



## CORRESPONDENCE

# Supported home-care schemes: the key to increasing outpatient care?

To the Editors:

We agree with CHOUDHURY *et al.* [1] that more patients (18–20%) could be managed at home by family practitioners with the application of current guidelines, but we would like to comment that a greater number of patients (approximately 60%) could be managed at home with additional supported home-based care.

As described by the authors, factors other than disease severity often prompt hospital admission. These include substance abuse, inability to cope alone at home, inability to take oral antibiotics, comorbidities and homelessness [2, 3]. The case for outpatient care based on severity markers is clear, but there is an urgent need for more evidence regarding early supported discharge schemes to facilitate the discharge of patients with more complex needs [4]. A randomised controlled trial from New Zealand, where both early supported discharge and admission avoidance models were used, showed patient satisfaction improved by 40% ( $p < 0.001$ ) in those allocated to supported home care [5]. A recent expert review suggested that supported home care for patients with community-acquired pneumonia (CAP) “shows enormous potential for improving the care of elderly and disabled patients, and should be further evaluated in terms of efficacy and cost-effectiveness” [6].

We recently conducted a retrospective study of the 58% of our CAP patients who had a CVRB-65 (confusion,  $>7 \text{ mmol}\cdot\text{L}^{-1}$  urea, respiratory frequency  $\geq 30 \text{ breaths}\cdot\text{min}^{-1}$ , systolic blood pressure  $<90 \text{ mmHg}$  or diastolic blood pressure  $\leq 60 \text{ mmHg}$  and age  $\geq 65$  yrs score  $\leq 2$ ). Two reviewers used pre-defined inclusion and exclusion criteria to assess eligibility to a supported home care scheme and found that 48% of these low-risk patients were deemed suitable for early supported discharge. We noted that in total 8.7% of patients experienced delayed discharge due to lack of social support, 10.9% due to delayed medical review or senior medical review, 4.3% due to awaiting medical investigations (urgent outpatient investigations would have been suitable) and 17.4% due to unstable non-pneumonia acute/chronic comorbidities. We feel that a more heterogeneous group of patients, including those with lower respiratory tract infections (LRTI) and even with hospital-acquired pneumonia could also safely benefit from such a service. The total potential reduction in length of stay, with an early supported discharge scheme utilising these broader inclusion criteria, was calculated at 2.75 (range 1–7) days. Hospital episode data from England for pneumonia, influenza with respiratory manifestation and acute LRTI (2009–2010) showed annual admissions of over 250,000 per year; this would amount to a potential saving of 687,500 bed-days annually.

We have considered what the components of an effective supported home care scheme for CAP would include. A complete

service should incorporate fast access to occupational therapy, physiotherapy and social services as well as to outpatient investigations and clinics. A supported home care scheme presents an opportunity to improve health policy, healthcare delivery and services and to reduce admission rates and nosocomial infections, all areas of major strategic importance internationally. This intervention is amenable to randomised controlled trial testing and we propose that such a trial is urgently needed. In order to maximise effectiveness, however, we suggest that conditions beyond CAP should be included, particularly with regard to mild-severity illness without the diagnostic radiological change required as part of the standard CAP definition.

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