Hospital Admission Risk Program (HARP)

Program Overview & Referral Pathway

HARP services people with chronic and complex health issues. HARP provides short term support and intervention (assessment, integrated care planning & coordination, education & monitoring, service linkages, GP liaison) to enable clients to better manage their condition in the community and reduce avoidable hospital admissions.

Melbourne Health HARP is a partnership between The Royal Melbourne Hospital (RMH), Merri Health, cohealth and Bolton Clarke. Catchments; Melbourne, Moonee Valley, Moreland City Council and those in surrounding areas who receive all their care from RMH.

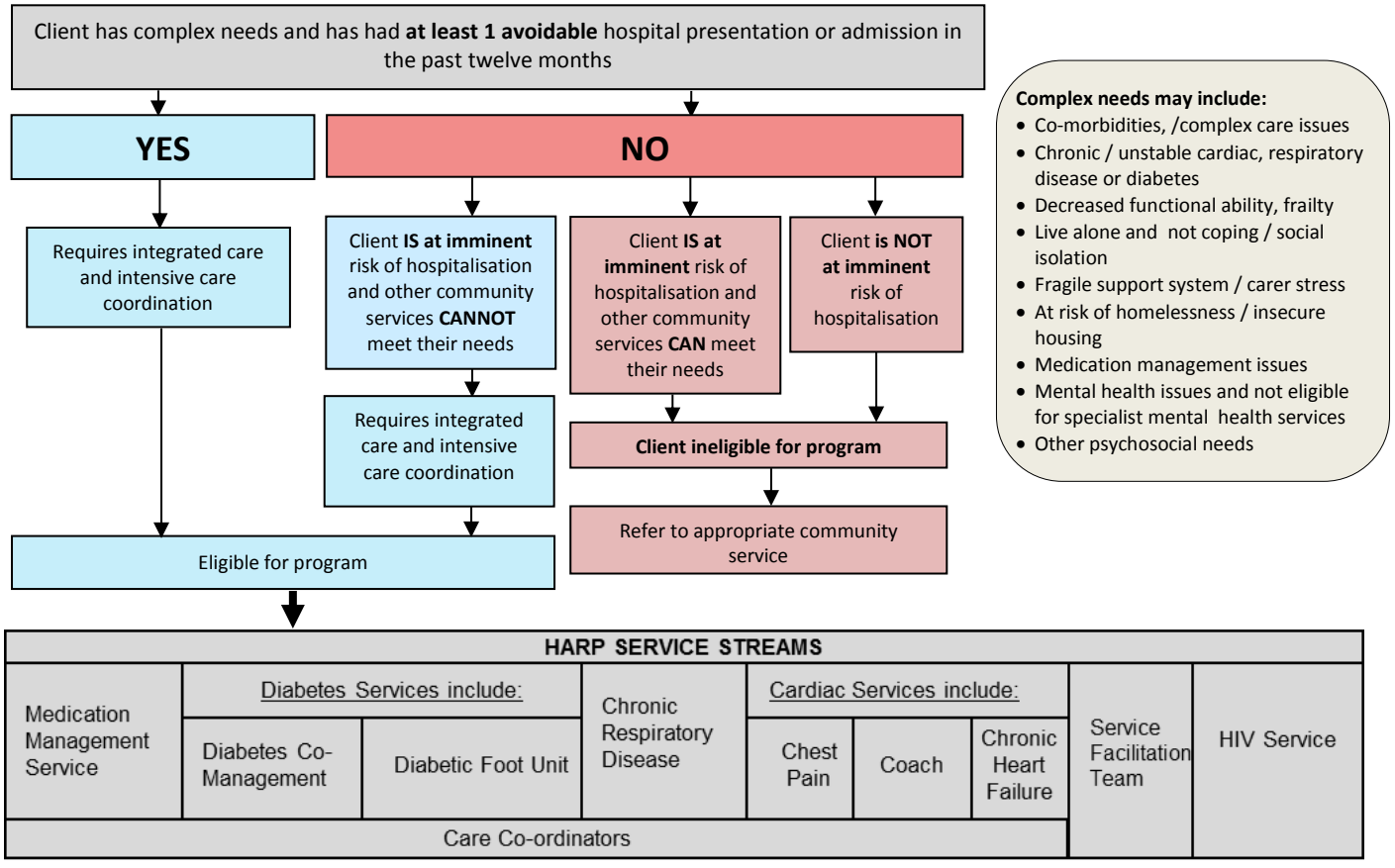
Who is eligible:

- Anyone who has had 1 or more avoidable ED presentation or hospital admission in the past 12 months or is at imminent risk of hospitalisation and community services CANNOT meet their needs AND
- Have complex medical or psychosocial needs and would benefit from short term, intensive input

Who is not eligible:

- Clients with acute psychiatric needs and meet the mental health eligibility – refer to an area mental health service
- Clients adequately managed by community services OR under 18 years OR do not consent for HARP services

Eligibility Decision Tree



Accessing the service

Wait times:	Clients are contacted within 3 days, seen in 7-10 days.
Cost:	Nil
All RMH inpatient referrals:	Call HARP Liaison on **(03) 9342 4530** as soon as needs are identified and PRIOR to discharge
All outpatient and community referrers:	Community referral forms to RMH Direct Access Unit (DAU) Fax **(03) 8387 2217**. Referrals to include: medical & social history, medications, current management plan, referral reason.
Website:	https://www.thermh.org.au/health-professionals/clinical-services/community-services/harp-complex-care

Contact

HARP Liaison **(03) 9342 4530**

MH-HARPreferrals@mh.org.au

HARP Service Streams Overview

Melbourne Health HARP is made up of the following service streams:

- Streams may co-consult or refer clients between each other to provide holistic and integrated support
- Hospital and GP liaison, community service referral and coordination are common to all streams

HARP Liaison	Provides identification and referral coordination support for all referrers into the program as required		
Service Stream	**Who is eligible?**	**Who is NOT eligible?**	**Service Includes**
Cardiac Services			
Chronic Heart Failure	• Exacerbation of CHF • Diagnosis of CHF which is confirmed on Echocardiogram		• New diagnosis support • Exercise, education, monitoring support • Clinic review • Educate on symptom recognition, care plan management including: daily weighing, fluid restriction, exacerbation management
Coach (Phone based service)	• Recent admission for a cardiac event with an intervention for IHD (CAGS or PCI) • Angiogram confirms cardiac risk factors and IHD	• Unable to participate in a phone conversation • Frailty or complex co-morbidities prevent exercise	• Post discharge coaching support throughout Victoria • Aim to reduce coronary risk factors
Chest Pain (Phone based service)	• Atypical Chest Pain i.e. GORD, angina • Non-ischemic chest pain	• Unable to participate in a phone conversation • Chest pain as a result of an ischemic event • Awaiting IHD intervention (CAGS or PCI)	• Post discharge coaching support throughout Victoria • Education to manage future chest pain
Respiratory Service			
Chronic Respiratory Disease	• Exacerbation of chronic respiratory disease confirmed on RFTs (COPD, Asthma) or CT Scan (Pulmonary Fibrosis, Asbestosis, Bronchiectasis or Interstitial Lung Disease), secondary pulmonary hypertension diagnosed on Echo		• Education to support: new diagnosis, symptom recognition, care plan management (inhaler and spacer technique, exacerbation management) • Exercise • Medication review and support • Respiratory Physician Review
Diabetes Services			
Diabetic Foot Unit	• Diagnosis of diabetes with current foot wound(s) or active diabetic foot complication(s)		• Hospital and community clinics provide support for wound management, vascular intervention, complex antibiotic management
Diabetes Co-Management	• Have diabetes that requires complex management • Would benefit from intensive input to improve self-management of diabetes	• Gestational Diabetes • Daily blood glucose level monitoring/assistance to administer daily insulin	• Education and self-management support to people with complex diabetes issues • Insulin initiation and stabilisation, continuous glucose monitoring
Other			
Service Facilitation Team	• Clients with complex comorbidities who require high level care coordination support • Known complex issues preventing engagement with care	• Urgent medical requirements or requiring 24hr support	• Intensive care coordination, assessment, advocacy • Connection with housing, employment, mental health, other specialist services
Care Coordination	• Any current HARP client who requires a comprehensive Ax	• Anyone who is not yet a current HARP client	• Intensive care coordination in addition to disease specific needs

Medication Management Service	• At risk of medicine-related problems including:
	  • Concerns with adherence, polypharmacy, medication changes
	  • Medication management issues (devices, cognitive impairment)
		• People living in Residential Aged Care	• Comprehensive home medication assessment, review, education and referrals as needed
			• Liaise with GPs and other health providers regarding drug therapy

HIV Service	• Diagnosis of HIV • Patients who require support with HIV management		• Assessment, support and education for clients with HIV diagnosis • Clinic and outreach support • Liaison with RMH VIDS, primary health care services and other providers