Guideline

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NSW Hospital in the Home (HITH) Guideline

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Corporate Administration - Information and data
Clinical/ Patient Services - Medical Treatment
Clinical/ Patient Services - Nursing and Midwifery
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Summary Hospital in the Home (HITH) services deliver selected types of patient-centred multidisciplinary acute care to suitable, consenting patients at their home or clinic setting as an alternative to inpatient (hospital) care. This guideline has been developed by clinicians to provide clear, standardised guidance to Local Health Districts and Specialty Networks regarding terminology, key elements and principles of HITH in NSW. They will also support Local Health Districts and Specialty Health Networks to develop, evaluate and monitor HITH services to meet local needs.

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Applies to Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Public Health System Support Division, Public Health Units, Public Hospitals

Audience Nursing, Medical & Allied Health, Local Health Districts, Speciality Health Networks,Medicare Locals

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GUIDELINE SUMMARY

NSW HOSPITAL IN THE HOME (HITH) GUIDELINE

PURPOSE

In NSW, Hospital in the Home (HITH) is defined as the range of service delivery models providing (acute and post-acute) care that is delivered in home (including Residential Aged Care Facilities), clinic or other settings as a substitution or avoidance of hospital.

The *HITH Guidelines* have been developed by clinicians to provide clear, standardised guidance to Local Health Districts and Specialty Health Networks (LHD/SHN) regarding terminology, key elements and principles of HITH in NSW.

The need for the delivery of acute care in the home as an alternative to care in a hospital setting is being driven by advances in medicine, increased pressure on the healthcare system and evidence of improved health outcomes for patients who spend less time in hospital.

The guidelines reflect evidence based best clinical practice, expert consensus and opinion and although the guidelines are not mandatory, they have been endorsed by clinicians and NSW Ministry of Health with an expectation that the key principles will be utilised in standardising practice across NSW.

KEY PRINCIPLES

The guidelines underlying principles will support LHDs/SHNs to develop evaluate and monitor HITH services to meet local needs.

Underpinning these guidelines are the following key principles:

- keeping people healthy and out of hospital
- local and system level strategic planning for growth of HITH to meet acute bed demand
- mandatory reporting and data collection framework
- consistency of evaluation
- leveraging of funding streams including Activity Based Funding

USE OF THE GUIDELINE

Hospital in the Home (HITH) services have been developed to deliver selected types of patient-centred, multidisciplinary acute care to suitable, consenting patients at their home or clinic setting as an alternative to inpatient (hospital) care.

Where suitable, HITH services are made available to both children and adults with certain types of conditions, able to be treated outside of a hospital setting. HITH is proven to be as clinically effective as hospital care and delivers as good, if not better, health outcomes for patients in a familiar setting.

The *HITH Guidelines* will assist in guiding LHDs/SHNs in developing and establishing HITH services and details the requirements for the consistent implementation of data reporting for HITH services by Local Health Districts.

REVISION HISTORY

Version	Approved by	Amendment notes
1.0	Director General	

ATTACHMENTS

1. NSW Hospital in the Home Guideline (HITH)

Hospital in the Home

Guideline

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  Mr Allan Went, Ministry of Health
  Ms Nicole Whittaker, Ministry of Health
- Local Health District and Specialty Health Network staff
  – Hospital in the Home service managers and clinicians
  – Data managers
  – Executives and managers.

TWO

About this Document

Hospital in the Home services in NSW provide acute, subacute and post-acute care to children and adults residing outside hospital, as a substitution or prevention of in-hospital care.

This document has been developed to provide clear, standardised guidance to Local Health Districts and Specialty Health Network managers and clinicians on the definition of service models of Hospital in the Home in NSW.

This guideline will provide definitions relating to Hospital in the Home (HITH) and outlines key elements and principles of service delivery models in addition to the data collection and reporting rules to ensure that HITH activity is captured for performance monitoring and Activity Based Funding.

This guidance will also support Local Health Districts (LHDs) and Specialty Health Networks (SHNs) to develop, evaluate, and monitor HITH services that meet local needs.

Successful implementation of this Guideline will assist with:

- Assessment of existing service models
- Local and system level strategic planning for growth of HITH to meet acute bed demand
- Consistency of evaluation
- Leveraging of funding streams including Activity Based Funding (ABF)
- Negotiation with Private Health Funds
- Establishing NSW HITH at the national level to contribute to relevant national negotiations.

It is proposed that as statewide implementation and evaluation of the service model occurs, a process of continuous improvement will be used to maintain the currency of this document.

2.1.1 Responsibilities of Local Health Districts and Specialty Health Networks

LHDs and SHNs can contribute to the NSW HITH strategy for improved consistency, outcomes, performance, efficiency and capacity by:

- Assessing current capabilities, opportunities and barriers in relation to HITH services to meet local population needs
- Developing District/Network level governance for HITH that:
  - Integrates HITH as part of overall acute demand management strategy
  - Establishes appropriate clinical, non-clinical and community engagement
  - Defines and implements a strategic plan to increase HITH capacity at both service and District/Network levels that align with the NSW HITH Guideline
  - Is included in strategic planning collaborative initiatives with Medicare Locals to facilitate local HITH development
  - Is included in local Clinical Service Plan development
  - Seeks opportunity to engage in service relationships with General Practice, other LHDs/SHNs private service providers, where appropriate
  - Evaluates and acts locally to continuously ensure HITH consistency, best outcomes, performance and efficiency.

2.1.2 Responsibilities of the Ministry of Health

The Ministry of Health can contribute to the NSW HITH strategy for improved clinical outcomes, financial performance and human resource efficiency by:

- Setting clear standards through the NSW HITH Guideline
- Establishing policy and processes that facilitates implementation of LHD HITH strategic plans, including:
  - Aligning system strategy with resource allocation and purchasing and performance frameworks
  - Data guidelines and rules
  - Funding model for Activity Based Funding for HITH including incentives
  - Charging model for private, compensable and ineligible patients
  - Service Agreements to reflect the purchasing and performance requirements for local provision of HITH
  - Service Compacts with the pillar agencies to support service model implementation, clinical engagement, quality and safety advice, reporting, evaluating and access to information
  - Developing relationships with state level general practice organisations on strategies to facilitate general practitioner involvement in HITH programs.

2.1.3 Responsibilities of the Agency for Clinical Innovation

The Agency for Clinical Innovation can contribute to the NSW HITH strategy for improved consistency, outcomes, performance and efficiency by:

- Establishing strong clinical engagement, innovation, implementation and evaluation networks with and between LHDs/SHNs at multiple organisational levels
- Establishing strong relationships with the Ministry of Health that facilitate aligning strategic, resource, purchasing and performance opportunities with demonstrated system priorities
- Seeking opportunity to integrate the NSW HITH Guideline service model strategically into the broader out of hospital landscape.

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Key Points – For Local Implementation

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Background

Hospital in the Home delivers equivalent or better outcomes, at better value compared with inpatient care for specific patient groups[1]

NSW Health aims to provide the people of NSW with the best possible healthcare. Hospital in the Home is a key strategy for achieving best patient outcomes as well as meeting critical goals and targets, including:

- NSW 2021[2] Goal 11 – Keeping people healthy and out of hospital
- Service Agreements between the Director General, NSW Ministry of Health and Local Health Districts/ Specialty Health Networks
- National Emergency Access Targets
- Activity Based Funding.

The NSW Ministry of Health is committed to a strategic and evidence based approach to managing the increasing demand[3] on hospital beds.

Evidence shows that both people and the health system benefit from access to acute care in alternate settings to inpatient care. These benefits include improved outcomes in clinical markers such as reduced levels of confusion and delirium in people who are cared for at home[4], high levels of acceptance of these models by General Practice[5] with no increase in carer burden[6]. Using Hospital in the Home when appropriate enables health teams and hospital beds to be managed more efficiently and effectively[7,8].

In a recent extensive meta-analysis of randomised controlled trials comparing HITH and in-hospital care, Caplan et al[9] showed unequivocally that HITH is safer and more efficient. The study analysed health outcomes, costs and patient and carer satisfaction, showing:

- A 19% reduction in mortality
- For every 50 patients treated in HITH, one life will be saved
- A 23% reduction in readmission to hospital
- HITH costs 26.5% less than in-hospital care
- High patient and carer satisfaction.

Patients and Carers

- ✔ Preferred by patients
- ✔ Able to recover in the comfort of own home
- ✔ Reduced risk of adverse events in hospital such as falls and infections
- ✔ Individualised care
- ✔ Patients and carers report high satisfaction with service
- ✔ Children feel less threatened in own environment/ greater parental role in care promotes family centred care principles.

Hospital

- ✔ More efficient use of hospital beds for acutely ill patients
- ✔ Improved Emergency Access Performance
- ✔ Reduced length of stay in hospital
- ✔ Reduced adverse events from hospital admission
- ✔ Increased staff satisfaction
- ✔ Better value
- ✔ Opportunity to leverage Activity Based Funding.

General Practice (GP)

- ✔ Improved, co-ordinated interaction with a specialised hospital service
- ✔ Appropriate care for patients in the comfort of their own home
- ✔ GPs manage patients in their own environment.

There are 67 services in NSW providing Hospital in the Home care. These operate under a variety of names and have developed heterogeneously, in response to identified local needs and as a consequence have a variety of operational systems.

Hospital in the Home services in NSW – August 2013

In 2011/12 there were over 18,000 admissions to HITH in NSW[10] which represents 2.0% of overnight separations in public hospitals[10]. By increasing admissions to Hospital in the Home to the published Victorian rate of 5.4%[11], NSW could release a potential annual efficiency of $33M.

Significant inequity in the uptake of HITH for targeted diagnostic related groups (DRG) also exists across NSW. For example, deep vein thrombosis (F63B) has the highest admission rate to HITH, with an average of 61% across the state.

However admission rates range greatly from 25-93% across different facilities. Cellulitis (J64B) admission rates range from 1-34%.

There is a clear opportunity to reduce unwarranted variation and increase the overall uptake through aligning HITH capacity to meet the needs of the people of NSW.

Hospital in the Home Program

A Hospital in the Home Program Working Group of Local Health District, Specialty Health Networks and General Practice experts was established in June 2011 to build capacity in Hospital in the Home for the sustainable provision of safe, effective and person-centred acute care in settings other than an inpatient bed.

