Preventing Unnecessary Hospital Emergency Department Transfers for Older People

5-6 May 2016,
The Park Event Space, Lakeside Dr, Albert Park, Melbourne, Victoria

Poor Elwood wasn’t sure if he was coming or going.
The seminar addresses opportunities and challenges by showcasing strategic approaches and innovations programs that assist to:

- alleviate demand and capacity pressures on hospital emergency departments (ED)
- enable older people living in the community/residential aged care (RACF’s) or at home to receive timely, appropriate urgent care
- assist vulnerable older people to avoid potentially unnecessary transfers to hospital emergency departments.

Change Champions & Associates is accredited for 12 CPD points from the Australasian College of Emergency Medicine
Activity ID 24950
Session 1
“I don’t want to go to hospital. Why can’t someone see me here?”

8.30-9.05  Registration

9.05-9.10  Welcome and Housekeeping

Chair:  Jas Streten, Consumer Representative

9.10-9.40  Opening Address
 Simone Corin
 Director, Health Programs
 Department of Health and Human Services Victoria

9.40-10.10  Keynote Address
 Primary and Secondary Prevention of ED attendance in independently living older people
 A/Prof Glenn Arendts
 Centre for Clinical Research in Emergency Medicine
 University of WA

10.10-10.40  Keynote Address
 CARE-PACT: integrated care for the acute healthcare needs of residents of aged care facilities
 Ellen Burkett
 Staff Specialist, Emergency Department
 Princess Alexandra Hospital, QLD

10.40-11.00  Questions to Speakers

11.00-11.30  Morning Tea
Session 2  Strategies for Reducing Emergency Department Presentations

Chair:  Tricia Greenway, Consumer Representative

11.30-11.50  Re-presentations to ED by elderly patients – Can this be reduced?
Dr Anil Paramadhathil
Director, Geriatric Medicine
Canberra Hospital and Health Services (CHHS), ACT

11.50-12.10  Shoalhaven District Memorial Hospital Aged Care Service Model
Dr Jeremy Christley
Head of Department, Aged Care, Shoalhaven District Memorial Hospital
Illawarra Shoalhaven Health Service District, NSW

Additional Authors: Narelle Evry, Co-Director ISLHD, Andrea Lee, Division Support Officer, ISLHD

12.10-12.30  Aged Care Emergency (ACE): A comprehensive Aged Care hospital avoidance strategy
Leigh Darcy
Special Projects Manager
Hunter Primary Health, NSW

12.30-12.50  Clinical Deterioration in Residential Aged Care Facilities
Clare Poker
Associate Program Director; Health Independence Program and Hospital in the Home
Northern Health (NH), VIC funded by Northern Metropolitan Medicare Local (NMML)

Additional authors: Samir Agwan, Project Officer

12.50-13.05  Questions to Speakers

13.05-14.00  Lunch
Session 3  Addressing Clinical Challenges in the Community

Chair:  Char Weeks, Change Champions & Associates

14.00-14.20  Evaluation of Advanced Care Planning and a 'Goals of Patient Care Form' for Residential Aged Care Facilities

Dr Marianne Mok
Advanced Trainee in Geriatric Medicine
Alfred Health, VIC

Co-authors:  Dr Barbara Hayes, Palliative Care Physician, Advance Care Planning Leader, Northern Health and Dr Penelope Harvey, Geriatrician, RECIPE Consultant, Northern Health, VIC

14.20-14.40  Management of Lower Respiratory Tract Infections in Residential Care Facilities by a Mobile Assessment and Treatment Service

Dr Sumitha Bhaskaran
Geriatrician
Alfred and Monash Health, VIC

Co-authors:  Poojay S, Department of Aged Care and Rehabilitation, Alfred Health, VIC, Austin N, Department of Business and Strategy Unit, Alfred Health, Hunter P, Department of Aged Care and Rehabilitation, Alfred Health, VIC

14.40-15.00  Reducing ED Re-Presentations in the 60+ Population

Jo-Anne Kennewell
Clinical Nurse Consultant
Bowral & District Hospital, NSW

15.00-15.15  Questions to Speakers

15.15-15.40  Afternoon Tea
Session 4  Making a Difference with Care in the Community

Chair:  Char Weeks, Change Champions & Associates

15.40-16.00  Keeping resident’s healthy at home

Angela Littleford  General Manager  Helping Hand, SA

16.00-16.30  Keynote Address

Using mobile Xray to extend primary and secondary care in elderly nursing home patients

A/Prof Michael Montalto  Director, Hospital in the Home  Epworth Hospital and Royal Melbourne Hospital, VIC

16.40-16.55  Questions to Speakers

16.55  Close

19.00 for 19.30  Networking Dinner

Canapes, three courses with beverages and entertainment  with
The Voice’s Maya Weiss and friends

The Willows  462 St Kilda Rd, Melbourne
Session 5  Innovation, Collaboration, Integration and Care Coordination

Chair: Mairi Neil, Consumer Representative

8.50-9.20 Opening Address
The “Pathway of Despair” for unwell older people

  Dr Chris Bollen
  General Practitioner
  Director, BMP Consulting, SA

9.20-9.30 Questions to Dr Bollen

9.30-10.00 Keynote Address
Care Coordination through Emergency Department, Residential Aged Care and Primary Health Collaboration: The CEDRIC Trial

  Prof Marianne Wallis
  Professor of Nursing, School of Nursing, Midwifery and Paramedicine
  University of the Sunshine Coast, QLD

  Dr Elizabeth Marsden, Consultant Emergency Physician,
  Sunshine Coast Hospital and Health Service, QLD

10.10-10.30 Ambulatory Care One Stop Shop

  Jo Masters
  Ambulatory Care Nursing Unit Manager
  Bankstown-Lidcombe Hospital, NSW

  Co-authors: Dr Bin Ong, Director, Ambulatory Care Unit, Gayle Cheung, Clinical Nurse Specialist, and
  Dr Vincent Ngian, Bankstown-Lidcombe Hospital, NSW

