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FOREWORD



The purpose of this document is to provide Program Guidelines which support the provision of the Metro Home Link program which has become one of the key platforms for the Better Care Program within Central Northern Adelaide Health Service (CNAHS).

CNAHS officially became the Contract Manager for the Metro Home Link program 1 July 2006. Since this time we have worked with our key stakeholders in order to ensure that the Program Guidelines reflect the intention of the program. These Program Guidelines have provided for maximum flexibility to support decision making, and accountability for both the referrers to the Metro Home Link Program and to our Service Provider – Hospital Support Services Inc.

It is important to acknowledge that there have been some changes from the previous Metro Home Link Program which was auspiced by Advanced Community Care Association (ACCA) however, we believe that through the continued interaction and feedback from our referrers, that the program will build on and enhance service delivery options to our patients/clients and their carers.

I would like to take this opportunity to thank all those staff who have contributed to the development of these Program Guidelines and if required please do not hesitate to contact the Better Care Program Project Officer on 82221404

A handwritten signature in black ink, appearing to read 'David Panter', with a stylized flourish underneath.

DAVID PANTER
Chief Executive Officer

1 PRINCIPLES & AIMS

1.1 The Central Northern Adelaide Health Service (CNAHS) Metro Home Link (MHL) Program is underpinned by the following:

- CNAHS Strategic Objectives:
 - Client Focused Care
 - Quality and Safety
 - Reorientation of Care
 - Optimising Resources
- CNAHS Consumer Participation Framework
- CNAHS Healthy Ageing for All (in progress)
- South Australia's Strategic Plan
- South Australia's Approach to Chronic Disease Strategy
- South Australian Patient Safety Framework

1.2 Program Principles

- Reduce Metropolitan Hospital Admissions
- Develop a Scalable Response
- Consumer Centered Care
- Outcome/Evidence-Based Measures and Quality
- Consistent and Recognised "Brand".
- Draw existing systems together including but not limited to Acute, Primary and Residential Health Care Sectors
- Access and Equity
- No Boundaries

1.3 Program Objectives

To provide appropriate alternatives to hospitalisation by working closely with general practice, hospitals, residential care facilities and community services to achieve:

- Identification of and early intervention for people who may be assisted to avoid a hospital admission or emergency department presentation.
- Reduce the incidence of ambulance transfers of patients between residential care facilities and participating hospitals.
- Improve the availability of advanced clinical professional care to support the General Practitioner.
- Identification of appropriate patients who may be assisted to leave hospital early or facilitate a timely and safe discharge from metropolitan public hospitals.

2 TARGET GROUP

Metro Home Link is a metropolitan wide service and patients are eligible for the service if:

1. They reside in metropolitan Adelaide (both community and residential care facilities and present to an emergency department or are at risk of being admitted to a metropolitan public hospital.
2. They reside in rural and remote areas but are admitted to a metropolitan hospital.
3. They are an in-patient of a metropolitan public hospital and could leave hospital earlier than otherwise possible if appropriate short-term home-based supports are made available.
4. They are an in-patient of a metropolitan public hospital and their risk of readmission can be reduced if appropriate short-term home-based supports are made available.

3 SERVICE DESCRIPTION

3.1 MHL - Hospital Avoidance¹

This program provides short-term flexible services (packages of care) that enable a patient presenting to a general practice, mental health service or hospital emergency department, who otherwise would have been admitted to a metropolitan hospital, to return safely² home or residential care facility thus averting an emergency department presentation and or immediate hospital admission.

3.2 MHL – Home Supported Discharge¹

This program provides short-term flexible services (packages of care) so as to enable a patient to immediately leave hospital earlier or on time and return safely to their place of residence. This program targets all persons in the Adelaide metropolitan hospitals who could be safely discharged home earlier if supports were made available, or where the patient is at risk of re-admission to hospital.

