

Improving Tasmanian's health at home

Delivering improved clinical care
in the community

Response to the DHHS Green Paper –
Delivering Safe and Sustainable Clinical Services
(Rebuilding Tasmania's Health System)

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Disclaimer

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Executive Summary

The goal of the Tasmanian health system should be quality care that is coordinated, centred on people's needs and focused on maximising their wellness through the provision of preventative and pro-active services as well as responsive healthcare, and delivered in the community wherever it is effective and efficient to do so.

Care Assess is a local, state-wide community health stakeholder committed to providing high quality assessment and care coordination services to ensure more people are living well at home, across Tasmania. Care Assess has extensive knowledge of the local community-based care system, has experience in delivering innovative models of care, and is committed to working with government to deliver better health and wellbeing outcomes for Tasmanians.

This submission provides a detailed and holistic response to the consultation questions raised in the Green Paper. Themes raised in the Green Paper, which are specifically addressed in this response include:

- Sustainability of the health system;
- Community Care;
- Emergency Care; and
- Elective Surgery.

Care Assess agree that Tasmania's health system is not all it should be and welcomes this opportunity to provide input into the future public health system of Tasmania. Care Assess is a dynamic organisation, providing high quality community-based services throughout Tasmania. We are committed to contributing towards an improved Tasmanian health system and being part of the solution.

Care Assess' overarching response to the question of how can the Tasmanian Government deliver safe and sustainable clinical services is to highlight the need for increased clinical care within the community. An increased and continued policy focus is required on delivering improved health and wellbeing outcomes through:

- *Improved clinical sustainability* through increased access to quality home health care alternatives, including community care substitutes for hospitalisation;
- *Improved discharge planning* through the involvement of community health professionals working within the hospitals;
- *Reduced avoidable admission and readmission rates* through development of widespread hospital avoidance and post acute programs; and
- *Improved community care* to promote active and healthy independence, and provide preventative support for clients with chronic health conditions.

To achieve DHHS' stated goals for the Tasmanian health system, it should provide increased opportunities for:

1. Services that support Tasmanians to lead independent and active life-styles, feel safe at home and stay connected to their communities;
2. Community-based services that support Tasmanians with chronic health conditions that enable them to live well and avoid unnecessary complications or crises;
3. Community-based services that support Tasmanians with complex or multiple conditions, enabling them to remain as well and independent as possible and to avoid deterioration or complications in their complex health conditions;
4. Community-based rapid response services that provide urgent care for people when their health or independence rapidly deteriorates, including effective alternatives to hospitalisation;
5. Community-based hospital alternatives, including access to home healthcare substitutes for hospital services;
6. Hospital discharge planning by independent community-based health professionals. Hospital and home care providers should work together to ensure patients can leave hospital once their health treatment is complete with good post-discharge support in the community to reduce the likelihood of an emergency re-entry into hospital. From a client's first contact with the Tasmanian hospital system, discharge planning should start – and patients and their carer(s) should be involved with their plans and goals to leave hospital;
7. Community-based reablement services and home rehabilitation when needed that prevent permanent disability, greater reliance on care and support, avoid hospital admission/re-admission or unnecessary length-of-stay, and provide adequate periods of assessment and recovery before any decision is made to move into long-term care. System-wide access to reablement and rehabilitation should be provided for services delivered outside the hospital setting and in the consumer's home whenever possible;
8. Tasmanians to make positive choices regarding entry into long-term care after reablement and rehabilitation services and other alternatives have been comprehensively exhausted. Residents of care homes should consistently receive the same access to all necessary healthcare services as people living at home;
9. Better support and planning for people who want or need it when nearing end of life. All end-of-life care services should provide informed choice and control to people, including the ability for people to remain at home during their end of life stage if possible and desired; and,
10. Community-based care coordination services that are planned around the full range of people's individual needs, and that truly prioritise prevention and support for maintaining people's independence at home. For people using more than one service, the system should provide access to community-based health professionals that independently coordinate care, ensuring that all providers and services work together in an integrated way. This would improve quality and service value by better ensuring people benefit from the right mix of services (of those that are available), in the right place at the right time.

The areas that Care Assess is particularly focused upon delivering best practice services throughout the State include:

- Wellness services including basic home support, short term home enablement and reablement services;
- Allied health care services particularly hospital-based, residential-based and home-based exercise physiology and occupational therapy;
- Community and primary care based care coordination services, case management and chronic diseases self-management services;
- Rapid response hospital avoidance services including urgent and coordinated/integrated primary and community care;
- Technology based support and care services including the use of assistive technology and telehealth;
- Supported hospital discharge services including clinical post acute care;
- Other alternatives to hospital services;
- Home and residential-based reablement services;
- Home and residential-based rehabilitation services;
- Residential care GP services, including comprehensive health assessments;
- Home and residential-based advanced care planning;
- Home and residential-based end-of-life services; and
- Independent assessment and care coordination services for people using multiple services.

Introduction

Care Assess is a Tasmanian home and community health care provider specialising in coordination of services that enable more people to live well at home across Tasmania.

The Tasmanian Government has commenced a reform of Tasmania's health services with the vision “to have the healthiest population in Australia by 2025, and a world-class health care system.” A Green Paper, *Delivering Safe and Sustainable Clinical Services* (Rebuilding Tasmania's Health System) was published at www.dhhs.tas.gov.au/onehealthsystem, inviting stakeholder submissions by 20 February 2015 addressing the consultation questions asked in the Green Paper.

