

CONFERENCE ABSTRACT

Reducing unplanned hospital admissions using an electronic system for sharing anticipatory care plans between primary and secondary care

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James Marple

NHS Lothian, United Kingdom

Introduction: It is widely accepted that the demographic revolution currently underway means that the current model of care in Scotland is unsustainable. The population is aging rapidly. There is a corresponding rapid rise in the number of people affected by multiple long term conditions and general frailty.

This abstract describes an innovative approach to systematically recording anticipatory care plans for a defined population at high risk of hospitalization and ensuring that the contents of the plan are readily available across the region in both primary and secondary care at all times

Short description of change implemented: The target population for this two year project was primarily determined by data from Public Health Intelligence (PHI). It is comprised of those individuals at the highest risk of admission to hospital according to the Scottish Patients at Risk of Readmission and Admission (SPARRA) risk prediction tool developed by PHI. This computer algorithm predicts an individual's risk of unscheduled admission to hospital within the next 12 months.

The target population of over 2,000 people consists of the top 0.25% of the population of 850,000 people living in Lothian region

It also encompasses those individuals who attend the Emergency Department frequently and some direct clinician referrals.

There are 3 groups within this population

1. Younger people who attend the Emergency Department frequently (YEDFA) aged 16 to 55
2. People under the age of 75 with multiple long term conditions (LTC)
3. Frail Elderly (FE) people over the age of 75

An anticipatory care plan (ACP) is developed in collaboration with the individual person concerned following a structured interview.

The contents of the ACP are made easily available 24 hours a day to all primary and secondary care staff and the ambulance service.

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The Key Information Summary (KIS) system developed in Scotland provides the tool necessary to share the contents of the ACP across the boundaries that currently exist between primary and secondary care.

Key stakeholders involved:

1. Primary care teams (127 practices) across 4 new health and social care partnerships
2. Rapid Response Community-based services (6)
3. Secondary care teams across 3 acute hospital sites

Key findings: One key finding is that the High Resource Individuals at greatest risk of unplanned admission to hospital identified by public health intelligence data are much more likely to live in deprived areas.

Targeting clinical services towards this group can have a direct impact upon health inequalities in addition to the anticipated reduction in hospitalisation

Detailed results and analysis will be available by May 2016

Highlights: The process of implementation has highlighted the central importance of effective information sharing across multiple different silos. A significant number of people in the target population already had anticipatory care plans in place. However, before the KIS system was made available it was very difficult to effectively share such plans outside the silo in which they were developed

It has also highlighted the need to forge collaborative links with the community based rapid response services. These services can provide the desired alternative to hospital admission for those people who have had a preference for care in their own home documented in the ACP.

The PACT team has had to adapt and evolve their plans to suit the three different sub-cohorts.

The plans made with the younger people who attend the ED frequently have a markedly different emphasis compared to those made with the older people in the other two sub-cohorts

Proactive engagement has been developed using a report system that identifies in real-time those members of the cohort who are currently in the ED; those who are currently occupying an in-patient bed and those who are due to attend out-patients.

On the other hand, many of the housebound people in the target population are not able to attend appointments easily. It has therefore been essential to collaborate with the general practitioners, community nurses and allied health professionals who provide care at home for the individuals concerned.

Conclusion: If the anticipated reduction in the number of unplanned hospital admissions is realized and can be shown to be cost effective then a long term sustainable version could be developed for much larger numbers of people.

The key elements of this model could also be adapted and transferred to other settings with local modification according to circumstance.

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Keywords: anticipatory; planning; admission; alternatives; inequalities
