Hospital in the Home- Community Aged Care

Initiative Type

Model of Care

Status

Deliver

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10 December 2023

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https://clinicalexcellence.qld.gov.au/improvement-exchange/hospital-home-community-aged-care

Summary

Frail Older persons are considered a vulnerable population; this vulnerability only increases in the COVID-19 environment. A model of care that provides the right care, while removing the need for this cohort having to attend an emergency department and/or be admitted to the inpatient setting was implemented. This resulted in minimising the risk of incidental exposure to COVID-19 while maintaining care provision. Toowoomba Hospital had an existing Residential Aged Care Support

Service (RaSS) and Geriatric Emergency Department Intervention (GEDI), model in place but had nothing to cater for the community dwelling frail older person in their home. Implementation of a Hospital in the Home- Community Aged Care (HITH-CAC) model targeted at the community dwelling frail older person was stood up within two weeks of receival of funding pertaining to the COVID-19 pandemic crisis. This provided a 360 degree wrap around for the frail older person aiming for a comprehensive hospital avoidance model across all sectors. Governance is provided by the GEDI geriatrician allowing for a robust patient pathway from the Emergency Department; guided by the GEDI staff to an admission onto HITH-CAC and/or short admission in the purpose renovated Acute Aged Care Unit (AACU). The AACU is situated outside the Emergency Department (ED) and can accommodate the frail older person, fast tracked through ED into a de-stimulated environment to be worked up by the HITH-CAC team and supported back into the community with the necessary supports.

Key dates

Mar 2020

Dec 2021

Implementation sites

Toowoomba Hospita

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Aim

The focus and aim of this project was to provide a Hospital in the Home service to frail older persons requiring acute, rehabilitation or gems type care within their home. This was intended to prevent unnecessary presentations and/or avoid unnecessary admission to the inpatient sector while reducing RSI for general medical inpatient teams. Intended results of implementation of this model of care provision in the patient's home were to expedite suitable patients out of the inpatient hospital setting; avoiding known risks a hospital setting poses to the Frail Older person's Hospital Acquired Complications (HAC), which are often more prevalent in the frail older population.

Benefits

The perceived benefits of segregating this patient cohort include decreased risk of transmission of communicable diseases and hospital acquired complications, targeted person-centred care delivered by a geriatrician relating to this specific cohort (frail Older Persons), requirements and dedicated resources focused on older person's care, reduction in social isolation and loneliness related issues, reduction in Emergency Department presentations and avoidance of unnecessary hospital admissions.

Background

The COVID-19 pandemic has created many needs among the community based frail older people in rural areas.

Solutions Implemented

Rapid implementation of the HITH - CAC model was required to meet the care needs of community based frail older persons at a time of crisis under a pandemic situation- COVID-19. Within 2 weeks this service was stood up and had 12 patients admitted which soon escalated to a constant of 15-18 patients. Holistic care is provided to both acute and restorative GEMs type sub-acute patients in their home by an interdisciplinary team of staff, inclusive of allied health, medical, nursing and pharmacy. The assessment unit - ACCU provides care to patients streamed from ED or community primary practice for workup and disposition determination, to determine best plan of care for hospital avoidance. Patients can also be referred directly from general practitioners or inpatient wards for consideration of inclusion onto HITH-CAC. Treatment can be provided to patients currently receiving

care under the HITH-CAC model, eligible for RaSS intervention or presenting to a rapid access appointment who require clinical procedures/ interventions e.g. iron infusions, ascites tap, blood transfusion and lumbar punctures.

Evaluation and Results

Evaluation of the model is ongoing with submission of a ethics waiver completed in May 2021 to review average length of stay on HITH-CAC, separations by month, average virtual bed occupancy, expenditure estimate, Gen med ALOS, Admissions direct from ED, representation rates, indication of frailty, consumer survey feedback, improvement to FIM score for virtually admitted under snap REHAB/GEM patient. Preliminary results indicate:

- shorter length of stay for specific sub-acute care types compared to traditional care - Average HITH-CAC Length of Stay is 4.7 days
- increased consumer confidence and satisfaction- Fantastic Consumer feedback received
- increased provision of care on HITH Services - in 9 months the HITH CAC had 640 Weighted Activity Units.
- demonstrated ability to increase and sustain bed occupancy numbers during a rapid implementation phase and beyond- Occupancy for HITH-CAC has been at 80-% or above since inception
- reduced incidence of hospital acquired complications and acute hospital readmissions

Lessons Learnt

Agility is key when rapidly implementing a new model of care in a changing environment. Creation of policy and procedure to ensure safe and effective care is an imperative part of service commencement. Historical timeframes and red tape for consultation and approval of policies and procedures were able to be reduced in light of the pandemic environment, which demonstrated some lags in the previous system. Patients are willing to receive care in the home environment, providing adequate support systems are in place for escalation of concerns.

References

Outcomes from similar models implemented by Queen Elizabeth II Hospital, Gold Coast Hospital and National Health Service (NHS) UK

PDF saved 22/12/2024