



NEWSLETTER

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EDITORIAL

By Sue Daly, Business Manager, VCACI

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VCACI Update

In July the VCACI forwarded a progress report to the Department of Human Services outlining its activities over the 1997/98 financial year. Within this time-frame staff of the Centre have completed a number of projects including:

- clinical guidelines for the management of anaphylaxis in HITH (reproduced in a previous newsletter),
- clinical guidelines for parenteral drug administration in HITH (to be included in our next this newsletter),
- coordination of 2 HITH seminars,
- publication and distribution of quarterly newsletters,
- a framework for the development of standards for HITH,
- a generic Variance Tool incorporating HITH variances for use with clinical pathways,
- a comprehensive review of cellulitis (to be submitted for publication),
- collaboration in development of a Hip Replacement Clinical Pathway at The Alfred,
- expansion of the HITH resource database,
- regular meetings with the Inner and Eastern Health Care Network HITH Coordinators,
- development of the VCACI enquiry database, and
- formal agreement to pursue a collaborative ambulatory care initiative with The Alfred and Johns Hopkins.

In consultation with the Department of Human Services we have finalised our key deliverables for 1998/99. A number of our key focus areas will continue from last year including facilitating clinical pathway development, standards for administration of Chemotherapy in the Home, additional HITH focussed clinical guide-

lines, continuing expansion of our ambulatory services reference database, and co-ordination of multi-disciplinary seminars in both metropolitan and rural locations.

In addition to these initiatives we are addressing a number of new areas including:

- bimonthly, state-wide HITH coordinators' meetings using video-conferencing facilities to link selected rural sites. The first of these was conducted in August with a video link to Mildura which proved highly successful,
- the development of key performance measures for comparing HITH program efficiency and patient outcomes,
- a minimum data set for HITH, and
- the VCACI web page which will contain information on our clinical guidelines, reference material and hot-links with other relevant sites.

New Appointments

Over the last few months we have made three new appointments within the Centre. New staff include Robyn Wall, Kaylene Fiddes and Carol Staley.

Robyn Wall

Robyn is a registered nurse with a Bachelor of Business (Marketing). She has worked in the position of Marketing Coordinator and Registered Nurse at Warringal Private Hospital and Cotham Private Hospital where her responsibilities included an educational needs analysis for GPs, marketing hospital services to GPs, public health promotion along with the delivery of homecare services. Robyn has extensive clinical experince in medical, surgical, paediatrics and neuroscience units.

Kaylene Fiddes

Kaylene's previous experience includes acute hospital and home care case management. During the 6 years she spent in the US, she enjoyed the opportunity to work in both the acute hospital and home health care settings. Within her acute home care role she managed patients with either medical or surgical conditions as per JHACO (US accreditation) homecare standards. Whilst working as a home care case manager she was able to seek further development in case management and critical pathways through a course at a community college in Arizona, and through participation in a number of conferences.

Upon her return to Australia, Kaylene worked in a case management position at Warringal Private Hospital, Heidelberg. In addition to the development of Gynaecology Case Management and the coordination of services for this patient population, she developed and implemented critical pathways for specific procedures.

She also covered the medical, oncology and home care case managers during her time at Warringal. Liaison with, and understanding of, community health services and groups was an integral part of her case management role.

Carol Staley

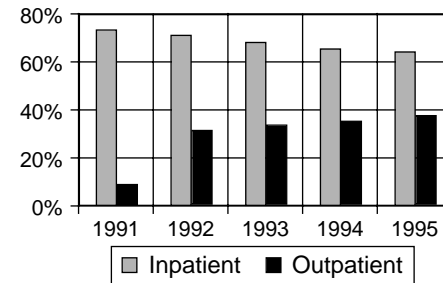
Carole's expertise within the community nursing environment is significant. Since 1994 Carole has recorded many achievements in her role as Manager of St Vincent's HITH program including the expansion of the Home Care Extension Unit which provides Hospital in the Home services to both general clients, and homeless clients residing in Sr Francesca Healy Cottage. In consultation with computer programmers, she developed a database to facilitate the collation of statistics to analyse service provision. Carole's past experience includes client coordinator for the Royal District Nursing Service in the Knox and Lilydale Centres. Carole has a number of professional affiliations and has presented papers at numerous conferences related to Community Nursing and Hospital in the Home. She continues to share her knowledge through collaboration with LaTrobe University and her involvement with the development of specialist subjects in HITH nursing.

VCACI Events

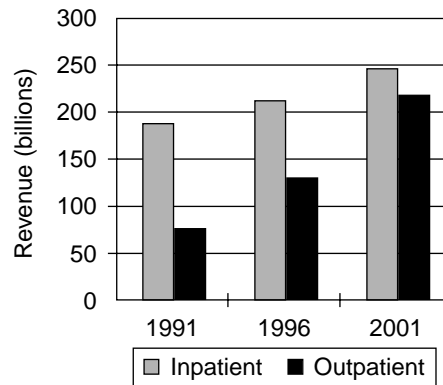
On the 16th June 1998, the VCACI hosted its second seminar in association with Hoechst Marrion Roussell at the

Fairfield Boat House. On this occasion our guest speakers were Dr Alex Padiglioni, PhD scholar, Fellow in Clinical Effectiveness, Infectious Diseases, Monash Medical Centre who presented on 'The Revenge of the Germs' and Marjorie Bauman, President and Chief Executive Officer, Johns Hopkins Home Care Inc who provided an overview of homecare in the United States. Alex provided an entertaining perspective on the threat of emerging resistant organisms including vancomycin resistant staphylococcus. Marjorie outlined current trends in US healthcare including the shifting focus from inpatient to ambulatory care models as shown in the following graphs.

Percentage of Gross Health Spending -US



Growth in Outpatient v Inpatient Services - US



continued on page 11

HITH ARTICLES

The June issue of the British Medical Journal contained 4 articles that are relevant to hospital in the home.

Summarised by Lisa Demos, VCACI

Shepherd S, Harwood D, Jenkinson C, Gray A, Vessey M, Morgan P. Randomised controlled trial comparing hospital at home care with inpatient hospital care: I: three month follow up of health outcomes. *BMJ* 1998; 316:1786-91.

This was a randomised controlled trial in Kettering General Hospital, UK of inpatient hospital care or hospital at home care in 5 groups of patients and their outcomes. The patients were recruited from primary or secondary care and included those recovering from hip replacement (n=86), knee replacement (n=86), hysterectomy (n=238), elderly patients with a mix of medical conditions (n=96) and patients with chronic obstructive airways disease (n=32). There was a 3 month follow-up of outcomes which included general health status, disease specific measures, hospital readmission, mortality, carer burden and patient and carer preferences for care.