The NSW HITH Program Working Groups' objectives are:

1. NSW HITH services have consistent, measurable and clearly defined service delivery models
2. NSW Local Health Districts have a clearly defined strategy to increase their HITH capacity to meet the needs of specific target patient groups and their broader community.

HITH capacity will not be increased in isolation of other programs and sectors, but will seek coordination and integration of out of hospital care that responds to patients needs, changing technology, best practice and the evolving collaboration with Medicare Locals.

The success of HITH depends on sponsorship* and strategic system planning from senior levels of LHD and SHN management, particularly in the early stages of program development. A strategic approach to HITH will reduce duplication or inequity of services within a district.

* See Key Definitions on page 26.

4.1 What is Hospital in the Home?

In NSW, Hospital in the Home refers to clinical services that have been established by LHDs/SHNs, ideally in collaboration with Medicare Locals and General Practice services to both substitute immediate and prevent future admission to inpatient hospital beds.

4.1.1 Definition

Hospital in the Home (HITH) services provide acute†, subacute‡ and post-acute§ care to children and adults residing outside hospital, as a **substitution** or **prevention** of in-hospital care. The place of residence may be permanent or temporary.

Substitution – The defining feature is that if the patient is not receiving the HITH service, the patient would require hospitalisation or a longer stay in hospital.

Prevention – Care that does not immediately substitute for a hospital stay, however it is provided as a preventative option to avoid an imminent hospital admission or readmission.

A person may receive their care at home (including Residential Aged Care Facilities) or in an ambulatory setting that may include a hospital, community clinic setting, school or workplace.

HITH care is short-term and preferably interdisciplinary, including doctors, nurses and allied health practitioners.

Hospital in the Home services must provide acute / subacute care substitution (Daily HITH – p.10). These services may provide additional preventative care (Intermittent HITH – p. 11) as an adjunct to maintain the short term continuum of care.

4.1.2 Patient Eligibility Criteria

These criteria must be satisfied to be eligible for Hospital in the Home:

- Presence of an acute, subacute or post-acute condition
- HITH service can safely provide the required patient care which meets evidence based guidelines
- Patients must be medically stable and not require high clinical support (multi-morbid patients with complex needs are eligible)
- Medical responsibility established and agreed based on HITH Principles
- Patient resides permanently or temporarily in catchment area
- Agreement of the patient or substitute decision maker¶ to receive HITH
- Adequacy of the home environment to provide the needs of daily living
- Safety of staff in the home is assured
- Access to a reliable mobile or landline telephone.

4.2 Hospital in the Home Principles

4.2.1 General

The following principles underpin the delivery of HITH care in NSW:

- **Person-centred**, continuing, comprehensive and interdisciplinary care
- Ease of **access** to the service by those who need it
- **Voluntary** patient participation
- **Cost neutral to patient** and carers - as a result of receiving HITH care, a Medicare eligible person should not incur costs in addition to those they would have if receiving care in hospital
- **Full involvement of patients** and carers through taking an active role in care planning and treatment, sharing responsibility for their own care with the HITH team
- **Time-limited** care with rapid response and transfer of care
- **24/7 Emergency Response** – processes for 24 hour, 7 day per week, emergency response
- High quality, safe care administered by appropriately skilled workforce.

† See Key Definitions on page 26.

‡ See Key Definitions on page 26.

§ See Key Definitions on page 26.

¶ See Key Definitions on page 26.

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HITH Service Delivery Models

In NSW a range of HITH services are required to meet the needs of individuals and systems.

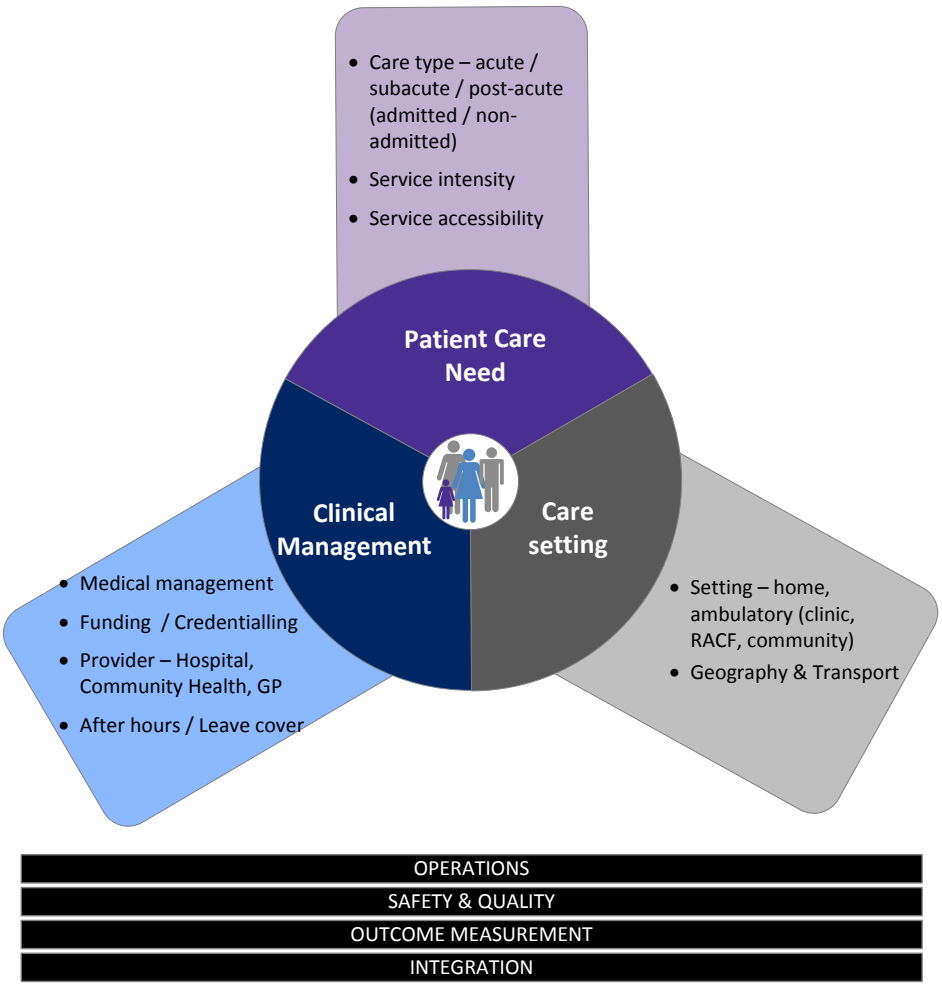
Mapping existing local HITH service models against the defining elements will assist LHDs/SHNs to understand and develop HITH services to meet both local patient and health service demand needs.

5.1 Overview

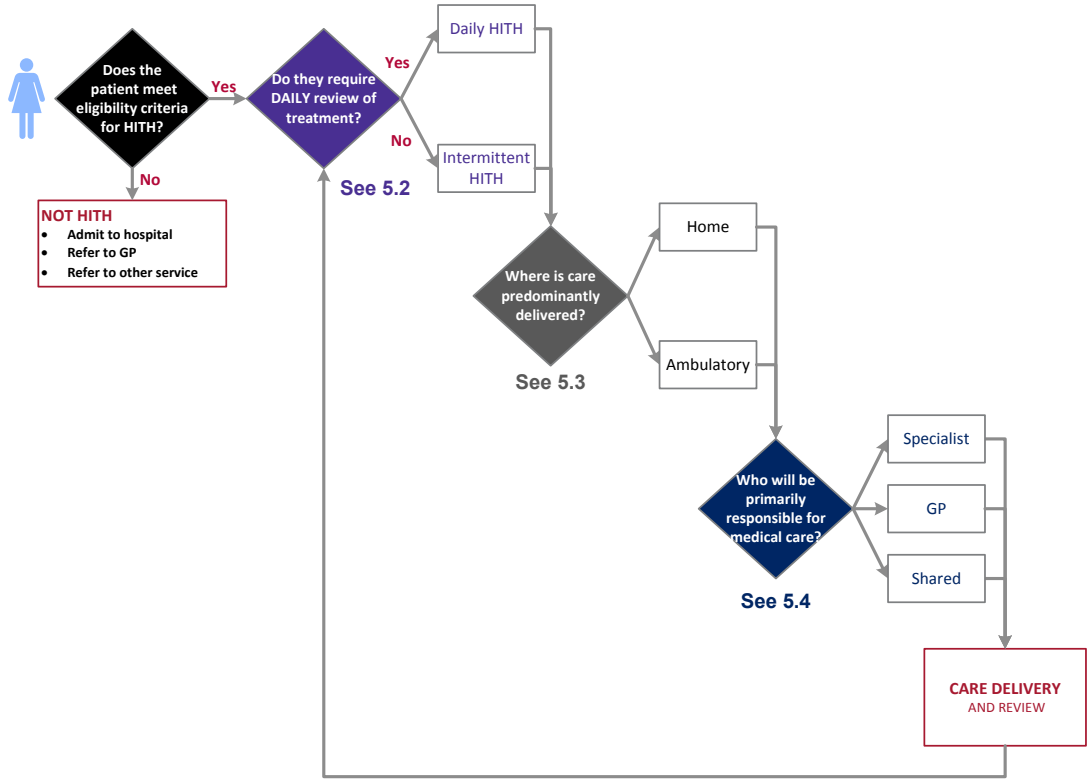
The approach to describing HITH service delivery models in NSW has been to firstly identify defining elements that differentiate one model from the others:

- Patient care need
- Clinical management
- Care setting.

Secondly, elements supporting operation and data processes have been identified that are consistent to all HITH models – operations, safety and quality, outcome measurement and integration.



The key elements define the decision points in delivering individualised HITH care.



The particular model(s) established across the state will depend on local need and resources. However, any chosen service delivery model will be consistent with these guidelines.

By clearly defining and classifying Hospital in the Home patients, LHDs/SHNs will be able to benchmark their HITH services with similar services and understand their HITH activity in relation to national and state activity targets.

5.2 Patient care need

The patient care need is the defining factor as to whether a person's entry to HITH is clinically equivalent to an admission or not.

