# Pathways to Independence

# a demand management strategy

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Government of South Australia

SA Health

# *Overview*

- Health Service Integration
  - who we are and what we do
- The growing demand
  - the need for more flow
- Medium term responses
  - target groups
  - Phase 1-3
    - chronic disease
    - early physical decline - falls
    - early cognitive& psychosocial decline
- Future directions

# *Health Service Integration*

> Primary health care team that works across the acute – community interface

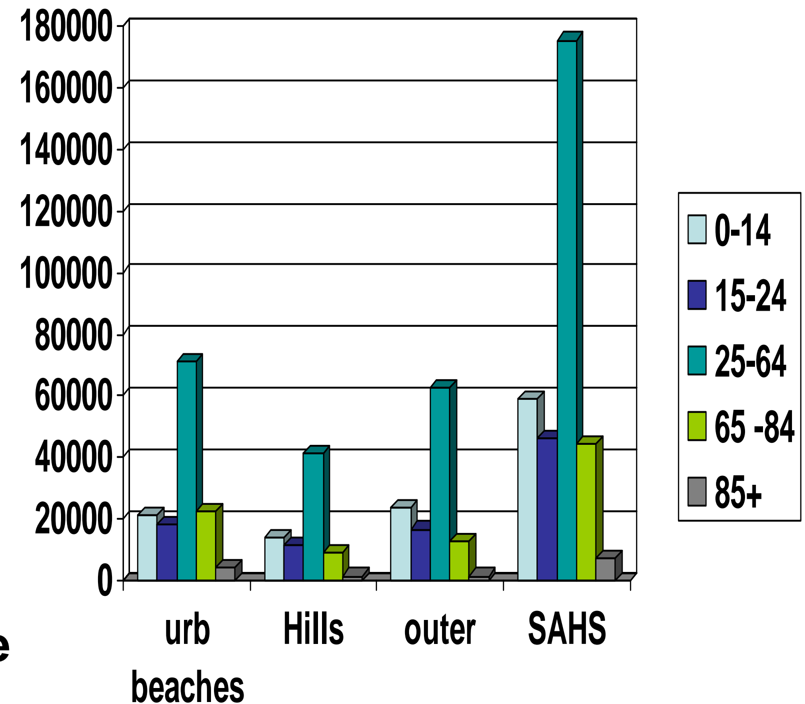
> Focus
  - avoiding hospital admissions
  - improving long term health

> Targets are to ↓ demand through:
  - avoiding presentations to ED
  - avoiding presentations becoming admissions
  - facilitating early discharges to ↓ OBD

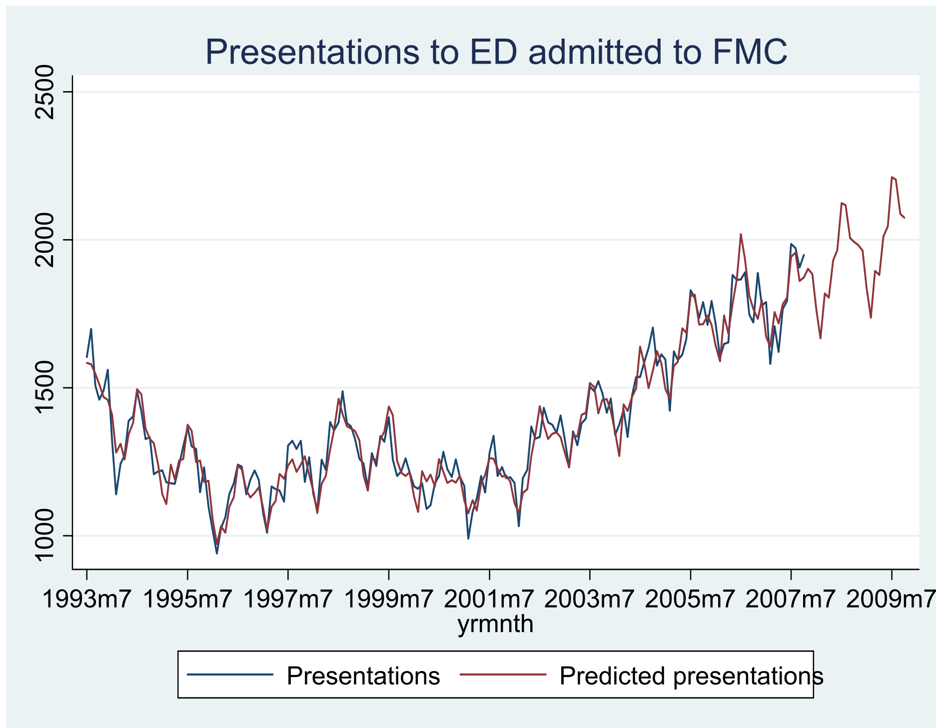
> Contribution to combined target
  - 4 hour target for ED
  - 48 hour target for AAU

# Southern Adelaide region

- Southern metropolitan Adelaide
- 1/5th of population of South Australia, 350,000
- 3 public hospitals, Private hospitals
- 2 EDs and 1 ARU
- 100 GP practices with approx 400 GPs
- Community based health services – state funded, private and NGO (Cmmwth funded)



# The Growing Demand




- 2X ED + 1 ARU
- past 5 years - FMC peak emergency demand for winter formed the new baseline demand level for the summer months - new peaks the next winter.
- additional number of ED adm per day expected in 2008 is 7 per day or an additional 2555 admissions. This equates to **40 additional beds**

