Policy

Policy Guideline

Hospital in the Home Policy Guideline

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Summary Hospital in the Home (HITH) services provide the spectrum of hospital admission criteria care types to children and adults outside of a hospital setting, in the patients permanent or temporary residence as a substitution for in-hospital care. The statewide Hospital in the Home Policy Guideline details the principles that underpin the HITH service delivery model for South Australia.

Keywords Policy, Guideline, Hospital in the Home, HITH, Hospital admission criteria, Hospital substitution, Hospital in the Home Policy Guideline

Policy history

Is this a new policy? *Y*
Does this policy amend or update an existing policy? *N*
Does this policy replace an existing policy? *N*
If so, which policies?

Applies to *All SA Health Portfolio*

Staff impact *All Staff, Management, Admin, Students; Volunteers*

EPAS Compatible *Yes*

Registered with Divisional Policy Contact Officer *No*

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Date	Endorsed by
16/06/2017	Lyn Dean, Executive Director, Operational Service Improvement and Demand Management

Approvals

Date	Approved by
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1. Objective

Hospital in the Home (HITH) services provide the spectrum of hospital admission criteria care types to children and adults outside of a hospital setting, in the patients permanent or temporary residence as a substitution for in-hospital care. Hospital admission criteria types include acute and subacute, such as Rehabilitation in the Home (RITH) and Geriatrics in the Home (GITH). The defining feature of the service is that if the patient was not receiving the HITH service they would require hospitalisation.

This state wide guideline details the principles that underpin the HITH service delivery model for South Australia. This guideline will assist Local Health Networks (LHNs) to develop local structures, models, policies and practices that will enable consistent access to HITH services across metropolitan and country areas.

The guideline provides definitions relating to HITH services and defines data collection and reporting rules to ensure that HITH activity is captured for performance monitoring and Activity Based Funding purposes. This will facilitate benchmarking of HITH services and activity at a local and national level.

2. Scope

This Policy Guideline applies to all SA Health entities, including Department for Health and Aging (DHA) and LHN administrative and clinical staff, who are involved in planning and/or undertaking a HITH service.

3. Principles

The following principles underpin the delivery of HITH:

- Patient centred and safe– Care is provided to the patient when they need it, first time. The patient is engaged as the central decision maker in all treatment and care decisions.
- Voluntary patient participation – patients will agree to receive their hospital level care in the home.
- Whole of system approach – Management of the patient care needs should be integrated into and with seamless transitions between acute,/ subacute intermediate care services and primary/community care sectors.
- Equitable – Care is developed and delivered in an equitable, affordable and sustainable ways. Services are designed to ensure that all patients are able to access the HITH service if they require it, irrespective of their place of residence. A state wide strategic approach to HITH will reduce duplication or inequity of services.
- Accessible –HITH services are designed to allow for rapid access by patients to hospital level care seven days a week, twenty-four hours a day. This includes a 24/7 emergency response plan.
- Respect – the patients cultural values are respected and considered in treatment options.
- High quality, safe care delivered by an appropriately experienced and skilled workforce.
- Cost neutral for the patient – a patient should not be financially disadvantaged by being admitted to a HITH service.

4. Detail

4.1 Location of HITH service provision

- The primary aim of HITH services is the provision of hospital level care within the patients home environment, although a patient may receive care in other settings during the same episode of care.
- Ambulatory care areas within the LHN may be the setting to deliver some episodes of care as required and negotiated between the clinicians and patients.
- Care may be delivered in the hospital setting if the patient is attending for another reason – such as a diagnostic test.
- Care may be provided wholly within a clinic setting if there have been identified safety issues for clinicians in the home of the patient.
- Some episodes of care may be delivered in the school or workplace upon negotiation with the patient, clinicians within the HITH service, and the organisation where the care may take place. It is assumed that the majority of patients requiring care that is hospital substitution level will not have returned to work or school.

4.2 Eligibility criteria for access to service and screening of eligible patients

- The patient's treatment needs meet the hospital admission criteria as defined in the Case mix Technical Bulletin.

