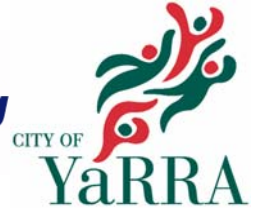




ST VINCENT'S
HEALTH



Royal
District Nursing
Service



SYSTEM LINKAGE AND INTEGRATION THE ONLY WAY FORWARD.....

Jane Evans, TRAAC Program Manager - St Vincent's Health

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What is TRAAC?

- **Treatment, Response & Assessment for Aged Care**
- a short-term case management program in Melbourne inner-city, based on an integrated health care model, connecting acute and community care sectors



Overview

- This presentation discusses the model and presents the findings on the efficacy of the program in reducing hospital emergency department presentations and hospital admissions
- Evidence so far is positive, that short-term case management within an integrated model can significantly reduce hospital stays for older people



The TRAAC Program

- HARP funded with aim to reduce Emergency Department presentations and admissions
- Community-based alternative to an unnecessary hospital presentation
- A response within 1 working day
- Comprehensive aged care assessment
- Increased home services for a time limited period
- Short-term case management



Who is our client?

TRAAC clients can be:

- the client that nobody wants
- 80 years plus and living alone
- living with a carer who is experiencing escalating difficulty in continuing in the role
- isolated, reclusive and sometimes living in squalid conditions
- experiencing rapid deterioration in a pre-existing or new health condition



The Integrated Health Care Model

- Definition: *“a discreet set of techniques and organisational models designed to create **connectivity, alignment and collaboration** within and between the cure and care sectors at the funding, administrative and provider levels.”*
(Kodner & Kyriacou, 2000)
- Linkage, service co-ordination and full integration
- Components of the model:
 - organisational
 - process
 - focus on quality of care
- Evaluation: of the model, and/or of client outcomes



TRAAC as an Integrated Care Model

- **New** alliances between the hospital and community care
- Satellite positions across acute and community
- The virtual team (accountability, meetings etc)
- Improved knowledge of acute, subacute and community services
- Consistent practice within the team using common tools
- Case managers changing their client management practices – developing a specialised aged care focus
- An appreciation and understanding of different work place cultures

TRAAC MODEL

Treatment Response & Assessment for Aged Care

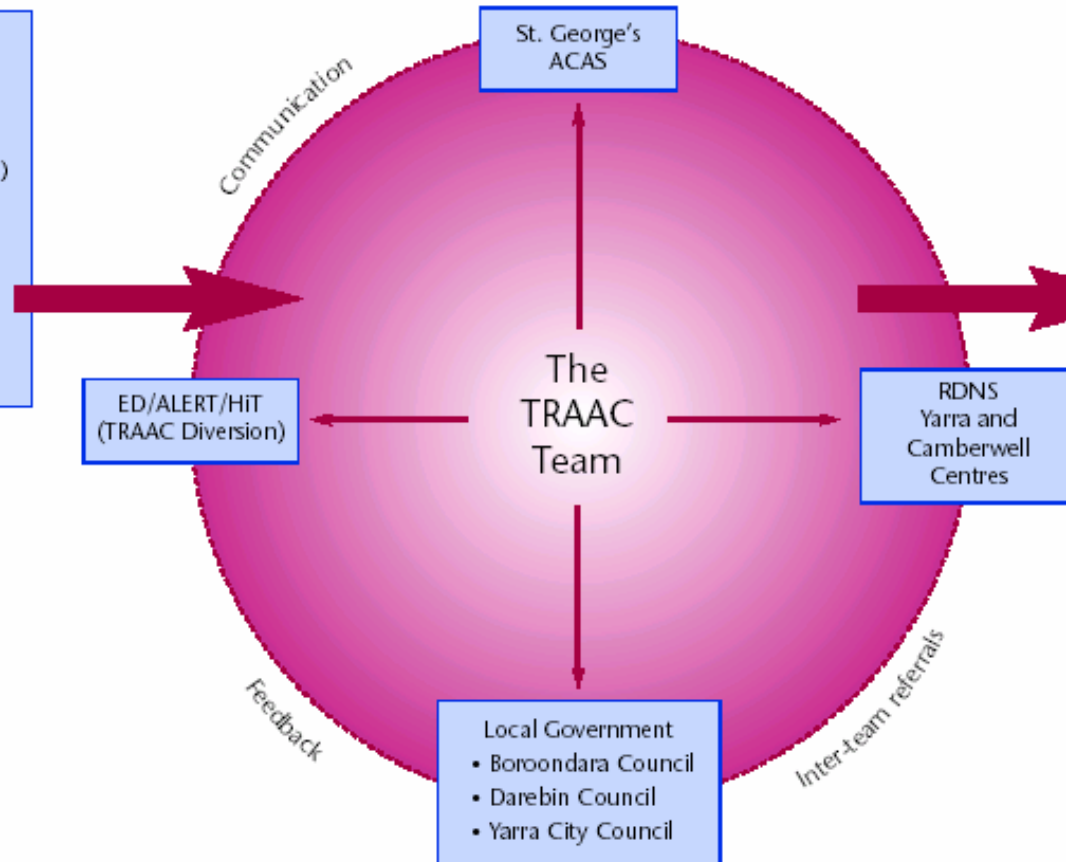
Initiative of Hospital Admission Risk Program (HARP)