The trial did not have the power to detect differences in morbidity or mortality and the number of patients recruited with chronic obstructive airways disease was small. There were no major differences in outcome between hospital at home care and hospital care for any patient group except patients recovering from hip replacement who reported a significantly greater improvement in quality of life with hospital at home care. 30% of patients with knee replacement, 14% of hysterectomy patients and 14% of hip replacement patients allocated to hospital at home, remained in hospital because of post-operative complications. Patients in all groups preferred hospital at home care except those with chronic obstructive airways disease. No differences were detected in carer burden. Carers of patients with knee replacement preferred hospital at home care whilst carers of patients with hysterectomies preferred hospital care. More elderly medical patients allocated to hospital at home care had to receive secondary care during the three month follow up than those allocated to hospital care.

Shepherd S, Harwood D, Gray A, Vessey M, Morgan P. Randomised controlled trial comparing hospital at home care with inpatient hospital care. II: cost minimisation analysis. *BMJ* 1998; 316: 1791-6.

This was a cost minimisation study within the above randomised controlled trial that compared the cost of providing hospital at home to inpatient hospital care from the perspective of the health service, the general practitioner and patients and their families. Data was collected on hospital costs, hospital at home costs, general practitioner costs and carer costs.

The median total health service costs were £2,379.67 for hospital at home patients and £1,247.64 for hospital patients (p=0.01). No difference was detected in total healthcare costs between hospital at home and hospital care for patients recovering from a hip or knee replacement, or elderly medical patients. However, hospital at home significantly increased healthcare costs for patients recovering from a hysterectomy and chronic airways disease. Hospital at home significantly increased general practitioners' costs for elderly medical patients and those with chronic obstructive airways disease thus shifting costs for these patients to primary practice. As most carers were retired they did not report loss of earnings. Patient and carer expenditure made up a small proportion of total costs and these were not significantly different between the groups. Use of sensitivity analysis to

decrease length of stay in hospital in the home by one day for patients with hysterectomy eliminated the differences in costs but had no effect on chronic obstructive airways disease. A 2 day reduction resulted in home care becoming significantly less costly for hysterectomy and a non-significant difference between the two groups for chronic obstructive airways disease.

Richards SH, Coast J, Gunnell DJ, Peters TJ, Pounsford J, Darlow M-A. Randomised controlled trial comparing effectiveness and acceptability of an early discharge, hospital at home scheme with acute hospital care. *BMJ* 1998; 316:1796-801.

This was a randomised controlled study in Bristol, UK of the effectiveness and acceptability of early discharge to a hospital at home scheme with routine discharge from an acute hospital. Hospitalised, medically stable, adult patients were recruited from general medical, orthopaedic and general surgical specialties and followed for 3 months. Randomisation was stratified by admission type in a 2:1 ratio to hospital at home (n=160) or acute hospital care (n=81). Outcomes measured included quality of life, satisfaction, physical functioning, length of stay and mortality.

Most patients were elderly, female and had been admitted for orthopaedic procedures (68%). The largest diagnostic category was fractured neck of femur (31%), other fractures (21%), elective hip replacement (11%), cerebrovascular accidents (10%), elective knee replacement (5%) and miscellaneous reasons (22%) such as chest infection or falls without fractures. A main carer was identified by 58% of hospital at home patients and 49% of hospital patients. There were no significant differences in patient mortality, quality of life, physical functioning and most measures of satisfaction at 4 weeks or 3 months. The only significant difference in patient satisfaction was that home patients perceived higher levels of involvement in decisions through discussions with staff at the 4 week follow up. The length of stay was significantly longer for patients receiving routine hospital care (geometric mean of 14 days vs 8.6 days length of stay in hospital at home scheme).

Coast J, Richards SH, Peters TJ, Gunnell DJ, Darlow MA, Pounsford J. Hospital at home or acute hospital care? A cost minimisation analysis. *BMJ* 1998; 316: 1802-6

This was a cost minimisation study within the above randomised controlled trial that compared the cost of providing early discharge to hospital at home to continued care in an acute hospital from the perspective of the NHS, social services and patients.

The mean costs over 3 months were £2,516 for hospital at home patients and £3,292 for hospital patients. Costs for general practitioners increased slightly with hospital at home from a mean of £89.54 to £118.74. Costs to patients were similar in both groups.

Under all the assumptions used in the sensitivity analysis eg altering valuation of aids and adaptations or including travel costs, the cost of hospital at home care was less than that of hospital care.

The difference became equivocal only when hospital costs were assumed to be less than 50% of those used in the initial analysis. This study concluded that the hospital at home scheme is less costly than care in the acute hospital.

SUMMARY OF PATCH V

by *Robyn Wall and Sharon Moreham, VCACI*

The fifth national conference for Post Acute Treatment and Care in the Home (PATCH V) was held on the 31 July and the 1 August 1998 at the Novotel Brighton Beach, Sydney.

Dr Brendan Nelson MP, Member for Bradfield, provided the first presentation in which he proposed that Australia was facing a period of change in all areas of life and society. He saw this change as 'values and tradition being challenged by progress', with this creating a climate of crisis of values and beliefs in Australian society. Dr Nelson advocated that Australia needs a strategic vision to guide it through this transition period. He also identified that a knowledge-based market is emerging and the development of PATCH is set against such micro-economic reform. Dr Nelson suggested that PATCH programs should be implemented, not because it will save money or decrease length of stay, but because it is consistent with Australia's strategic vision and it meets the needs of patients. He also identified a need for national leadership in the PATCH area.

Professor Ian Webster AO, Professor of Public Health at the University of New South Wales, provided the second introductory address. He gave a history of the Australian Public Hospital system from the 1960s to the present, encompassing many aspects of healthcare, from the structure, management, and diseases treated and managed, through to relationships with patients. Professor Webster identified that the hospitals have become places of intense and time-limited activity and it is now appropriate to re-think how they operate and their relationship with the community. He suggested that PATCH fits into this review. Professor Webster also identified areas where treatment outside hospital is preferred such as mental illness and management of drug and alcohol problems. Professor Webster also discussed social issues (such as unemployment, isolation, and lack of family support), that may affect patient's outcomes on leaving hospital and therefore affect their outcome on any PATCH program.

He suggested that special and innovative arrangements are needed for marginalised people such as the homeless, mentally ill, persons living alone, single-parent families and the poor. He raised concerns about inequities in programs of early discharge from hospital and the burden on non-government community organisations.

