Care@home

Department of Health

Model of Care

Background

The growing pressures on the healthcare system, particularly within the Tasmanian Health Service (THS), highlight the need for innovative, evidence-based approaches to improve access and expand service capacity. One effective solution is the integration of virtual care modalities, which can significantly enhance timely and equitable access to healthcare.

By establishing statewide models of care supported by diverse digital health tools, we can collaboratively ease the strain on the system, promoting healthcare that is more accessible, efficient, and sustainable in response to increasing demand.

Care@home

Care@home, formerly known as COVID@homeplus, was launched in December 2021 and has since delivered over 50,000 instances of care to Tasmanians in their homes or places of residence. This statewide interdisciplinary service leverages virtual care technologies to remotely support patients in better managing their illnesses at home, improving health outcomes, and reducing potentially avoidable hospital admissions.

The service will work towards establishing itself as a state-wide navigation hub, designed to provide a single point of access for home and community-based care. With a goal to streamline the process for both consumers and clinicians, helping them identify appropriate care pathways to support individuals in their preferred environment.

The service aims to:

- enhance patient health outcomes.
- reduce potentially preventable hospital admissions.
- optimise care delivery in place, ensuring patients receive appropriate support in their preferred environment.

Service Principles

The following service principles are achieved through collaborative teamwork, providing a comprehensive and responsive service that meets the needs of patients and the Tasmanian community.

Patient-Centred Approach

- Focuses on improving accessibility, equity, and the overall patient experience.
- Incorporates individual patient preferences, needs, and values into the care process.
- Empowers patients to actively participate in managing their health through education and tools.

Supporting Community and Primary Care

- Strengthening and better coordinating the delivery of home, community-based and intermediate care services across a range of care areas.
- Developing flexible and sustainable service delivery models that promote integration across primary and secondary care, particularly for people with chronic conditions.
- Providing access to services regardless of the patient's geographical location
- Promoting primary care as the first point of call for health care.

Providing Alternative Care Options (Hospital Avoidance)

- Reducing potentially preventable presentations to the Emergency Department (ED), admissions or readmissions to acute care facilities.
- Tailored services including care coordination, navigation, and management for those at higher risk of unplanned hospital presentations, admissions, or readmissions.
- Providing enhanced care in the community setting, with a view to relieving pressure on hospitals and the healthcare system

Service Governance

The Care@home service operates within the governance framework of the Tasmanian Health Service (THS), with executive oversight provided by the Executive Director of Nursing / Director of Services Home and Community Care.

The Nursing Director - Care@home, and Medical Lead – Care@home hold management accountability and delegated responsibility to effectively manage the service on a day-to-day basis. These key roles are supported by a range of technical and operational leadership positions, ensuring the efficient and effective delivery of care.

Hours of Operation

The Care@home service operates 24 hours per day, seven days a week, statewide across Tasmania, with medical officer support available daily between 0900 hrs and 2100 hrs.

To connect with a member of the Care@home team for referral and patient eligibility inquiries, call **1 800 973 363**; seven days a week and select **option 2.**

Care@home

All referrals are assessed by the Care@home team to determine their suitability for virtual community-based care.

For the **Chronic Disease Management Program**, referrals are reviewed for eligibility by the Care@home team from **Monday to Friday**, 0830 to 1630 hrs. Referrals received outside of these hours will be actioned on the next business day.

Referral & Assessment Process

Care@home offers two referral pathways:

1. Patient Self-Referral Pathway

1800 973 363

Online enrolment form
care@home
health.tas.gov.au

2. Health Care Professional Referral Pathway

TAS Secondary Triage

1800 973 363

Select option 2 to speak to a healthcare professional

TAS Field Referral

1800 973 363

Select option 2 to speak to a healthcare professional

HCP Referral (Community)

eReferral referred to site: South, Community and Primary Health

Referred to Specialty: Care@home

HCP Referral (Hospital)

Kyra Flow
IQ Notes >

Specialist Referral: Care@home

Once the referral has been received, an initial clinical assessment will occur within 2 - 24 hours of self-enrolment or referral depending on the source of referral and service being requested.

Eligibility Criteria

Patients who meet the following criteria can be enrolled in the corresponding service pathways:

Acute Virtual Monitoring Program

- Self-Referral Pathway - Diagnosis of COVID-19, other respiratory illnesses such as Influenza (flu) or flu-like illness, or flu-like symptoms
- Healthcare Professional Referral Pathway - Exacerbation of a chronic condition or short-term illness that requires additional community-based care and management that can be delivered virtually.

Chronic Disease Management Program

- Adults who have a diagnosis of one of the specified chronic diseases (Diabetes Mellitus, Heart Failure, Chronic Obstructive Pulmonary Disease), or
- Patients who can be supported with care navigation and health coaching to manage their long-term chronic health condition, or
- Have a confirmed diagnosis of Post COVID-19 Syndrome (three months post onset of symptoms with symptoms for at least two months), or
- Have Cardiovascular Disease and/or related heart condition which is suitable for Cardihab - a remote, clinically validated digital cardiac rehabilitation platform.

General Eligibility Criteria

- Care can be safely delivered in the community setting using Virtual Technology.
- The patient or medical decision maker consents to enrolment in the service.
- The patient has 24-hour access to a working telephone and be able to use it to escalate care if required.

A person may not be suitable for the Care@home service if:

- they are medically unstable i.e. complex or acute medical needs that exceed the capacity of a virtual service
- they have care needs that can be provided by Primary Care or THS Community based services
- their needs are better suited to hospital-based inpatient care, rehabilitation, or transition care
- the patient or medical treatment decision-maker does not consent to the service.

Where a referral is not suitable, the Care@home team will document in the individual's Medical Record and communicate the rationale with the referrer.

Acute Virtual Monitoring Program

Provides healthcare into a patient's home using virtual care technologies to support the management of short-term illnesses or conditions where clinical care can safely be delivered using virtual technology.

Patient cohort includes **patients with non-life-threatening acute presentations as well as supporting early hospital discharge and transition back into the community.**

Clinical care is delivered utilising a variety of modalities, including video call and remote monitoring devices which report, collect and transmit patient health data for evaluation and care planning.

Remote Monitoring Pathways are used to guide monitoring, management, and support of patients with specific conditions i.e. Respiratory Illness, COPD, Heart Failure.

Benefits of the service include:

- Reduces the risk of emergency presentations and hospital admissions/re-admissions.
- Supports the transition from acute hospital admissions back to community care.
- Shortens the length of hospital stays when patients are transferred to Care@home.
- Improves access to healthcare for the community.

Chronic Disease Management Program

The arm of the service, has a primary focus on health coaching, navigation, and care coordination, **targeting those with the highest risk of hospital presentation or readmission** with a diagnosis of Diabetes, Heart Failure and COPD, alongside those living with long term chronic conditions e.g. Post COVID Syndrome.

The service provides remote support, care navigation and education for individuals to better manage their chronic conditions and improve their overall health status. Care is delivered in partnership with the individual's General Practitioner (GP) or in some instances may be managed by the Care@home team (including General Practitioners) until the patient is navigated back to the care of a primary care provider.

Patients enrolled in this stream will receive virtual care consults from the interdisciplinary team for up to a period of three months, this is seen as the optimal timeframe to guide patients through the changes necessary to positively impact their health.

Benefits of the service include:

- reduces the risk of emergency presentations and hospitalisations.
- improves health outcomes and enhances access to healthcare.
- empowers patients to better manage their chronic conditions.
- enhances coordination of care and disease management.

Please note – Care@home is not an emergency or urgent care service, if your patient requires emergency care, please call 000.