REFERRAL SOURCE

- Client/carer
- St. Vincent's Hospital Melbourne Emergency Department (ED)
- General Practitioner (GP)
- Community Nursing
- Special Residential Service (SRS)
- Community Services
- Residential Care Facilities

TRAAC Diabetes Nurse

TRAAC ENTRY POINTS



RESPONSE

- Standard Agency Response
- TRAAC RISK SCREEN
 - Risk of presentation to hospital
- TRAAC RESPONSE
 - Holistic Assessment
 - Flexible Care Planning
 - Short Term Case Management
 - Geriatrician/Medical Clinics
 - Brokerage Funds
 - Allied Health
 - GP HITH
 - Acute/subacute/Psych Services
 - Information Provision
 - Community Services

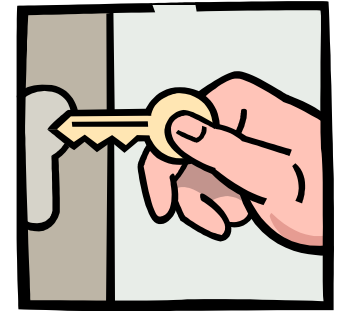


Integration – challenges

- Lead organisation accountable for budget and reporting
 - Structures and processes for governing the partnerships; resource sharing principles and procedures
- Inter-sectoral relationships between acute and community
 - Resource sharing principles and procedures
 - Consultation and communication strategies
 - Dual accountability & review procedures
 - Outcome evaluation

What's different about TRAAC Case Management?

- Key hole case management
- Intensive, short term support
- Home based alternative to a hospital emergency department presentation
- Rapid access to a multidisciplinary team of medical and allied health services
- Preventative model



What's different?





Without TRAAC.....

- Split between care and cure (connectivity, system and relationship)
- Behind closed doors (keyhole...)
- Unplanned hospital presentations and admissions
- Loss of client rights and choice - system takes over
- No continuity of transition into longer term care



Outcome evaluation – indicators from the literature

1. Decrease in hospital use
 - No of (re) admissions over time
 - Combined rates of death and re admission
 - Emergency Department presentations over time
 - Length of hospital stay
2. Use of non-hospital resources
 - Use of outpatient and community resources eg. GPs
3. Client outcomes/perceptions
 - Quality of life measures
 - Client satisfaction measures / carer
 - Client overall health status over time