5.2.1 Description

Patient care need is the acuity and intensity of care required by an individual.

5.2.2 Context

Care need is determined through comprehensive clinical assessment, agreed by the medical officer responsible and reviewed regularly. Care will be delivered according to individual need with respect to their safety and that of the care delivery team. The NSW Admission Policy[12] defines the criteria for an admitted patient based on definitions of intended medical care and intended procedure. Intensity and acuity of need will change, and service delivery should reflect this.

5.2.3 Categories

Daily HITH

An individual requiring at least daily clinical care and assessment of their treatment needs will be classified as clinically equivalent to an admitted** patient.

Daily HITH **substitutes** for inpatient care and may include acute and rehabilitation care types. Access to medical care must be available 24 hours per day, in the home or other setting.

** See Key Definitions on page 26.

Assessment of treatment needs is performed by an experienced clinician and may be done face-to-face or as a combination of face-to-face and telephone assessment. Telephone assessment must be documented in the medical record and a documented escalation process must be established for each individual.

Intermittent HITH

An individual with predominantly post-acute care needs who requires less than daily clinical assessment of their treatment needs to prevent admission or return to hospital will be classified as non-admitted. Intermittent HITH is delivered in order to **prevent** an imminent hospitalisation or a readmission. It is clinically equivalent to non-admitted care.

Key points to remember

- Patient care need for HITH is categorised as Daily or Intermittent
- Daily HITH data will be collected in the Patient Administration System / Admitted patient data collection
- Intermittent HITH Data will be collected in the Non-Admitted Patient data collection
- Data processes must capture the transition of a patient's care need between Daily and Intermittent HITH.

5.3 Care Setting

Differentiating the various care settings recognises that the best location to deliver optimal care may depend on the patient need and local service options.

Hospital in the Home services and LHDs/SHNs will note that there are different costs required to deliver care in different locations.

5.3.1 Description

Care setting is the predominant place where the care is delivered.

5.3.2 Context

For all service delivery models of HITH, the patient resides outside of the hospital.

An individual may receive care in a number of settings during the same episode of care. The predominant setting is used for categorisation purposes to improve outcome measurement and benchmarking and to facilitate Activity Based Funding.

Due to the complexities of people's lives a variety of settings should be available. This permits patient choice and allows for a degree of patient empowerment.

5.3.3 Categories

Home

Care is delivered in the individual's place of residence. This may include a Residential Aged Care Facility or supported accommodation in the community.

Ambulatory Setting

Care is delivered in a hospital clinic, community health or primary care centre or other community setting such as a school or workplace.

Where care is delivered in a school or workplace, the organisation must also consent to the individual receiving care in that location.

Key point to remember

- A variety of care settings are available to align with local need and resources.

5.4 Clinical Management

The various models of clinical management have evolved to provide greater access to HITH. This variety does not change the care received by the patient but results in different costing, funding and data implications for LHDs/SHNs.

Opportunities to integrate clinical management between LHDs/SHNs and General Practice will be dependent on local circumstances, particularly with the evolution of Medicare Locals.

5.4.1 Description

Clinical management is primarily defined by the medical officer who is managing the episode of HITH care.

5.4.2 Context

HITH services require organisational and clinical governance systems that take into account patient acuity, clinical accountability and delivery of quality outcomes.

While clinical management is ultimately about patient care, it is important to note that in developing HITH services, different clinical management models will have varying implications for funding options.

5.4.3 Categories

Medical Management

It must be clear to the patient, their carer and the patient's team who is responsible for medical supervision during the HITH episode of care.

Processes for 24/7 emergency medical response should be established locally, including cover for leave and after hours.

Specialist care

A staff specialist, VMO, locum medical officer or private specialist accepts medical management of the patient. A junior medical officer cannot take on this role.

General Practice (GP) care

A General Practitioner accepts medical management of the patient.

GPs without admitting rights cannot provide the medical supervision for Daily HITH patients where they are remunerated through Medicare. (See page 15 for further discussion)

Shared care

A medical management arrangement of a combination of Specialist and GP care is agreed.

Shared care can be defined as joint participation in the planned delivery of care of different specialist medical officers or a GP and a specialist medical officer[13]. This model is common in chronic disease management, mental health and antenatal care.

Essential elements are agreed:

- Clear practitioner responsibilities
- Procedures and protocols
- Resource allocations.

Interdisciplinary Care Delivery

Regardless of the medical management model in place, the HITH care delivery team can vary, with consequent implications for local resourcing. There is not strong evidence for a preferred structure.

Stand alone HITH team

The team is formed specifically for the purpose of delivering HITH care. In this model, the HITH service has its own medical, nursing, allied health and domiciliary care and support staff that are employed and resourced directly as the HITH team.

Such a model allows for an option where a HITH team may be resourced separately from an acute hospital, and services are entirely delivered by a primary/community care team.

HITH integrated team

The team is devolved with medical, nursing, allied health and domiciliary care and support staff employed by a mixture of hospital, community and primary care providers. This HITH team is coordinated and functions according to the individual needs of patients, without the need for dedicated HITH resourcing.

Such a model allows for flexibility to meet the demand needs of the system, so that more clinicians can be integrated into the team to meet high demand, or released back to their primary, acute and community teams as required.

In this model it is essential to ensure that there is no ambiguity as to the medical management of the patient.

Supervised Self-Administration

Supervised self-administration has been demonstrated to have equivalent outcomes to health care worker administration in selected patients receiving intravenous treatments[14,15]. The patient or their carer chooses the option of clinician supervised self-administration and is educated to administer therapy by the HITH team e.g. administration of home IV antibiotics.

The care is directed by a medical officer. The HITH team reviews the patient care daily (non-face-to-face), and has a minimum weekly face-to-face assessment of progress by the treating medical officer and HITH team. The patient and their carer are supported by 24 hour on call nursing and medical staff.

Paediatric Hospital in the Home

Currently, dedicated paediatric HITH services are situated in tertiary paediatric hospitals. Other paediatric services may also provide HITH care within the suite of care delivered.

The general principles of HITH relating to patient care need, care setting and medical management apply to services targeting children and young people.

Additional objectives from NSW Kids and Families[16] can be applied to the delivery of HITH services to children and young people:

- Equitable universal access to children's health services across the spectrum of care
- Children achieving their optimal health and developmental outcomes
- Adherence to the principles of patient centred care
- The ability of a child to enter the health system at any place and be given the right level of care in the most appropriate environment
- The system will respond to the child
- Safe services are provided as close to home as possible
- Parents have responsibility as primary carers for their children's health and need to be actively engaged in building the child and family's health and wellbeing.

Principles for Paediatric HITH

- The majority of paediatric patients eligible for HITH require short term acute treatment (these acute episodes may or may not be associated with longer-term conditions)
- Children with palliative care needs requiring episodes of acute care may also be eligible
- Specialist acute paediatric skills (medical, nursing & allied health) are required for the best outcomes for children and families receiving Hospital in the Home
- Clinical management of paediatric HITH will predominantly be through specialist care, i.e. General or Sub-Specialist Paediatricians (including neonatologists) who are appointed to hospital based acute service's
- Shared care models of care are often provided between local paediatric services and tertiary paediatric centres.

Key points to remember

- For each entry to HITH, medical management is agreed and documented
- Where a GP management model is used, local processes for funding a GPs activity are established
- It is not essential that a HITH team has its own dedicated clinician resources. It is possible to use an integrated model to flex capacity to meet the needs of patients as required.

5.5 Integration of HITH Service Delivery

A locally appropriate, district-wide approach to HITH service planning and delivery is recommended. This approach should clarify the service roles of related programs and seek integration of programs with primary and community care where possible.

Integration is concerned with the processes of bringing organisations and professionals together, with the aim of improving outcomes for patients and service users through the delivery of integrated care[17].

Integration ensures continuity, which is fundamental to high-quality care. Without it, care is unlikely to be clinically effective, safe, personalised, efficient or cost-effective[18].

Hospital in the Home most significantly interfaces with hospitals, General Practice, Primary and Community Care and Chronic Disease Management programs. Defining clear roles, responsibilities and opportunities to work collaboratively is essential to reducing clinical risk within siloed services and unnecessary duplication.

5.5.1 Integration with Acute Facilities

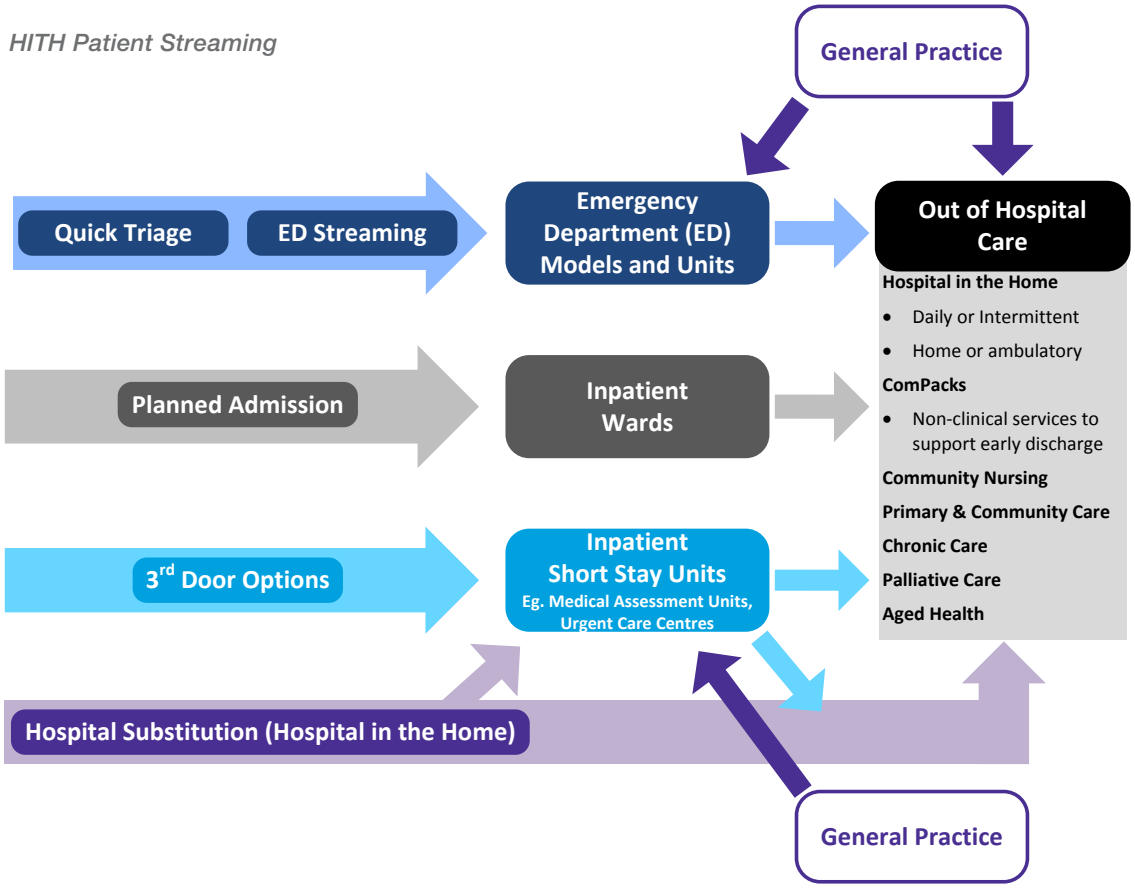
HITH provides acute care delivery through hospital substitution. In managing demand, HITH development should intersect with Emergency Department models of care, planned admission strategies and short stay (ED bypass/3rd door) options.