Care Assess' public stakeholder submission focuses on several of the key questions asked by the Green Paper:

- Is the Tasmanian health system all it should be; are existing services sufficient; where are the gaps?
- How do we promote and maintain safe primary and community care to consumers and communities such that they seek out these services rather than attend Emergency Departments when their conditions are more advanced?
- How do we determine which services to focus on to expand the role of primary and community care?
- What services currently delivered in a hospital setting do you think could be safely delivered in the community?
- How can we better support consumer involvement in your healthcare decisions?
- What additional areas should we be considering for interstate partnerships in order to improve service within Tasmania?

Care Assess addresses these questions by surveying the continuum of care and highlighting effective ways in which the community and primary care sector can work together better – in the words of the Green paper – “to promote wellness, limit the long-term impact of complex and chronic conditions, keep people out of hospital, and ultimately, improve the quality of life of Tasmanians.”

What we know can work

Care Assess agree that the Tasmanian health system is not all it should be. We should be open to change in order to improve outcomes for all Tasmanians regardless of where they live; and Care Assess is open to this change.

What is needed is a significantly higher priority on community and primary care within the Tasmanian health system, shifting the focus from hospitals to effective and efficient community and primary health care in the home; in particular:

- Access to services that better support the self-management of health conditions within the community, based upon a wellness approach;
- System-wide access to reablement services and pro-active care coordination that is focused on the prevention and management of chronic conditions; and
- Access to quality home healthcare alternatives including community care substitutes for hospitalisation.

The goal

Quality care that is coordinated, centred on people's needs and focused on maximising their wellness through the provision of preventative and pro-active services as well as responsive healthcare, and delivered in the community wherever it is effective and efficient to do so.

The solution

Care Assess agree that a fundamental re-design and reform of the Tasmanian health system is required to overcome the weaknesses of the current system and to respond to the future challenges.

A significant shift in the focus and culture of the current system as a whole is needed, to give a much greater priority toward the provision of community and primary care, including basic home support services through to clinical community services as an alternative or substitute for hospital services. To succeed in this goal the health system needs to be re-designed around people's wellness and delivered in ways that maximise their independence at home.

A system-wide approach to integrating the hospital system with the community and primary care system is needed, including providing appropriate resources for independent community and primary care providers to deliver effective, efficient and innovative community and primary care services as an alternative and/or substitute for hospital care services.

This system-wide approach is needed to ensure access to effective and efficient community and primary care solutions that provide preventative and pro-active home support and care services, while maintaining safety and quality of care.

It's about making quality *home care* the goal. In summary, a significant re-focus is needed to prioritise investment in community and primary services that deliver:

- Wellness and preventative support services
- Reablement home care services
- Home healthcare and hospital-alternative services

Wellness

Health and care services when people become ill or dependent are only part of the solution; a system that promotes and supports people's 'wellness'¹ and independence would enable a significant proportion of Tasmanians to increase their own abilities to lead healthier and safer lives and rely less on hospital and emergency response services.

The Tasmanian health system needs to be re-designed to focus on people's wellness, as it is currently designed around responding to illness/injury. Focusing on preventative and pro-active ways to improve Tasmanian's health at home is a significant part of the solution to alleviating the cultural dependence on high-cost and reactive healthcare.

A wellness mode of practice in the health system would focus all services on maximising each individual's ability to self-serve and care for their own health, physical function and social well-being, as well as apply a greater focus on promoting and providing broader access to wellness, reablement and preventative care strategies.

All health and care services should:

- Assist consumers by helping them to manage their health and care as much as possible;
- Enable them and their family to reduce their risk of developing new long-term conditions, or live more comfortably with existing ones;
- Help consumers learn or regain skills or abilities necessary for daily living.

Definitions:

¹ '**Wellness**' is a mode or practice that focuses on working 'with' people in support of their abilities to self-manage and self-care (rather than the traditional mode that focuses on doing things 'for' people based on their inabilities).

² '**Enablement**' is a specialised wellness service that aims to minimise or reduce functional *decline*.

³ '**Reablement**' is a specialised wellness service that aims to increase or improve functional independence.

⁴ '**Rehabilitation**' is a specialised health services that aims to resolve health issues.

Improving support of...

1. Active and healthy independence

The Tasmanian health system should increase support for people to lead independent and active life-styles, feel safe at home and stay connected to their communities.

Wellness promotion and allied health care

- We know that a significant proportion of the burden of disease among people aged 60 and over is potentially avoidable through changes to lifestyle.
- The health system can do more to promote and support Tasmanians to adopt a healthy lifestyle; increasing the proportion of the population undertaking regular exercise, not smoking, reducing alcohol consumption, healthy eating, and preventing obesity will significantly reduce the burden on the system in the long term.
- A greater focus on allied health care services is needed. In particular, broader use of Exercise Physiologists providing evidence-based tailored exercise interventions would have a wide range of benefits for people's balance, wellbeing, mobility, and cognition and bone fragility.

Address the wider determinants of consumer health

- We know that consumer health and wellbeing in later life will be affected by determinants of health over the course of their life; some of which consumers have some control over, such as a lifestyle and housing.
- The system needs to adopt a life-long approach to consumer health and wellbeing to address the wider determinants of consumer health; assisting individuals make changes throughout the course of their life because of the positive effect changes to their lifestyle now can have upon better wellbeing in the long run.

