Integrating Care for Frequent Service Users in Goulburn

The right care, at the right time, in the right place

Health Southern NSW Local Health District

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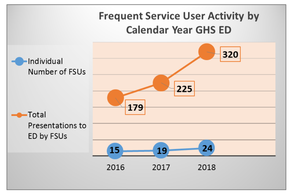
Case for Change

The NSW Health Strategic Framework for Integrating Care[1] outlines reducing ED presentations for Frequent Users as a priority. Goulburn Base Hospital (GBH) has a population of Frequent Service Users (FSUs) attending ED 10 or more times in 12 months with an exponential number of presentations over the last 3 years. There is a clear negative perception of FSUs whose pattern of unplanned and repeated attendance suggests lack of care coordination. No one has asked these patients what they need to stay healthy at home, placing them at risk of poorer health outcomes.



Graph 1: Number of FSUs & presentations to ED by year

Hospital and Community Health (Goulburn Health Service (GHS)), local Ambulance and General Practice do not collaborate in the care of FSUs despite frequent overlap. Most teams are working in isolation ('silos') resulting in fragmented care and system inefficiencies.

*"Integrated care is **vital** to improving outcomes for vulnerable and at risk populations and people with complex health and social needs"[1]*

FSUs are not recognised as a vulnerable population and are often ineligible for existing programs. These patients are falling through the cracks, continuing to access emergency care rather than being supported to take more control of their own health in the community.

Goal and Vision

Improved and timely access to integrated care for patients who are frequent users of health services in Goulburn.

I will be known as someone needing extra help

There will be one person helping me get what I need to stay healthy

I will be able to get the help I need when I need it

I will have a plan which covers all my health needs

Everyone whose helping me with my health will know what's going on

I will be in control of my health

Objectives

- ✓ The percentage of the total number of FSUs presenting to 1 or more participating agencies in 2019, who will be formally identified, will increase from 0% to 30% by 31 December 2019.
- ✓ The percentage of representations within 1 week to GHS ED by FSUs will reduce from 42% to 20% by 1 June 2020.
- ✓ Increase the number of identified FSUs in Goulburn with evidence of care coordination from 0 to 75% by 1 June 2020.
- ✓ FSUs receiving care coordination report 50% increased satisfaction with access to services they require by 31 December 2020.

Methods

✓ Diagnostics — July - Nov 2018 — *ETHICS APPROVAL PROCESS for patient interviews 19 June – 29 Oct

GP Interviews (n=4)	Patient file audits (n=19)	Literature Review	Review of similar projects (n=6)	Patient Interviews (n=3) *
Key Informant Interviews (n=8)	2017 ED Data Analysis	Staff interviews (n=30)	Ambulance Paramedic focus group (n= 6)	Ambulance Frequent User Data Analysis

✓ Solutions — Nov - Dec 2018

Activity	Stakeholders
Workshop 1 - Blitz	Primary Health Network (n=2), GPs (n=1), Community Health staff (n=13)
Workshop 2 - Power of 3	Acute Hospital staff (n=1), Community Health staff, Ambulatory (n=1)
Workshop 3 – Brainstorming	Paramedics (n=7), Paramedic Students (n=2)
Literature Review	Project team (n=3), Steering Committee (n=1) Clinical library (n=1)
Acute Care staff interviews	ED CMO (n=2), A/ DON (n=1), ED NUM (n=1), ED Nurse Educator (n=1)

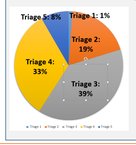
✓ Implementation Planning — January 2018

Diagnostics

Who is a Frequent Service User in Goulburn?

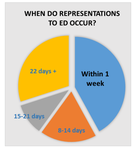
The Data says…

- 276 presentations to ED
- Number of visits range: 10-25
- Admission rate ~ 28% = 281 bed days
- 70% presentations on week days
- 37% arrived by ambulance
- Pain most common reason for presentation (29%)
- More likely to be male
- More than half aged < 65
- ~20% identify as ABTSI.
- Most had one or two specific GPs named over that year.
- Only ~10% eligible patients referred to any other services despite indication for same
- No FSU had evidence of follow up after presentation



Graph 2: Urgency-Triage category of FSUs

Presented to ED 10 or more times in 2017 n = 19



Graph 3: FSU representations to ED

The Patient Voice…

Limitation: Only 3 of the 19 FSUs engaged in an interview of their experience

"It was easy to ask questions but damn hard to get information"

"My GP told me to go to ED. ED told me to go to my GP"

"My GP is an angel"

"They fixed that up for me and then I went home. Straight from the ED. I didn't know why I was unwell. I was worried about it, yeah".