10.30-10.50 Taking Care of our Elderly Across One Million Square Kilometres

  Karen Dixon
  Manager Strategic Clinical Change
  Country Health SA


10.50-11.00 Questions to Speakers

11.00-11.20 Morning Tea
Session 6  Emergency Care for Older People Closer to Home

Chair: Leslie Leckie, Consumer Representative

11.20-11.50  Invited Presentation
Acute aged Care in the Community—improving the client experience and providing ED diversion
A/Prof Mary O’Reilly
Executive Clinical Director, Ambulatory and Community Services
Eastern Health, VIC

11.50-12.20  Invited Presentation
There’s no Place like Home
GEM at Home. Transforming Healthcare
Stephanie Murphy
Nurse Unit Manager, GEM at Home
Alfred Health, VIC

12.20-12.40  The PresCare Sub Acute Care pilot project: Appraisal of emergency transfer data and nursing staff perspective
Barbara O’Neill
Associate Lecturer, PhD Candidate
School of Nursing and Midwifery
Central Queensland University, QLD

12.40-12.50  Questions to Speakers

12.50-13.45  Lunch
Session 7  Care in the Community

Chair:  Char Weeks, Change Champions & Associates

13.45-14.10  Rural Residential In Reach Model for ED Avoidance
   Danielle Kennedy
   Community Nursing Services
   Northeast Health Wangaratta, VIC

   Co-author: Deanne Burge, Community Nursing Services
   Northeast Health Wangaratta, VIC

14.15-14.35  The Impact of the Acute Aged Care Nurse Practitioner – A Model of Hospital Avoidance
   Amy Bowen
   Nurse Practitioner
   Geripractix, NSW

14.35-14.45  Questions to Speakers

14.45-15.15  Roundtable Learnings Round Up

15.15  CLOSE
9.10-9.40  Opening Address  

Simone Corin  
Director, Health Programs  
Department of Health and Human Services Victoria  

Bio  

Simone Corin is experienced in healthcare administration, working across policy, clinical governance, consumer participation and performance reporting.  

In her current role as Director of Health Service Programs at Department of Health and Human Services, Simone oversees policy design, service planning, program management and funding policy development of ambulatory and inpatient services across the care continuum.  

Her portfolio responsibilities include emergency and critical care; maternity and paediatrics; specialist acute and surgical services; sub-acute, post-acute and end of life care. A key aspect of her role is the design and delivery of innovative and evidence-based health care for older Victorians and those with complex and chronic needs, both within and outside of traditional care settings.  

This role includes the regulation of private hospitals and day procedure centres as well as non-emergency patient transport.  

Simone was previously Director of Safety and Service Improvement and Deputy Director Pharmacy Services Melbourne Health and has a Bachelor of Pharmacy from Monash University.
9.40-10.10  

**Keynote Address**

Primary and Secondary Prevention of ED attendance in independently living older people

**A/Prof Glenn Arendts**

Centre for Clinical Research in Emergency Medicine

University of WA

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**Bio**

Glenn Arendts is Associate Professor in Emergency Medicine at the University of Western Australia, Chair of the College for Emergency Medicine Geriatric Interest Group and a consultant emergency physician. He is chief investigator on several national studies to improve acute care for people in residential aged care and conducts ED based clinical research with a focus on hospital avoidance and harm minimisation strategies in older people.
10.10-10.40  Keynote Address

CARE-PACT: integrated care for the acute healthcare needs of residents of aged care facilities

Ellen Burkett

Staff Specialist, Emergency Department
Princess Alexandra Hospital, QLD

Bio

Dr Ellen Burkett is an Emergency Staff Specialist at the Princess Alexandra Hospital and clinical lead of the Metro South-wide CARE-PACT program. She is a senior lecturer with the University of Queensland where she is also currently a PhD candidate with the Centre for Research in Geriatric Medicine.

She has research interests that include health systems research and quality improvement in the ED setting, with a current focus on improving care of older persons in the ED.
Bio

Dr Anil Paramadhathil is the Director of Geriatric Medicine at Canberra Hospital and Health Services, in the ACT. He is a senior specialist at the hospital and also works in the private sector. He trained in NSW and the ACT and has an interest in exploring new models of care.

Abstract

On an average, 400 patients over the age of 85, present every month to ED at CHHS. About 100 get discharged and of these, 70 re-present to ED within 28 days. 75% of re-presentations end up in admission to hospital.

The Community Geriatric Service contacted the discharged patients, through a phone call and organised appropriate follow-up. The project commenced in September 2015 and is ongoing.

To the best of our knowledge, this approach has not been trialled previously

A list of patient over the age of 85, discharged the previous day was obtained from ED Information System. The patients were contacted by nurses from Community Geriatric Service and an algorithm was followed to determine appropriate pathways. The process was constantly reviewed and refined, as required. Information on re-presentations to ED within 28 days of initial discharge is collected.

The data is currently being analysed and will be presented at the meeting
Dr Jeremy Christley is the head of the Department of Aged Care and Rehabilitation at Shoalhaven District Memorial Hospital. He has worked in acute and subacute aged care and rehabilitation in regional NSW and Victoria for the past 25 years. Dr Christley is also on the executive of the Rural Health Network which was established in recognition of the need for a coordinated approach involving rural health service providers and consumers, in identifying, reviewing and monitoring innovative practice and appropriateness of models of care, including access through technology, for potential implementation in rural communities. The Agency for Clinical Innovation and the Rural Health Network are a collaborative body which work in partnership with Local Health Districts, Consumers and other rural health service providers in providing advice to the Rural Health Priority Unit and the NSW Ministry of Health to inform development of policy, models of care and clinical pathways for rural communities.

Abstract

Over the past five years, the Shoalhaven District Memorial Hospital Aged Care Team has developed an integrated Aged Care Service model which epitomises the Core values of Illawarra Shoalhaven Local Health District. The Shoalhaven District Memorial Hospital Aged Care Team has formed strong, cohesive partnerships with the 13 local Residential Aged Care Facilities, Primary Health Network and Community Service Providers to work together to improve Aged Care Services in the Shoalhaven.

