Central Adelaide Local Health Network (CALHN) Fact sheet

Hospital Avoidance in CALHN

The Central Adelaide Local Health Network (CALHN) have developed and collaborated with numerous hospital avoidance services that support patients being managed in the community.

This fact sheet provides a brief description of the various hospital avoidance options that might be available for your patient, including patients in a residential aged care facilities or telehealth patients. Interpreters can be used with all listed services, as required.

The information in this fact sheet can also be found in HealthPathways SA under Hospital Avoidance and Discharge Support Services (see the SA specific pages). Registration will provide you access to all the resources on Health Pathways SA.

CALHN Integrated Care Coordinators (CICC)

The CALHN Integrated Care Co-ordinators (CICC) are a team of highly skilled nurses who specialise in hospital avoidance strategies. CICC can help you navigate which service best fits your patient's needs.

Please note, CICC is a CALHN only program. However, CICC can still advise on state-wide services (such as My Home Hospital) and other hospital avoidance initiatives available for patients outside the CALHN catchment area.

Contact information:
Phone: 7133 9998
Email: HealthCALHNIntegratedCare@sa.gov.au

Integrated Care Geriatrics Service

The Integrated Care Geriatrics Service have established a Single Point of Contact- 'SPOC' to assist GPs and referrers by providing expert clinical advice and health navigation for patient >65 residing in the CALHN catchment.

The SPOC can assist you in navigating the available Hospital Avoidance Services for your patient including the Multi-Disciplinary Community Geriatrics Services, Geriatrics in the Home, BRIGHT Sefton and Woodville and the Residential Aged Care In-reach team

The SPOC is available 7 days a week including Public Holidays from 8am to 8.30pm.

Contact information:
Phone: 7133 9993
SA Health Integrated Care

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CALHN BRIGHT – Sefton Park and Woodville

'Bringing Responsive, Integrated Healthcare To our Community'

CALHN BRIGHT – previously known as HASDS, provides multidisciplinary rapid assessment and acute care for patients 16 years of age and older who:

- have care needs that exceed the capacity of primary care or community services **and**
- are on a trajectory to an emergency department, but do not require 'emergency level' care **and**
- can safely receive care in an alternate health care setting.

The BRIGHT multidisciplinary team consists of Nurses, Nurse Practitioners, Doctors, Physiotherapist, Occupational Therapists, Pharmacists, Podiatrists, Social Workers, and Dieticians.

BRIGHT offers

- Medical imaging (plain CT and X-ray)
- Telemetry
- Pathology
- Timely assessment and treatment for consumers with complex unmet health needs who are likely to (re) present to an emergency department or hospital.
- Short-term intervention, wrap-around support and onward referral to community care so the consumer's ongoing care needs can be met.
- Access to CALHN hospital speciality services, when required, including direct admission pathways.
- Expertise to support vulnerable consumers who may have complex physical and psychosocial needs.
- Speciality face-to-face and telehealth consultation

BRIGHT specialises in wrap-around care that can provide rapid follow up in the community, link into homelessness services, or referral directly to out-of-hospital services such as Hospital in the Home (HITH), Geriatrics in the Home (GITH), My Home Hospital, and the Multidisciplinary Community Geriatrics Service (MCGS).

Referrals
BRIGHT are a **referral-only** service. Referrals can be made by contacting a dedicated clinical referral hotline. Please call to discuss specific patient referrals with the medical officer on-duty to determine if the patient is suitable to receive care at BRIGHT.

A Navigator will advise the most appropriate BRIGHT service location based on capacity at each site and patient need.

Contact information:
Reception: 7133 9991
Direct Referral Phone: 7133 9992 * **referrers only**
Opening hours: 8.30am to 9.30pm - 365 days a year, including public holidays
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My Home Hospital (MHH)

My Home Hospital (MHH) employ their own GP and non-GP specialist clinician teams who assume responsibility for care. However, a patient's regular GP is still encouraged to liaise with MHH clinicians. Patient monitoring through MHH is by a combination of in-person visits and virtual care (using equipment lent to the patient from MHH).

Please note, patients must be over 13 years of age, have access to a mobile or landline phone, live in the Adelaide, Gawler, Mount Barker or Southern Fleurieu regions, and live in a safe and suitable environment.

MHH includes doctors, nurses, allied health practitioners, some x-rays, blood tests, medication and other support services depending on the patient's needs.

