

Hospital in the Home - the State perspective

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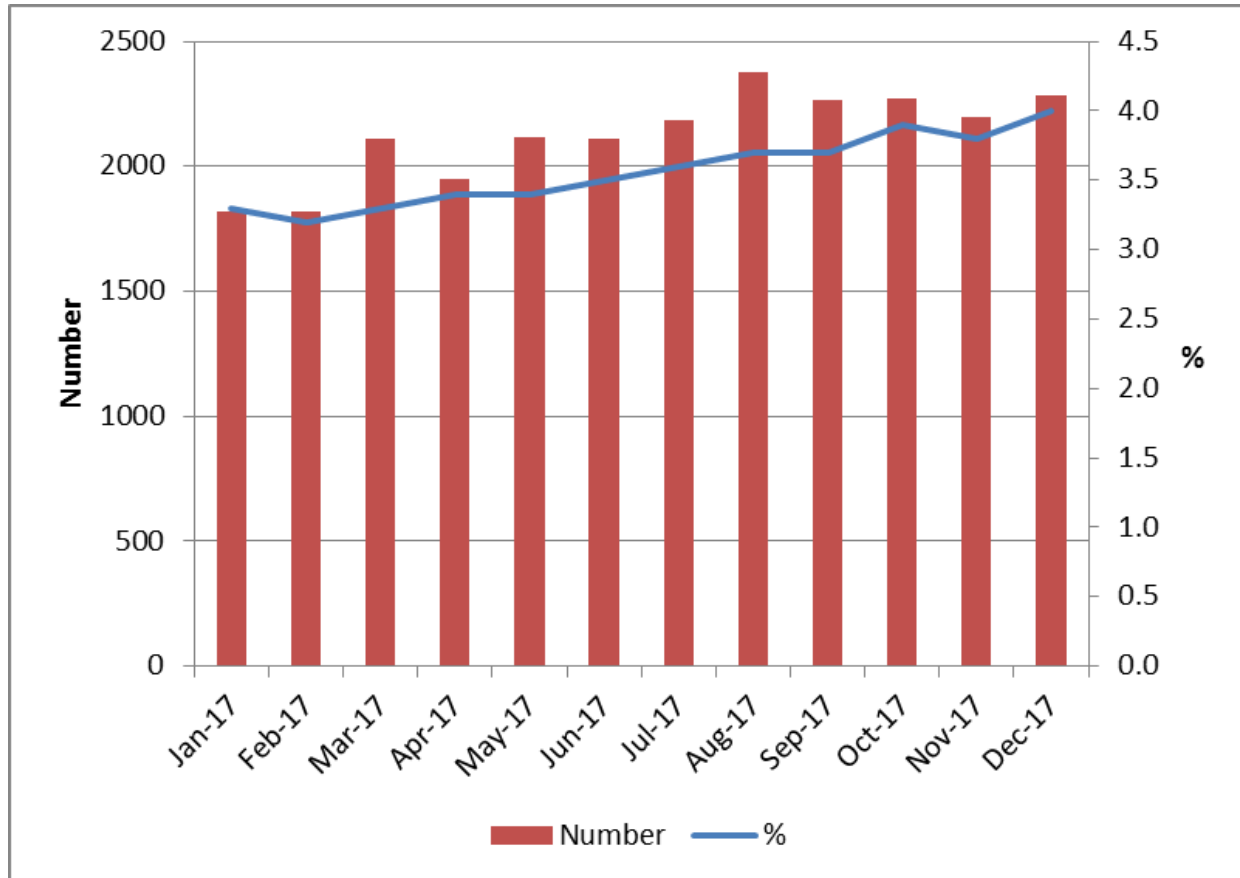
Health