Minimise people's social isolation and age-friendly communities

- We know that loneliness, social isolation and social exclusion all increase people's risk of poor health. The health system as much as possible needs to assist consumers to build positive and supportive relationships with close family members, or seek to participate in alternative networks in their community.
- All health and care services should facilitate the involvement of consumers' family, friends and community

Treatment of needs that limit people's independence

- We know that common health needs significantly affect people's independence, wellbeing and social engagement; for example, mobility problems, foot health, chronic pain, visual and hearing impairment, incontinence, malnutrition and oral health.
- People's independence can also be affected by a lack of access or poor quality of treatment.
- The design of the Tasmanian health system needs to address the need of people for the right advice and assistance, so that services are put in place to address these common needs such as help with household repairs, minor

property adaptations, and other practical support such as domestic assistance, personal care and social support.

- It will significantly benefit the wellbeing and independence of Tasmanians at home if the design of the health system is able to address the need to be proactive to identify and assess these problems early, and get in place solutions to meet these needs.

The need for more basic home support enablement² services

- Successfully diverting people from hospital where appropriate depends on having sufficiently resourced home support and care services in place.
- In Tasmania, the demand for basic home support is currently over-strained and projected to grow dramatically in the next decades; investment in basic home support is needed to address the negative impacts of waiting lists on the local health and home support systems, because a delay in basic home support increases the likelihood that (without timely service provision) consumers will seek out alternative but higher cost care provision (such as hospitals).
- Considering existing programs are insufficient to cope with the growing demand for ongoing support for consumers with functional disabilities (enabling them to live independently in the community), there is a significant need for the provision of short term assistance to individuals before determining whether ongoing support is required (which can often be unnecessary).
- Short term home support enablement services provide an effective mechanism to deliver support when needed in a timely way wherever a delay is required or is unavoidable prior to determining whether or not ongoing support is required or appropriate.
- The applicability of short term home support enablement has broader implications beyond the aged care population. The provision of short term packages of basic home support is an enablement approach which is needed more broadly wherever consumers are seeking to access health system services before assessment services are able to qualify needs and plan/implement less immediate solutions.

Improving support for...

2. People with long-term conditions

The Tasmanian health system should provide access to improved community-based services for people with chronic health conditions that enable them to live well and avoid unnecessary complications or crises.

Providing continuity and care coordination

- We know that people living with chronic conditions will do better if a GP is at the centre of their care, maintaining regular contact with them.
- General Practitioners can make a big contribution toward providing better coordinated care that is centred on consumers' health and wellbeing needs.

Care management delivered through integrated locality-based teams

- Existing community-based care providers such as Care Assess are able to provide consumers with a pro-active approach to care involving assessment of needs and care planning, to better support GPs.
- The design of the Tasmanian health system should leverage existing local community care capacity as part of a wider program that seeks to integrate consumer care to provide good access to primary prevention and care management services, wellness, and coordinated community-based packages of reablement or rehabilitation services.

Consumer involvement in planning and coordinating care

- We know that a key aspect of good management of long-term conditions is ensuring that the services and support provided reflects the consumers and their family's individual circumstances and preferences.
- Care Assess is an example of an existing community-based provider with a demonstrated effective approach in undertaking care coordination for complex care consumers by engaging consumers and all relevant providers in collaborative care planning and the management of a single holistic care plan.
- Collaborative care planning and care coordination should be a key priority for the re-design of Tasmania's health system, considering that interventions and care planning approaches that focus on single conditions can lead to chaotic overall care for consumers.

Telehealth and information sharing

- We know that telehealth can play an important role in enabling face-to-face assessment of consumer needs and review of care in remote or rural locations.
- Technology is also a valued means for consumers to communicate and stay socially connected within their community.
- We also know that better information sharing between systems and increased publication of performance information can improve the efficiency of services and the continuum of care between hospitals and primary and community care providers.
- The Tasmanian health system should consider measures to achieve 'joined up' data and reporting, by providing clear directions around the future use of

technology and standards that will allow community sector organisations to interface with government systems.

Providing support and education for families and volunteer carers

- We know that informal caregiving has a crucial role in maintaining people's independence and wellbeing; the health system needs to be designed to better incorporate carer support into all health and care plans.
- Providing better support for carers should be a key priority for the Tasmanian health system in improving Tasmanian's health at home; all health and care providers need to focus on service provision for the unpaid carers of patients
- The Tasmanian health system needs to provide better targeted peer support, education, information, training and respite.

Existing Program: Care Assess GP Health Assessments and Care Plans

Scope: Care Assess undertake Comprehensive Health Assessments and Care Planning (including Comprehensive Medical Assessments in Residential Aged Care) on behalf of General Practitioners.

History: Since 1999 Care Assess has collaborated with General Practice through the provision of health professionals such as nursing and allied health care services to provide home assessment and care coordination under the supervision of the client's GP.

Evidence: Care Assess has demonstrated a long established ability to provide nursing and clinical assessment services, work with general practice and interface between community, primary care and residential care.

Existing Program: Care Assess HACC Home Support Program

Aim: To coordinate provision of basic short term home support for Tasmanians needing assistance to remain at home.

History: Since 2002 Care Assess has utilised an independent brokerage model to coordinate a range of basic home support services for consumers across Tasmania, including domestic assistance, personal care, social support and home maintenance.

Evidence: Care Assess has demonstrated the strategic provision of *short term* basic home support wherever appropriate. This approach is very relevant to rural/remote regions where distance can preclude immediate assessment.

Improving support for...

3. People with complex conditions

The Tasmanian health system should improve the availability of community-based services for people with complex multiple conditions that enable them to remain as well and independent as possible and to avoid deterioration or complications in their complex health conditions.

