Health Care Without Walls

Implementing Systemic Home Hospital

Stephen Carmody

General Manager Health

1 A Bit About Silver Chain

2 What We Have Been Doing For Many Years

3 What We Are Implementing Now

4 Key Success Factors

who cares... we care

Across the State

EVERY MINUTE. EVERY HOUR. EVERY DAY. WE CARE.

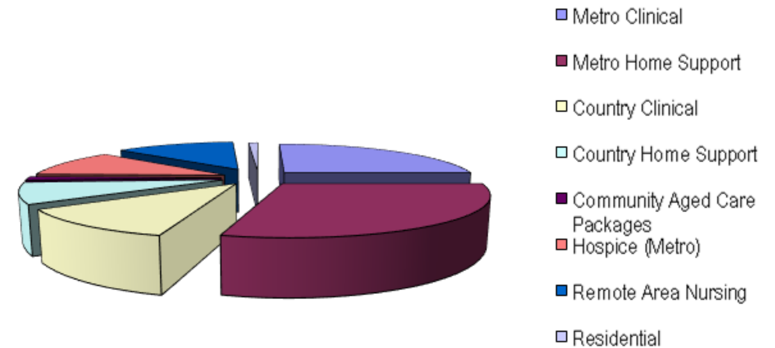
Perth-Carnarvon - 902km (561 miles)
Perth-Eucla - 1436km (892 miles)
Perth-Walpole - 423km (268 miles)

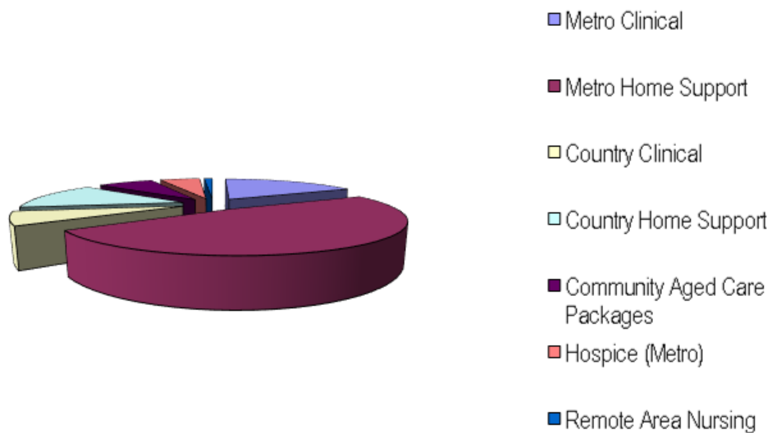
Metropolitan Centres

EVERY MINUTE. EVERY HOUR. EVERY DAY. WE CARE.

Activity Profile

- 41,346 Clients
- 1,418,083 Hours of Care
- 1,909,995 Occasions of Service
- 12,192,336 km travelled
- 2,553 Staff
- 660 Volunteers





Core Services

SILVER CHAIN

- HACC Home Support (Home Help and Personal Care)
- C/wealth Aged Care Packages 576 CACP and 128 EACH
- 6 Residential Aged Care Facilities
  (RCF – Approx 400 beds)
- Community Hospice Program
- H@H, PAC, CU evolving to Silver Chain Home Hospital
- Access Care Network
  - Personal Alarms
  - Department of Veteran's Affairs (DVA)
  - Shared infrastructure
  - Fee For Service (FFS)

who cares... we care

- IT
- Customer Centre
- Quality Team
- Project Management Office
- Fleet Management
- Management tools
- Logistics focus
- Asset Management