Four speakers presented papers on funding issues. Helen Longland, National Manager of Acute Services, MBF noted that funders are increasingly realising that the acute in-hospital setting may not be the best place for their members. She emphasised that MBF and many other funds are focusing on ways to ensure that their members access the right services, in the right location, at the right time, for the right cost. She saw three major issues in the funding of post-acute care - quality, financing, and social issues. Helen related the quality issues to such things as evidence-based practice, accountability, and continuity of care. She identified insurer issues relating to funding structures such as the reinsurance pool discouraging the development of outpatient programs, risk assumptions by providers of care, fund holding for services over time and in alternate settings, and the use of post acute care to offset inpatient stays. Helen suggested social issues encompassed the presence or absence of support structures in the patient's environment which are not health related, such as physical environment and access to home carers. She emphasised that in the delivery of all care, the focus of MBF is changing from being a passive funder of care to being a discriminating purchaser of services on behalf of their members.

Shaun Larkin, General Manager, Strategic Development, HCF provided an overview of the private health insurance market in which premiums have increased above inflation and membership is declining, with the young and healthy not entering and high users (often the elderly) remaining. He also commented that it is a highly regulated industry and there are onerous billing and claiming

systems for members. Shaun asserted that HCF has similar attitudes to MBF also emphasising the importance of the right care, at the right time, for the right price and the elements that he considered to be important in addressing these priorities.

Professor Don Hindle, National Director of the Australian Healthcare Association (AHA) commented on AHA policy ideas for funding. He suggested that the private health insurance industry is an agent of the government because of the high regulation of the industry. Professor Hindle also suggested that the current arrangements for funding were chaotic for both public and private funding, and that there are large opportunities for cost shifting. He proposed a new model of funding in which all funding goes to Area Health Services. He advocated clinician centred clinical pathways across all settings as a core element to improving the delivery of health care and improving the funding issues.

Dr Beres Wenck, President Elect of the AMA Queensland Branch commented that Australia is following the world trend of shifting care from the secondary sector to the primary sector but that the funding is not following this shift. She advised that AMA supports PATCH but that it needs to meet the major principles of care, which she outlined as being safe, high quality, cost effective, and meeting patient and carer satisfaction. Dr Wenck noted that no perfect model had yet been developed for HITH and clear cost-benefits had not yet been demonstrated. She suggested that HITH would become a community acute integrated service in which hospitals would provide protocols, guidelines, and pathways (in conjunction with community services), up-skilling of community providers, a liaison role, and linkage enabling easy return to hospital if required. She saw relationship building as important, with respect for GPs and the community nurse by hospital specialists and hospital nurses increasing. Dr Wenck suggested that the AMA had a role in building such relationships and developing policies for PATCH.

Mary Brittain-White and Derek Austin from Retriever Communications reviewed developments in technology since last year's conference with particular emphasis on developments in mobile communications relevant to PATCH. They focussed on hand held devices such as Windows CE Version 2 and developments in mobile telephones. Derek advised that pen operated systems are considered to be important in future technology including the development of digital paper on screen rather than applications being menu driven.

Debbie Killian and Debbie McNamara from the Bankstown Health Service reported on a trial of handheld technology for charting episodes of care in their home nursing service. Some of the advantages in using hand held technology identified during the trial included: improved continuity of care, improved communication, improved documentation and accountability, and improved quality of charting. They estimated that the hand held technology could save in the order of \$8,090 on average per nurse per year.

Dr Keith Suter, a social commentator and broadcaster, closed the end of the first day of the conference with a comment on the social impact of PATCH. Dr Suter suggested that there have been three eras of change; the agricultural revolution, the industrial revolution and we are now entering the information era. He saw PATCH fitting into this new information era. He believed that it isn't a matter of whether PATCH would be implemented but how soon. He warned that we are also entering an era of reform fatigue which is a world wide reaction against the pace of change, and those developing PATCH programs may come up against this fatigue in establishing this form of care.

Dr Suter also highlighted demographic implications for PATCH. He suggested that there are three separate population groups; those born prior 1945, those born 1946 to 1966, and those born after 1967. Dr Suter stated that the first group were the backbone of social capital in Australia, knowing the need to work together and look after people. He suggested that the second group, who are driving the pace of change now, are a selfish generation in the western world. They have grown up in a society where every-

thing was provided and they don't want to care for others. He saw the third group as being very transient with no children, no mortgage, and no marriage. Dr Suter questioned whether PATCH would work with these generational differences that hold different world views, and while PATCH is technically feasible there may be very significant social obstacles.

Dr Suter identified a lack of awareness of the existence of PATCH in the general population and that any publicity needs to argue that PATCH is good for the individual because the population in general is not very interested in what is good for society. Dr Suter also suggested focussing on the benefit to people if campaigners want PATCH to become a media issue. He advocated demonstrating that PATCH is good economically to the bureaucrats, as campaigners need to talk to them in their own language - economics.

A brief gathering of those interested in networking for campaigning for the development of PATCH was held.

Wayne Cahill, a partner, at Blake Dawson Waldron provided a medico-legal update focusing on liability - practitioner risks and accidents in the home. This session covered such areas as general liability (negligence and non-delegable duty of care), occupational health and safety, and risk management by organisations. Wayne stated that the employer has an obligation to ensure the health, safety and welfare at work of all employees. Adequate training should be provided, and written policies and procedures should be in place which are both understood and followed by all employees. Policies are legally required to be monitored and reviewed, incorporating analysis of any incidents (including trend analysis).

Several PATCH models were presented throughout the conference, including those used by Toowoomba Base Hospital (TBH) and Princess Alexandra Hospital (PAH), both in Queensland. Dr Greg Comadira, Director, Emergency Department, TBH spoke on the economics of HITH programs in relationship to their survival. An interesting aspect of his discussion focused on the HITH model used by TBH. The basis of their model is that HITH staff in the ED review all acute patients and any that meet the HITH cri-

teria are admitted straight into the program, hence bypassing the in-hospital bed. Any patient meeting the criteria has to have their unit justify why they cannot be admitted directly to a HITH bed if the issue arises. Thus hospital beds are not closed, but relocated into the community.

Kerri McLeod, Clinical Nurse, in Transitional Care, at PAH Queensland, presented the model used by PAHs Transitional Care Unit. This program focuses on elective surgery and involves GPs as one of the key stakeholders. GPs were involved in all aspects of the program's establishment and are crucial players in the patients' care and recovery. Information sheets were developed by surgeons for each patient group and these are faxed to GPs with the patient's discharge summary on the day of discharge. The transitional care team continue to care for the patient in their home on discharge from PAH, under the guidance of the parent unit and in liaison with the GP. On completion of the program, the GP completes an evaluation form and sends it back to the hospital. The program is under constant review to ensure that both patient and GP needs are being addressed.