Assessment and follow-up of people identified as frail or with dementia

- We know that even a relatively minor illness can cause a sudden decline in the ability of someone who is frail or who has dementia to function at home – recognising client frailty is a very important step in assisting them remain as well and independent as possible and to avoiding an unnecessary decline in their health.
- The Tasmanian health system should provide system-wide access to assessment and planning through independent community health professionals able to coordinate an integrated plan for long-term treatment and follow-up where appropriate.
- The assessment should cover elements such as consumers' medical, social, environmental and psychological situation, as well as their abilities to function in their daily living.

Falls prevention and community services

- We know that falls can lead to serious injuries, loss of confidence and independence at home. Falls are a leading cause of older people going to hospital, and often result in long-term care.
- Preventing falls should be a key priority of the Tasmanian health system, as they are increasingly common.
- The Tasmanian health system should work with community health providers to implement wider reaching strategies to prevent falls, focusing on identifying and addressing risk factors such as postural instability, muscle weakness, visual impairment, home hazards and side effects from some medications.

The under-utilised benefit of exercise physiology

- We know that exercise can dramatically improve overall health, wellbeing and ability to function in daily life.
- The Tasmanian health system re-design should consider the need for provision of direct access to exercise physiology, in addition to other more well established services of allied health care professionals.
- Promotion and provision of exercise classes and individualised exercise programs is a key example of how the health system could integrate with community health services to better focus on wellness.

Providing good care for people with dementia

- We know that accurate and early diagnosis of dementia is very important in order to provide information and support for people with dementia and their carers when the condition begins to cause problems that are life-limiting.
- As well as support services and specialist services, the Tasmanian health system should provide increased access to training and education to carers of

people with dementia, as well as service coordination services that provide assistance to people in navigating and maximising existing care options.

Reducing inappropriate medication

- We know that people with multiple conditions are likely to be on multiple medications, and that over-treatment with medication can add risks, which may outweigh the benefits.
- Reducing inappropriate medication should be a key priority of the Tasmanian health system, ensuring health professionals prescribing medication give full consideration of interactions between drugs, ageing and disease, and patients' ability to adhere to medication regimes, as well as prioritising their own goals for treatment.
- Health and care providers should structure regular pro-active reviews and adjustment of medications.

Existing Program: Care Assess Chronic Diseases Self Management (CDSM) program

Aim: Care Assess' Chronic Diseases Management (CDM) program works with Tasmanians with chronic diseases to improve their health outcomes by providing health coaching to enable consumers to better manage their chronic disease(s), and providing care coordination of services to increase access to planned supports.

History: Since 2013 Care Assess has established and managed the CDSM program under the Tasmanian Medicare Local (TML) Care Coordination Program, utilising existing capacity to develop an efficient model that leverages a limited base funding per year.

Outcomes: In the first year of the CDM program, Care Assess worked with over 100 consumers, enabling them to understand more about their health problem, better manage their own health, engage with their doctor and other health services, and link them with services to help them manage their illness and better support them to stay at home.

Existing Program: Care Assess Home Care Packages and Consumer Directed Care

Scope: Care Assess currently manage 70 Home (Aged) Care Packages for consumers undertaking Consumer Directed Care (CDC).

History: Across Tasmania since 2011 Care Assess has been an Approved Provider of Flexible Care under the Aged Care Act 1997, now providing high-level clinical care for consumers at home as an alternative to residential aged care.

Evidence: Care Assess has significant experience in the provision of nursing and community care for consumers living in the community with complex/multiple needs, including frailty, dementia and chronic diseases.

Improving support for...

4. People in times of crisis

The Tasmanian health system should increasingly support community-based rapid response services providing urgent care for people when their health or independence rapidly deteriorates, including effective alternatives to hospitalisation.

Continuity of primary and home care

- We know that many hospital presentations are preventable, and that people continuing to see their doctor regularly may reduce their chances of an unplanned re-presentation to the hospital.
- Similarly, discontinuous or disjointed home care can compromise the quality of people's health and wellbeing.
- The Tasmanian health system needs to address the issue that vulnerable people often lack the family and support network to maintain regular health assessments in the surgery.
- GPs are often at capacity and therefore (although dissatisfied) are unable to provide the extra support specific to the situation of a patient with complex needs.
- Better integration of home care and primary care services would enable independent community-based health professionals to coordinate care responses for consumers with complex conditions that can be delivered in the home rather than in the surgery, hospital or through emergency services.
- Community-based care planning teams would be able to collaborate with General Practice while also drawing from and supporting other organisations and the wider community as they coordinate and maximise the care and support needed for consumers.
- Addressing the burden of complex care needs in the home must involve placing the home care professional at the centre of the care team with consumers in the home.
- It's about making the shift from a disease focus to a patient-centred care planning system that gives priority to home care.

Urgent primary and community care

- We know that people with complex needs can deteriorate rapidly at any time, in or out of hours, and when this happens consumers need effective and speedy support from health professionals who understand their individual circumstances and conditions; people need to know who to call in a crisis and they need to do it quickly (within and outside of usual hours).
- The Tasmanian health system needs to leverage and invest in existing home care provider capacity able to deliver reliable provision of independent health professionals in the community to assess consumers' level of risk, coordinate access to out-of-hours advice and in home support services when needed.

Providing urgent, coordinated home care

- International evidence shows that effective crisis or rapid response services have a positive impact on the care pathway and outcomes for all consumers as well as reducing unnecessary admissions to hospital or residential care.

- Care Assess is an example of an existing home care provider available with health professionals and capacity to rapidly respond in a crisis with a team approach, including out of hours – providing quick assessment of consumers' individual care and support needs where appropriate.
- Home care providers are perfectly placed to stabilise the situation and put together a care plan that avoids an unnecessary trip to hospital or to long-term residential care.

