The Role of Community Geriatrics in Avoiding Hospital Admissions

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Structure of the talk

- Increase in hospital admission rate.
- Review of current evidence base for admission avoidance schemes.
- Present services available through Mid Yorkshire NHS Trust.
- Future improvements.
Increase in Emergency admissions

- The number of emergency admissions in England rose by 11.8% over the five year period (2004/05 to 2008/09).
- Mid Yorkshire 2010/11 - 3.5% growth in A&E attendance and 4.4% increase in emergency admission.
- Wakefield a significant outlier in terms of attendances per ‘000 population.
- Significant variations between NHS Trusts.
- Significant variations between primary care trusts.
- Significant reduction in bed base @ pinderfields.
- No clear link between deprivation and the rise in emergency admissions.
Increase in Emergency admissions

- High emergency admissions due to acute exacerbation of one or more long term condition.
- Incidence of chronic disease increases with age.
- Hospital presentation by the over 75 years are growing 20% per annum.
- People over 85 years nearly ten times more likely to have emergency admission compared to 20s, 30s, 40s.
- Half of hospital beds are occupied by the people aged >65 years.
- Patient preference to stay at home/care near home
NEED STRATEGIES TO REDUCE HOSPITAL ADMISSIONS-evidence based, right time, right person, right way
Case management
Crisis resolution teams
Intermediate care
Telehealth
Team-based interventions in A&E
Pro active management of long term conditions.
Example in England- successful

- Torbay- recent research has shown a reduction in the use of acute hospital beds, lower than expected emergency admissions for the population aged 65 and over, and minimal delayed transfers of care.

- Achieved through a long term commitment to integration (health and social)

- Teams are aligned with GP practices and work within a single budget that enables resources to be pooled and used flexibly.
Kaiser, Ever Care and Pfizer approaches

- All of these models include some form of case management
- Kaiser focus on integrating organisation and discipline.
- Evercare model target people at highest risk
- Some evidence to suggest improved quality of life, and fewer hospital admissions and days spent in hospital.
- Models formally trialled in PCTs in England.
- Case studies suggest some positive benefits in Kaiser Model
Patient pathway

Person in community → A&E → Inpatient care → Discharge → Person in community

Community geriatrics to reduce hospital admissions
Current services through Community Geriatrics
Mid Yorkshire NHS Trust

- Telephone advice.
- Receive phone calls form GP/other health care professionals- admissions/not, divert care appropriately, follow up
- Wednesdays (Dr. Razik), Fridays (Dr. Stanners) other days Dr. Grimshaw as available.
- Community secretary – 01924 542481 If you want to speak to a consultant otherwise-
For DVs the referral letter should be faxed to single point of contact. There phone number is 01924 327591. Fax- 01924 327590

All referrals to SPOC

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SPOC phone number is 01924 327591.
Fax- 01924 327590
Domiciliary visit

Domiciliary visit referral requests

Faxed to SPOC

SPOC fax to community secretary at Mid Yorkshire

Confirmation to GP with time and date of DV

Consultant perform DV
Domiciliary visits case examples

- Mrs. SE. Urgent referral. 84F, From NH, PMH-Chronic kidney disease, type 2 DM, Hypothyroidism, Hypertension, recurrent UTI and Dementia.

- “Becoming slightly less responsive, and generally not her self”. Haemodynamically stable.

- Domiciliary visit- treatment for UTI, subcutaneous fluid with community team, repeat bloods with DN, OPA USS pelvis.

- Recovered, remained in NH.
Mr. TH. 81F. From NH

- Known vascular dementia, CKD stage-3, OA.
- “Unusual type of twitching movement of his mouth”.
- DV review- Possible tardive dyskinesia (orofacial), side effect of medications.
- Medications adjusted, better, remained in NH.
- Mr. TJ. 88F.NH. Known patient with Alzheimer’s dementia, COPD.

- “General deterioration, rigidity, ?Parkinson’s need treatment”.

- DV- Comprehensive assessment- End stage Alzheimer’s dementia.

- Palliative approach, not for PD medications, other in appropriate medications stopped, for dietician and SALT in put. Not for hospital admissions, Discussion with NH staff and family to keep in care home.
Mrs. LR. 81F. At home. Known angina, asthma, and hypertension.

Recent A&E admission with ? Fall- fracture radius and ulna.

“Dizziness, no postural hypotension”.

DV review- Vertebro-basilar insufficiency due to ?spondylosis. MRI OPA- Multilevel degenerative disk disease in the cervical spine with apparent cord encroachment.

Analgesia, education, referred to Neuro surgeon for opinion.
Community team

- My therapy
- Community matron/nurses
- Subcutaneous fluid/IV therapy team
- Rapid response team
Elderly in reach service (Hospital)

- Early assessment of elderly admissions.
- Comprehensive geriatric assessment
- Early MDT input
- Discharge planning
- Coordinating services.
Intermediate care bedded facilities

- Three units- Queen Elizabeth house (Wakefield), Monument house (Pontefract), Kings dale unit (Wakefield).
- Currently step down facility
- Regular input by Community Geriatrician
- Work closely with hospital and community
Future developments to reduce hospital admissions

- Identify high risk admissions - Risk assessment tools
- PARR (Patient At Risk of Readmission)
- EARLI (Emergency Admission Risk Likelihood Index) to identify those aged 75 years or over who are at risk of admissions.
- Refer – input by MDT, nursing, geriatrician
Community Virtual ward

- MDT, Community Geriatrician in put
- Use of clear criteria
- Use of risk modelling tool to identify at high risk of admissions
- Potential to be cost effective
- Evidence
Geriatrician in A&E

- Some evidence - early senior review reduce hospital admissions.
- Comprehensive assessment
- Discharge planning
- Follow up domiciliary visit
Follow up visit

- Some evidence to support follow up visit by a doctor within 30 days of discharge reduce readmission rates.
- GP/Geriatrician
- Identify high risk category
- Improve transition of care-communication
- Single point of contact
Pro active case management
(Primary care transformation scheme)

- COPD, heart failure
- Mental health - (Torbay)
- More integration with Community Geriatric service
Step up care

- Step up admissions to intermediate care units eg dovecote.
- GP beds
- Input by community Geriatrician
Care home services

- Advance directive
- Medication review
- Falls
- Dementia
- High standards in care home-teaching, training
References


Thank you.