Several scientific papers were presented covering the economics and patient mix of various PATCH programs around the country. These included presentations by Beth Viertel, Nurse Practice Co-ordinator, at the Townsville District Health Service, Queensland, who presented the findings on a central catheter tip study, and Cathy Gibson, Charge Nurse, of the Bone Marrow Transplant Unit, Christchurch Hospital, New Zealand, who presented an evaluation of the Biopatch(tm) antimicrobial dressing for insertion site management of indwelling central venous catheters. The Biopatch study looked at the effectiveness of the Biopatch dressing (which contains controlled release chlorhexadine) in the management of central venous lines in chemotherapy and bone marrow transplant patients. Results have shown a five-fold reduction in the incidence of catheter related infection, and the study is to be transferred into a randomised controlled trial for further evaluation. This presentation won the award for the best scientific paper.

IMPLEMENTING THE HEALTH OUTCOMES APPROACH

7th & 8th August 1998

By Kaylene Fiddes, VCACI

Implementing the Health Outcomes Approach Conference was convened in Canberra on 7th and 8th August. Michael Moore, ACT Minister for Health and Community Care, gave the opening address in which he presented "Setting the Agenda". Setting the Agenda, which has only recently been launched, is the vision for a healthy community in the ACT and gives the directions for health and community care in the ACT based largely on an outcomes approach.

Keynote Address

Professor Allen Hutchinson from the University of Sheffield (UK) presented the keynote address on issues for outcomes implementation: international perspectives. Outcomes assessment tools have been widely developed, however, Professor Hutchinson acknowledged there have been difficulties in their implementation into clinical practice and identified some common barriers. Some of these barriers have included little experience by clinicians, lack of understanding, and the requirement of change in clinical practice.

Professor Hutchinson suggested a framework for implementing outcomes measures. This highlighted the use of appropriate measures, education on methods, systems to support assessment and implementation, and professional and political support. He also advised that some had called for education on outcome measures to be included in undergraduate clinician studies and in continuing medical education. Professor Hutchinson emphasised that implementa-

tion requires evidence-based strategies and the "keep it simple" approach.

Government Initiatives and Future Plans

The Deputy Secretary of the Commonwealth Department of Health and Family Services, David Borthwick, reminded us that Australia, in fact, has a good health system by international standards, but it is also one of the more costly. He stated there is an adjunction for evidence based practice and cost effectiveness. The Coordinated Care trials and the development of the Medical Services Advisory Committee were cited as examples of things being done to improve outcomes and contain costs.

David Butt, Chief Executive, ACT Department of Health and Community Care, reiterated the common message that implementing outcomes into practice is difficult. Mr Butt discussed the development of a Consumer Call Centre staffed by nurses which offered interactive IT and referral to appropriate services. He elaborated further that Information Technology could also provide the opportunity for telehealth and chat lines for patient support groups. Additionally, he discussed a potentially better use of services in primary care. An example of this is visiting community nurses instead of GPs, where appropriate, to allow GPs to give specialised services.

Kate Moore from the Consumer Health Forum discussed three key issues on outcomes and their relation to the consumer. Firstly, Ms Moore expressed that the communication between consumers and

providers is poor. Secondly, she questioned the focus on outcomes, asking "why the focus on outcomes when the process is in decline" and thirdly, Ms Moore identified research issues, including the data comes from consumers, that the data is frequently used without their permission and that the data is not respected.

Consumer Issues

Further consumer viewpoints came from Kathy Mott of Consumer Perspectives, South Australia. Kathy called for a partnership with consumers stating consumers are "often the after thought". Kathy stated that outcomes lacked consideration of discharge planning and the process of what happens during hospitalisation. Kathy advocated the use of pathways as a great tool for a patient knowing exactly what's going on. Kathy also called for more consumer participation or involvement in decision making.

Dr Brian Williams from the Department of Epidemiology and Public Health, University of Dundee, UK discussed patient satisfaction surveys and asked:

- are satisfaction tools accurately reviewing patient thoughts and satisfaction?
- do the patients actually evaluate the service at all? and,
- are the questions on the questionnaires poor because they can prompt misleading answers?

He presented recent research and concluded that reported satisfaction may not be a good indicator of a patient's experience, patient satisfaction remains impor-

REGULAR FEATURES

In future issues of the Newsletter we plan to include regular features such as . . .

- HITH Pharmacy issues
- HITH Program Showcase
- Recent Research Findings
- New Product Information
- HITH Case Studies
- Summaries of relevant publications
- Relevant conferences, short courses, workshops and seminars

tant for health behaviour and to improve services, patient's experiences of health care must be collated.

Following on with patient satisfaction surveys and consumer perspectives, Mary Draper from RMIT University discussed a report she co-authored on patient satisfaction surveys. Mary called for a move from consumer feedback to consumer participation and stressed the importance of bringing together understanding between health staff and the consumer.

Martin Fletcher, of the Health Services Outcomes Branch, also spoke of the importance of consumer participation. The Centre for Consumer Participation is being developed and its aim is to provide a mechanism which gives health providers and consumers access to research, approaches and methods of consumer participation. The Centre, then, will look at patient participation methods and models.

Measuring Health Outcomes

Dr Andrew Garratt from the Department of Health Sciences and Clinical Evaluation, University of York (UK) discussed the use of generic (SF-36) and condition specific tools/questionnaires following research comparing the two. In summary, Dr Garratt found that both instruments have a role in measuring outcomes, that specific instruments are more responsive to change and that extensive testing of SF-36 and specific instruments demonstrates suitability for evaluative studies. Dr Garratt stated the results of their study lent support to the use of generic and specific instruments as they provided complimentary information and should be used together for outcomes assessment.

Dr Bruce Shadbolt of The Clinical Health Outcomes Centre, ACT, proposed the "approach of scientifically evaluating clinical treatments using real-time hypothesis of treatment protocols against clinical expectation of the health outcomes." This approach reviews clinical guidelines and uses them in practice. It also involves standardising expected outcomes along with evaluation of expected outcomes of treatment at pre-determined points. This approach is being developed at the Clinical Health Outcomes Centre in collaboration with the Medical and Radiation Oncology Departments at The Canberra Hospital.

Jean Slutsky from the Agency for Health Policy and Research, USA provided a background on The National Guidelines Clearinghouse and the Evidence-based Practice Centres. The National Guideline Clearinghouse's web site will be available in mid December of this year. This will enable access to thousands of guidelines. Additionally, guidelines which have been developed on individual conditions will have tabular comparison. Jean also advised of the twelve Evidence-based Centres in the US and Canada. These Centres look at health research and analyse this research.