Community understanding of emergency services and ambulance

- We know that going to hospital may not necessarily be the best option for a person in a health crisis, and can introduce a number of risks to a person's health, such as infection, stress and a decrease in their level of confidence at home.
- Tasmanian hospital emergency departments can be better designed to assist people to remain at home if needed, including the provision of community health professionals able to divert consumers to home support and care whenever a patients' health does not require them to be admitted to hospital. Rather than merely sending people home who present to hospital, assisted access to community assessment and services should begin at hospital.
- Tasmanian ambulance services can also play an increasingly important role in allowing people to remain at home when hospitalisation is avoidable.
- As well as training in helping people to remain at home when appropriate, opportunities should be made available for paramedics and ambulance services to work more collaboratively with home care providers in facilitating access to hospital-alternative services.

Using technology to reduce risks

- We know that there are a range of technologies available to support people at home such as falls alarms and devices to monitor vital signs or movement beyond safe areas.
- Combined with effective access to home support and care services, the Tasmanian health system re-design should factor in the strategic importance of home healthcare technology in reducing people's risk of hospitalisation or moving to long-term care.

Existing Program: Care Assess HACC Hospital Avoidance Packages (HAP)

Aim: To provide a targeted intervention delivering short-term intensive home support services for patients at risk of unnecessary hospitalisation.

History: Since 2012 Care Assess has provided a rapid response strategy to coordinate temporary and intensive support of clinical care and basic home support across Tasmania.

Evidence: Care Assess has significant and demonstrated capacity in the provision of nursing and community care for consumers living in the community with complex/multiple needs, including frailty, dementia and chronic diseases.

Gaps: The scope of the existing hospital avoidance program is limited to Commonwealth HACC clients. It should be expanded in scope and resourced to provide a system wide approach to preventing unnecessary hospitalisations.

Improving support for...

5. People needing hospitalisation

The Tasmanian health system should provide additional opportunities for community-based hospital alternatives, including access to home healthcare substitutes for hospital services.

Comprehensive assessment prior to hospitalisation

- We know that hospitals can receive significant numbers of presentations from people seeking care, and the key to appropriate admission as well as appropriate access to home healthcare alternatives or substitutes to hospital services is responsive and comprehensive assessment.
- By assessing people fully, Tasmanian hospitals will be able to better deliver long-term benefits to patients, including enabling them to remain in their own home with less health decline, where possible.
- Hospital assessment staff should work in teams together with independent community health assessment professionals to identify reversible health problems, plan wellness, reablement or rehabilitation goals, and their support needs on leaving and returning home.

Safety and prevention in hospital

- Safety remains a key priority for the Tasmanian hospital system; hospital staff need to continually seek to prevent falls, pressure sores, hospital acquired infection, and medication errors, for example.
- We know that maintaining patients' continuity of care is critical; hospital staff should minimise ward moves and ensure patients always have a named, accountable health professional coordinating their care.
- We also know that among the potentially preventable harms of hospitalisation for older people, immobility as a result of bed rest is significant.
- In addition to ward staff encouraging patients to stand and mobilise as early and as often as possible, and monitoring patients' levels of mobility from admission to discharge, the Tasmanian hospital system should also consider the strategic benefit of incorporating the services of community-based exercise physiologists, who are able to implement evidence-based interventions during and following a patients' length of stay in hospital.

Reducing patient time in hospital

- We know that there are a number of things that hospital staff can do to effectively minimise any delay in patients going home from hospital to receive community health or home care services, including delays in leaving hospital, delays in receiving home assessment or home support services.
- Hospital staff should refer patients for community or home care services well before they are expected to be discharged; however discharge planning and referrals are much more likely to be effective and efficient if conducted by independent community-based health professionals who can integrate better between the hospital and home care interface.
- If patients are already receiving community services before going to hospital, service provider(s) need to be informed about a patient's hospital stay so that

they can be ready to support them as soon as it is safe for them to go home (and so they can cancel concurrent service plans during their hospital stay).

- The Tasmanian health system should consider the benefits of pre-active readmission clinics prior to planned surgery due to their potential to better prepare clients for their procedure, possibly shorten hospital stays and reduce the chances of readmission from complications after returning home. Clients would be physically stronger going into hospital and have a better knowledge of what to expect post surgery.

Substitutes for hospital services

- For patients who require hospital admission for certain diseases, such as community-acquired pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and cellulitis (for example), the Tasmanian health system should provide access to effective substitutes for hospital services.
- We know that 'hospital at home' programs have been demonstrated to be effective overseas and in Australia² in providing hospital-level care in a patient's home as a full substitute for hospital care.
- These programs have demonstrated evidence of cost-effectively treating acute illnesses, while also improving quality and safety.
- Assessment for patient suitability for these programs including identifying target illnesses could happen at Tasmanian hospitals, ambulatory sites or by paramedics, under the clinical governance of a consultant doctor.
- Patients could be transported home by ambulance to receive extended nursing care, which could be reviewed regularly by a consultant doctor or Nurse Practitioner directing the clinical services.
- The patient's primary care GP should be notified at program commencement, and could be given the option of clinical governance of the program.
- Otherwise, when the patient is ready for discharge from the program by the consultant doctor, their care could be handed over to the patient's primary care GP.
- Community Nurse Practitioners may be a particularly appropriate solution for patients with more advanced conditions (such as palliative care patients or patients with chronic disease complications) to reduce demand on Emergency Departments through the provision of a primary care response. The position of Community Nurse Practitioner may be especially useful in rural and remote areas where there is limited provision of after-hours services.

