

# Communique | Meeting 1 2020

## Key messages

The council supports a shift in how healthcare is delivered in Victoria with home-based care the norm for acute and subacute services.

The council supports the expansion of preventative care by hospitals in partnership with primary care services.

This shift requires:

- clear direction and commitment at the system, organisational and clinician level
- patient and carer understanding of the purpose and benefits of home-based care which includes their full partnership in healthcare planning and decisions
- the development of a comprehensive multidisciplinary team with a high level of clinical competence to deliver safe effective care.

Refer to pages 6-8 for main discussion points.

## Home-based care becoming the new norm

On 28 February 2020, the Victorian Clinical Council (the council) met to explore the potential for growth in home-based care in Victoria. The council focused on two strategies to keep people out of hospital:

1. The delivery of acute and sub-acute admitted services in a person's home.
2. The role of acute health services in preventing or reducing the symptoms and complications of established disease through the provision of community-based, non-admitted care.

The motivation for the day's discussion was a desire to reduce the harm associated with hospitalisation. Vulnerable populations, such as the frail elderly, are particularly at risk of poor outcomes, with these outcomes often unrelated to the medical reason for their admission.

The substitution of admitted care from the hospital ward to the home setting is occurring in Victoria through the Hospital in the Home (HITH) program, but despite pockets of progress, the full potential of home-based admitted care has not been fully realised. Progressive models for prevention, delivered by acute health services, highlight the prospect of achieving better outcomes for people with complex care needs.

Home-based care provides an opportunity for the system to take a giant leap forward towards person-centred care. The principle of person-centred care is often stated but is rarely realised. For home-based care to flourish, it is clear that each person, their carer and the context of their lives must be understood for healthcare staff to partner successfully in the delivery of care.

The Department of Health and Human Services' Health Reform Team partnered with the council secretariat in preparation for the meeting. The delivery of home-based care is a departmental priority at this time.

### Meeting purpose

To provide advice to the Minister for Health and Secretary of the Department of Health and Human Services on the potential for safe transition to expanded home-based care in Victoria.

The focus of discussions was on:

- **substitution of care** – the substitution of in-patient acute and sub-acute care to the home setting
- **prevention** – improving outcomes for people with chronic and complex conditions through preventive approaches delivered in the community.

## SUBSTITUTION OF CARE



Substitution of acute or sub-acute admitted hospital-based care to the home setting. Substitution may occur for all or part of the admitted care pathway.

### Presentations

The council heard from the following experts:

#### Matthew Zammit, patient

Matthew has received care through HITH on more than one occasion and has experience as a registered nurse. For Matthew, the strength of receiving care in the home is the ability to continue to participate in significant parts of your life.

He noted important considerations relating to the design and delivery of home-based services, in particular:

- The provision of care in the home is not the same as providing care in a ward setting, it requires its own practices and language.
- Patients must clearly understand the service that they are agreeing to receive, including expectations of themselves, their carers and of clinical staff.
- Patients may feel isolated and disempowered without good access to clinical staff and information, this is particularly important for HITH programs where you are unable to access your normal primary and community care supports.
- The carer must understand their role in supporting a successful home-based care admission. The care plan also needs to encompass the needs of the carer.

### **Associate Professor Michael Montalto, Director, Hospital in the Home, Epworth Hospital**

Michael is currently the clinical director of the HITH unit at Epworth Hospital.

To run a safe HITH program, he believes you need:

- strong clinical leadership with clear clinical governance and executive support.
- to provide a 24/7 comprehensive service including a full-time medical director with supporting medical staff, well-trained nursing, pharmacy, and allied health staff, and with access to all diagnostics, just like any other unit of the hospital
- running a safe HITH service also means identifying and accepting patients whose condition is sufficiently stable for home management.

Michael acknowledged barriers to increasing the demand for HITH services, including: a lack of understanding of the service and its benefits; and an entrenched medical culture of risk aversion and a reluctance to transfer care to other teams.