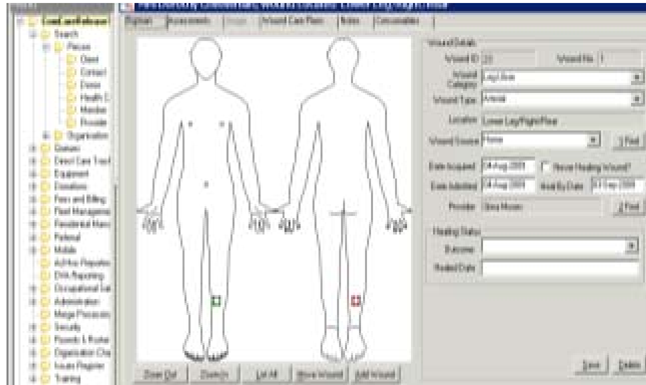
who cares... we care

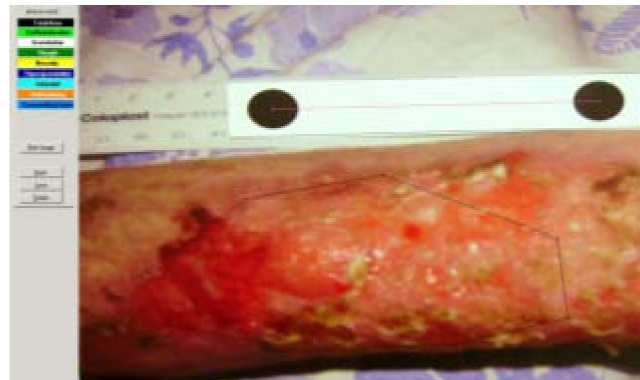
Clinical

- Diagnosis
- Care indicator associated with client need
- Link care indicators to care plan
- Print care plan to leave in home
- Record variance which may affect the goal set for the client

COMCARE
Client Management System

Wound Management





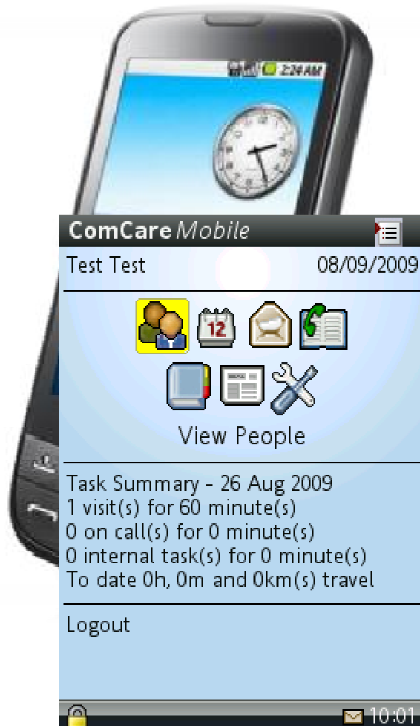
- Can record multiple wound location
- Each wound retains its own history and progress
- Graphical representation of the wound healing progress against the system specified healing parameters
- History of wound products used during the healing process
- Defines the regions of the wound and calculates the area of the wound regions to create the healing graph

