Expanding HITH Services

Metro North Health Service

Presenter: Bridgette Chapman

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Please email a copy to: kate.tynan@healthroundtable.org

Key Problem

- Metro North Hospital and Health Service (Metro North) – Hospital in the Home has capacity to increase activity and improve utilisation.
- The acute hospital facilities throughout Metro North experience ongoing bed pressures and patient flow challenges.
- Some patient cohorts have the potential to have poorer outcomes secondary to being managed in the hospital setting rather than in their own homes.
- There are a number of patient cohorts that may be suitable for HITH that haven't yet been identified as appropriate.
- Traditional barriers to HITH still exist: lack of marketing, reduced confidence in non-traditional healthcare provision, governance issues

Why it's important to be seen as Metro North

- Metro North HHS covers an area of 4,154 square kilometres and represents approximately 20 per cent of the Queensland population.
- The MNHHS resident population is projected to increase by 28 per cent or approximately 250,000 people by 2026.
- Greatest change projected in northern region of the district (North Lakes and Caboolture).
- Recognition that all MNHHS acute facilities face similar performance pressures and patient flow challenges and would benefit from improved HITH utilisation.
- Whilst one size doesn't fit all, similar models of care are likely to be successful in increasing HITH utilisation when implemented across acute facilities.
- Integration of skills and experience of clinicians from across the district facilitates innovation and will provide the most robust and sustainable HITH models of care for the future.

Aim of this innovation

- To identify patient cohorts that would have good outcomes by being transferred into HITH for some, if not all, of their acute episode of care.
- To prepare the service appropriately for proposed service expansion ensuring robust structures are in place to be cohort ready for sustainable utilisation
- Current proposals include:
  - COPD pathway
  - GEM (Falls) HITH
  - RITH (Rehab in the Home)
  - ED early identification and transfer

Baseline Data

- Current activity for each model:
  - COPD pathway = 1.8% of COPD patients in Caboolture Hospital
  - GEM (Falls) HITH = N/A – data suggests 30 patients/month would be eligible
  - RITH (Rehab) = 10 patients since January
  - ED early identification and transfer = 24 for trial month at TPCH

- Projected increase in activity for each model:
  - COPD pathway = 25% of COPD patients in Caboolture Hospital
  - GEM (Falls) HITH = 360+ patients/year
  - RITH (Rehab) = 120+ patients/year
  - ED early identification and transfer = 288+ patients/year

Key Changes Proposed

COPD model of care - CBH and TPCH

Primary objectives of the project:

- Help reverse current rates of preventable hospital admission, readmissions and representations by optimising utilisation of HITH.
- Increase HITH admissions from Caboolture and The Prince Charles Hospital ED from 1.8% to 20% of COPD patients.
- Reduce the 28 day representation and readmission rates at Caboolture Hospital for COPD admissions
- Improve management of COPD in the community by linking with PHN, encouraging self management and implementing COPD action plans.

RITH (Rehab in the Home) - RDH

Primary objectives of the project:

- To provide intensive, goal orientated rehabilitation (nursing and allied health) in the home environment over a 2 week period.
- Ensure smooth transition/ re-establishment from hospital to home under the guidance of the rehabilitation team.

Key Changes Proposed

ED early identification and transfer – TPCH

Primary objectives of the project:

- Rapid transfer to HITH following ED presentation
- Reduce National Emergency Access Targets (NEAT)
- Improve patient flow and reduce acute facility bed pressure
- Increase HITH utilisation
- Manage patient in the most appropriate environment

GEM (Falls) HITH – TPCH and RBWH

Primary objectives of the project:

- To provide home-based allied health and nursing (incl. pharmacy) assessment and management of recurrent or high risk fallers presenting to ED under the guidance of a geriatrician for a 2 week period
- Reduce fall related ED presentations, injuries, readmissions and hospital bed days
- Improve functional outcomes and quality of life of frequent and high risk fallers
- Enable streamlined, multifaceted onwards referrals and liaison with PHN

Outcomes so far

- Integration of the Metro North teams – acute facilities and community working as a cohesive team to develop and integrate patient-centred pathways within the health continuum.

- Identification and prioritisation of a number of potential patient cohorts to improve utilisation and progress HITH service expansion throughout the district.

- Recognition of the need to formulate robust structures to adequately plan for service expansion and ensure sustainability. The foundations have being laid for the progression of Metro North HITH into the future.