A variety of innovative initiatives have been developed and implemented by the Aged Care team and these have resulted in improved patient/client outcomes in the Shoalhaven region and have decreased unnecessary hospital Emergency Department transfers of elderly people. These programs have included:

1. Geriatric Outreach Clinics in Aged Care Facilities run by geriatricians with Clinical Nurse Consultant support and telephone support for patients within aged care facilities.
2. Advance Care Directives workshops are held throughout the Shoalhaven covering the what, where, why, when & how of Aged Care Directives.
3. Changes to the Transfer process for Residential Aged Care Facilities residents who may need to be assessed in the Shoalhaven District Memorial Hospital Emergency Department.
4. The provision of direct admission to 23-hour ward under geriatricians for patients in Aged Care Facilities requiring non urgent treatments such as transfusion and the ability to provide and extended treatment role in the Aged Care Facilities using Hospital in the home.
5. Managers & Clinical Co-ordinator’s Meetings including representatives from Shoalhaven District Memorial Hospital & all Residential Aged Care Facilities in the area and Community Services.
6. Hospital Tours where local Aged Care service providers, community & facility based, are invited to tour Shoalhaven District Memorial Hospital.
7. “Understanding Dementia” workshops developed for staff in residential aged care facilities, families, friends and carers of people diagnosed with dementia, volunteers, community groups, nurses and allied health.
8. Caring for the Confused Older Persons Workshops.

The effect of these interventions has been a 50% reduction in the number of clients presenting to the Emergency Department at Shoalhaven District Memorial Hospital from Residential Aged Care Facilities over the past 3 years.
Bio

Leigh Darcy is the manager for the Aged Care Emergency Program at Hunter Primary Care. She has worked with the program since 2013. Leigh has extensive experience in program management and implementation, building communication networks and engagement of stakeholders. She managed a number of practice improvement programs over the past 10 years. Leigh enjoys the challenge of implementing new models of care and supporting managers to work with their teams to affect cultural change.

Abstract

The Aged Care Emergency (ACE) service has been successfully implemented at Hunter New England Acute Hospitals over the past 6 years. The program provides support for staff in Residential Aged Care Facilities (RACFs) in the management of deteriorating patients and facilitating the journey for patients who are transported to hospital. There has been significant improvement in service provision and relationships with stakeholders since the governance and financial commitment to the service has become a shared arrangement between the Local Health District and Hunter Primary Care (Formerly Hunter Medicare Local).

In 2012- A 2 year pilot concluded at John Hunter Hospital in Newcastle with 4 partnering RACFs

Now, approx. 80% of RACFs in Hunter region (Newcastle, Lake Macquarie, Maitland, Upper Hunter, Tomaree, Armidale Tamworth and Manning region) have implemented the system (6500 RACF beds)

Emergency Departments (ED’s) participating include JHH, Belmont, Calvary Mater Newcastle, Maitland Hospital and Manning Rural Hospital, Tamworth, Armidale, Singleton and Tomaree Community Hospital

ACE is an established and successfully integrated service and in 2014/15 was awarded;

- The Medicare Local Innovator of the Year (National)
- 2 Hunter New England Quality Awards for Building Partnerships and Integrated health care
- Innovation grant to introduce telehealth
- A National Better practice award from the Aged Care Quality Agency “EmbrACE the ACE“ submitted by BUPA Cardiff

A critical success factor for ACE, pivots around the development of close relationships between the RACFs, GPs, Ambulance NSW and the local Hospital. Trust that enhances the provision of a good clinical handover including goals of care and timely appropriate transfer to a referral hospital when necessary is essential.

Key results from Hunter Medical Research Institute’s (HMRI) Evaluation of ACE

- Measured costs/savings and stakeholder perceptions
- ACE has resulted in annual savings of $920,000
- Calls to ACE that resulted in residents being managed in the RACF (i.e. ED transfer prevented)
  - during business hours- 74%
  - after hours- 86%

This presentation discusses how we built an ACE service that better meets the needs of our elderly residing in RACFs with strong stakeholder relationships. It outlines our consultation method, implementation plan and outcomes providing a blueprint that can be adapted to suit varied health settings.
Clinical Deterioration in Residential Aged Care Facilities

Clare Poker

Associate Program Director; Health Independence Program and Hospital in the Home
Northern Health (NH), VIC funded by Northern Metropolitan Medicare Local (NMML)

Additional authors: Samir Agwan, Project Officer

Bio

Clare Poker, B.App.Sc Nursing, Grad Dip Adv Clinical Nursing, CCRN has been immersed in the breadth of acute health care for several decades. In addition to experience as a clinician, educator, nursing workforce and program operations manager, Clare has never strayed far from her fundamental passion - working in the unique “health moment” of patients. Clare values the individuals closest to the “work of caring”, understanding support and education of carers will ultimately provide timely respectful care to those in need.

Abstract

In November 2014 Northern Health (NH) commenced a pilot program working with five Residential Aged Care Facilities (RACFs). The aim of the pilot was to build workforce capacity in early identification of clinical deterioration in residents. The secondary aim was to enhance timely communication between the key resident carers, Patient Care Attendants (PCAs) and the nursing team who are responsible to action expert nursing, medical or paramedical support. The ultimate intention of the program was to reduce unnecessary presentations to The Northern Hospital Emergency Department (ED). The targeted five RACFs combined a total of 429 beds. The staffing cohort were Patient Care Attendants (n = 275). The pilot program employed a Project Officer and Clinical Nurse Consultant (CNC) Aged Care for education. Data from 2014 coupled RACF resident Emergency Department presentations of less than 24 hours with the patient’s presenting condition. The clinical themes identified were:

- Lung/Breathing and Heart Problems
- Brain and Behavioral Problems
- Urinary tract and dehydration problems
- Bowel and Anemia related problems
- Pain, skin and pressure related problems

Education and training materials were developed and delivered to the RACF PCAs. The strategy was innovative as it invested in Patient Care Attendant education. This prompted the PCAs to become familiar and alert to the “usual” resident state and consequently be able to observe changes in the resident’s physical or behavioral condition.