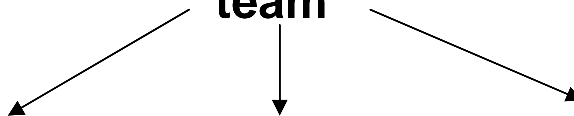
- **Other pressures**
  - budgetary demands
  - Elective surgery strategy targets

- Number of process redesign strategies have been undertaken with success

# *Health Service Integration team*

**AAU / ED / WARDS**

**Health Service integration team**



**Substitution Services**

**Transition care Program**

**Recovery @ The Bay**

**McLaren Vale & DWMH**

Care Awaiting Placement **(under development)**

**Short term Avoidance / Early discharge**

**MHL**

**Short term packages**

**Medium term avoidance**

**Chronic Disease Community program**

**Minimising functional Decline**

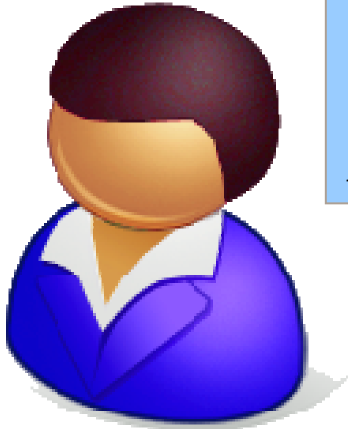
Complex case Management

Telehome monitoring **(under development)**

# Phase 1: Chronic Disease

- Casemix $, burden of illness & predicted increase in prevalence; hospital utilisation & readmission rates
  - **COPD,**
  - **Heart Failure**
  - **Diabetes**
- Case file audit identified - **almost half** of the admissions - classified as **preventable**
- **Communication** between acute & community services - bring sectors together to coordinate care
  - to fully resolve acute issues
  - monitor and respond early to acute deteriorations in chronic conditions
- **Easier access** to Allied Health, incl support with anxiety and depression & oral health - *right time, right place, right service*