ComCare
Client Management System

who cares... we care

ComCare Mobile

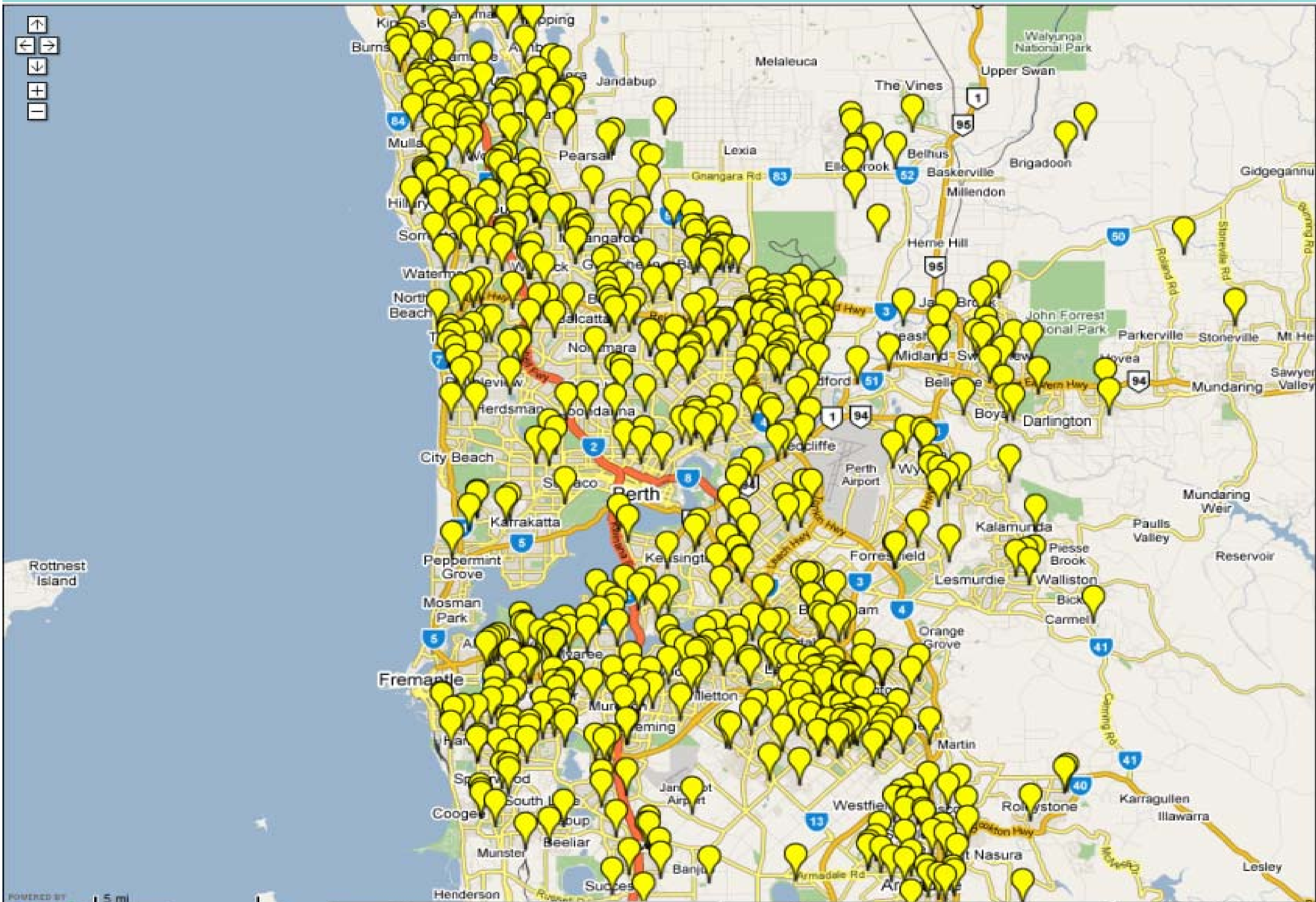
SILVER CHAIN



- Clients
- Contacts
- Access comments
- Service details
- Task details
- Questionnaires (assessments)
- Clinical details
- Wound management
- Schedule/roster
- Timesheet
- Admission wizard
- Messages
- Alerts
- Maps
- OSH checklist
- Client equipment
- Manuals (nursing and quality)

COMCARE
Client Management System

we care


Melaleuca
The Vines
Upper Swan
Walyunga National Park
Jandabup
Lexia
Pearsall
Belhus
Baskerville
Millendon
Brigadoon
Gidgegannup
Gnangara Rd
Herne Hill
John Forrest National Park
Parkerville
Stoneville
Midland
Hovea
Mundaring
Sawyers Valley
Darlington
City Beach
Perth
Perth Airport
Karrakatta
Peppermint Grove
Mosman Park
Rottnest Island
Fremantle
Kalamunda
Piesse Brook
Walliston
Lesmurdie
Pauls Valley
Mundaring Weir
Reservoir
Carmel
Orange Grove
Martin
Karragullen
Illawarra
Roleystone
Lesley
Coogee
Beeliar
Munster
Success
Henderson
Westfield
Armadale Rd
Powered by Google
5 mi
5 km
Allocate
100
Dump
Cluster
Show Clients
Show New
Dump
Proposed
Hide Providers