The objective ‘Interact Stop and Watch Early Warning Tool version 4” 2011 Florida Atlantic University was used to report changes in residents conditions. The project was governed by a Project Steering Committee. CNCs facilitated education sessions. Clinical themes were linked to observations which may indicate early clinical deterioration. The education space was informal. The educators used intuition to gently coerce the participants to share case studies to reinforce the learning. Participants were assured they were a valued workforce. The validated Interact tool was used by PCAs to document observations, prompting the nursing team to assess the resident and reviewed Advanced Care Directives. This would inform the action plan. Enablers included in-facility education, use of case studies and empowering the PCAs to become advocates for residents by initiating timely assessments. Challenges included variable RACF executive commitment, RACF bed closures and staffing changes. Challenges with literacy/documentation were evident as some PCA staff reported “fears they would get it wrong”.

The post education evaluation indicates that 90% of participants agreed that the education had built their confidence in early identification of changes in resident’s health conditions. 100% of participants agreed that once educated, PCAs could promptly escalate changes to the Nurse in Charge.

Results ED presentations from pilot RACFs;

April 1 2014 to June 20th 2014 baseline 120 presentations.

April 1 2015 to 20th June 2015 during the project 82 presentations a 31.7% decrease

June 20th to September 20th 2015 sustained at 79 presentations or 34.2% decrease.

PCA are motivated and effective first line observers of early clinical deterioration in RACFs.
Evaluation of Advanced Care Planning and a ‘Goals of Patient Care Form’ for Residential Aged Care Facilities

Dr Marianne Mok

Advanced Trainee in Geriatric Medicine
Alfred Health, VIC

Co-authors: Dr Barbara Hayes, Palliative Care Physician, Advance Care Planning Leader, Northern Health and Dr Penelope Harvey, Geriatrician, RECIPE Consultant, Northern Health, VIC

Bio

Dr Marianne Mok MBBS, B. Med Sci (The University of Melbourne, 2009) is a final year advanced trainee in Geriatric Medicine. She completed Basic Physician Training at Austin Health and Northern Health. During her advanced training, she provided medical care to patients in Residential Aged Care Facilities through the RECIPE (Residential Care Intervention Program in the Elderly) outreach service at Northern Health. She is currently training with Alfred Health, undertaking an elective term in Aged Psychiatry, and will be doing a Diploma in Palliative Medicine later this year.

Abstract

Background: Uptake of Advance Care Planning (ACP) and the documentation of patients’ preferences and treatment plans in Residential Aged Care Facilities (RACFs) is limited. In the absence of a plan for management of deterioration, transfer to the Emergency Department is often the default RACF management. An extension to the process of ACP is proposed: doctor-completed medical treatment orders, specifically, a RACF-specific Goals of Patient Care (GOPC) document.

Objectives: To evaluate the practices, barriers and enablers of ACP and a trial GOPC form in RACFs.

Design: This is a mixed methodology study using two questionnaires, incorporating a hypothetical case scenario, a simulated Advance Care Plan, and a simulated RACF GOPC form.

Methods, Setting and Participants: Purposive sampling was used to recruit participants from the Northern Health RECIPE (Residential Care Intervention Program in the Elderly) outreach database. Questionnaires were distributed to General Practitioners, Emergency Physicians, Consultant Geriatricians, Aged Care Registrars, and RACF staff in the northern suburbs of Melbourne, Victoria. Data collection spanned between March to May 2015. Twenty-six medical practitioners and 32 RACF staff were recruited. Results from completed questionnaires were organised using Microsoft Excel, and free-text data assessed thematically.

Results: Findings from this study identify the challenges for ACP in RACFs to include timing and perceived lack of urgency of discussions, limitations of resources, and patient-related barriers, such as cultural values, family conflict, and lack of a Substitute Decision Maker. The RACF GOPC form was rated highly as easy to use and understand, translating patient preferences into a clear management plan to guide decision-making by staff, ambulance officers, and locum or covering doctors. Some participants, however, did not understand the role of the GOPC form despite the written explanation. Analysis of responses to the provided scenario revealed that 41% of RACF staff changed their management after viewing the completed GOPC form. Of these, majority chose an option that was less aggressive; 60% changed their response from calling an ambulance for transfer to hospital, to calling a locum doctor.

Implications for Practice: Education, increased resources, and collaboration amongst healthcare providers are required to improve the effectiveness of ACP in RACFs. Similarly, medical practitioners and RACF staff would require education about the role of the RACF GOPC form prior to implementation. However, findings from this study suggest that the GOPC form may have benefits additional to those of ACP.

Conclusion: The RACF GOPC form has potential to assist medical decision-making and person-centered care at a time of deterioration, and may help avoid unnecessary hospital transfers from RACF.
Management of Lower Respiratory Tract Infections in Residential Care Facilities by a Mobile Assessment and Treatment Service

Dr Sumitha Bhaskaran

Geriatrician
Alfred and Monash Health, VIC

Co-authors: Poojay S, Department of Aged Care and Rehabilitation, Alfred Health, VIC, Austin N, Department of Business and Strategy Unit, Alfred Health, Hunter P, Department of Aged Care and Rehabilitation, Alfred Health, VIC

Bio

Dr Sumitha Bhaskaran is a geriatrician currently working at Alfred and Monash Health in Victoria. She has a keen interest in exploring alternative methods of healthcare delivery to older people living in the community and is also involved in the GEM at home program at Alfred Health.

Abstract

Background: Lower Respiratory Tract Infection (LRTI) is a common infectious syndrome in Residential Aged Care Facilities (RACFs) and the leading cause of death within this population. It is unclear whether LRTI is best treated in the RACF or an acute hospital.

Aims: To assess 30-day mortality of RACF residents with LRTI treated by a Mobile Assessment and Treatment Service (MATS) compared to an acute hospital.