" No one told me what was happening"

"Ambulance were marvellous! I felt safe with them"

Ambulance & Health Service staff say…

"I suspect those 19 would require a more individualised approach" VMO

[there is] "no time to contact other staff for input" ED Dr

100% doctors surveyed had not heard of existing MDT programs (n = 14)

"The issue is getting your head around what services are available and getting it quickly" GP

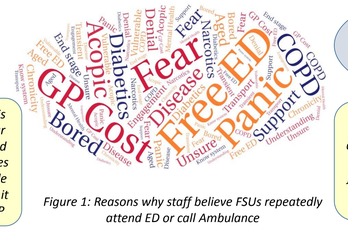


Figure 1: Reasons why staff believe FSUs repeatedly attend ED or call Ambulance

"We're not multidisciplinary. We meet, that's it!" Community Nurse

" [we need] alternate referral pathways, not just us guessing" Paramedic

KEY ISSUES	ROOT CAUSES
Lack of care coordination for FSUs	No system for identification of FSUs.
FSUs not accessing relevant services	FSUs not followed up or referred Inconsistent point of entry/ access for services confusing
Lack of integration in current model of care	Siloed teams with limited support to replace outdated models of care Existing MDT forums not working and poor awareness of their existence Many FSUs not eligible for existing complex care or MDT programs.
Poor continuity of Care between ED / Ambulance to community	FSUs not followed up or referred Key agencies not involved in continuum of care / poor communication Patients +/- carers and GPs not involved in MDTs

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Acknowledgements

Judith Hallam — Manager, Redesign & Innovation |SNSWLHD
Netty Swinburne Mepham — Manager Integrated Care | SNSWLHD

[1]*NSW Health Strategic Framework for Integrating Care (2018): Health and Social Policy*

Partnering with

COORDINARE phn SOUTH EASTERN NSW — Ambulance Service of New South Wales — Clinton Medical Centre

Implementation

Quick Wins

IDENTIFICATION of Frequent Service Users	STATUS
Manual flag in Firstnet (ED system). Alert in electronic medical record (emr) for acute and Community Health staff.	Created
FSU flag in Ambulance Data Terminal	Established
Risk stratification tool for FSUs identified and trialled	Complete

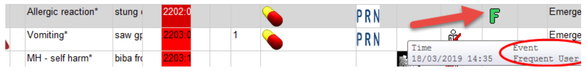

Figure 2: Frequent User Manual Set Event in FirstNet system used in ED

PRIORITY given Frequent Service Users	STATUS
Telephone contact with FSUs within 48 hours of discharge from ED or referral to program from Ambulance, GP or other source	Endorsed
All GHS community services recognise FSUs as a high priority and offer next available appointment.	Endorsed
GP at nominated practice will give patient identified as FSU priority appointment .	Pending

Solutions

CARE COORDINATION for Frequent Service Users	STATUS
Referral for Care Coordination utilising existing Community Centralised Intake- single point of contact	In Process
Intensive, short term care coordination provided by a designated clinician to assist transfer from ED to community. Care coordinators trained in and use HealthChange® methodology to empower patients.	In Process

SINGLE CARE PLAN for Frequent Service Users	STATUS
Care Coordinator develops an integrated self- management plan in partnership with the patient and carer, GP and other appropriate service providers. The patient keeps a copy which can be accessed by Paramedics. Patients will have a plan of action if they require non-urgent care and be empowered to use it.	In planning stage

MULTIAGENCY CASE DISCUSSION involving Frequent Service Users	STATUS
Ambulance, health service staff, GP, patients and carers agree to participate in collaborative meetings/ discussions to manage and coordinate care. GHS staff will go to where is most convenient for the patient and GP and utilise Telehealth facilities where possible.	In planning stage

Person Centred Care ← Collaboration Between agencies ← Primary Care based ← Targeted to need ← Continually improved ← Shared Information

Sustaining Change

- Key members of the Implementation Team have undertaken Change Agent Assessments and are training in Accelerating Implementation Methodology.
- The project Steering Committee continues to meet 3 monthly , maintaining sponsors from Ambulance, GHS (acute and community), the PHN, General Practice and 2 community representatives.
- Patient stories will be gathered from time of program enrolment in order to evaluate and share progress. The PHN will assist in gathering patient stories and sharing successes with the GP network as a promotional strategy for integration.
- Staff providing care coordination will model the process and assist other staff to provide this across the health service.
- Care coordinator will visit ED daily and Ambulance weekly to promote identification and enrolment.

Conclusion

The framework for Integrating Care is not supported by the current ways of working. Health services in Goulburn are not integrated and therefore unable to deliver this care to those with complex needs.
The number of FSUs in Goulburn provides a cohort small enough to pilot interagency, collaborative care coordination with a number of ED presentations significant enough to provide opportunity to effect changes on health costs and inefficiencies.

Diagnostics reveals that many FSUs are young and without a specific diagnosis, leaving them ineligible and overlooked for existing multidisciplinary programs. There is an opportunity to improve the experience and health outcomes for these individuals as they transition from acute care to the community. Successes can be promoted to influence a paradigm shift in the way we perceive and treat FSUs in the future.

Next steps

The Implementation and Project Team continue to meet fortnightly. This agenda includes a business component using the PDSA cycle to modify the implementation plan as required and also a patient based discussion of current FSUs who may benefit from the program. Identification is being achieved through retrospective FSU data analysis to allow recruitment and piloting of solutions. Once evaluation measures have been completed and successful outcomes achieved for at least 5 FSUs, the program will aim to recruit FSUs prospectively as they attend ED, call Ambulance or see their GP.