# *Case study – phase 1*



**COPD**
**Smoker**
**⇩physical activity**
**Admitted to hospital with a chest infection**

COPD advice given by resp nurse

Ref to Allied Health within hospital

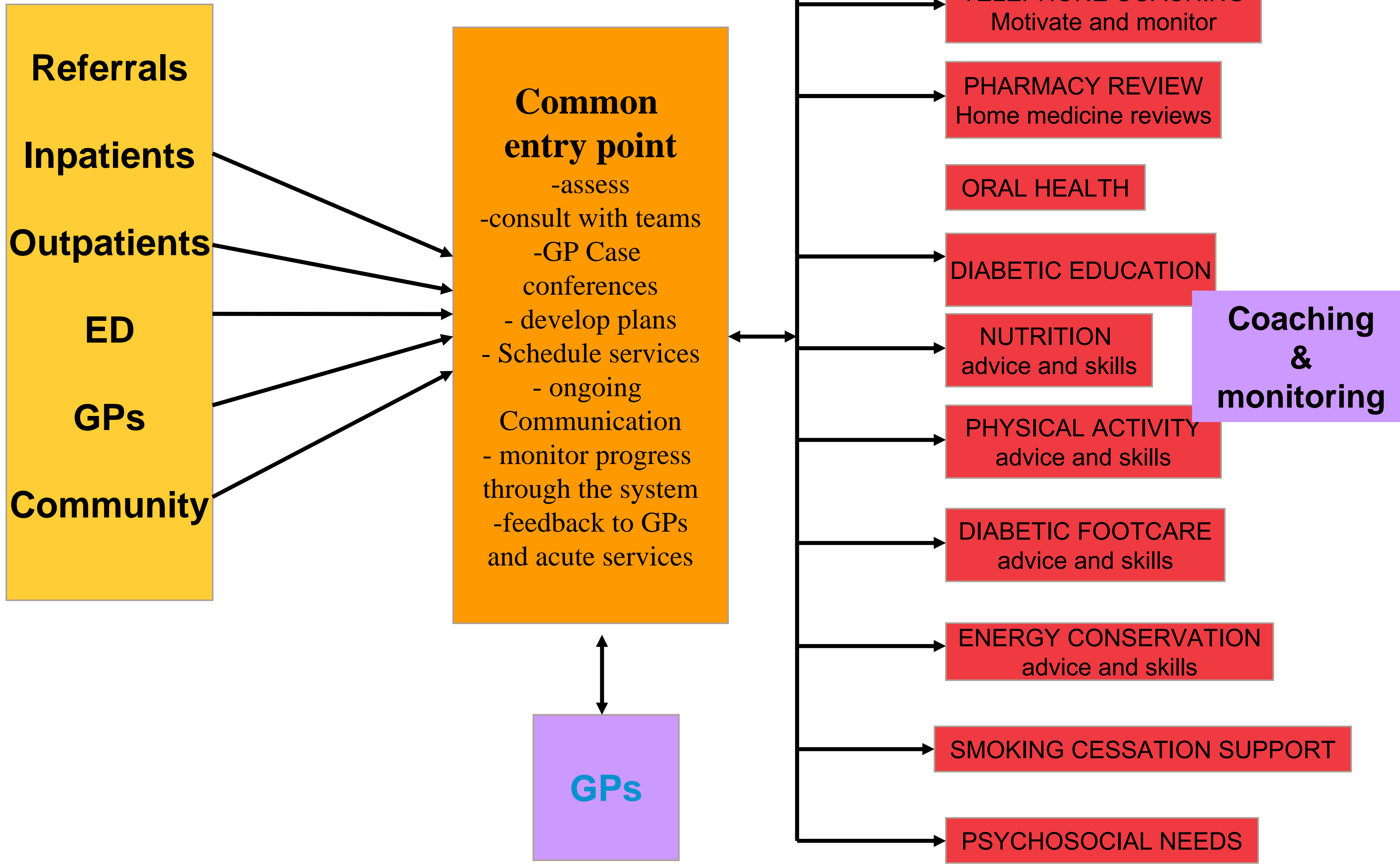
Discharged into community

Continued smoking, reducing physical functioning
Recurrent illness, socially isolated, anx & depr

# *Design of the program – content & form*

- **Services based on agreed clinical guidelines & pathways**
- **Service reform & systems approach was required to support this response**
  - active screening process -Pull
  - coordination & consistency
  - communication & referral pathways across sectors
  - increased capacity within community – skills & access
  - evidence based practice in action
  - underpinned with self management approach

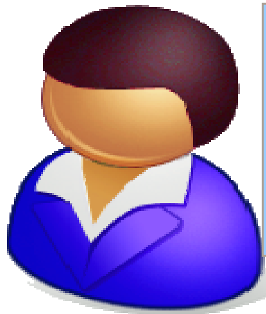
# Chronic Disease Community program PATHWAY



# *Acute sector & GP engagement*

- early involvement
- addressing their issues
- working with diversity – flexibility & consistency
- utilising known systems
- making it the easiest choice
- closing the communication loop
- case conferences

# *Case study – phase 1*



**COPD**
**Smoker**
**⇩physical activity**
**Admitted to hospital with a chest infection**

COPD advice given by resp nurse

Ref to Allied Health within hospital

→ Referral to CDCP

- Assx of needs
- Case conference
- (discuss action plan)
- Scheduling of services
- PharmacyGP
- Involvement of

PT for home ex, br ex
NRT
Telephone coaching
HMR
Oral health

Discharged into community

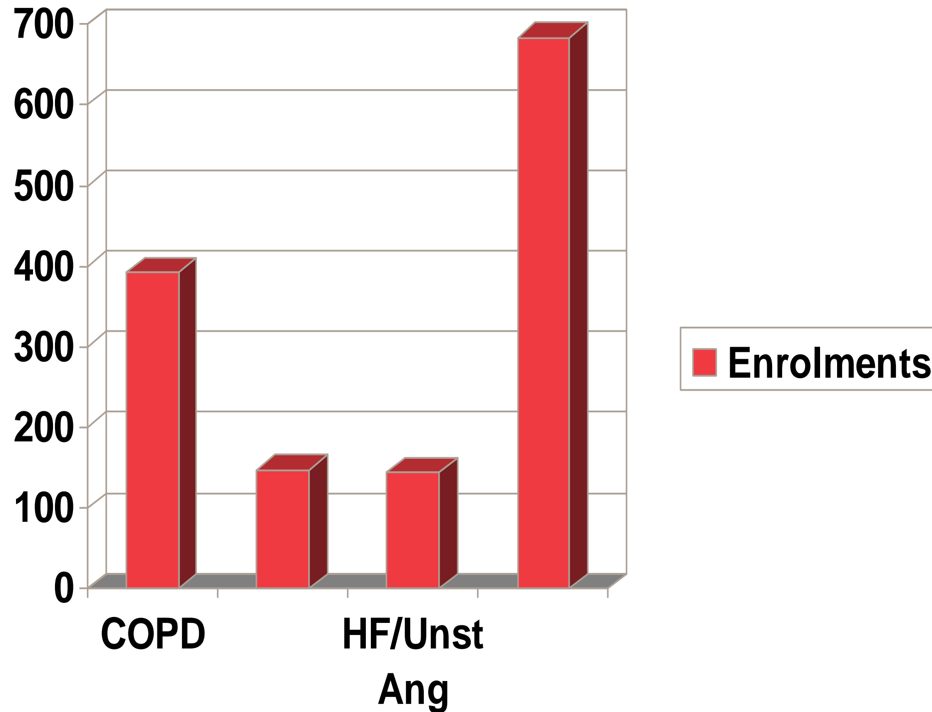
walking regularly,
considering pulm rehab, stopped smoking,
improved adherence to action plan with medication review
new dentures, social activ.
No further admissions to hospital

# *Evaluation framework*

Qualitative & Quantitative analysis

- impact on hospital utilisation rates
- risk factor measures (HbA1c, BP)
- number of people on care plans
- AQoL; self efficacy and goal achievement
- process eg Discharge Summaries/ timing; recall and monitoring