3.2.1 Support services are provided on a short-term basis where the referrer provides evidence that a package of care will avoid an emergency department presentation, hospital admission or extended stay in hospital.

3.3 Types of assistance available may include:

- Nursing Management – general and advanced specialist care

¹ As of October 1 2006, the Advanced Care in Residential Care Living program (ACRL) has been encompassed within the mainstream MHL program. As a result, all services offered to the residential care patient will be reflective of those services delivered within the generic MHL Program. Services such as tracking of residential care patients and the provision of residential care management plans will no longer be available under the program.

² The term safe & safely as it appears in this document relates to the patient's ability to manage activities of daily living without risk of harm or is without risk (or low risk) of sudden life-threatening physical or mental deterioration

- Medication assessments and or administration of medications
- Allied Health – Occupational Therapy, Physiotherapy, Speech and other allied health services depending on client need
- Provision of technical assessment interventions eg ECG / bladder scans
- Acute interventions including blood transfusions and hydration therapy
- Personal Care – activities of daily living
- Carer Respite
- Transport – to appointments directly related to illness & episode of care
- Overnight support
- Emergency accommodation
- Childcare – assistance and respite for the unwell patient
- Domestic services (grocery shopping, meal preparation, housecleaning)
- Medical equipment where there is a direct health gain
- Palliative Care support management
- Referrals to ongoing community services where appropriate. *(Please note that this service is **not** designed to replace good discharge planning, but rather ensures that those patients identified during a MHL episode of care with an unexpected long term need are referred onto the appropriate community support.)*
- Other services as negotiated by Transitional Care staff, General Practitioner or Better Care Project Officer.

Note: Metro Home Link can provide support care for those patients admitted to Hospital in the Home (H@H). In such cases H@H personnel will be the lead organisation responsible for the delivery of patient care.

3.3.1 Referrals can be made 24 hrs day 7 days week.

3.3.2 Home assessments will be made between the hours of 8.30am and 6.00 pm, 7 days a week.

3.3.3 Patients on the program have access to telephone support 24hrs per day.

3.4 Packages of Care

3.4.1 The criteria for allocating a MHL package of care is that the allocation must clearly demonstrate that the provision of a package of care will enable a patient to immediately avoid a emergency department presentation or hospital admission or that the patient is able to to be discharged earlier resulting in the saving of a hospital bed day and is not a substitution for poor discharge planning.

3.4.2 Care packages are designed to be allocated one package per patient but aimed at reducing menu-driven service delivery. Therefore flexibility within package allocation exists. (I.e. maximum of 2 x packages per patient) However the allocation of a double package must be approved by an authorised CNAHS staff member as follows:

1. Acute Care sector - Hospital Transitional Care key staff.
2. Mental Health sector - Mental Health Transitional Care

- Coordinators.
3. Residential Care sector- Residential Care Site Manager, Registered Nurse / General Practitioner / Practice Nurse.
 4. Community sector- General Practitioner and or Practice Nurse or Better Care Project Officer.
 5. Where the Acute Care / Mental Health / General Practice staffs are not available to approve packages the Better Care Project Officer can proxy for all staff. Double package of care will require an approval form to be signed by the authorising staff member.
- 3.4.3 Examples of packages of care include personal care, assistance with activities with daily living, through to technical nursing care and or allied health expertise.
- 3.4.4 Packages are restrictive of purchase of goods (outside of medical equipment) unless an immediate positive health outcome is identified, as negotiated with CNAHS Transitional Care Staff or as negotiated with the patients General Practitioner and or Practice Nurse.
- 3.4.5 Mental health patients require a diverse range of services that can be seen to sit outside mainstream service delivery of the program. CNAHS Mental Health Directorate has endorsed package flexibility for the purchase of goods and services as required. However the allocation of a package must clearly demonstrate that the provision of a package of care will enable the patient to immediately avoid an emergency department presentation, hospital admission or that the patient is able to be immediately discharged earlier, resulting in the saving of hospital bed days. Where referrer or HSS call centre staff are unclear as to the appropriateness of a referral request, Mental Health Transitional Care Coordinators will be contacted for package approval.
- 3.4.6 There is an expectation that patients may require a suite of services to support hospital avoidance or early discharge. The provision of single items of equipment to facilitate the patient's separation is not an appropriate use of package resources and as such will not be funded under the MHL program. There may be "special circumstances" where this criteria does not apply. In such cases it will be the responsibility of the hospital or Mental Health Transitional Care staff or General Practitioner to assess the patient's needs and determine appropriate use of resources.
- 3.4.7 Packages of care to patients living in residential care facilities must reflect the need for advanced clinical and or technical professional care or support care that is outside the capacity and scope of practice for the residential care facility where the patient lives both in frequency and intensity on a daily basis.
- 3.4.8 CNAHS acknowledges that limits do exist on the capacity of some residential care facilities regardless of supports offered by this program to manage the unwell patient. Implementation of a hospital avoidance or early discharge package of care must be undertaken in negotiation with the patients individual residential care site.

