



Support for people who are frequent users of emergency departments

Context

- There are small groups of vulnerable people in our community who rely heavily on hospitals and emergency departments (ED) for treatment yet still have some of the poorest health outcomes. These people often have more than one complex health issue and some have social situations that contribute to their poor health.
- In Western Australia (WA), for people presenting to an ED, the average number of attendances a year is two. However, there are a small number of people who attend much more frequently, with some over a hundred times a year.
- Frequent presenters comprise approximately five per cent of all ED attendances, and attend ED an average of 8.8 times per year, equating to almost 20 per cent of all ED attendances.
- The most frequent hospital attenders include the following vulnerable groups:
 - Aboriginal people
 - people with mental health issues
 - people who attended for drugs and/or alcohol related issues
 - homeless people.
- The difficulty in creating programs for the frequent presenter cohorts is that individuals may have multiple chronic conditions, including mental health or drug and alcohol related issues and may also be homeless. Typically many services are unable to manage this complex mix of conditions despite the need. Given the issues faced by frequent presenters are often complex, a one approach care program may not suit everyone. Programs must be able to adapt to suit the needs of their clients.
- The WA health system is unlikely to be able to deliver community support programs alone. Key partnerships with primary care, not-for-profit organisations, community groups and other government agencies are important in providing support to frequent presenters.
- While frequent presenters are generally high risk patients, approximately 15-35 per cent of patients can be classified as 'rising risk'. These people have one or two well managed chronic diseases, their symptoms are not severe, and the person may have broader social risk factors.⁽¹⁾ In any given year approximately 18 per cent of people classified as 'rising risk' have the potential to move into the 'high risk' category. It is vital that this cohort is identified and supported to help keep people as healthy as possible.⁽¹⁾
- Evidence from around the world indicates that for the five per cent of frequent attendees to ED we should trade high-cost hospital services for lower cost community management, and for care that is suited to the individual's needs. For the next 15-35 per cent of the population who have a

rising risk profile, whose health problems could worsen, support should be provided to prevent future crises.

Exemplars considered

A range of exemplars were identified throughout the course of the SHR in public submissions, Clinical and Consumer and Carer Reference Groups, Working Groups and in public forums. The following exemplars are indicative, however are not an exhaustive list of the exemplars considered throughout the SHR.

Royal Perth Hospital Homeless support service⁽²⁾

- The Royal Perth Homeless support service is a collaborative service between Royal Perth Hospital and the Homeless Healthcare General Practice. This is a hospital in-reach team that aims to improve outcomes for homeless people by supporting their time in hospital. The service focuses on improving discharge planning and continuity of care by linking individuals with community-based services to address other health and social needs.
- This program has shown to be effective, with reductions in the number of ED attendances by the study's participants.
- Feedback from one of our most vulnerable populations, homeless people, has confirmed the impact specific programs can have. People with lived experience of homelessness welcomed the introduction of the Homeless in-reach team and said it has made a major difference to them because the team knows and understands them. This innovative program is beginning to address the complexity of issues faced by one WA's most vulnerable groups.

Monash Watch, Victoria⁽³⁾

- Monash Watch is a telephone-based care team in Melbourne, Victoria, that provides follow up support, health coaching and care coordination services for people with chronic or complex health conditions who have been discharged from Monash health service.
- The service is staffed by a physiotherapist, a nurse and an occupational therapist that function as health coaches, as well as trained non-clinical staff who function as 'tele-care' guides. The staff work with the patient, their general practitioner, local council and social services, community services and the hospital to provide necessary care. A small Monash Watch team is located in the local area and stays in regular contact with patients. Patients have contact up to five times a week depending on their level of need.
- The model uses a computer system called the Patient Journey Record that utilises rule-based algorithms to analyse the answers and information provided. Results are still pending, however it is reported that there is already an approximate 20 per cent reduction in length of stay for enrolled patients, and there is an expected reduction of 15 per cent in hospitalisations. Despite the relatively modest reduction in hospitalisations the cost-benefit ratio is very high for Monash Watch because the cost of the intervention is low.

HealthOne, NSW⁽⁴⁾

- The New South Wales government has funded and initiated a number of models, such as HealthOne Mt Druitt (HOMD) in an effort to integrate primary and community health services for

people with chronic and complex health conditions. These models bring together general practitioners with State community health services and other health professionals into multidisciplinary teams.

- HOMD operates in a socially disadvantaged area, using a model based on 'virtual care' planning. It aims to improve the coordination of care for people with complex health needs, providing the relevant referrals to reduce unnecessary hospitalisations. Under the HOMD model, two general practice liaison nurses organise multidisciplinary case conferences, coordinate care between care providers and communicate information their patient's general practitioner or case manager.
- An evaluation of HOMD found that 30 per cent of people enrolled in the program had no hospital admissions after enrolment. Among those who did present to hospital the number of emergency department presentations and length of stay in the 12 months following enrolment was significantly less than in the 12 months prior to enrolment. The evaluation reported the program significantly improved the quality of life of the people enrolled. Referrals increased to allied health services and over time the sources of referrals changed from hospitals to other health service providers, families, friends and neighbours.

Compassionate Communities, United Kingdom⁽⁵⁻⁷⁾

- Frome is a village in the United Kingdom that launched a 'compassionate community' program to address the relationship between loneliness and ill-health. The compassionate community project reduced hospital admission by 17 per cent and resulted in a 21 per cent reduction in costs in 2016-2017 compared to 2013-2014.
- This is a good example of the effect of a community on health. There are many opportunities in WA to foster compassionate communities, in rural towns or local government areas in Perth.



This background paper was developed by the Sustainable Health Review secretariat to inform the work of the Sustainable Health Review Panel. Every effort has been taken to ensure accuracy, currency and reliability of the content. The background paper is not intended to be a comprehensive overview of the subject nor does it represent the position of the Western Australian Government. Changes in circumstances after the time of publication may impact the quality of the information. Background papers are published in full at: www.health.wa.gov.au/sustainablehealthreview.

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