# *Activity Data to date*




Enrolled to date

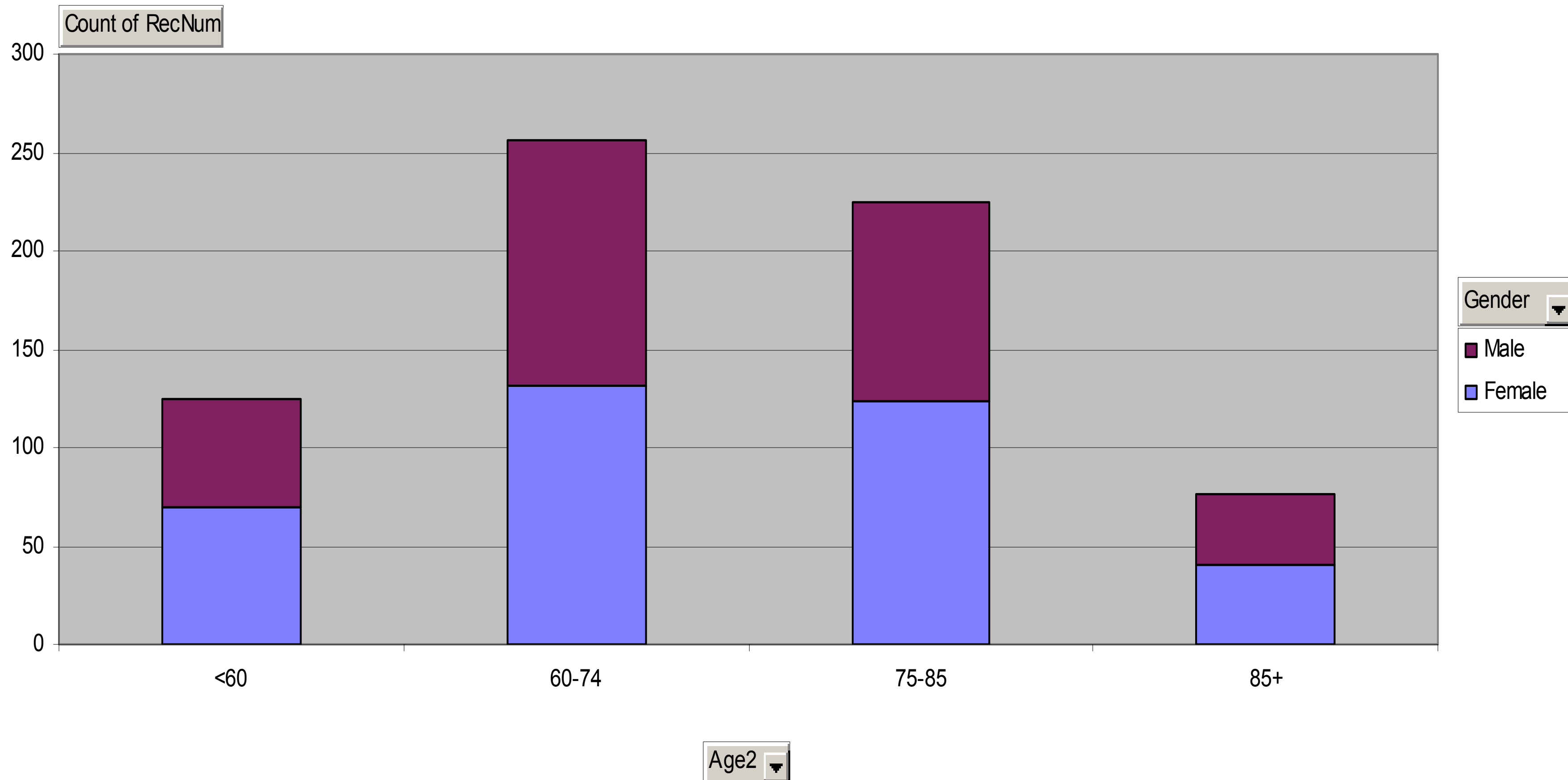
- **COPD - 392**
- **Diabetes – 147**
- **CHF/unst angina – 144**

TOTAL – 683

Referrals generated – 2102

Av 3 services per person

# Demographics – age & gender



## *Outcomes*

- **number of admissions for chronic condition – 12 months**
  - once enrolled on the program compared with
  - prior to participating in the program analysed for 239 individuals.
- reduction in admissions by 58 %

- **works equally well for people living in low and high socio economic areas**
- **particular benefit for older people**

# *phase 2 – Early physical decline falls*

- For SAHS in 2005:
  - 1,624 people adm after a fall, 400 # NOF; 17,864 bed days
  - 1500 people 65 yrs+ to FMC ED with a fall
  - 400 people 65 yrs+ SAAS 'lift only ' no hospital presentation.
    - 37% repeat fallers at risk of hospitalisation without managed service follow up
- Evidence - assessment & intervention post ED for fall will reduce falls & need for health care (Close et al, 1999, and Salter et al 2006)
- low referrals to falls prevention services

