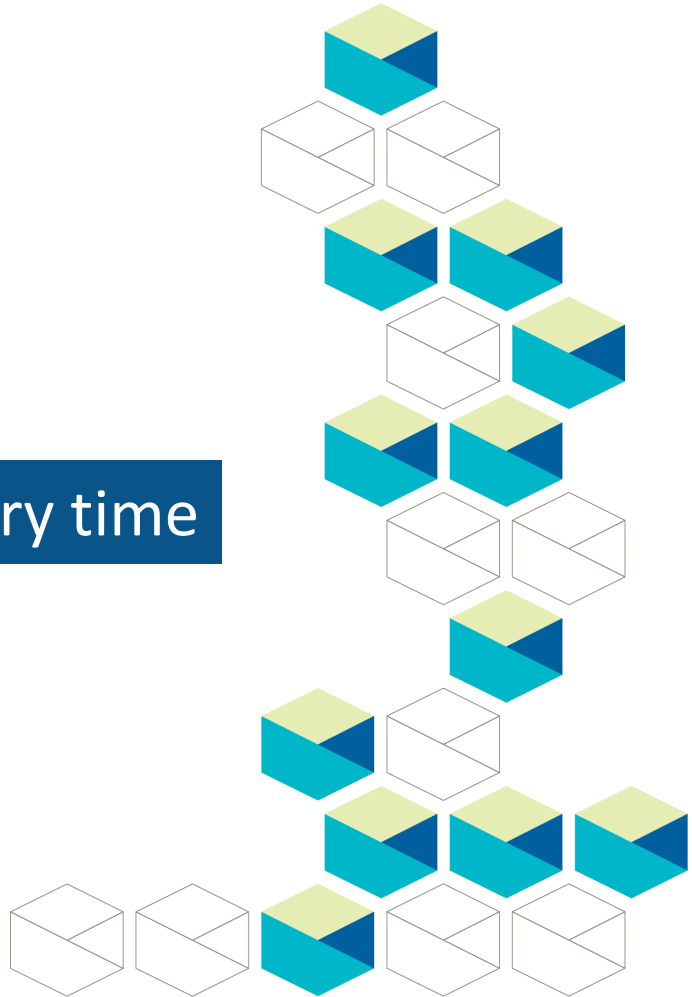
Government of **Western Australia**
South Metropolitan Health Service
Fiona Stanley Fremantle Hospitals Group

FSFHG CHOICE Team

Consider **H**ome **O**ver **I**npatient **C**are **E**very time

Roshini Mohan - Consultant Geriatrician

Vesna Milasinovic - A/Team Leader & Senior Occupational Therapist



FSFHG CHOICE Team

The **Sustainable Health Review** (2019) recognised that older adults are at greatest risk of further complications from hospitalisation. In response, Fiona Stanley Fremantle Hospital Groups (FSFHG) launched the **CHOICE Team** (2019) to help our hospital **C**onsider **H**ome **O**ver **I**npatient **C**are **E**very time

CHOICE Team FTE

- 1.0 Geriatrician
- 1.6 Clinical Nurse
- 1.0 Coordinator / Allied Health Clinician
- 2.0 Snr Occupational Therapist
- 1.0 Snr Physiotherapist
- 2.0 Snr Social Worker
- 1.0 Clerical

Strategic objectives for CHOICE

1. Promote a home first mind-set ☑
2. Rapid response clinic for frail patients ☑
3. Discharge to Assess care model ☑
4. Support long term care planning occurring outside of hospital ☑
5. Develop ED avoidance and tertiary hospital avoidance pathways ☑

Promotion of a ‘Home First’ / CHOICE Mindset

What does a CHOICE culture look like?

- **Shared decision making** and **positive risk taking** that keeps the unique values, life circumstances and preferences of our patients at the forefront of our decisions
- Changing our clinical perception of patient risk with an aim to optimise outcomes by minimizing length of stay
- Weighing the ‘*perceived risk of discharge*’ against the ‘*known risk of admission*’

Culture building strategies

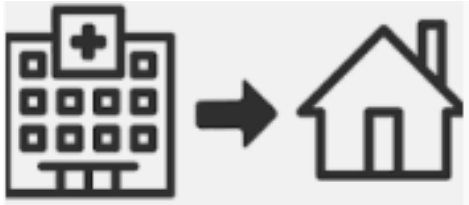
- Education and training
- Community engagement
- CHOICE Steering Group and CHOICE Champion Groups
- Extensive in-reach and collaboration
- Changing hearts and minds through good news stories
- Publishing success
- CHOICE monitoring dashboard