### **Dr Sue Matthews, Chief Executive Officer, The Royal Women's Hospital**

Sue spoke about her experience with Home Care Ontario (HCO). This program is based on the philosophy of 'home first' before hospitalisation. HCO is nurse-led with access to a medical professional 24/7. The service provides case coordination, nursing, allied health, social work, pharmacy, personal support and home support.

Most of the HCO care (74 per cent) is provided by personal support and home support workers. Personal support assists people with activities such as activities of daily living. Home support is non-medical support that enables people to stay at home – e.g. home maintenance services.

The HCO approach prevents or reduces the rate of deterioration of a person's condition and enables early substitution of care from the acute setting to the home. This means reduced hospitalisation and length of stay, a reduced need for higher levels of care such as aged-care services, reduced hospital-acquired infections, and greater patient satisfaction.

Sue believes this model would achieve great outcomes in Victoria and would drive:

- better integration across primary, social, community, mental health and home settings
- workforce development by increasing the number and scope of practice for nurse practitioners
- the necessary shift in mindset for clinicians, from being the expert in someone's life to sharing expertise with someone and empowering them to choose what is right for them.

### **Associate Professor Peter Hunter, Clinical Program Director of Rehabilitation, Alfred Health**

Peter spoke about Alfred Health's sub-acute, home-based care program, Better at home. This program is a substitution service for rehabilitation and geriatric evaluation and management services. The driver for change is about meeting the challenges faced by the service, providing person-centred care and improving outcomes.

It is known that older patients are at greater risk of harm when hospitalised. There is also evidence supporting rehabilitation in the environments in which people live – it is more meaningful and promotes incidental exercise.

The Better at home program faces challenges relating to the perception that people are safer in hospitals; this belief persists despite data proving otherwise. There is also a belief that the quality of care is better in hospitals. This has been addressed by structuring the program like a normal ward-based program, employing highly credible clinicians and building a profile to allay concerns of risk.

## Panel discussion

A panel discussion with Associate Professor Michael Montalto, Dr Sue Matthews and Associate Professor Peter Hunter covered the:

- need to clearly identify and define the care required, and then to design the service to meet that need
- importance of understanding the continuum of care and of supporting seamless transitions at the right points in time
- potential for general practice involvement in HITH-delivered care
- importance of the role of the carer.

## PREVENTION



Prevention of hospital admissions by supporting at-risk patients to stay well at home. Here the focus is on patients with complex care needs and the hospital's role in improving quality of life and reducing the symptoms or the complications of a disease the person already has.

## Presentations

The council heard from the following experts:

### Jo Stevens, Manager Chronic and Complex Care, Barwon Health

Jo spoke about Barwon Health's evolving health surveillance program which included: a pilot of a remote patient monitoring program, the adoption of HealthLinks, and more recently an extension of HealthLinks to a chronic heart failure program.

Remote patient monitoring aims to respond early to any deterioration in a person's condition and to support the person in self-management at home:

- The service requires patients to submit daily biometric data and to complete a health survey. Observations that sit outside of their set parameters are automatically flagged with the clinical team who then contact the patient.
- The patient is supported in identifying self-management techniques for their symptoms. The team also engages with the patient's general practitioner for inclusion in the management plan.
- Processes for the escalation of care are developed, including pathways that do not automatically lead to the emergency department.

This approach has also been shown to reduce presentations to the emergency department, admission rates and lengths of stay, improve health literacy, improve quality of life and reduce anxiety and depression.

## **Dani Smith, Director of Ambulatory Services, The Royal Children's Hospital**

Dani detailed the development of the Complex Care Hub which supports care for children with complex care needs. Prior to this initiative these children experienced multiple admissions per year and attended numerous specialist clinic appointments. Their care was provided by multiple teams and services, it was fragmented and often crisis driven.

The Complex Care Hub currently supports up to 380 families with:

- care coordination, within the Royal Children's Hospital and the community
- timely access to advice and support with an escalation plan for families
- family partnership through empowerment and advocacy
- promotion of health independence through individualised patient care plans, goal setting, and supporting growth of patient and family self-management skills and capacity.