# Case study – phase 2

COPD, non-smoker,
⇩physical activity, reports some tumbles

Ambulance picks up x2

Attends ED x1 – given referral to falls Clinic

Has no transport to get the clinic & feels no longer necessary
Does not attend

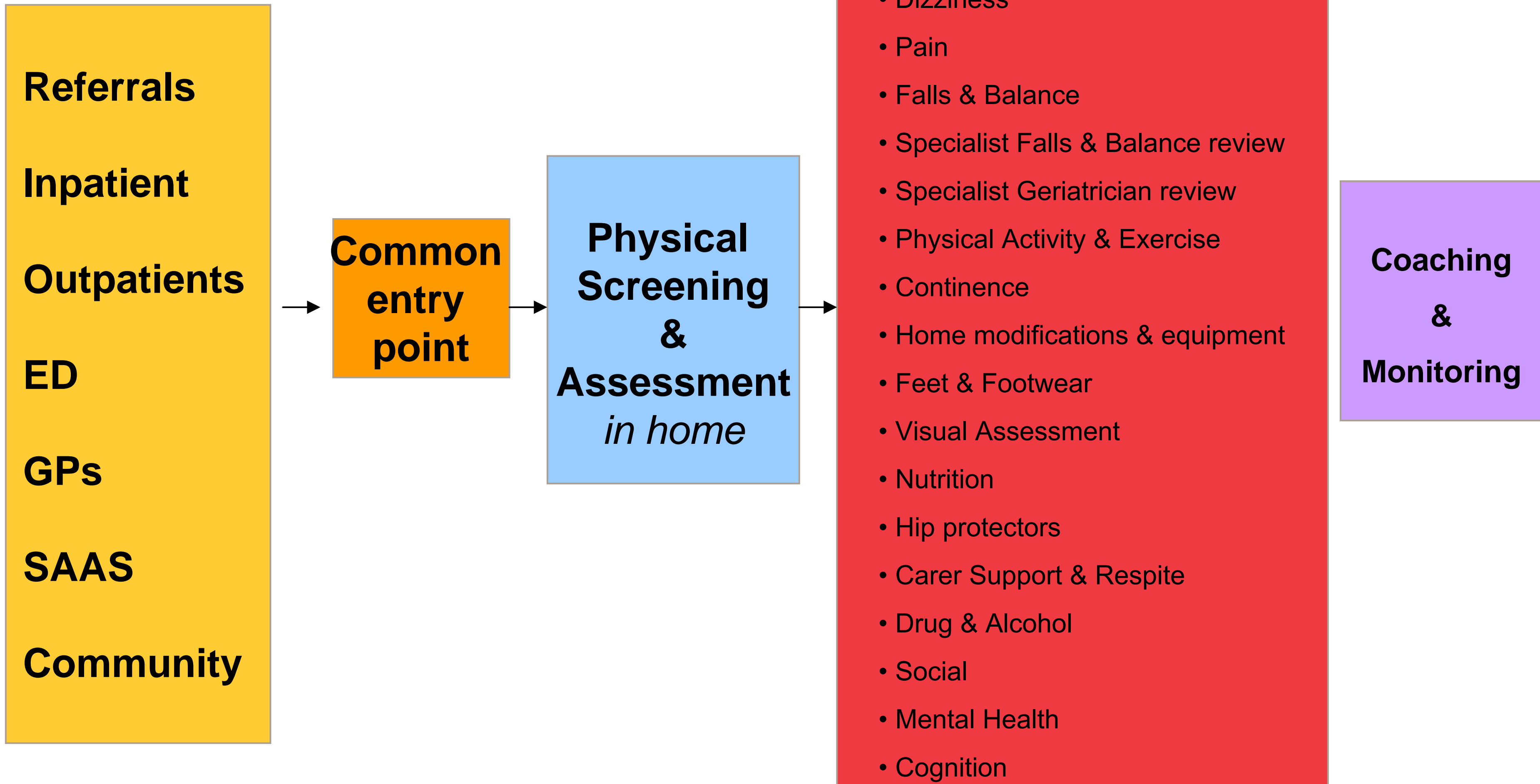
Has another 2 falls the second of which results in a #NOF requiring an admission of 9 days then rehab

# *Evidence*

- The underlying **principle** for effective falls prevention is to identify the individual's modifiable risk factors & deliver strategies to reduce each risk factor , **(from Hill et al, 2004)**
- The most effective falls prevention strategies have achieved a reduction of over 50% in falls rates (Close, 1999, Campbell, 1999).
- Multiple intervention are very effective with NNT (numbers needed to treat in order to prevent one adverse outcome) of between 9.8 (Weatherall 2004) and 11(Chang et al, 2004) to reduce fall rates.

# Minimising Functional Decline

Early physical decline -
Taking Care To Avoid Falls



# Case study – phase 2

COPD, non-smoker,
⇩physical activity, reports some tumbles

Ambulance picks up x 1
Ambulance officer refers to
Minimising functional decline

Referral to
pathways to
independence

Matched to local
Assessor
Assx of needs in home
Care plan developed
Scheduling of
services
Involvement of GP

