Community Older Persons Intervention & Liaison Outreach Team

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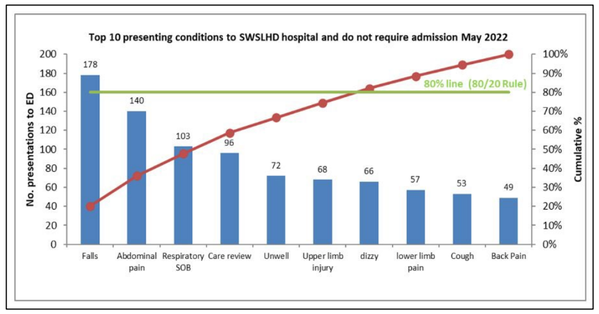
Health South Western Sydney Local Health District

Leading Care, Healthier Communities

Case for change

SWS is expecting a 74% increase in the number of persons ≥ 65 years of age by 2031. The highest growth, 92% will be in the age cohort ≥ 85 years of age. The current growth rates in Emergency Department (ED) presentations across SWSLHD will challenge capacity resulting in stretched resources and may impact the inability to provide quality, safe and timely care. Many of these presentations could be assessed and treated by General Practitioners (GP) or other urgent care providers in the community. Treating low acuity conditions away from EDs will ensure that resources can be directed to more acute presentations. As well as prioritising resources, older people experience long waits in crowded EDs and can develop hospital associated complications such as falls. Therefore, assessment and treatment of low acuity conditions in more appropriate environments should be explored.

Diagnostics



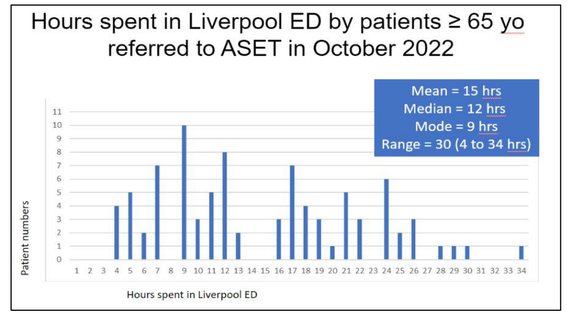
'Unnecessary ED encounters' by patients ≥ 65 years at Liverpool Hospital in October 2022

Method:

Real time audit of patients referred to Liverpool ASET during the month of October 2022 that could have been managed safely in the community n=88.

Retrospective Audit of eMR patient records of identified patients conducted by 2 x Clinical Nurse Consultants (CNC) to confirm appropriateness :

Cost per Occupied Bed Days (OBD) calculated for patients identified as being appropriate for community management n=61.



Potential savings $ 163,828 / month from Liverpool Hospital

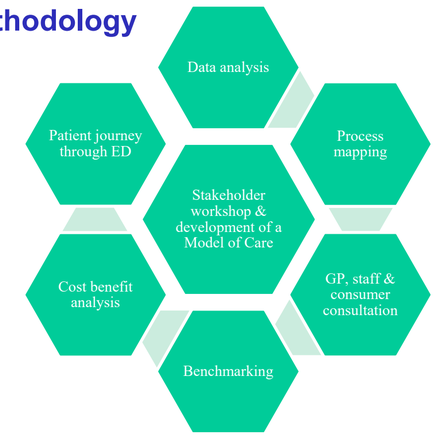
Goal

To reduce low acuity ED presentation in older people aged ≥65 years across SWSLHD.

Objectives

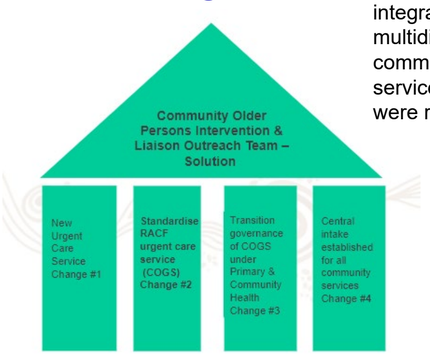
- 10% reduction in the average monthly number of presentations to ED from 3,400 to 3,000, in patients aged ≥65 years categorised triage as 3, 4 or 5 that did not require admission to hospital across SWSLHD.
- 10% reduction in the average monthly number of admissions from ED from 2,700 to 2,400 in patients aged ≥65 years categorised triage as 3, 4 or 5 across SWSLHD.
- Provide a positive experience for older people ≥ 65yrs accessing acute care across SWSLHD as per a designed patient experience survey.
- Enhance relationships with Primary Care providers to strengthen access to healthcare services across service boundaries demonstrated by stakeholder experience survey.