- Following a comprehensive clinical assessment, it is determined that the care required is clinically equivalent to what would otherwise require an admission to an inpatient hospital bed.
- The treating medical team determines that the patient is clinically stable and the patients' health care needs are able to be attended safely in the out of hospital setting.
- A minimum of a daily visit or daily assessment by the HITH service is required. Exemptions to daily visit requirements may be made for unique service specific requirements such as the WCHN Respiratory HITH program.
- Suitability for HITH services may be considered for patients who do not wish to stay in hospital for personal, psychological or social reasons.
- The patient agrees (or patients substitute decision maker agree) to receive HITH services.
- The patient lives permanently or temporarily in the HITH visiting area.
- The patient is contactable via telephone.
- If required, the patient has the support of a carer at home or in close proximity
- The patient is able to transfer and mobilise safely using aids as required, except for patients who reside in aged care facilities or have disabilities.
- The patient has access to transport, except for patients who reside in aged care or disability settings.
- For paediatric patients, a guardian must be available and a nominated adult is to be present during treatment of minors.
- Consent process for minors living alone under 16 undertaken as per the SA Health Consent to Medical Treatment and Health Care Policy Guideline
- A safe and appropriate environment for visiting clinical staff is provided.

4.3 Exclusion criteria

- The patient does not meet hospital admission criteria.
- HITH does not provide non-admitted or community based care such as:
  - Simple venous access device management;
  - Wound care and drain management which does not require daily intervention or ongoing clinical intervention;
  - Trial of Void. There may be specific exceptions to this ie remote patient admitted to rural hospital because of distance;
- Pre admission care for planned or elective admissions that can be managed by the General Practitioner (GP) or in an outpatient setting.
- Follow up telephone calls post discharge do not constitute HITH activity, without a face to face component.
- Meets the inappropriate same day admission criteria as described in the Technical Bulletin

4.4 Service entry

- Local processes that facilitate access ease and equity will be developed to accept HITH referrals from:
  - Referral from a GP to Inpatient Team
  - Referral from Nurse Practitioner
  - Referral from Outpatient Clinic setting
  - Referral from Emergency Department
  - Referral from Inpatient Team, including another LHN
  - Referral from Private Hospitals
  - Referral from Medical Specialists in the community
- Development of electronic referrals will enhance the referral process.
- Patients are transferred to HITH as part of a continuous episode of care or admitted to HITH as an entire episode of care.

4.5 Service delivery types (face to face, clinic based, tele health technology)

- Telemedicine, a broad term that encompasses a range of technology-enabled healthcare services from virtual doctor's visits to remote patient monitoring, has the potential to revolutionise the way healthcare professionals interact with, diagnose and treat their patients. Telemedicine consultations may constitute the equivalent of a home visit when provided as follow up consultations.
- Telephone consultations are considered HITH activity only when delivered in combination with face to face care. Telephone calls alone are not considered a HITH service delivery.

4.6 Corporate and Clinical Governance

- Health service organisation leaders implement governance systems to set, monitor and improve the performance of the organisation and communicate the importance of the patient experience and quality management to all members of the workforce.
- Corporate Governance
  - Establishment of a corporate governance structure which includes representation from all relevant clinical levels and professionals within the LHN
  - HITH services are to be incorporated into the LHN planning and demand management strategies.
- Clinical Governance

- As per the funding requirements, the patient must be admitted to HITH under a medical officer with admitting rights to the LHN.
- The admitting Medical Officer must be working within their recognised scope of practice.
- It must be clear to the patient, the carer and the HITH team who is responsible for the medical supervision during the HITH episode of care. For each entry to HITH the medical management is agreed and documented.
- Patient has access to multi-disciplinary services as needed.
- Care to be reviewed in a multidisciplinary case conference with care plan updated as required.

4.7 Case management and care planning

- An initial Care plan is to be developed collaboratively with the patient incorporating a safety and risk assessment addressing:
  - Consumer driven goals (RITH):
  - Clinical risk
  - Home safety, access, parking and animals
  - Aggression risk patient/carer/family other people
  - Communication devices in the home – including mobile coverage
  - Drug/alcohol or smoking assessment
  - Other non-clinical support required.
  - Estimated discharge date
  - Clear transfer of care and case management – clinical handover process as per SA Health Clinical Handover Guideline policy 2010.
- HITH services shall have access to the hospital inpatient health record during the entire episode of care.
- All documentation is collated and will form a part of the inpatient health record. All documentation is to be integrated into the inpatient health record on discharge from HITH.
- HITH clinicians and patients have access to translating services (person or phone) at all times during the episode of care.