Methods: Observational study of patients with LRTI in a major public hospital over 12-months. Patients were included if they were from an RACF and diagnosed with LRTI as per McGeer’s Criteria. Patients were classified as being treated in hospital or by MATS. Primary outcome measure was 30-day mortality.

Results: 92 patients were included in primary analysis with 37 and 55 patients treated in hospital or by MATS respectively. Median (IQR) age for the total group was 86yrs (81-91) with no significant difference between groups. The difference in 30-day mortality was not statistically significant between the hospital and MATS groups (10.8% and 21.8% respectively p=0.172). The MATS group had a significantly higher proportion of patients from high level care (p=0.0001) and altered mental state (p=0.034). High level care residence and altered mental state were significantly associated with 30-day mortality (p=0.045 and p=0.002 respectively).

Conclusion: These findings suggest that MATS can provide an alternative solution to the delivery of healthcare to RACF residents with LRTI. Further research is warranted to assess the cost-effectiveness of treatment of LRTIs in RACFs compared to the acute setting.
Bio

Jo-anne Kennewell is the Clinical Nurse Consultant in aged care at Bowral & District Hospital, I have been in this position since 2013. I clinically cover the emergency department, Day surgery, medical and surgical patients, out-patients memory clinic and also outreach to local residential aged care facilities as well as liaising with emergency services and conducting home visits.

Abstract

Our strategy aimed to reduce the proportion of patients over 60 years of age representing to the Emergency Department (ED) within 48 hours of discharge. We utilised a post-discharge follow-up phone call and where required, a Functionality and Mobility assessment. Overall, results were positive, with the intervention showing significant improvement in representation rates from 2012 to 2013. As a result, risk stratification and referral pathways from ED are being explored.

Additionally, as a result of the strategy we adopted, a local Residential Aged Care Facility has begun rotating their Postgraduate Nursing staff through Bowral & District Hospital to develop their Nursing skills and experience the hospital journey of their Older Persons with a cognitive impairment.
15.40-16.00  Keeping resident’s healthy at home

Angela Littleford

General Manager
Helping Hand, SA

Bio

Angela Littleford is the General Manager for Helping Hand Aged Care in South Australia. She is responsible for residential services, serving 600 residents and over 7000 clients through community based services. Her role encompasses independent living options for older people, housing, community based packages of care (including CDC), residential care and dementia care.

Prior to this Angela was the Chief Operating Officer for RDNS, which provides a range of health and community support services. Services encompassed acute, sub-acute, palliative and rehabilitation/restorative program areas. Prior to joining RDNS, Angela spent five years in NSW working predominantly with NSW Health on the state-wide Clinical Service Redesign Program. She led the State-wide Clinical Service Re-design program to improve the care of older people and people with chronic disease; with NSW Health. Angela completed her PhD research in the area of innovation in the care of older people with chronic disease and the relationship of innovation to policy.

Angela has over 25 years’ experience in managing a range community services focused on improving the health and well being of older people.

Abstract

Helping Hand has five residential facilities, caring for 600 older people across Metropolitan Adelaide. Due to changes in the aged care sector, most significantly the increase in home based services along with stringent financial assessment prior to entry into residential aged care; many older people are successfully living in the community for longer. However the corollary effect is that when older people do enter aged care, it is a necessity due to physical, cognitive or familial factors. Increasingly aged care is becoming synonymous with sub acute care, for example at one of our sites which caters to the needs of 100 residents 98% are classified as high care using the Aged Care Funding Instrument.

Keeping our residents away from busy Emergency Departments and preventing unnecessary hospitalisation is an ongoing challenge. There is no single solution, however a range of strategies have proven effective in reducing ED presentations and hospitalisation. These strategies include partnerships with the acute sector to cater to the needs of the resident who is palliative; effective use of Extended Care Paramedics and comprehensive care planning with the General Practitioner, family members and the care team. The use of Advance Care Directives is vital. A series of case studies will be presented that highlight the effectiveness of these strategies and the challenges still to be overcome.
Thursday 5 May 2016

16.00-16.30 Keynote Address
Using mobile Xray to extend primary and secondary care in elderly nursing home patients
A/Prof Michael Montalto
Director, Hospital in the Home
Epworth Hospital and Royal Melbourne Hospital, VIC

Bio

Associate Professor Michael Montalto is the Head of Hospital in the Home at Royal Melbourne Hospital and at Epworth Hospital. He has been involved in Hospital in the Home care since 1992 as a clinical leader, researcher, writer and policy planner. He has published over 20 peer reviewed papers and a book. He obtained his medical degree and PhD from the University of Melbourne in 1986 and 1999 respectively. He served on the Victorian Health Minister’s Health Innovation and Reform Council from 2011-2014.

In 2013 he was the RMH project lead for the establishment of a mobile Xray service funded by the DOHHS to provide mobile Xray services to residents of RACFs in the northwest region of Melbourne. This pilot study was completed in 2015. He remains a Director of Aged Care Imaging (Australia).
Opening Address

The “Pathway of Despair” for unwell older people

Dr Chris Bollen
General Practitioner
Director, BMP Consulting, SA

Bio

Chris Bollen is a GP at Oakden Medical Centre and director of BMP Healthcare Consulting, a management consulting company supporting companies interested in healthcare. Areas of expertise include systems for chronic disease management, care of older people, the primary health care/community/hospital interfaces, quality improvement and change management. Clients include Medicare Locals, ReturnToWorkSA, aged care providers, Deloitte Touche Tohmatsu, and the Improvement Foundation.

He is currently Vice-President Modbury Hospital Foundation Board, and a member of RACGP SA&NT Faculty Board, having previously been Treasurer, Chairperson and CEO of several dynamic healthcare organizations. Other current roles include membership of the Australian Commission on Safety and Quality in Healthcare Clinical Communications Advisory Group, the Kidney Check Australia Taskforce (KCAT) and the Centre of Research Excellence in Frailty Advisory Group.

