



Hospital Demand Management Strategy

An Update on the Hospital Admission Risk Program (HARP)

HARP in Context

The Victorian Government has committed \$582 million over four years through the Hospital Demand Management (HDM) strategy to strengthen the capacity of the health system to manage increasing emergency demand pressures. The importance of prevention within the HDM strategy has been highlighted with an allocation of \$150 million over the four years to June 2005.

HARP aims to improve people's health outcomes and reduce the rate of growth in demand for public hospital services by preventing the avoidable use of emergency departments and emergency inpatient services. It will do this by:

- Developing preventive models of care that involve both the hospital and the community.
- Focusing on people who have a manifest health need, often where their disease or condition is chronic or complex.
- Giving priority to high volume and/or frequent users of the acute public hospital system.

2001–02 HARP Projects

More than 40 prevention initiatives were funded in 2001–2002, including:

Emergency Demand (ED) Care Coordination

Through this initiative, care coordinators from both nursing and allied health backgrounds provide an extended hours service, seven days per week, to patients who have complex problems, are older or are at high risk of admission due to psychosocial factors.

Care coordination has been implemented at most metropolitan health services and early results demonstrate

prevented admissions, increases in the number of referrals to community-based services and decreased length of stay for patients in the ED. Most projects have also reported high levels of patient and staff satisfaction.

Critical success factors identified by these projects include:

- Multidisciplinary assessment
- Risk screening
- Links and partnerships with other providers
- Integration with existing services
- The skill base of care coordinators
- The availability of brokerage funds.

Organisational and practice changes included improved discharge planning processes, enhanced relationships with community-based service providers and a significant reduction in 'social' admissions.

Bayside Health's model of care coordination has decreased waiting times in ED for people with complex care needs and, where people have been admitted, ensured that coordination of the required services to support their discharge has been established earlier in their care. Data from the initial phase of the project shows a 20 per cent decrease in waiting times in ED for these patients from 6.8 hours to 5.4 hours.

Disease Management

Eleven Disease Management projects were established in 2001–2002 through HARP funding, focusing on Congestive Cardiac Failure (CCF), Chronic Obstructive Pulmonary Disease (COPD), and general disease management. Disease management projects emphasise an evidence-based approach, patient self-management, multidisciplinary care and collaboration between health services.



While the projects vary in design, some common principles include:

- Patient and family education to support self-management
- Practical support at home
- Coordination of care
- Collaboration with local GPs
- Provision of community-based rehabilitation to COPD patients.

One CCF project also includes home visits by pharmacists.

The Austin and Repatriation Medical Centre (ARMC) Disease Management Project for Patients with Chronic Respiratory Disease, at the time of reporting, had 99 patients. The initial impact of the program has been extremely encouraging with the average re-admission rate for these patients decreasing by over 80 per cent, and ED presentations decreasing by 65 per cent.

Acute Primary Care Liaison

HARP has established a variety of Acute Primary Care Liaison Projects in nine metropolitan hospitals. The majority of these projects have involved the recruitment of a GP Liaison Officer to improve linkages and communication with local GPs. One project has also incorporated liaison with other primary care providers, including the residential and community care sector and alcohol and drug services.

In partnership with the Inner Eastern Melbourne and Melbourne Divisions of General Practice, St Vincent's Hospital has established a Hospital in the Home (HITH) General Practitioner Liaison Service. To date, a total of 42 GPs have been appointed to the Associate Visiting Medical Staff and a further 100 have expressed interest in the program. Affiliated GPs are trained, clinically supported and remunerated for their participation. The model gives GPs admitting rights to HITH enabling them to develop an acute treatment plan and have an episode of care managed entirely outside of the hospital. Both GPs and patients have expressed satisfaction with the arrangement and it is expected that the number of patients in the program will grow over the next year.

Prevention Initiatives Targeting Seniors

Seniors are disproportionately represented in their use of hospitals and have therefore been targeted by a number of

HARP initiatives. These projects include care coordination, rapid outreach services, functional maintenance programs and falls prevention clinics.

