

The Southern Health CRIP (Complex Resource Intensive Patients) Program for frequent attenders

**A multidisciplinary approach to
reducing attendances in the Emergency
Department**

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integrity • compassion • accountability • respect • excellence

Southern Health

Better Health for Our Community

Care Co-ordination

- Interdisciplinary team consisting of allied health and nursing (OT, Physio, Nursing, Social Work) in the Emergency Department (ED)
- Facilitate patient flow through early assessment and intervention, risk screening and discharge planning
- All ages and all clinical areas
- Shared clinical competencies
- 56 cubicles (includes medical assessment unit)
- 64,700 patients treated in ED past 12/12

Why CRIP?

- Care Co-ordination team identified a subgroup of patients to ED, who would frequently re-attend with complex care needs
- Due to their complexity, high demand on resources and involvement of multiple teams they require a co-ordinated approach
- Identified need for a targeted program to address this issue

Frequent attenders

- Audit of Southern Health EDs identified approximately 1000 patients, 8 or more presentations in a 12 month period
- Multiple co-morbid medical, social, behavioural and psychological problems
- Need for consistent and effective delivery of care to ensure meeting individuals health care needs in most appropriate way
- Current research definitions of frequent attenders

Statistical over view (March 09-10)

- 5000 attendances for people with 8 or more presentations
- Frequent attenders are more likely to....
 - Be divorced
 - Be aged either 40-50 yrs or 70-80 yrs
 - Arrive by ambulance or police
 - Be admitted to hospital
 - DC self at own risk / against medical advice
 - Present with psychiatric or respiratory complaints
 - Be admitted to a mental health unit
 - If DC, to residential care facility

CRIP program

- CRIP (Complex Resource Intensive Patients) Program
- Steering committee with hospital and community teams and engagement with Ambulance Victoria
- Core CRIP committee established
- Care Co-ordination (Allied Health), Nursing, Medical, Addiction Medicine, Psychiatry, Ambulatory and Community Care, Clinical Risk Manager

CRIP program

- Aim to provide the patient with their multi-disciplinary needs in the most consistent and streamlined approach possible
- Monthly meetings
- Delegate is responsible for the development, implementation and monitoring of ED Care Plans
- Care Planning Meetings – key stakeholders
- Referrals

Pilot Case

- 59 y.o female
- Lives alone, supportive family, disability pension, son with autism recently in care
- Hx: somatoform disorder, chronic back pain, recurring UTI's, diabetes, cardiac risk factors
- Frequently presented with back pain, abdominal pain, reported GI bleeding, chest pain, urinary symptoms
- Multiple investigations and minor procedures
- Complex social and behavioural issues

The Interventions

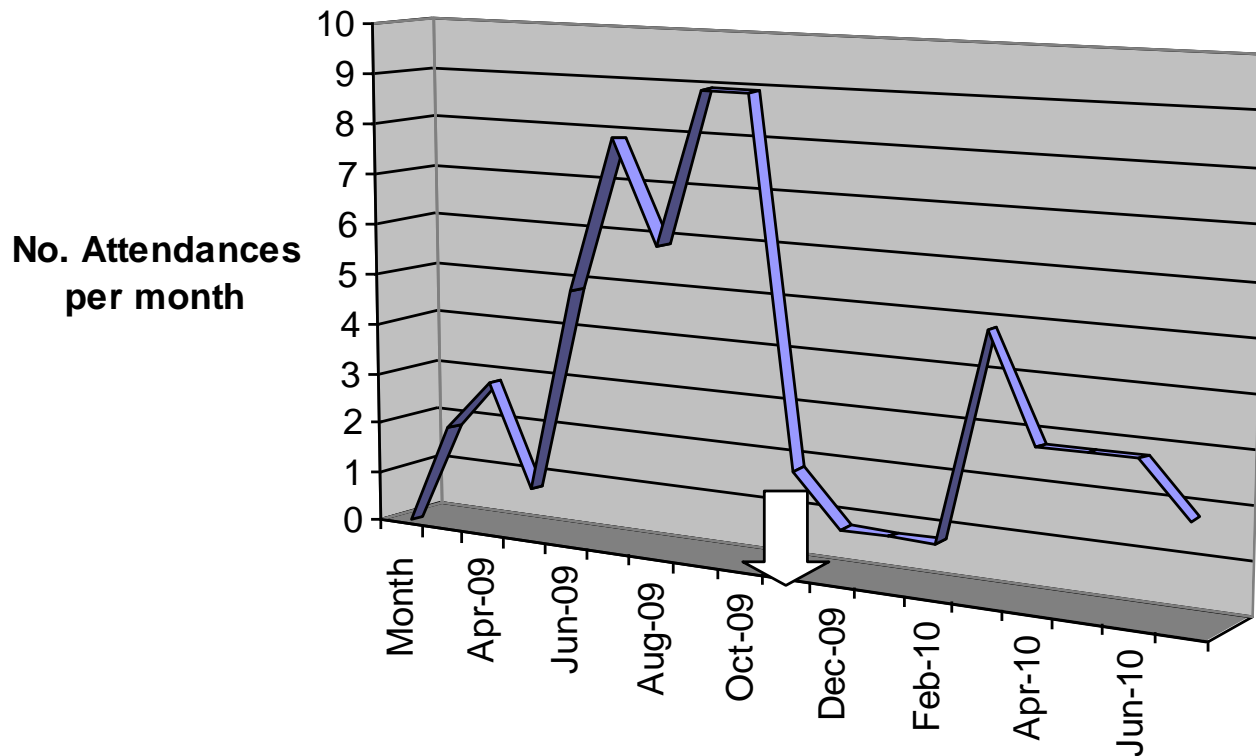
- 61 presentations from March 09 – July 10
- Intervention
 - Multidisciplinary team meeting
 - Family involvement
 - Referral to community case manager
 - Development of ED care plan
 - GP liaison
 - Expanding social network