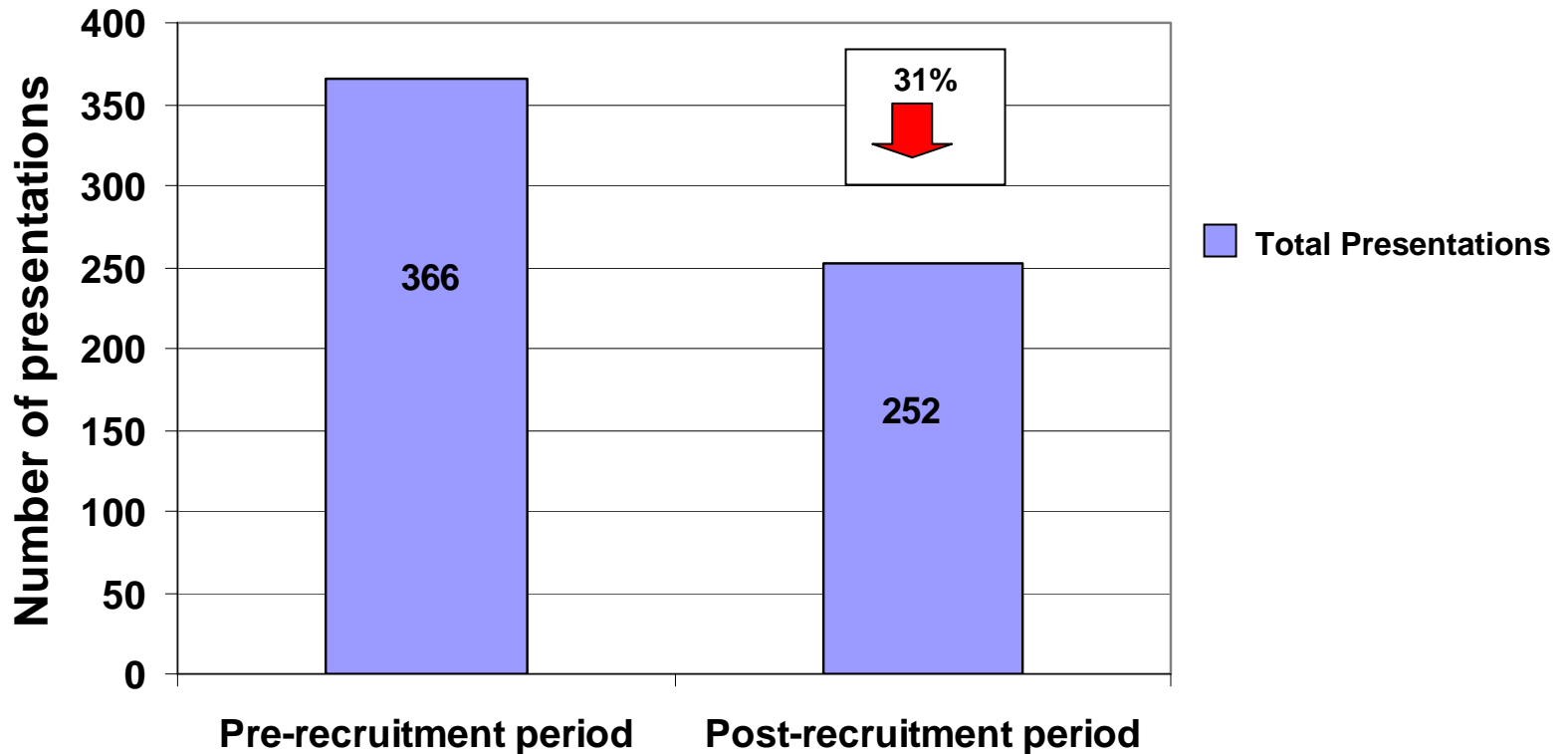
Is TRAAC making a difference, the evidence so far...