Health Outcomes and Integrated Care

Mark Page from TEAM Care Health Coordinated Care Trial, one of the 13 Australian trials, outlined their model of care coordination in an aged care population. They seek to increase liaison with GPs and other providers, for example domiciliary nursing, and use a GP assessment plan which has been well received. Some interventions include education to GPs on disease processes typical in the

elderly and the referral to local pharmacists for assessment for high risk patients.

Ros Sorenson from the Department of Health and Family Services, Canberra discussed the phases of the National Demonstration Hospital Projects, stating that the final phase would focus on GP Division-Hospital integration. She stated in this phase they were looking for innovation in acute care in the home and GP links. She stated there was a need for joint tools between hospitals and GPs.

Lisa Rodgers from the Australian Council on Health Care Standards discussed the approach of the Dandenong District Diabetes Service to implementing and evaluating a community diabetes program for NIDDM patients. Indicators were developed and a Patient Health and Satisfaction Questionnaire (developed through Diabetes Integrated Care pilot project funded by the NSW Health and the Commonwealth) were used in the evaluation. In total, 17 indicators were developed focusing on service provision for the patient, for GPs and patient outcomes. Having established baseline data the service is now looking at opportunities for improvement.

Closing Address

Dr Doris Zonta of ACT Health and Community Care summarised some of the key themes presented during the conference. She reiterated the need for a "keep it simple" approach in implementation. She also reinforced that there is a need to integrate outcomes into clinical practice and that there needs to be the provision of information to providers and consumers. Finally, she highlighted the need to remember whose outcomes are being evaluated: those of the consumer.

ARE YOUR MAILING DETAILS CORRECT?

If not, let us know:

Name: Title:

Company: Telephone:

Address Fax:

Mail to: VCACI, 3rd Floor, East Block, The Alfred, Commercial Road, Prahran.

Email to: A.Loran@alfred.org.au

Fax to: (03) 9276 6901

SHOWCASE OF OUR HITH PROGRAM

WANGARATTA DISTRICT BASE HOSPITAL

Our program is called Hospital in the Home—Outreach Program, and was developed through a “need” for an outreach HITH service arising. It is based at Wangaratta District Base Hospital (WDBH) which is the base for many local hospitals, who refer to it for consultancy. The program allows patients to be transferred to their home environment with all the supports that the WDBH HITH program offers - clear medical and nursing guidelines, back-up support, patient information, protocols, and discharge planning for medical reviews.

The WDBH HITH program is part of an amalgamated specialist team called the Home Based Nursing Service. This service provides palliative care, stomal therapy, continence specialist care, and district nursing as well as HITH. The HITH program was integrated with all other home-based nursing services in November 1997. The outreach WDBH HITH program commenced on the 27th April 1998 as a response to a patient's request to be home for Easter as he had been in WDBH and a Melbourne hospital for nearly two months. The aim of the service is to provide HITH for patients who have received acute treatment at Wangaratta District Base Hospital, in order that they go home earlier but still remain under the care of their Consultant.

Since May we have expanded the service to include several outreach hospitals. The participating local district hospitals include Myrtleford, which is part of the Alpine Health Services and is located 75 kms south east of Wangaratta. Cobram District Hospital and Yarrawonga Hospitals are about the same distance north, and are situated in the Moira Shire,

whilst Mansfield Hospital is 90kms south west as part of the Delatite Shire. Finally, it encompasses the Ovens & King Community Health Centre, whose district nurses provide HITH to people south, in the Moyhu and King Valley districts.

So far the Outreach program has treated five people at Yarrawonga, one at Mansfield, and one in Moyhu with repeated admissions. These patients have received long term antibiotics through PICC lines, post operative care, acute wound care, removal of drainage tubes, and anti-coagulation therapy.

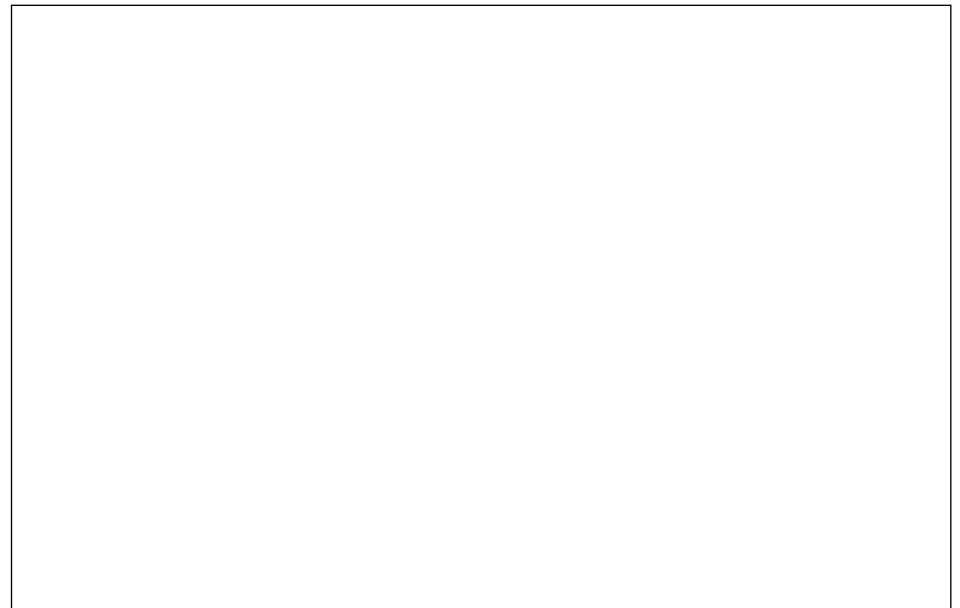
We pay the Outreach District Nursing Service on a brokerage system, having set up Service Agreements between the Wangaratta District Base Hospital HITH program and each outreach hospital.

The key people are the Home Based Nursing Service Manager, the Clinical Nurse Specialist (HITH), and the Outreach District Nurses. The Consultant

or Medical Registrar telephones the patient's local GP and/or writes a letter. We confirm this correspondence by telephone to the GP and explain how the program works and their involvement.

We use telephone, fax, and hospital couriers such as the linen service, pathology nurses, and radiographers, to maintain contact with the outreach staff, and to transport equipment and consumables. We also report to the Consultant's Registrar regularly or the Consultant personally when necessary.