In addition, paediatric HITH teams may consider facilitating links with Neonatal Intensive Care Units, Specialist Children's Hospitals, Paediatric inpatient and specialist teams, Ambulatory Care, Medical Assessment Units and their Palliative Care, Social work and Psychology services.

5.5.2 Integration with General Practice

General Practice is the predominant provider of primary care in Australia delivering over 118 million patient consultations each year[19]. Integration with General Practice (GP) is essential for successful outcomes and capacity building for HITH services.

HITH Patient Streaming



In an environment of national and state health reform the relationship between LHDs, SHNs and GPs is changing, collaboration between Districts, Networks and Medicare Locals will be critical in the success of HITH development across NSW.

General Practice and HITH

HITH is delivered through a range of clinical management models that include General Practice. With differing practice size, workforce and capacity there is no single approach to integrating local HITH development within General Practice, however there are different local implications for each model.

GP ONLY	**GP only** (clinical management and care)
	GP (medical management) and **Practice Nurse / Residential Aged Care Facility (RACF) nurse** (clinical care)
GP AND LHD	**GP** (medical management) and **LHD Specialist/ nursing / allied health** (clinical care)
LHD ONLY	**Specialist** (medical management) and **LHD nursing / allied health** (clinical care)

In considering options for GP integration with HITH programs, there are barriers and incentives for developing HITH services in partnership with General Practice these include:

INCENTIVES	BARRIERS
■ Preferred by patients ■ Maintains continuum of care ■ Broadened scope of practice ■ Potential financial incentive for GP ■ Direct access to medical specialist review as required ■ Opportunities for GPs and practice team to access education related to key conditions ■ Access to common clinical guidelines and other decision support resources ■ Access to state funded additional team members	■ Lack of GP capacity to take on additional workload and responsibility ■ Unclear processes for remunerating GPs to manage admitted patients ■ History of difficult GP – LHD relationships ■ Practice nurse availability ■ Requires ongoing education and evidence base ■ Funding of consumables ■ Real time access by GP to secure messaging medical records, test results ■ Integration and connectivity between GP and LHD IT systems ■ Adequate levels of support and access for GPs

Remuneration of GPs in HITH

Inclusion of GPs in clinical governance models for HITH requires clear interdisciplinary and organisational agreements, transparent remuneration strategies and shared decision support tools. The appropriate model should be decided locally, considering the implications for each option.

GP management of non-admitted patients is funded by Medicare. Without admitting rights, a GP cannot claim the Medicare rebate for reviewing Medicare eligible HITH patients.

Options for remunerating GP management of admitted patients are:

GP OPTION	IMPLICATIONS
1. Provide GP with admission rights to HITH services	■ Enables direct admission to HITH, bypassing ED with clinical management remaining with GP ■ Medications / disposables funded by LHD ■ Credentialing issues – Requires local Medical and Dental Advisory Committee approval – May need to consider Virtual Facility – Added resources required for a GPs 'admitting rights' arrangements – Consider accreditation options ■ Requires development of partnerships with community based pharmacists to stock participating doctors surgeries with the required medications
2. Brokerage with Medicare Locals / GPs	■ LHD purchases GP services – Brokerage through Medicare Locals – Contract for direct payment to GP ■ Avoids GP claiming Medicare for inpatient care ■ Medications / disposables funded by LHD

5.5.3 Integration with Medicare Locals

Medicare Locals are primary health care organisations established to coordinate primary health care delivery and tackle local health care needs and service gaps. They will drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities, including improving integration and accountability across the health system.

Medicare Locals will be accountable for meeting 5 strategic objectives[20]

- Improving the patient journey through developing integrated and coordinated services
- Provide support to clinicians and service providers to improve patient care
- Identification of the health needs of local areas and development of locally focused and responsive services
- Facilitation of the implementation and successful performance of primary health care initiatives and programs
- Be efficient and accountable with strong governance and effective management.

As Medicare Locals commence and develop, LHDs/SHNs will need to explore opportunities for reorienting and reconfiguring the way health care and services are provided across the hospital-community interface.

This will inevitably include exploring ways to reduce unnecessary preventable hospital admissions, which include HITH strategies.

Some suggested strategies[21] are:

- Establish a formal collaborative agreement which identifies shared priorities, agreed ways forward and specific responsibilities for each initiative
- Establish clinical governance processes which include feedback of clinical information to local levels to support local clinical quality improvement processes
- Establish open and effective communication mechanisms to routinely share information on local needs and availability of services
- Develop information resources that meet the needs of General Practice and the community
- Share knowledge and expertise when developing services
- Identify and mitigate barriers to General Practice participation in service delivery
- Joint workforce development strategies.

5.5.4 Integration with Chronic Care programs

More than half of all potentially preventable hospitalisations†† are from selected chronic conditions[22].

Effective collaboration between HITH services and chronic care programs is essential for effective exacerbation management through the delivery of acute care in the home as a substitute for hospital care. Shared care planning could include an exacerbation action plan specifying this preference for care.

See Appendix A for a model of Chronic Disease Management showing relationship to HITH.

5.5.5 Integration with Community Nursing

Community nursing includes both general community nurses undertaking home (domiciliary) visiting and specialists conducting services such as nurse-led clinics focusing on chronic disease, child health, women's health, palliative care and other specialties. Community nurses work with a population health focus in a variety of settings. They are involved in coordinating care in multidisciplinary environments[23].

Coordinated delivery of HITH within the Community Nursing service ensures the continuum of care is maintained, reduces duplication of service and takes advantage of existing skill and relationships within primary health care.

†† See Key Definitions on page 26.

SIX

Operations

The key operational elements of Hospital in the Home are common to all service delivery models.

6.1 Referral process

- Local referral processes should be made as simple as possible to promote HITH access and equity.
- Referral to HITH must be made as a result of a clinical decision.
- Local processes should be developed to accept referrals from:
  - Emergency Department
  - Outpatient clinics
  - Hospital wards and clinics, pre-admission and medical staff
  - General Practice
  - Specialists - private, community based, rooms
  - Medical Assessment Units or similar short stay units
  - Direct referral from external referrers to avoid inpatient admission
  - Private hospitals
  - Nursing homes, hostels and aged care facilities
- Case finding will facilitate a coordinated referral to HITH.

6.2 Service entry – developing an initial care plan

- Following referral, the HITH service should ensure patient agreement and registration processes are complete
- A local risk assessment process should occur at time of referral:
  - Clinical risk including a medication risk assessment
  - Physical environment of the home, associated access arrangements, parking and animals
  - Aggression risk from patient and/or others
  - Manual handling risks
  - Utilisation/effectiveness of communication devices in the home and surrounding areas (eg mobile phone coverage)
  - Drug and alcohol concerns, including smoking in the home
  - Non-clinical support required
- The patient and/or carer should be fully informed about the operational details of the HITH service, and provided with contact information
  - 24/7 emergency contact information and response processes are essential for the patient and carer to understand
- A two-way relationship should be established with the patient's GP, whether they are managing the HITH care or not, and other care providers as relevant
  - If the patient does not have a GP, the HITH team will work with the patient to identify one
- A comprehensive assessment of the patient, carer and their environment is necessary for an individualised care plan to be developed (see 6.3). The plan is made in conjunction with the patient, their carer and other service providers. The patient should be provided with a copy of the care plan, including:
  - Instructions on what measures to take should any complications arise and how to contact the on-call service
  - Medication management plan
  - Information on transport arrangements / options
  - Information regarding the service, pharmaceutical use, rights and responsibilities of patient, carer and staff
  - It may be necessary to translate this information for culturally and linguistically diverse patients and gain confirmation that the patient fully understands the information
- The patient and/or carer have the right to withdraw from the HITH service at any time, or if the HITH staff find that home based care is unsafe or ineffective. Intermittent HITH patients can be referred to alternative services.
  Daily HITH patients can be admitted/readmitted to the inpatient facility for the remainder of their episode of care. The medical officer, the patient's GP and other community-based services must be notified of the patient's change in care arrangements as soon as possible.

6.3 Care plan review processes

- A collaborative care plan is developed for each individual and reviewed regularly. The care plan should consider not just the medical and nursing care required but also the individual's social, functional, environment status, needs and advance care planning choices
- Patients and carers are partners in the care process and are encouraged to actively participate
- Planned medical review is required to ensure tailoring of the treatment plan to the patient's need
- HITH services will establish processes to ensure the recognition, response to and management of patients who are clinically deteriorating
  Patients and carers are supported through education and written information of the symptoms of deterioration and understand the actions required.
  Refer to PD2011_077 *Recognition and Management of Patients Who Are Clinically Deteriorating.*

6.4 Capacity and Workload Management

- HITH is part of whole of system planning to deliver patients the best care and manage acute demand.
  It is essential that Daily HITH services are facilitated to flow, by ensuring that substitution patients only occupy the service for as long as they clinically require
- The system requires HITH service planning strategies that can support a fluctuating workload including:
  - Early patient referral
  - Inclusion in patient flow management e.g. inclusion in Patient Flow Portal
  - Early notification of significant clinical events eg operating theatre closure, potential workforce shortages such as medical conferences.

