

Partnerships in Health

HARP falls prevention service

History of HARP

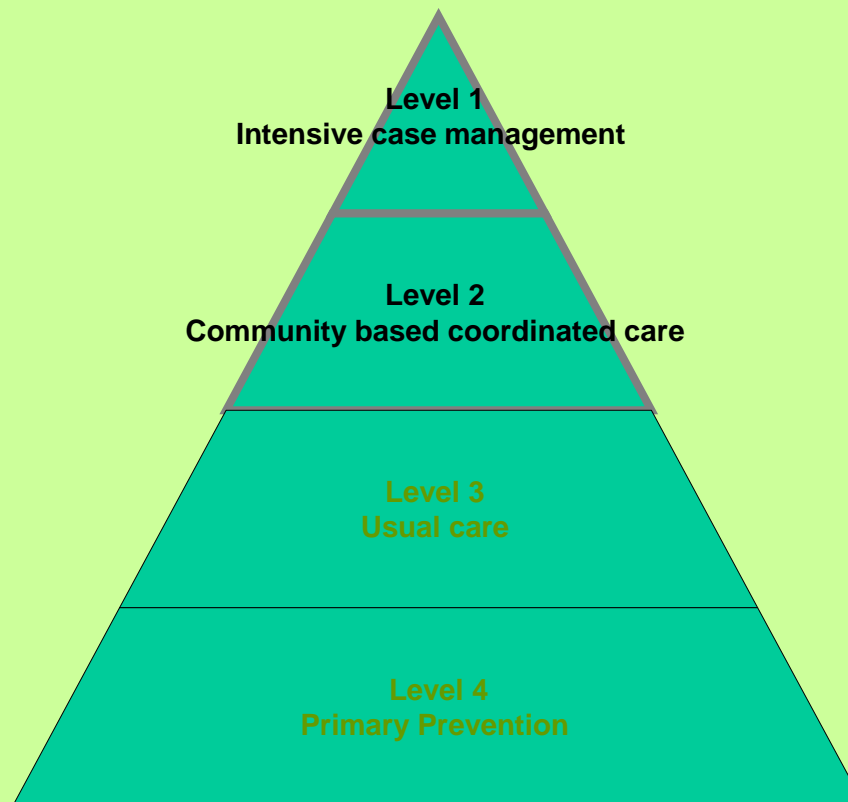
- To provide services for people with complex and chronic conditions who are at risk of frequent hospitalisation
- Aims to improve health and social outcomes and reduce hospital demand
- Developed as part of the hospital demand management strategy in 2003
- Pilot programs mainstreamed in 2006

Partnerships in Health (PIH)

- Doutta Galla Community Health Service
- Melbourne Division of General Practice
- Melbourne Health
- Moreland Community Health Service
- RDNS



DHS levels of chronic and complex management



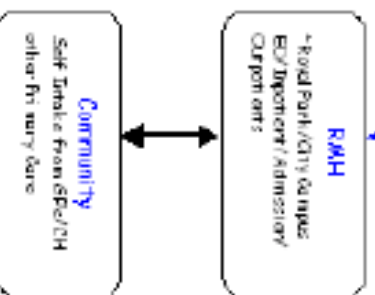
HARP CDM SERVICE COMPONENTS

- Chronic Respiratory: Asthma, Melbourne Easy Breathers (COPD)
- Chronic cardiovascular: Heartwise, Cardiac coach
- Medication Management outreach pharmacy
- Psycho-social support services: psychology, ED frequent attendees
- Chronic and complex care needs: Falls prevention, Service co-ordination/ case management –acute and community
- Diabetes

