



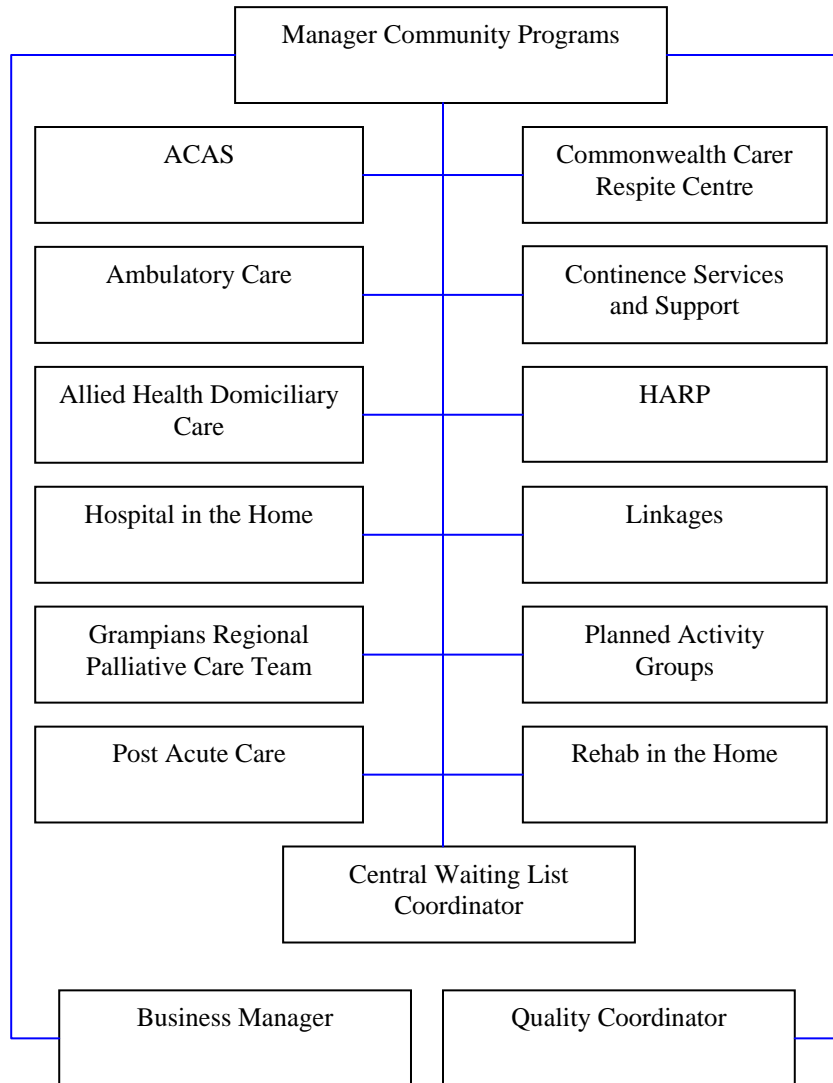
Managed Decline: Community Programs Central Waiting List Management Project

Programs as partners in working to improve care for older people
Keren Day



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Background



- 12 Programs form the Community Program sector of BHS



Background



- Individually funded and managed services
- Demand for services = extended waiting times
- Lack of consistency (intake processes)
- No universal client management system
- Episode of care commenced when admitted
- No structure or resources to meet needs of 'waiting' clients
- Unable to monitor or respond to functional decline
- A 'black hole' in our aim to provide the right care to the right person in the right place at the right time



Background



- Pre ACAS Web based waiting list
- Pre CareLink
- Pre ACNA
- Pre Inter-rai



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Aim



- To minimise functional decline for community program clients by identifying when decline was occurring and offering appropriate intervention as required
- To improve the service provision across the community program sector of BHS through greater partnership
- Congruent with the aims of the Centres for Promoting Health Independence
 - Person centred care
 - Minimising functional decline



Project Model



- Project Officer – a resource to:
 - Develop and manage the project
 - Facilitate increased partnership between the programs
- Secured Community Program's funds for a resource to operate/manage the Central Waiting List
 - Waiting list co-ordinator (0.6 EFT)



Project Model



Centralised Managed Waiting List

- 3/12 Community Programs participated
- Referrals received and processed by the participating programs
- Accepted referrals with waiting period > 1 month forwarded to project for management during that time
- Clients >65 years
- 6 months



Project Model



- Primary contact media was phone
 - Tools sourced or adapted for use over the phone
 - Measure and monitor functional decline in key domains
 - Cognition
 - Mobility
 - Nutrition
 - Continence
 - Emotional health
 - Carer Stress (where applicable)



Project Model



- Initial screening/assessment
- Develop short-term care plans
- Ongoing monitoring (2-4 weekly prn)
- Response to identified needs = intervention
 - Triage for earlier introduction of services
 - Referral for other services for unidentified needs
 - Reminder calls for appointments
- Advocacy role
 - Point of contact for clients
 - Use of the question “how are you?”