A snapshot of HITH in NSW

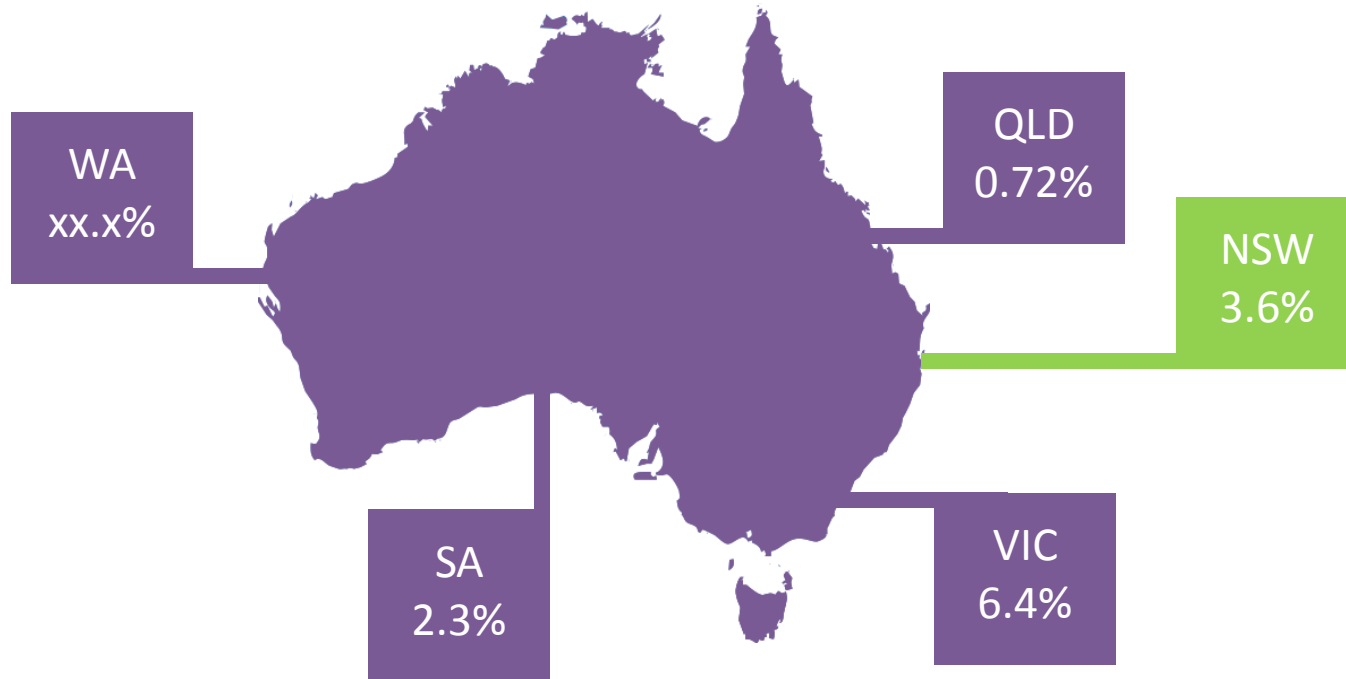
In NSW in 2017:

- 47 hospitals provided adult HITH
- 16 hospitals provided paediatric HITH
- ~ 25,500 HITH admissions
- On average 2,125 HITH admissions / month
- Admissions increased (~ 21%) compared to 2016.
- Overnight HITH admissions /total overnight admissions = 3.6%

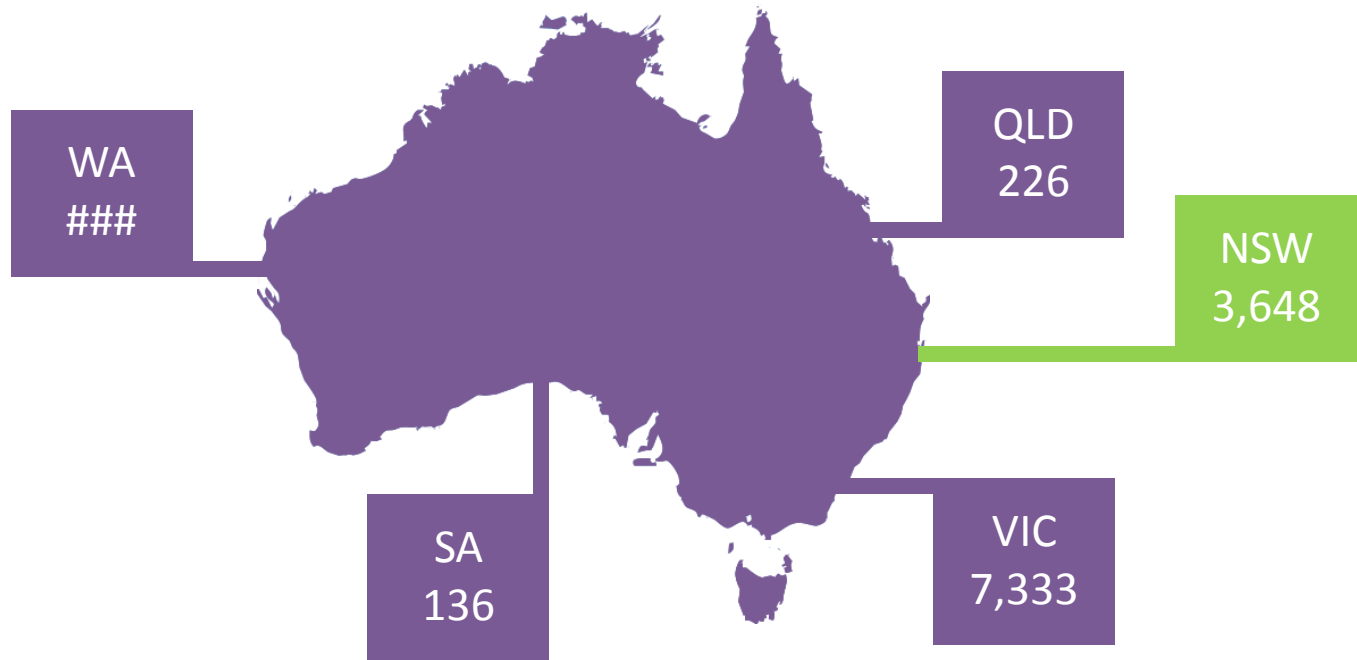
What do we want to achieve ?



