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

- **Client has complex needs and has had at least 1 avoidable hospital presentation or admission in the past twelve months**
  - **YES**
    - Requires integrated care and intensive care coordination
  - **NO**
    - Client IS at imminent risk of hospitalisation and other community services CANNOT meet their needs
    - Requires integrated care and intensive care coordination
    - Client ineligible for program
    - Refer to appropriate community service

Eligible for program

Complex needs may include:
- Co-morbidities, complex care issues
- Chronic / unstable cardiac, respiratory disease or diabetes
- Decreased functional ability, frailty
- Live alone and not coping / social isolation
- Fragile support system / carer stress
- At risk of homelessness / insecure housing
- Medication management issues
- Mental health issues and not eligible for specialist mental health services
- Other psychosocial needs

HARP Service Streams

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<th>Medication Management Service</th>
<th>Diabetes Services include:</th>
<th>Chronic Respiratory Disease</th>
<th>Cardiac Services include:</th>
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<td>Diabetes Co-Management</td>
<td>Diabetic Foot Unit</td>
<td>Chest Pain</td>
<td>Coach</td>
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Care Co-ordinators

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.

Contact

HARP Liaison (03) 9342 4530
MH-HARPreferrals@mh.org.au

HARP | HP08.01 | Shared Services Team Leader | Version 1.0 | September 2018
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

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<tr>
<th>HARP Liaison</th>
<th>Service Streams Overview</th>
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<tr>
<td></td>
<td>Provides identification and referral coordination support for all referrers into the program as required</td>
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<table>
<thead>
<tr>
<th>Service Stream</th>
<th>Who is eligible?</th>
<th>Who is NOT eligible?</th>
<th>Service Includes</th>
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<tr>
<td><strong>Cardiac Services</strong></td>
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</table>
| 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 |
| | | • Post discharge coaching support throughout Victoria  
| | | • Aim to reduce coronary risk factors |
| 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 |
| 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 |
| HIV Service | • Diagnosis of HIV  
| | • Patients who require support with HIV management | • Comprehensive home medication assessment, review, education and referrals as needed  
| | | • Liaise with GPs and other health providers regarding drug therapy |
| | | • Assessment, support and education for clients with HIV diagnosis  
| | | • Clinic and outreach support  
| | | • Liaison with RMH VIDS, primary health care services and other providers |