One issue we have found, apart from logistics of how to set up the ongoing management and organisation (which was the major factor), is staff education. This includes education on PICC lines as the Registered Nurses had never seen and didn't know about PICC lines, and also education on anaphylaxis policies, protocols, and management. Resolution of these issues includes providing ongoing



and repetitive education sessions. A study day for anaphylaxis was very successful, with excellent feedback received.

We have learnt to be better prepared for new areas of care through study days, group meetings of Registered Nurses, planned visits to the Director of Nursing, and have learnt not to rush things. We have also learnt that daily contact with staff (usually DNS) to give support, feedback, and problem resolutions is important.

We discovered that our paper work was in fact well organised, the documentation process was clear, communications well defined, and lines were open and accessible. The courier delivery service worked well, except for weekends.

At the moment the program is limited and not utilised by all hospitals with some showing a lack of interest. We have also found that the brokerage system needs continual reassessment, as it can be costly.

We aim to promote the Outreach Program to non-participating hospitals. We also plan to provide ongoing education through the current newsletter, study days on the latest development in clinical applications, and annual updates on CPR and anaphylaxis management.

*Catherine Hattersley
Cathy Nicol
Jackie McLeod*

CASE STUDY

WANGARATTA BASE DISTRICT HOSPITAL

OUTREACHING HITH — A BASE HOSPITAL TO THE LOCAL HOSPITALS

Nineteen year old Mr M presented to Wangaratta District Base Hospital (WDBH) from Myrtleford in early February with a history of 10 days of sore throat followed by nausea, vomiting, and diarrhoea. He had a temperature of 39°C with rigors and chills and he complained of left inguinal fossa pain. Blood tests showed: platelets 35, WCC 10, hypokalaemia, hypoalbuminaemia, and thrombocytopenia.

Mr M lives with his grandmother who is fit and well and he has supportive aunts.

On admission to WDBH, a scan showed internal jugular vein thrombosis. A chest xray showed extensive bilateral interstitial pneumonia with underlying collection of pleural fluid. After consultation with a Melbourne professor he was diagnosed with suspected Le Miere's syndrome, which is a throat infection from fusobacterium, causing internal jugular thrombosis and septic emboli.

He was transferred to Royal Melbourne Hospital, and returned to WDBH in mid-March following drainage of a pectoral muscle chest wall abscess with bilateral pleural effusions. A Cook PICC line was inserted as long term antibiotics were necessary. Mr M now 20, was low in spirits, had lost 15 kgs in weight, and Easter was approaching. He really wanted to be home with his family and friends after 2 months in hospital and being very sick - but how? His antibiotic regimen was strictly 6 hourly IV Benzyl Penicillin and IV Metronidazole that included a 4am dose.

HITH was suggested and investigated to see what could be offered. It took 8 days to prepare service agreements between the hospitals, explain HITH to patient/carers/staff and hospital management, provide education to the nurses in the District Nursing Service as well as the Hospital, have a family meeting, organise a 4am taxi service (luckily

he lived two doors from the hospital), and elect a case manager for reporting mechanisms so he could be finally transferred to HITH outreached to Myrtleford.

Treatment went smoothly. Daily phone contact with the Nurse Case Manager enabled any concerns to be resolved before they became a problem - like how to get more drugs from the pharmacy via the Pathology courier service. Mr M stayed on the program for 16 days. There was one visit by HITH staff to assess his program and provide support.

We have found that one education session is never enough. The process needs to be repeated and reinforced constantly but delicately. There is a fine line between being repetitive and authoritarian and reinforcing yet supportive.

Mr M was visited 59 times. He sometimes made 4am visits to the hospital, taking his equipment and history (which the Night Nurse completed) with him.

All round the results were successful. Mr M recovered very quickly, socially as well as physically. He put on weight and returned to his studies. He was very well supported by family and friends. Finally, from a professional point of view it was extremely successful. The outreach nurses supported by hospital management felt they learnt about new techniques and also about Community Nursing and its totally holistic approach to care.

Since this case we have outreached to other areas. We have fine tuned our methods for maintaining supplies, consumables, and communications, but just when we think we've got all problems mastered, another unexpected situation occurs!

*Catherine Hattersley
Cathy Nicol
Jackie McLeod*

UPCOMING CONFERENCES

Ninth National Congress 1998

Navigating Cyberspace

October 14-15, Carlton Crest Hotel, Melbourne

Contact: The Conference Organisers Pty Ltd

Phone: (03) 9521 8881

Sponsored by Home Healthcare. Royal District Nursing.

Canadian Intravenous Nurses Association

Facing the Challenge of the Next Millennium

October 21-23, 1998, Canadian Pacific Hotel, Toronto East

Phone: 0011 1 416 299 1500

Taking a Drug Discovery into Pre-Clinical Development

First in a series of Workshops

October 22, 1998, Victorian College of Pharmacy, Royal Parade, Parkville

Contact: Drug Information Association

Phone: (02) 9518 9580

Cancer, Culture & Clinical Innovation in Cancer Management

October 22-25, 1998, Hamilton Island, Queensland

Phone: 1800 808 108

3rd National Allied Health Conference -

Towards 2000, Opportunities, Obstacles, Outcomes

November 4-6, 1998, Carlton Crest Hotel, Brisbane

Phone: (07) 3240 2187

COSA - 25th Annual Scientific Meeting

Targeted Therapies

November 25-27, 1998, Sydney Hilton Hotel and Wesley Centre, Sydney

Phone: (02) 9380 9022

League of Intravenous Therapy Education

The Direction for the New Millennium

February 25-27, 1999, Marriott City Center, Pittsburgh, PA

Phone: 0011 1 412 678 5025

American Academy of Ambulatory Care Nursing

24th Annual Conference - "Embracing Expertise and Diversity: Pioneering

Uncommon Roles for Uncommon Times"

