Case Management of high-risk and vulnerable patients to prevent avoidable hospitalisations in Cairns – a case series highlighting the achievements and lessons learned.

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Abstract
Far North Queensland has an excess burden of repeated and avoidable admissions (often for exacerbations of chronic and complex conditions) among a relatively small cohort of high-risk patients. A pilot program in Cairns [the “CBH Hospital Avoidance Program” (HAP)] where 68 patients were intensively case managed by two Registered Nurses over a two-year period (2009-12) showed a 45% reduction in ED presentations, a 60% reduction in hospital admissions, a mean reduction in average length of stay of 4.6 days per patient and 1,610 total bed-days avoided.

In 2014, the Hospital Avoidance Program was redesigned and extended with additional resources such as Registered Nurses and Aboriginal Health Workers specifically trained in complex case management. High-risk patients with chronic conditions (including angina, asthma, COPD, CCF and diabetes) are identified from Cairns Hospital EDIS and HBCIS data and undergo a comprehensive social and health needs assessment performed by a dedicated Case Manager, completed at hospital or at a home visit immediately after hospital discharge. The Case Manager then helps the participant access health and other services in the community, assist in attending medical appointments and answer questions about medication and other health-related issues. Information is shared with the patient’s GP and/or other local health services. The contact is provided on an ‘as needed’ basis to ensure the patient achieves maximal independence and self-management at home.

We would like to present a series of case studies highlighting the achievements and lessons learned from this program.