Summary

Home Based care will be the primary mode of care provision for RACC services throughout the COVID 19 pandemic. Community Rehabilitation Program and Better at Home are two services within the RACC program that provide home based rehabilitation and quality care to people within their own home. Both services aim to facilitate earlier discharge from hospital, prevent clinical deterioration leading to hospital admission and improve patients' function and community access. To increase the number of patients referred to home based rehabilitation services, changes will be made to the referral pathway including referral management.

Background

Staff have reported confusion with understanding the difference between Better at Home and Community Rehabilitation Program. This has been further impacted by the change in care delivery and workforce profile of Community Rehabilitation Program.as part of the RACC pandemic response. . This has resulted in an increase in referrals to Better at Home for patients who could be more appropriately managed by the Community Rehabilitation Program.

To alleviate confusion, possible delays in discharge from hospital and the requirement to complete multiple referrals, changes have been made to the referral pathway, most notably, how referrals to Better at Home are triaged and accepted. It is important to note, there will be no change to how each service operates in relation to their patients or models of care. Referrals to Better at Home from acute services will now be reviewed by the RACCS team, which aligns with the current management of all acute referrals to subacute admitted services. The RACCS team will either accept and waitlist the referral to Better at Home or determine an alternative discharge destination is indicated and forward the referral on themselves. This removes the need for referring teams to re-refer. It will be the role of the RACCS Team to communicate with referrers as well as patients and families. Referrals to Better at Home from Caulfield Hospital will now be triaged and managed by the Caulfield Bed Manager and will follow the same process outlined above.

These changes to subacute referral management will:

- Align the management of all referrals to subacute admitted services
- Simplify the process for referrers by introducing a central point of referral management for subacute admitted services
- Introduce the process of referring to a home based rehabilitation service
- Allocate patients to the most appropriate home based service, based on patient need
- Eliminate the need for referrers to complete multiple referrals if the initial location of care is not appropriate or recommended
- Manage the transition of inpatients to either Better at Home and Community Rehabilitation, as well as between the two services
- Deliver care consistently across all services

Referral Management

Please refer to Appendix one for referral management flowchart

- RACCS Team triages referral from acute services. If appropriate will accept and waitlist
- Caulfield Bed Manager triages referral from subacute services. If appropriate will accept and waitlist

*Any complex referral can be discussed with Better at Home Nurse Unit Manager

*Referrals received on weekends can be accepted and managed by Better at Home service directly

Establishment

The introduction of the Home Based Services Program will be achieved through Stages:

<u>Stage 1: Setting up</u>

- Communication to relevant teams
- Community Rehabilitation team to review the current restrictions on service delivery with the aim to increase face to face interventions to facilitate earlier discharge from hospital or prevention of clinical deterioration leading to hospital admission applying all Infection Prevention Strategies
- Community Rehabilitation will maintain workforce levels according to RACC pandemic response stage
- Establish a Home Based Services Program with regards to referral management at each site:
    - Establish referral management process for each site
        - RACCS team triages referral from acute services. If appropriate will accept and waitlist
        - Caulfield Bed Manager triages referral from subacute services. If appropriate will accept and waitlist
        - All referrals to be reviewed within 24 hours of receipt
    - Triage and allocation
        - Referrals to be triaged according on patient need and acuity
        - Central point of allocation will be established with key contacts/experts from each service available for advice
        - Home risk assessment tool and process to be aligned across both services (including who completes and when)
    - Communication
        - Standard communication to be developed for referrers (including who completes this, what communication method is used and timing)
- Review and improvement of the Better at Home Powerform to include rehabilitation goals and to better align with the CRP referral form. This will improve the front end triage of referrals and reduce any duplication
    - Until power from is updated all Better at Home referrals to include patient goals and contact person in the comments section
- Community Rehab team member to attend the Better at Home Patient Communication Rounds in order to support Better at Home discharge planning.

Stage 2: Implementation

- Communicate changes to organisation and/or referrers
- Introduce Home based services Program

Recommendation

To alleviate confusion, possible delays in discharge from hospital and the requirement to complete multiple referrals, changes have been made to the referral pathway, most notably, how referrals to Better at Home are triaged and accepted.

All patients referred to the service will continue to have identified patient centred goals, medical needs that can be met through the home based service and must reside in the specified catchment.

Appendix One: Referral Management Flowchart