4.8 Patient pathways and criteria led discharge

- The journey through the HITH service should be seamless. Tools such as evidence based clinical practice guidelines and criteria led discharge – incorporating HealthPathways, support patient flow from admission to discharge from HITH service.
- Documented estimated date of discharge informed by clinical criteria post clinical assessment.
- Patient pathways facilitate the discharge patient of the HITH patient to post acute care such as outpatient appointments or community based services as soon as it is identified that the patient no longer requires hospital level care/ hospital substitution.

4.9 HITH Staffing

- LHNs have a HITH medical role that provides leadership, advocacy among medical peers, coordination and development of medical aspects of HITH services.
- Supports different disciplines within an interdisciplinary model (eg Nurse Practitioner or Pharmacist).
- Nurses and allied health practitioners providing acute/subacute care in the community are supported to work towards their full scope of practices
- Individual staff members take responsibility for maintaining their competence to deliver high quality, safe care in an out of hospital setting.
- Staff providing care have the appropriate competence and expertise, eg paediatrics, maternity etc
- Roles and responsibilities are understood and there are clear lines of communication and accountability within the HITH service.

4.10 Medication and consumables management

- HITH services meet the National Safety and Quality Standards for medication safety.
- All medications related to an acute care episode provided within the HITH model are funded by the LHN.
- Medication management must comply with the Controlled substances Act 1984, incorporating the code of practice for storage and transport for drugs of dependence.
- Medication polices, guidelines and practices need to be adapted for the home environment.
- Medication incidents and errors must be reported via the Safety Learning System.
- There are appropriate policies or guidelines in place to minimise the risk of (and to manage) anaphylaxis.
- Appropriate and responsible selection of antibiotics as per antimicrobial stewardship guidelines.
- Consumables related to the episode of care provided within the HITH model are funded by the LHN.

4.11 Quality and Safety

- Staff will practice within a Work Health and Safety Framework developed within their LHN.
- HITH services have a system in place to recognise and manage the deteriorating patient.
- If the patient requires a physical transfer back to the LHN, pathways are developed to avoid the Emergency Department if clinically appropriate.
- Systems for incident, adverse event and complaint management are in place.

- Ongoing evaluation of the HITH services is undertaken - including the implementation and utilisation of state wide LHN patient, staff and stakeholder satisfaction surveys.
- Clinical indicators are developed and used to monitor HITH services.
- There are systems in place to evaluate risk to both patients and staff when providing care in the home, including policies developed for patient and staff management practices in situations of extreme weather such as but not limited to extreme heat, fire danger and flood situations.
- Systems are in place for patients who are identified as being at risk of harm are referred for appropriate ongoing services or management.

4.12 Funding

- HITH services are financed based on the admitted criteria. HITH is funded based on the application of Activity Based Funding (ABF) as per the SA Casemix Manual. HITH services contribute to the LHNs acute throughput target.
- The Service Level Agreements (SLA) between DHA and LHN's outlines the health and other services to be provided by an LHN: funding provided to the LHN's to deliver these services; purchased activity and Key Performance Indicators.
- Whilst patients remain under the HITH model of care the below items are funded with the ABF allocation:
  - Consumables
  - Clinical Services
  - Clinical investigations
  - Intervention medications
  - Equipment
- Tier 2 outpatient funding cannot be claimed for outpatient activity or other non HITH activity whilst a patient is an admitted patient to a hospital under the care of HITH. This also applies to patients receiving services in Medicare-funded outpatient clinics. Additionally Medicare funded pathology and radiology cannot be accessed for HITH patients.
- GPs with patients on HITH cannot claim the Medicare rebate for reviewing public HITH patients.
- Payment for HITH services may also be as follows
  - Health funds for those patients who are privately insured, elect to be private and the health insurance agrees to pay:
  - Third parties for Compensable patients (e.g. Motor Accident Commission, Work and Return to work);
  - Patients who are Non-medicare or self-funded. The fee for Non-medicare patients is 1,986 (as at September, 2016) which currently is same fee charged for inpatient bed stays.
  - Patient information statements should be developed to articulate billing arrangements for non-medicare eligible and privately insured admissions.