Quantitative

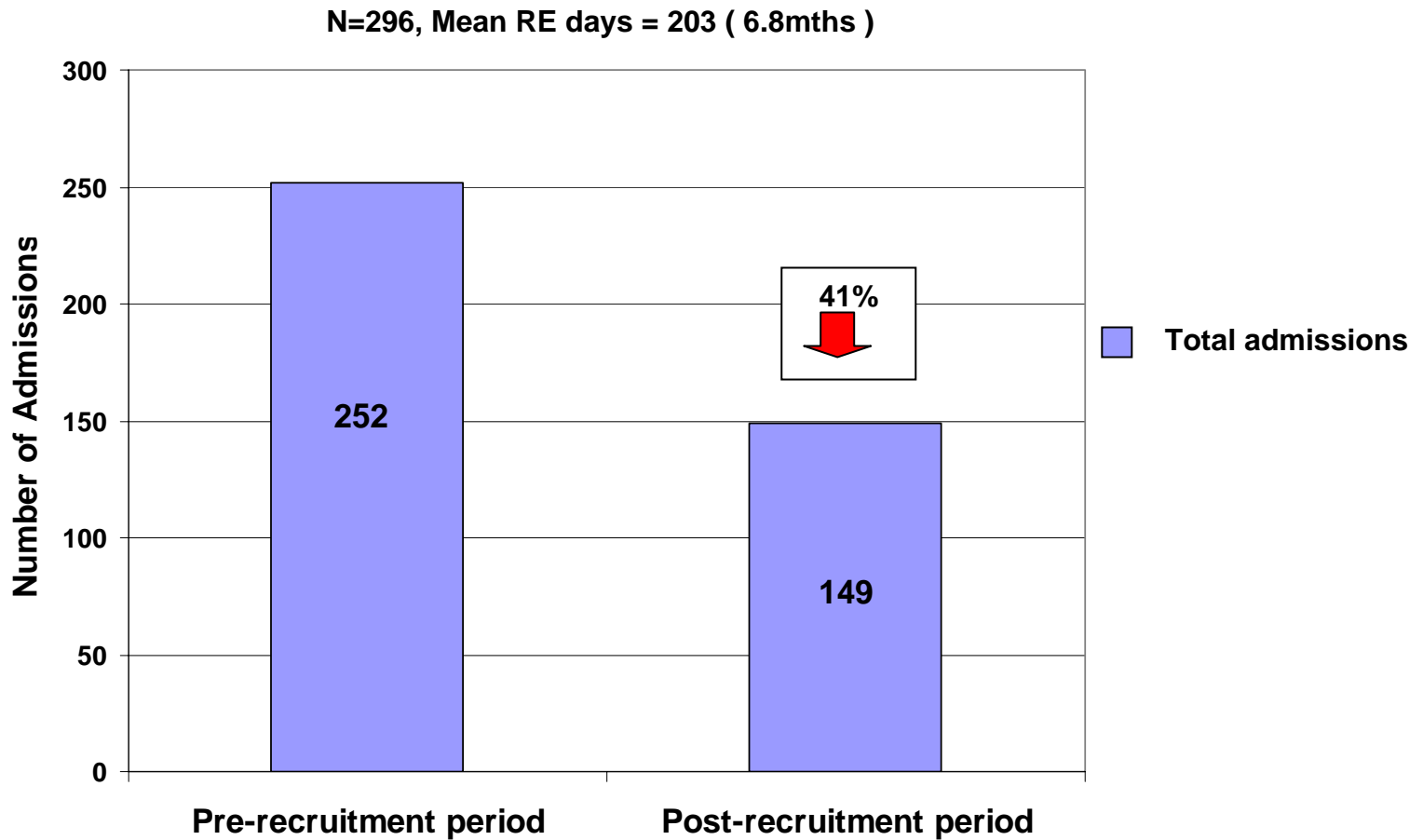
- 977 clients seen by TRAAC 2002-04
- Comparison of an average of 6.8 months pre TRAAC recruitment with post TRAAC recruitment
- 31% reduction in total Emergency Dept presentations (n=296)
- 41% reduction in hospital admissions (n=296)
- 150% increase in length of hospital stay (n=296)

Total Number of ED Presentations

N=296, Mean RE days = 203 (6.8 mths)



Total Emergency Admissions





Is TRAAC making a difference cont..?

Qualitative

■ The client:

- Client / carer satisfaction survey n=34 (37% return rate)
- 94% (32/34) responded that the support received was what was needed
- 79% (23/29) responded that they were more confident in their living environment
- 97% (28/29) responded that they would contact TRAAC in the future when needed



Is TRAAC making a difference cont..?

■ Our staff:

- Staff and managers involved with the program completed a survey on their experience of integration (n=11). Survey scale range: ‘great improvement (5)’ to ‘great deterioration (1)’
- Collaboration between acute and community services rated an average of 4.1
- Speed of response to client needs rated an average of 4.5
- Overall capacity to organise appropriate care for clients rated an average of 4.5



Evidence from the Literature

- Non-integrated model – follow-up nurse model: no-effect on re-admission rates and ED presentations (Brand et al, 2004,[AUS] Dalby et al, 2000 [CAN])
- Integrated model – adult day health care model with multidisciplinary team care management: large decrease in hospital admissions and length of stay, fewer nursing home admissions and better health outcomes (Kodner & Kyriacou, 2000 [USA])



Thinking beyond

- Short term case management
 - How long?
 - Step back / gap
- The revolving door
 - Aged care system
 - TRAAC
- Funding
 - How to plan and remain sustainable?
- Developing an evidence base
- Integrated models for the future
 - Can it work elsewhere?