1	A Bit About Silver Chain
2	What We Have Been Doing For Many Years
3	What We Are Implementing Now
4	Key Success Factors

who cares... we care

- Silver Chain Hospice Care Service funded by Department of Health WA.
- Contracted to provide palliative care to people in their last 60 days of life (taken as an average).
- Current average length of stay is 92 days.
Range 1–900+ days.
- Currently have 511 clients and their families.
- No Maximum. Highest number = 680 (2007)
- Age range pre-natal to 102 years.
- Average 2,000 deaths per year.

who cares... we care

Research has shown that :

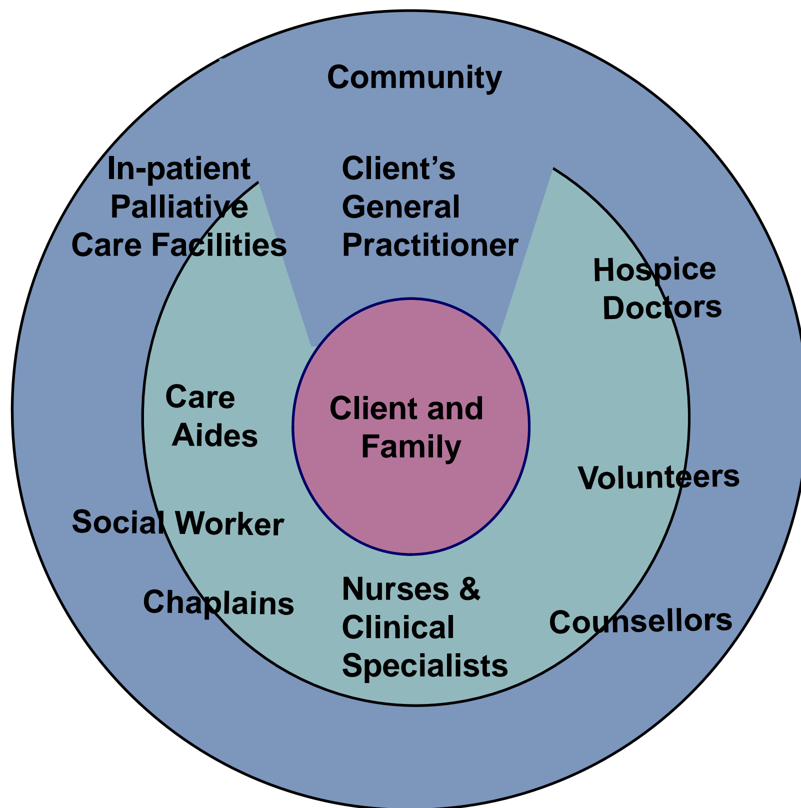
- "if given the choice, up to 80% of patients with cancer would prefer to die at home, but the proportion who realise this desire is much smaller"

(Burge, Lawson & Johnston, 2003, p265)

who cares... we care

A Unique Model Of Care

Providing a home palliative care service in Metropolitan Perth. Eight teams operating out of three Metropolitan bases.



What is unique?

- The way we work with General Practitioners.
- The size of the service - coverage of the full Metropolitan area.
- Comprehensive nature of the service.
- The technology used
- Type of clinical procedures done in the home.
- Outcome - keeping people at home.

who cares... we care

- Make contact with client and/or family same day as referral.
- Same day visit by RN possible.
- 24 hour coverage stand up RNs.
- Regular evening/night visits - short term only.
- No specific time visits given – too difficult.

who cares... we care

What we really do:

- Build capacity within families to care for their own - filling gaps through skills transfer, encouragement, technical care, psycho-social and spiritual care.
- Active control of burdensome symptoms - physical, psycho-social and spiritual.
- Stand alongside people at the terminal stage or when death does occur - normalising death.
- Support at bereavement - identify and intervene with at risk, complex grief responses.

