



Hospital Demand Management Strategy

Hospital Admission Risk Program (HARP): Reducing the Demand Pressures in Acute Public Hospitals

What is the context of HARP?

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 demand pressures.

Following extensive consultation with hospitals through the Patient Management Taskforce a new approach to the management of demand for hospital services is being implemented.

This new approach focuses on the service system as a whole rather than on fragmented interventions or single organisations. It promotes appropriate pathways of care for people using health services and encourages models of care that respond to current demands for health services. Collaboration between health providers is emphasised under this new approach.

What is HARP?

The importance of prevention within the Hospital Demand Management Strategy has been highlighted with an allocation of \$150 million over four years. The Hospital Admission Risk Program aims to avoid unnecessary use of emergency departments and inpatient services in the hospitals targeted by the HDM Strategy. This will be achieved by ensuring models of care are developed so that people have their health and medical conditions better managed both within the hospital and while at home.

How will HARP reduce demand pressures on hospitals?

HARP funded initiatives will reduce the increase in demand pressures on hospitals by:

- ▶ Targeting conditions where the evidence shows patients with such conditions are associated with frequent use of emergency, outpatient or inpatient services.
- ▶ Promoting models of care that focus on groups of patients who frequently access hospitals, and which are based on best practice.
- ▶ Enhancing access to and systematic use of primary health services, particularly GPs, where their involvement in a patient's care will avoid unnecessary emergency presentations and/or reduce hospital admissions and readmissions.

How will HARP be targeted?

Prevention strategies may be aimed at a number of different levels such as providing health information, screening, immunisation, undertaking health education and so on. These are generally referred to as primary prevention (broadly directed to the general population) and secondary prevention (more focussed on at risk groups).

HARP will focus on tertiary prevention—that is, avoiding unnecessary emergency presentations and hospital admissions and readmissions. As such it will target people who have manifest disease and often where their illness has become chronic.



Whilst HARP initiatives will clearly focus on tertiary prevention this does not mean the initiatives will only be undertaken in an acute environment. Indeed, collaboration with specialist services in the community and primary care providers will be critical to ensuring the effectiveness of new approaches to delivering care. Within these collaborative arrangements it is anticipated that hospitals will have a central role.

HARP will be informed by the growing range of activities in prevention, early intervention and disease management. These include Integrated Disease Management pilot projects under the Primary Care Partnership Strategy and recent changes in the Medical Benefits Schedule which provide for the proactive management of asthma, diabetes, longer consultations and for care planning, case conferencing and health assessments.

How will HARP be managed?

HARP is a collaborative strategy between hospitals, GPs, community providers, key clinical groups, consumers, research bodies and the Department of Human Services.

Reflecting this, a **HARP Reference Group** is being established that brings together a range of stakeholders with an interest and relevant expertise in the area including clinicians, primary health, health services, consumers and carers, professional bodies and the Department to provide strategic direction and monitor implementation of HARP. The Reference Group will consider and provide advice on:

- Target population groups or conditions with most potential for preventing hospitalisations.
- Models of care that have demonstrated efficacy.
- Trends in morbidity and care options.
- Evaluation of initiatives funded.
- Best practice for management of patients.

Additionally the Secretary of the Department, Ms Patricia Faulkner, has established a **HARP Departmental Steering Committee** that is chaired by the Executive Director of Policy and Strategic Projects, Mr Shane Solomon. The Committee will oversee the implementation and ongoing evaluation of HARP and ensure that a whole of Department approach is achieved.

The Reference Group will report and provide advice to the Steering Committee. The Chairperson of the Reference Group will be a member of the Steering Committee.

A diagram outlining the relationships between the various HARP stakeholders is included in this bulletin.

What are the next steps?

- Provide a background paper that will present an analysis of the VAED and VEMD data to assist in understanding which groups of patients are contributing most to the demand pressures and the characteristics of these people. The background paper will also present a description and summary of the various literature reviews and studies that have been undertaken on (1) those high volume conditions which are amenable to prevention strategies and (2) which models of care are effective in reducing emergency presentations &/or hospital admissions.
- Prominently feature within the Hospital Demand Management Conference in March presentations and workshops focussing on prevention initiatives.
- Develop guidelines for the 2002–2003 HARP funding round. The Government has committed \$33 million to fund HARP initiatives in 2002–2003.

