



# Home Support Services: Emergency Department Avoidance Program

**Presented by**

Virginia Bullock, Managing Director

Victoria Henstridge, Quality Coordinator



# OVERVIEW

- Home Support Services
- Hospital Avoidance Program
- Implementation and Management of Program
- Case Studies
- Summary



# HOME SUPPORT SERVICES



# HOME SUPPORT SERVICES FOUNDATIONS

HSS has a 19 year history of providing acute and sub-acute care using a unique centralised, coordinated case management model in the community

HSS now operates strategic hospital avoidance programs in conjunction with the South Australia and Queensland Departments of Health



# HISTORY

*The first hospital in the home in Australia*

- 1989 – Home Support Services Pty Ltd [Home Nurses]
- 2004 – Commonwealth Recognised Outreach Provider
- 2004 – First private Chemotherapy in the Home program in Australia
- 2006 – Metro Home Link (Department of Health SA)
- 2008 – Home Health Link (Department of Health Qld)



# HOSPITAL AVOIDANCE PROGRAM



# ALTERNATIVE TO ED PRESENTATION

- A community-based avoidance program:
  - Holistic program
  - Safe management
  - Rapid response
  - Positive outcomes



# EMERGENCY PRESENTATION- HOW DO YOU AVOID IT?

## 1. Involve and gain participation from:

- General Practitioners
- Ambulance services
- Community services
- Aged care facilities
- Public

## 2. Education to all referring sources

- Program awareness
- Identify patients
- Confidence in the program



# EMERGENCY PRESENTATION- HOW DO YOU AVOID IT?

## 3. Create ease of use for referring sources

- Single point of referral
- Ease of access

## 4. Deliver holistic case managed care

- Unique Case Management model
- Skilled and experienced team
- Individual patient needs considered



# IMPLEMENTATION AND MANAGEMENT OF AVOIDANCE PROGRAM



# HSS PROGRAM OBJECTIVES

- Avoid an ED presentation, hospital admission, or facilitate an early supported discharge
- Rapid response short-term care at home
  - 24 hours, 7 days per week
- Effective holistic Case Management
- Ease of access
- Best Practice with effective Clinical Governance
- Patient safety
- Providing a cost-effective program



# Developing an Holistic Case Management Model

- Team complexity
  - Significant education, investment and experience
    - Case coordination
    - Service delivery
    - Administration
- Systems and processes
- Information Management infrastructure
  - Specifically tailored to hospital avoidance



# Developing an Holistic Case Management Model

- Knowledge of existing community services
  - Long-term services
  - Other services available
- External Service providers
  - Selection
  - Relationships
  - Accountability



# ELIGIBILITY, CRITERIA AND SUITABILITY

## Eligibility:

- All ages
- All diagnoses
- All socioeconomic circumstances

## Criteria:

- At risk of admission to an emergency department or hospital

## Suitability:

- Patient safe
- Medically stable



# CASE MANAGEMENT MODEL

HSS' case management model represents a dynamic, integrated and multidisciplinary model of health care delivery, which incorporates interdependent and collaborative arrangements to ensure cost-effective, quality care.



# CASE MANAGEMENT MODEL

- All care provided within holistic framework:
  - Centralised management
  - Initial assessment in patient's home
  - Individualised care plan development
  - Liaison with treating doctors/GP/other health professionals or agencies
  - Communication with patient/carer/family
  - Long-term services organised for continuity of care
  - Patient advocacy



# CASE MANAGEMENT MODEL OUTCOMES

- Ensures the best outcomes for individualised patient needs
  - Patient-centred, goal-orientated care delivery
  - Continuity of care/long-term needs considered
  - Maximum optimal level of health
  - ED presentation avoided