March 10-16, 1999, Hyatt Regency, San Francisco, CA

Phone: 0011 1 609 256 2350 Fax: 0011 1 609

Email contact: aaacn@mail.ajj.com

NHMRC Clinical Trials Centre

Data Management for Clinical Research

Various Short Courses

Contact The University of Sydney

Phone: (02) 9562 5000 Fax: (02) 9565 1863

1997/98 HITH Service Enhancement Grants Seminar

continued from page 2

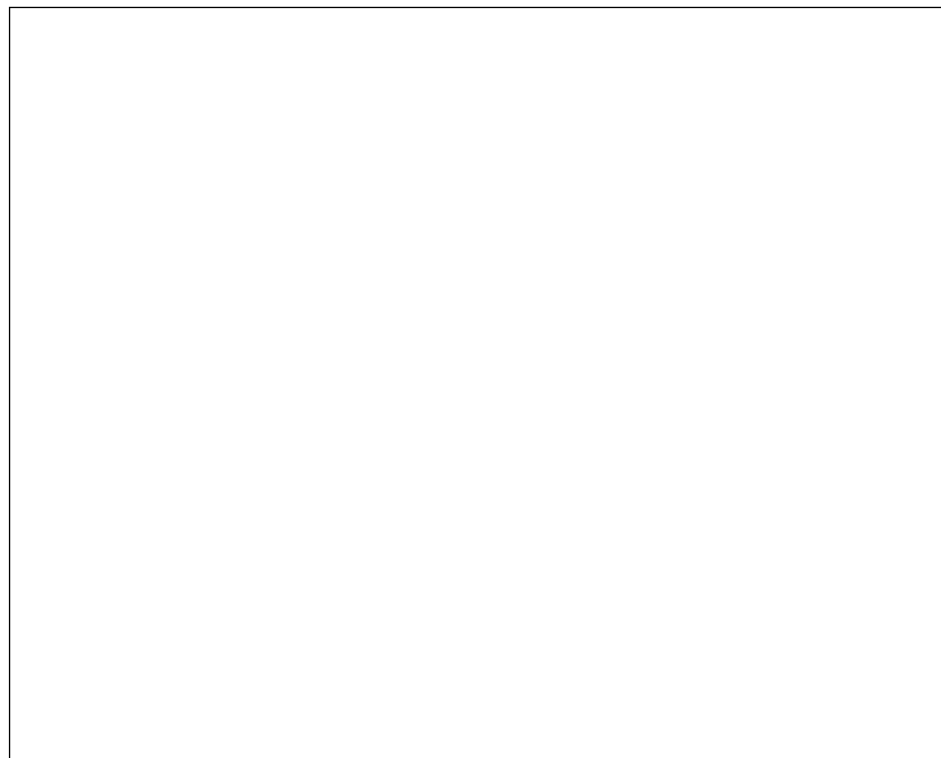
Marjorie's visit coincided with the International Ambulatory Care Think Tank chaired by the Hon Rob Knowles, Victorian Health Minister on 17th June 1998. Along with a number of colleagues from Johns Hopkins, Marjorie explored opportunities for collaboration with the VCACI and The Alfred for research and development in ambulatory care including HITH. This visit culminated in a memorandum of understanding between these key stakeholders to undertake a joint venture in this area.

On 19 November 1998 the Victorian Department of Human Services and VCACI will convene a seminar highlighting the outcomes from the previous round of HITH Enhancement Grant funding. This all-day event will give each of the 13 grant recipients the opportunity to share their research and results with a wider HITH audience. Areas to be covered at the seminar include:

- research into HITH treatment models,
- development of HITH education and training for nurses and GPs, and
- improving HITH care for patients and their carers.

The seminar will be followed by a dinner meeting of the newly-established Victorian HITH Co-ordinators group, making the day an important one for HITH professionals to attend.

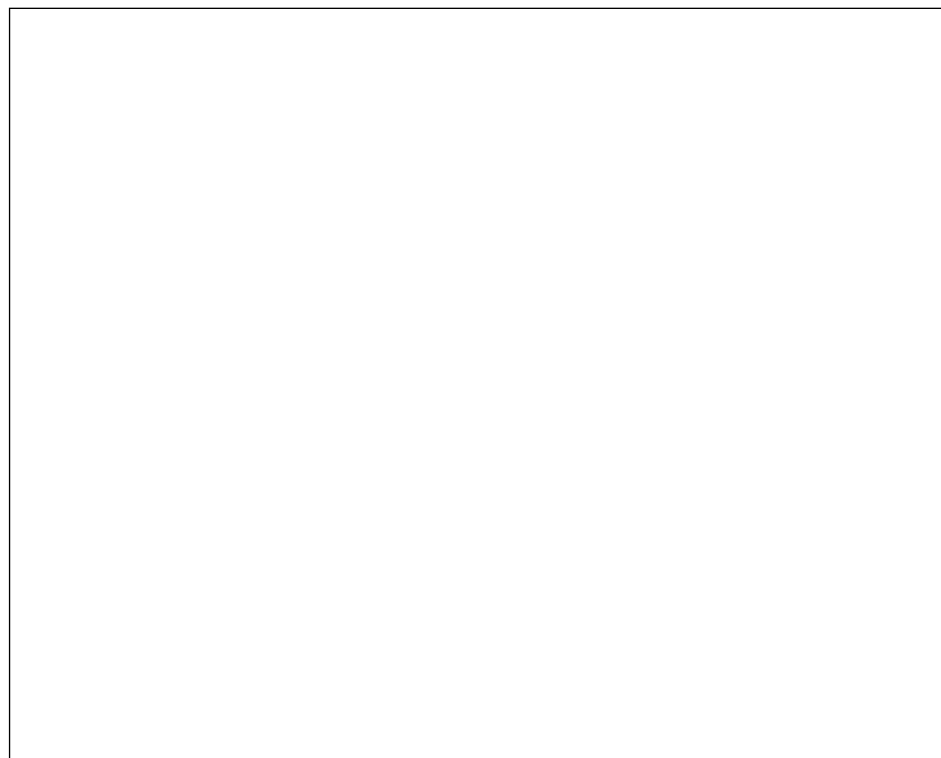
For further information regarding this seminar please contact Sharon Kitt via email s.kitt@alfred.org.au or telephone (03) 9276 6527.



CONTACT US

We are keen to receive your feedback so that we can address areas of interest to you. Please feel free to contact us if you:

- would like more information about the VCACI,
- wish to be added to our mailing list,
- have feedback, ideas or items for future Newsletters,
- would like to share details of forthcoming conferences, seminars or workshops,
- would like more information on HITH/ Acute Care in the Home Issues.



Marjorie Bauman exploring the community in Australia.