This approach has substantially reduced bed days, emergency department presentations and waiting time in the hospital for specialist clinics. It has reduced stress, improved experiences for families and continues to realise efficiencies.

## **WORKSHOP: SUBSTITUTION OF CARE**

The council considered the following three questions:

- Who could benefit from a shift to home-based care?
- What are the obstacles to home-based care?
- How do we drive the change?

*'What do we need to do to get you home?'*

– Council member

## **Key discussion points**

### **Benefits of home-based care**

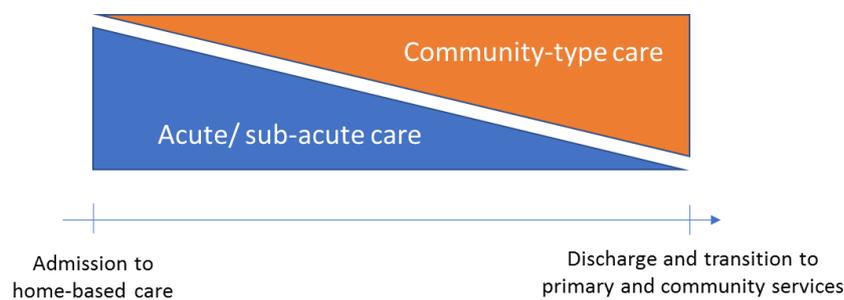
- Realises truly person-centred care.
- Reduced incidence of hospital-acquired infections and reduces deconditioning.
- Reduced carer burden and stress due to:
  - having clear management plans and 24/7 access to clinical staff
  - reduced travel to hospital, which is particularly relevant for carers of children.

### **Model of care**

- Home-based care should be considered first, before inpatient care.
- Patient consent for home-based or inpatient care is required.
- The capability and capacity of the patient and carer to support the home-based care admission should be assessed, along with the ability of the healthcare team to fulfil identified need.
- The home-based care service should be a 24/7 service with:
  - clear clinical governance and management systems to ensure the safety and quality of care, including escalation of care when required a full-time medical director
  - a multi-disciplinary team of medical, nursing, pharmacy and allied health staff
  - equivalence of access to all diagnostics.

- The service would benefit from, where possible, the inclusion of multiple medical units such as general medicine, surgery, maternity, paediatrics and sub-acute services.
- Care coordination would help to manage the person's changing care needs and support transition to primary and community services.
- Assessments for the safety of patients, carers and clinicians need to be built into the model.
- The inclusion of elements of community care would support transition into these services at discharge. Figure 1 represents the conceptual progression of care.

**Figure 1: Conceptual progression of care**



### Workforce

- All staff require specialist skills and equipment to manage patients autonomously and safely.
- All staff should be trained in cultural safety so that care is respectful of diversity.

### Supporting successful change

The council acknowledged that making home-based care the norm would fundamentally change how patients are managed in the acute and sub-acute setting. For a successful transition, the government and health services need to work with clinicians and the community to establish trust in the service, that it is safe and effective.

Several key determinants for change were discussed:

#### ● Leadership

- Government setting clear expectations for the expansion of home-based care services, including inclusion in the statement of priorities.
- Board and senior executive support are essential.
- Local teams to advance the model of care to meet local needs.

#### ● Planning and implementation

- Consistency in the model of care across the state to support equity of access and outcomes.
- Collaboration at the regional level could reduce duplication in effort and identify opportunities for the sharing of resources and the realisation of efficiencies.
- Including staff and patient representatives in the development process to support buy-in, reduce friction to change and identify effective solutions to local challenges.
- Investment in enabling technology including telehealth, with support for data-sharing and electronic medical records to support clinical decision-making.

### ● **Getting clinicians and patients on-board with the change**

- A community awareness campaign to inform of the benefits and address concerns around home-based care.
- Acknowledge the culture of paternalism and risk aversion within medicine, promote the benefits and address reasons why clinicians may be reluctant to provide care in the home.
- Identify clinical champions across the disciplines to promote and drive the change.
- Support clinicians to be comfortable with the reduced sense of control that can come with shared decision-making and being in someone's home.
- Ensure training programs for all clinical disciplines provide an understanding of the rationale for change and include a home-based care rotation.