HITH in Australia - Overnight Separations



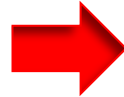
HITH in Australia - Same Day Admissions



What do we want to achieve ?

- HITH as a true extension of the hospital
- Adult and paediatric services
- Going beyond “avoidable admission” DRGs
- Standardisation
- Clear governance lines
- Better data

Hospital in the Home
Guideline



Adult and Paediatric
Hospital in the Home
Guideline

HITH = Admitted Patient Care

- A HITH patient must fulfill the same criteria for admission as any other admitted patient
- Admission is based on the **decision** of the clinician with admitting rights
- Admitting clinician assumes responsibility for ongoing care planning, treatment regimens and medication orders

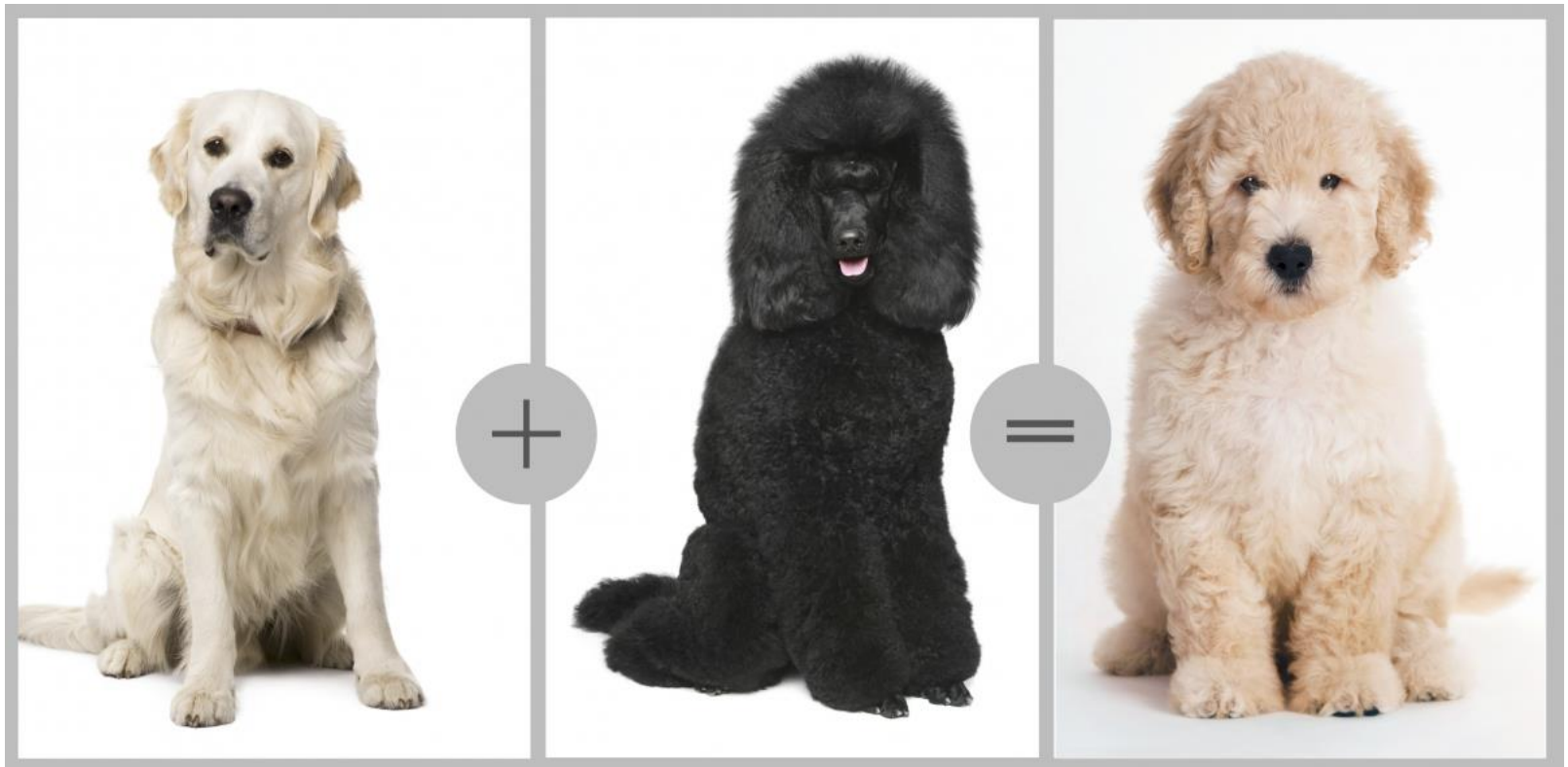
Criteria for HITH admission

- Patient has an acute/sub-acute condition but is medically stable enough to allow treatment at home or outside of a hospital ward
- The care required is clearly defined with a predictable prognosis and minimal risks of complications
- The home environment is suitable
- The patient/carer is competent to manage the condition and know when to escalate care

HITH Care

- Care should be patient and family orientated
- Assessment and treatment is performed by an experienced clinician
- A care plan is developed
- Care should be standardised and based on evidence based guidelines
- Clinical review should occur within 24 hours of admission into HITH
- A set of vital observations should be conducted once per day (minimum)