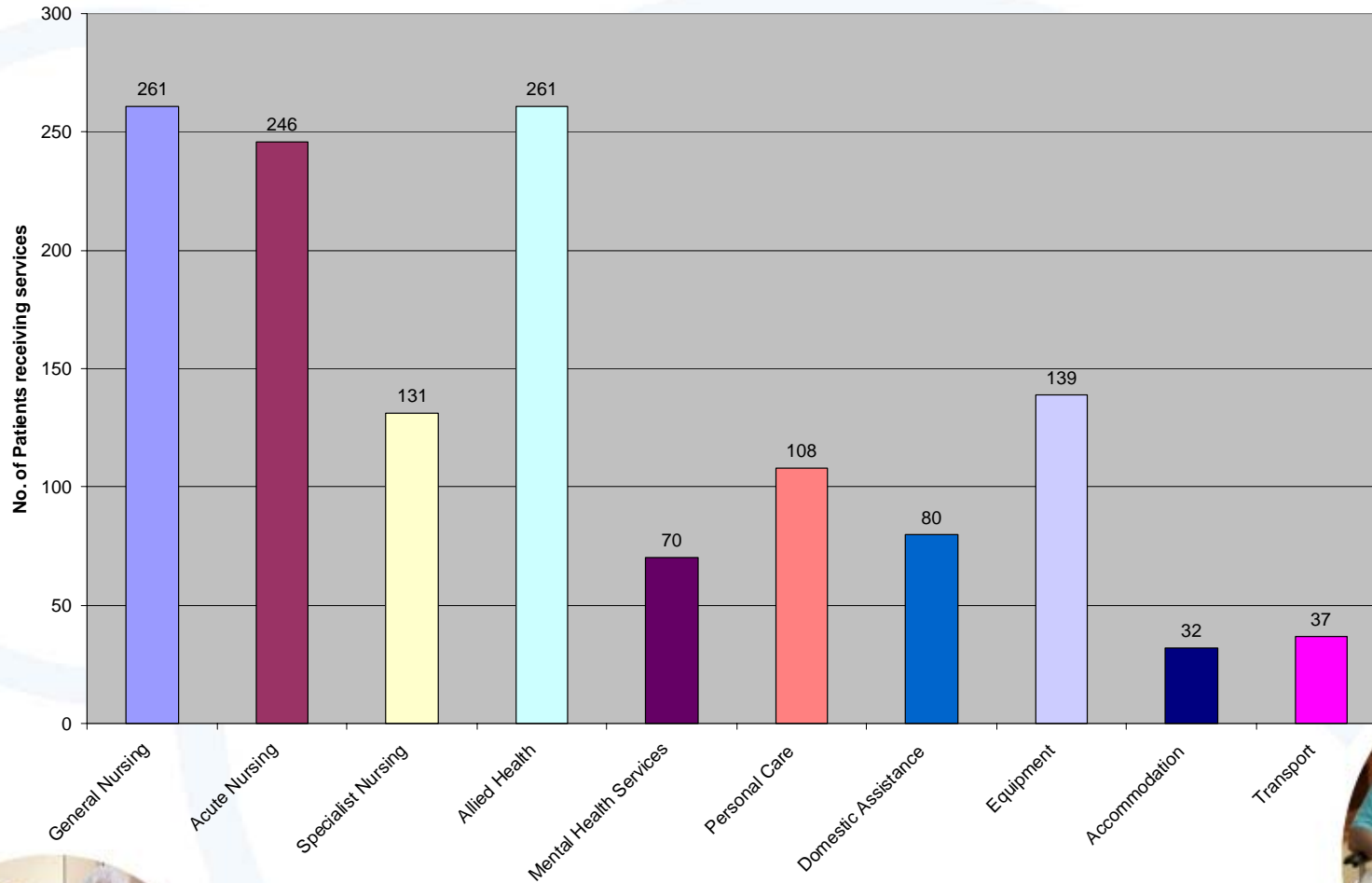


# SERVICE PROVISION

- Allied Health (equipment, home assessments)
- Home Support (personal care, domestic)
- Acute Care (intravenous antibiotics, wound care)
- Mental Health (transitional support)
- Midwifery/Paediatric (postnatal support)
- Accommodation (post-procedure, short-term)
- Rehabilitation (orthopaedic, cardiac)
- Transportation (doctor appointments)
- Aged Care Facilities (blood transfusions)



# SERVICE PROVISION

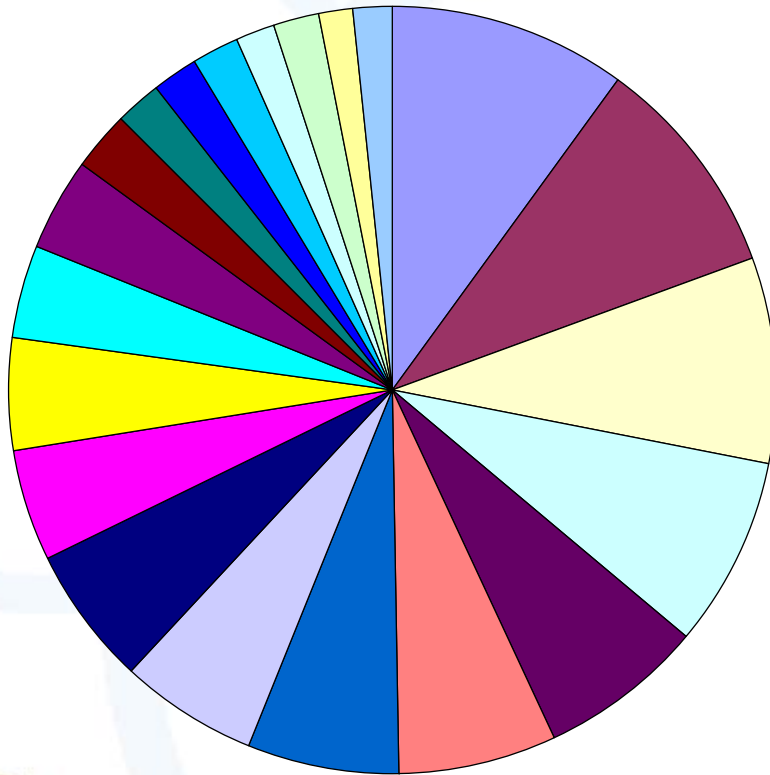


# EXPERIENCED TEAM

- Multidisciplinary team of experienced Case Managers
- Trained and experienced staff deliver acute care services
  - Registered Nurses, Registered Midwives
  - Occupational Therapists, Physiotherapists
  - Personal Care Attendants, Domestics
- Specialist Staff
- Partnership with other providers
  - Equipment, transport, accommodation



