HOMES Team

Initiative Type

Model of Care

Status

Sustained

Added

11 December 2018

Last updated

06 June 2022

URL

https://cnxp3cuvtvrn68yjaibaht5ywrxspj7m.clinicalexcellence.qld.gov.au/improvement-exchange/homes-team

Summary

The HOMES service client group is Aboriginal and Torres Strait Islander people with complex chronic diseases. During initial assessment client’s goals, and health and social care needs are identified. Multidisciplinary case conferences identified strategies to maximise client’s health and facilitate goal achievement. Subsequent assessments at 6 months reviewed health status and progress towards

goal achievement.

Key dates

Jul 2017

Jun 2018

Implementation sites

Metro South Hospital and Health Service

Key Contacts

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Aim

Ensure that the health system works for the patients and that the patient’s needs are identified as the clients perceive it.

Benefits

- Client led, ensuring the focus is on future outcomes and strengths that clients can bring to their goal.
- Building on the characteristics of the clients.

Background

Aboriginal and Torres Strait Islander people carry a heavy burden of chronic disease. HOMES was initially an exploratory study investigating the feasibility, acceptability and appropriateness of a primary health care led, homebased, case management model of patient centred multidisciplinary chronic disease care and has now been implemented into the Southern Queensland Centre of Excellence (SQCoE) core business.

Solutions Implemented

The HOMES Model of Care incorporates six areas of care being:

- Assessment
- Planning
- Monitoring
- Linking
- Advocacy
- Outreach

Evaluation and Results

The results of the evaluation of HOMES as a research study were:

- Participants' self-rated health status had significantly improved.
- Depression rates fell from 62 per cent to 39 per cent (PHQ-9 assessed).
- mean HbA1c decreased from 8.0 per cent to 7.6 per cent ($p<0.0001$)
- mean BP fell from 134/77mmHg to 121/74mmHg ($p<0.0001$)
- participants became active members of their health care team
- primary health care personnel appreciated the patient-centred case conferences, and the in-

depth follow-up of patients

We found the that Model of care meets the clients care needs resulting in:

- staff feeling that caring for the client was easier for both the client and the health professional
- proactively improving the client's health outcomes
- improving social, emotional and cultural well being
- empowering the client to after their own health
- the relationship between case manager/ nurse navigator is based on mutual trust and respect
- the team work in a culturally sensitive way
- nurse navigator and case manager are adaptive to all situations and needs.

Lessons Learnt

What our clients say: *"in terms of human dignity, this is really a dynamic service. Like from my perspective… when you can live in this comfort zone where you know you're able to be supported, it makes one hell of a big difference to soldiering on… but as I said, the top end of all of this is value and feeling dignified with such a wonderful service… Male participant.* The HOMES Study team identified that it needed to be supported to create the model of care that it had set out to achieve. This was done by utilising the innovative evaluation known as Developmental Evaluation. This saw the HOMES Team members undertaken extensive team meetings and workshops where the features of value for the model of care were developed along with the strong sense of what the model of care actually was to provide for the clients. A large component of the evaluation was for the HOMES Team members to learn how to apply reflective practices to their daily work day and identify what was done well and what could have been done better. This practice reflected in the production of the "Theory of Change" document which tracks how the model of care was created. Now that HOMES is part of SQCOE core business, the team continue to include developmental evaluation workshops as part of "normal practice" which ensures that we as health care professionals continue to evolve the program for our clients and the community we provide a service to. With the creation of the Nurse Navigator – Indigenous Chronic Disease, the COE Leadership Team identified that this new model of care linked and worked well with the HOMES model of care. It was therefore put into place that the Nurse Navigator – Indigenous Chronic Disease position would support the HOMES Clinical Nurse Case Managers and the Aboriginal Health Worker within its portfolio. This has allowed the Model of care to develop further by providing senior nursing support to the case managers and clients. Having this support and guidance, the "behind the scenes" of HOMES improved dramatically with Triage Meetings being commenced which identified how clients were travelling within a 5-tiered system, i.e. Intensive, Managing, maintaining, transitioning and Inactive based on the client's health requirements. To ensure that clients were receiving appropriate person-centred care, the HOMES Team produced Workplace Instructions which helped the team with day to day occurrence's. HOMES has secured an Indigenous Health Worker role within the Team who supports the model of care administratively as well as culturally, this role continues to evolve with delegation frameworks being developed as the roles skill set increases which will enable the Health Worker to become prominent in providing care for the clients alongside the Case Manager and Nurse Navigator. Knowing that the HOMES Team were permanently part of core business for the SQCOE, several areas within HOMES have been reviewed and taken on change. This includes but not limited to the

following:

- Adaptation of all assessments and templates (withdrawing all research topics).
- Creating roles and responsibilities documentation (including the Nurse Navigator, Clinical nurse case managers, Health Worker and the Healthy Mob Strong Community Program Coordinator).

- Streamlining practices, e.g. Referrals, Triage and Case Management.
- Peer Audit documentation has now been developed, audits will commence in early 2019.
- HOMES Service Profile as well as HOMES Information booklets for clients advising them of their health rights etc.

All the work has been successfully implemented within the team and it is continually evaluated throughout the year. We do this during our developmental evaluation workshops allowing the team to use “blue sky thinking”, which if there were no limits, where would we want to see HOMES go. Blue sky thinking gives staff the ability to see past the current model of care and see how the model of care can be adapted, given the resources and has assisted the model of care to develop to what it is today, different from when it was a research study whilst that the model of care retained its integrity while adapting to the change from a research study to normal practice.