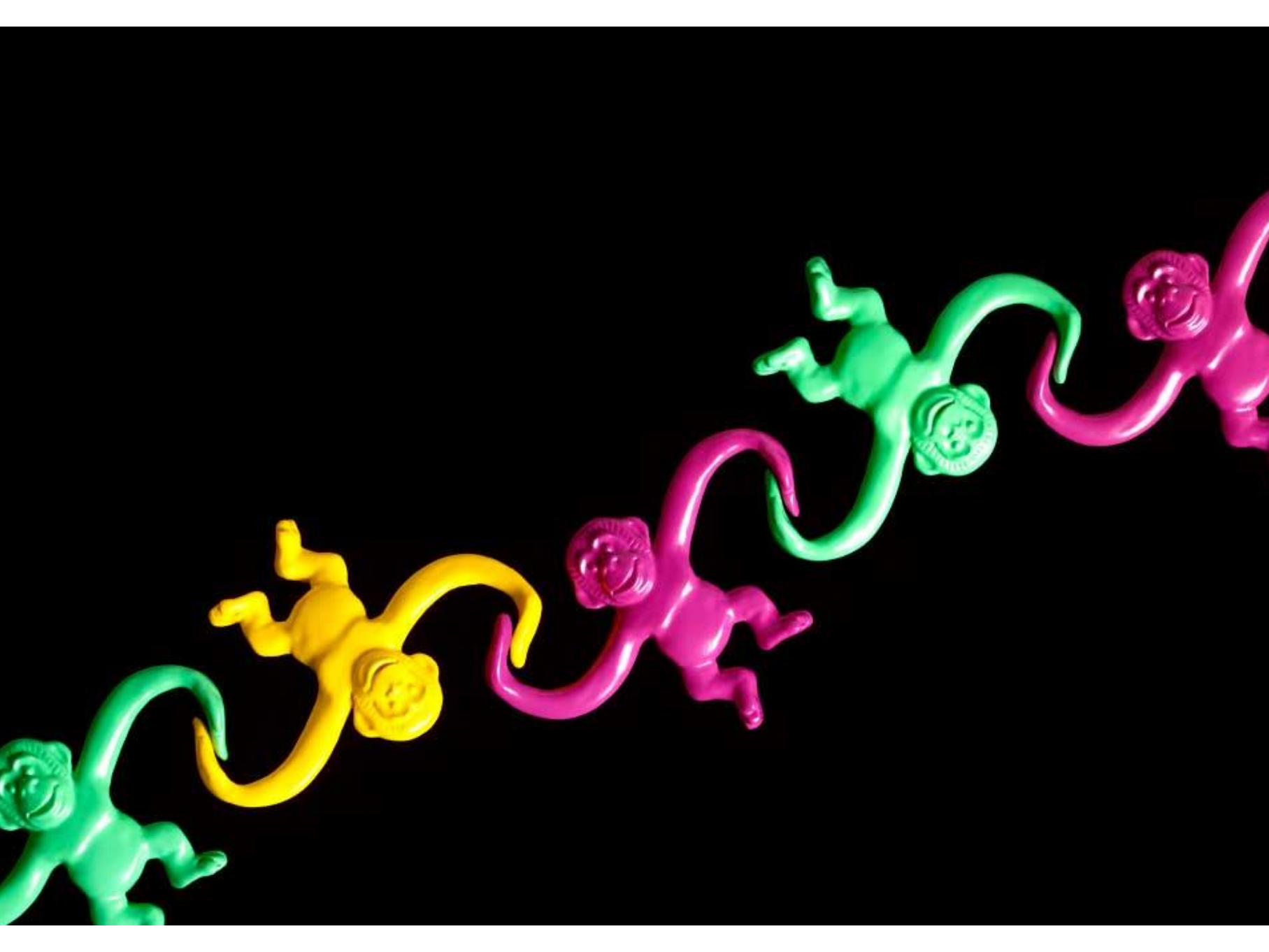
HITH Team as a Hybrid



Admitted Substitution + Non Admitted = HITH Service

The clinical champion







- The **intent** of HITH is that the patient is treated at home.
- The care delivery setting will depend on :
 - Initial clinical & risk assessment
 - Local service delivery model
 - Patient preference
 - Available resources



Recognising Clinical Deterioration

- Processes in place for early recognition, timely response and rapid escalation
- Earlier and lower threshold
- Documented processes for escalating care



Medication

- Second person checks
- Supply