Victorian HITH Contact Names and Numbers

					Telephone	Fax
Angliss Health Services	Albert Street	Upper F'tree Gully	Mr Wayne	Massuger	(03) 9764 6242	(03) 9764 6114
Austin & Repat Medical Centre	Studley Road	Heidelberg	Ms Helen	Fithall	(03) 9496 3378	(03) 9496 3359
Austin & Repat Medical Centre	Studley Road	Heidelberg	Ms Lisa	Hill	(03) 9496 5775	(03) 9496 5772
Austin & Repat Medical Centre	Studley Road	Heidelberg	Ms Kim	Lumsden	(03) 9496 3603	(03) 9459 0971
Bacchus Marsh Memorial Hosp.	P.O. Box 330	Bacchus Marsh	Ms Jan	McEgan	(03) 5367 2000	(03) 5367 4537
Bairnsdale Regnl Health Service	Day Street	Bairnsdale	Ms Gael	Traa	(03) 5750 3274	(03) 5752 6683
Ballarat Base Hospital	P.O. Box 577	Ballarat	Ms Patricia	Twaits	(03) 5320 4676	(03) 5320 4549
Benalla & District Memorial	P.O. Box 406	Benalla	Ms Robyn	Kelly	(03) 5760 2258	(03) 5760 2246
Bendigo Health Care Group	P.O. 126	Bendigo	Ms Robyne	Fahy	(03) 5441 0222	(03) 5441 0916
Box Hill Hospital	Nelson Road	Box Hill	Ms Helen	Hamilton	(03) 9895 3442	(03) 9895 4901
Central Wellington Health Service	Guthridge Parade	Sale	Ms Paula	Hart	(03) 5144 4111	(03) 5149 6633
Colac Com. Health Svces Hospital	Corangamite Street	Colac	Ms Marie Louise	Tucker	(03) 5230 0275	(03) 5230 1191
Dandenong Hospital	Box 478	Dandenong	Ms Dana	Kiley	(03) 9554 8416	(03) 9554 8453
East Grampians Health Service	P.O. Box 155	Ararat	Mr Ray	Elsworthy	(03) 5352 2221	(03) 5352 4612
Echuca Regional Health	P.O. Box 25	Echuca	Ms Diane	Egan	(03) 5482 2800	(03) 5482 5478
Geelong Hospital	P.O. Box 281	Geelong	Mrs Helen	Wadsworth	(03) 5226 7108	(03) 5226 7302
Hamilton Base Hospital	P.O. Box 283	Hamilton	Ms Betty	Joosen	(03) 5571 0222	(03) 5571 0240
Goulburn Valley Hospital	102 Corio Street	Shepparton	Ms Christine	Ryan	(03) 5831 6390	(03) 5822 2584
Kyneton District Health Service	P.O. Box 34	Kyneton	Ms Judith	Bloomfield	(03) 5422 1177	(03) 5422 2373
Latrobe Regional Hospital	Locked Bag No 1	Moe	Ms Rosemary	Nation	(03) 5127 0608	(03) 5127 0775
Maroondah Hospital	P.O. Box 135	East Ringwood	Mr Ian	Jackson	(03) 9871 3712	(03) 9871 3716
Mercy Public Hospitals Inc	Clarendon Street	East Melbourne	Ms Ann	Turnbull	(03) 9270 2237	(03) 9270 2777
Mildura Base Hospital	P.O. Box 306	Mildura	Ms Sheena	Clark	(03) 5022 3333	(03) 5022 3470
Monash Medical Centre	Locked Bag 29	Clayton	Ms Fran	Chambers	(03) 9550 2433	(03) 9550 6925
Monash Medical Centre	246 Clayton Road	Clayton	Dr Lindsay	Grayson	(03) 9550 4564	(03) 9550 4533
Peninsula Health Care Network	P.O. Box 52	Frankston	Dr Michael	Montalto	(03) 9784 7241	(03) 9784 7242
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Dr Guy	Toner	(03) 9656 1190	(03) 9656 1408
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Ms Cathy	Watty	(03) 9656 1055	(03) 9656 1415
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Ms Helen	Fawns	(03) 9656 1312	(03) 9656 1922
Peter MacCallum Cancer Institute	St Andrews Place	East Melbourne	Ms Lois	Buchanan	(03) 9656 1353	(03) 9656 1415
Portland & District Hospital	Bentinck Street	Portland	Ms Michelle	Henningsen	(03) 5521 0333	(03) 5521 0358
Royal Children's Hospital	Flemington Road	Parkville	Ms Jann	Cooney	(03) 9345 6548	(03) 9345 6231
Royal Melbourne Hospital	Grattan Street	Parkville	Dr Denise	Ruth	(03) 9342 8549	(03) 9342 8548
Royal Melbourne Hospital	Room W224 - 2 W	Parkville	Ms Jane	Peirce	(03) 9342 7801	(03) 9342 7700
Royal Melbourne Hospital	2 Grattan Street	Parkville	Ms Joanne	Moss	(03) 9342 8597	(03) 9342 8268
Royal Women's Hospital	132 Grattan Street	Carlton	Ms Pamela	Bull	(03) 9344 2324	(03) 9348 1840
St Vincent's Hospital	41 Victoria Pde	Fitzroy	Ms Tamara	Rowan	(03) 9288 3818	(03) 9288 3848
Stawell District Hospital	P.O. Box 116	Stawell	Ms Jan	Sherwell	(03) 5358 8572	(03) 5358 4092
Swan Hill District Hospital	P.O. Box 483	Swan Hill	Ms Dallas	Brown	(03) 5033 9310	(03) 5032 9528
The Alfred	P.O. Box 315	Prahran	Ms Di	Richards	(03) 9276 3908	(03) 9276 2794
The Williamstown Hospital	P.O. Box 125	Williamstown	Ms Allison	Chircop	(03) 9393 0133	(03) 9393 0178
Wangaratta District Base Hospital	P.O. Box 386	Wangaratta	Ms Cath	Hattersley	(03) 5722 0348	(03) 5721 9526
Warrnambool & District Base Hosp	Ryot Street	Warrnambool	Mr Mark	Johnstone	(03) 5563 1682	(03) 5563 1627
Werribee Mercy	300 Princes Highway	Werribee	Ms Vicki	Geytenbeek	(03) 9216 8700	(03) 9216 8777
Werribee Mercy	300 Princes Highway	Werribee	Ms Wendy	Dunn	(03) 9216 8691	(03) 9216 8692
West Gippsland Hospital	Landsborough Road	Warragul	Mrs Marie	Young	(03) 5623 0611	(03) 5623 0609
West Wimmera Health Service	P.O. Box 231	Nhill	Ms Lynne	Fraser	(03) 5391 4222	(03) 5391 4228
Western Hospital	Gordon Street	Footscray	Mr Elwyn	Davies	(03) 9319 6199	(03) 9319 6314
Wimmera Health Care Group	Baillie Street	Horsham	Mrs Pat	Dodson	(03) 5381 9184	(03) 5381 9187
Wodonga District Hospital	Vermont Street	Wodonga	Dr Andrew	Watson	(02) 6051 7470	(02) 6051 7477
Wodonga District Hospital	Vermont Street	Wodonga	Ms Dianne	Wicks	(02) 6051 7334	(02) 6051 7319



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