

# OUTREACH CASE MANAGEMENT PROJECT

The Alfred Hospital  
Infectious Diseases Social Work

Leanne Dalla-Vecchia, Angelo  
Morelli, Sharon Horvat-Danilovic,  
Deborah Cox, Suellen Peak

# Project Background

- Established May 2003 in response to emergence of People Living with HIV/AIDS (PLWHA) with increasingly 'complex needs' and lack of co-ordinated service response

**Complex needs** defined as patient group with HIV and:

- ✓ *multiple co-morbidities*; psych, D & A, HIV related cognitive impairment; HEP C
- ✓ *multiple psycho-social issues*; legal, accommodation, poverty, social isolation, adherence with medications, sexual at risk behaviours
- ✓ at risk of multiple admissions to hospital relating to 'acopia' (not coping)

# Background

- A team restructure enabled the establishment of an Outreach Case Manager position to undertake and evaluate a 12 month pilot project.
- The model proposed was for Intensive Case Management for PLWHA with complex needs facing barriers to accessing existing mainstream case management services.

# Project Aims

- Implement an Outreach Case Management model of care for PLWHA with complex needs
- Improve the overall continuity of care and quality of life for PLWHA with complex needs
- Reduce inpatient admissions and length of stay related to psychosocial stressors and a diagnosis of acopia
- Provide 'transitional' case management until community case management established
- Improve communication between key stakeholders
- Evaluate the program and make recommendations

# Method

**Resources** - Full time Grade 2 Social Worker employed to implement, develop and evaluate project.

**Model** - Intensive case management model using assessment, planning, linking, monitoring, co-ordinating and advocacy.

**Eligibility Criteria** - Clients must be HIV+; Alfred patients; have complex needs; at risk of 'acopia' related admissions.

# Method (cont)

## Evaluation

Combination of qualitative and quantitative methodologies:

- Assessment tool applied upon referral
- A comprehensive psychosocial assessment was conducted upon admission to the project
- Data collected compared 11 months prior/during
- Client and Service provider satisfaction surveys