3.4.9 High Resource Package (High Cost Patients). High cost packages may be available for those patients whose needs are assessed as outside the value of a double package of care. Criteria will be developed to support future allocation of resources. In the interim a High Cost Package will only be available following approval by the Executive Director Service Development or Better Care Project Officer.

3.4.10 It is acknowledged that the location of service delivery may differ from the location of the referral, but the package acquitted will be related to the region from where the referral originated.

3.5 Flexibility & Type of Service

3.5.1 Services must be flexible in the type of services delivered and the time and venue of services delivered. Services are required to be tailored around an individual or the care their family's need that allows them to receive care in their home and convenient community locations, and to manage the risk factors, signs, symptoms and changes in their illness or chronic disease.

Due to the nature of the population group within CNAHS particular services may need to be delivered to meet the needs of specific patient populations requiring specialised care i.e. disability / chronic disease programs.

3.6 Single Point of Referral

3.6.1 A single point of referral is required to assist with facilitating a seamless referral to Metro Home Link no matter where the referral is originated.

3.6.2 The single 1300550654 phone number will enable referrers to call 24 hours a day to refer patients to the Metro Home Link program.

3.7 Time Delivered

3.7.1 Services are to be short-term in nature and rapid in their response.

3.7.2 Some patients will receive care in shorter time periods but there are also patients who may require longer care or higher intensity care. Therefore the service must provide flexibility in length and needs of service (i.e. a package of care may be required to be delivered over a 14 day period.) However this service is not a long-term care service and it is expected that the majority of packages will not exceed 7 days of service.

3.7.3 Metro Home Link will be required to acknowledge all referrals to the program within one hour of receiving referral via fax or phone. Receipt of MHL acknowledgment confirms patient acceptance to the program.

3.7.4 The first patient contact will occur within two hours of patient separation. In the case of avoidance, the first patient contact will occur within two hours of acceptance of referral.

3.7.5 Service provision will commence within 24 hours of initial contact.

3.7.6 The majority of patients will receive a face-to-face assessment of their needs in their own home and where required to those patients who live in residential care accommodation. A medication review will be undertaken where a medication authority is completed with referral.

3.8 Care Planning

3.8.1 A short term care plan will be developed for each patient. The development of this care plan must involve, wherever possible, the patient and their caregiver(s) the medical practitioner and current case manager.

3.8.2 The care plan must be goal orientated as negotiated with patient / carer with optimal transition to ongoing services as required.

3.8.3 The care plan is monitored by the service provider and will be reviewed for change in patient conditions as appropriate.

3.8.4 A copy of the care plan will be provided to the patient and their nominated General Practitioner where appropriate.

3.8.5 On discharge from the service, the patient's General Practitioner and referrer will receive a summary of care delivered.