6.5 Transfer of care

- The decision to cease HITH treatment is made by the team when the patient no longer requires acute or post-acute care as a substitution or prevention of in-hospital care
- HITH patients have the option of self-discharge, under the same process as from hospital
- HITH patients are referred to mainstream community-based services as soon as it is clinically and operationally feasible to do so
- The HITH patient's maintenance care and/or ongoing monitoring and review are identified, and a plan is developed prior to transfer of care including the clinician responsible
- On discharge patients and carers should be provided with:
  - Discharge referral information, medication management plan and follow up appointments for Specialists, GPs and other agencies
  - Community support contact information and referral made, where appropriate
- HITH patients should not be discharged from the service until clear processes are in place for ongoing care, if required
- When a patient completes a HITH episode, the treating General Practitioner receives a discharge summary from the HITH service
- A clearly defined pathway for patients to access a higher acuity service should be available for those patients who require access to hospital based care
  - Where it is necessary for a patient to return to hospital and finish their care as a hospital in patient, consideration should be made to access care via alternative routes rather than through the Emergency Department
- Clinical Handover occurs according to NSW Health policy directive PD2009_060 *Clinical Handover – Standardised Key Principles.*

Key point to remember

- HITH services will have systems in place, where clinically appropriate, to avoid a patient representing through Emergency Department

6.6 Eligibility for Community Packages (ComPacks)

- A ComPacks package is a **non clinical** case managed package of **community care** available for people being transferred home from a **participating** New South Wales Public Hospital
- Each package is available for up to 6 weeks from the time of the transfer home. There is no age limit
- Daily HITH (hospital **substitution**) patients may meet other referral criteria are eligible for ComPacks upon transfer of care to home. They do not have priority to ComPacks access

- For information regarding eligibility and referral processes, please contact your local LHDs/SHNs, ComPacks representative
- For general information please visit the ComPacks website at http://www.health.nsw.gov.au/compacks/Pages/default.aspx.

6.7 Eligibility for Commonwealth Transition Care Program

- Transition Care provides short-term care that seeks to optimise the functioning and independence of older people after a hospital stay. Transition Care is goal-oriented, time-limited and therapy-focussed. It provides older people with a package of services that includes low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support or personal care. It seeks to enable older people to return home after a hospital stay rather than enter residential care prematurely[24]
- Potential recipients must undergo an assessment by an Aged Care Assessment Team (ACAT) and each package is up to 12 weeks
- Because recipients can only enter the program directly on discharge from hospital, Intermittent HITH patients may be eligible for Transition Care. Since still classified as an inpatient, a daily HITH patient is not eligible for this service. For information on eligibility, please contact your local ACAT.

6.8 Information Management and Technology (IM&T)

- See section 7.3 for detail on HITH data collection and reporting
- Development and management of local IM&T systems must allow timely and accurate HITH documentation, data collection and reporting
  - The hospital medical record is maintained for the Daily HITH patient
  - Medical record documentation must comply with PD2005_004 *Medical Records in Hospitals and Community Care Centres*
- Opportunities for mobile technology and telehealth are encouraged.

6.9 Continuous Quality Improvement

- A significant feature of successful HITH services' is 'local solutions for local problems,' therefore any state-level quality evaluation and improvement should leverage off locally tailored continuous improvement processes
- It is recommended HITH services employ a broad range of strategies to assess service outcomes, and quality measures, which support evidence based practice approaches, such as:
  - Patient feedback surveys, and consumer participation in service planning
  - Peer review of services and clinical standards
  - Consistent performance and outcome data to inform planning and evaluation
  - Documented quality improvement plan
  - Best practice development and innovation and information sharing processes (literature reviews, guideline development, journal club)
  - Partnerships between metropolitan and rural services for mentorship and skill sharing,
  - Benchmarking, collaborative or multi-centred research into the efficiency and effectiveness of HITH in NSW is encouraged
- Clinical outcomes that should be monitored locally include:
  - Clinical standards
  - Readmission rate
  - Length of stay
  - Adverse events
  - Waiting times
  - Patient experience of care, and functional status
- In addition to the above quality improvement processes mandatory reporting should be monitored and evaluated
- Adverse event monitoring with Incident Information Management Systems and Severity Assessment Code (SAC) rating.
  Morbidity and mortality/quality review measurement and analysis PD2005_608 *Patient Safety and Clinical Quality.*

6.10 Health Reform, Costing and Funding

As part of Health reform in NSW, for the first time, Local Health Districts and clinicians have budgets that are transparent. Local managers, communities and clinicians now work together to ensure that the funding allocated is more directly linked to patient care.

Since July 1 2012 as part of funding reform, all Local Health Districts have been given budgets that set out clearly how their services are funded according to the levels of activity they need to undertake in their community (Activity Based Funding).

With the advent of National Activity Based Funding (ABF), there is an imperative to count, categorise and cost the significant admitted and non-admitted activity that occurs in NSW Hospital in the Home, to be able to capture that activity.

6.10.1 Activity Based Funding

The Independent Hospital Pricing Authority (IHPA) has determined that, from 1 July 2013, the scope of public hospital services eligible for Commonwealth funding will be:

- All admitted programs, including Hospital in the Home programs. Forensic mental health inpatient services are included as recorded in the 2010 Public Hospitals Establishment Collection
- All Emergency Department services
- Non-admitted services.

Non-admitted Services

The listing of in-scope non-admitted services is independent of the service setting in which they are provided (e.g. at a hospital, in the community, in a person's home). This means that in scope services can be provided on an outreach basis.

To be included as an in scope non-admitted service, the service must meet the definition of a 'service event' which is:

- An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record[26].

The introduction of ABF is a key component which aims to improve the standards of care, strengthen accountability and performance reporting and enhance efficiency and capacity of the public health system. In developing the funding policy the ministry has the following overarching policy objectives:

- Person Centred Care - promotion of systems and processes that focus on improving patient care and outcome independently of the setting and delivering services in a cost effective way
- Equity – fairness of funding across LHDs/SHNs and achievement of comparable access to health service by local population
- Coherency – consistency in objectives and outcomes across all funding policy approaches
- Balance – encourage a focus on and encourage an appropriate balance within outputs, outcome and quality
- Efficiency – use of resources in a way that maximises the production of services
- Clinical Engagement - encourage clinicians and managers to identify variations in cost and practices so that they can be managed to improve efficiency and effectiveness
- Create explicit relationship between budget and service provisions
- Consistency with the national funding developments such as the National ABF framework.

The objectives are measurable and will provide an important step in evaluating the effectiveness of the funding model at the end of each funding cycle.

In achieving the funding policy objectives included for HITH services, development of ABF in NSW is guided by the following criteria:

- Minimising perverse incentives – the model should minimise unintended incentives that conflict with the policy goals
- Stability - the model results should not wildly fluctuate from year to year and the model should remain flexible to evolve over time
- Simplicity and comprehensibility – the model structure should be as simple as possible and be able to be understood by stakeholders

- Validity – the model can withstand critical review and includes up to date data
- Transparency, objective and evidence based – any changes to the model should be clearly communicated and justified with sound rationale and evidence
- Administrative ease – the model should be simple to administer locally.

Implications

As a significant contributor to hospital resource management and sustainable access to health care, HITH services require realistic allocation of resources to enable them to function and grow.

- The major HITH expenditure is in human resources, equipment and where the patients are classified as inpatients, pharmacy. Consideration of funding streams for long-term or expensive drugs should be considered on an individualised basis
- Motor vehicles, with on-site parking and mobile phones are 'tools of trade', and must be available to staff at all times
- Equipment for loan to assist with activities of daily living must be available at all times, provision made for retrieval and cleaning of this equipment and workplace health and safety requirements addressed.

As a first stage in costing HITH, The NSW Ministry of Health engaged Health Policy Analysis to provide a costing and funding model for HITH. The subsequent recommendations have been considered and a plan for baseline and ongoing costing will be established to develop ABF methodology for HITH.

6.10.2 Chargeable Patients

- Currently, the only Financial Classes for HITH are for Public, Reciprocal Health Care Agreement and Department of Veterans Affairs (DVA)
- For Intermittent HITH patients, use non-admitted gazetted rates
- The NSW Ministry of Health negotiates and gazettes all chargeable rates
- Future HITH costing will inform state and national negotiations with the DVA and Private Health Funds to facilitate remuneration for chargeable patients from these sources.

6.10.3 Funding pharmaceuticals

- Pharmaceuticals are a major cost driver for HITH services
- For Daily HITH patients, as for other admitted patients, the Local Health District or Specialty Health Network is responsible for meeting the costs of pharmaceuticals. For these patients, high cost drugs and related equipment include intravenous therapy, compounded antibiotics and drug infusion pumps
- For Intermittent HITH patients, who are clinically equivalent to non-admitted patients, pharmaceuticals are funded through the Pharmaceutical Benefits Scheme
- Districts and Networks must have sufficient, dedicated drug budgets for HITH to ensure there is no additional cost to the patient for receiving hospital substitution care
- Processes for transparent acceptance of costs must also be established for cross district referrals and GP managed patients so that the patient is not disadvantaged due to their place of residence or medical management.

Key points to remember

- Develop locally appropriate referral processes that facilitate access ease and equity
- Risk screening occurs at the time of referral
- Collaborative care planning occurs between patient, carer, GP and HITH
- HITH services will have systems in place, including an afterhours procedure, to recognise and manage deteriorating patients
- HITH services will have systems in place, where clinically appropriate, to avoid representation through the Emergency Department
- Collaborative care plan review should occur between patient, carer, GP and HITH to tailor the treatment plan to patient needs
- HITH services will have systems in place for effective clinical handover at the transfer of care
- Information management systems must support coding, record management, data collection and reporting for HITH
- Develop quality, safety and professional improvement processes to share innovation and implement local solutions for local problems
- Daily HITH is eligible for Activity Based Funding at equivalency to inpatient care.