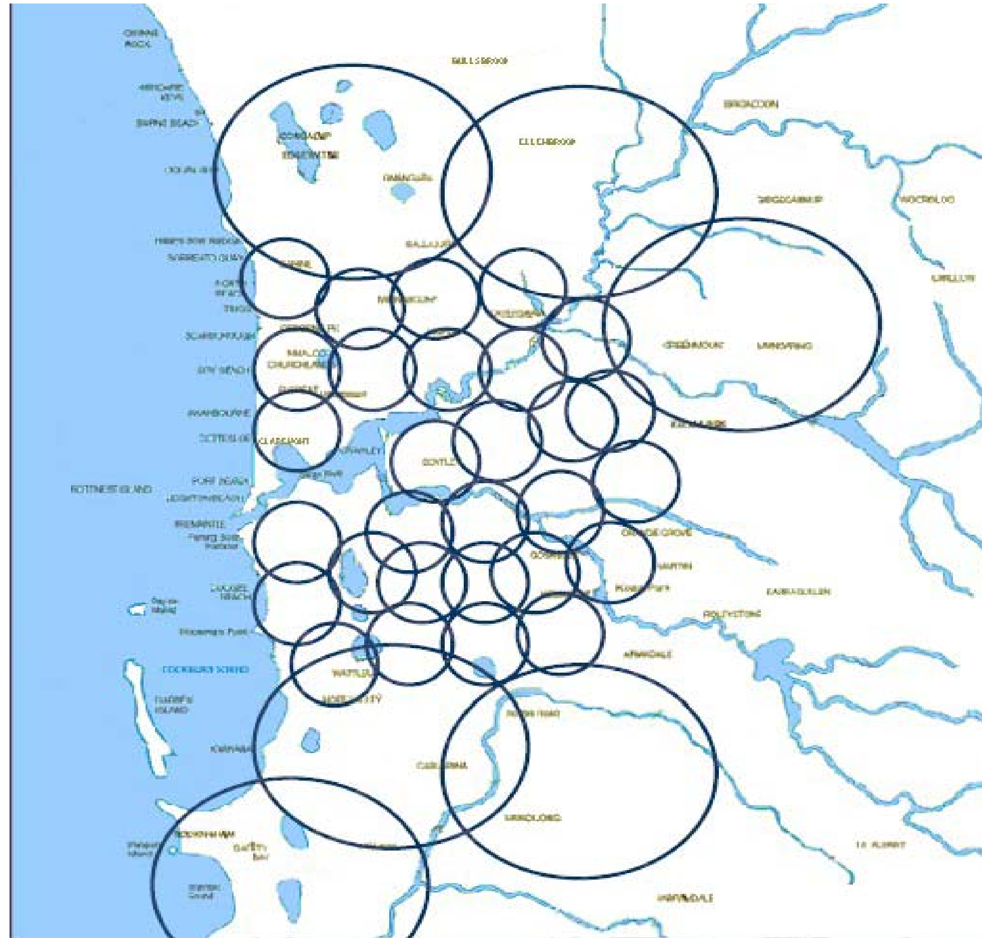
who cares... we care

Efficient Service Model

EVERY MINUTE. EVERY HOUR. EVERY DAY. WE CARE.

