

Mapping health service utilisation and health information exchange for people with disability living in supported accommodation

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BACKGROUND

Many people with intellectual disability (ID) need assistance to access health care, and may not be able to effectively communicate regarding their health needs. Approximately one quarter of this cohort live in supported accommodation. Disability service organisations providing this support play a role in ensuring care is accessed appropriately.

However, we do not know:

1. What health services are currently utilised by this population;
2. The impact of supporting health service access on the sustainability of the organisation; or
3. The level or quality of health information exchange occurring to support care coordination.

With reforms occurring in both health and disability sectors, it is critical that we develop the evidence base to inform policy, and develop solutions to better meet the needs of this vulnerable population.

METHOD

A web-based surveillance tool was developed in REDCap, with feedback from a steering group comprising of organisational representatives, clinicians, and policy makers from the health and disability sectors. The survey included targeted questions for each occasion of service relating to the type of health service accessed, how the client was supported to access the health service, and quality of health information communicated between the organisation and the health service.

The survey was implemented in six partner disability service organisations providing accommodation support to people with disability of moderate to complex functional impact in Perth, Western Australia. Data will be collected until December 2020. Organisation-specific codes are used to deidentify client data, and to provide quarterly reports to each organisation for planning and quality improvement purposes.

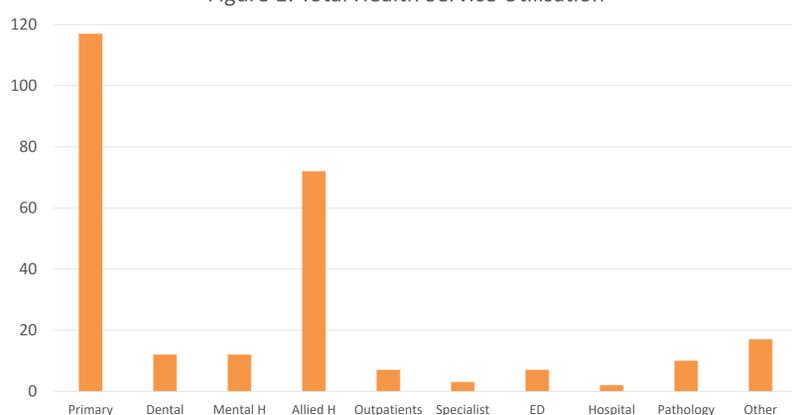
The University of Western Australia HREC provided approval for this study.

RESULTS and DISCUSSION

Given the different structures and clientele of each of the six organisations, an implementation approach with pragmatic decision-making and on-going support was taken, to ensure the quality of the data collected. As such, the processes and scale of data collection varied between organisations, with three organisations choosing to collect data from a sub-set of their client base.

Preliminary data highlight the varied utilisation of health services. Data presented relate to a typical month for one organisation providing services to 101 clients across four geographical areas (Figure 1).

Figure 1: Total Health Service Utilisation

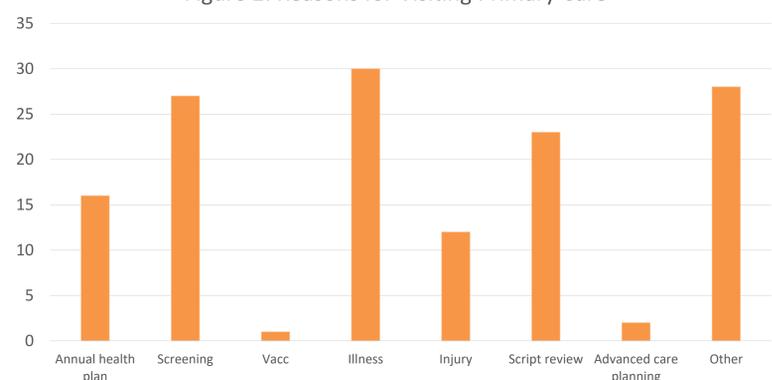


Within the organisation, the average level of service events per client varied between geographical regions (2.1–3.2), although 17 clients accessed services five or more times. Typically (96%), clients attended the health service with a support worker or other staff member in the organisation. At times, an additional support worker was brought in to back-fill the staff member supporting the client, totalling 16.7 unfunded days across the organisation for the period, with 54% from one geographical area alone. When there was need to contact the medical guardian, there was an additional impost on managerial time. While taking 15 minutes on average, in practice this equated to 2.3 days in the highest service use area.

Organisations generally provide transport for their clients to access health services, either by organisation vehicles (68%), or by a staff member's car (5%). Provision of transport together with the temporary redeployment of staff also impacts other clients, with approximately 25% of service events resulting in lost opportunity for other clients' planned activities.

An analysis of the reasons for primary care service utilisation (Figure 2) highlights a proactive response by the organisation, with 48% of primary care service events including annual health checks, other screening, vaccination, and reviews of medication. In contrast, only 30% was reacting to illness or injury.

Figure 2: Reasons for Visiting Primary Care



Primary care appointments often require follow-up support by the organisation. More than 40% of service events resulted in referrals (e.g. to medical specialists, allied health, or pathology), and 42% resulted in changed medication regimes.

The exchange of health information was not optimal. For primary care visits, a health summary was provided to the clinic at 70% of service events, with the staff member or client with disability providing verbal information 75% or 10% of the time respectively. In return, the organisation received either written or verbal information from the clinic 31% or 28% of the time respectively.

CONCLUSION

While there have been challenges in implementing the survey, there is support within organisations because of the benefit of regular reporting targeted towards their planning and quality improvement needs. For example, the variance between geographical areas highlights the need to examine processes and staffing requirements to support high service users.

Preliminary data are presented here, however the collective dataset provides opportunity to move beyond the anecdotal evidence to identify key interface issues to target with any intervention. The data will also inform the development of solutions and business models tailored to better meet the health needs of this vulnerable cohort.

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For the health and wellbeing of people and communities in need.