3.8.6 In the event a patient declines services the referrer will be informed.

3.9 Interface with Health Services

3.9.1 The service provider must develop appropriate interfaces with referral services (i.e. hospital emergency departments, hospital wards, general practices etc.) as well as with services that a patient may be required to transfer onto.

3.9.2 In consultation with Executive Director Service Development or Better Care Project Officer, flexible consideration may be required for each Health Service area.

3.9.3 Service improvements between the service provider and CNAHS Health sites is encouraged, however, all initiatives must be undertaken in consultation with the Executive Director Service Development or Better Care Project Officer.

3.9.4 Vulnerable Groups

A key principle of Metro Home Link services is that there will be no barriers. It is recognised that vulnerable groups may require responses to be developed and services tailored to the requirements of the following special target groups:

- Aboriginal and Torres Strait Islander
- People from rural and regional areas.
- Homeless people
- People with mental illness
- People with chronic disease
- People with disabilities

4 REFERRAL GUIDELINES

4.1 Referrals will be accepted from health care professionals from the following areas post-patient assessment:

- All Medical Practitioners
- General Practice
- Hospital Emergency Departments and ward areas
- Glenside Hospital and Community Mental Health teams
- Hospital at Home Programs
- Community services following consultation with patients General Practitioner
- Residential Care Facilities

Referrals can be made to the Contact Centre on **1300550654**, 7 days a week / 24 hours a day.

4.2 Patient Assessment

All patients must be assessed against the following criteria:

4.2.1 Without the provision of a MHL package of care, the patient is at immediate risk of emergency department presentation / hospital admission or delay in hospital separation.

4.2.2 Patient meets hospital avoidance / home supported discharge eligibility criteria.

4.3 Referral Process

4.3.1 Acute Care and Mental Health Services

Referral pathways within CNAHS hospitals, mental health services general practice and residential care areas are specific. Please see referral pathways attached.

4.3.2 Community Sector

Excluding mental health community services, all referrals generated from the community sector must be undertaken in consultation with the patient's General Practitioner or Practice Nurse. In line with the programs objectives, the General Practitioner is responsible for determining whether a MHL package of care substitutes for an emergency department presentation and or hospital admissions.

In the event the patient's General Practitioner is not available, consent for referral can be negotiated with the Practice Nurse or the Better Care Project Officer.

4.3.3 Residential Care Facilities

Similar to the acute care setting, referrals to the program can be made directly from all residential care facilities following a clinical patient assessment.

Packages of care to the residential care patients must reflect the need for advanced clinical and or technical professional care or support care that is outside the normal day to day capacity and scope of practice for “that” residential care facility both in frequency and intensity on a daily basis.

4.4 Contact Centre

The Contact Centre will act as the first point of contact in all but exceptional cases to:

- Answer general enquiries from health professionals
- Take enquiries and record referrals as required by the minimum dataset

4.4.1 Referrals can be made 24 hrs a day 7 days a week. Referrals can be made via the phone: 1300550654 or fax: 83724900

4.4.2 To assist program monitoring a minimum set of information is required to be collected by the contact centre on behalf of the region. It is the referrer’s responsibility to ensure this information is provided at the time of the referral. This minimum set includes mandatory fields that must be completed before a referral will be processed.

Patient information requirements are:

- name and home address (where patient is to receive treatment) **(mandatory field)**
- date of birth **(mandatory field)**
- diagnosis
- past history
- reason for referral **(mandatory field)**
- services required **(mandatory field)**
- if appropriate medical cover including Dr. name and contact details
- patient emergency contact
- current medications
- significant past history
- summary of presenting problem, (hospitalisation)
- hospital name
- hospital ur number **(mandatory field)**
- ward area **(mandatory field)**
- name of person making referral (including professional classification)
- contact number
- General Practitioner name and contact details
- Allergies
- Occupational Health Safety concerns
- Hospital discharge date **(mandatory field)**