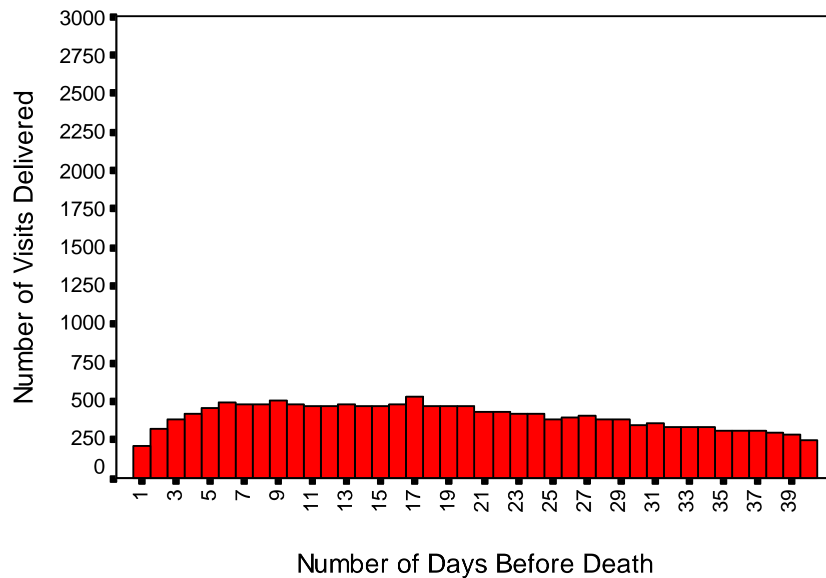
Minimise travel

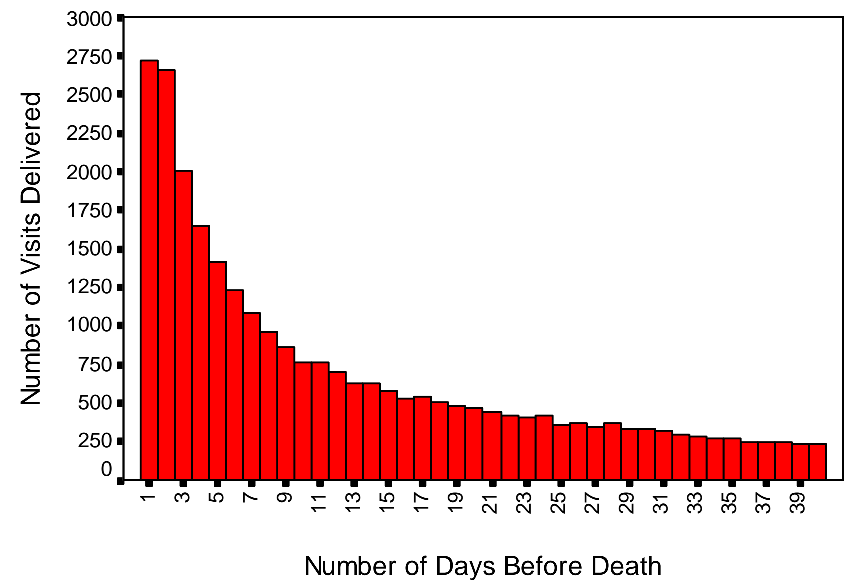
Maximise hours client care



who cares... we care

The last 40 days - The number of Silver Chain Visits provided





A home care service that aims to assist the person to die at home will cost more to deliver than a home care service that supports the care of an in-patient facility with the terminal care provided in an in-patient setting.

who cares... we care

A Whole Of Sector View

hospcost homecost No of clients

Average Total Cost: 0, 2000, 4000, 6000, 8000, 10000, 12000, 14000, 16000, 18000, 20000

