SOME REFERENCES ON COMMUNITY BASED CARE and ADMISSION AVOIDANCE and INTEGRATED CARE / OUT OF HOSPITAL CARE

CONTENTS

Greg Dropkin on Warrington, St Helens, West Cheshire and Liverpool – ACOs & MCPs

http://www.labournet.net/other/1703/stpaco2.html

Evidence?

The NHS is supposed to deliver evidence-based medicine, clinicians are educated on that basis, and new treatments are only licensed after passing rigorous trials and cost-benefit analysis. What's the point to medical school or nurse training if evidence is tossed overboard?

The St Helens plan purports to list evidence for each of their plans. None of it is referenced. For example "Stand alone telephonic case management has been estimated to reduce admissions by 5%." Says who? The Nuffield Trust (pp85-6) says there is mixed evidence on case management. Research at the University of Manchester published in 2015 is entitled "Effectiveness of Case Management for 'At Risk' Patients in Primary Care: A Systematic Review and Meta-Analysis". From the abstract (https://www.ncbi.nlm.nih.gov/pubmed/26186598):

This was the first meta-analytic review which examined the effects of case management on a wide range of outcomes and considered also the effects of key moderators. Current results do not support case management as an effective model, especially concerning reduction of secondary care use or total costs.

St Helens says "Social prescribing has saved Newcastle West CCG an estimated £2 - £7 million". This is actually the Ways to Wellness programme (http://www.newcastlegatesheadccg.nhs.uk/nhs-in-newcastle-commits-1-65m-to-improve-long-term-health-conditions/) which started in 2015 and runs for 7 years. It hasn't been evaluated yet. Nuffield (p95) describes it as a "large scale trial". The actual savings it will achieve are, at this stage, only projected.

Warrington says "Evidence shows that proactive planning using risk stratification is a key tool to improving outcomes". Again, no reference for that. The Nuffield review (pp87-9) found risk stratification tools still struggle to identify 'at risk' individuals at the point before they deteriorate. A virtual ward is a model of home-based multidisciplinary care based on the idea of a hospital ward. Intended to avoid emergency admission or readmission, patients are typically identified using a risk stratification tool. As Nuffield reported, an evaluation of three NHS virtual wards targeting patients at risk of admission found no reduction in emergency hospital admissions in the six months after admission to the ward, but it did find a decrease

in elective admissions and outpatient attendances. There was no reduction in overall hospital costs.

Overview on proposition that there are alternatives that can replace hospital care
NHS For Sale: Myths, Lies & Deception. Jacky Davis, John Lister, David Wrigley. 2015 pp 44-47- Are alternatives any cheaper? Do they even work? [references in book] http://keepournhspublic.com/ Monitor. Moving healthcare closer to home: a summary **It is difficult to cut costs across a local health economy in the short run** Although schemes can help hospitals avoid future capital spending, it is difficult for local health economies to save costs in the short run through community-based schemes. Three of the four schemes we modelled did not break even within five years. This is because: • Schemes can take up to three years to set up, recruit and become sufficiently credible to attract referrals. So providers and commissioners should not expect immediate impacts. • Even when schemes are cheaper per patient, it may be difficult for the local health economy to realise any savings. A local scheme (or schemes) will only lead to health economy-wide savings if it consistently diverts enough patients from local acute hospitals to allow them to close bed bays or wards. The cost saving is then only realised if providers and commissioners have the will to close down capacity that is freed up. In the context of rising demand for acute care, commissioners and providers will need to be entirely confident that community-based schemes can safely absorb expected extra demand before they will feel justified in closing acute capacity. However, community-based schemes will help commissioners and providers to avoid or delay future capital spending whether acute capacity is closed or not. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459400/moving_healthcare_closer_to_home_summary.pdf
Is there evidence for community based care reducing hospital admissions safely?
Effect of an Intensive Outpatient Program to Augment Primary Care for High-Need Veterans Affairs Patients – A Randomized Clinical Trial. JAMA, December 2016 **Question** Does an intensive outpatient program for high-need patients change utilization patterns and reduce costs in an integrated setting with a patient-centered medical home? **Findings** In this randomized clinical trial of a Veterans Affairs intensive outpatient care program, the intervention was well received by a random sample of high-risk and high-cost patients but achieved reductions in hospitalization rates and costs similar to those of usual Veterans Affairs primary care. **Meaning** Implementing intensive outpatient care programs in integrated settings with well-established medical homes may not prevent hospitalizations or achieve substantial cost savings. http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2594282
David Oliver. Preventing hospital admission: we need evidence based policy rather than “policy based evidence”. BMJ September 2014; http://www.bmj.com/content/349/bmj.g5538

"In July 2014 commissioners throughout England published projections for reductions in urgent admissions to their local hospitals.1 But the size and speed of these reductions were not informed by any credible peer reviewed evidence—they rarely are.

Recent reviews by the Universities of Cardiff and Bristol on admission prevention and by the health think tank the Nuffield Trust on new models of service in the community, found that the big and rapid reductions were illusory, once the findings had been peer reviewed and control data taken into account." [other references in article]

Roland M, Abel G 2012. Reducing emergency admissions: are we on the right track? BMJ 2012;345;e6017, 16 September 2012
http://www.bmj.com/content/345/bmj.e6017 - [further 22 references in article]

"*Most admissions come from low risk patients, and the greatest effect on admissions will be made by reducing risk factors in the whole population... even with the high risk group, the numbers start to cause a problem for any form of case management intervention - 5 percent of an average general practitioners list is 85 patients. To manage this caseload would require 1 to 1.5 case managers per GP. This would require a huge investment of NHS resources in an intervention for which there is no strong evidence that it reduces emergency admissions."* [thanks for finding, Greg Dropkin]

http://www.biomedcentral.com/content/pdf/1744-8603-9-43.pdf Does investment in the health sector promote or inhibit economic growth?