- Medicine supply on referral from another service



Same Day Admissions



- Admission & separation occur on the same day
- Not about duration of the stay
- Based on condition, acuity, clinical and support needs of patient
- Admission warrants clinical review & oversight

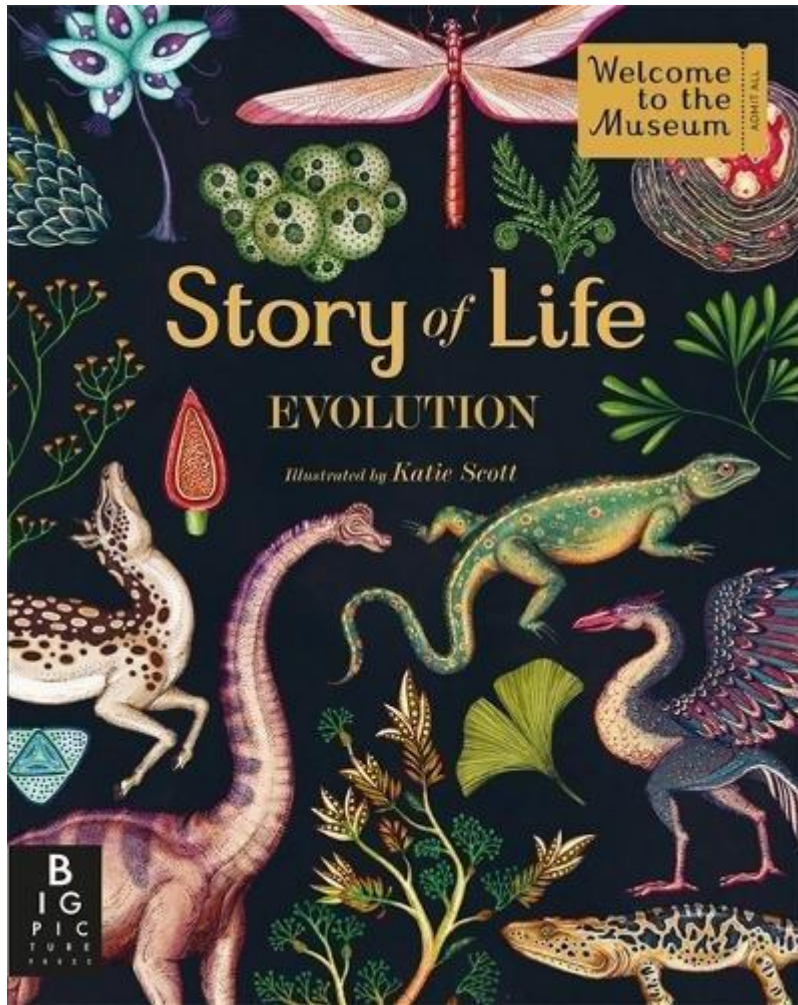
Costing HITH



- Understanding cost drivers of HITH
- Insights into the mix of cases and how this compares with other HITH service
- Capacity to compare costs with other HITH services in NSW
- Capacity to undertake higher quality costing of HITH into the future
- Quantifying the impact of different models of care and service delivery options