An additional \$1 million for Falls and Mobility Clinics has been allocated from HARP. This funding has enabled the establishment or expansion of ten clinics provided by metropolitan health services. An additional \$500,000 was recurrently allocated to community-based falls projects.

Bayside Health's Rapid Assessment Service provides frail aged and chronically ill patients with a range of services that reduce their need for inpatient services. Referrals are received through a single point of contact. This program includes a Mobile Assessment and Treatment Service (MATS) that provides on-site assessment and management of primarily residential care clients by hospital nursing and medical staff. To March 2002, MATS had 121 referrals, preventing 18 ED presentations and 17 admissions in that time. Another component of the Rapid Assessment Service is the Assessment Team which provides a multidisciplinary comprehensive assessment and rapid response to discharge planning. Patients are followed up in the community to ensure their conditions are improving and brokerage funds are used to provide immediate supports for patients where required. To March 2002, the Assessment Team received 166 referrals, prevented 58 admissions and six ED presentations.

Other Prevention Projects

HARP has also funded Barwon Health's Home Volunteer Buddy Service and a telephone advice line at Western Health.

The Western Health After Hours Telephone Hospital Access Advice Unit operates daily between 3 and 11pm and is staffed by experienced ED nurses who provide telephone advice to clients regarding the most appropriate health service to use for their particular problem. The unit currently takes over 500 calls per month. Of the 1,285 calls received within a three-month period, 24 per cent were referred to a GP for ongoing care. A survey of 130 callers found that 96 per cent of callers would highly recommend the service to others. Improved links with community providers and protocol driven practice have been cited as positive aspects of the project.

2002–2003 Funding Round

The 2002–2003 funding round was conducted through an expression of interest process. Ninety-three expressions of interest were received from hospitals, Divisions of General Practice and other community-based service providers. Fifty proposals were shortlisted for development as detailed submissions.

The HARP Reference Group took a central role in the assessment of proposals and the Departmental Steering Committee endorsed its recommendation for funding of 42 of the detailed submissions. The total value of the 2002–2003 funds allocated to date is \$15.21 million.

Table 1: Newly Funded Projects 2002–2003 by Model of Care

Condition, Cohort or Model of Care Targeted	Number of Projects	2002–2003 Funds Allocated	% of Total Funding
Disease Management			
<i>General Disease Management (including CHF)</i>	10	\$3,856,232	26%
<i>Diabetes</i>	5	\$1,626,060	11%
<i>Respiratory (including COPD and Asthma)</i>	6	\$1,255,187	8%
Focused on Seniors	8	\$3,984,268	26%
Mental Health/Psychosocial Need	5	\$1,858,843	12%
Care Coordination/Case Management Models	5	\$2,113,565	14%
Other	3	\$518,478	3%
Total	42	\$15,212,633	100%

Outcomes for Primary Care

Throughout the funding round, the importance of service linkages between acute and primary care organisations was emphasised. A strong level of collaboration has generally been demonstrated between acute and primary care. A significant outcome of the funding round has been the level of engagement with primary care services:

- 79 per cent of the projects (33 out of 42) involve funds being channelled to primary care agencies.
- 24 per cent either have a primary care agency as lead (six projects) or all the positions are being located in a primary care agency (four projects).
- 26 per cent (eleven projects) have discrete incremental staff positions being added within primary care agencies.
- 29 per cent (twelve projects) involve payments to collaborating primary care agencies.

The 2002–03 funding round has consolidated and built on the foundations established through the Acute-Primary Care Liaison projects that were resourced in the previous funding round. A further two liaison projects have been

funded making a total commitment of \$1.8 million in 2002–03 dedicated to resourcing the capacity for primary care and acute to interface across the 10 separate sites this funding applies to.