² E.g. <http://silverchain.org.au/wa/health-care/home-hospital/>

Hospital in the Home

- One example of hospital substitution in Tasmania was the LGH's Hospital in the Home service.
- The cessation of this service due to funding cuts caused many clients that could be treated in the community to unnecessarily utilise the acute sector. These clients included consumers requiring intravenous antibiotics (e.g. cystic fibrosis), Vacuum Assisted Closure (VAC) dressings and regular blood transfusions (haemophiliacs).
- Oncology patients currently need to regularly come into the acute sector to take bloods and have dressings to intravenous ports in addition to chemotherapy and/or radiotherapy.

National Approaches: Silver Chain Home Hospital

Care Assess and the Silver Chain Group have been working in a collaborative partnership for over 8 years sharing research and models of care, having formed a productive and beneficial partnership that demonstrates the Tasmanian health system's goal of strengthening interstate partnerships.

Silver Chain Group commissioned PricewaterhouseCoopers (PwC) to assess the economic value of its Home Hospital model.³ Silver Chain Group currently provides a 'virtual' hospital model in Western Australia, South Australia and Queensland. Their model has been designed to provide a complete substitute for a range of traditional medical inpatient stays, from referral right through to discharge within the patient's home. Data obtained by Care Assess from this analysis demonstrates a reduction in health system costs as a result of:

- Providing equivalent care in a lower cost setting;
- Avoiding treatment costs that would otherwise be incurred as a result of hospital acquired or associated infections;
- Avoided Emergency Department (ED) presentations and ambulance transfers where transfer to an acute hospital ED is unnecessary;
- Delayed entry into residential aged care facilities as a result of the psychological benefit to patients and their carers who feel more able to cope at home having avoided in-hospital care.

³ Unpublished data obtained from Silver Chain Group.

Improving support for...

6. People following hospitalisation

The Tasmanian health system should provide improved opportunities for hospital discharge planning by independent community-based health professionals. These opportunities should include scope for hospital and home care providers to work together to ensure patients can leave hospital with effective and timely post-discharge support in the community to reduce the likelihood of an emergency re-entry into hospital. From a client's first contact with the Tasmanian hospital system, discharge planning should start in collaboration with community health and care providers.

Early assessment and discharge planning

- As part of patients' daily review, Tasmanian hospital staff should not only focus on whether patients need a hospital bed, but what they require in order to go home safely and promptly.
- The Tasmanian hospital system should implement effective measures to start discharge planning from before or when patients enter hospital.
- This should involve independent community health professionals working as hospital-based discharge and liaison coordinators, providing community-based health care assessment and care coordination functions to ensure continuity of care from hospital based care to community-based care.

Involving patients and their carer(s) in discharge planning

- Community health professionals working as hospital-based discharge and liaison coordinators would be able to involve patients and their carer(s) from the outset in discharge plans so that they can make informed decisions and choices that will maximise their independence post-discharge in their home environment.
- We know that fully involving patients in early and better discharge-planning will reduce their risks of needing to go back in to hospital after coming home.
- These dedicated roles would ensure that patients have sufficient notice and are expecting and prepared to go home as early and as safely as possible.
- Such hospital-based discharge and liaison coordinators could identify and address goals and any concerns patients have about going home.
- These roles could also be specified as the health professional that patients should initially contact post-discharge if there is a problem, and should liaise with the hospital as appropriate.

Assessment and support after discharge from hospital

- We know that after leaving hospital, the risk of patients readmitting to hospital or losing their independence at home (and needing to consider a nursing home) is reduced by a home health assessment from a health professional and the provision of short-term home support (such as domestic assistance and personal care) and where necessary clinical home care (such as nursing, occupational therapy and exercise physiology).
- A Transitional Care Package may be available to provide rehabilitation and additional support in the immediate period after hospital, but more often and more widely applicable are the short term home support services of a local

home care provider such as Care Assess, with the clinical capacity to provide an individually tailored package of basic and clinical services based upon health professional assessment and care planning.

- The Tasmanian health system should also provide access to specialised reablement programs to provide aids and equipment, personal care, nursing and allied health interventions for a time-limited period in order to help patients learn or re-learn how to manage their health at home following a hospital stay.
- We know that short term increases in basic home support and community care can help patients recover and regain their independence at home as quickly and as much as possible.

Consumer contributions and direct investment in health and care services

- The Tasmanian health system should consider the value of making it easier for consumers to contribute financially to their care.
- We know that consumer contributions can significantly increase the value of publically funded services when individuals 'top up' home care services with a direct investment, which makes available other service types they can benefit from (for example, extra nursing care) .
- We also know that the personal commitment involved when consumers directly invest in their own health (like any investment) increases their motivation; in turn, their extra contribution and increased level of motivation can over time significantly improve their health and wellbeing.
- The Government could consider a 1:1 financial co-contribution scheme to encourage this and match consumers' investment in their healthcare.

Alternatives to hospital

- A comparison with other Australian jurisdictions and international evidence demonstrate that the Tasmanian health system should give significant priority towards investment in community-based post-acute care programs that can deliver efficient and clinically effective improvements in outcomes for patients presenting for hospital admission and requiring discharge from hospital.

Existing Program: Care Assess HACC Post Acute Packages (PAP) program

Attached: *PAP Program Evaluation - HACC Post Acute Packages (PAP) Program - Quantitative and Qualitative Evaluation, Final Report – 20 February 2015;*

History: Across Tasmania since 2004 Care Assess has delivered a supported discharge program – the HACC Post Acute Packages (PAP) or “Post Acute” program which provides a range of integrated services that support timely discharge from hospital, promote faster recovery from illness, and reduce the chance of unnecessary acute hospital re-admission and premature admission to long-term residential care.