Patients are visited in their home at least once daily, up to a maximum of four times daily, and have regular contact with the care team. This means patients can receive the acute care they need while enjoying all the comforts of home, which can have a positive impact on health and wellbeing.

The service provides acute hospital-level care for the following conditions:

- infections requiring IV antibiotics (e.g., cellulitis, pneumonia, mastitis)
- exacerbation of respiratory conditions
- heart failure
- post-operative care (ENT/Breast Surgery)
- deep vein thrombosis (DVT) and pulmonary embolism (PE)
- gastrointestinal conditions
- other conditions for which in-home care is considered safe and appropriate.

Patients have access to a doctor 24/7 during their admission.

Health professionals are welcome to refer patients 24 hours a day, 7 days a week.

Contact information:
Phone: 1800 111 644
Fax: 1800 333 644
Email: referrals@myhomehospital.com.au
Online Referral Form

Priority Care Centres (PCCs)

Priority Care Centres (PCCs) are funded by The Department for Health and Wellbeing (DHW) and Adelaide Primary Health Network (APHN). There are 5 PCCs across Adelaide, located in Elizabeth, Hindmarsh, Marion, Mount Barker, and Para Hills West. Whilst they are co-located with a general practice clinic, they are not integrated with this practice and have their own referral pathways and governance processes.

PCCs are staffed by GPs and Nurse Practitioner candidates who take-over the care of the patient. After this episode of care, they will provide a discharge summary back to the referring GP.

PCCs may be a suitable option if you have a patient who may need a prolonged procedure exceeding clinic capacity, such as management of:

- Simple fractures / sprains
- Plaster / back slab / splint application
- Minor wounds, cuts, lacerations, including suturing.
- Burns management.
- Skin infections incl. mild cases requiring intravenous antibiotic.
- Rehydration
- Mild first trimester bleeding
- Ear/eye issues (use of slit lamp)
- Urinary tract infections

Referral to a PCC can be completed by a GP and/or Practice Nurse via the mobile numbers below, or via the online referral form. Responses to online referrals will usually be received within 10 minutes. The form contains links to both the PCC referral criteria and a live dashboard to view current PCC wait times and capacity.

Contact information:
Elizabeth: 0466 935 910
Hindmarsh: 0466 869 090
Marion Domain: 0466 698 616
Mount Barker: 0428 719 656
Para Hills West: 0468 554 626

Please note, each PCC has individual opening times and hours of operation.

Metropolitan Referral Unit (MRU)

The Metropolitan Referral Unit (MRU) is a South Australian Community Care Program that provides nursing services through a panel of nursing providers. They can support post-acute care, immediate hospital avoidance, and emergency department (ED) avoidance, including:

- Wound care - including post-operative, negative pressure wound therapy (NPWT), diabetic foot and vascular wounds, burns, compression dressings, and drains.
- Medication assistance - including administration, supervision, intravenous administration through central access lines (i.e., PICC, portacath), chemotherapy disconnections, and sub cut medication administration.
- End of Life Care nursing support
- Continence device changes (i.e., catheter) and trial of voids
- Blood transfusions* - *Patient must have received a previous blood transfusion without any reactions and must have mobility or frailty limitations that limit access to ambulatory units.

MRU will liaise directly with a patient's GP, Outpatient Department (OPD), or LHN Home Team if a medical review is required whilst a patient is admitted under MRU.

Contact information:
Phone: 1300 110 600
Fax: 1300 546 104
Email: health.mru@sa.gov.au
Website: www.sahealth.sa.gov.au/MRU

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Urgent Mental Health Care Centre (UMHCC)

The Urgent Mental Health Care Centre (UMHCC) has been designed as an alternative to ED presentation for patients 16 years and older experiencing mental health crisis. This is a walk in/self-referral service that patients can present to 24 hours a day, 7 days a week (including public holidays). If you as a GP refer your patient, they do ask that you ring ahead to check that they have capacity.

People less than 16 years old, under an Inpatient Treatment Order (ITO), or who have been administered intramuscular medication to manage acute mental health symptoms are **not** appropriate for the UMHCC.

Contact information:
Phone: 8448 9100 or 13 14 65 (urgent referral)
Email: umhcc@neaminational.org.au
215 Grenfell Street, Adelaide SA 5000

For more information

CALHN GP Integration Unit
T: 7133 9995
E: Health.CALHNGPIntegrationUnit@sa.gov.au

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Government of South Australia