Follow Chris on Twitter @BMPConsulting http://au.linkedin.com/in/chrisbollenbmphealthconsulting/
Friday 6 May 2016  

Prof Marianne Wallis and Dr Elizabeth Marsden

9.30-10.00  

Keynote Address  

Care Coordination through Emergency Department, Residential Aged Care and Primary Health Collaboration: The CEDRiC Trial  

Prof Marianne Wallis  
Professor of Nursing, School of Nursing, Midwifery and Paramedicine  
University of the Sunshine Coast, QLD  

Dr Elizabeth Marsden, Consultant Emergency Physician,  
Sunshine Coast Hospital and Health Service, QLD

Bios

Marianne Wallis is Professor of Nursing at the University of the Sunshine Coast, Queensland and Adjunct Professor of Nursing at Griffith University, QLD. She was Chief Investigator in the NHMRC Centre for Research Excellence in Nursing and is currently a member of the Scientific Advisory Committee for the Queensland Emergency Medicine Research Foundation and the Board of the Australian Vascular Access Society. Marianne and her team were awarded $1.15m by the Department of Social Services to trial a model of service delivery to improve the care of residents in aged care facilities who develop an acute illness.

Dr Elizabeth Marsden is an emergency physician with a keen interest in geriatric emergency medicine currently working at Nambour General Hospital, Queensland. She is a Chief Investigator for the CEDRiC project for which the team was awarded $1.15m by the Department of Social Services to trial a model of service delivery to improve the care of residents in aged care facilities who develop an acute illness. She is also an avid surfer and will soon be travelling with great anticipation to Wales, UK to surf the wave pool in Snowdon.
Bio

Jo Masters is the NUM of the Ambulatory Care Unit at Bankstown Hospital, NSW. She has a medical nursing background and has worked in Ambulatory Care since its inception in 1993. Jo is passionate about Hospital in the Home as the future direction for health care provision in Australia. She envisions growth in this field to be directed by enabling ED and hospital avoidance pursuits.

Abstract

Bankstown Hospital is an acute general hospital located in South Western Sydney Local Health District. We are a tertiary Hospital with 454 beds offering a range of inpatient and outpatient services to cater the local community.

The Bankstown Ambulatory Care Unit compromises of One Director, one Registrar, one Resident and Nurse Unit Manager. There is 1.5 FTE clerical and 12.11Fte nursing staff. The major services provided by the unit are the Day Hospital and clinics; and Hospital in the Home (HITH).

Streamlining of services has been shown to produce benefits in efficiency and reduction of costs both in the corporate and health sectors. The collocation and integration of Day Hospital and Hospital In The Home (HITH) in Bankstown has allowed us to develop acute assessment clinics incorporating streamlined pathways linking us with our major partners (ED, General Practitioners (GPs) and hospital inpatient wards).

The Acute Assessment Clinic (AAC) was formalised in 2012 incorporating ED triage and GP streamlined pathways. It is a secondary referral clinic taking referrals from GPs and community nurses (after GP discussion). In 2014, the Extended Care Paramedics (ECP) pathways were added along with the Medical Assessment Unit (MAU) clinic.

We reviewed the data for the 12 month period from August 2014 to July 2015. During this period there were 305 referrals to the AAC. There were 159 referrals from GPs, 46 from ED triage, 98 from specialists, 2 from ECP. Following assessment, 224 were transferred to HITH, 30 were admitted as inpatient (8 to MAU, 22 to other inpatient wards), 1 to another hospital, 4 left before assessment and 46 were discharged on oral antibiotics back to the GP. There were two representations to the service within a month of those who were discharged back to the GP. The numbers of referrals have continued to grow. During the three month period from January to March there were 126.

The AAC provides a streamlined pathway for HITH appropriate patients by demonstrating the strategy of “the right time right place and right care” is achievable.
Karen Dixon is the Manager Strategic Clinical Change for Country Health SA Local Health Network where a key aspect of her role is to identify and facilitate innovative opportunities for improving access to health services for people living in rural and remote South Australia. She oversees a range of programs and change processes while strongly advocating for country consumers and health workers. Karen seeks innovative ways to overcome the challenges faced by the tyranny of distance, with a recent example being the successful implementation of the Virtual Clinical Care Home Tele-monitoring program for people living with a chronic condition(s) in country SA. Karen has a background in occupational therapy and a strong commitment to reducing the disparities between health outcomes for people living in rural areas as compared to their city cousins as evidenced by the 14 years she has worked in rural health.

Abstract

Country Health South Australia Local Health Network (CHSA) covers a geographical area spanning one million square kilometres. CHSA views our population as a service of 465,000 beds, with approximately 20% of these beds belonging to people over 65 years of age. Multiple comorbidities associated with chronic disease and social issues are among the challenges in keeping this group of people out of our hospitals and emergency departments (ED).

To overcome the tyranny of distance and workforce issues, sustainable health services must be integrated to incorporate general practice and allied health professionals and must utilise innovative e-health strategies to provide an effective service.

CHSA has partnered with the Country SA Primary Health Network to implement two major e-health initiatives aimed at integrating and improving care for our older population.

1. Silver Connections: providing timely nurse supported video consultations between aged care residents and GPs during or immediately following an event, potentially preventing an admission to the ED. GPs are able to undertake a supported assessment and provide approval for drug alterations where appropriate or if necessary recommend a transfer to the ED. This project has shown reduced numbers of avoidable hospitalisations for residents in participating facilities.

2. Country Access to Cardiac Health (CATCH): providing a central referral point for streamlined admission to cardiac rehabilitation (CR) programs and an alternative mode of CR to increase the number of people completing programs. Geographical resources prevent many country patients from accessing traditional CR. Introduction of a central referral point has improved the referral of eligible patients to 94.8%. The provision of telephone based CR has shown significantly improved participation rates, completion rates and reductions in the number of all cause readmissions and length of stay for patients involved in the program.