Demand: In order to manage demand Care Assess' Post Acute program has historically needed to exclude sub-acute patients or patients admitted for rehabilitation in hospital (due to limited and fixed funding). The need to accept referrals into this program from hospital wards requiring supported discharge for sub-acute or rehabilitation patients, has been identified by Care Assess' existing referrers from all major hospitals state-wide.

Increasing reablement for...

7. People after illness or injury

The Tasmanian health system should provide improved opportunities for community-based reablement services and home rehabilitation to provide services for Tasmanians after a significant illness or injury. This will help prevent permanent disability, avoidable reliance on care and support, avoidable hospital admission/re-admission or unnecessary length-of-stay, and to provide adequate periods of assessment and recovery before any decision is made to move into long-term care. System-wide access to reablement and rehabilitation should be provided for services delivered outside the hospital setting and in the consumer's home whenever possible.

Reablement³ services

- There is significant evidence supporting the strategic effectiveness of delivering reablement services within the community. Reablement is a relatively new approach to delivering care and support to consumers in their own home to help them to accommodate their conditions and regain their ability to live independently.
- Based upon a wellness mode of practice, reablement is a specialised and short term service that assists people to learn or re-learn daily living skills or abilities – this differs from traditional home care which serves consumers by undertaking tasks and activities for them in view of consumer limitations or inabilities.
- Broadly applicable to people with chronic diseases, disability and ageing, reablement is similar but also different from rehabilitation; it is home-based and focuses on basic assistance to promote and increase consumers' independence rather than focusing on clinical services to resolve health issues (such as physiotherapy).
- However international evidence has demonstrated that the leadership and input of clinicians, especially occupational therapists and exercise physiologists, is necessary in maximising the benefit of reablement services.

Rehabilitation⁴ services

- The Tasmanian health system should also consider the strategic merits of more residential-based and community-based rehabilitation services as a substitute for existing services delivered in day hospital settings by health providers.
- As a health service aimed at speeding patients' recovery from an illness or injury through the use of physical and occupational therapy, existing home health providers such as Care Assess are able to safely deliver efficient and effective rehabilitation services in the home as well as in a residential care setting where appropriate.

Successful transition from reablement or rehabilitation

- We know that community-based reablement and rehabilitation models are more efficient and effective, at the end of a period of reablement or rehabilitation, at assessing and coordinating consumers' ongoing home care

needs to provide those services necessary to maintain the progress that consumers have made.

- For consumers that did not have ongoing care in place prior to the program, an independent community-based health professional will be better placed than hospital staff to undertake referrals and coordinate supports that maximise the benefit of available programs.

Assistance from aids, equipment and technology

- Basic aids, equipment and simple home modifications can play an important role in enabling consumers to remain independent within their home environment; the use of everyday and low cost technology can improve consumers' ability to manage at home and achieve their goals.
- The Tasmanian health system should consider improved mechanisms to increase awareness and access to aids and technology to make it easier for patients to take-up assistive technologies – including inexpensive devices that we know can improve almost every area of daily life.
- A key priority for the Tasmanian health system should be increasing ease of access to Occupational Therapists, whose services can profoundly benefit the wellness and independence at home of not a few key target groups within the system, including older Tasmanians and people with chronic conditions and disabilities.

Existing Program: Care Assess HACC Home-based Independence Packages (HHIP) program

Attached: *HHIP Quantitative Evaluation - Final Report – 30 June 2013;*

History: Since 2007 across Tasmania HHIP has provided a 12-week intensive reablement program for HACC eligible consumers motivated to work with health professionals to increase their independence at home.

Evidence: Care Assess has conducted an independent quantitative evaluation of the HHIP program (June 2013); key findings from this evaluation were that:

- HHIP contributed to a statistically significant improvement in consumer outcomes;
- HHIP was effective at reducing consumer service delivery hours for consumers receiving prior HACC services. Additionally, HHIP was effective at preventing increases in service delivery hours – which is strategic considering referrals to HHIP are made in response to requests for increased services.
- These findings revealed HHIP is successful at achieving its program aims, as an intensive reablement service.

Scope: Strategically, the Care Assess' PAP and HHIP programs need to utilise the opportunity afforded by the intervention for reablement of patients returning home from hospital. For example; applying a reablement philosophy to the Post Acute program would maximise the potential benefit of this service not only for consumer outcomes but also for the home support system itself. This could be done by complimenting existing services with a focus on skills for daily living, and services to help people recover skills and confidence to live at home.

Improving support for...

8. People needing residential care

The Tasmanian health system should improve support for people needing to make positive choices regarding entry into long-term care after reablement and rehabilitation services and other alternatives have been comprehensively exhausted. Residents of care homes should consistently receive the same access to all necessary healthcare services as people living at home.

Reducing unnecessary long-term care

- We know that older people and their carer(s) who are considering long-term care should benefit from a comprehensive assessment of their need for care to ensure they have received adequate treatment of any health/medical problems that led to their decision to move, including access to adequate reablement and rehabilitation services.
- We also know that wherever possible, patients should not move into long-term care directly from hospital.
- The Tasmanian health system should improve community awareness and access to alternatives such as enhanced home support services, enablement, reablement and rehabilitation programs, including the use of aids, telecare, and home modification services, and consideration of a move to age-friendly housing, seeking carer support and end-of-life care at home.
- Tasmanian care recipients and their carer(s) should be fully informed and involved in decisions about the location of their future care.