SEVEN

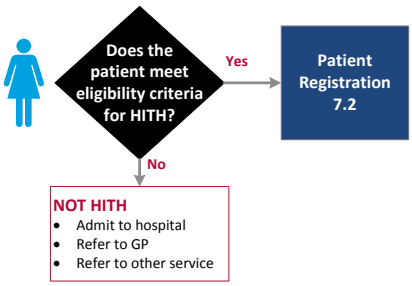
HITH Data Guidelines

With clear data collection and reporting guidelines for HITH, NSW will achieve greater transparency and consistency in classification, counting and costing of this type of care.

It will also enable better evaluation of the benefits and outcomes of this type of care.

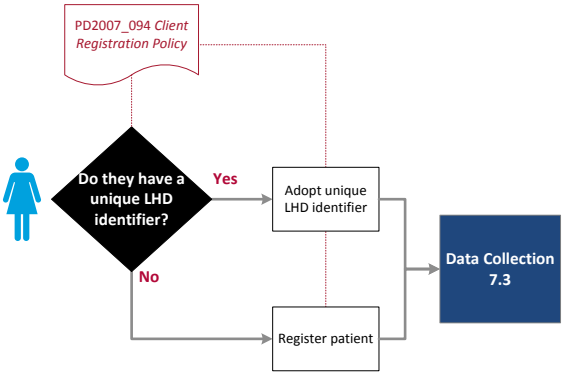
The process for HITH data collection and reporting is shown in **Appendix B**. These guidelines apply to all services providing HITH care, whether operationally under a hospital or community health line of management.

7.1 Patient Selection



The patient must meet the eligibility criteria for HITH (see page 8). If these criteria are not met, the patient will be admitted to a hospital bed or referred to other post-acute or primary care service according to their needs.

7.2 Patient Registration



Client registration is the process of identifying and collecting data on an individual and recording of that data within a Local Health District-wide client registration database for the purpose of uniquely identifying that individual.

The allocation of a Local Health District unique patient identifier, to be used as a unique key for that client/patient, is a product of this process.

The intent of client registration is to be able to link information held on a client/patient and thereby, support the delivery of services to that client/patient and the management and understanding of services and service needs.

Patient registration involves all of the following:

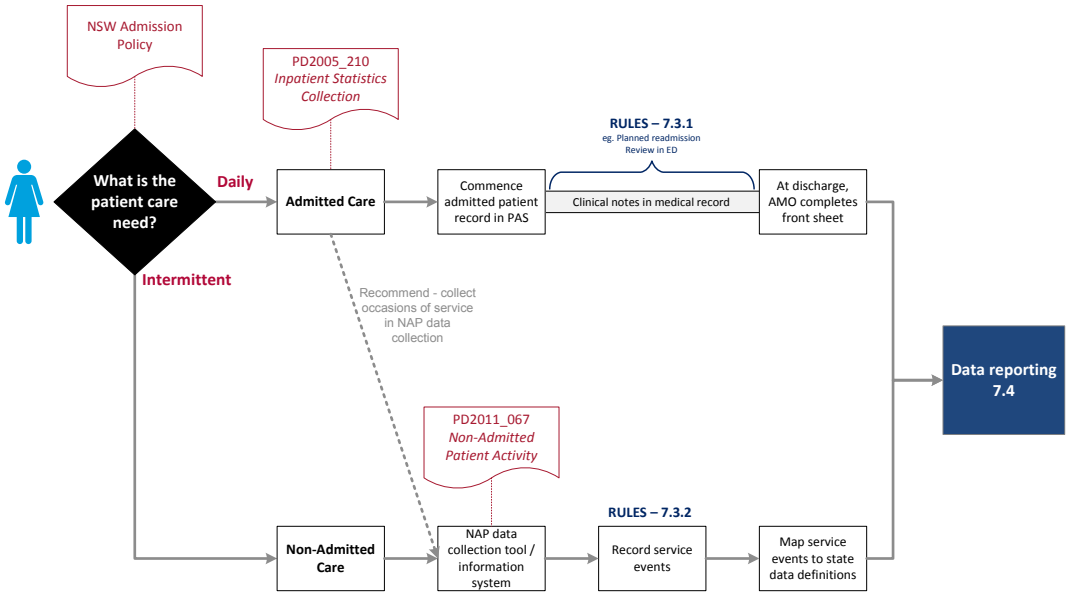
- **Gathering minimum standard information** about a client/patient of a health service to ensure that the client/patient is properly identified
- **Searching** the LHD-wide client registration database to determine if the client/patient has already been registered
- **Recording mandatory information** about the client/patient or **updating existing information** in the LHD-wide client registration database, and populating any other copies of this information with the updated information, ensuring that information held by the health service is correct and up-to-date
- **Allocating a Local Health District unique patient identifier** to new clients/patients.

Registration is for the purpose of providing health care to the client/patient or other related functions.

Key point to remember

- Each patient entering HITH care will be registered according to PD2007_094 Client Registration Policy

7.3 Hospital in the Home Data Collection



7.3.1 Daily HITH

- Daily HITH patients are admitted into the admitted Patient Administration System (PAS)
- Data is collected according to NSW Health Policy Directive PD2005_210 Inpatient Statistics Collection (ISC) – Public Facilities Separations Dated from 1 July 2001]
- Daily HITH patients are admitted to Bed Type 25 – Hospital in the Home – General.
- Care setting is not defined or collected in the NSW Admitted patient data collection so must be collected locally, in a HITH, community health or outpatient system.
  - Care setting includes home, RACF, Ambulatory care or combination.

Admitted Patient Data Collection Rules - HITH

- Acute and Rehabilitation as Service Category are valid
- Inpatient ward to Hospital in the Home Bed Type 25 – execute ward transfer
- Planned and Unplanned presentation of patients to Emergency Departments – use Type of Visit – "13 – Current Admitted Patient Presentation"
- Renal Dialysis patients – as for any other inpatient requiring renal dialysis.
- In the Non-Admitted patient data collection, Service type 224 Admitted Patient Service Contact - Hospital in the Home (Daily HITH) may be used for staff recording occasions of service for Daily HITH (admitted) patients, for example Allied Health staff – these occasions of service are excluded from non-admitted activity reporting.

Transfer to Non-Admitted care

The decision to end daily HITH treatment is made by the team when the patient does not require further involvement of hospital substitution services. Subsequent post acute care is transferred to outpatient clinics and or community health /services. Transfer involves clear communication and documentation of the patient and their care to the appropriate community health services, General Practitioner or Medical Specialist.

On transfer of care, activity reporting against Hospital in the Home Bed Type 25 will cease.

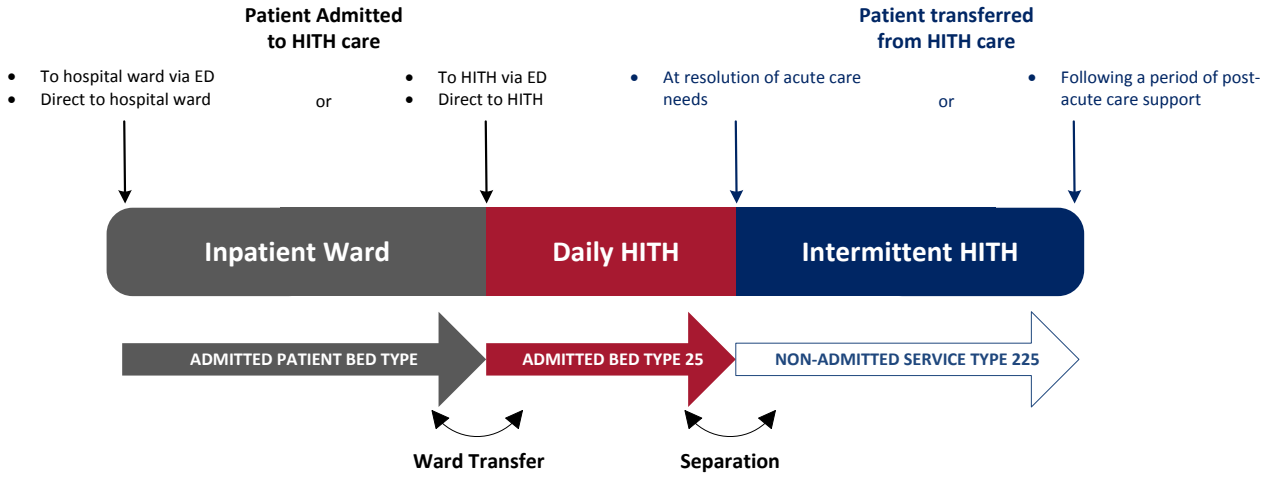
7.3.2 Intermittent HITH

- Intermittent HITH data will be collected according to PD2013_010 *Non-Admitted Patient Activity Reporting Requirements*
- If LHD has a community health or outpatient information system that allows the recording of each service event (interaction with patient) then:

Non-Admitted Patient Data Collection Rules – HITH

- Use Service type – *225 Hospital in the Home Intermittent – Non Admitted*
- Provider type is reported by individual provider. A combined visit to a single patient by multiple providers will be reported as a non-admitted occasion of service (NAPOOS) for each provider
- Planned and Unplanned presentation of patients to Emergency Departments – use *Type of Visit* – "04 – Outpatient Presentation"

7.3.3 HITH data collection summary



7.4 Hospital in the Home Data Reporting

The desired patient outcome is improved health and increased independence of people who can receive clinical care in their home and reducing preventable hospitalisations, therefore reducing demand on inpatient hospital services. The goal of reporting is to determine the number of patients receiving HITH care that would otherwise require inpatient treatment. This data will also inform costing of HITH services in the current ABF environment.

The requirement for reporting of HITH activity to NSW Ministry of Health does not require LHDs/SHNs to change the name of service teams.

Supporting definitions for the calculation of KPIs and Service Measures included in Schedule E of the 2013/14 Service Agreements have been published in the Ministry's "Health Information Resources Directory "(HIRD), located on the Ministry's Intranet, which is accessible to all LHD/SHN staff.

