



Metro Home Link PLUS SOUTHERN REGION GUIDELINES

In addition to the standard 7 day Metro Home Link program a more resource intensive package is available from 10th April 2007 to cater for more complex patients or those requiring more convalescent time **who are 65 years and older or Aboriginal and Torres Strait Islanders 45 years and older.**

Metro Home Link PLUS is funded under the provision of the Commonwealth's Council of Australian Governments (COAG) Long Stay Older Patient Initiative in recognition that some groups of older patients may not fit existing post acute or transition program entry criteria and have long stays in hospital, or are discharged prematurely and are at high risk of representation and readmissions.

Metro Home Link PLUS is available for both earlier and safe **Discharge** referred from wards, and **Hospital Avoidance** referred from General Practice, hospital Emergency Departments, Residential Care Facility or Community Mental Health Services.

1. THE TYPES OF PACKAGES available

1. Restorative care package of care (longer time frame), or
2. High Acuity package of care (higher intensity resources)

These are both resource and time limited to approximately 2 to 4 weeks or an equivalent of 4 packages. It would be applied if a double standard MHL package would not assist.

2. PRINCIPLES OF PACKAGE APPLICATION - ADMISSION CRITERIA

- Packages should still meet the requirement of providing *immediate* substitution for hospitalisation, facilitate an early discharge, or reduce the immediate risk of readmission - current MHL eligibility criteria
- Evidence a single or double package of standard MHL package care does not meet patient needs and or achieve required outcome
- Patients should not be immediately eligible for any other available hospital discharge or avoidance services.
- MHL PLUS is one part of longer term plans that should be in place for any client. It is not a substitute for discharge planning.
- The *normal package funding* is applied and care is not expected to exceed approximately 4 weeks or equivalent of 4 packages.

3. WHICH SERVICE SHOULD I CHOOSE? Patient Identification

- **MHL standard** - this is still the short term, rapid, flexibly responsive service which assists the person requiring post acute care generally for up to 7 days
- **MHL PLUS** – 65 years old for medium to higher intensity nursing and restorative care or therapies to regain a patient's level of functioning and independence. It may involve input everyday and GPs may be actively involved in the MHL PLUS period of approximately 4 weeks service provision.
- **ACH Health & Nursing Services (HNS) Short Term Packages** – longer term post acute care for about 3-5 hours support per week (low level) up to 12 weeks; restorative model; personal care /domestic / equipment./ nursing/ linking to ongoing services 1300 300 811 Fax 83573255
- **Hospital at Home** – where hospital medical supervision and acute intensity nursing services are required.

4. REFERRAL for MHL PLUS is through the Metro Home Link Coordination Centre on 1300 550 654 or fax the referral on 83724888 **AS PER BELOW CHART.** Key staff in each of the 3 southern hospitals will have knowledge of this service

5. WHAT KINDS OF SERVICES CAN MHL PLUS PROVIDE?

1 RESTORATIVE CARE PACKAGE OF CARE (LONGER TERM)

Has active engagement of the GP

Package of care focused on regaining a patient's level of functioning and independence through the provision of low intensity therapies, personal care and transitioning of the patient to longer term community support services where needed.

Flexible in type of service delivery but is resource and time limited to approximately **2 to 4 weeks or an equivalent of 2 to 4 packages.**

The types of services provided are

- Low to medium intensive professional therapy including occupational therapy, physiotherapy, speech therapy, social work, and pharmacy. eg post # NOF at Residential Care Facility or therapy intervention for restorative care/ functional decline or maintenance, at a lower level than goal oriented interdisciplinary rehabilitation.
- Domestic assistance eg shopping, food preparations, bill paying, and house cleaning.
- Personal care assistance
- Nursing interventions
- Supportive accommodation or respite care(residential or in home)
- Long term care linkages based on referrer discharge planning i.e. ACAT assessments / referrals to long term community support services.
- Longer term education eg colostomy management; Baxter pumps
- Convalescence
- An essential component of the care plan includes assessment of need for home medication management review and falls risk assessment, and
- prevention strategies such as:
 - referral to Primary Health Care services including Chronic Disease Community Program; GP Plus ; home falls assessment for entry onto southern falls prevention pathway

2. HIGH ACUITY PACKAGE OF CARE

Has active engagement of the GP

Package of care enables medium to higher intensity therapies or interventions to be delivered in the home and residential care setting to avoid lengthy admissions together with the active engagement of their GP.

There is increased flexibility in type of service but limited to approximately **2 to 4 weeks or, an equivalent of 2 to 4 packages.**

The types of services provided are:

- Medium intensity hospital type professional treatment including nursing, occupational therapy, physiotherapy or speech therapy. eg therapy intervention for restorative care/ functional decline, at a lower level than goal oriented interdisciplinary rehabilitation.
- Examples include blood transfusions, TDS antibiotic therapies, peritoneal dialysis education and intensive chest physiotherapy.
- Investigative therapies such as blood monitoring; building capacity for interventions such as ECG taking
- Domestic assistance i.e. shopping, food preparations, bill paying, and house cleaning.
- Personal care assistance
- Supportive accommodation
- Long term care linkages based on referrer discharge plans i.e. ACAT assessments / referrals to long term community support services.

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REFERRAL FLOW CHART

Call 1300 550 654
24hrs 7 days
for referrals & information
OR
Fax all documentation to: 8372 4888



MHL Referral
form required for
ALL CLIENTS
(unless referral is phoned)

Mental Health
Referral form
for Mental
Health clients

+

Medication
Authority if client
requires medication
to be administered
by a nurse

+

Anaphylaxis
Treatment Protocol
if client requires
IV Therapy or IV/IM
antibiotics



Central Case Coordination
Multidisciplinary team of experienced Case Coordinators,
including Occupational Therapists, Social Workers, &
Specialist RN's (*midwifery, paediatrics, acute care, mental
health and residential care*) will plan & manage the delivery
of individual patient care.



Care provision



- On completion of care patient is discharged & summary sent to referrer and GP
- Linkages to ongoing services are organised as required