People with complex health and social issues who frequently attend emergency departments: Tackling the systemic challenges

The Health Alliance has been asked by Metro North HHS and Brisbane North PHN to look at the population of people with complex health and social needs who frequently attend emergency departments. As a group, this population cohort experience complex physical and mental health issues, along with social needs such as housing and social connection. They interact with many different parts of the health system, however there has historically been a lack of service coordination, and services are not often delivered in a timely, efficient and effective way. Recent innovative approaches in RBWH Emergency and Trauma Centre (ETC) working with the NGO sector are showing how better coordination, case management and intensive community follow up can improve the health system response and better meet the needs of these patients.

Health service provision

- Services are under strain in attempting to provide care to this population group
- There is a volume of work delivered that is largely unpaid
- Mainstream processes can create further barriers to accessing care

Providing comprehensive and holistic care to people with complex needs takes a considerable amount of extra time, and this is often not possible in emergency department or general practice settings.

Within these constraints there are service providers who undertake additional work to provide effective care, however because this work is not supported by the structure of the system, much of it is both unpaid and unrecognised.

Usual care pathways that involve scheduled appointments and multiple steps to receive care (eg. referrals to other services, scripts for medication) can create further barriers for this group. There are some examples of attempts to reduce these barriers by advocating for urgent appointments, providing transport to appointments and assisting a person to get medication immediately, however these appear to be the exception rather than the norm.

Integration and communication

- Social services and healthcare services tend to be funded and delivered in silos
- Effective and timely information sharing between agencies can be difficult to achieve

Health and social services tend to be funded and delivered in siloed ways and it can be difficult to achieve a coordinated response for people who require support from many different parts of these sectors.

Between and within agencies, there are technical, legal and cultural barriers to sharing sensitive and confidential patient information. This can affect the timeliness, quality, effectiveness and efficiency of care. Some service providers undertake additional efforts to ensure information is shared, including hand delivery, and there are some promising advances to improve information sharing including the GP viewer and some programs with shared care plans. However, these too appear to be the exception rather than the norm.

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Effective programs are not delivered to scale

- Effective programs tend to be small in scale
- Funding is often unsustainable or under threat

There are now good examples of coordinated responses between hospital, primary care and social services in North Brisbane. The Working Together to Connect Care program has successfully worked to identify people with complex needs, improve communication between agencies, and coordinate care between the hospital and the community. Other examples include the Homeless Health Outreach Team and integrated service delivering within Aboriginal Medical Centres. Relatively, however these programs are small in size and not delivered to scale across the region. As a result, there are times when only the most complex people can be targeted.

A further consideration is the timing of effective interventions. All providers working with this group have noted the very high deathrate, suggesting that an effective coordinated care response can come very late in a person's health journey.

The way forward?

- Can the Working Together to Connect Care experience be applied earlier and in community settings?
- Is there potential for a shared care plan across the patient journey?
- Can the referral pathways be shaped to better support this population group?
- What are the requirements for an outcomes framework?

The Working Together to Connect Care program operating out of RBWH ETC has demonstrated improved outcomes for the identified patient group. The definition used for a "frequent presenter" within this program captures the highest users, but there are probably many others who would benefit from more coordinated healthcare responses who have not reached this high rate of presentation. The core elements of this program, including case management, coordination across health and social sectors, case conferencing and the development of a shared plan, could be adopted more widely in the sector, presumably with similar results expected.

The case for earlier intervention for this group is compelling given the poor health outcomes experienced. What would it take to apply a more coordinated care model earlier in a person's health journey? What would a shared care plan across the patient journey look like?

The high non-attendance rate when people in this population group are referred for more specialist care results in inefficient use of specialised care appointments, and missed opportunities for timely interventions. Consideration of a more creative solution is warranted. Would a drop-in multispecialty team approach work better? (eg. mental health and drug and alcohol specialists available alongside a chronic disease physician).

The current positive experience of some members of the Health Alliance core group, coupled with the learnings from the literature review, point to considerable room for improving the care for this group. The group has developed a more comprehensive outcomes framework to guide this work.

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