In the geographically stretched and resource constrained environment of Country SA, improving the care of elderly patients through improved patient outcomes and reductions in inappropriate ED presentations and admissions can only happen through integration of health services and utilisation of effective e-health initiatives. Partnering with the Primary Health Network has provided two successful programs for our elderly patients, to show reduced hospital presentations and admissions. These demonstrated improvements benefit both the patient and the health care system. Innovative projects utilising existing resources, latest technology and strong partnerships with the Primary Health Network will enable CHSA to deliver services readily available in metropolitan areas, to reduce the inequality gap.
Invited Presentation

Acute aged Care in the Community—improving the client experience and providing ED diversion
A/Prof Mary O'Reilly
Executive Clinical Director, Ambulatory and Community Services
Eastern Health, VIC

Bio

Mary O'Reilly is executive Clinical Director, Ambulatory and Community Services for Eastern Health, Melbourne, Victoria. She is also Director, Infectious Diseases and Infection Prevention and Control, and Clinical Adjunct Associate Professor, Monash University School of Medicine Nursing and Health Sciences.

Mary is an executive member of the Victorian Medication Therapeutic Advisory group and Vice President Hospital in the Home Society, Australasia. Mary has an interest in quality and risk in health care and promotion of care in the ambulatory setting including residential care including a focus on diversion from acute health care facilities and Emergency Departments where appropriate

Abstract

The advantages of avoiding unnecessary ED transfers for everyone including our older clients are well known, however we often have difficulty in achieving this.

There are many facets to avoiding unnecessary ED transfers for older people.

A strong comprehensive primary health care service is key to promote health and deal with health issues. This needs to be supported by linkages with further expert clinical support in a timely manner including for long term issues eg dementia and behavioural issues and also acute response to deterioration.

A variety of models can be used for the acute care escalation including rapid access to aged care clinicians, medical, nursing and allied health not only in the clinic setting but also at home and in residential aged care facilities to provide expert advice and management support. There can also be partnership with hospital in the home services including provision of services in residential aged care as an ED and hospital diversion strategy.

A/Prof O'Reilly will present the model and services developed at Eastern Health in partnership with community to support older clients to remain well and at home aiming to improve their experience of care.
11.50-12.20  Invited Presentation

There's no Place like Home

GEM at Home. Transforming Healthcare

*Stephanie Murphy*

Nurse Unit Manager, GEM at Home

Alfred Health, VIC

**Bio**

*Stephanie Murphy*, Nurse Unit Manager of the Alfred Health GEM at Home Unit in Victoria. She established and developed the GEM at Home service which opened in September 2015. Prior to GEM at Home, Stephanie managed the Alfred Health age care assessment service.
The PresCare Sub Acute Care pilot project: Appraisal of emergency transfer data and nursing staff perspective

Barbara O’Neill
Associate Lecturer, PhD Candidate
School of Nursing and Midwifery
Central Queensland University, QLD

Project Team: Trudy Dwyer, Associate Professor, CQUniversity, Kerry Reid-Searl, Professor, CQUniversity, Dee Jeffrey, Manager Service Improvement & Innovation, PresCare, Sandra Thomson, Chief Clinical Officer, Facility Manager, PresCare Alexandra Gardens, Lynne Parkinson, Professor, CQUniversity

Bio

Barbara O’Neill’s area of research is nursing staff perspective on managing the deteriorating resident in residential aged care. She was the principal investigator on the PresCare Sub Acute Care pilot hospital avoidance project and has published and presented at national and international conferences on this topic. She is currently the research assistant on an AusHSI Implementation Grant project that is developing a robust protocol to roll out a hospital avoidance initiative for the aged care industry. She also served as the principal investigator on a project aimed at expanding the community palliative care model using a Link Nurse role.

Abstract

PresCare, a regional not-for-profit aged care provider, designed a hospital avoidance program, based on a traffic light approach, to identify and treat eight common clinical conditions that lead to emergency transfers from residential aged care to hospital. The program was piloted at the 94-bed Alexandra Gardens Residential Aged Care Facility (RACF) in Rockhampton. The aim was to reduce hospital transfers through early detection and provision of subacute care at the facility. The program included decision-support tools, clinical skills training for staff, new diagnostic equipment, and input and support from the local medical community. PresCare partnered with researchers from Central Queensland University to evaluate the program. Studies like this are typically evaluated by looking at transfer data. However in this study, we also examined nursing staff perspectives before and after the introduction of the program. This information was considered important because nursing staff are key stakeholders in hospital avoidance efforts and are the ones who will utilise the available resources; therefore, their perceptions are needed to inform future projects. The findings indicated that in the two years prior to the implementation of the program, there were 52 and 60 hospital admissions respectively, and the total length of stay was 444 days and 427 days. For the period in which the pilot hospital avoidance program was in place, there was a marked reduction in both areas, with 30 hospital admissions and a total length of stay of 151 days. Nursing staff generally had a very positive attitude towards the program and found the structure and support beneficial; however, there were concerns about managing more subacute care for residents without additional staffing support. The role of staff ‘Champions’ was created to help introduce the program and support the staff, but this role was found to be divisive, with non-Champions feeling excluded and less important to the process. In conclusion, there were almost half as many admissions and a reduced length of stay for residents admitted to the hospital during the pilot program period. After the program, nursing staff were more aware of their role in managing clinical deterioration and providing subacute care and felt the program provided tools and resources to better support this area of their work. Recommendations for future programs included greater involvement of all stakeholders early on without labeling or targeting any specific group, promoting the program through posters and other methods, and supporting staff through regular meetings and feedback.
Danielle Kennedy
Community Nursing Services
Northeast Health Wangaratta, VIC

Co-author: Deanne Burge, Community Nursing Services, Northeast Health Wangaratta, VIC

Bios

After qualifying as a Registered Nurse in 1996, Danielle Kennedy spent 15 years working in various health care settings in the United Kingdom, predominantly in Haematology-oncology, with a special focus in intravenous access. She began placing PICCs in 2009 and went on to develop a nurse led PICC insertion service as a part of her MSc (Cancer Nursing). On returning to Australia, she has now entered a Nurse Practitioner internship within the Community at Northeast Health Wangaratta and works across Hospital in the Home; Residential in Reach and District Nursing. She is also in the process of completing her Masters in Nursing (Nurse Practitioner).