The HIRD is accessible through the Ministry's Intranet Site and can be found at: http://internal4.health.nsw.gov.au/hird/browse_data_resources.cfm?selinit=K

7.4.1 Hospital in the Home Activity – MANDATORY

This service measure is reported monthly in the Health System Performance report. Targets for admitted activity are defined for each LHD/SHN in Schedule D of the 2013/14 Service Agreement.

This measure aims to monitor the number of patients receiving acute and post-acute care in Hospital in the Home as a substitution and/or prevention of hospitalisation.

It is expected that there will be an increase in the number of people receiving HITH care and therefore reducing demand on inpatient care.

7.4.2 Avoidable Admissions for targeted conditions – MANDATORY

In NSW, Avoidable Admissions are a group of acute, low complexity Diagnostic Related Groups (DRGs) that can be safely and effectively managed in alternate settings to inpatient hospital care[27]. People with these Avoidable Admission DRGs are target populations for daily HITH, however **service delivery is not limited to just these diagnoses** – other Medical and Surgical DRGs may be appropriate for HITH.

This service measure is included in Schedule E of the 2013/14 Service Agreement. It aims to reduce hospital admissions for selected conditions.

It is expected that this will result in improved health and increased independence for people who can be kept well at home, while reducing unnecessary demand on hospital services.

7.4.3 HITH Outcomes - RECOMMENDED

To supplement the mandatory reporting requirements, these measures should be collected and monitored locally to evaluate service effectiveness and efficiency.

MEASURE	VALUE
DAILY HITH	
Length of Stay – ALOS in HITH – ALOS total	Days
Separations – Bed Type 25	Count
Bed Days – Bed Type 25	Count
Readmissions – Planned and Unplanned	% by type
Ward Utilisation – HITH only – ED and HITH – Ward and HITH – ED/Ward and HITH	% by type
Referral source	% by type
Age	Histogram
Sex	% M/F
Preferred Language	Count
Financial Class	% by type
Indigenous status	Count
Diagnosis	Count
INTERMITTENT HITH	
Length of Stay	Days
NAPOOS	Count by type
Referral source	% by type
Age	Histogram
Sex	% M/F
Preferred Language	Count
Financial Group	% by type
Indigenous status	Count

EIGHT

Key Definitions

Acute care

An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following[28]:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury,
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of illness or injury
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions
- perform diagnostic or therapeutic procedures.

Acute care is short-term and high intensity.

Admitted

A HITH patient would be admitted if, following a clinical decision on the necessary care and treatment, they meet one or more of the following admission criteria[29]:

Intended medical care

- The patient's condition requires clinical management and/or facilities not available in their usual residential environment
- The patient requires observation in order to be assessed or diagnosed
- The patient requires at least daily assessment of their treatment/medication needs.

Intended procedure

- The patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available.

Features of admitted HITH care include:

- Presence of an acute or subacute condition that would require hospitalisation or a longer hospital stay if HITH were not offered. In the absence of a hospital alternative program the patient would be admitted to an acute hospital bed or have a longer length of stay in acute care.
- Patients must be medically stable and not require high clinical support, patients with co-morbidities and complex needs can be included. A medical officer has determined that the patient can safely receive the appropriate level and type of services in a hospital alternative program;
- Access to acute level medical care is available 24 hours per day; the provision of medical care involves local arrangements made between medical specialists based in the ambulatory care setting and the General Practitioner. It will be clear to the patient, and to the patient's team who is responsible for patient's medical care during the HITH episode of care.
- Agreement of the patient/carer to receive a hospital alternative service.
- Adequacy of the home environment to provide the needs of daily living. The provision of these services is in the home and/or a component of this care may be provided as an outpatient or day clinic.

Interdisciplinary care

Interdisciplinary teamwork differs from multidisciplinary teamwork[30].

Multidisciplinary care is discipline oriented, with various professionals working in parallel, using different plans of care. Role definitions are clear and are managed under hierarchical lines of authority.

Interdisciplinary care involves regular collaborative meetings of all disciplines to discuss patient status and the evolving plan of care. It is characterised by shared decision-making and flexible leadership.

Non-Admitted

A HITH patient would be non-admitted if the HITH admission criteria are not met.

Person-centred care

Providing care that is respectful of and responsive to individual preferences, needs and values and ensuring that a person's values guide all clinical decisions[31].

Post-acute care

An episode of post-acute care for a person is one in which the principal clinical intent is prevention of deterioration in the functional and current health status of a patient following an acute illness or injury[32].

Post-acute care is short-term and lower intensity. It may require further complex assessment or stabilisation, and requires care over a time-limited period.

Potentially Preventable Hospitalisation

Potentially preventable hospitalisations (PPHs) are those conditions where hospitalisation is thought to be avoidable if timely and adequate non-hospital care had been provided.

The three broad categories of PPHs that are used in national reporting include *Vaccine-preventable, Acute and Chronic*. PPH categories can be sourced from the *Victorian ambulatory care sensitive conditions study*[33].

Subacute care

Subacute care means rehabilitation, palliative care, geriatric evaluation management, and psychogeriatric care as defined in the National Health Data Dictionary[32].

Sponsorship

Sponsorship is the single most important factor in ensuring fast and successful implementation[34].

Sponsors authorise, legitimise and demonstrate ownership for a change: possess sufficient organisational power and/or influence to either initiate resource commitment (*Authorising Sponsor*) or reinforce the change at the local level (*Reinforcing Sponsor*).

Substitute Decision Maker

A substitute decision[33] maker (SDM) is one made on behalf of an individual who lacks capacity to make their own decision. Substitute decision maker is a collective term for those appointed or identified by law to make substitute decisions on behalf of an individual whose decision-making capacity is impaired.

A SDM may be appointed by the individual (e.g. one or more Enduring Guardians appointed by the individual under statutory provisions), appointed for (on behalf of) the individual (e.g. a Guardian appointed by a Guardianship Tribunal), or identified as the default decision-maker by the NSW Guardianship Act (such as spouse, carer) as the 'Person Responsible'.

Person Responsible

The NSW Guardianship Act establishes who can give valid consent for medical treatment to an incompetent patient aged 16 years and over. Consent of the Person Responsible is required in relation to provision of minor and major medical treatment. The Act establishes a hierarchy for determination of who is the Person Responsible as follows:

- The patient's lawfully appointed guardian (including an enduring guardian) but only if the order or instrument appointing the guardian extends to medical treatment
- If there is no guardian, a spouse including a de facto spouse and same sex partner with whom the person has a close continuing relationship
- If there is no such person, a person who has the care of the patient (otherwise than for fee and reward)
- If there is no such person, a close friend or relative.

Also see Office of the Public Guardian Fact Sheet http://www.lawlink.nsw.gov.au/lawlink/opg/ll_opg.nsf/vwFiles/PR.pdf/$file/PR.pdf

NINE

References

1. Deloitte Access Economics (2011) *Economic analysis of Hospital in the Home* (HITH)

2. NSW Department of Premier and Cabinet (2011) *NSW 2021 – A plan to make NSW number one*, Sydney.

3. Commonwealth of Australia (2010) *Intergenerational Report 2010 Ageing Pressures and Spending*

4. Leff B, Burton L, Mader SL, Naughton B, Burl J, Inouye SK, Greenough WB, Guido S, Langston C, Frick KD, Steinwachs D and Burton JR (2005) Hospital at home: feasibility and outcomes of a program to provide hospital-level care at home for acutely ill older patients. *Annals of Internal Medicine*;143:798-808.

5. Lemelin J, Hogg WE, Dahrouge S, Armstrong CD, Martin CM, Zhang W, Dusseault J, Parsons-Nicota J, Saginur R and Viner G (2007) Patient, informal caregiver and care provider acceptance of a hospital in the home program in Ontario,Canada. BMC *Health Services Research*. 30 (7).

6. Leff B, Burton L, Mader SL, Naughton B, Burl J, Koehn D, Clark R, Greenough III WB, Guido S, Steinwachs D, Burton JR (2008) Comparison of Stress Experienced by Family Members of Patients Treated in Hospital at Home With That of Those Receiving Traditional Acute Hospital Care. *Journal of American Geriatric Society* 56(1):117-23

7. Caplan G (2006) Hospital in the home: a concept under question. *Medical Journal of Australia*:184(12) 599-600

8. DLA Phillips Fox (2010) Report on evaluation of Hospital in the Home Programs – Department of Health. Available at http://www.health.vic.gov.au

9. Caplan GA, Sulaiman NS, Mangin DA, Aimonino Ricauda N, Wilson AD and Barclay L (2012) A meta-analysis of "hospital in the home". *Medical Journal of Australia* 197(9):512-9

10. NSW Admitted Patient Data Collection

11. Cooper G (2011, November). *Binging it Home in Victoria? Everyone is a Winner*. Paper presented at the 4th Annual HITH Society Australia Scientific Conference 2011, Sydney

12. NSW Health (2012) Draft Admission Policy

13. Smith SM, Allwright S, O'Dowd T (2009) Effectiveness of shared care across the interface between primary and specialty care in chronic disease management. *Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD004910. DOI: 10.1002/14651858.CD004910.pub2

14. Dobson P, Loewenthal M, Orford N (2010) A comparison of nurse versus patient / carer administered home IV therapy. *1st World Congress on Vascular Access* (WOCOVA), Amsterdam, June 2010.

15. Matthews PC, Conlon CP, Berendt AR, Kayley J, Jeffries L, Atkins BL and Byren I (2007) Outpatient parenteral antimicrobial therapy (OPAT): is it safe for selected patients to self-administer at home? A retrospective analysis of a large cohort over 13 years. *Journal of Antimicrobial Chemotherapy* 60(2): 356-62

16. NSW Health (2012) *Future Government Arrangements for Children and Young People's Health Services in NSW*. Available at: http://www.health.nsw.gov.au/resources/nswkids/pdf/nsw_kids_expert_group_rep.pdf

17. The King's Fund (2011) Clinical and service integration: *The route to improved outcomes*. London: The King's Fund. Available at: http://www.kingsfund.org.uk/publications/clinical_and_service.html (accessed on 13 April 2012)

18. The King's Fund (2012). *Continuity of Care for Older Hospital Patients: A call for action*. London: The King's Fund. Available at: http://www.kingsfund.org.uk/publications/continuity_of_care.html (accessed on 11 April 2012).