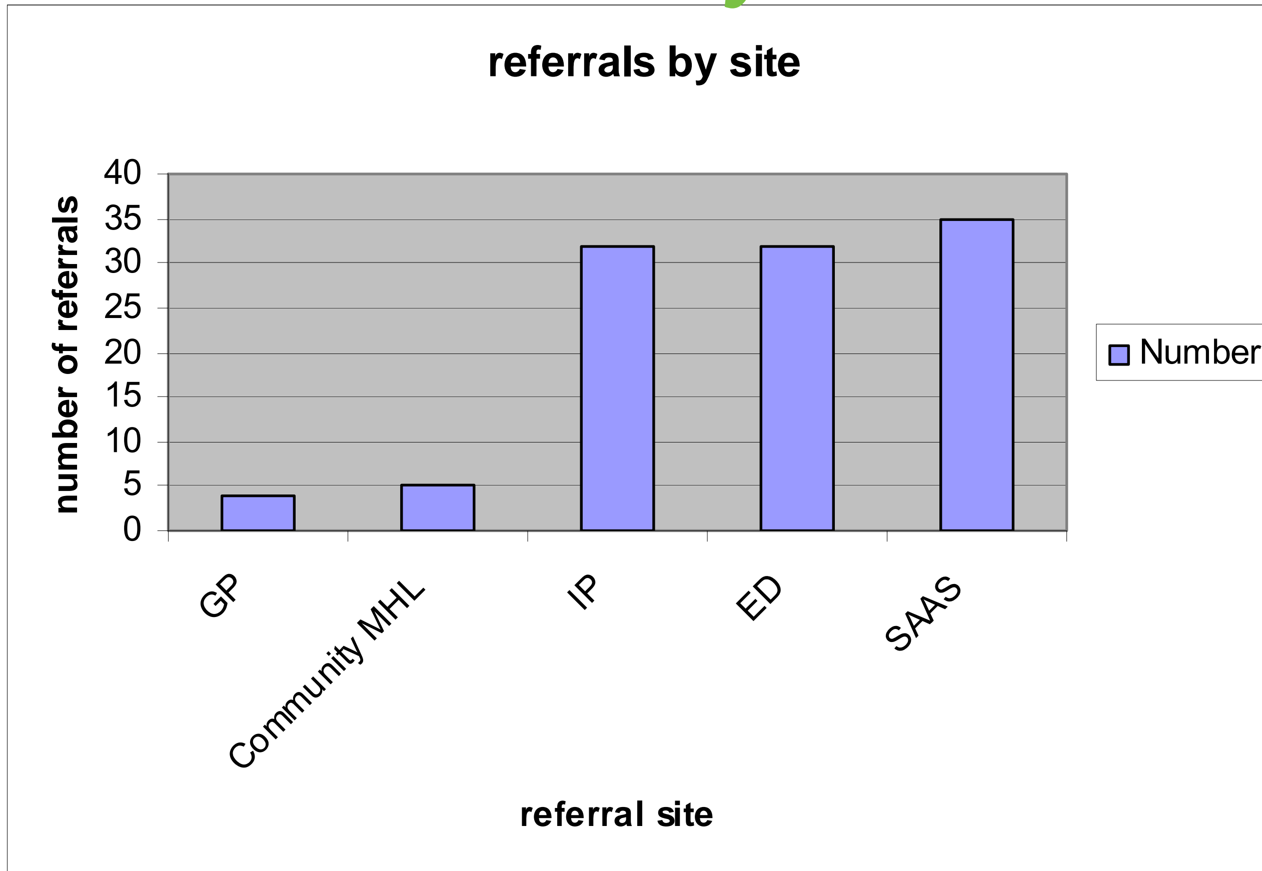
Local falls prevention
group
Review with optician
HMR

