GEM@Home (Geriatric Evaluation & Management at Home)

# Service Description

Providing a service similar to bed-based Geriatric Evaluation and Management (GEM) in the client’s own home, GEM@Home will provide care for the person who needs assessment and treatment for conditions associated with ageing, cognitive dysfunction and chronic illness.

With the aim of providing care both for clients who would otherwise be admitted to hospital and to clients who are transitioning home after a hospital presentation, referrals will be received from a broad range of areas including acute (including Emergency Department) and subacute wards, Transition Care Program, Eastern Health community services and other community-based service providers such as General Practitioners. A detailed referral pathway for each care setting can be reviewed in *Attachment 1.* Outlines the process for acceptance of a client into GEM@Home with associated key performance indicators.

The target population will live in the Eastern Health catchment but referrals from areas adjacent to this will be considered. While the typical client will be older, there are no restrictions for people under the age of 65 and Aged Care Assessment Service review is not required for entry.

Once admitted to the program, care will be delivered by an interdisciplinary, 7 day a week team consisting of a Consultant Geriatrician, Nursing, Allied Health, Pharmacy and Personal and Domestic assistance services (via brokerage). Where appropriate and agreeable, the client’s family/carer will also be an integral support person.

The nature and frequency of visits by GEM@Home staff will be determined based on clinical needs with clients being placed into one of two streams, Daily and Community. Daily clients will receive an initial visit within 24 hours of admission into the program and be visited each day during their episode of care whereas Community clients may not be seen as urgently following admission or seen as frequently. All clients will be assessed by a Geriatrician.

Aiming for an average length of stay between 2-4 weeks, GEM@Home will assist clients to achieve their goals-of-care in their own home and facilitate referrals for ongoing community support post discharge.

**Green Light Clients – able to be accepted by Clinical Coordinator without consultation with GEM@Home Geriatrician**

* Older people (age> 65) with complex, chronic or multiple health care conditions
* Multiple dimensions of condition(s) unable to be assessed or managed through GP or other outpatient clinic/community service
* A combination of Geriatrician, Nursing and/or Allied health involvement necessary to achieve goals (medical/functional/restorative). This may include clients who require timely, interdisciplinary support to achieve a successful discharge to their home environment.
* Client (AND carer if appropriate) consent to participation in the program
* No need for specialist opinion, investigation or management best provided in a bed-based care setting
* Current vital signs stable with documentation of any altered MET call criteria (if referred from bed-based services)
* No Medical Consultation or Exclusion Criteria present

# Medical Consultation Clients - requiring Clinical Coordinator consultation with GEM@Home Geriatrician

* Clients who are being discharged with some associated risk (e.g. concerns about mobility/functional tasks/support in the home environment, discharging against treating team advice)
* Clients requiring ongoing acute medical management - oxygen, enteral feeding , IV antibiotics /fluids/therapies, specialised dressings, transfusions, tracheostomy, chemotherapy, drain tubes (these needs may be able to be met by GEM@Home collaboration with HITH)
* Clients with significant behaviours of concern, mental health or drug and alcohol issues
* Clients awaiting a VCAT hearing for the appointment of a decision maker

# Exclusion Criteria

* \*Clients residing in Commonwealth-funded Residential Aged Care
* Clients that better suit Post-Acute Care, Community Rehabilitation Program, Residential Transition Care Program #or direct placement into residential aged care
* Clients who are actively dying/in terminal phase of illness

**\*** Clients who reside in other facility types (e.g. supported accommodation) may be referred

**#** Clients awaiting entry to Community Transition Care Program can be considered