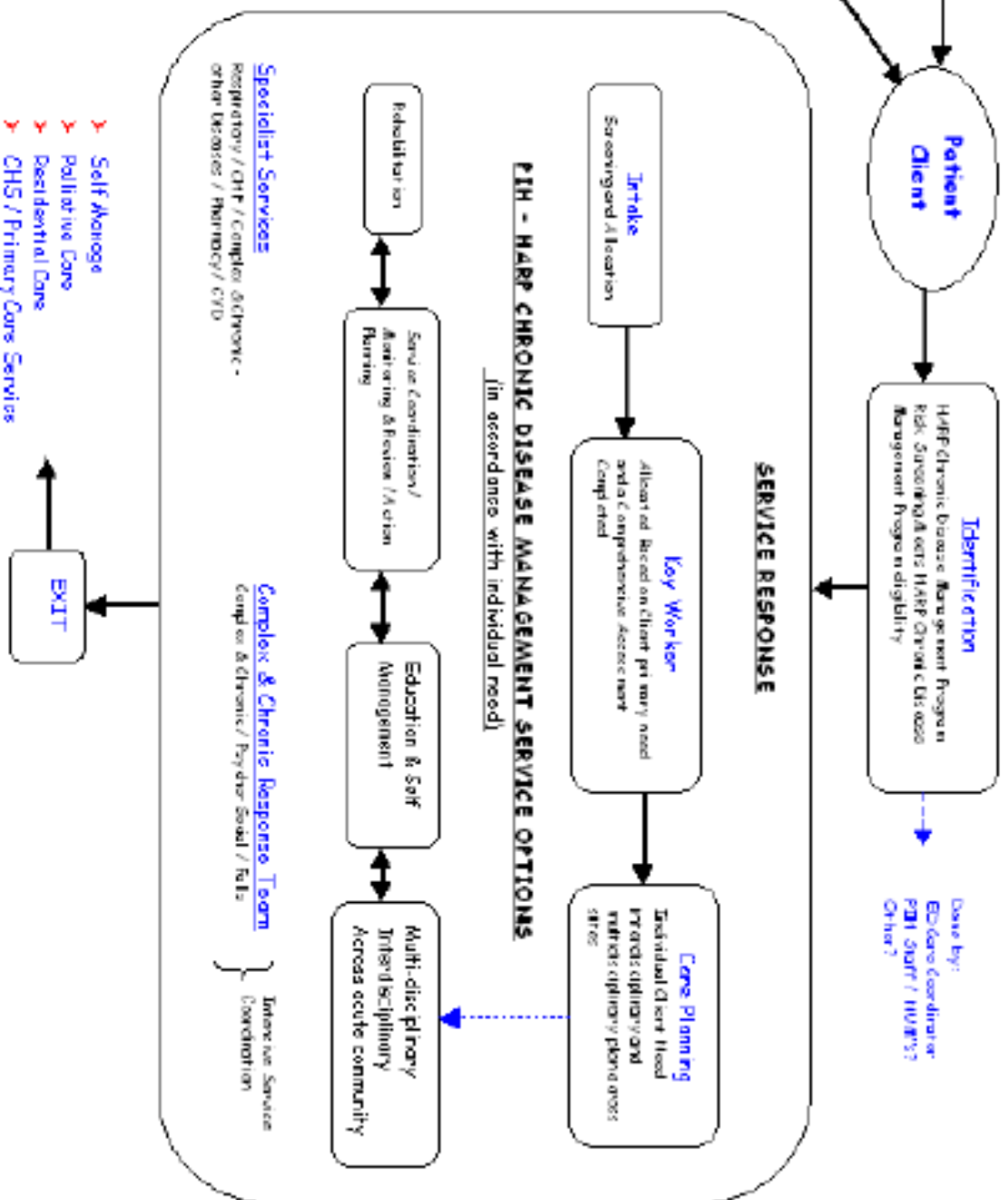
Eligibility Criteria

Service	Eligibility Guide
Diabetic foot	PVD, Peripheral neuropathy, foot ulcer
Cardiac coach	Cardiology admission for heart attack/surgery
Heartwise	LVF and admission for heart failure in last 12/12
Melbourne Easy Breathers	Mod-severe COPD on RFT, SOBOE,
Falls prevention	Fall related admission/presentation to ED in last 12/12
Psycho-social	Complex psycho-social needs (homelessness, mental health issues) with frequent ED presentations
Psychology	
Service co-ordination/ case management	Complex needs requiring interim case management

REFERRAL POINTS



CLIENT FLOW



Falls Prevention Program

- Attendances at RMH ED reviewed March 2000- February 2002 indicated 1000 presentations annually with 'falls' in triage description. Almost 50% admitted. Average age 80.
- Outreach falls service established in Oct 2002

Outcomes of pilot

- Reduction in falls and risk injury profiles
- Reduction in falls efficacy scores
- Reduction in falls related injury scores
- Reduction in risk of admission
- Reduction in risk of ED presentation
- Improvements on AQoL

Current Falls program staffing

- CHN 0.5 EFT
- Physiotherapist 1.7 EFT
- OT 0.5 EFT
- AHA 0.7 EFT
- Access to HARP psychologist, interim case mangers and other programs
- Managed by senior clinician and HARP program manager

Current service

- Initial assessment (home visit) within 24 hours of referral for urgent clients or 5 days for non urgent
- Action plan developed and implemented
- Aim to exit client from program within 6-12 months
- Option of exercise/education group program

Group program

- 8 clients or less, supervised by 3 staff
- Attend weekly for 8 weeks
- 2 hour session
- Education includes medication management, podiatry, psychology and links to community services
- Clients assisted to transition to community based group



Falls and the chronic disease model

- Chronic disease is a more important predictor for falls than polypharmacy
- Clients often have complex health and social needs
- Emphasis on exercise and self management strategies

Future direction

- Working towards an integrated falls service with other regional providers
 - MCHS
 - DGCHS
 - CTS
 - Falls and balance and vestibular clinic

Future Direction

- Geriatrician input
- Increased engagement of GP's in care planning
- Servicing residential care fallers
- Working with PCP and other stakeholders to promote physical activity for people with chronic disease
- Trial of InterRAI tool