with KL & her family that she is no longer safe to drive	Family removal of car keys

Tasmanian Government

Hospital@home

Identification of patient goals, made in conjunction with her and her family, based on her values & wishes.

Goal	Progress	Outcome
Deprescription to reduce pill burden & risk of adverse events Simplify medication administration	Pharmacy home medication reconciliation, review of appropriateness of current therapies & deprescribing recommendations	Deprescribing: daily administration regimen Old medications removed from home Arrangements made to prepare Webster Pak
To remain supported in her own home for as long as possible To avoid future hospitalisations, maintain symptom control & die in her own home	Future planning & treatment goals of care discussed in the setting of multiple progressive life-limiting illnesses	Goals of care changed to C (palliative, treatment aim is quality of life) Referral made to community palliative care

Questions

Hospital@home (South)

Launch date: 20 November 2023

Referral line: 1800 329 042 **(from 20 November 2023)**

Tasmanian HealthPathways is a web-based information portal developed by Primary Health Tasmania. It is designed to help primary care clinicians plan local patient care through primary, community and secondary healthcare systems.

tasmania.communityhealthpathways.org

Username: **connectingcare**

Password: **health**

Tasmania

Search HealthPathways

HealthPathways

Tasmania

- Home
- COVID-19
- About HealthPathways
- Aboriginal and Torres Strait Islander Health
- Acute Services
- Allied Health
- Child Health
- Investigations
- Legal and Ethical
- Lifestyle & Preventive Care
- Medical
- Mental Health and Addiction
- Older Persons' Health
- Medicines Management
- Public Health
- Specific Populations
- Surgical
- Women's Health
- Our Health System

Tasmania
HEALTHPATHWAYS

Health Alert

Follow the new Novel Coronavirus (COVID-19) pathway for up to date information on the assessment and management of suspected cases.

Primary Health Tasmania – Coronavirus (COVID-19) response

Department of Health:

- Coronavirus
- Notifiable disease info
- Public Health Emergency Declaration

Latest News

19 February

DHHS Tasmania - Public Health Alerts

See all public health alerts

Pathway Updates

Updated – 19 February
COVID-19 Assessment and Management in Aged Residential Care

Updated – 18 February
COVID-19 Vaccination Information

Updated – 18 February
Personal Protective Equipment (PPE)

Updated – 10 February
COVID-19 MBS Items

Updated – 5 February
COVID-19 Telehealth

VIEW MORE UPDATES...

- DIGITAL HEALTH GUIDE
- PRIMARY HEALTH TASMANIA
- RACGP RED BOOK
- FINDHELPTAS
- MBS ONLINE
- NPS MEDICINEWISE
- PBS
- TASMANIAN HEALTH DIRECTORY

Hospital@home

Caution: This page is in development.

DRAFT

Background

South

tasmania.communityhealthpathways.org

Username: **connectingcare**

Password: **health**

Some final words

- After this webinar ends, your browser will open a link to an evaluation survey.
- Statements of attendance will be emailed to participants.
- For event queries, please contact events@primaryhealthtas.com.au

Disclaimer

- Information presented in webinars organised by Primary Health Tasmania can come from a number of sources, and does not necessarily reflect the views of Primary Health Tasmania. Every reasonable effort is taken to ensure the information is accurate and current.
- The content is general in nature – please refer to any referenced guidelines or standards for further information. Health professionals should rely on their own independent inquiries and professional judgement when making any decisions.
- Primary Health Tasmania and the Australian Government are not responsible for any injury, loss or damage however arising from the use of or reliance on the information provided in this webinar.

phn TASMANIA
An Australian Government Initiative

primary health TASMANIA

Stay informed

www.primaryhealthtas.com.au

www.facebook.com/primaryhealthtas

www.twitter.com/TasPHN
@TasPHN