

# Healthy at Home

(Previously the SAFTE Care Program)

## Frequently Asked Questions

### What is Healthy at Home?

The Healthy at Home Program has evolved from the Sub-Acute Fast Track Elderly (SAFTE) Care Program.

Healthy at Home supports the care of older people (65 years and older or 45 years and older for the ATSI population) whose medical condition is starting to decline. The intention is to avert further deterioration and improve the older person's condition before they become too unwell and need to go to hospital.



### Why aim to support people at home?

Older people often become disorientated and are at higher risk of infection. It is best wherever possible for older people with sub-acute illness to avoid hospital if appropriate and be cared for at home.

### How is Healthy at Home different to existing services?

Healthy at Home is a complementary service aimed at building capacity into existing health and community service systems. It works on the premise of joint health and Community Options assessments and management of an older person.

### Healthy at Home offers:

- ★ a response within 48 hours of referral, 7 days a week
- ★ access to a clinical team that may include a Geriatrician, nursing and allied health e.g. physiotherapist, occupational therapist
- ★ access to clinical diagnostic services
- ★ access to a Community Options case manager for up to 6 weeks
- ★ coordination of care between all health and community service providers
- ★ establishment of long term sustainable care (versus episodic care).

The Healthy at Home team works in partnership with specialist providers such as Aged Care Assessment Teams, dementia services and general practitioners to meet individual needs.



**1800 152 149**

24 hours a day, 7 days a week.

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### There are a lot of services aimed at older people, how do I know where to refer?

Your role is to identify that a person has a need. It is our commitment to meet that need with the most appropriate service in the shortest possible time frame.

### What does a case manager from a service such as Community Options offer?

A case manager works with the individual to develop a care plan that focuses on both short term and long term needs. It involves the individual, family/carers, GP and service providers e.g. Home Care, Meals on Wheels and health services. A case manager works as the central point of contact and coordination when the individual's needs are complex and many service providers are involved.

### Who can refer to Healthy at Home?

Any service provider such as a GP, community nurse or volunteer worker can make a referral to the service. Carer/self-referral is also possible.

### How do I know when to refer to Healthy at Home?

A referral should be made at the first sign of deterioration in an older person. This is usually observed as a change in a person's usual capacity to manage activities of everyday living e.g. walking, caring for themselves, need for support, increased confusion or more frequent need for medical intervention. These simple behavioural changes are warning signs that an older person's health is beginning to decline and that intervention is required.

### How do I make a referral?

You can call the Referral and Information Centre on **1800 152 149**, 24 hours a day, 7 days a week. The referral process takes approximately 5 - 10 minutes. You need to provide information about the person needing the service e.g. name, address, date of birth, next of kin and the reason for referral.

*Healthy at Home*

is a partnership between

**NSW HEALTH**



**Ambulance Service  
of New South Wales**

**NSW Community Options**



### Divisions of General Practice

HKR Division of General Practice

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