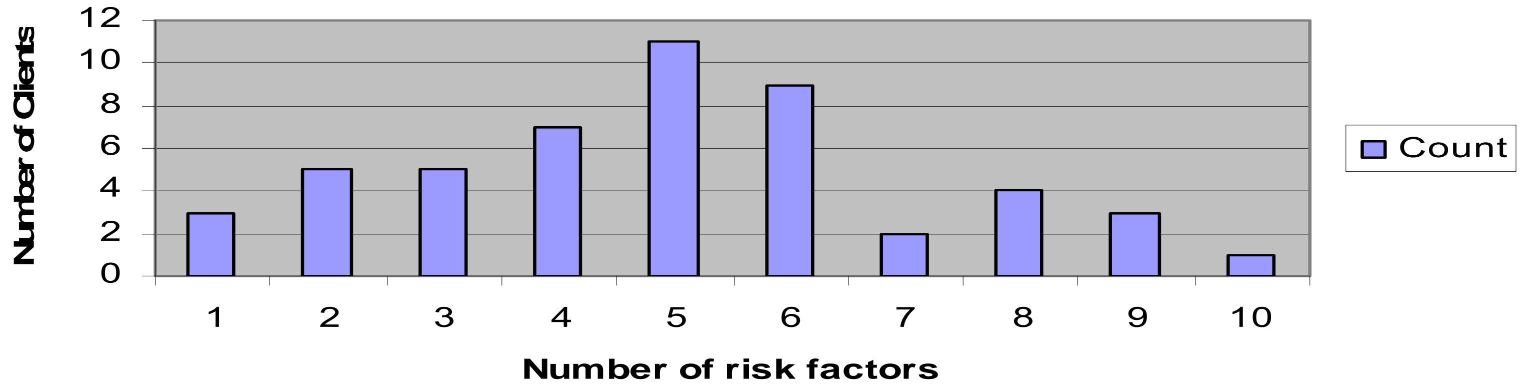
Review over 12months

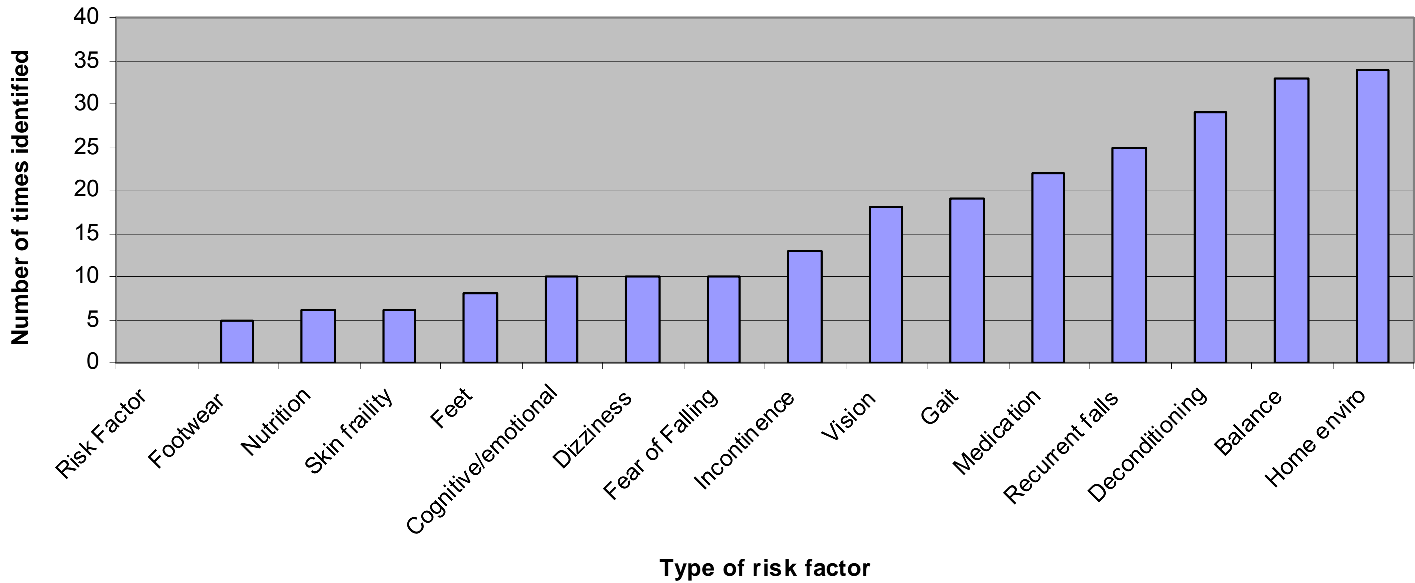
Attending weekly falls and balance
classes
Volunteer transport sourced
New glasses prescribed
Dosette organised by GP and Pharmacist

Walking to shops twice a week and joined
local Tai Chi class
No further falls

# *Minimising Functional Decline activity*




Complexity: number of risk factors per patient
Number of Clients
12
10
8
6
4
2
0
1
2
3
4
5
6
7
8
9
10
Number of risk factors
Count


Most common risk factors
Number of times identified
40
35
30
25
20
15
10
5
0
Risk Factor
Footwear
Nutrition
Skin fraility
Feet
Cognitive/emotional
Dizziness
Fear of Falling
Incontinence
Vision
Gait
Medication
Recurrent falls
Deconditioning
Balance
Home enviro
Type of risk factor

# *Pathways to Independence Framework*

- Chronic Disease Community program
- Minimising Functional Decline - physical

# *Phase 3 – early cognitive decline*

- ESRG024 Dementia, delerium & non traumatic stupor /coma accounts for 9761 OBD in 2006/07 for southern region public patients > 65yrs
- Often do not fit into criteria of existing services
- Nationally dementia carries the greatest burden of disease for older Australians – set to become the number one cause of disability burden in Australia by 2016 (Access Economics, 'Dementia Estimates and projections: Australian States and Territories' February 2005)

## *Leading 12 contributing conditions to Years lost to disability, 75+ years old, Southern Region*

| Burden of disease condition | Southern Region |
|---|---|
| dementia & alzheimer's disease | 42.5 |
| age-related vision disorders | 19.6 |
| other nervous system disorders | 16.6 |
| stroke | 14.8 |
| parkinson's disease | 13.1 |
| adult-onset hearing loss | 12.0 |
| ischaemic heart disease | 11.5 |
| osteoarthritis | 5.9 |
| colorectal cancer | 4.5 |
| peripheral arterial disease | 4.4 |
| chronic obstructive pulmonary disease | 4.3 |
| prostate cancer | 4.1 |
| **Leading 12 conditions** | **153.3** |

# *Case study – phase 3*

Some memory issues , admitted to hospital with a UTI

Admitted for UTI – Daughter expressed concerns & ↑ stress
Assessment by social worker in the hospital