# Client Profile

12 people participated in project

- 7 males: mean age = 32.5 years
- 5 females: mean age: = 31 years

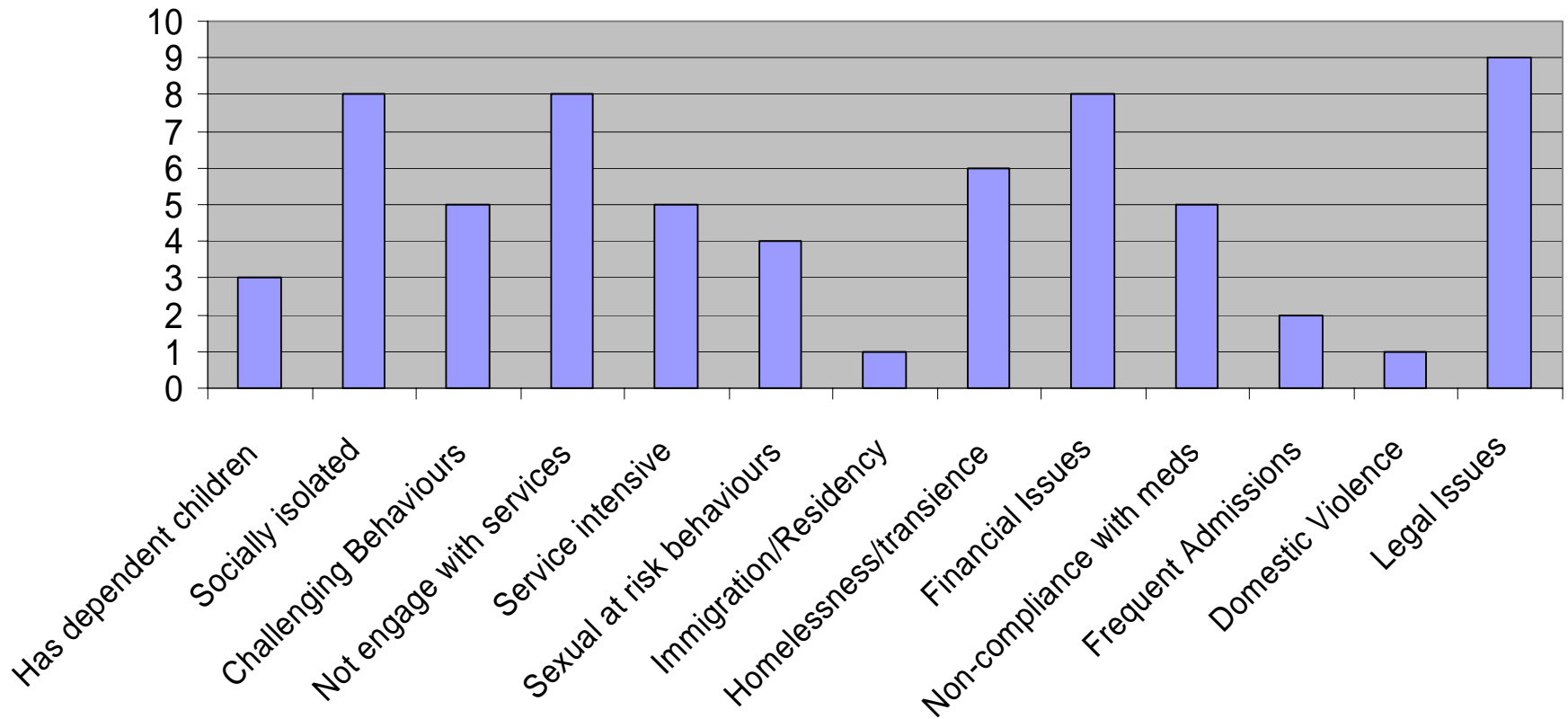
Average time in project = 7.1 months

- Longest = 11 months
- Least = 2.8 months

Covered range of suburbs in metropolitan  
Melbourne

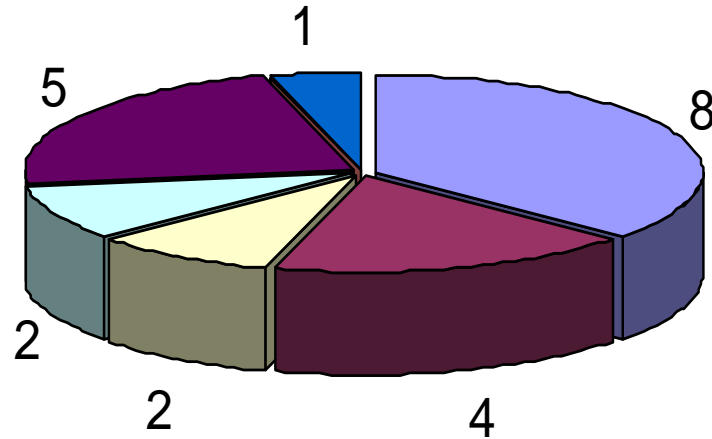
# Client Profile

## High Risk/Need Indicators



# Client Profile

## Co-morbidities



■ Drug & alcohol