Relative Value Unit Study

- In routine costing of admitted care, HITH is often not differentiated from ward-based care
- Most hospitals do not have information for the allocation of clinical staff costs (nursing, medical and allied health) amongst patients receiving HITH
- RVUs specify, in relative terms, the costs that should be allocated to each patient based on their clinical profile and other relevant characteristics



HITH is an
evolving
model of
care



Human brain is still evolving, says scientist

THE human brain is still evolving, scientists said today.

Researchers at the University of Chicago have identified two genes linked to brain size which are rapidly evolving in humans.

man evolution — the growth of brain size and complexity — is likely still going on.

"Meanwhile, our environment and the skills we need to survive in it are changing faster than we ever



“I believe it is an honour to be accepted into a person’s life during an often vulnerable time when they need care. To then be accepted into their home to deliver that care is a true privilege”.

What do we need to make it happen?

- Medical governance
- Developed clinical pathways for referral
- Presence
- Ability to flex - No bed block
- Sticking to real acute care substitution
- Vision

E@H TRAFFIC LIGHT SUMMARY: CELLULITIS Cellulitis – Is this Patient Suitable for HITH?

Patients with Cellulitis (excluding bursitis, abscess, post-op wounds)
 If Diabetic – refer to "E@H Management of Diabetics with Lower Limb Infections"
 Pathology - FBE, U&E, LFT, CRP, BSL, Blood Culture (if history of fever) Skin Swab (if discharging ulcer) XR (if ulcer > 4 wks)

General:

- Rigors
- Unstable BP
- Acute confusion
- ARF
- Neutropenia / immunocompromised

Cellulitis-specific:

- Cellulitis related to bite (human, animal)
- Water or soil related injury
- Penetrating or high velocity injury
- Over joint or prosthesis
- Facial/orbital cellulitis (needs 24 hours IP observation)
- Hand cellulitis (Refer to E@H Traffic Light: Hand Cellulitis)
- Uncontrolled pain
- Bone / tendon on view, skin necrosis
- Ascending lymphangitis
- Bone or joint infection (see separate E@H Clinical Practice Guideline)
- Pregnancy (need to discuss with Medical Obstetric Unit)

RED
 Unsuitable for Direct Admission Under E@Home Cellulitis Pathway

Cellulitis-specific:

- Weight > 100kg (needs F1 CC line for higher doses)
- Abnormal LFT (discuss with ID)
- Abscess/bite/burns or abscess (not covered by this guideline, discuss with E@H doctor)
- Erythematous legs (usually not cellulitis)
- Localised swelling under erythema (exclude hematoma/abscess)
- Surgical site infection (discuss with ID)

ORANGE
 May be OFF-PROTOCOL acceptance only after discussion with E@H Registrar or Consultant

Check for risk factors for complicated care

- ≥2 Active co-morbidities (e.g. cellulitis and high BSL)

When accepted:

1. Parent Unit allocated for patient (usually E@H)
2. Complete E@H written referral
3. Write up medication chart

GREEN
 If fulfills E@H Criteria, call 9871 3197 to refer patient

- Antibiotics (adjust for renal function)
- If no allergies or mild penicillin allergy Cephazolin 2g IV BD AND Cephalexin 1g PO QID for first 24 hours until E@H visit then 1g PO BD (at 2pm and before bed)
- If severe / immediate penicillin hypersensitivity Clindamycin 600 mg IV tds (PICC)
- If tinea, chart terbinafine cream topically daily
- If cracked heels, chart urea cream topically daily
- Thromboprophylaxis per EH Thromboprophylaxis guidelines

Check for Risk factors for Complicated Care

≥2 Active Co-morbidities	Cognitive Impairment	Psychiatric Disorder	Discharged < 252 ago
Alcohol or Substance Abuse	Lack of Social Supports	Injecting Drug use	History of non-compliance

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