# DIAGNOSES



- Falls
- Mental Health
- Genitourinary
- Fracture
- Cancer
- Dementia
- Post-Op
- Other Disability/Mental Health
- Other\*
- Cardiac
- Vascular
- Wounds
- Homelessness
- Chest Infections
- Cellulitis
- Decubitus Ulcer
- CVA's
- IV
- COAD
- Transfusions
- Palliative

\* Mobility, Debility, Gastroenteritis, PEGS, Diabetes.



# CASE STUDIES



# CASE STUDY 1- ACUTE NURSING

## Patient:

- 73 year old female presented to GP

## Primary Condition:

- Decubitus ulcer on Right leg
- Cellulitis Right leg

## Social:

- Lived on own – son supportive and lived close by

## Secondary Conditions:

- Type 2 diabetes, peripheral vascular disease

## Referral to Avoidance Program:

- BD intravenous antibiotics for 5 days
- Wound Management



# CASE STUDY 1- ACUTE NURSING

## Services Provided:

- Registered Nurse assessment
- Registered Nurse visits for:
  - Intravenous management
  - Wound management
  - Diabetic education visit for diet and BSL monitoring
- GP visits coordinated and supported



# CASE STUDY 1- ACUTE NURSING

## Outcome:

- GP Review on day 5:
  - No further IV required, Patient commenced oral antibiotics
- Involvement of son on diabetes education for continued support for his mother
- BSL's stable
- Patient and son more confident with diabetes monitoring
- Wound care was continued by community services
- Ongoing review by GP



# CASE STUDY 2- MEDICAL

## Patient:

- 84 year old lady presented to GP

## Primary condition:

- Fall resulting in left shoulder injury

## Social:

- Lived alone, socially isolated, no family or formal support services in place. Neighbour assisted with meals/shopping and transport.

## Secondary conditions:

- Urinary tract infection, chronic obstructive airways disease, asthma

## Referral to Avoidance Program:

- Assessment of patient and home environment



# CASE STUDY 2- MEDICAL

## Services Provided:

- Registered Nurse assessment
  - Personal care assistant provided hygiene
  - Domestic assistant for home maintenance
- Occupational Therapist home assessment
  - Occupational Therapist provided education on falls prevention including the removal of loose rugs and mats
  - Grab rails installed in the shower and toilet, and a hand held shower hose arranged
  - Referral to Day Therapy Centre for Falls Balance Classes
  - Personal alarm organised



## CASE STUDY 2- MEDICAL

### Outcome:

- Patient safely discharged from program to ongoing care of GP and ongoing community services
- Patient commenced Falls Balance classes
- Patient became independent with all personal care
- GP follow-up for UTI



# CASE STUDY 3- MENTAL HEALTH

## Patient:

- 51 year old gentleman referred from community mental health service

## Primary condition:

- Major depression

## Social:

- Lived alone, anti-social behavioral issues

## Secondary conditions:

- Bipolar disorder, borderline personality disorder, anxiety

## Referral to Avoidance Program:

- Assist with management at home and link up with community services



# CASE STUDY 3- MENTAL HEALTH

## Services Provided:

- Registered Nurse assessment
  - RN visited daily for medication administration
  - Carer to assist patient with GP visit for medication review
  - Domestic clean attended
  - Visits arranged to community groups for coffee and social interaction
  - Personal care attendant visit for shopping and to take patient on bus to familiarise with public transport
  - All pre-arranged social support services attended
  - Follow up-GP review arranged
  - Mental Health Community Key Worker liaison



# CASE STUDY 3- MENTAL HEALTH

## Outcome:

- Patient independent in personal care
- Patient was safely discharged to ongoing GP management and Community Mental Health Support Program for medication management
- Community group visits for social interaction continued
- Referral placed to community service for ongoing medication management
- Patient independent in personal care



# SUMMARY



# SUMMARY

- Hospital avoidance programs
  - Community-based holistic program
  - Rapid response
  - Ensure safe patient management
  - Positive outcomes
- Referrals
  - In 12 months approximately 20,000 patients treated
  - Significant bed days saved



# A HSS STORY

'I am an 82 yr old widow living on my own with no family nearby to help me when my health is not too good. On recommendation I asked my Dr to refer me to you for help with my chest; I have a bad infection, which was making me quite ill. The Dr faxed you on Friday morning and by lunchtime everything was set in motion to help me. I was amazed and so pleased at the very quick and efficient response I had. I won't go into details but by Monday afternoon I was feeling a very different person and so cared for. Please thank all the staff concerned in helping me when I was feeling so lost and miserable. Thank you again.'



Thank You  
from the  
Home Support Services Team