Number Of Clients: 0, 200, 400, 600, 800, 1000, 1200

Number Of Inpatient Days: 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40

who cares... we care

Pain

10
8
6
4
2
0

Ave SAS at First Visit | Ave SAS at Episode Midpoint | Ave SAS at Final Visit

10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0

who cares... we care

SILVER CHAIN

Nausea

10
8
6
4
2
0

Ave SAS at First Visit

Ave SAS at Episode Midpoint

Ave SAS at Final Visit

10 9 8 7 6 5 4 3 2 1 0

who cares... we care

Bowel Problems

10
8
6
4
2
0

Ave SAS at First Visit

Ave SAS at Episode Midpoint

Ave SAS at Final Visit

10 9 8 7 6 5 4 3 2 1 0

who cares...
we care

Breathing Problems

10
8
6
4
2
0

Ave SAS at First Visit | Ave SAS at Episode Midpoint | Ave SAS at Final Visit

10 9 8 7 6 5 4 3 2 1 0

who cares... we care

SILVER CHAIN

Fatigue

10
8
6
4
2
0

Ave SAS at First Visit | Ave SAS at Episode Midpoint | Ave SAS at Final Visit

10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0

who cares... we care

Why Has Hospice Worked?

SILVER CHAIN

- It has been constant over 20 years
- It has been consistent across metro Perth
- It involves, links and supports patient's GP
- It has sound clinical governance
- It provides good service to families and patients
- 60% Die at Home

"It is just how it is done in Perth"

who cares... we care

Other Hospital Substitution Activity

- In the past 4 years, Silver Chain has also delivered:
  - H@TH
  - Post Acute
  - Community Nursing
  - HACC Nursing

who cares... we care

1	A Bit About Silver Chain
2	What We Have Been Doing For Many Years
3	What We Are Implementing Now
4	Key Success Factors

who cares... we care

Gap In Service Delivery

Cost of Care

1200
1000
800
600
400
200
0

1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51 53

Time

Australia has excellent Primary Care and world leading Acute Care

who cares... we care

Gap In Service Delivery

Gap In Service Delivery

In the current FFS system, occasionally the primary care provider can not provide the level of care necessary to meet the patient's needs.

Cost of Care

1200
1000
800
600
400
200
0

1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51 53

Time

who cares... we care

Gap In Service Delivery

Gap In Service Delivery

Cost of Care

1200
1000
800
600
400
200
0

Service opportunity
Right Care,
Right time,
Right place
Right intensity

1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51 53

Time

who cares... we care

- Integrating the existing H@TH, PAC & CN programs
- Creating a new Priority Response Assessment Team (PRA)
  - 24/7 Nurse Practitioner
  - Medical back-up
  - 4 hour minimum service delivery
  - Tight clinical and protocol support
- Extensive expansion of HATH, PAC & CN ($19 m F.I.N.E.)
- Additional Personal Care support
- Large investment in IT and remote monitoring.
- Aim – 500 bed “virtual hospital” in the community – Systemic hospital substitution:

“Home Hospital”

who cares… we care

Why A Home Based Health Service?

Acute sector (Hospital) needs to develop:

- Dedicated IT
- Supervision and monitoring processes
- Vehicle and fleet management
- New facilities designed for hub operations
- Communications
- Productivity optimisation capacity (70%)
- OSH
- Relationship management with other community players
- Comprehensive geographic spread

Hospitals have:

- High level clinical governance

Community Health Sector needs to develop:

- Higher level clinical governance
- New relationships with hospitals

- **Community Health Sector has:**
- Dedicated IT
- Supervision and monitoring processes
- Vehicle and fleet management
- New facilities designed for hub operations
- Communications
- Productivity optimisation capacity (70%)
- OSH
- Relationship management with other community players
- Comprehensive geographic spread

who cares... we care

Friend In Need – Emergency (FINE) scheme

Patient unwell at home (includes residential care)

Referral sources

Self
Family/Carer
Ambulance
GP
Med Specialist
Residential care staff
Outpatient Service
Day Hospital
ACAT
Cmty Service
Complex Care Coordinator
Others

RCL Outreach
NMAHS & SMAHS

RCL Line

Telephone TRIAGE

Hospital

Emergency Department

ED Care Coordination Teams

Options on exit from ED:

Inpatient ACUTE care

Options on exit from hospital care

Outpatient clinics & Day Hospital Services

HITH, RITH Homelink, RAILS etc

In-patient sub-acute

Options on exit from sub acute care

Care Coordination Hospital In-reach

Usual Community Care system:

HACC (& PEP)
CACP
EACH
Residential Aged Care
DVA
DSC
Carer respite
Private
Other

ACCESS Networks

- Sub-acute community
- TCS

N

Need for Complex Care Coordination

Y

Complex Care Coordination:

Long term planning and support
Liaison and partnership with GP
Disease management plan and Emergency plan
Carer support needs
Longer term coordination and liaison with services
Across all of care continuum

NMAHS and SMAHS

Silver Chain **Non-inpatient ACUTE and COMPLEX care**

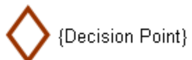
Intake:
Call line to Ambulatory Liaison Service
Rapid service delivery response
(see service / intervention types below)

Intervention
Multidisciplinary
Supports patient and carer through episode
Aims to link to community services as required and continue monitoring until stable/confident

Underpinned by Medical Governance & GP management of patient

Key SCNA service / intervention types

Priority Assessment Service	Hospital at Home Service	Post Acute Care Service	Community Nursing Service	Home Support Packages

 {Decision Point}

Critical Success Factors

Silver Chain Home Hospital

Priority Response Assessment (PRA) (Notin EOI Scope)	Hospital at Home (HATH)	Post Acute Care (PAC)	Community Nursing (CN)

- Principle 1 — Single point of entry (24/7)
- Principle 2 — Integrated, coordinated, multidisciplinary services
- Principle 3 — Robust clinical and medical governance
- Principle 4 — Engagement with key stakeholders
- Principle 5 — Utilisation of technology
- Principle 6 — Patients access to equipment, consumables & pharmaceuticals
- Principle 7 — Metro wide

who cares... we care

Shared Language/Understanding

SILVER CHAIN

	Silver Chain Home Hospital	
In scope	**Acute Care**: having or experiencing a rapid onset and short but severe course	**Sub-acute Care:** characterized by an onset that is not as abrupt as in the acute form and with symptoms less severe and of shorter duration than chronic illness
What's the difference?	Requires 24 hr on-call medical coverage	Requires medical point of reference
Who provides medical governance?	Medical coverage (and governance) provided by Silver Chain medical team	Medical coverage (and governance) provided by patients GP or referring specialist. If not available, may be provided by Silver Chain medical team
Do they prevent hospital admissions/presentations?	Alternative: patient would definitely be admitted to an inpatient hospital or present to ED	Alternative: patient may possibly be admitted to an inpatient facility or present to ED.
What other names are used for the services?	HITH HATH Priority Assessment Service	Post Acute Care Community Nursing Early Discharge programs
	Hospital Substitution: care provided as direct alternative to inpatient care **Hospital Avoidance**: care provided to prevent a hospital admission/re-admission or ED presentation	**Hospital Avoidance**: • Providing care to prevent the need for admission to hospital eg proactive management/intervention to prevent deterioration • Providing care to enable discharge from hospital eg management of post-operative wounds; dehiscence

1 A Bit About Silver Chain
2 What We Have Been Doing For Many Years
3 What We Are Implementing Now
4 Key Success Factors

who cares... we care

What Have We Learnt Over The Years?

SILVER CHAIN

- It takes time to cause systemic change.
- Consistency and comprehensiveness is crucial.
- Community Care should be based in the community – building the community systems. (Hospital outreach is often temporary and inconsistent.)

who cares... we care

- Clinical Governance is essential for both:
  - Quality of care
  - Clinician confidence

- Organisational Governance is critical – one organisation must be accountable for results.

- Acute care in the community is not a casual undertaking. Sophisticated technology, logistics, HR systems, quality systems and governance is necessary – “it must be core business”.

who cares... we care

EVERY MINUTE. EVERY HOUR. EVERY DAY. WE CARE.

Thank You

Stephen Carmody

General Manager Health

who cares... we care