Information sharing

- When a person moves into a care home, there should be a transfer of their health information to the care home to enable the staff to build on the assessment information that has already been compiled.
- Home care providers of community nursing already working as the person's 'care coordinator' or 'case manager' are well placed to assist with health information and communication with specialists and other services such as the pharmacy (for medication reviews).

Comprehensive Medical Assessments

- Medicare fund annual health assessments for residents of care homes, which can be conducted by a community-based nurse on behalf of a resident's GP. These "comprehensive medical assessments" are underutilised and can significantly improve residents' health and care.
- Assessment of residents' health should be a continuous and regular process; not a one-off event when they enter the care home.

Improving choice and control for...

9. People nearing end of life

The Tasmanian health system should continue to improve access to better support and planning for people who want or need it when nearing end of life. All end-of-life care services should provide informed choice and control to people, including the ability for people to remain at home during their end of life stage if possible.

Improved advance care planning

- We know that where possible people will benefit from identifying goals in advance for their last year of life through discussing and planning care, including issues such as under what circumstances they would want treatment to stop.
- We know that early involvement in planning end-of-life care increases people's choice, control and support and the likelihood of them being able to die at home if wanted.
- The Tasmanian health system should continue to increase support for all General Practitioners and/or health professionals in initiating advance care planning as soon as they suspect that a patient may be approaching the end of life.
- We know that ongoing assessment of patients' physical, mental, social and spiritual needs will better enable them to make goals and enable health professionals to make referrals to community-based palliative care services or other relevant health and home care professionals as needed.

Advance care planning for residents in residential care

- If people are living in residential care, it is important they know that their facility does not need to take them to hospital when they are very near the end of life; they can (with the right support) remain in residential care at the end of life, if they wish to.

Providing home-based end-of-life services

- Home care providers with nursing services can provide comprehensive end-of-life care services, including health professional primary care and emotional support.
- Home care providers should follow a personalised care plan, and consumers and their carer(s)/family should have as much involvement in that plan as they are able to provide.
- Consumers also need to receive regular communication, assessment and management of their symptoms, and be provided with psychological, social and spiritual support as well as physical.

Improving care coordination for...

10. People using multiple services

The Tasmanian health system should provide improved opportunities for community-based care coordination services to meet client's individual needs, and truly prioritise prevention and support to maintain patient's independence at home. For patients using more than one service, the system should provide access to community-based health professionals that independently coordinate care, ensuring all providers and services work together in an integrated way. This would improve quality and service value by better ensuring people benefit from the right mix of services (of those that are available), in the right place at the right time.

Improving quality of care

A community-based health professional working independently as a care coordinator can help improve a patients' quality of care. Independent care coordination ensures better quality, person-centred care, for consumers and their carer(s) due to:

- Assessment and planning which fully identifies consumer needs and goals in order to optimize care-recipient outcomes and carer's support.
- Quality control, providing:
 - Increased level of choice for consumers, as all direct-care services are brokered without bias/conflict; and,
 - Flexibility/adaptability of services, individually tailored to consumer needs, preferences and goals.
- Coordination of care, increasing consumer access to planned supports.
- Care-management, provided by qualified health professionals (Registered Nurses or equivalent Allied-Health Professionals):
 - Utilising evidence-based health practice; and,
 - Independent, professional assessment regarding levels of need.
- Value-for-money, based on:
 - Increased affordability from better-practice purchasing/brokerage;
 - Increased accountability/transparency over service usage; and,
 - Broader/comprehensive resourcing of care, providing added services via extensive referral network/linkages (including primary, allied health, and community providers).
- Reablement, through provision of health coaching:
 - Extra support and information/education for consumers and carer(s), helping consumers to maximise their abilities and health/wellbeing; and,
 - Best preparing consumers and particularly their carer(s) to enable them to best manage their health or their ongoing role as carer(s) as the consumers' condition(s) change.
- Reablement through provision of care coordination:
 - Coordination of shared care through better informing and collaborating with all other health professionals and care providers necessary to maximise consumers' health outcomes.

Improving value for money

A community-based health professional working independently as a care coordinator is able to optimise each of the variables and priorities that will benefit consumers' care. Existing literature, consumer feedback and our practice experience demonstrate that an independent health professional, working together with consumers as a team to coordinate care, can effectively increase the value of services by:

- Increasing consumer and carer understanding, motivation, control and choice; and in turn,
- The consumer, carer and care coordinator team is empowered to optimise all relevant variables and priorities that increase the value of services – this includes increasing service access (availability and timeliness), service affordability (price and frequency), and service quality (appropriateness and safety).

Existing Services: Care Assess Health Personnel Services

Care Assess currently provides clinical health professional services including nursing and allied health care. We provide nursing services including health assessments, care planning, clinical care coordination, case management, and chronic disease management. We also provide allied health consultation including occupational therapy, exercise physiology and social work.

These services can be provided on behalf of General Practice or Health and Care Providers in the community or in residential aged care; funding includes:

- Medicare Benefits Schedule (MBS) primary care items
- Coordinated Veterans' Care (CVC) program,
- Tasmanian Medicare Local Care Coordination Program
- Home and Community Care (HACC)
- Home (Aged) Care Packages (HCP)
- Department of Veterans' Affairs, Veterans' Home Care (VHC)
- Workers compensation (Work Cover),
- Health Funds (Insurance), and
- Privately for individuals or organisations, able to pay a fee-for-service.

Feedback and more information

Care Assess welcomes your feedback!

- Please let us know if you would like to follow up on any of the content in this submission. You can email the Managing Director at md@careassess.com.au
- Please help us improve! You can also provide feedback or comment by emailing the Quality Manager at feedback@careassess.com.au

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