CHOICE team at Fiona Stanley Hospital

Discharge to Assess Model of Care

- **Discharge to Assess** is a new practice which has been proven to shorten length of stay (LOS) and improve patient outcomes

- At the time a patient no longer requires acute inpatient care, discharge to assess (DTA) programs divert ongoing assessment and care into the patient's home and / or community



The FSFHG CHOICE Team is considered an **extension of the ward**
It is a **hospital-outreach team** that, in essence, completes 'discharge planning' in the community rather than in the hospital setting

Benefits of diverting care into the community

- A familiar environment and routine is important for people with a cognitive impairment
- Incidental household activity will help maintain strength
- Rehabilitation and reablement can be tailored to meet real life goals
- Function is more accurately assessed in the home environment
- Decisions about long-term care are **life changing** and need to be made **at the right time** and **in the right place** (*not during a crisis or when medically unwell*)

Most importantly…

CHOICE Team

- CHOICE Allied Health and Nursing
  - 7-day service / 8AM – 4PM
- CHOICE Geriatrician ‘Rapid Response’ Clinic
  - Monday – Friday
- MDT Meetings
  - Daily (to discuss complex cases as required)
  - Ad hoc discussions with Geriatricians (as urgent matters arise)

CHOICE Allied Health Service

- **Assessment** and **optimisation** of patients in their home environment *instead* of the inpatient setting, relating to (but not limited to):
  - Function
  - Cognition
  - Falls risk
  - Long-term care needs
  - Onward referrals to community services

After assessment, the team can provide immediate therapy, prescribe social care (interim home care packages (IHPs)), refer onward to community services, optimise the home environment and coordinate care needs

CHOICE Nurse Outreach Service

- A flexible service designed to help transition our more vulnerable and frail patients' home

- Includes (but not limited to):
  - Medication review
  - Education
  - Wound management (short term)
  - Catheter care
  - Symptom monitoring
  - Care coordination

- Service delivery includes telehealth and home visits

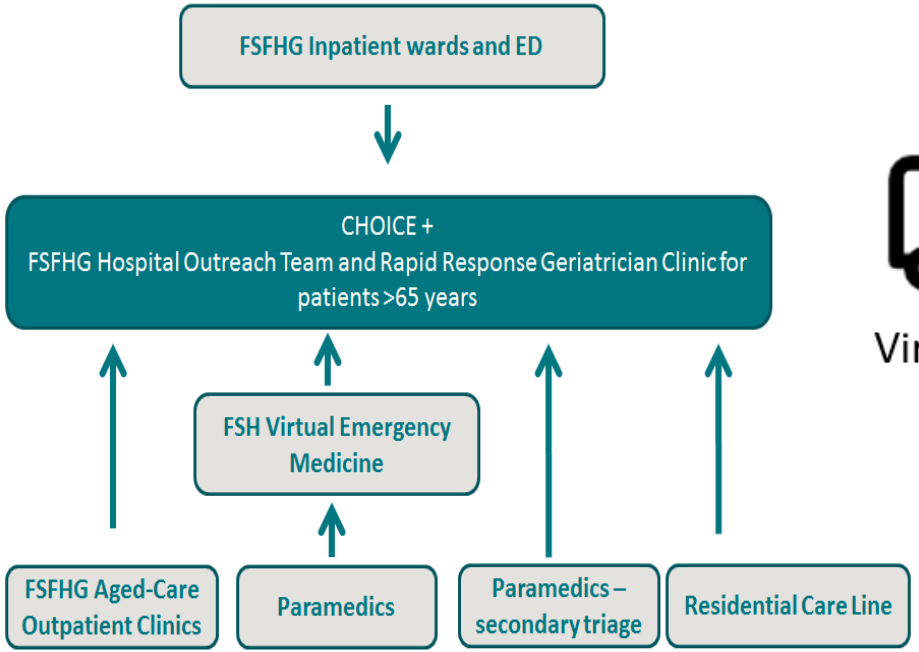
CHOICE Geriatrician ‘Rapid Response’ Clinic