Deanne Burge has a varied nursing background following her initial registration in 1985 at Preston and Northcote Community Hospital. Various roles in Melbourne Metro working in Critical Care, Anaesthetics and PACU. In 1999 Deanne made the move to Rural Victoria, and it was here that she developed a passion for the care of the older person in the Residential Aged Care Sector in small rural facilities. Since this time she has worked in rural and remote settings in both the acute and aged care areas across Victoria and Western Australia. In 2008, Deanne secured a role as a Nurse Practitioner Candidate in Wangaratta and endorsed as an Older Persons NP in November 2011 after a 3 year internship. She now practices in sub acute covering in three different programs. Deanne has professional affiliations with the ACN, ACNP and is one of the founding conveners of the Older Persons Nurse Practitioner Collaborative in Victoria.

Abstract

With an aging population and a very fiscally managed healthcare system, the Residential in Reach (RIR) model aims to provide contemporary clinical practice in the assessment and management (in appropriate circumstances) of acute medical conditions that would otherwise result in a resident of a residential aged care service (RACS) or a client in the Community potentially presenting to an emergency department or being admitted to hospital. The RIR model provides an alternative clinical pathway to help combat the demand and capacity pressures placed on emergency departments by an aging population and promotes elderly clients remaining in their home environment.

Primary RIR objectives are to:

- Reduce avoidable presentation of residents/clients to the Emergency Department by providing an alternative model of care
- Provide clinical support & education to clinicians
- Provide comprehensive reviews of RACS residents and Community clients
- Foster collaborative relationships with Emergency Department staff, General Practitioners, RACS and Community nursing staff to develop models of care, provide coordinated management plans and initiate clinical practice

Currently at Northeast Health Wangaratta (NEHW), we have a RIR Nurse Practitioner and Community Nurse Practitioner Candidate who work towards promoting the above objectives.

With an increase in an ageing population comes the complexity of chronic disease management and the introduction of advanced care planning, delivery of care requires a reactive and accommodating alternative approach to care and management of this vulnerable population. RIR supports a dynamic way for delivering ageing care in the community, leading to the implementation of treatment and chronic care plans, early intervention in the management of chronic disease and the prevention of acute exacerbations.
Bio

Amy Bowen is an Acute Aged Care Nurse Practitioner with a 20 year background in Emergency Nursing. She holds post graduate qualifications in Cardiac, Acute and Critical Care Nursing and a Masters of Nursing. She has vast experience in staff education and mentorship and specialises in palliative care, trauma and advanced practice. Amy was lucky enough to win the APNA Nurse of the Year award in 2015 for Innovation and Quality assurance for her work in hospital avoidance.

Abstract

Introduction:
The Acute Aged Care Nurse Practitioner (AACNP) has its foundations in the model of hospital avoidance. The aim of the paper is to examine and explore the impact of the AACNP on the health outcomes of the 350 residents in my care and on the financial and clinical outcomes of the local Emergency Department (ED).

Issue:
The default outcome for residents of Aged Care facilities (ACF’s) involved in acute events such as pain, infections, falls, injuries, and exacerbation of chronic and complex illnesses is to be transferred emergently to the local ED. Many of these events are either avoidable or manageable in the ACF. The AACNP was initiated and established to provide rapid assessment, diagnosis and treatment for the residents on ACF’s with a view to hospital avoidance. The role was not available in the Northern Sydney Network so I created by own role, foundation, scope, procedures and policies to open my own business currently caring for 350 patients through collaborative arrangements with 4 general practitioners across 5 ACF’s.

Outcomes:
Multiple outcomes will be discussed including the evolving role of the AACNP, the changing culture for the registered nurses in the ACF’s, and the impact thus far on the ED and the numbers of avoidable admissions.

Recommendations:
Amy Bowen will discuss challenges and benefits of the role and future implications for succession planning and role development and growth. She will also make recommendations for the other NP’s wishing to progress toward Nurse-led clinics.
Tricia Greenway began in the health sector as an advisor to the Federal Minister for Aged, Family and Health Services. This was followed by a decade as senior Policy Manager at Arthritis Victoria and still lots of work as a consumer advocate on several National Committees. Today her years of experience in caring and supporting her elderly mother (in the Northern suburbs of Melbourne) make her a very relevant Chair at this seminar.

Les Leckie is a member of the Consumer Dementia Research Network (part of Alzheimer’s Australia) and this network works with researchers in the field of dementia. He is active as consumer at the Walter+Eliza Institute of Medical research. This involves consumers working with researchers in cancer, infectious disease and immune disorders. Les has a medical technology, pharmaceutical and government background.

Mairi Neil has taught creative writing in community houses for 20 years. She coordinates the Mordialloc Writers’ Group, which she founded in 1995. She facilitated the publication of 9 anthologies, enabling over 60 writers to be published for the first time. Mairi volunteered editing skills to Central Bayside Community Health Services in 2009. Recruited to join the work group for Consumer, Carer and Community Participation, for 6 years she was a consumer voice framing policy and ensuring the readability of Quality of Care Reports.

Jas Streten is a Melbourne City Mission Volunteer Visitor Aged Care. He is also involved with St Vincents Hospital Melbourne on the Consumer Advisory Committee, the Specialist Clinics Advisory Committee, the Catalyst (Innovation) Committee and the Partnering With Consumers Project Working Group.

Char Weeks is Chief Executive at Change Champions & Associates. She home cared for 87 year old mother, Alison, with dementia who foot stampingly refused to be admitted to a nursing home. In between reactivating Change Champions & Associates and running Emotional Intelligence workshops, Char is a nursing home visitor with her dog, Goliath. She is a member of the Community Advisory Committee and Partnering With Consumers Project Working Group at St Vincents Hospital Melbourne.