Methodology



Solution design

To establish an integrated multidisciplinary community service. 4 changes were required.



Solution design workshop with COPILOT staff

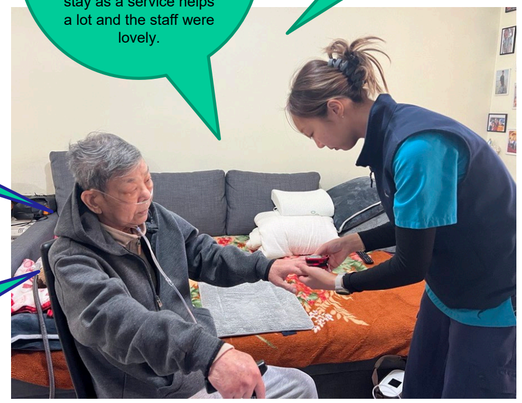
Clients and carers feedback

I wish this service was around when my father was alive. This service is very needed and myself and mother were very happy with this service. This needs to stay as a service helps a lot and the staff were lovely.

The staff were so informative and very caring. Highly recommend

I found it great how quickly the service from COPILOT was implemented for my grandma until we were able to sort out other services

I felt safe after speaking with her (COPILOT clinician)



Client receiving an assessment by COPILOT staff

Results January - June 2024

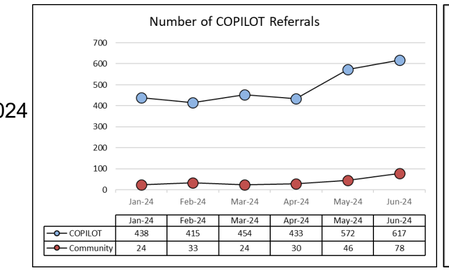
COPILOT (RACF & Community) Activity

- **2929 referrals** received between Jan-June 2024
- **5811 OOS** between Jan-June 2024

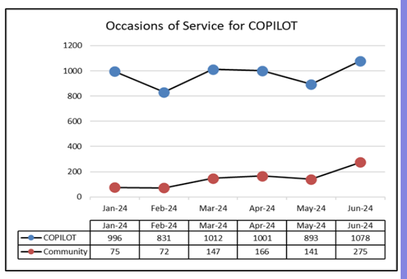
New COPILOT Community Arm

- Results (time to contact clients from referral):

KPI	Average
P1: 4 hrs	1.8 hours
P2: 24 hrs	14.3 hours
P3: 72 hrs	15.1 hours



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
COPILOT	438	415	454	433	572	617
Community	24	33	24	30	46	78



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
COPILOT	996	831	1012	1001	893	1078
Community	75	72	147	166	141	275

2377 avoidable ED presentations between Jan-June 2024
235 avoidable hospital admissions leading to **3384** saved bed days between Jan-June 2024 by the new community arm of COPILOT

Activity

The average length of stay on the COPILOT community service is 14.4 days

75.3 % of our clients score as Frail 876 235

21.9 % of our clients scoring as Pre-frail

69.4% of clients received Advanced Care Directive / Planning education/resources

Experience of Carers and Patients (My Exp. Matters)

100% reported they "felt involved in decisions"

100% reported "Information was explained so they could understand"

100% reported they were "treated with respect and dignity"

100% reported they "had confidence and trust in the COPILOT clinicians"

SWSLHD estimated cost savings January - June 2024

$ 4,918,916 cost saving avoidable ED presentations Jan - June 2024

$ 1,545,307 cost savings from avoidable admissions (new community service arm only) after removing total service costs Jan - June 2024

Sustaining change

The team has partnered with the Primary Health Network (PHN) and NSW Ambulance to develop referral pathways, starting with falls due to their high presentation rate. Regular meetings between the PHN, ambulance, and SWSLHD ensure alignment of urgent care services. COPILOT staff work in EDs to engage ambulance crews and ED staff, raising service awareness and addressing referral issues through weekly huddles. Patient stories are shared at facility and district meetings.

Lessons learnt

- Communication and consultation is vital
- Change management is a complex process that requires robust planning and communication with deliverables and timeframes
- Communication and establishing close networks and links with referral sources for COPILOT is vital to ensure reputation and confidence in the referral pathways
- Medical support is essential in maintaining and delivering a safe and quality service within a high acuity population

Acknowledgements

COPILOT implementation and Steering Committee, Primary & Community Health Executive Team; Project Sponsor and Redesign Lead