The indicative timing for establishing HARP is:

Activity	Indicative timeline
Establish the HARP Reference Group and Departmental Steering Committee	December 2001
Feature HARP within the HDM Conference	March 2002
Announce the 2002/03 funding round and provide funding guidelines	March/April 2002
Provide an evidence based review of prevention strategies	April 2002



Prevention initiatives funded in 2001/02

All Metropolitan Health Services and Barwon Health have been funded for prevention activities in the current financial year. Some examples of these projects include:

► **The Alfred Disease Management Program for General Medical Patients**

An integrated disease management model of care for general medical patients was established with one-off funding in February 2000 that focused on proactive management and ongoing review for patients with complex needs. The model incorporates regular follow-up by the General Medical Unit Physicians and a structured communication process between the Disease Management Care Coordinator, GPs, and other community providers caring for these patients. This initiative has proven to be effective in preventing admission (59 out of 170 patients who are enrolled in the program are being actively case managed in the community) and decreasing the readmission rate (from an average 3.5 admissions per person to 2.3 per person) for selected patients suffering from a chronic illness. Funding for this project was continued under the 2001/02 prevention funding.

► **General Practitioner Liaison Service at Western and Sunshine Hospitals**

Western Health Service is introducing General Practitioner Liaison Services at Western Hospital, Footscray and at Sunshine Hospital. The service will provide general practitioners within the hospital's catchment with training and consultation from emergency physicians and/or geriatricians. The improved liaison with general practitioners will enable them to provide their patients with improved access to allied health and personal care. The service aims to avoid acute hospital admission or presentation to emergency departments of patients with chronic medical needs and facilitate discharge from inpatient episodes.

► **St Vincent's Hospital Assessment, Liaison and Early Referral Team (ALERT)**

ALERT uses clinicians to assess, co-ordinate and purchase services for clients with complex and ongoing needs. The service prevents the need for admission for

some patients and reduces delays in discharge for patients requiring community services. The service provides after hours coverage and links in with GP services, Hospital in the Home, Post Acute Care or Home & Community Care as soon as these services become available and covers situations where the patient is ineligible for these services.

► **Geelong Hospitals' Home Buddy Volunteer Service**

This service provides a co-ordinated volunteer workforce that accompanies frail aged patients home after a hospital visit and provides support whilst they settle back into their homes and regain their confidence. The service provides support until the patients' independence is restored. Barwon Health intends to make the service available to the Geelong Hospital emergency department, GPs and other primary care providers to assist in reducing acute hospital admissions.

► **Monash Medical Centre's Rapid Transfer of ED Patients to Sub Acute Care**

This project focuses on facilitating the transfer of appropriate patients from the Emergency Department to the aged care services at Kingston Centre. The service will operate 24 hours a day to ensure that patients receive the most appropriate care in a timely manner and will prevent their unnecessary admission to acute services. The project has three key dimensions: (1) the upskilling of nurses in sub acute to manage more complex care needs, (2) extension of allied health services to 7 days per week and (3) extension of medical cover to 24 hours/7 days per week in sub acute care.

► **Eastern Health's Pre Hospital Prevention program**

This project targets individuals with multiple chronic conditions who frequently attend the Emergency Department for treatment and admission. This group can present with concurrent conditions and/or complex social issues that require extensive time to plan and implement effective management plans within the community.



► Disease Management for Congestive Cardiac Failure and Chronic Obstructive Pulmonary Disease

Melbourne Health is initiating Disease Management projects for patients with congestive cardiac failure and chronic obstructive pulmonary disease to improve the overall management of patients with these conditions across the continuum of care from the acute hospital to the community. Research has demonstrated that this approach to caring for patients with chronic conditions can reduce readmission rates and the length of hospital stay on subsequent admissions.

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