Almost one-quarter of projects funded in the 2002–03 funding round involve project leadership and/or all the additional staffing positions being located in a primary care agency. Linkages with general practice have been enhanced with two projects being led by Divisions of General Practice; these will target diabetes and asthma. Additionally, an after-hours primary medical clinic will be established at the Northern Hospital to provide more appropriate care for people presenting to the Emergency Department with conditions that would be better treated by a general practitioner.

Strong collaboration with community health has also been demonstrated with additional capacity being funded through HARP projects within the range of services that are already provided by Community Health Centres. Community Health Centres will lead three of these projects.



Considerable flexible service and brokerage funding is provided for in the HARP projects that have been approved. Primary care agencies will be resourced through this funding to provide additional services to meet the needs of those people assessed as being at risk of hospitalisation.

Complex Psychosocial Issues

A key challenge for the hospital system is the unmet needs of people who frequently present to emergency departments (EDs) with a range of psychosocial issues. The presenting problem may or may not be related to a medical condition, and the underlying causes frequently relate to unmet social and health needs rather than an emergency medical problem. These patients may present with mental health conditions, self-harming behaviour, overdose, or alcohol and other drug problems. They are commonly complicated by social isolation and, in some cases, homelessness.

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In 2002–2003, HARP funded five projects, with a total allocation of \$1.85 million that address the needs of this group of people. These initiatives include:

- The Royal Melbourne Hospital (RMH) will use care coordinators in the ED to identify clients with psychosocial issues. The model is one of community ‘in-reach’ to the ED. It will emphasise increased liaison, collaboration and protocols between participating agencies to provide more integrated care.
- RMH also identified the opportunity to improve options for psychiatric patients in ED. A step-down unit, managed by Doutta Galla Community Health Centre, will provide accommodation and clinical supervision for mental health inpatients who require sub-acute care while waiting for residential rehabilitation or supported accommodation to become available.
- St Vincent’s Health will build on existing practice to develop a coordinated response between their ED and community services, including community health centres, RDNS Homeless Persons Program and Ozanam

House. The project will promote coordination of care for people with complex psychosocial needs in the community where they can be more effectively assisted.

- Plenty Valley Community Health, in partnership with the Northern Hospital ED, the Northern Division of General Practice and other partners, will establish a specialist coordinating unit to work alongside clinical mental health services and drug and alcohol services targeting people using the Northern Hospital’s ED who have attempted suicide or displayed self-harming behaviour.
- Peninsula Health will extend its psychiatric service to the Frankston and Rosebud EDs and expand psychiatric triage to the wider community through a 24-hour, seven-day service. The project will have a drug and alcohol component that will strengthen linkages with community-based alcohol and other drug services.

HARP Projects in Rural Areas

In 2002–2003, HARP will invest a total of \$3,602,829 in prevention projects delivered through regional hospitals and local community-based services. These funds comprise newly allocated 2002–2003 funds of \$1,380,408 and recurrent expenditure of \$2,222,421 from projects funded in 2001–2002.

Table 2: Distribution of HARP Funding

Regional Health Services	HARP Funding
<i>Barwon Health</i>	<i>\$1,174,771</i>
<i>Latrobe Regional Hospital</i>	<i>\$791,543</i>
<i>Ballarat Health Services</i>	<i>\$634,135</i>
<i>Bendigo Health Care Group</i>	<i>\$529,580</i>
<i>Goulburn Valley Health</i>	<i>\$472,800</i>

Consumer and Carer Participation in HARP

The view that health outcomes for people can be significantly enhanced when consumers and their carers are directly involved is well supported by a growing body of evidence. While applicable to all models of care, disease management models, with their scope for self-management, provide clear opportunities for consumer participation.



Through a joint HARP and Primary Care Partnership (PCP) strategy, the Chronic Illness Alliance has been engaged to work with disease management projects funded under HARP and PCP Integrated Disease Management. The Chronic Illness Alliance will conduct a series of workshops to enable project staff to share their experiences of working with consumers and develop strategies for more actively involving consumers and carers in their projects.