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Client numbers



N=202	May	Jun	Jul	Aug	Sep	Oct
New clients	21	68	14	45	16	38
Discharged from waiting list	3	38	30	44	35	39
Monthly total of managed clients	21	92	73	93	71	77
Interventions	4	15	14	14	18	16



Identified needs requiring intervention



- Referral for unidentified needs eg. incontinence
- Change in appointment venue to better meet needs (home visit)
- Carer Stress
- Respite needs
- ADL reassessment required
- Priority changes for referred program
- Provision of information about services
- Increase in existing HACCC services
- Brokerage (limited)



Case Study 1



- Elderly woman referred to Continence Clinic
- Waiting list screening identified – Parkinson’s disease, carer status for husband with multiple health problems with current services of HH x1/fortnight + MOW x2/wk
- By time got to initial Continence Service Appt
 - ↑ HACC Services
 - Ref to ACAS for respite assessment and successful application for respite
 - Intro of Carer’s support services including involvement in carers’ forum & Carers Choice support worker
 - Phone contact for support and advice

Case Study 2



- Elderly man, wheelchair bound, referred to continence serv
- Waiting list screening identified – carer was daughter, single mum, post MVA with mobility issues herself, difficulties with transferring father & managing the incontinence, no carers allowance, burnt out
- By commencement of Continence Service:
 - Ref to ACAS respite care options – on list as high priority
 - Ref for OT assessment - transfers out of bed
 - Ref to Carers' Choice – care support worker in place
 - Extra day at Planned Activity Group
 - Ref to Social Worker @ Centrelink for financial counselling

Qualitative Outcomes



- Written surveys of clients & service providers
- **Client:** Improved support
 - Earlier detection of functional decline
- **Client:** Improved service readiness
 - Service better informed - Info at 'handover' was current
 - Client better informed
- **Process:** Improved collaboration
- **Process:** Changing work practices



Client feedback



- “When I saw J ... she mentioned how grateful she was for your phone assistance. She said you made her feel important and not forgotten or not just a number in a big system”
- “Made aware of what help is available to my situation”
- “Eases your mind and makes you feel happier”
- “The service is good, I think older people need prompting more”



Barriers/limitations



- Difficult to break down silos
- Finding agreement and common ground with vastly different services
- Not always able to influence services to reprioritise clients with changed status (often a resource issue)
- Limited funds and scope to meet needs during ‘waiting’
- Working mostly over the phone
- Constantly changing sector



Ongoing benefits



- Able to continue to track functional decline using the standardised tools
- Training provided for community program staff
 - Use of the tools
 - Flags for action identified
 - Guidelines for response



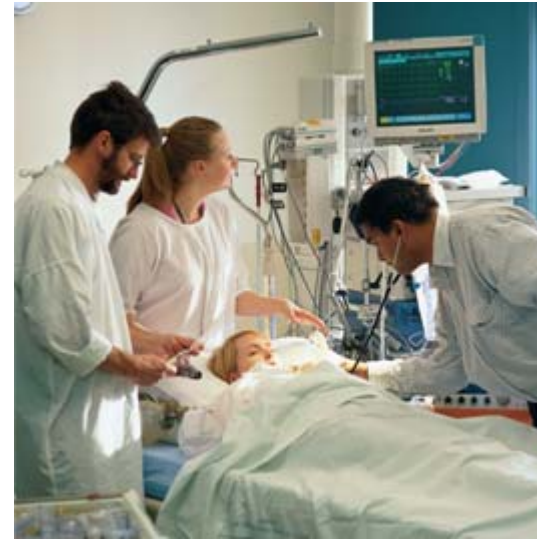
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Current status



- Agreement that position should be ongoing – project becomes program
- Expand to pick up other Community Programs
 - Broken some of the ‘ice’ for ongoing partnership
- Looking at how the model fits with Transitional Care
- Looking at how this could fit within Single Point of Entry in development





Thank you.



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