■ HIV Related cognitive impairment

■ Diagnosed psychiatric condition

■ Intellectual Impairment

■ HEP B/C

■ Physical impairment

■ Other cognitive impairment

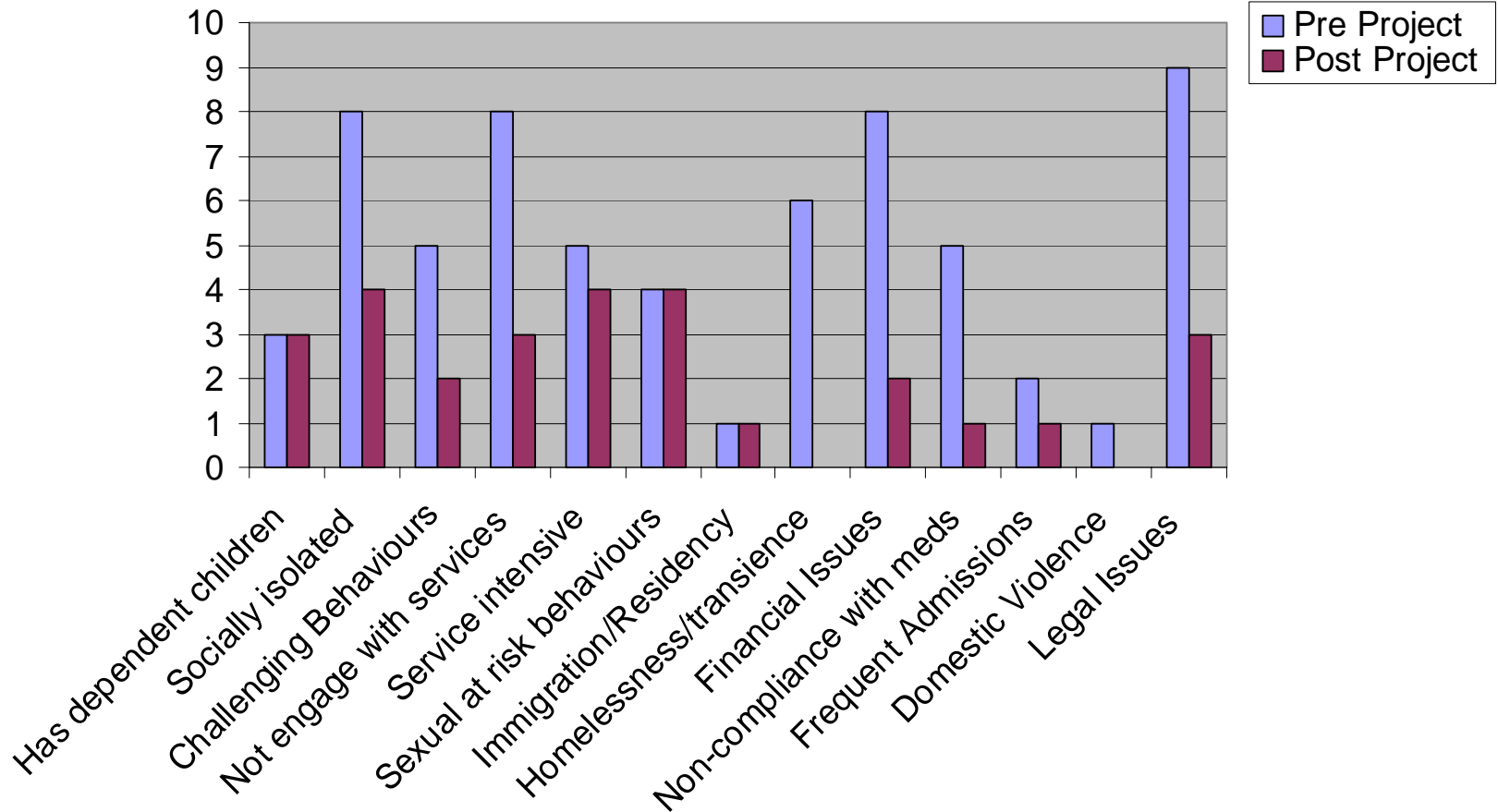
# Evaluation

Period June 2003 - May 2004

- High Risk/Need indicators
- Hospital admissions
- Length of stay in hospital
- Client satisfaction survey
- Service provider survey