19. GP NSW (2012) *A Guide to Understanding and Working with General Practice in NSW.* Sydney: GP NSW.

20. Department of Health and Ageing (2011). *Guidelines for the establishment and initial operation of Medicare Locals*. Canberra: DoHA.

21. GP NSW (2012) *Factsheet: Understanding and Working with NSW Medicare Locals*. Sydney: GP NSW.

22. AIHW 2011. *Australian hospital statistics* 2009-10. Health services series no. 40. Cat. no. HSE 107. Canberra: AIHW.

23. Owen A et al. (2008) *Community health: the evidence base. A report for the NSW Community Health Review*. Centre for Health Service Development, University of Wollongong

24. Commonwealth of Australia (2011) *Transition Care Program Guidelines*. Available at http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-transition-guidelines.htm

25. Cooper G (2011, November). *Bringing it Home in Victoria? Everyone is a Winner*. Paper presented at the 4th Annual HITH Society Australia Scientific Conference 2011, Sydney

26. The Pricing Framework for Australian Public Hospital Services 2013-14 http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/pricing-framework-public-hospitals-2013-14~04-in-scope-hospitalservices

27. NSW Avoidable Admission Strategy information available at http://www.archi.net.au/resources/performance/avoidable/avoidable-admission

28. AIHW (2012). National Health Data Dictionary

29. NSW Health (2012) Draft Admission Policy

30. Körner M (2010) Interprofessional teamwork in medical rehabilitation: a comparison of multidisciplinary and interdisciplinary team approach. *Clinical Rehabilitation,* 24 (8):745-55. Epub 2010 Jun 8.

31. National Research Council (2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press, Print.

32. Adapted from AIHW (2012). National Health Data Dictionary

33. Victorian Government Department of Human Services. *The Victorian Ambulatory Care Sensitive Conditions Study*, 2001-02. Melbourne: VGDHS, 2004. Available at http://www.health.vic.gov.au/healthstatus/admin/acsc/report0102.htm

34. Implementation Management Associates, Inc. (2009) *Accelerating Implementation Methodology* (AIM): A practical guide to change project management. Lakewood: IMA World Wide.

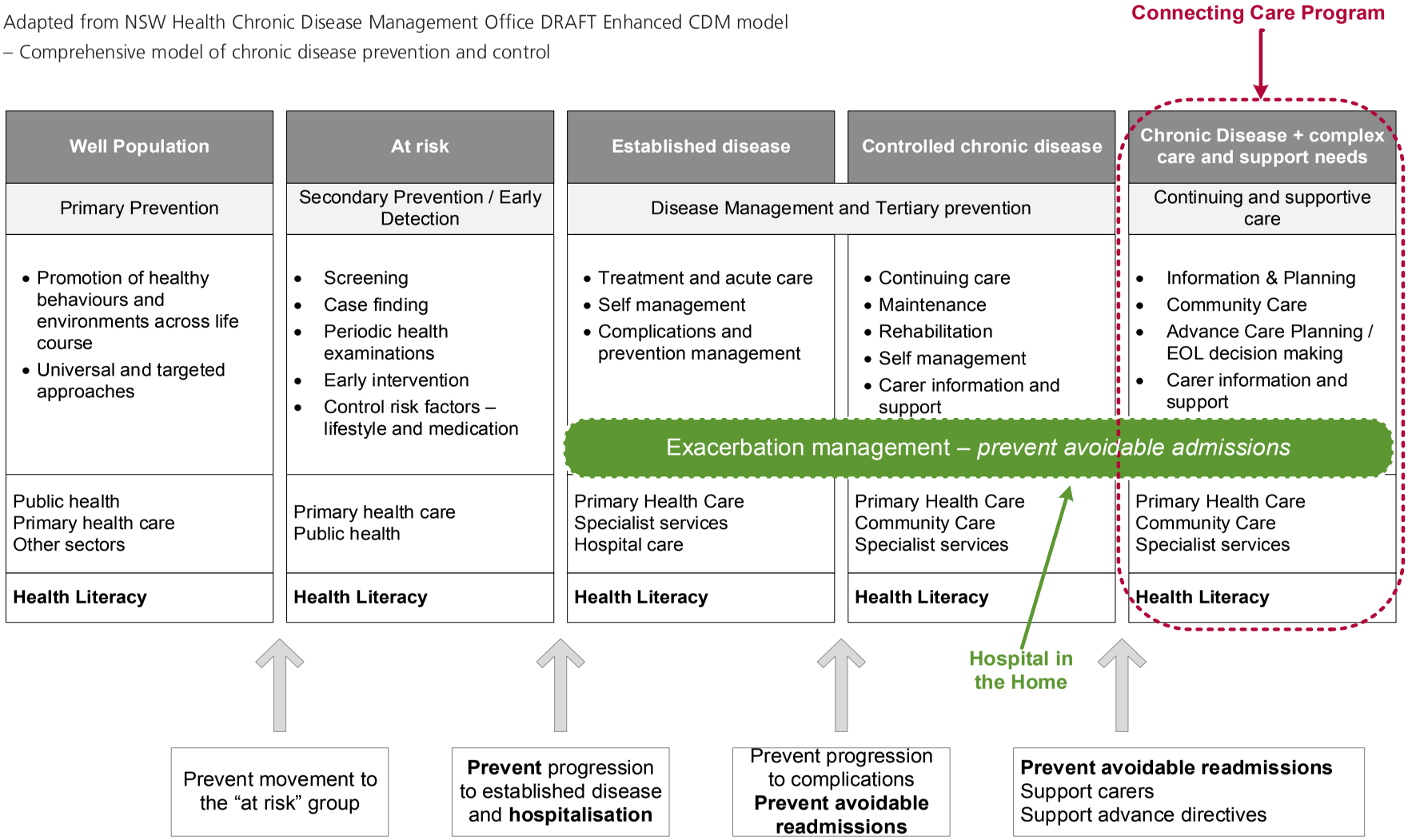
35. NSW Health (2012) *Draft Advance Planning for Quality Care at End of Life – Strategic and Implementation Framework*

TEN

Appendix A

10.1 HITH Integration with NSW Chronic Disease Management Program

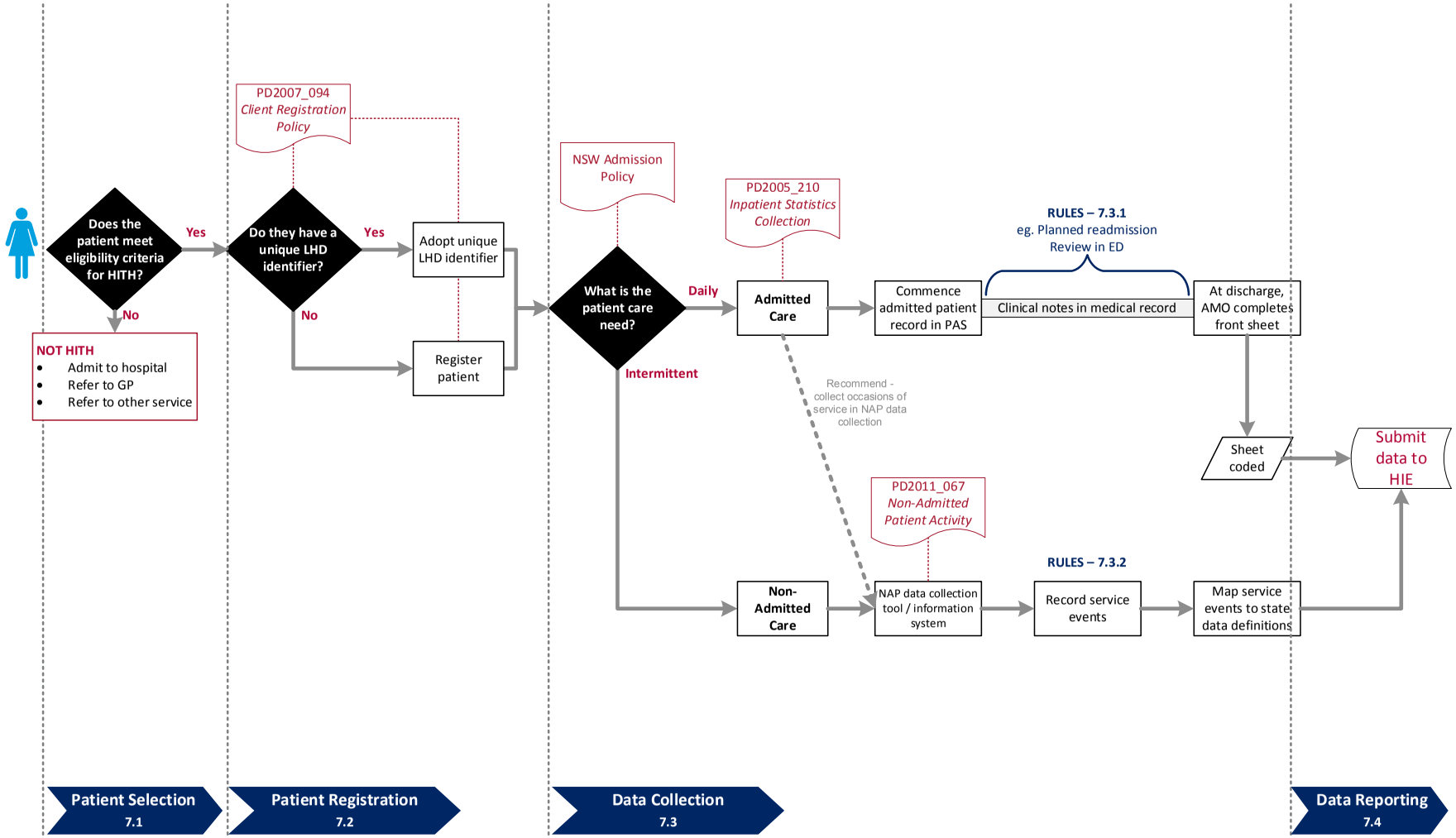
Adapted from NSW Health Chronic Disease Management Office DRAFT Enhanced CDM model – Comprehensive model of chronic disease prevention and control



ELEVEN

Appendix B

11.1 HITH Data Collection and Reporting process



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