4.13 Measurement of activity

The following information is to be collected and monitored, analysed, benchmarked and reported if appropriate via the local LHN processes:

- Diagnosis
- Age
- Separations
- Bed Days
- Gender
- Indigenous
- Relative stay index
- Referral Source
- Length of stay (LOS) – Average length of stay (ALOS) in HITH and total ALOS
- Ward utilisation % – HITH only, ED/HITH, WARD/HITH, ED/WARD/HITH
- Re admissions – planned and unplanned
- Financial Class (for insurance purposes)
- English as a second language
- FIM change (RITH)

4.14 Key Performance Indicators

- Fewer unplanned readmissions within 28 days (HITH versus non HITH with the same DRG)
- Total average length of stay is less than to or equal to the average length of stay for the same DRG group managed in hospital
- Number of unplanned physical transfers back to the LHN whilst under the care of HITH services
- Less adverse events (HITH versus non HITH with the same DRG)
- Level of satisfaction with HITH service for patients, carers and clinicians

4.15 HITH program integration

- Hospital in the home interfaces with hospitals, intermediate care services, community nursing and allied health services, chronic disease management programs and General Practice - Integration of HITH services is essential to provide for a seamless continuum of care for the patient from the acute setting to the community setting.
- Service coordination is essential to transition the patient from the acute/subacute HITH episode to post-acute services reducing duplication and importantly clinical risk.
- HITH services should plan appropriate referral to and engagement of other programs.

- HITH services remain the case manager until clinical handover occurs.
- Criteria led Discharge and Clinical practice guidelines should incorporate admission, discharge and transfer of care points in the patient journey. Development of distinct eligibility criteria for each program is essential.
    - Integration with the GP
    - Integration with community nursing services
        - Outsourced nursing contracts – Metropolitan Referral Unit
        - Commonwealth Funded programs Commonwealth Home support program(CHSP), Transitional Care Program (TCP),
    - Integration with Chronic Disease programs
        - LHN specific chronic disease programs – (eg Respiratory Integrated Care)
    - Integration with Primary Health Networks
        - Healthcare Hubs
    - External service providers.

4.16 Inter-hospital/ HITH transfer

- Transfer of an admitted patient from a hospital or HITH service to another HITH service involves separation from a hospital/HITH service and admission to another HITH service.
- The patient must be accepted by a medical officer with admitting rights to that LHN and appropriate clinical handover will occur.
- It should be planned with the patient and HITH service receiving and admitting the HITH patient. The needs of the patient, capability of the receiving service, clinical governance and risk management are key elements in planning the transfer.

4.17 Separation

- Separation of a patient from HITH occurs when acute or subacute admitted care is no longer required. Appropriate planning and communication is required to enable timely separation and continuity of care.
- Discharge planning commences on the patients admission to the hospital and/or HITH, is regularly reviewed and the plan is documented
- Appropriate referral to services is undertaken at the earliest possible opportunity
- Appropriate clinical handover occurs including the provision of information to patients, carers, GPs and community services including a formalised discharge summary.
- The discharge summary will include diagnosis, treatment plan, and follow up appointments.
- Clinical Handover will occur as per the SA Health Clinical Handover Guidelines 2010
- Patients have the option to self-discharge under the same process as from a hospital.

4.18 Privately insured patients in public health services and HITH

- Prior to 30 June 2008, the Australian Government set a private health insurance default benefit rate for Commonwealth- accredited HITH services. With the introduction of the Private Health Insurance Act 2007, the Australian Government abolished the default benefit 1 July 2009. From this time jurisdictions have had to negotiate separate HITH services rates with individual health insurers. DHA is currently in negotiations with Private Health Insurers.
- No patient shall be financially disadvantaged by admission to a HITH service

5. Roles and Responsibilities

Chief Executive Officers, Local Health Networks are responsible for:

- Endorsing and promoting compliance with this Policy Guideline.
- Nominating an executive sponsor to lead Policy Guideline implementation.
- Referring any significant strategic issues to the Department for Health and Ageing.

Chief Operating Officers, Local Health Networks are responsible for:

- Ensuring mechanisms are in place to enable the requirements of this Policy Guideline to be applied, achieved and sustained.
- Ensuring local procedures are reflective of the requirements detailed in this Policy Guideline.
- Ensuring local procedures are developed in consultation with the executive sponsor, senior HITH managers and clinical staff.
- Establishing local monitoring and reporting processes to ensure the active management and review of HITH activity and Key Performance Indicators as outlined in Section 4.13 and 4.14 of this Policy Guideline.
- Reviewing HITH program performance and implementing local improvement strategies.
- Escalating any significant strategic issues to the relevant Chief Executive Officer.