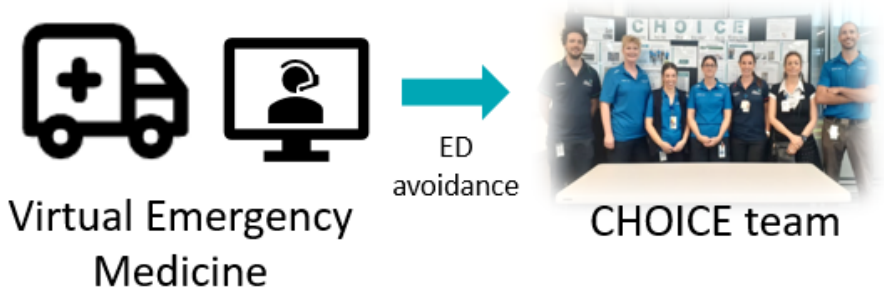
- Timely access to a Geriatrician to support **early** discharge plans / admission avoidance alternatives

- Follow up and management of (but not limited to) :
  - Delirium follow up and management
  - Acute on chronic pain in frail patients at high risk of analgesic side effects
  - Falls and mobility related issues (requiring urgent review)
  - Deprescribing and complex polypharmacy
  - Cognitive impairment with urgent risks identified
  - Acute on chronic medical conditions, such as congestive cardiac failure, where early clinical review after discharge is beneficial

- Service delivery includes telehealth and outpatient clinic appointments (home visits are considered case-by-case)

Pathways to CHOICE

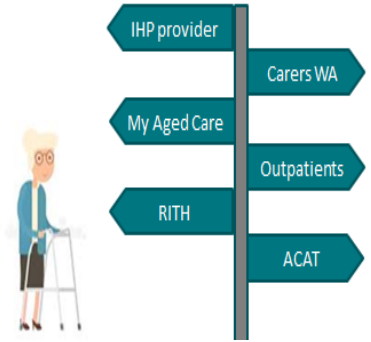




Pathways from CHOICE

- Transprofessional assessors can refer for **interim hospital packages** after discharge
- **Strong community partners** such as Aged Care Assessment Teams (ACAT), Rehabilitation in the Home (RITH), Complex Needs Coordination Team (CoNeCT) and Carers WA
- Experienced staff trained in **crisis management**, including the ability to find emergency respite beds
- Can **directly admit** clinically suitable patients to the Fremantle Hospital **Rapid Assessment and Treatment Unit (B9N)** under the care of a Geriatrician (ED Avoidance)

Direct admission pathways back to our Aged-Care wards
(ED avoidance)



These safety nets allow our more vulnerable patients to embrace positive risk and **give home another go** with the assurance that they will be followed up by a responsive and accessible service

Patient Inclusion Criteria

- Our CHOICE Team has a preference for:
  - Older adults discharged within the **first 72 hours** of their admission
  - Older adults who are **stranded** in hospital despite **no longer improving** in the inpatient setting
  - Older adults requiring support for **long-term care planning**
  - Older adults with health conditions that require a **contextual in-home assessment** (e.g. patients with a cognitive impairment)
  - Frail patients, especially those between 4-7 on the Clinical Frailty Scale (CFS)
  - Urgent community referrals (admission avoidance opportunities)

Referral process

- Phone call to the CHOICE Team Leader (0466 713 334)
- Referrals accepted from any discipline
- Out of hospital (OOH) referrals will be triaged the next morning

Primary targets are **Clinical Frailty Scale (CFS) 4-7**

Clinical Frailty Scale

Site: Fremantle Hospital **Unit:** Rehabilitation and Aged Care **Drop Box:** CHOICE Project

Where to from here?

- Continue **CHOICE culture** promotion, with emphasis on supporting positive risk-taking amongst staff
- Nurture **admission avoidance** pathways (i.e. ambulatory care model to assess non emergent, semi acute older adult patients by providing comprehensive Multidisciplinary management; reduce unnecessary tertiary ED presentation/hospital admission)

**Collaboration with primary care physicians and other community health care providers in identifying suitable patients who require semi acute geriatric review in a day case hospital setting to minimise tertiary care presentation

Lessons learnt

- Essential components for a successful Discharge to Assess (DTA) service
  - Invest in **culture building** (key component)
  - Target the hospitals' front door
  - The DTA team requires immediate access to care services, basic aids / equipment, and strong community partnerships
  - Have streamlined pathways back into hospital **that avoid ED**

Home is where the heart is…