# Outcomes/Evaluation

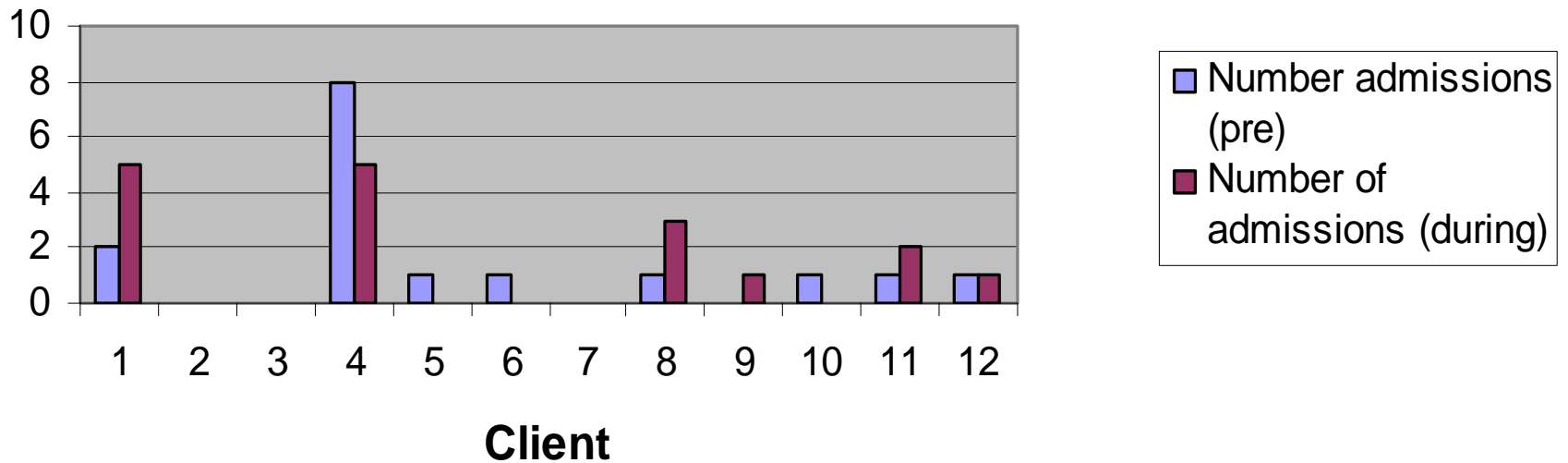
## High Risk /Need Indicators



# Outcomes/Evaluation

## Number of Admissions for Pre/During

Number of Admissions

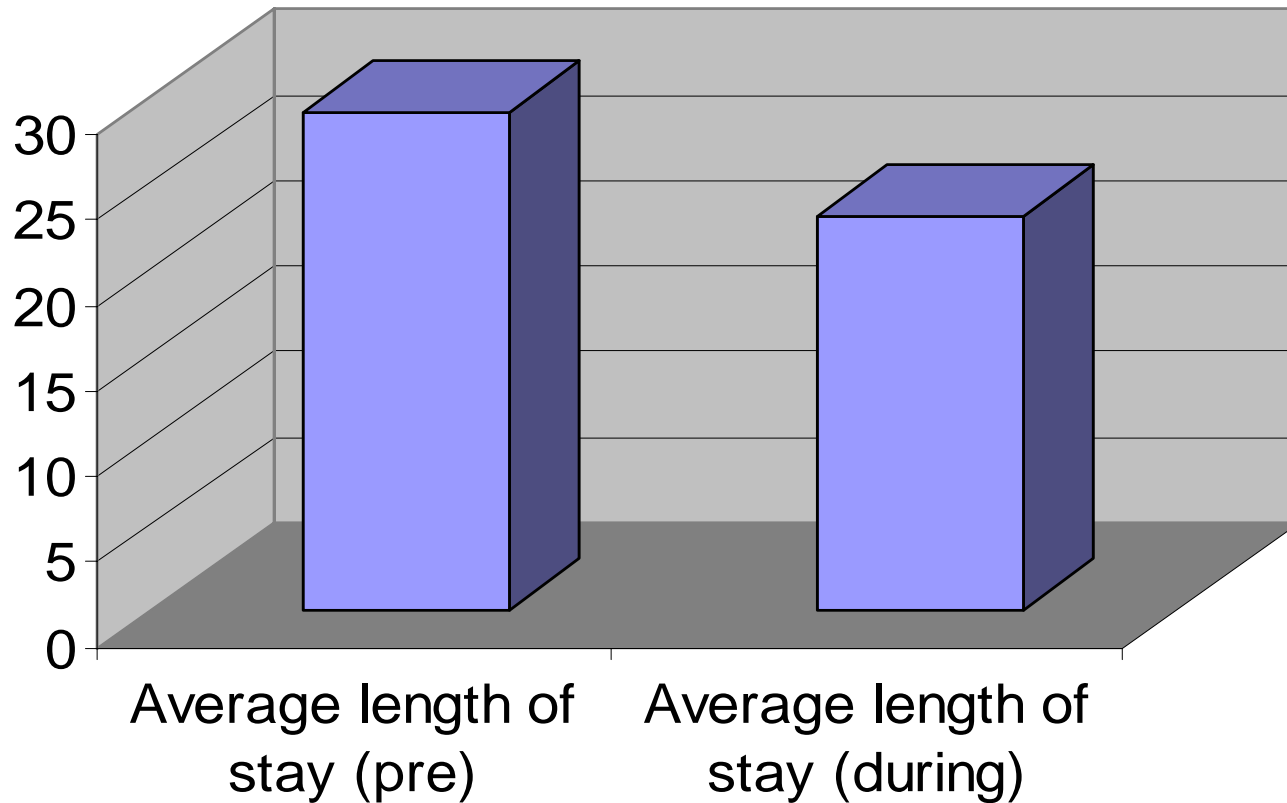


# Average Length of Stay

Client	Average length of stay (pre)	Average length of stay (during)
1	8.38	9.83
2	0	0
3	0	0
4	8.38	27.2
5	2	0
6	14	8
7	0	0
8	5	3.33
9	0	5
10	17	8
11	294	142
12	6	74
<b>Average</b>	<b>29.16</b>	<b>23.11</b>

# Outcomes/Evaluation

## Average Length of Stay



# Outcomes/Evaluation

## Confidential Client Survey

- 12 responses, n = 12
- ✓ Believed project assisted in meeting their needs and improving overall quality of life
- ✓ Assisted in better access to health care

*“Got my life going again, put me in touch with people and services. Overcome medication problems and feel better in myself”*

*“Everything is easier and better”*

# Outcomes/Evaluation

- Service Provider evaluation survey
- 6 responses, n= 38

*”Improved quality of life for client through follow up and continuity of social worker”*

*“For shared clients, there has been more communication and understanding about their overall health issues”*

*“Close contact with clients who could easily be lost to follow up”*

# Summary

- Model of care implemented assisted in the co-ordination of care of a small group of clients with HIV and complex medical and social issues
- Number of hospital admissions varied
- Length of stay reduced
- Improvement in communication with service providers
- Reduction in high risk/need indicators
- Care plans implemented ensured co-ordination of care
- Clients self reported improved quality of life and reduction in social isolation

# Barriers

- Fluctuations in health preventing individuals from being accepted by mainstream services
- Inability of mainstream case management services to adequately support clients without co - case management
- Lack of appropriate mainstream case management services
- Refusal of clients to accept referral to/or engage with other services

# Recommendations

- Implement as part of ongoing service
- Subject to monitoring, eligibility criteria for clients of the service are broadened to include non-Alfred clients
- Resources and educational sessions be developed to promote awareness of the service
- The Alfred Statewide HIV/AIDS Service take a lead role in promoting, educating and supporting appropriate HIV and non-HIV community based agencies in provision of case management services
- Continue to monitor and evaluate