Social Work referred to multiple agencies

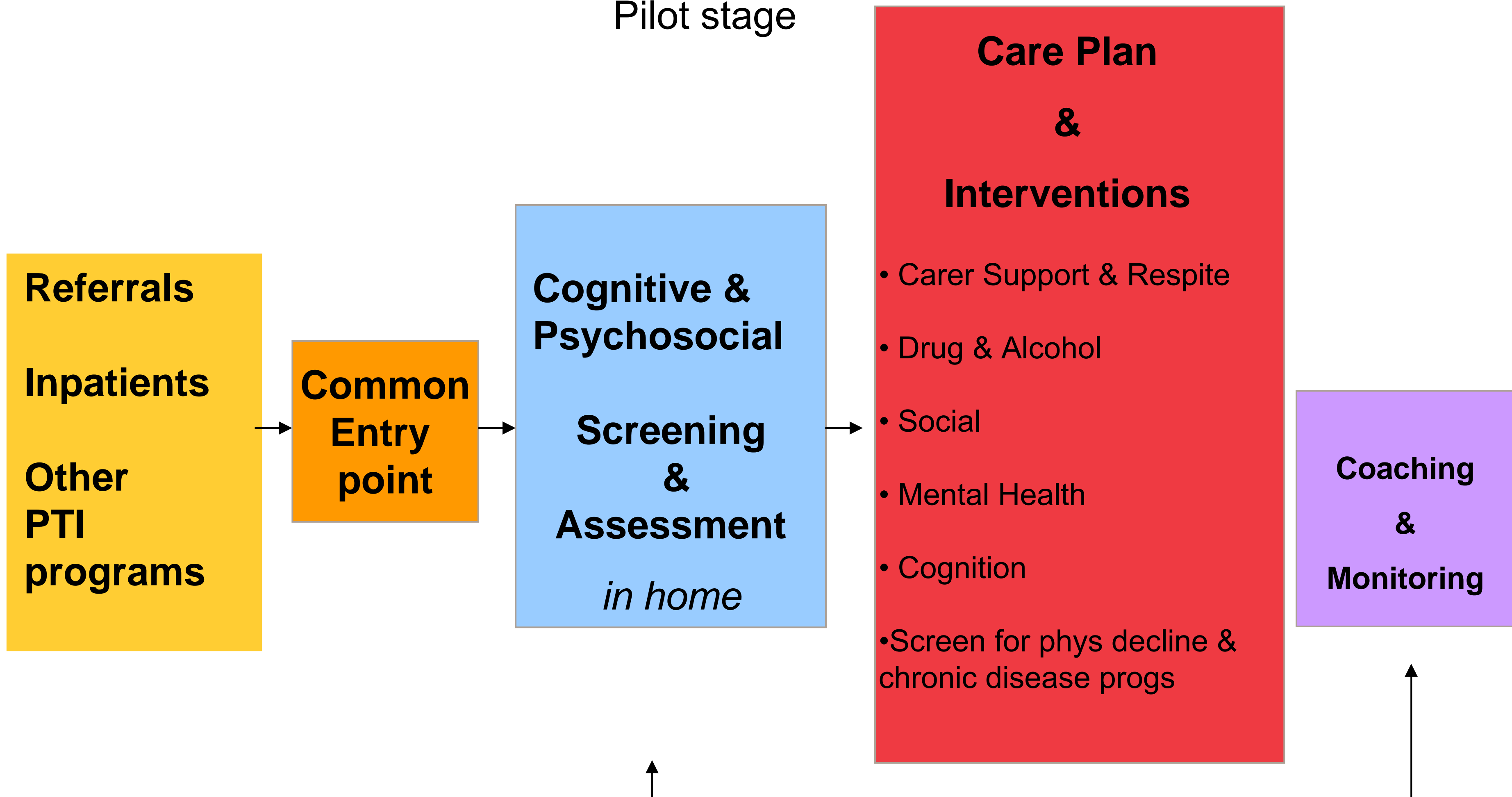
Client put on waiting lists

Continuing deterioration
Admission to start placement process

# Minimising Functional Decline

Early Cognitive & Psychosocial decline – supporting wellbeing

Pilot stage



# *Case study – phase 3*

Some memory issues , admitted to hospital with a UTI

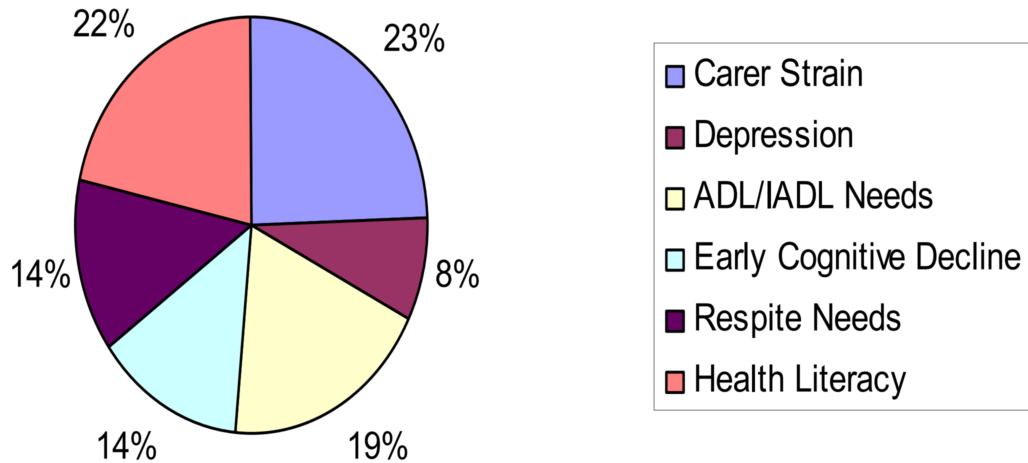
Admitted for UTI – Daughter expressed concerns & ↑ stress, social worker referred to Pathways to Independence

GP follow-up of memory issues
Community services for IADL assistance, increase social activitiy and carer support and respite

Living independently with services provided 3/7
Joined weekly art class
Daughter strain decreased

Home Visit
Cognitive screen and psychosocial assessment
Care plan developed
Scheduling of services
Involvement of GP
Review over 12months

# *Early findings*



# *Pathways to Independence Framework*

> Chronic Disease Community program

> Minimising Functional Decline
  - Physical
  - Cognitive / Psychosocial

# *Future directions*

- Case management for complexity
- Telehome-monitoring
- *The public sector is managing the bulk of 85 year olds and over, and this is very resource intense in both complexity and care needs. One elderly complex admission takes up resources to the extent of up to 3 admissions of a younger person."*[1]

  [1] Source: Southern Epidemiology Service SAHS 2006

# *Questions*

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