Program Managers are responsible for:

- Oversight of care provided by the HITH program.

- Escalating any significant HITH program issues to the Chief Operating Officer.

Clinicians are responsible for:
- Ensuring that HITH patients receive treatment in a safe and timely manner.

Administrative staff are responsible for:
- Ensuring administrative tasks are performed in a timely manner as to not delay admission to or discharge from the HITH program.

6. Reporting

6.1 All hospitals must submit admitted patient activity data (hospital morbidity) to ISAAC in accordance with the data standards and submission schedule set by Corporate Data Collection Systems (CDCS), Information Management, Department for Health and Ageing

6.2 Admitted patient data must be submitted on a monthly basis, being received by the 16th of each month by CDCS.

7. EPAS

- Not applicable

8. National Safety & Quality Health Service Standards

The HITH Policy Guideline aligns to the identified Australian Commission on Safety and Quality in Health Care National Safety and Quality Health Service Standards identified below:

 National Standard 1 Governance for Safety and Quality in Health Care	 National Standard 2 Partnering with Consumers	 National Standard 3 Preventing & Controlling Healthcare associated infections	 National Standard 4 Medication Safety	 National Standard 5 Patient Identification & Procedure Matching	 National Standard 6 Clinical Handover	 National Standard 7 Blood and Blood Products	 National Standard 8 Preventing & Managing Pressure Injuries	 National Standard 9 Recognising & Responding to Clinical Deterioration	 National Standard 10 Preventing Falls & Harm from Falls
☒	☐	☒	☒	☒	☒	☒	☒	☒	☒

9. Other

- Not applicable

10. Risk Management

A risk management approach underpins the service delivery and management of HITH services throughout the public health system. LHNs are responsible for establishing local guidelines and procedures to support primary and operational risk mitigation

11. Evaluation

This Policy Guideline will be evaluated and reviewed every five years from date of approval, to ensure it remains current. Key Performance Indicators have been described in section 4.13 of this guideline.

12. Definitions

In the context of this document:

acute care means 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: manage labour, cure illness or provide definitive treatment of an 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, or perform diagnostic or therapeutic procedures.

Admitted patient means someone who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital in the home or rehab in the home patients). The patient may be admitted if one or more of the following apply:

- 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 medication needs.
- 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 (e.g. cardiac catheterisation).
- There is a legal requirement for admission (e.g. under child protection legislation).
- The patient is aged nine days or less.

care setting means the location in which the HITH service provides care to the patient. HITH services are designed to provide care in the home. The "home" can be permanent or temporary and can include Residential Aged Care Facilities, Hotels and boarding houses.

clinical Governance means the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks and fostering an environment of excellence in care for consumers.

clinical handover means the communication process that enables the "transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis". This is an all-encompassing statement intended to include all interactions about the care of an individual patient.

non admitted Care means that the care required does not meet the Admitted Care requirements. Such care can be provided in outpatient departments, emergency departments or community settings.

Post-acute care means an episode of care for a person in which the primary clinical intent is the prevention of deterioration in the functional and current health status of a patient following an acute illness or injury. Post-acute services aim to assist patients discharged from a hospital, including emergency departments, acute and subacute services who require short-term, community based supports to assist them in recovery in the community.

Sub-acute care means rehabilitation, palliative care, geriatric evaluation management, and psychogeriatric care.

13. Associated Policy Directives / Policy Guidelines

Documents to read in conjunction with this guideline:

- Casemix funding for South Australian Public Hospital – technical bulletin 2015 – 2016
- SA Health Clinical Handover Policy Guidelines 2010
- National Safety and Quality Health Service Standards (NSQHSS)
- Consent to Medical Treatment and Health Care Policy Guideline

14. References, Resources and Related Documents

Australasian Clinical Indicator Report: 2007–2014: 16th edition (2015). Hospital in the Home. The Australian Council on Healthcare Standards Health Services Research Group, University of Newcastle Accessed online http://www.achs.org.au/publications-resources/australasian-clinical-indicator-report/

Casemix Funding for South Australia Technical Bulletin 2015-16 Section 20 Hospital at Home Services (H@H)

Controlled substances Act 1984 https://www.legislation.sa.gov.au/LZ/C/A/CONTROLLED%20SUBSTANCES%20ACT%201984/CURRENT/1984.52.UN.PDF