STAAR-SA (State Action on Avoidable Rehospitalisations and Unplanned Admissions)

Members of STAAR-SA Project Team at the Oct 2021 Forum

What is the challenge?

SA hospitals are facing escalating demand from frail older people with multiple long-term conditions who have complex health and social care needs. Current approaches to avoidable hospital admissions/readmissions in SA are fragmented. While there is evidence about strategies to improve older patients' experiences of hospital discharge and reduce hospital readmissions, they are not implemented systematically across South Australia.

STAAR-SA overview

The STAAR-SA project aims to improve pathways of care for older people aged 65 years and over after discharge from hospital. The project is funded by an MRFF Rapid Applied Research Translation (RART) grant, administered by Health Translation SA, and focuses on older people living in the community and residential care, who have had an aged care eligibility assessment and are particularly vulnerable to admission/readmission to hospital. A state-wide approach is being taken and the project is partnering with metropolitan and regional Local Health Networks, Primary Health Networks, the 3 South Australian universities, SAHMRI, aged care, government and non-government agencies and the Council of the Ageing SA. STAAR-SA consists of three programs of work (work packages) and an update on each area of work is below.

Updates from STAAR-SA Work Packages

Work Package 1: using the integrated aged care and health care data from the Registry of Senior Australians (ROSA), the project examined how often older people experience hospitalisation and emergency department (ED) presentation after an initial ACAT and what the key risk factors are. The outcome from the analysis identified that about 22% of individuals, who have had an aged care eligibility assessment (referred to as an ACAT), experience an unplanned hospitalisation within 90 days and that about 23% of individuals had an ED presentation within 90 days of their ACAT. The risk is somewhat higher in males than females and other key contributing factors are the number of recent hospitalisations or ED presentations, being frail, number of medications taken, and living in a regional/rural area. These contributing factors can help service providers identify people at high-risk and prioritise them for assistance to avoid requiring hospital-based care. Several predictors of hospitalisations and ED presentations are identified at the time of ACAT, which highlights that this is an actionable period for targeting at-risk individuals to reduce hospitalisations. The same type of analysis was done to examine how often older people experience hospitalisation or present to ED, after entering into permanent residential care. The analysis found that 18% had an unplanned hospitalisation and around 23% had an unplanned ED presentation, following permanent entry into residential care. Common risk factors include being an older male, a history of delirium, complex health and physical care needs, high use of health care services including previous hospital attendances and visits to GPs, and multiple medication use. This information could be used at the time of residential care entry, to identify high risk individuals and inform care planning. Further information can be found in the two attached publications.

Work Package 2: evaluating the cost-effectiveness of programs/services that patients, who have had an ACAT, may be accessing and comparing this with a control group from the ROSA data. A selected out-of-hospital service from each metropolitan Local Health Network, is being evaluated and the pathways of patient care for each program will be documented. The results of this analysis will be available mid-2022.

Health Translation SA is a NHMRC accredited Advanced Health Research and Translation Centre that aims to accelerate the translation of research along the impact pathway to improve health outcomes for South Australians. It has nine Partners.

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Chrissie Isaksson, QIC Network Manager, and members of the STAAR-SA QIC Teams, at Learning Session 3, held in June 2021

Work Package 2 (update continued)

In addition to the health economic component and to gain insight into the consumer perspective, the Council of the Ageing (COTA SA), through their Plug-in initiative, undertook interviews with consumers and/or carers, who have used these out-of-hospital services in the past 12 months. Overwhelming, each service was highly valued by clients and/or family members and carers. Key themes to emerge from the interviews were around a highly skilled workforce that was trusted, knowledgeable and caring.

The participants highlighted the importance of having access to a single point of contact, which facilitated the continuity of accurate information and follow-up.

Work Package 3: this program of work involved the establishment of Quality Improvement Collaborative (QIC). Local health network clinicians, aged care providers and other cross-sectoral stakeholders, came together to learn, share and benchmark outcomes with the goal of increasing the quality of care for older people at times of transition. Nine QIC teams were formed to test ideas using a 'proof of concept' approach that had the potential to reduce unplanned admissions and re-presentations for older people. The QIC teams met for three learning sessions held over 6 months, with the first session focussing on quality improvement methodology, identification of initiatives for teams to test and project planning. The second learning session provided an opportunity for the QIC teams to share their progress to date and the final learning session focussed on the outcomes, evaluation and sustainability.

Initiatives undertaken by QIC Teams:

- **Virtual Support Pilot** (SALHN, NALHN and CALHN joined to form 1 team) - to reduce unplanned admissions/re-presentations to hospital for residents of residential aged care facilities (RACF) who are at imminent risk of hospitalisations
- **NALHN GEM2RACF** - improving transition from hospital to RACF for patients with 'challenging behaviours' due to Behavioural and Psychological Symptoms of Dementia (BPSD)
- **SALHN EOLC** - improving End of Life Care planning for patients transitioning from hospital to residential care for the first time
- **SALHN Home Rehab** – reducing unplanned up-transfers for patients on home rehabilitation
- **CALHN Hospital to Home** ('There's something missing in the middle') - improving transition from hospital to home for patients at high risk of representation due to their non-clinical care needs
- **SA Pharmacy High Risk Medication Review** - improving identification of patients at risk of re-presentation to hospital due to high-risk medications, and developing pathways to facilitate medication review in the community
- **Country Virtual Clinical Care Service** - improving identification and monitoring of consumers receiving community home care packages who are at risk of presenting/re-presenting to hospital due to their chronic condition or functional decline

Many of the above initiatives have transitioned into 'business as usual' or been used to inform system design changes to support improved transitions of care from hospital to home, both in the community and in residential aged care facilities.

The STAAR-SA Forum attendees listening to Betty's story at the beginning of the event

Work Package 3 (update continued)

An evaluation of the QIC process was undertaken using a mixed methods approach and the results indicated that it was a very positive activity in terms of building a network across organisations and progressing quality improvement projects which aimed to achieve the same overall goal. In addition, most participants reported that they were probably likely or definitely likely, to maintain the relationships they had developed through the QIC process, after the project ended.

STAAR-SA Forum- October 2021

In October, the STAAR-SA Project Team, in partnership with Health Translation SA and Wellbeing SA, facilitated a forum, which was held in the SAHMRI auditorium. The aim of the event was to share the progress of the STAAR-SA project to date, plus showcase related health service and policy delivery aiming to improve out-of-hospital care for older South Australians. The event began by hearing from Betty, a consumer who shared her experience by video, about being discharged from hospital late at night and sent home via a taxi to an empty house when she wasn't feeling well enough to return home. Her story 'set the scene' and highlighted the need for this important work being undertaken through the STAAR-SA project.

The event consisted of presentations and stimulating panel discussions. The presentations included findings from across the 3 STAAR-SA programs of work and other aligned state-wide work such as the Wellbeing SA Integrated Care Strategy, future approaches to health care using digital and virtual care services, and comparison data between SA and other states on the aged care and hospital interface. There were two panel discussions, one with a focus on improving connections across sectors and hearing from panel participants about new initiatives being undertaken to keep older people out of hospital. The second panel discussion considered where to next, with a focus on aged care and potential opportunities for partnerships and future work.

There was an excellent turnout for the event with a diverse and wide range of sectors represented in the audience, including consumers. The high attendance showed that there is a real interest in learning more about current hospital avoidance initiatives and supporting older people at times of transition. The Forum provided a strong platform for informing the planning of the final stages of the STAAR-SA project and follow-up initiatives in this important area of health and aged care.

A summary of the Forum will be circulated in the new year and the STAAR-SA Project is due to be completed by the end of June 2022.

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