Hospital@home & @OAH – challenges & practices

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Overview

1. Summarize home care programmes in HA

2. Describe the challenges and local solutions

3. My views on potential improvements

3 home care programmes

- Community Geriatrics Assessment Service (CGAS): old age home residents

- Integrated Care Model (ICM/IDSP): high risk elderly at home

- Virtual Ward (VW): patients near end-of-life

Purposes

Control demands

Improve care

Common characteristics

- Target at high-risk medical elderly patients

- Provide post-discharge support @ the place of residence

- Geriatricians-lead & hospital-based

- (ICM has elements of transitional care)

Outcome

- VW: 30% reduction in bed-days and admission*

- CGAS: reduce ~15% AED med admission, 5% reduction in total bed-days**

- ICM: 16% reduction in AED med admission 90-days post d/c; 15% reduction in acute med bed-days 90-days post d/c; improve patient satisfaction***

*preliminary evaluation, pre & post comparison, PMH 2012
**pre-post comparison 2010, HAHO Statistic & Workforce Dept
***case-control study 2011, HAHO Statistic & Workflow Dept

Modest improvement in hospital utilization

Little data on improvement in quality of care

Challenges & Practices

Identify the right patient: HARRPE

- Locally developed to identify elderly with high probability of re-admission within 28 days

- Consists of 14 variables:
  - Prior utilization in 1 year
  - Socio-demographics
  - Co-morbidity
  - Type of index episode

- Auto-generated daily on medical elderly admission

- Adopt by ICM & VW, supplement by referral

HARRPE

Advantage

- Locally validated

- Risk stratified

- Computer auto-generated

Limitation

- Limited to elderly medical patients

- Generated on admission

- Re-admission risk as a proxy debatable

- Professional assessment still required

Inter-face with in-patient care

- Engaging in-patient team for discharge planning is difficult
- Assessors: allied health / nurses
- CGAS has no formal interface
    - RCHE programme@PMH

User Acceptance

Cost

Convenience

Quality?

Access information @community

- Record-keeping at the site of service
- Remote access to CMS from aged home
- Discharge summary
- ?mobile device in the future

# Providing intervention @community

- No mechanism in the community, service limited to office hour

- Drugs
    - Emergency pack at discharge
    - Expedite dispensing process
    - Verbal order
    - Ad hoc out-patient attendance

- Laboratory tests

- Other intervention e.g. parenteral fluid

Practicing acute Medicine @community

- Nursing support: CNS & Geriatrics Visiting nurse

- Allied health support: limit to PT & OT

- Training: no formal training programme

- Clinical protocols & guidelines

Continuity of care

- How care plan continue when patient readmit
- Conventional means of communication
- Electronic records
- Alert flags: reminder function
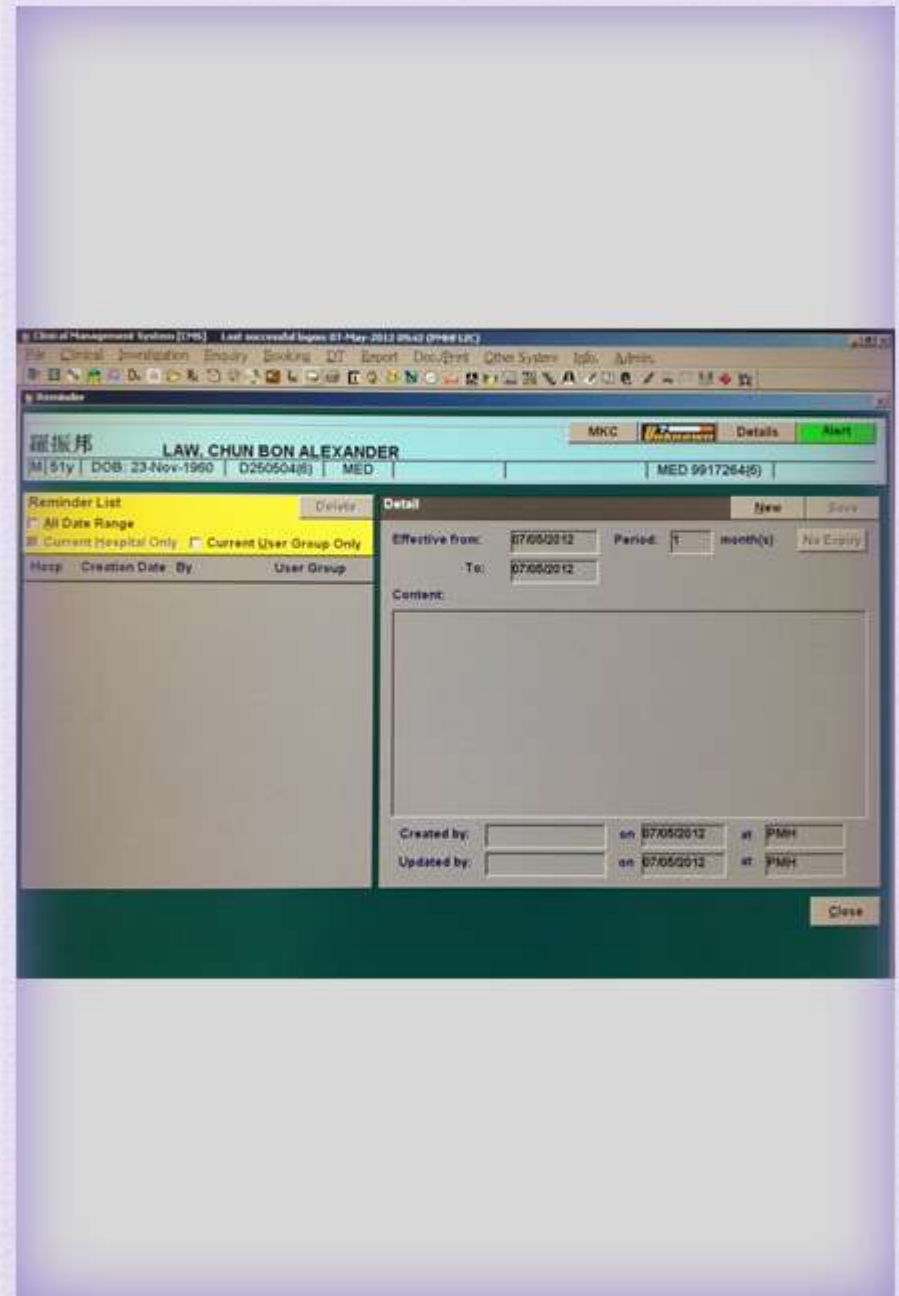
Supervision & quality assurance

- Deliverables: mainly activity figures

- Lacking KPIs on quality

- Clinical audit subjected to individual subject officer

- On-site supervision difficult & lacking: regular case conference in VW & ICM

- RCHE programme, KPI:
  - Medical bed-days/resident/month
  - AED attendance rate/resident/month

Collaboration with social services

Challenges

- Incoherence in policies

- Lack incentives

- Divergent interest

- Capacity of staffs

Practices

- Build relationship

- Engage stakeholders

- Find common ground

- Contractual arrangement in ICM

Potential Improvements

3 Keys

Empower CNS

Enhance roles
Extend service hours

Integrate services

With In-patient care processes
Between different out-reaching programmes

Strengthen governance

Key Performance Indicators
Build-in quality assurance mechanism

Conclusion

- h@h provides an alternative to hospital care

- Literature review suggests h@h can do more

- HA has established basic models, success depends on individual manager

- Some basic elements must be addressed before the programmes can be further developed

- X-bureau policy coordination is required for long term success

Thank You!