*'Any condition could have some percentage of the care at home. We shouldn't look at individual conditions – it is more about managing a person in their home and, in a patient-centred way, looking at what needs they have.'*

**– Council member**

## **WORKSHOP: PREVENTION**

The council considered the following two questions:

- Who would benefit from a preventive approach?
- How do we harness clinician commitment towards achieving the best outcomes for patients to embed a preventive approach in care?

### **Key discussion points**

#### **Model of care**

- Members agreed that preventive efforts by acute health services would benefit people with chronic and complex conditions. Complexity needs to be considered across physical health, mental health and psychosocial wellbeing.
- The model is person-, family- and carer-centred and includes at a minimum:
  - case coordination, multidisciplinary care and support to remain in the home
  - medical and social care planning
  - tiered levels of care to address needs over the care continuum
  - agreed escalation processes.
- The service is connected with acute, mental health and primary and community care services. A shared-care philosophy would ensure that information flows between general practice, the service and specialist care teams to support care and the prevention of deterioration.

#### **Supporting successful implementation**

- Clear articulation of service objectives and performance expectations is required from the Department of Health and Human Services. These directives need to be mindful of the patient cohort and the long-term nature of their condition.
- Funding models and funding allocation within the health service needs to enable the model of care.

## CONCLUSION AND NEXT STEPS

The council would like to acknowledge the timing of this meeting in terms of the pandemic that is currently impacting Victoria and its health system. The system, government, departments, health service managers and clinicians are busy managing the emerging crisis and we are grateful for all of those members who were able to attend and contribute to the day's work.

An advice piece will be written and passed on to the Department of Health and Human Services' Secretary and the Minister for Health, the Hon. Jenny Mikakos. All advice will be published on Safer Care Victoria's website once completed.

*'We live in a city where demand exceeds capacity. In this context, person-centredness implies an ethical obligation to move patients who are well through the system to create capacity for patients who are waiting to be seen.'*

– Council member

## RESOURCES

The following resources were provided in preparation for the meeting:

- NHS Scotland's review – Hospital at Home<sup>1</sup>
- Mercy Virtual – Dr Gavin Helton<sup>2</sup>
- Mercy Virtual – Overview<sup>3</sup>
- Mercy Virtual – A nurse's perspective<sup>4</sup>
- Case studies – Home based care<sup>5</sup>

### Additional reading

- Dr Michael Montalto: Hospital in the Home, The King's Fund<sup>6</sup>
- What the hospitals of the future look like<sup>7</sup>



Associate Professor Jill Sewell AM

Chair, Victorian Clinical Council



<sup>1</sup> [ihub.scot/media/6928/2020205-hospital-at-home-guiding-principles.pdf](https://ihub.scot/media/6928/2020205-hospital-at-home-guiding-principles.pdf)

<sup>2</sup> [youtube.com/watch?v=d-Fu2mpK5iE](https://youtube.com/watch?v=d-Fu2mpK5iE)

<sup>3</sup> [youtube.com/watch?v=kHAdIJ3gtpY](https://youtube.com/watch?v=kHAdIJ3gtpY)

<sup>4</sup> [youtube.com/watch?v=XH1PvCtqlqc](https://youtube.com/watch?v=XH1PvCtqlqc)

<sup>5</sup> Citation for an internal, unpublished document

<sup>6</sup> [kingsfund.org.uk/audio-video/dr-michael-montalto-hospital-home-victoria-australia](https://kingsfund.org.uk/audio-video/dr-michael-montalto-hospital-home-victoria-australia)

<sup>7</sup> L Landro 2018 What hospitals of the future will look like. Wall Street Journal: [wsj.com/articles/what-the-hospitals-of-the-future-look-like-1519614660](https://wsj.com/articles/what-the-hospitals-of-the-future-look-like-1519614660)