The Alliance will also develop a knowledge base of literature and case studies that will document examples of consumer and carer participation in disease management programs and consumer focused indicators for evaluation of disease management projects. Additionally, the Alliance will provide limited support to individual projects in relation to consumer and carer participation.

Sharing the Lessons about Prevention

It is important to share lessons about how best to manage patients with identified risk of hospitalisation. Each funded project has identified strategies to do this, such as publishing articles in relevant journals, giving presentations and poster displays at conferences and workshops, posting information on the Internet, disseminating reports and evaluations and developing networks involving similar models of care. To support the sharing of information, the Department will revise the way it manages the HDM website to ensure that project level information can be accessed.

Independent Evaluation of HARP

A HARP Evaluation Sub-Committee of the HARP Reference Group was formed in March 2002. This sub-committee is chaired by Associate Professor Jeremy Anderson, Director of the Centre for Clinical Effectiveness, Monash University. The Department of Human Services will appoint an independent evaluator for HARP and it is expected that the successful consultant will commence the evaluation shortly.

The evaluation methodology will incorporate three tiers:

- (i) Individual project level.
- (ii) Assessment of the effectiveness of similar initiatives across sites and services.
- (iii) A 'whole of system' level.

Different evaluation aims and objectives will be prioritised as HARP progresses. In the first instance the evaluation will focus on:

- Identifying lessons from the 2001–2002 prevention initiatives.
- Identifying, in collaboration with HARP stakeholders, key indicators and a consistent reporting format to be used by HARP projects.
- Collecting baseline data on acute health service utilisation and clinical measures for 2002–2003 funded projects.

The independent evaluator will prepare two reports a year for service providers on evaluation findings and provide recommendations for service development. The evaluator will also prepare two reports a year for the Department, providing recommendations for policy development and implementation.

Hospital Demand Management Conference

A four day conference will be held between 25 and 28 March 2003: The conference will include a focus on HARP. It will highlight the learnings, showcase good examples of preventive models of care, and consider practice change implications. International and national speakers will also feature.



HARP Working Parties

The HARP Reference Group has established six working parties to undertake detailed work in priority areas that provide opportunities to have a significant impact on the health status of people at risk of hospitalisation.

A Mental Health Working Party is in the process of being established.

Each of the working parties will produce a report to be released in March 2003 to inform the 2003–2004 HARP funding round.

Table 3: HARP Working Parties

Working Party	Chair	Department of Human Services Contact
CHF Disease Management	Dr Jan Davies National Institute for Clinical Studies	Robyn Wall Phone: 9616 8280 Email: robyn.wall@dhs.vic.gov.au
Community/Hospital Interface	Mr Pier de Carlo Western Region Health Service	Ian Coverdale Phone: 9616 8958 Email: ian.coverdale@dhs.vic.gov.au
COPD Disease Management	Assoc Prof Don Campbell Clinical Epidemiology & Health Service Evaluation Unit	Robyn Wall Phone: 9616 8280 Email: robyn.wall@dhs.vic.gov.au
GP/Hospital Interface	Dr John McEncroe General Practice Divisions Victoria	Ian Coverdale Phone: 9616 8958 Email: ian.coverdale@dhs.vic.gov.au
Integrated Care for Complex Needs	Dr Peter Hunter St Vincent's Health	Paul Williamson Phone: 9616 6941 Email: paul.williamson@dhs.vic.gov.au
Technology	Assoc Prof John Rasa Eastern Health	Susan Sdrinis Phone: 9616 9804 Email: susan.sdrinis@dhs.vic.gov.au
Mental Health	Professor Bruce Singh University of Melbourne	Phyl Halpin Phone: 9616 8767 Email: phyl.halpin@dhs.vic.gov.au

The project briefs for each of the working parties are on the HARP website:

www.health.vic.gov.au/hdms/harp.htm

For Further Information

Visit the HARP website: www.health.vic.gov.au/hdms/harp.htm or contact one of the HARP project officers:

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