http://www.hsj.co.uk/Journals/2014/11/18/l/q/r/HSJ141121_FRAILOLDERPEOPLE_LO-RES.pdf Commission on hospital Care for Frail Older People HSJ and Serco

S Purdy. Interventions to reduce unplanned hospital admissions. 2012. A series of systematic reviews of 18000 studies and includes a very handy two page summary of evidence.
http://www.bristol.ac.uk/primaryhealthcare/researchpublications/researchreports/

*"**Background:** The overall aim of this series of systematic reviews was to evaluate the effectiveness and cost-effectiveness of interventions to reduce UHA* [unplanned hospital admission]*. Our primary outcome measures of interest were reduction in risk of unplanned admission or readmission to a secondary care acute hospital, for any speciality or condition. We planned to look at all controlled studies namely randomised trials (RCTs), controlled clinical trials, controlled before and after studies and interrupted time series. If applicable, we planned to look at the cost effectiveness of these interventions."*
*"**Conclusions:** This review represents one of the most comprehensive sources of evidence on interventions for unplanned hospital admissions. There was evidence that education/self-management, exercise/rehabilitation and telemedicine in selected patient populations, and specialist heart failure interventions can help reduce unplanned admissions. However, the evidence to date suggests that majority of the remaining interventions included in these reviews do not help reduce unplanned admissions in a wide range of patients. There was insufficient evidence to determine whether home visits, pay by performance schemes, A & E services and continuity of care reduce unplanned admissions."*

[See below for further extracts on individual areas reported on]

Effect of targeted intervention to population 'at risk' of admissions

http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/red_cross_research_report_final.pdf The effect of the British Red Cross 'Support at home service" on hospital utilisation. Nuffield Trust

"We analysed data on hospital use in the six months after referral to Support at Home. The Red Cross group had a 19% higher rate of emergency admissions than the control group. Accident and emergency visits were also similarly higher. Nonemergency admissions, however, were 15% lower in the Red Cross group than in the matched control group. There was no significant difference between the two groups in terms of outpatient attendances." [extract from executive summary]

On Integrated care

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf The reconfiguration of clinical services: what is the evidence? Kings Fund. Candace Imison

http://www.nuffieldtrust.org.uk/sites/files/nuffield/evidence-base-for-integrated-care-251011.pdf

http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0005/81266/BP-08-1210-035.pdf

On impact of social care

David Oliver president, British Geriatrics Society, and visiting fellow, King's Fund.
We cannot keep ignoring the crisis in social care. BMJ May 2015;
http://www.bmj.com/content/350/bmj.h2684

http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2594282

Intermediate-based Care

http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf

Executive summary begins: "Intermediate care and re-ablement services are a key plank of government healthcare policy to provide health and care closer to home."

David Oliver. BMJ. Improving access to intermediate care
http://www.bmj.com/content/356/bmj.i6763

Telephonic case management

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Tony O’Sullivan, with addition by Brian Fisher 2 October 2015

S Purdy (2012) **Interventions to reduce unplanned hospital admissions** which is a series of systematic reviews of 18000 studies and includes a very handy two page summary of evidence.

http://www.bristol.ac.uk/primaryhealthcare/researchpublications/researchreports/

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Executive summary of findings under individual categories

Overall **case management** did not have any effect on UHA although we did find three positive heart failure studies in which the interventions involved specialist care from a cardiologist*"*

"specialist clinics for heart failure patients, which included clinic appointments and monitoring over a 12 month period reduced UHA. … There was no evidence to suggest that specialist clinics reduced UHA in asthma patients or in older people."

Community interventions: Overall, the evidence is too limited to make definitive conclusions. However, there is a suggestion that visiting acutely at risk populations may result in less UHA e.g. failure to thrive infants, heart failure patients.

Care pathways and guidelines: There is no convincing evidence to make any firm conclusions regarding the effect of these approaches on UHA, although it is important to point out that data are limited for most conditions.

Medication review: no evidence of an effect … in older people, and on those with heart failure or asthma carried out by clinical, community or research pharmacists … the evidence was limited to two studies for asthma patients.

Education & self-management: Cochrane reviews concluded that education with self-management reduced UHA in adults with asthma, and in COPD patients but not in children with asthma. There is weak evidence for the role of education in reducing UHA in heart failure patients.

Exercise & rehabilitation: Cochrane reviews conclude that pulmonary rehabilitation is a highly effective and safe intervention to reduce UHA in patients who have recently suffered an exacerbation of COPD, exercise based cardiac rehabilitation for coronary heart disease is effective in reducing UHA in shorter term studies, therapy based rehabilitation targeted

towards stroke patients living at home did not appear to improve UHA and there were limited data on the effect of fall prevention interventions

Telemedicine is implicated in reduced UHA for heart disease, diabetes, hypertension and the older people.

Vaccine programs: … the effect of influenza vaccinations on a variety of vulnerable patients. A review on asthma patients reported both asthma-related and all cause hospital admissions. No effects on admissions were reported. A review on seasonal influenza vaccination in people aged over 65 years old looked at non-RCTs. The authors concluded that the available evidence is of poor quality and provides no guidance for outcomes including UHA. A review on health workers who work with the elderly showed no effect on UHA.

Hospital at home: This was a topic covered by a recent Cochrane review of hospital at home following early discharge. Readmission rates were significantly increased for older people with a mixture of conditions allocated to hospital at home services.

We found insufficient evidence (a lack of studies) to make any conclusions on the role of finance schemes, emergency department interventions and continuity of care for the reduction of UHA.