Interventions

- Intervention implemented in Nov 09
 - Admissions prior to intervention 43 (March – Nov)
 - Admissions post intervention 18 (Nov - July)
- Reduced length of stay
- Reduced ED presentations
- Fewer complications
- Engaging with community services and GP
- Patient has clear understanding and expectations
- Not attending other local ED's

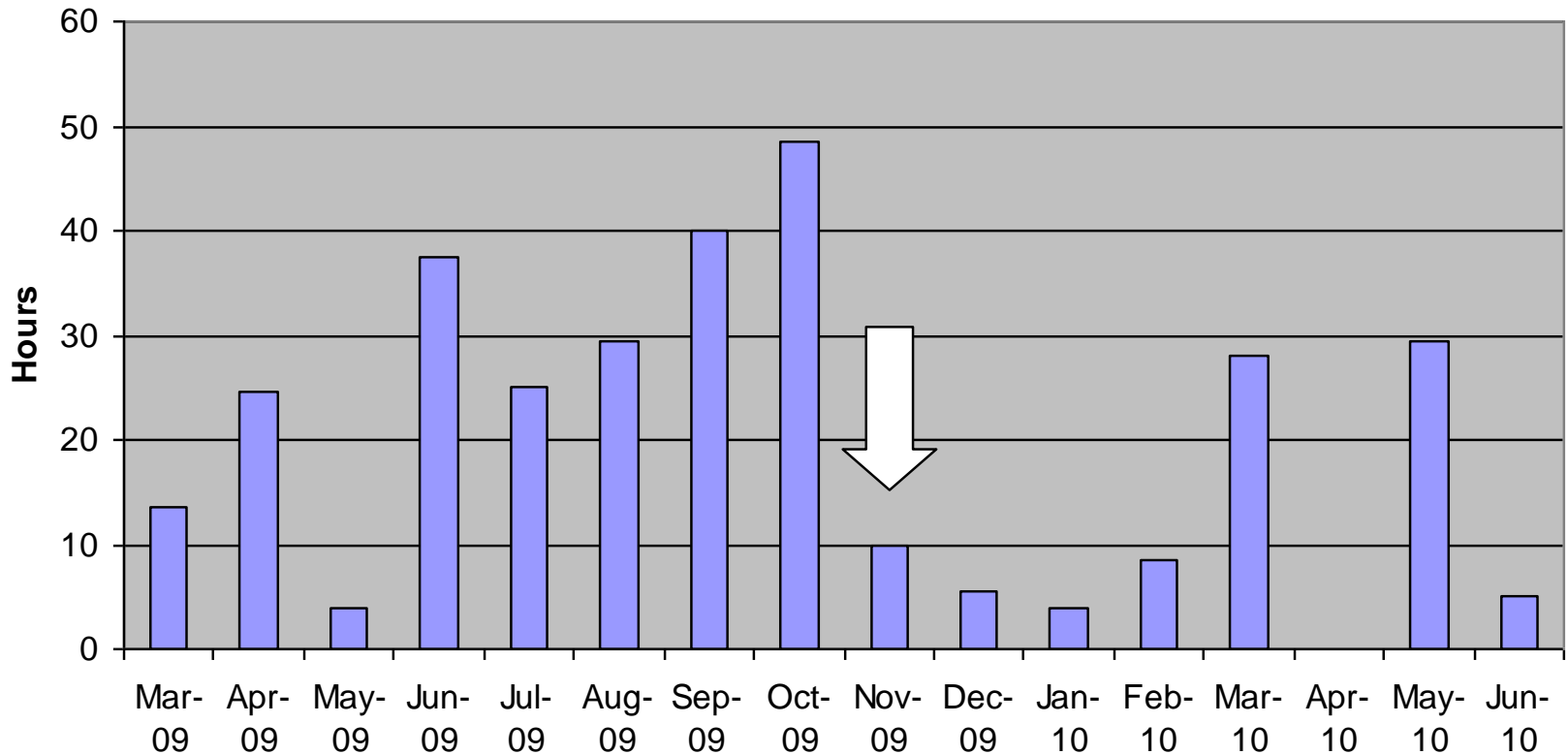
Attendances over time – Pilot Case

Attendances per month for pilot case



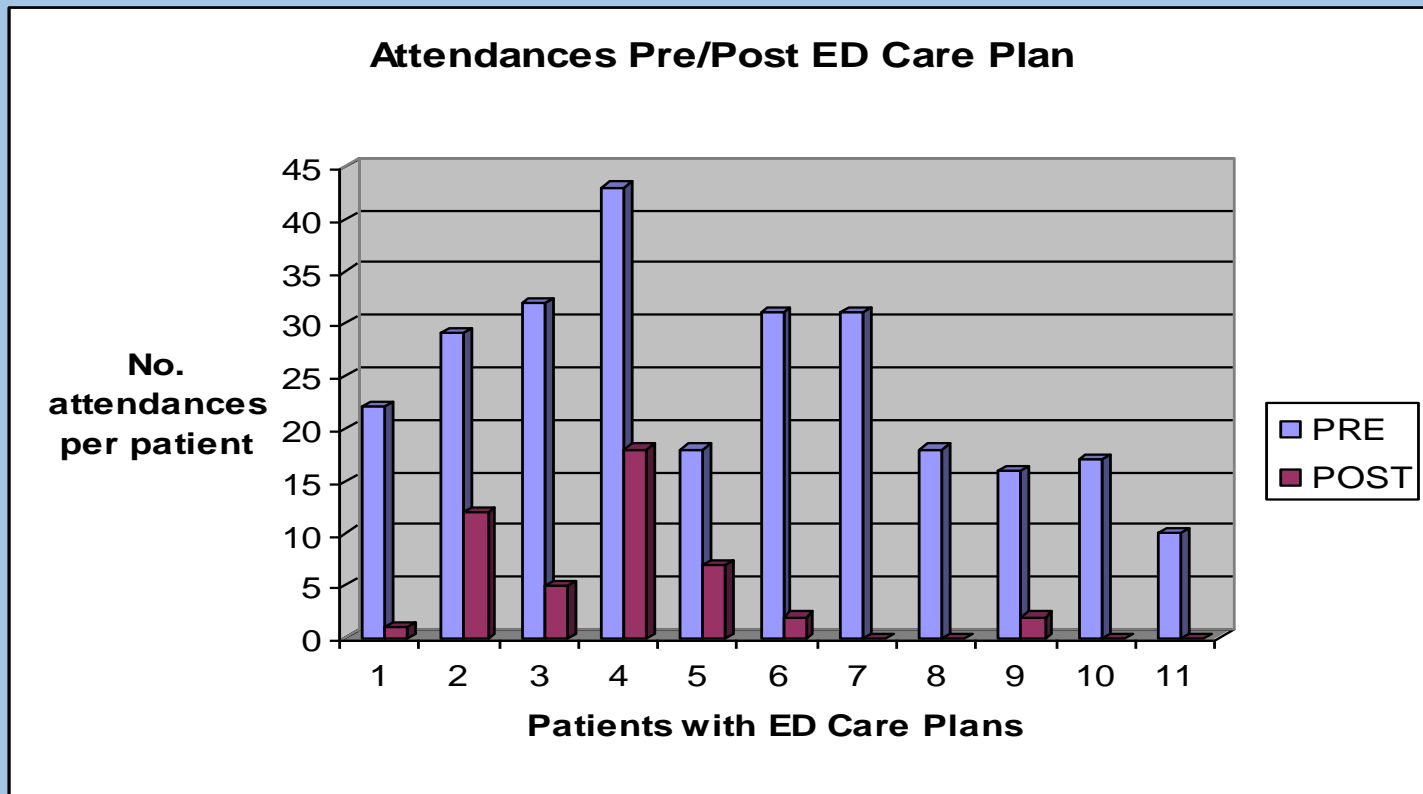
LOS in ED pre/post intervention

Hours spent in Department per month- Pilot Case



Outcomes

- Since the commencement of the CRIP program we have successfully completed 11 ED care plans with another 6 in draft format. (not comparable time period)



Points to consider

- What is it that has made a difference to reduce this patients attendances?
- What needs are being met by attending the ED / what behaviour is being reinforced?
- How are we meeting this patients complex care needs?
- Have we achieved a greater understanding by looking into this individuals case?
- Psychosocial factors
- Labeling 'frequent flyers' and 'the boy who cried wolf'

Future directions for CRIP

- Targeted interventions for specific patient groups
- Further research into impact of interventions
- Research Grants
- Links with Ambulance service, general practice and community services
- Outreach – short term case management
- Sharing ED care plans with other networks / statewide programs

Thankyou

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